East Sussex Maternity Services
Consultation on Reconfiguration

Option 12: New Ways of Working for Local Maternity Care

9th September 2007

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1 Introduction & Summary

This paper is an East Sussex Maternity Services Liaison Committee response to the 2007 consultation by the East Sussex joint Primary Care Trusts entitled 'Creating an NHS fit for the Future'.

The MSLC believe the options developed by the PCT remove choice from women, and would result in services being provided in a large medicalised unit that may meet the needs of medical staffing but is not beneficial for women, babies and midwives.

'Option 5a – saving lives' developed by the local campaign group also outlines ways of keeping local obstetric care and has much to commend it. However, that option focuses on a medical model, is of unknown cost, may not be efficient in use of consultant time, is not innovative in skills mix on labour wards, and does not further develop midwifery skills and responsibility.

Option 12 develops a range of new ways of working (including new roles), based on proven, successful experience from other parts of the UK.

The Option 12 proposals would provide improved access to midwife-led care for all women, not just those who wish to use a stand-alone midwife-led unit. Option 12 is EWTD compliant, within RCOG guidelines and significantly reduces dependence on new trainee doctors for the delivery of obstetric care by enhancing the role of midwives.

Option 12 recognises the expectations of the National Service Framework on Maternity and its delivery plan 'Maternity Matters' for commissioners and service providers to commit to the national choice guarantees. These focus on local choice for women including maternity team and midwifery-led care, as well as the option for home births.

The Primary Care Trusts proposed single site options are likely to reduce income to East Sussex Hospitals Trust by £600k and increase costs by £550K per annum – a total of £1.15M per year adverse financial impact. Set against this, the requirement for a relatively modest increase in doctor numbers as outlined in the proposal will represent good value for money.

In 2006 the largest maternity unit (Brighton) serving East Sussex women closed for more hours then either Eastbourne or Hastings (which closed the least). There is no local evidence that a larger unit will close less often – only wishful thinking. If the proposed single site closes to admissions then women in labour really will have nowhere to go. Development of sufficient capacity and the avoidance of complete closure in East Sussex would be best served by the retention of two obstetric units.

2 Why change is required

2.1 European Working Time Directive

From August 2009 European Working Time Directives (EWTD) require that doctors do not work more than 48 hours a week. This requirement can be averaged over at least a 17 week period, subject to some additional restrictions on rest time between shifts and length of over-night working. It should be noted that this directive applies to work for one employer. It is still possible for a doctor working 48 hours for an NHS Trust to do additional private work outside the NHS.

2.2 Modernising Medical Careers

Modernising Medical Careers (MMC) will change the availability of junior doctors in the service and affect their immediate levels of competence prior to completion of that part of their training. In particular the Senior House Officers (SHO) role, on which many services rely, will be replaced by Foundation Trainees (FT) and Specialist Trainees (ST).

2.3 ROCG Guidance

The Royal College of Obstetricians & Gynaecologists (RCOG) recommend an increase in Consultant presence on Labour wards. This will be a minimum of 40 hours per week for units greater than 2500 births per year and 60 hours per week for units of 4000 births or more per year by 2009. (The RCOG recommendation for small units with fewer than 2500 births per year is that they regularly review and manage their risk, to provide a safe service.)

2.4 National Service Framework and Maternity Matters

The government has asked the NHS to commit to 4 national choice guarantees by the end of 2009. These include choices for women on how to access maternity care (with self referral and direct access to a midwife or if they wish a GP); choice of type of antenatal care (care provided by a midwife or maternity team care); choice of place of birth (birth supported by a midwife at home, birth supported by a midwife in a local midwifery unit or birth centre, birth supported by a maternity team in a hospital); and that all women will be able to choose any available hospital in England.

2.5 Sub-Specialisation

There is also a (non-statutory) pressure from a medical careers perspective to have larger births populations within one unit in order to offer consultants greater opportunity for sub-specialisation. Research, publication writing, career advancement (and to a degree private practice) usually takes place within these sub-specialisations.

3 Finding an Appropriate Solution

3.1 Balance of Pressures

The various drivers of change outlined above exert pressures on the maternity service in different directions. The optimal solution will therefore be one that balances these different pressures while satisfying the changing medical circumstances. At first consideration it might seem the only solution is to move to one site, but there are other options and issues for consideration.

3.2 Central Hospital Not Considered?

The fundamental geography of East Sussex is that there are two main centres of population some 20 miles apart with poor travel connections between the two. One possible solution might be to build a new hospital sited centrally to East Sussex (e.g. Bexhill). Although initial capital costs might be high, this could prove to be a long-term robust option that provides significant savings over the next 20 years.

