Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**21 March 2013**
By:	**Assistant Chief Executive**
Title of report:	**East Sussex Healthcare NHS Trust Maternity and Paediatric Services**
Purpose of report:	**To notify HOSC of decisions made by the Board of East Sussex Healthcare NHS Trust (ESHT) regarding temporary reconfiguration of obstetric and inpatient paediatric services on safety grounds.**

RECOMMENDATIONS

HOSC is recommended to:
1. Consider the temporary service changes agreed by the ESHT Board.
2. Request that the Trust, in conjunction with their commissioners, bring forward proposals for the long term clinically and financially sustainable provision of these services to HOSC as soon as possible, following engagement with stakeholders.
3. Until proposals are brought forward, request regular progress updates as part of future reports on the implementation of the Trust's Clinical Strategy.

1. Background

1.1 On 8 March 2013, an extraordinary meeting of the East Sussex Healthcare NHS Trust (ESHT) Board was called to consider safety issues relating to the Trust's maternity and paediatric services.

1.2 This followed a review of the services by the National Clinical Advisory Team (NCAT) on 4 January 2013. The NCAT review was carried out at the Trust's request due to concerns which had been raised internally. NCAT made specific recommendations to the Trust in their final report of February 2013.

1.3 A summary of the issues considered by the ESHT Board and their decisions is attached at appendix 1. The NCAT report is attached at appendix 2. The full ESHT Board papers are available on the Trust's website at www.eastsussexhospitals.nhs.uk/about-us/meetings .

1.4 In summary, the ESHT Board decided that consultant-led obstetric services and inpatient paediatric services should be temporarily located only on the Conquest Hospital site. A midwife-led unit for low risk births and an ambulatory paediatric service will be retained at Eastbourne DGH. Other services including the Crowborough Birthing Unit, elective gynaecology, outpatient and community services are unaffected. It is intended to implement the temporary reconfiguration within the next 6-8 weeks.

1.5 Darren Grayson, Chief Executive, Lindsey Stevens, Head of Midwifery, Dr Jamal Zaidi, Divisional Director and Dr Dexter Pascall, Clinical Lead for Obstetrics from ESHT, together with Amanda Philpott, representing East Sussex Clinical Commissioning Groups (CCGs), will attend HOSC to discuss the reports.

2. Consultation requirements

2.1 NHS organisations are required under health scrutiny legislation to consult HOSC when considering a proposed 'substantial development or variation' of services. However, there are certain exemptions to this requirement.

2.2 NHS organisations are not required to consult HOSC *"if they believe a decision has to be taken on an issue immediately because of a risk to the safety or welfare of patients or staff"*,

where, *"allowing time for consultation could place patients or staff at risk"*. In these circumstances the NHS organisation is required to notify HOSC of the action taken and the reasons for it.

2.3 Any decisions regarding permanent changes to service configuration, which would not be taken on an urgent basis, would be subject to the usual consultation requirements. It would also be expected that any consultation would be undertaken in conjunction with commissioners of the service.

2.4 The ESHT Board agreed that proposals for the long-term future of the services should be brought forward for consultation no later than 18 months from the date of the Board decision.

3. Implications for other services

3.1 The decision by the ESHT Board to temporarily reconfigure obstetric and inpatient paediatric services is likely to have a knock on impact on other services, most notably the ambulance service and neighbouring hospital Trusts, if residents who would normally use Eastbourne DGH decide, or are directed, to use other hospitals

3.2 Responses have been sought by HOSC from Brighton and Sussex University Hospitals NHS Trust (BSUH) and South East Coast Ambulance Service NHS Foundation Trust (SECAmb) regarding the potential impact on their services and how this will be managed. These responses will be circulated separately before the HOSC meeting when received.

4. ESHT Clinical Strategy

4.1 HOSC has been following the development of the Trust's Clinical Strategy for over two years. The Committee is aware that the strategy is based around eight Primary Access Points (PAPs) or service areas, two of which are maternity and paediatrics. These two PAPs are very closely interlinked.

4.2 The development of these PAPs was informed by a maternity review in 2011. Following this review the PAPs had reached the stage of having agreed preferred 'models of care' and having identified a range of potential delivery options.

4.3 Alongside the ESHT strategy development, a pan-Sussex project, 'Sussex Together' has been considering the provision of maternity and paediatric services across the entirety of East and West Sussex and Brighton and Hove. The further development of the ESHT Clinical Strategy in relation to maternity and paediatric services has been awaiting the outcomes of this wider work.

4.4 HOSC has previously agreed that any proposed service changes arising from the Clinical Strategy which constitute service reconfiguration, i.e. changing where or whether a service is provided in the future, would amount to a substantial variation in service requiring formal consultation with the Committee.

