



Lewisham & Greenwich Branch

81 Greenwich South Street

London

SE10 8NT

Email: liza\_taylor@yahoo.com

10 April 2008

Dear Sirs

**A picture of health – a consultation on changes to healthcare in the London Boroughs of Bexley, Bromley, Greenwich and Lewisham**

I am writing to respond to the above consultation on behalf of the Lewisham and Greenwich branch of the NCT (National Childbirth Trust).

The NCT is the UK's leading charity for new parents, established in 1955, with over 70,000 members nationally. The charity's aim is for all parents to have an experience of birth that enriches their lives and gives them confidence in being a parent, and the quality and focus of maternity care makes an important contribution to this. We provide support to, and campaign on behalf of parents and parents to be, whatever their background or economic situation. The NCT campaigns nationally and locally for flexible, individualised maternity services, which promote normality in childbirth and allow parents to make informed choices regarding their own birth experience.

The Lewisham and Greenwich branch currently has over 800 members, all of whom are resident in areas affected by the consultation and therefore service users of the hospitals concerned. As our membership is made up predominantly of expectant parents and parents of very young children, this response concentrates on the proposals that relate to maternity services and neonatal care.

We are aware that there is a questionnaire available, and have encouraged our members to complete individual responses. However, we do not feel that it provides sufficient space to articulate the concerns that our members have voiced. Please also note, that while the comments below refer to national and local published data in support of our arguments, they are based on the views of our local members.

Whilst we welcome many aspects of the current proposals, which will enhance choice for maternity service users in Greenwich and Bromley, we are concerned that access to maternity services in the Lewisham and Bexley areas will be reduced under the proposals to close maternity services at University Hospital Lewisham (UHL) under options 1 and 3, and Queen Mary's Sidcup (QMS) under all 3 options. We would like to draw your attention to point 2.3 of the Cabinet Office Code of Practice, which states that "As far as possible, consultation should be completely open, with no options ruled out".

The key points of our response are summarised below: a detailed discussion of each point is included in the appendix to this letter.

- **We believe that all women should have access to both obstetric and midwife-led care as well as the option of home birth. We therefore believe that obstetric services should be retained at UHL as well as at PRUH and QEH with midwife-led units available at all four hospitals.**
- **We believe that the option of developing or retaining a standalone midwifery-led unit on any site facing the closure of birthing services should be seriously considered, in order to allow as many women as possible to experience continuity of carer when accessing antenatal, intrapartum and postnatal services.**
- **We also believe that no reconfiguration of services should result in a reduction of the number of neonatal cots available across Bexley, Bromley, Greenwich and Lewisham and ask that concrete proposals in relation to the future provision of neonatal services be clarified as soon as practicable and that options are put forward for consultation before any changes are made.**
- **In addition we request assurance that replacement services will be operational before any existing services are closed.**
- **We also would like to know what steps will be taken to improve the quality of care offered by all the hospitals under review. All four hospitals were in the bottom quartile of the most recently published Healthcare Commission survey of maternity services, with only QEH achieving a rating of fair. Our members consistently tell us that they meet overworked and under-resourced staff, that good support for infant feeding is patchy, and that postnatal facilities are dirty and understaffed.**

If you would like to discuss any of the points outlined in more detail, or if you have any further queries, please do not hesitate to contact me at the addresses above.

Yours sincerely

Liza Taylor

*Branch Treasurer*

Cc:

Joan Ruddock, MP

Bridget Prentice, MP

Jim Dowd, MP

Clive Efford, MP

John Austin, MP

Nick Raynsford, MP

Cllr Janet Gillman

Cllr Mick Hayes

Cllr Chris Maines

Cllr Sylvia Scott

Cllr Chris Roberts, Leader, Greenwich Council

Sir Steve Bullock, Mayor of Lewisham

Cllr Ian Clement, Leader, Bexley Council

Cllr Elizabeth Truss

Michael Chuter, Chair, Joint Committee of PCTs

## Appendix

### **1. Lewisham and Greenwich NCT welcome the following aspects of the proposals:**

#### **1.1 We support the aim of encouraging women to have as natural a birth as possible.**

A straightforward birth offers more likelihood of a prompt and full recovery for women and a better start for babies. The Maternity Care Working Party's (MCWP) normal birth consensus statement, endorsed by members of the MCWP including the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, recommends that all maternity services use the same definition of normal birth, collect and publish normal birth statistics and regularly take action to increase the normal birth rate towards a realistic objective of 60%, with measurable improvement taking place by 2010<sup>1</sup>.