3.3 Midwife-led Unit is a Minority Option

The single site option is presented as an opportunity to develop a new midwife led birth unit on the Crowborough model. Such a unit is desirable, but is being offered as an *alternative* to a local obstetric unit by the PCT. This is done in a misleading way as it is presented as an option for a majority of women. In practice midwife-led units only cater for a minority of women and in practice at least two-thirds of women from one town or other will still have to travel to another town for their maternity care.

3.4 Risk Management

Risk management in maternity services is rated under the Clinical Negligence Scheme for Trusts (CNST). The current obstetric service in East Sussex has obtained the highest CNST Level 3 status – one of only 3 services to obtain this status in the Strategic Health Authority Region. The current service is therefore seen as a safe service.

Development of a midwife-led unit some 20 miles away from the nearest obstetric unit brings its own risks. Encouraging some 500 women each year to start labour nearly one hour away from obstetric support is a greater risk than maintaining an obstetric unit below 2500 births. It should also be noted that 'Maternity Matters' advocates home birth as a real choice for many women. A single obstetric unit would bring longer transfer times (in the event of complications) than currently exist for some of the local population.

3.5 Another Option Required

It is quite clear that none of the options proposed by the Primary Care Trust meet the five pressures on the service outlined in Section 2. Option 12 is designed to meet each these five pressures in a compliant, safe and forward-looking way.

4 New Ways of Working for Two Obstetric Sites

4.1 Option 12 Summary

Option 12 ensures that all-risk obstetric services for women in labour can be provided in both Hastings and Eastbourne, while also developing sub-specialisation opportunities for consultants based on the total birth population of 4000 per year across the East Sussex Hospitals area.

As identified in Option 5, for some very high risk women (perhaps 50 per year) obstetric care might be more appropriately provided in a regional teaching hospital such as Brighton. This already takes place, and is not likely to change under single site conditions.

In addition to this, Option 12 proposes improved access to midwife-led care for all women, not just those who wish to use a stand-alone midwife-led unit. Option 12 is EWTD compliant, within RCOG guidelines and significantly reduces dependence on new trainee doctors for the delivery of obstetric care by enhancing the role of midwives.

There are examples in other parts of the UK of services being delivered in a safe effective way in units as small as either Hastings or Eastbourne. They have achieved this by developing new ways of working. The MSLC is not suggesting the wholesale establishment of a service developed in another hospital for another population in different circumstances, but rather to take the examples and learning already in existence and develop a service tailored to East Sussex geography and needs.

Option 12 identifies ways in which the Hospitals Trust and Primary Care Trust can redevelop maternity services in East Sussex to be fit for the future without reducing the sites from which these services are delivered.

4.2 Medical Manpower Management

Small obstetric units elsewhere in the UK have developed effective ways of managing consultant presence and obstetric cover on labour wards. Criticism has been made of the North Devon Hospitals Trust working arrangements at Barnstaple because with their current medical manpower of 4.75 consultants and 4 Specialist Obstetric Registrars they are not EWTD compliant.

NDHT have always made it clear that this has been by ***choice*** as the middle grade doctors have preferred to work additional sessions to obtain additional salary. When working hours are restricted to 48 hours per week they will recruit (probably) three or four additional middle grade doctors to provide sufficient cover. This total of 7 or 8 middle grade obstetric doctors will also provide sufficient time for day-time supervision and obstetric training.

The current consultant establishment in Barnstaple utilises a co-operative agreement between the consultants regarding holiday arrangements. One consultant (0.75 wte) provides holiday cover for all the other consultants in the department. This ensures that only one consultant is on holiday at any one time thereby ensuring extremely effective medical manpower management.

A consultant labour-ward presence of 40 hours per week is not quite achieved, and therefore an additional consultant will need to be recruited to provide this cover. This will also reduce the on-call rota to 1 in 5 or 1 in 6. Experience from elsewhere (i.e.: Central Middlesex Hospital) indicates that an on-call rota of 1 in 6 typically creates an actual on-call attendance of 1 in 12.

4.3 Combined Midwifery Unit

North Devon Hospital Trust has developed effective ways of providing real midwifery-led care within the maternity unit. They offer team case-load midwifery (which they believe reduces midwife stress compared to individual case-loading) a midwife will come into the unit with each woman in labour.

If a (low-risk) woman chooses midwife-led care then her room is designated and shown (by a slider on the door) as under midwifery-led care. The medical team are then able to focus on women not choosing, or not suitable, for low-risk midwife-led care. In the event that complications in labour arise for a low-risk woman, then the midwife can obtain immediate medical support and the woman can be re-designated as under consultant-led care without physically moving from her room. This change will also be shown by the slider on the door.