4.5 In considering any proposed permanent service reconfiguration HOSC would need to examine how previous recommendations in relation to maternity services have been taken into account. This would include recommendations made by the Independent Reconfiguration Panel in 2008.

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ENSURING SAFETY FOR OBSTETRIC AND NEONATAL SERVICES

1. Executive Summary

1.1 The Trust needs to take rapid action to ensure that obstetric, gynaecology and paediatric services it delivers can be operated safely reducing the risk of future harm to the health and well being of the mothers, babies and children using the Trust's services.

1.2 The primary driver for this action is the need to ensure that the shape of the current service supports the delivery of safer obstetric and neonatal services for every woman and baby whatever their risk or place of birth. This means taking steps to enable clinicians with the right skills to meet the needs of mothers, babies and children in the right place at the right time.

1.3 The rationale for action is based on the current risks to patient safety which are that:

- for some patients some of the time the safety and quality standards we would expect and require are not being met
- our dependency on mitigating actions means the cumulative risk of service failure is at an unacceptable level
- the delivery of a safe service could become rapidly unsustainable leaving us little time to implement effective mitigating actions.

1.4 The risks are driven by five factors:

- the increase in the number and proportion of mothers whose pregnancies are considered higher risk and are more likely to need senior medical support (including increases in women with co-morbidities and obesity)
- medical and midwifery staff with the required competencies are not available 7 days a week 24 hours a day
- an ongoing dependency on temporary medical and midwifery staff
- the risk mitigations in place may fail at short notice resulting in the need to take unplanned action to ensure safety (including diverting mothers between sites)
- the availability of clinical leadership in a service that is delivered on multiple sites.

1.5 The Trust has put in place multiple mitigations to address the risks within the service and is assured that it has taken all reasonable measures to secure the safety of patients using the service now. These mitigations have been continuously reviewed and revised following internal and external review and the analysis of the root causes of serious incidents. It is clear that the complexity of the mitigations required and their reliance on direct consultant/senior

clinical input to provide support means that they are increasingly fragile and liable to breakdown in an unplanned way.

1.6 The requirement to act now to improve the safety of the service has been identified through analysis of the increasing number of serious incidents that have occurred in the last 3 months. This analysis prompted the Trust to seek a further review of the service risks by the National Clinical Advisory Team (NCAT) in January 2013 and through a Risk Summit in February 2013. Both concluded that the Trust was operating with unsustainable levels of risk and therefore should take urgent action to secure the safety of the service. They recommended that actions should also be taken to assess and support clinical decision making and strengthen leadership arrangements.

1.7 The options available for securing the safety of the services by reducing these risks to reasonable and acceptable levels were considered by the Trust Board on 8th March 2013. Each of the options was assessed against their ability to address the factors that have resulted in the current patient safety risks. This analysis built on the work on delivery options already undertaken through the development of the Trust's Clinical Strategy and by the Independent Maternity review in 2011.

1.8 Although the primary driver for the change is the safety of maternity and neonatology provision, the options have also taken into account the interdependencies that exist between maternity and gynaecology services and neonatal and paediatric services. These interdependencies mean that change will also be required in paediatric and gynaecology services to secure a safer configuration overall.

1.9 The Board agreed to implement the preferred option of maintaining the provision of a consultant led obstetric service, neonatal service (including the Special Care Baby Unit), in-patient paediatric service and emergency gynaecology service at the Conquest Hospital only and establishing a stand alone Midwifery Led Unit alongside enhanced ambulatory paediatric care in the form of a short stay paediatric assessment unit at Eastbourne District General Hospital.

1.10 This option makes no change to the following services:

- Crowborough Birthing Centre
- Out-patient gynaecology
- In-patient gynaecology for elective surgery
- Out-patient paediatrics
- Out-patient ante-natal clinics
- Early pregnancy services
- Maternity Day Unit provision
- Community midwifery services
- Community paediatric services.

1.11 The Board considered the evidence and information presented on why this option will mitigate the current risks in a robust and sustainable way. The agreed option will allow the Trust to:

- Reduce its reliance on the temporary staff currently required to fill medical, midwifery and nursing shifts in Obstetrics and paediatrics. a reduction in the requirement to use temporary staff
- Provide additional hours of supervision by senior staff taking consultant presence on the delivery suite up to a minimum72 hours a week from the current 40 hours with the possibility that this will be extended to 98 hours
- Increase the opportunities for staff to develop and maintain their skills and capabilities
- Provide sufficient flexibility to accommodate activity levels significantly above or below anticipated.