#### **1.2 We welcome the aim of enabling 7% of all women to give birth at home, compared to the current levels of around 2%.<sup>2</sup>**

The NCT believes that all women should have the option of home birth available to them, if that is their choice, and welcomes the choice guarantees contained in the government White Paper *Maternity Matters*<sup>3</sup>, due to come into force next year. Before the decision is taken to close any existing hospital based maternity services we would like to receive information regarding the number of additional community midwives which will be employed to support the projected increase in home births and seek assurance that these additional community midwives will be in post before any existing hospital based services are closed.

#### **1.3 We welcome the proposals to develop midwife-led birthing units alongside the doctor-led units at the Princess Royal University Hospital (PRUH) and Queen Elizabeth Hospital (QEH).**

We acknowledge that this will increase the choice of service for women in Bromley and Greenwich, who have previously only been able to choose this option by travelling further a-field or paying for private care. We are encouraged by the aim to enable at least 1,000 women to give birth in these units, given that they are associated with higher maternal satisfaction, more straightforward labour and birth and more support for breastfeeding. Onsite midwifery-led units are essential in order to provide women with a real choice regarding their experience of childbirth, as described in *Maternity Matters*<sup>4</sup>.

---

<sup>1</sup> Making normal birth a reality, Consensus statement from the Maternity Care Working Party, November 2007

<sup>2</sup> Department of Health, Maternity survey 2007

<sup>3</sup> Department of Health. *Maternity matters: choice, access and continuity of care in a safe service*. London: Department of Health; 2007

<sup>4</sup> Ibid

**1.4 We support the proposal to provide more services in the community, closer to people's homes, and believe that this is essential in maintaining access to good quality maternity services for disadvantaged and vulnerable groups.**

We fully support the proposed provision of midwifery led services from an increased number of locations in the community and endorse the vision to have obstetric antenatal care and maternity ultrasound available in community health centres. We believe that this is essential in ensuring access to maternity services for groups (for example refugees and recent migrants, very young mothers and mothers with several children) who for logistical, language, economic or other reasons would find it difficult to travel to hospitals for appointments.

**2. Lewisham & Greenwich NCT is concerned about the following aspects of the proposals:**

**2.1 The proposals to provide more services closer to people's homes do not correspond with the plans to stop providing birth services at Queen Mary's Sidcup and University Hospital Lewisham (UHL).**

We are very concerned that the closure of birth services at QMS and the closure under options 1 and 3 of birth services at UHL will mean increased travel distances for women in labour. In particular, women living in Greenwich and Lewisham who would previously had the choice of giving birth at UHL will have to travel eastwards to QEH, which entails negotiating the A2/A102 Blackwall Tunnel approach. This three to four mile journey can take up to forty minutes at peak times for a private car: when congestion is particularly bad even a blue light transfer may not be significantly faster.

If it is necessary for staffing reasons to concentrate obstetric services on 3 sites, it does not necessarily follow that the existing midwife-led unit at QMS could not be retained. Before a decision is taken to close the midwife-led unit at QMS, we would request that evidence be presented that a midwife-led unit at QMS would not be viable for medical or financial reasons

**2.2 We question whether the proposed larger units will actually be more effective in improving care for all women.**

We note with interest that by concentrating care on fewer sites, there will be increased consultant presence on the labour wards of the doctor-led units. We agree that this increase in coverage may be beneficial for high risk women and we recognise that QEH in particular serves a socially and economically diverse client base which may have greater need of this coverage. However, we are very concerned that financial pressures and workforce changes are the primary drivers for the proposals for large maternity units, and not evidence that larger units provide higher-quality, woman focussed care. In *Safer Childbirth* The Royal College of Obstetricians and Gynaecologists recommends levels of consultant presence for maternity units of different sizes, with increasing levels for larger units, but does not

advocate the concentration of birthing services in ever larger units. Safer Childbirth explicitly recognises that a maternity network includes births at home, in midwifery units and in obstetric units<sup>5</sup>. We strongly believe that any changes to the way maternity services are provided should be based on clear evidence that they will improve care for women and their families. This includes improving safety and normal birth rates, supporting breastfeeding and recognising birth as the foundation of a new family.

