Responding to a proposal for merger or reconfiguration of Maternity Services Provision in Northern Ireland

A GOOD PRACTICE GUIDE

The Royal College of Midwives

KEY CONTENT

KEY QUESTIONS

- Why is the reconfiguration proposed? (P.5)
- Does it fit with the framework for the provision of services? (P.5)
- What are the objectives to be achieved? (P.6)
- Do the proposals meet the best practice? (P.6)
- Is the reconfiguration influenced by financial pressures? (P.6)
- Will the reconfiguration be clinically led and evidence-based? (P.6)
- Will there be a public consultation? (P.7)
- How will the reconfiguration affect other aspects of the service? (P.7)
- Have education and training needs been taken into account? (P.7)

KEY PRINCIPLES

- Quality (P.8)
- Accessibility (P.9)
- Physical capacity (P.9)
- Home births (P.10)
- Stand-alone midwife-led units (P.10)
- Co-located MLU (P.11)
- Obstetric units (P.12)
- Workforce capacity: midwives (P.13)
- Workforce capacity: obstetricians (P.15)

PREPARING YOUR RESPONSE

- Identify the issues (P.16)
- Talk to stakeholders (P.16)
- Engaging with politicians (P.16)
- Media interest (P.17)
- Responding to the consultation (P.18)

FURTHER RESOURCES

- Policy documents (P.18)
- Reports and strategy documents (P.18)
- Other staff groups (P.19)
- Local maternity services user groups (P.19)
- Politicians (P.20)
- Royal College of Midwives (P.20)

EXECUTIVE SUMMARY

This document is for Royal College of Midwives (RCM) regional/national officers and RCM activists. Its aim is to help them respond professionally and constructively to proposals for mergers or reconfigurations of maternity services. The outcome of which is intended to ensure services of the highest quality are provided for women and their babies.

Any proposal for the merger or reconfiguration of a maternity service should help deliver a service to women which will comply with relevant policy for maternity services (section 2).

RCM activists faced with a proposed merger or reconfiguration of a maternity service should seek answers to a range of key questions (section 2);

- Why is the merger or reconfiguration proposed?
- The purpose or rationale – is it clearly explained?
- Does the proposal fit within the relevant policy for maternity services?
- What are the objectives to be achieved?
- Is there more than one option which might meet these same objectives?
- Do the proposals meet national standards of best practice?
- To what degree is the proposal based on financial pressure and is the case for cost savings proven?
- To what extent has the proposal been clinically led and to what extent are assumptions within it evidence based?
- To what extent will there be public consultation?
- To what extent has there been user involvement in the development of maternity services to date?
- Have education and training needs been taken into account?

RCM activists should consider some key principles when considering proposals for service merger or reconfiguration (section 3);

- There has to be adequate physical capacity to deliver the service both in hospital and in the community. This capacity has to take into consideration the policy driver of choice and the need for women to transfer from one model of care to another.
- Homebirth should be a genuine choice for women and the service model must take into account the need and ability for safe and speedy transfer in an emergency.
- There is no recommended minimum or maximum activity for a midwifery led unit. Their financial viability will be affected by staffing models and by the activity undertaken, particularly in terms of the number of women who birth there. Their cost effectiveness should be looked at as part of a total package of service delivery.
- Standalone midwifery led units and home births must be marketed positively to women who may not be aware of the services they offer.
- Standalone and alongside midwifery led units are safe where the selection criteria and practice guidelines are agreed by the multidisciplinary team and formally audited on a regular basis. When accessed by appropriate women this can lead to reductions in medical interventions, increased breastfeeding rates and higher levels of maternal satisfaction. Alongside midwifery led units must however be safely staffed and must not become an over flow facility for high risk women or women requiring epidurals.
- There is no recommended minimum or maximum activity for an obstetric unit however the RCM and the RCOG question how an obstetric unit delivering over 6000 births a year can deliver personalised care and the RCOG has advised that units over 8000 births a year are potentially less safe and will not necessarily save costs as they will require staffing by two teams of obstetricians.
- The assumption that the closure of a hospital A&E and associated emergency services should automatically result in the closure of an obstetric unit should be tested. The number of women who may be put at risk should be assessed and alternative ways of managing women at expected risk and unexpected emergencies should be explored. New ways of managing care in the face of a changing workforce should be explored.
- The recommended minimum midwife to women staffing ratio across a maternity service offering a full range of choices is 1:28. Adequate numbers of support workers should be in place to ensure the midwifery time is not spent on administrative tasks. In the postnatal period maternity support workers can support midwives to provide high quality care but cannot undertake the role of the midwife.

