Appendix 6

East Sussex 'Fit for the Future' Consultation 2007
Option 12 Proposer: Response to HOSC

Introduction

The invitation to submit this paper was received at 10 pm on Thursday 10th January (when I returned from work), with a deadline of 17th January. I fly abroad for a week on Friday 11th morning, returning after the deadline has passed. This paper is therefore only a brief summary, written in haste to register my wish to give further evidence to HOSC about the PCT options appraisal process.

Option 12 Development

Option 12 was developed by East Sussex Maternity Services Liaison Committee (MSLC) members, (who give of their spare time voluntarily) as a response to concerns about the lack of options, other than single site, in the PCT proposals. The MSLC is comprised of users, clinicians and midwives who have a good working knowledge of the maternity service and are committed to excellence and a women-centred focus for that service.

In generating Option 12, the MSLC drew not only on the local multi-disciplinary knowledge of its members, but also gathered examples of innovative ways of working from elsewhere in the UK. In particular, a case study from the NHS Institute for Innovation and Improvement document "Focus on normal birth and reducing Caesarean section rates" was seen as particularly relevant to the East Sussex situation. Visits were made to North Devon Hospitals Trust and North Lincolnshire and Goole Hospitals Trust to gain first hand knowledge of new ways of working.

The MSLC also developed Option 12 in the light of 'Maternity Matters' which is the implementation programme for the government's National Service Framework on Maternity. **Option 12 was considered by Professor Field (New Options Assessment Panel) and passed as viable and appropriate for further development and appraisal.**

Option 12 Assessment Process

Subsequent to being informed that Option 12 had successfully passed the 'New Options Assessment Panel' no further request for information of feed back was received from the PCT. I attended the consultation feedback meeting on 5th October primarily to ask about the process for public consultation on the new options now available. No process for public consultation was offered, and Nick Yeo explained that the options evaluation would now be an internal PCT process. I objected to that, and asked for at least an opportunity to present the benefits of Option 12 to the PCT Boards. It was agreed that this "would be considered".

On 18th October I received an invite to present Option 12 to the joint PCT Boards on 5th November. I spoke to Michael Wilson about feedback from the internal PCT evaluation, and in particular detail on costings, and was led to expect some feedback soon. This proved to be not forth-coming, and no further information was available at all by 5th November prior to presentation to the PCT Boards.

The presentation slot on 5th November was limited to 10 minutes. Option 12 contains proposals for some new innovative ways of working with which PCT Board members in particular would not be familiar. A proper appreciation of Option 12 need me to explain these new ways of working, to show how they would work in the specific East Sussex situation, and then to outline how the whole Option

12 model would fit together to address to different pressures (EWTD, RCOG, etc) that currently bear down on the maternity service locally. Having done that the presentation would then have gone on to deal with issues of cost-effectiveness, (including consideration of the impact of Payment by Results) and then shown how Option 12 would allow the service to attain the objectives outlined in 'Maternity Matters'. **This was simply not possible in 10 minutes, and as a result the PCT Board's knowledge and understanding of Option 12 was cursory, at best. The MSLC is designed to be an advisory body to the PCT on local maternity services. They have not given this body due opportunity to offer this advice in a effective and meaningful way.**

Chief Executives Recommendation Paper

There are (amongst other issues) three important points regarding Option 12 that are not dealt with adequately in the Chief Exec's Recommendation Paper

1) Clinical effectiveness and quality has only been considered in relation to the obstetric site, not to the maternity service as a whole within geographical East Sussex. There has been an unbalanced focus on clinical effectiveness and quality at the acute obstetric site only. The paper fails to evaluate overall clinical effectiveness, safety and quality across other geographical parts of the service and in offering a midwife-led unit and home births as safe options. (At the Board Meeting on 21st December it was noticeable that board members were anxious to claim that they had no option but to follow RCOG guidance on minimum size of acute unit, but **were prepared to ignore RCOG advice on the maximum distance and time that a midwife-led unit should be located from an acute unit.** This was very much a case of selective listening to advice in order to support a pre-judged decision.)

2) The costing for Option 12 is far too high, and appears to have been understood to include a "full tier of first on call", when this is not in fact the case. I had requested from the PCT an outline of the costing procedure and assumptions prior to evaluation, but for the PCT's own internal reasons this was not made available. On of the key benefits of Option 12 is cost-effectiveness through the use of Advanced Midwifery Practitioners (as confirmed in the case study in the NHS Institute for Innovation & Improvement Report) and my own work shows me that as good a financial balance is obtain from Option 12 as from either Options 3 or 4. **The PCT Board were misled on this aspect of Option 12 without this having been agreed (or any contact made) with Option 12 proposers.**

3) Option 12 is fully capable of providing 60 hours of consultant labour ward presence by 2009 as is claimed for option 4. It has not been highlighted as such at present as there is not yet a confirmed CNST requirement for this to be the case. However, should this be required for CNST, it is acheivable within the consultant hours provided. Option 12 actually provides more total consultant hours available in total that Option 4. A move to 60 hours only requires one additional PA of 4 hours from each consultant each week. **The ability to provide 60 hours cover is presented in the Chief Executive's Recommendations as a key reason for preferring a single site, and was misleading to the board, especially without checking the particular issue with the Option 12 proposers.**

These three misunderstandings are fundamental to the options evaluation process that board members were asked to undertake, and sadly misrepresent Option 12. I astounded that no consultation or checking was first done with Option Proposers as had been initially promised.

I asked Michael Wilson (and copied Nick Yeo) to circulate my e-mail on these three points above to all board members on Wednesday morning (19th December) so that they are aware of my concerns in relation to Option 12 evaluation well before the board meeting on Thursday morning.
This was not done. I asked (in writing) the Chair of the PCT Boards for an opportunity to speak at the 21st December meeting and **this was ignored.**

Richard Hallett, 11th January 2008