### **2.3 We object to the fact that there is no provision, in any of the proposed options, for a standalone midwife-led birth unit.**

If doctor-led services are to be consolidated on fewer sites due to financial pressures, it does not follow that midwife-led birth services also need to be restricted. If women are truly to be offered a full range of choices as to where they give birth, a standalone midwife led birth unit would be included as a realistic option.

Evidence from research into stand-alone birth centres suggests that they are very positive environments for normal birth and provide good outcomes for mothers and babies: this is reflected in the high levels of satisfaction for mothers with their care<sup>6</sup>.

We note that the pre-consultation business case outlines the advantages of standalone midwife led birth units: “they provide a more woman friendly and less medicalised atmosphere, and they are more effective in promoting normality”. We strongly believe that if women are to be encouraged to have as natural a birth as possible, these standalone units would be one of the most effective ways of achieving this aim.

Since standalone midwife-led units offer an opportunity to provide more community-based care, we find it counter intuitive that this is not included as an option, given that more community-based care is clearly a desired outcome of the reconfiguration.

### **2.4 We are concerned that the reconfiguration documents make no explicit proposals about current issues such as staffing levels and continuity of care, and postnatal care.**

In particular, we are concerned about the poor ratios of midwives to the numbers of women using the maternity services in this area. Bromley Hospitals NHS Trust has less than 26 midwives per 1,000 births and we understand that the other three trusts have similar ratios. This is well below the average of 31 per 1,000 births identified by the Healthcare Commission report on maternity services and far below the 36 per 1,000 ratio recommended by the Royal Colleges to enable one-to-one care in labour. We would like to point out that as well as recommending higher levels of consultant cover in larger units, *Safer Childbirth* also strongly recommends that women in established labour receive one-to-one care from a midwife. We therefore believe that midwifery staffing levels are calculated and implemented

---

<sup>5</sup> Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists et al. *Safer childbirth: minimum standards for the organisation and delivery of care in labour*. London: RCOG Press; 2007.

<sup>6</sup> Saunders D, Boulton M, Chapple J, et al. *Evaluation of the Edgware Birth Centre*. Edgware: Barnet Health Authority; 2000.

according to birth setting and case mix categories to provide the midwife-to-woman standard ratio in labour (1.0–1.4 WTE (whole time equivalent) midwives to woman) with immediate effect<sup>7</sup>

We are also concerned that the proposals to retain antenatal and postnatal services at QMS and UHL and close birthing services at these sites will adversely affect the maternity services' ability to provide continuity of care to all women. A modern maternity service should provide high quality care of a consistent standard and continuity of carer from the antenatal through to the postnatal period, ideally provided by the caseload midwifery model of care. It is important that every woman is supported throughout her pregnancy, labour and birth by a health professional who is known to her wherever possible. This allows a trusting relationship to develop between the woman and her carer and makes the woman feel more respected, relaxed and confident about giving birth, thereby contributing to positive birth outcomes. Enabling women to establish a relationship of trust with a health professional also allows positive health messages to be more effectively communicated, which is particularly important in disadvantaged communities facing health inequalities where many women have other health issues.

We welcome the aim in the pre-consultation business case for all women to have a designated midwife to care for them in established labour for 100% of the time. We note from the *National Service Framework for Maternity Services*<sup>8</sup> that maternity care providers need to ensure that women receive this level of care, but we want reassurance that there will be a significant investment in midwifery capacity for this to happen.

QEH in particular has experienced acute capacity issues: according to information obtained by the Conservatives under the Freedom of Information Act, it closed its delivery suite to admissions 15 times during 2007, and delivered in excess of four thousand babies, significantly in excess of planned-for capacity.

Feedback from our members (and incidentally the 2007 Healthcare Commission Maternity Services Survey) about the cleanliness and staffing levels of the postnatal facilities is consistently poor, which we believe to be directly related to capacity issues.

Anecdotally, our members tell us of hardworking and dedicated personnel serving a difficult client base as best they can with the resources they have. Very broadly, women who have had high risk pregnancies and/or births report a more positive experience. Conversely, women who had straightforward deliveries often report feeling that they were not treated with respect or compassion and did not feel they received enough postnatal support in feeding and caring for their babies.