Guidance is given to activists as to the preparation of their response and resources that are available to support them (sections 4 and 5).

Introduction

This guide provides a framework, rationale and advice to assist RCM regional/national officers and local maternity service activists to respond to a proposed merger or reconfiguration of their local maternity services.

The guide is based on current policies, good practice advice and experience from those who have been through similar exercises. The principles set out below should be viewed within the context of the RCM's purpose which is to:

- Promote.
- Support.
- Influence.

There is very little evidence to underpin different service configurations, with most guidance based on consensus or experience. In response to the lack of evidence the RCM has utilised existing current standards and policies to develop this good practice guide to provide a framework and rationale by which proposed service reconfiguration may be assessed.

1 – Background

Maternity service providers face considerable challenges providing safe, high-quality services that meet the needs of women and their families in a sustainable manner. Government policy, the European Working Time Directive (EWTD), medical and technological advances, rising public expectations and the desire to improve the quality of care, all contribute to the need for change. The configuration of services (how they are provided across different sites) may be considered a constraint to achieving the local vision for maternity services provision.

Essentially reconfiguration means that the way in which services are delivered will change. The drivers for proposed changes in maternity service provision (reconfiguration) are either 'direct' i.e. specific to maternity services e.g. to meet local service users' needs/national policy/financial sustainability or 'in-direct' i.e. in response to other service reconfiguration, such as the proposed closure of an accident and emergency department. Reconfigurations of services can take a range of forms including departmental re-organisations, mergers and closures of departments and hospitals and the provision of new service units. Changes to the configuration of services may be met with considerable opposition due to uncertainty about what will replace established services, from health professionals, professionals in other services, service users, the general public and politicians. The case for change can be complex, with decisions needing to balance key areas of safety, quality, clinical effectiveness, best practice, accessibility, staff retention and recruitment, and sustainability. Any proposals for service change should be based on unambiguous and objective principles that provide a strong case for change.

There are very few studies of UK hospital mergers but one study presented by Andrew Taylor, Director, NHS Co-operating and Competition Panel at The Nuffield Trust, Annual Health Strategy Summit 2010 found that:

- Cost reductions were much smaller than anticipated.
- A negative impact on the recruitment and retention of staff.
- Time required to restructure organisations was always underestimated.
- Negative effect on service delivery due to loss of managerial focus.
- Analysis to date does not seem to show that larger hospitals are more efficient or have a lower cost base than smaller ones.

Maternity services operate in an environment characterised by constant and accelerating organisational and policy changes. With the prospect of reduced funding settlements for the foreseeable future, and pressure on the HSC to identify significant efficiency savings, the RCM expects that the pace of change and pressure to reconfigure services will accelerate over the coming months and years. The best advocates to respond to proposed changes are local people, including the midwives, obstetricians and other staff who work in the service. However there is the need to test the case for reconfiguration as service changes can be necessary and welcome.

This good practice guide is a tool by which RCM national officers and local activists can critically analyse proposed reconfigurations of their local maternity services. By testing the proposed changes against the rationale and key questions set out below, an evidence-based local response can be developed and the need and appropriateness of further actions assessed.

2 – Key questions you need to ask

The reconfiguration must not only offer a solution to short-term deficits; it must be part of a programme designed to improve the quality of service delivery and sustained by financial stability and both short and long terms plans.