1.12 The Board also considered the information presented to inform the choice of site for the consultant led in-patient services and noted that the current arrangement of the physical estate used for these services meant that changes could be undertaken at the Conquest site within a reasonable time frame and at significantly lower cost than at the Eastbourne site.

1.13 The Board also considered the potential risks that will arise through the implementation of a change in configuration. This included consideration of the additional distance that patients would have to travel to access consultant led maternity care and in patient paediatric services. The Board was able to draw on information from other Trusts where similar arrangements are in place and on the evidence from Royal Colleges on best practice and the future of service provision.

1.14 In addition the Board considered the Birthplace programme (National Institute for Health Research November 2011) which has provided evidence on the outcomes associated with different settings for birth in the NHS. The Birthplace study considered planned births in freestanding midwifery units (FMU) and alongside midwifery units (AMU). It found that there were no significant differences in adverse perinatal outcomes for births in these units compared with planned birth in a consultant led obstetric unit.

1.15 The Board noted that the Birthplace report states that for low risk women ‘Freestanding and alongside midwifery units appear to be safe for babies and offer benefits to both the mother and baby’ It identifies that the benefits arise from lower intervention rates including substantially fewer intrapartum caesarean sections and higher breast feeding rates. It comments that transfer rates to consultant led units during labour or following birth are about 20% for women delivering their second or subsequent baby with rates for women having their first child higher at up to 36%. The research led to recommendations for policy and practice including the recommendation that FMUs and AMUs were provided where possible to extend choice for low risk

mothers. The Board was aware that South East Coast Ambluance service already operates to clinical protocols for the transfer of women between midwifery and consultant led units and that assurances had previously been received regarding speed of emergency transfer when required.

1.16 The Board also considered how the interdependencies between obstetrics, gynaecology and paediatrics and other service provision including accident and emergency services, anaesthetics, general surgery, ENT, musculoskeletal/orthopaedics and support services such as critical care, diagnostics and interventional radiology would be managed and received assurances that the risks arsing from the proposed change could be mitigated.

1.17 The Board was mindful of the outcomes of the stakeholder engagement undertaken during the development of the Trust's clinical strategy and the Maternity review and of the Equality Impact Analysis undertaken to support this work. It stressed the importance of communication during the period of implementation and transition to the new service arrangements and noted that a communication plan that included specific communications with booked patients and staff had been developed.

1.18 The Board noted that safe implementation of the change in configuration would take six to eight weeks to allow time for the estates changes required to support the change to be made. It also noted the arrangements in place for providing the clinical commissioners with assurances about the service in the transition period including daily reports on the staffing and safety of the service.

1.19 The Board was clear that the decision to implement this revised configuration was being made on safety grounds only. This decision had to be made in advance of the outcome of the work being undertaken across Sussex on the strategic future of maternity, neonatology and paediatric services. Implementation of the decision would not prejudge the outcome of the strategic work or the process that will be required to develop and deliver a long term strategic solution. A clear process, governance and decision making arrangements are in place to agree the longer term configuration of these services through public engagement and consultation. Consultation on the long term solution will take place at the earliest possible opportunity and within eighteen months of the Board decision. The Board agreed that the preferred option should operate until a long term solution is found.

NCAT review

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To: NHS South of England

East Sussex NHS Healthcare Trust
Maternity & Paediatric Services

Date: 4 January 2013

Venue: Eastbourne District General Hospital

NCAT Visitors:
Professor Kate Costeloe (Professor of Paediatrics, Barts and the London)
Suzanne Truttero, (Midwifery Advisor)
Dr David Richmond (Vice President RCOG)

In attendance: Malcolm Stewart, Medical Advisor to NHS South of England

Introduction:
NCAT was asked to review proposals to change the configuration of maternity, gynaecology and paediatric services of the East Sussex NHS Healthcare Trust with a particular focus upon the safety and sustainability of each of the services. We were asked to consider models of care but not be site specific.

Background to Review:
Eastbourne District General Hospital merged with the Conquest Hospital (Hastings) as a single Trust in 2002 integrating with community services in April 2011 to manage all NHS activity as East Sussex NHS Healthcare Trust. These hospitals are the main providers of maternity and paediatric care although the Trust also provide a stand alone midwife unit at Crowborough (45-60 minutes travel from Eastbourne). Both acute sites have 24/7 Accident and Emergency departments and provide emergency and elective services for obstetrics, gynaecology and paediatrics (including level 1 neonatal care, day case paediatric surgery and some emergency surgery for children >2 *years*).

Neighbouring facilities are available at Brighton (20 miles west of Eastbourne) which in addition to a full range of obstetrics and gynaecology services is the Regional Level 3 neonatal Unit, Ashford in Kent (25 miles to the east, with Level 3 neonates) and Pembury (20 miles to the north, with Level 2 neonates).