---

<sup>7</sup> Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists et al. *Safer childbirth: minimum standards for the organisation and delivery of care in labour*. London: RCOG Press; 2007.

<sup>8</sup> Department of Health. *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health; Department for Education and Skills; 2004.

### 3. Neonatal care

It is of great concern to us that although Professor Alberti's paper discusses maternity services in some detail, only passing reference is made to neonatal care, despite the fact that the proposals flowing from the clinical case he makes for change entail the closure of the 22 cot neonatal unit at UHL, and the 6 cot special care baby unit at QMS. Although the summary on page 14 of the public consultation document indicates an enhanced level of care at PRUH and QEH under all options, this is not elaborated on anywhere else in the document, and is not commented on in detail in the supplementary documentation.

It is therefore far from clear whether the reduction in the number of intensive, high dependency and special care cots resulting from the closure of two existing units will be fully compensated for by creating additional capacity at PRUH and QEH. There is also no commitment given that the number of funded cots (as opposed to the cots that hospitals currently operate) will be maintained or increased. This is important since we are aware that both hospitals mentioned routinely operate more cots than they have funding for.

There is no suggestion that the existing facilities are underused: a recent National Audit Office report surveyed neonatal units nationally and found that on average, units had to close to admissions at least once a week.<sup>9</sup> Moreover, the NAO also notes a nationwide shortage of neonatal nurses, meaning that many units are unable to operate to capacity. BLISS, the premature baby charity estimated in 2006 that in order to maintain appropriate staffing levels London alone needed a further 540 neonatal nurses.<sup>10</sup>

Any reduction of neonatal cot capacity raises the likelihood of babies having to be transferred after birth to hospitals with capacity and/or the facilities to care for them. When applied to extremely premature babies of less than 26 weeks' gestation, transport after birth has been shown to adversely affect long-term clinical outcomes for those children.<sup>11</sup>

Transfer to a hospital outside the immediate area also has significant adverse impacts on the family of a sick or premature baby. This may lead to mother and baby being cared for in different hospitals, or siblings being cared for in different hospitals in the case of multiples, with the attendant physical and emotional strain that this places on the family.

Moreover, in redistributing neonatal care services, thought should be given not only to planning space for additional cots, but for parent facilities. For example, the existing neonatal unit at Lewisham has three twin rooms available for parents, whereas the units at QEH and PRUH each have one, and it is difficult to see how additional accommodation could be included in an enlarged unit. These facilities are extremely important to families and are principally used to help parents prepare for discharge in a supportive setting. If babies are being discharged with ongoing medical needs such as supplemental oxygen, they allow parents to familiarise themselves with the equipment. For babies who are breastfed at

---

<sup>9</sup> NAO report, *Caring for vulnerable babies: the reorganisation of neonatal services in England*

<sup>10</sup> BLISS press release, 21 February 2006. Available from [www.bliss.org.uk](http://www.bliss.org.uk).

<sup>11</sup> Arch Dis Child Neonatal Ed 2003 May; 88(3); F256.

discharge, rooming-in facilities are critical in supporting the establishment of breastfeeding, since they allow mothers to become more confident in feeding in a quiet and private setting.

In addition there are the costs of travel, parking and food which a recent BLISS report estimated as totalling approximately £189 a week<sup>12</sup>, which many families in the affected area can ill afford, especially as the family of a sick baby does not normally receive additional financial or community support until he is discharged from hospital. This figure does not reflect the much higher cost of transport within London, nor the fact that parking is charged for at relatively high rates at the PRUH and QEH<sup>13</sup>. This is all the more important given that babies born to families of low socioeconomic status and/or members of ethnic minorities are more likely to require neonatal care.

In addition, we would challenge the relevance of the statement that “30% of newborn babies that require high dependency....care are transferred to hospitals outside these *boroughs*” when surely the appropriate measure of whether transfers are excessive is whether babies are transferred outside the neonatal network, which is defined differently. Unless it is envisaged that the enlarged units at PRUH and QEH would be level 3 units, babies requiring this level of care would still be transported to Kings College Hospital or St Thomas.

***We therefore ask that concrete proposals in relation to the future funding and staffing of neonatal services be clarified as soon as practicable. We recognise that babies cared for at larger centres tend to have better clinical outcomes<sup>14</sup> but do not believe there should be any reduction in either the number or type of cots available, as it is likely to result in more transfers of babies after birth and thus separation from their mothers.<sup>15</sup>***

#### **4 Practical considerations**

The consultation asks for respondent's views on the accessibility of services under the new proposals. The comments that follow are specific to the accessibility of maternity services under the proposals.