Below are a set of key questions that should, as a minimum, be applied when assessing the viability and desirability of a proposed service change:

1. **Why is the service reconfiguration proposed? For example is it expected to:**
   - Address clinical safety issues.
   - Improve choice and the quality of care.
   - Enhance delivery of a service (for example, by combining two small adjacent maternity units).
   - Increase specialist services (e.g. severe pre-eclampsia and cardiac disease).
   - Provide care closer to the home.
   - Respond to a recognised failure.
   - Assist in a financial recovery.
   - Respond to newly built hospital (may be Private Finance Initiatives (PFI).
2. **Does the proposal fit within the framework for maternity services?**
   - Do the proposals follow both the national and local strategic policy direction?
   - Has a full risk assessment been carried out?
   - Is the safety of mothers and babies paramount?
   - Is there absolute clarity around responsibilities and clear protocols governing transfers before, during and after labour provided on a network basis, so that women can transfer flexibly and in a timely manner between different levels of care?

- Has the local ambulance service been informed or involved in the discussions?
- How does the reconfiguration impact on neonatal services?

3. What are the objectives to be achieved?

- Is there clarity?
- Is the proposed way the only way?
- Is it urgent?
- Will the change be sustainable both clinically and financially in the longer term?
- Are any of the objectives conflicting or contradictory? For example, is it possible to reconcile proposals to centralise services with an objective to increase choice and accessibility?

4. Do the proposals meet best practice in terms of:

- Evidence on service models.
- Quality.
- Safety.
- Choice.
- Clinical appropriateness.
- Accessibility.
- Responsiveness.
- Efficiency.
- Effectiveness.
- Prevention.
- Equity.

5. To what degree is the reconfiguration based on financial pressure?

- Are services being cut without detailing the investment in the services that will replace the scaled-down service or demonstrating a genuine reduction in the need for a service? Are services being lost in totality entirely to save costs (e.g. closing a stand-alone birth centre)?
- Is the reconfiguration only offering a solution to short-term deficits; it must be part of a programme of service improvement sustained by financial stability.
- Are there any financial dependencies that will change as a consequence of a reconfiguration and weaken other HSC services, potentially destabilising them?

6. To what extent will it be clinically led and evidence-based?

- Have stakeholders been properly consulted on the reconfiguration?
- Can you be confident of the clinical reasons for the reconfiguration? For instance, were the choices for reconfiguration driven by political considerations, perhaps to retain a popular but clinically less preferable site?
- How will the clinical benefits of the reconfiguration be measured (against national standards of care, for example)?
- Have the potential effects of any transfer of services been assessed and mitigated in advance?
- Have the responsibilities for clinical delivery and competency been defined in advance of any transfer of services? Is there clinical involvement and leadership in the proposal?
- Where an Emergency Department is moved away from a hospital, does adequate emergency support remain for the rest of the hospital?

7. To what extent will there be public consultation?

- Have service users' and the general public been engaged in developing the proposals for change? Does the consultation comply with the recommendations in the *DHSSPS Guidance on strengthening personal and public involvement in health and social care* and *regional MSLC guidance?*
- Have public communications been considered, to ensure relevant and clear information is easily accessible to the public? Information needs to be provided in a way that is easily understood.

8. How will the reconfiguration affect other aspects of the service?

- Where services are reconfigured there may be knock-on effects for other areas of the health service. Does reconfiguration destabilise other departments to their detriment?
- Will a hospital remain clinically viable where a specialty is moved to another site?

9. Have education and training needs been taken into account?

- Will the reconfiguration result in a reduction in training opportunities for trainees and students?
- Will the reconfiguration result in a drop in the number of student posts?
- How will research and teaching be delivered if reconfiguration takes place? This will need serious consideration, especially in areas near to a medical school.
- Have providers of higher education including midwifery and medical education been consulted?
- How will this be reflected in numbers of students and their level of support in each area?

3 – Key principles of excellent maternity care for consideration when reconfiguring services

Midwifery-led models of care are ideally suited to the planned reconfiguration of acute services. Maternity services are well placed to respond to these challenges as the majority of care already takes place in local community settings provided by community based midwives.

The following section examines the guiding principles for common issues maternity services face when reconfiguration of services is proposed, and signposts readers to the available supporting evidence.