In a catchment area of some 900 square miles with only one main centre of population, establishment of a separate continuously staffed stand-alone midwife-led unit would be difficult without disruption to team case-loading. The midwives believe that in their local circumstances the combined unit gives genuine reality to midwife-led care and is a model that could be of benefit elsewhere. The team midwives will also manage home births.

4.4 Reducing Dependence on New Trainee Doctors

Senior House Officers (SHO) are doctors in training who have no specific obstetric experience when they start their few months ‘work experience’ in an obstetric unit. The MMC changes to doctor training mean that SHOs will soon be replaced with FT1s (who may have even less hands-on experience) and this has implications for obstetric units. However, many obstetric units are now regarding SHOs as supernumerary to obstetric medical cover, especially at night when little effective training or supervision can take place.

North Lincolnshire Hospitals Trust has trained a number of Advanced Midwifery Practitioners (AMP) at the Grimsby site to supplement the use of SHOs. Advanced Midwifery Practitioners can fulfil every required role of an SHO on a labour ward, and because they do not ‘come and go’ as trainees, can offer better continuity to obstetric units for first line medical cover.

Option 12 recommends that each site trains 6 senior midwives to take on the role of Advanced Midwifery Practitioners (as establishment at Grimsby). This is sufficient to provide 24 / 7 cover to support the middle grade Specialist Registrars who provide labour ward obstetric cover for the 128 or 108 hours per week when consultants are not present on the labour ward.

This 'first line' rota of Advanced Midwifery Practitioners can also include new trainee doctors, who may either be on obstetric placement as part of general training, or may be intending to specialise in obstetrics. These trainee doctors will gain labour ward experience alongside the AMP's and as well as gaining medical experience will also develop greater understanding of midwifery roles and expertise.

4.5 Reducing Caesarean Section Rates

Diana, Princess of Wales Hospital at Grimsby has a 17% caesarean section rate and is quoted as a case study in the *NHS Institute for Innovation and Improvement "Focus on: Caesarean Section".* Achievement of a low caesarean section rate is attributed to

a) continuity of experience provided by Advanced Midwifery Practitioners as front-line medical staff and

b) the integrated working relationship that they are able to develop over time with the Specialist Registrars who provide the 24 / 7 obstetric cover within the unit.

Reduction in the high East Sussex caesarean section rate (currently running at 25%) should be one of the key PCT public health concerns in obstetrics. The maintenance of two smaller 'non-medicalised' units that include new ways of working such as Advanced Midwifery Practitioners and Combined Midwifery-led Care will make a significant step towards this objective.

4.6 Consultant Sub-Specialisation

Consultant sub-specialisation is commonly in fertility, oncology, gynaecology and early pregnancy. A birth population of 4000 births per year provides sufficient critical mass to make these sub-specialisations viable. In North Lincolnshire sub-specialisation is managed by consultants who provide their specialisation across the two sites at Scunthorpe and Grimsby.

In many cases a consultant with a sub-speciality will hold clinics on each site as appropriate to the number of women. Already in East Sussex some consultants have contract that make them trust-wide rather than specific to one site, and this principle would be extended. In some cases it will be necessary for women to travel to the other site, but this will be a relatively small number of women, and be acceptable. It is a very different matter from expecting over 1000 women in labour to travel to the other site.

These opportunities for sub-specialisation across a birth population of 4000 births per year will help to maintain the ability of East Sussex Hospitals Trust to recruit and retain high calibre doctors.

4.7 Summary of Obstetric & Maternity Staffing for Option 12

Sub-specialisation Arrangement for Consultants			
	Eastbourne	**Hastings**	**Notes**
Fertility Oncology Gynaecology Early Pregnancy	**East Sussex Hospitals Trust Combined** Birth Population of 4000 Birth per Year **Provides critical mass for sub-specialisation**		*Similar arrangement as North Lincolnshire* *5 PAs per consultant available to cover clinics, surgery and sub-specialisation*
Clinics	**Consultants & women travel for clinics.**		