We agree that the establishment of midwife-led birthing centres at existing centres, an increase in home births and more antenatal and postnatal care in the community should in principle mean that for women in Greenwich, Lewisham (under option 2) and Bromley women's access to maternity services is as good in future as at present.

However, the concentration of birth services on fewer sites begs questions about the adequacy of existing transport and parking facilities. Of the four sites under review, UHL is the only one with comprehensive public transport links, and the only one within walking distance of a railway station. Despite exhortations by the hospitals to patients to use public transport, in reality many face the choice of a long and time consuming journey by bus or a

---

<sup>12</sup> BLISS press release, 28 November 2007. Available from [www.bliss.org.uk](http://www.bliss.org.uk).

<sup>13</sup> Some discounts are available for parking for long-stay patients but free parking permits are not available at either hospital.

<sup>14</sup> NAO report, *Caring for Vulnerable Babies: the reorganisation of neonatal services in England*

shorter and more costly journey by car. As noted above, this can affect whether certain at-risk groups attend appointments, compromising quality of care.

At Queen Elizabeth in particular, existing car parking facilities appear to be at capacity, particularly on days with high clinic attendances, and it can take up to thirty minutes to find a space. Offsite parking is severely limited by the Common on one side and the Army barracks on the other.

**We therefore ask for clarification of how, given the proposed increases in capacity of maternity and other services at PRUH and QEH, access to the sites by both public and private transport will be improved.**

## **5 Communication of the proposals**

We are aware that the consultation process has been under way for some time, however we would seriously question whether, prior to publication of the three options, women using maternity services had actually been consulted and asked what services they would like to have.

There are three Maternity Services Liaison Committees (MSLCs) working in South East London, and one of the main objectives of these committees is to advise the PCTs commissioning maternity care on all aspects of maternity services, including the configuration of those services. We would like to know why none of these MSLCs had been asked for their input prior to the consultation.

We note that point 1.2 of the Cabinet Office Code of Practice on consultation states that “it is important to identify proactively relevant interested parties and those whom the policy will be likely to affect. These groups should be contacted and engaged in discussion as early as possible in the policy development process.” In addition, the government White Paper *Maternity Matters* states that PCTs and partners are expected to use MSLCs or similar fora to agree on a common set of objectives for maternity services, set the service specification for maternity services and to be the local voice in the production of the PCT prospectus<sup>16</sup>.

We were also concerned to discover that apart from members who were likely to use maternity services at QMS, few were aware of the extent of the changes proposed, and a significant number of people resident in areas affected by the proposals had not received a direct mailing of the summary consultation document, although copies were available in health centres. For those that did receive the document, although the cover artwork shows a mother and baby, it shows them in a domestic and not a healthcare setting, and there are no images of pregnant women. The main body of the document makes few explicit references to maternity services and neonatal services, and it is only on studying the table at the back that it becomes clear that this is a major change in configuration. As a result, although many of our members recalled having seen the document, they did not realise its relevance to them or their families.

---

<sup>16</sup> Department of Health. *Maternity matters: choice, access and continuity of care in a safe service*. London: Department of Health; 2007

## 6. Needs assessment

We note that *Maternity Matters* states that maternity care should be included in a strategic needs assessment to be undertaken by PCTs and local authorities by 2009 in order to allow commissioners and partners to achieve a thorough understanding of the demand for and provision of maternity and associated services and allow them to commission effectively<sup>17</sup>. We would like to know whether or not this strategic needs assessment has been carried out in South East London and the ways in which the results of this strategic needs assessment have informed the proposals to reconfigure the ways in which maternity services are provided across Bexley, Bromley, Greenwich and Lewisham.

We also note that the closure of Queen Mary's Sidcup is likely to result in more women accessing maternity services at Guys and St Thomas's Hospital in Lambeth and Darent Valley, Dartford. The closure of Lewisham would almost certainly result in increased numbers of women using Kings' and Mayday in Croydon. We would like to request information regarding the involvement of these trusts in the consultation process, including the involvement of the MSLCs, and would like to know what plans they have in place to absorb the extra demand for their maternity services.

---

<sup>17</sup> Ibid