3.1 – Quality

The key consideration is whether the proposed changes will result in better outcomes and an improved quality service for women and their families? In other words, will maternity care be safer, more effective and result in an enhanced experience for women and babies?

Any reconfiguration must take into account the recommendations in the forthcoming *Review of Maternity Services in Northern Ireland,* due for publication in mid-2011.

Maternity services will need to demonstrate what impact reconfiguration will have on outcomes such as:

- The midwife as the first point of contact. The RCM recommends that healthy women with uncomplicated pregnancies should be offered a midwife as their lead professional, being the first point of contact to confirm, book, assess and plan care.
- The number of women receiving their initial health and social care assessment as early as possible.
- The number of women who receive 1:1 care during established labour.
- Indicators of midwife-led care, including home birth rates, normal birth rates, number of women using water as pain relief etc.
- Intervention rates, particularly caesarean section and instrumental delivery rates.
- Improved breastfeeding initiation rates and continuation of breastfeeding at six weeks.
- An improved birth to midwife ratio.
- Women's satisfaction with the care they received.

Q. Will the proposed reconfiguration:

- Lead to an overall improvement in the quality of maternity care for women and families?
- Lead to specific improvements in safety, clinical effectiveness and women's experience of maternity care?

3.2 – Accessibility

Another important consideration will be the impact of proposed changes on the time it takes and distance that women have to travel to access maternity services? Reconfigurations based on centralising maternity services not only restrict choice for women and families; the increased travel time and distance that result from centralisation may reduce accessibility to services as well. According to a report by the think tank Reform, *"the drive to centralisation... has often led to maternity services being provided at a considerable distance to women, with no clear gain in improved outcome for mother and baby"*[1].

Centralising services can lead to the transfer of social costs (time, childcare arrangements) and economic costs (fares, parking) to women and their families. Such proposals can therefore have a disproportionate and adverse impact on the most vulnerable and socially excluded women. When assessing the impact of reconfiguration proposals on accessibility to services, it will also be important to consider the potential impact on women with additional health and social care needs.

Q. Will the proposed reconfiguration:

- Lead to a significant increase in travel times and distances for women to access maternity services?
- Have a disproportionate impact on vulnerable and socially excluded women?

3.3 – Physical capacity

The term 'physical capacity' when applied to maternity services refers mainly to the capacity of a service to provide physical space/beds for the provision of in-patient antenatal intrapartum and initial postnatal care although the majority of antenatal care is provided either in community settings such as GP practices or in clinics within the acute out-patient department.

Q. Will the proposed reconfiguration:

- Make it more or less likely that the service will be able to provide appropriate care for all women?
- Are there clearly defined care pathways for each pathway level?
- Will these pathways enable women to exercise an informed choice in respect of location of antenatal care, type and place of birth and location of postnatal care?

[1] Bosanquet N, Ferry J, Lees C, Thornton J (2006) *Maternity Services in the NHS* p.28

3.4 – Home Birth Service

Home birth should be positively promoted as a real option and there should be adequate numbers of appropriately educated and competent midwives to support this. A genuine offer of a home birth service requires a service model which truly supports this offer.

To support safe, high quality midwife-led care there must be clear and agreed standards for transfer of women from home or midwifery units in case of complications. Best practice would underpin this requirement by ensuring that women whose risks can be anticipated are cared for in an obstetric-led unit. For the vast majority of other women the key is firstly excellent preparation and skills of midwives so they can deal with emergencies, secondly facilities for stabilisation before a timely safe transfer.

Q. Does the home birth service model:

- Have an agreed home birth vision and philosophy across the maternity service? Is there organisational commitment to support the service at all times regardless of the clinical activity within the acute provider setting?
- Have an evidence based assessment to determine the most appropriate place of birth? Is this a dynamic assessment continuously reviewed throughout the woman's pregnancy?
- Clearly identify the team providing the woman's care including her named midwife and contact number displayed on the front of her handheld notes?
- Provide an on-call rota that will ensure the woman will know at least one of the midwives attending her home birth?
- Offer a flexible work pattern for midwives, including part-time and annualised hours?
- Consider innovative ways to provide home birth services?
- Offer sufficient CPD for midwives to support practice?