General Obstetrics for Intra-partum Care			
	Eastbourne	**Hastings**	
Labour Ward Cover	Birth Population of 1950	Birth Population of 1750	(Possibly 2400 at Eastbourne with closure of PRH at Haywards Heath)
	5.5 Consultants (2.5 PA per consultant to give 40 hours cover)	**5.5 Consultants** (2.5 PA per consultant to give 40 hours cover)	*Each site as per strengthened arrangement for Barnstaple*
	7 Middle Grades 168 Hours per week *(of which 40 hours also have consultant cover)* 32 hrs each per week	**7 Middle Grades** 168 Hours per week *(of which 40 hours also have consultant cover)* 32 hrs each per week	*Barnstaple existing arrangement plus recruitment of 3 MG for EWTD. Sufficient MG currently available within ESHT.*
	6 AMPs cover 24/7 + trainee doctor posts as required for VTS / FT (Current Number 4)	**6 AMPs cover 24/7 + trainee doctor posts as required for VTS / FT** (Current Number 3)	*AMPs model as per North Lincolnshire Hospitals (Grimsby)*

Midwifery Provision			
	Eastbourne	**Hastings**	
Midwifery Management	Head of Midwifery across all Trust sites		*As existing East Sussex Hospitals*
	Delivery Suite Co-ordinator	Delivery Suite Co-ordinator	*As per 2005 East Sussex Hospitals*
Midwifery Provision	Increase establishment to new birth-rate plus level.	Increase establishment to new birth-rate plus level.	*New up-to-date evaluation required.*

5 Gynaecology

Option 12 envisages that both sites are able to continue providing in-patient gynaecological services for women, and able to deal with (the relatively rare) gynaecological emergencies that do arise.

It is, however, quite possible that sub-specialisation within East Sussex Hospitals Trust means that one of the units develops greater expertise in gynaecology and become the centre for major gynaecological surgery.

6 Paediatrics

Option 12 envisages the continued provision of level 1 SCBU at both Eastbourne & Hastings. The viability of this has been argued by Dr Keith Brent, Consultant Paediatrician (paper 24th July). He notes that with 5 consultants in Eastbourne and 4.5 consultants in Hastings around 46 hours per week of consultant presence is provided on each site.

This same paper also argues that a single site provide very limited economies of scale on staffing, nor make coping with staff sickness any easier. There might also be ways that two sites could offer better utilisation of doctors' time.

7 Financial Considerations

7.1 Additional Consultant Posts

Some 3 additional substantive consultants posts will be required over an above the existing 8 wte consultants. This approximates to £360K per annum. The currently funded 7 Middle Grade obstetricians will continue, though some saving will be made against the current empolyment of 8 middle grade doctors on each site. (In effect some of the middle grade posts will be turned into consultant grade posts, minimizing the actual on-cost.)

7.2 Cost-effectiveness of AMPs

A significant cost (of paying for new SHOs) will be avoided by the use of Advanced Midwifery Practitioners in place of SHOs in the first line medical cover rota. This will also offer the more experienced midwives in the trust opportunities for career advancement (as an alternative to management), thereby assisting with midwife retention and work satisfaction.

It should however be noted that the total number of midwives is likely to rise in line with activity & 'birthrate plus'. The last formal 'birthrate plus' evaluation was undertaken in 2003, since when activity levels have risen by 7%.

7.3 Overhead Costs

Overhead costs are generally allocated by number of staff (payroll, recruitment, training, etc) or by area of building required (rates, utilities, maintenance, servicing, etc). Neither of these parameters will change significantly under single site conditions, and these costs will stay broadly similar.

7.4 Avoidance of Loss of Income

It is generally accepted that the closure of one of the obstetric units will lead to a loss of women to maternity providers outside East Sussex. This is probably true in either direction, but we do have estimated numbers relating to the potential closure of Eastbourne obstetrics.

The modelling undertaken by Brighton (PCT and Hospitals Trust) indicates that *"if Eastbourne no longer provided obstetric services the the likely flows of women to Brighton would be 600."* (Letter from D Grayson & P Coles; 3 May 2007)

The value of this lost income under payment-by-results is over £600k per annum. (This is calculated on the intra-partum PbR tariffs only. If the community midwifery tariff costs due in 2009 are used then the potential loss of income rises to around £1M)

7.5 Dedicated Obstetric Anaesthetists

A single site of around 3000 births per year (or over) would require a team of dedicated obstetric anaesthetists *(or at least an extra tier of anaesthetists - CSR 2004 Dr Walmsley).* The cost of this was then estimated at £550K, though this cost is now probably higher.

7.6 Indications on Financial Balance

A single site is likely to reduce income by £600k and increase costs by £550K – a total of £1.15M adverse financial impact. Set against this, the requirement for a relatively modest increase in doctor numbers as outlined above will represent good value for money. Even if slightly more doctor recruitment is required (in the light of MMC changes under way) then this option will still remain with a positive financial balance.