3.5 – Community Midwifery Units

3.5.1 – Stand-alone unit

The birth centre model increases choice for some women in relation to place of birth and recent maternity drivers make clear the need for Community Midwifery Unit (CMU) options within the framework.

There is very little evidence to underpin a recommended optimum activity to ensure financial viability for a stand-alone CMU. It may be more useful not to assess CMUs in the context of their financial viability alone but as part of the required service 'package of provision' offer, of which no one part is viable without the other in a choice, quality, safety and financial context.

A stand-alone CMU can also offer an increase in physical capacity when existing hospital based facilities do not have the capacity to meet projected increases in activity. However this is dependent on the appropriate women being signposted to these facilities along with the successful and positive marketing of the facility.

For issues regarding safety and quality for a stand-alone CMU please see the home birth service information in section 3.4 above.

Q. Does the stand-alone CMU:

- Offer antenatal and postnatal care too?
- Maximise its links to other relevant services providing early year's services such as family planning services, social services and Sure Start services?
- Flexibly deploy staff to ensure a high quality, safe and cost effective service? This can include:
    - Appropriately trained and supervised Maternity Support Workers (MSWs) providing support services at the birth centre working with the midwives in the birth centre. This may include:
        - Being part of the staff team in the birth centre 24/7. This may include activities such as running a breastfeeding cafe as well as being a friendly face to welcome women and their families when they arrive in established labour.
        - Responsibility for environment maintenance, cleanliness, stock etc.
- Offer flexible work patterns to midwifery staff? These may include:
    - Case-loading.
    - Midwifery team care.
    - Annualised hours.

3.5.2 – Co-located CMU

Co-located CMUs may be alongside or in the same grounds as services provided by a maternity care team in a hospital setting. If a co-located unit can meet both the needs and the demand from women at low risk, the provision of a stand-alone CMU may not be necessary.

The principles and evidence for provision are the same as that for a stand-alone CMU (see above). A key consideration for both types of unit is whether the demographic profile of local childbearing women supports the establishment of a CMU.

For example, in areas of high deprivation, a significant proportion of local women may be deemed of high risk and therefore may not be eligible to receive midwife-led care.

Co-located units do provide a more cost efficient use of workforce as midwives and support workers can be deployed flexibly within the whole service during times of peak activity. However, this can also be detrimental to genuinely offering a midwifery-led service if the service is subject to midwives availability. Ideally a co-located unit will be staffed by a midwife-led team and supported by strong local leadership.

There is anecdotal evidence that 'risk-creep' can occur in co-located units i.e. staff may develop a higher tolerance to deviation from the 'normal' pathway than that tolerated in a community setting as they may be falsely reassured of the proximity of quick access to obstetric services.

It is vital that continuous risk assessment remains a dynamic process in the care of all women who may transfer in and out of midwifery-led care at different points of their pregnancy.

Q. Does the co-located CMU:

- Offer sufficient capacity to meet the needs of the majority of women at low risk who chose not to use epidural analgesia during labour?
- Have a flexible model of staffing to ensure that it remains open even during times of high pressure on the acute unit?

3.6 – Obstetric units

The size and facilities available in maternity units varies across Northern Ireland according to the total clinical activity provided and the population that it serves. The number of births per unit/per year ranges from 1000 to 5500 with the majority ranging between 2000 – 4000 births per year. (www.birthchoiceuk.com).

There is very little evidence to underpin a recommendation for the optimum size for an obstetric unit. However maternity units with <2500 births per year and large units (RCOG definition >6000 births per year) may not benefit from economies of scale.

The RCM believes that maternity units undertaking up to 6,000 births a year are more personal and woman-friendly than large units and that there may be issues of safety if units become very big and are not appropriately staffed. For very large units i.e. those undertaking more than 8000 births a year, the challenge will be to demonstrate they are able to achieve the same quality and safety standards as smaller units.

The RCM recognises that maternity units undertaking less than 2500 births a year may not be economically viable and may need to consider different models of delivery of care. However, where it is proposed to close a maternity unit undertaking less than 2500 births a year, careful thought must be given to the impact this have on neighbouring maternity units and consideration given to establishing a midwifery-led service as an alternative. The RCM also believes that the closure of a hospital's A&E department should not automatically lead to the assumption that the maternity unit should close as well.

Q. Does the proposed reconfiguration of obstetric-led services:

- Make it more or less likely for the service to deliver high quality, safe and flexible maternity care?
- Meet the care needs of all women?

3.7 – Workforce capacity

3.7.1 – Midwives

The workforce model requires the staffing and skill mix levels to reflect the local model of care, case mix, the needs of women, their families and service design. In particular, midwifery staffing levels should conform to the principles set out in *Safer Childbirth*:

- The total establishment of the maternity service should reflect the need for continuous care; labour ward staffing requirements cannot therefore be considered in isolation or separated from antenatal and postnatal provision within the acute sector, as well as in primary care and community settings.
- Equally, staffing of the labour ward must not be at the expense of other areas, such as community midwifery or the home birth service.
- Maternity services should develop the capacity for every woman to have a designated midwife for her when in established labour for 100% of the time.

In addition, the RCM Position Statement *Staffing Standard in Midwifery Services* states:

- The Royal College of Midwives supports a minimum ratio of 1 midwife per 28 births per year. Falling outside this ratio is a strong indication that a service should undertake a thorough workforce review.
- Midwives working in caseload practices, giving total care and attending the majority of their births should have a caseload of 1:35 women.
- Midwives should be supported in practice by appropriately qualified support workers and administrative staff.

Proposed changes to the configuration of maternity services should not lead to these principles being compromised. However, there may be occasions when it will be possible to get staff to develop their competencies in response to changes to the configuration of maternity services. For example, where in-house paediatric services have been withdrawn from a hospital, some Health Boards have developed the role of Advanced Neonatal Nurse Practitioners (ANNP). ANNPs are mainly nurses or midwives who have been used to provide Level I and Level II care in a number of locations in Great Britain including:

- Lothian Health Board – on site at Royal Edinburgh Infirmary and St John's Hospital in West Lothian.
- Greater Glasgow and Clyde Health Board – at the Princess Royal Maternity Unit and the Southern General Hospital Maternity Unit.
- Ayrshire and Arran Health Board – at Ayrshire Maternity Unit, Crosshouse Hospital.
- Ashington Hospital, Northumberland. Evaluation of advanced neonatal nurse practitioners: confidential enquiry in to the management of sentinel cases concluded: *Good quality neonatal care can be delivered by advanced neonatal nurse practitioners alone, without the support of resident junior paediatricians.*
- Special Care Baby Unit, Princess Royal Hospital, Sussex where a team of ANNPs is being developed.
- Regional Intensive Care Unit, Liverpool Women's Hospital where the ANNPs are experienced nurses who have undertaken further training in the care, examination and treatment of babies.

Nevertheless, it is imperative that midwives continue to drive a shift to more normal births – especially for those women who are low-risk and without complications. So while proposals to broaden the remit of a midwife's role are advanced for the best of reasons, what is actually required to improve outcomes is for there to be more time for midwives to focus on each woman, so that her individual needs can be identified and her pregnancy and birth can be kept as normal as possible.

A further consideration in respect of reconfiguration proposals is the impact that any changes have on the ability to recruit and retain midwives.

Q. Does the proposed reconfiguration of maternity services:

- Make it more or less likely to make it possible to achieve recommended midwife staffing levels?
- Ensure that midwives can provide 1:1 care in labour?
- Take into consideration new ways of working and skill-mix?

3.7.2 – Obstetricians

Safer Childbirth recommends the following obstetrician staffing levels:

- All units with more than 2500 births a year should move to 40-hour consultant obstetrician presence on the labour ward.
- Units with between 2500 and 4000 births a year should have a minimum of 60 hours of consultant obstetrician presence.
- Units with between 4000 and 5000 births a year should have a minimum of 98 hours consultant presence.
- Units with more than 5000 births a year should aim to reach full consultant obstetrician presence (although this is dependent on adequate consultant expansion).

Q. Does the proposed reconfiguration of maternity services:

- Make it more or less likely to make it possible to achieve recommended staffing levels?
- Take into consideration new ways of working and skill-mix?

4 – Preparing your response

All HSC organisations have mechanisms in place for partnership working and negotiation with the recognised trade unions (the RCM being one of these unions). They will also have locally agreed mechanisms for consultation on proposed changes that may occur. In theory, therefore there should be adequate time for you to prepare for and engage with the consultation process. Ideally you would have been involved from the beginning but this may not always be the case.

Evidence is crucial. You must be well informed and credible from the outset. It is worth asking yourself the following questions:

- Can I back up all the things I say in response to the proposed change?
- Can I effectively challenge statements with which I disagree?
- What has been the experience of similar changes elsewhere?

In order to be confident that you have everything you need to answer the above, it is important that before you start you do as much homework as possible. There are benefits to doing a search in relation to previous reviews. Has a review been carried out in the past, what was the rationale, what were the recommendations and were they implemented? How does this fit with the current review?

Is there support for the change? It may be that service users', staff and management are supportive of the proposal e.g. the setting up of a stand-alone birth centre. If this is the case and the proposals clearly fit with the College's core values there is no need to challenge the proposal. However, if the proposals do not meet with the RCM's core values or the key questions above, then you will need to challenge the proposal.

Once you have made the decision the take up the issue on behalf of the RCM it is important to decide an action plan:

Identify the issues

- Clearly identify the issues which are non compliant with the best practice described above. Where possible, reference the relevant policy and outline how the proposals diverge from the policy.

Talk to stakeholders

- What do midwives think of the proposals? There may be different opinions about the merits of the reconfiguration, so it is important to convene a meeting of all midwives in order to agree a common position and identify campaign objectives.
- Are staff working in other specialties affected by the changes? How have other trade unions and professional bodies reacted to the proposals? Building a coalition and campaigning alongside other NHS staff can prove effective; but always be aware that different groups may have slightly different priorities.
- Are there active organisations representing users of maternity services, such as NCT branches or an MSLC or Netmums/Mumsnet? Your campaign will get a massive boost if you can demonstrate that service users are on your side.

Engaging with politicians

- Is there political support or opposition? Whoever your MLA is, they will want to know about what is going on in their constituency. Health issues, and particularly threats to local health and social care services, are normally high up the agenda for most MLAs. Don't forget as well to contact local councillors, who can be of vital importance in making recommendations on decisions affecting the local HSC.

Politicians at all levels will want to try to get involved, especially in a popular local campaign. But be careful not to let the campaign be taken over by politicians; always keep it as your campaign, not theirs.

Media interest

What is the view of the media? Local papers, radio stations and other media are always searching for important local news stories – there is little more important than changes to the local NHS, especially if this involves threats of closure. It is a legitimate part of the work of the RCM representative to speak to the media, whether on a matter of local concern or as part of a wider concern. If you are going to speak to a journalist you should always observe the following points:

- Always make it clear that you are speaking on behalf of the RCM and not in an individual capacity.
- Stick to the main issues and focus on the key messages the RCM wish to make. Resist being sidetracked, having words put in your mouth or any attempt to personalise issues.
- Never claim to or give the impression you are speaking on behalf of your employer or another NHS organisation.
- As a matter of courtesy, you should advise your employer (line manager and press office) that you may be speaking to the media.
- Immediately report – to your RCM representative or full-time officer – any attempt by your employer to prevent you speaking to the media or penalise you for doing so.
- **Current legislation, local LRA Codes of Conduct and the RCM all recognise your right and obligation to carry out your activities as a trade union representative. It is illegal for your employer to 'gag' you or otherwise discipline you for going about your legitimate business as an RCM representative.**
- The RCM press office will always be happy to advise or assist you if you are unsure about dealing with the media. For contact details please see page 20.

One important way to alert local journalists to what you are saying and doing is to issue a press release. The press release is a simple means of alerting the media whenever something interesting is happening. So consider issuing a press release when: you launch your campaign; you need to publicise campaign activities, such as collecting signatures for a petition; an important meeting is coming up; or when you need to set out your position on the reconfiguration proposals.

Keep in touch with the journalists you are sending the press releases to so you can ensure you are giving them all the information they need to put your side of the story across. Local people need to hear what you are saying, so getting the media on your side has to be a key objective.

Responding to the consultation

- Do not make assumptions. Remember, just because something is in a document it does not mean that it should not be checked and challenged. For example a CMU may be under threat of closure due to poor uptake by women. However it is worth checking whether this option has been **genuinely** offered to **all** suitable women. Is the referral criteria evidence based? When and by whom is the choice of birth place discussed?
- Take into consideration the geographical area that is being discussed. What impact will the proposed changes have on the surrounding maternity services providers? Have they been involved with the consultation and what is their view?
- Use the principles and key questions above to formulate and support your response. Any proposed changes that will provide a service that fails to meet the principles set out in this document should be questioned and, if needs be, vigorously opposed.
- Develop your own counter-proposals, base these on current policy and the principles set out above, and underpin them with as much evidence as you can muster in relation to local services. Our experience is that a well presented, closely argued case, supported by evidence and linked to positive outcomes for women and midwives, can command widespread support and influence the final decision on local services.

5 – Further resources, tools and documents

Resources

Policy documents

Regulation and Quality Improvement Authority (RQIA) (2010) *Review of Intrapartum Care Services*

Royal College of Midwives (2000) *Vision 2000*

Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Paediatrics and Child Health (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*

Reports and strategy documents

It is worth regularly checking the websites of health and social care trusts, Health and Social Care Boards and the Public Health Agency for details of any recent policy statements or strategic plans relating to maternity services. You can also access papers from recent board meetings, annual reports and other useful information, such as population profiles and performance data.

The Local Supervising Authority Midwifery Officer (LSAMO) annual report is another useful source of information. As well as information about statutory supervision, the reports typically contain information about births and clinical activity and midwifery workforce statistics. The reports are collated by the NMC and available to peruse and/or download from **http://www.nmc-uk.org/Nurses-and-midwives/Midwifery/Supervisor-of-midwives/Local-Supervising-Authority-Reports/**

Useful contacts

Other staff groups

Reconfiguration proposals may impact on other specialties and affect a range of NHS staff groups. The local staff side organisation can act as a useful means for bringing different staff groups together. The main trade union and professional bodies for NHS staff groups and the most relevant of the medical royal colleges are listed below:

- NIPSA - **http://nipsa.org.uk/**
- Unison - **http://www.unison.org.uk/**
- Royal College of Nursing (RCN) - **http://www.rcn.org.uk/**
- The British Medical Association (BMA) - **http://www.bma.org.uk/**
- Unite - **http://www.unitetheunion.com/default.aspx**
- Royal College of General Practitioners (RCGP) - **http://www.rcgp.org.uk/**
- Royal College of Obstetricians and Gynaecologists (RCOG) - **http://www.rcog.org.uk/**
- Royal College of Paediatrics and Child Health (RCPCH) - **http://www.rcpch.ac.uk/**
- Royal College of Anaesthetists - **http://www.rcoa.ac.uk/**

Local maternity services users groups

The best campaigns are those that unite local midwives with mothers and mothers-to-be. There may be a well-established Maternity Services Liaison Committee (MSLC) or branch of the National Childbirth Trust (NCT); note as well that many maternity services users will be members of online communities such as Netmums and Mumsnet:

- Your maternity unit should have contact details for your local MSLC
- National Childbirth Trust (NCT) - **http://www.nctpregnancyandbabycare.com/home**
- Mumsnet - **http://www.mumsnet.com/**
- Netmums - **http://www.netmums.com/**

Politicians

IIf you do not know who your MLA is you can input your postcode to **www.ritetothem.com** and you will be given contact details for your local representative.

Royal College of Midwives

The RCM is here to help you. Our regional and national officers can offer advice and support on how best to respond to reconfiguration proposals. And RCM headquarters staff can assist with contacting politicians, identifying policy documents, collating best practice evidence or drafting press releases.

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