Brighton additionally has a children's hospital providing a range of specialist services. Emergency neonatal transport is provided by a dedicated service covering Kent, Surrey and Sussex and integrated with the London service. In 2008 an Independent Review Panel for the HOSC reporting to the Secretary of State rejected a proposal made by the PCT to reconfigure maternity services for East Sussex bringing in-patient consultant led facilities to a single site at Hastings. A Maternity Strategy was subsequently developed covering the period 2009 – 12 to provide safe and sustainable services on both sites. This has been difficult to achieve and a number of subsequent reviews have questioned the sustainability of the two site consultant led option. There is currently no strategy for maternity and paediatric services in place. The Trust has been financially challenged for some years. It has failed in two attempts to achieve Foundation Trust status.

The Trust has produced a Clinical Strategy document “Shaping our Future” outlining potential efficiencies to save £104 million over the next 3-5 years from a 2012 income of approximately £280 million. These proposals continue to evolve. At the launch of the 2009 Maternity Strategy an arrangement was brokered whereby the maternity services have had an additional £3.1 million from the PCT to offset part of their deficit over and above tariff. This is likely to cease in 2013-14

As part of Shaping our Future some services have already been reviewed in the context of providing a safe, effective and efficient service which can be afforded within the current financial envelope and are out for consultation. These include: single site provision of non-elective Surgery and Trauma and Orthopaedics at Hastings and of Stroke care at Eastbourne, while Cardiology, Acute Medicine and Accident and Emergency Services continue across both sites.

While the maternity, gynaecology and paediatric services are considered as part of the ‘Shaping our Future’ programme they are also being considered as part of a pan Sussex review entitled “Sussex Together” which is looking at six clinical areas of which maternity and newborn care and services for sick children are two. The maternity and newborn reference group’s remit is to determine the:

Unit size and consultant presence
The midwifery workforce numbers and need for 1:1 care in labour
Future demands of maternity care and patient demographics/flows
The mothers’ experience of the services.

The sick children reference group remit is to ascertain:

Whether there is sufficient activity and workforce to maintain six 24/7 inpatient units.
Whether parents are prepared to travel and what distances.

The principal driver for service redesign in East Sussex is the chronic difficulty in providing safe and sustainable in-patient services in both maternity and paediatrics across both hospital sites. A number of options for the services are under review none of which envisages reduction of out-patient work, including ante natal and post natal clinics, at either site.

The present clinical consensus appears to focus upon bringing in-patient obstetrics, gynaecology and paediatrics (including neonatal care) onto a single site; a new build does not seem an option. There does not appear to have been the same level of debate or attention of the Crowborough site to determine its sustainability although we understand that it is being considered within Shaping our Future..

Present Services.

Maternity and Gynaecology :

There were 4293 deliveries in 2010-11 with approximately 250 at Crowborough and 2000 at each of the hospital sites. Projections of births to 2014-15 suggest a marginal decline to 3981. Emergency obstetrics anaesthesia and pain relief services are provided by the on call anaesthetic team from each site who also cover the ITU facilities.

Births at Crowborough average 20/month (Range 15-27). In 2012 there were an additional 47 intra-partum transfers (40 primiparous and 7 multiparous). Of these, surprisingly only 6 transferred to Eastbourne,36 transferred to

Pembury and 4 to the Princess Royal Hospital and 1 elsewhere. None transferred to Hastings. We have not been given information about the bookings relative to East Sussex PCTs or Commissioning Groups nor the income and expenditure of that unit.

Standard maternity and newborn outcome metrics from 2010-11 that we have seen suggest better than average SHA performance in some indices e.g emergency and elective caesarean section numbers. Metrics for 2012, however, are of concern particularly for emergency caesarean sections (RAG rated as Red or Orange for most months to date particularly at the EDGH site) and elective section rates, vaginal birth after section rates, maternal admissions to ITU, shoulder dystocia and babies born in poor condition at birth with low APGAR, low cord pH or a diagnosis of Hypoxic Encephalopathy. Some of the latter metrics involve very small numbers and comment is difficult.

Recent Dr Foster reports have shown the Trust as a significant "red" outlier (2010-11 and 2011-12) for Obstetric Trauma at caesarean section with expected rates of 3.1 against observed rates of 20. Most of these will occur in an emergency situation and consequently medical and midwifery staffing presence and experience are crucial. Emergency measures were put in place on 29th June 2012 such that all elective sections were to be directly supervised by a consultant or CCT holder. In addition all sections performed at full cervical dilatation require direct consultant supervision for all locums and ST trainees at ST 3-4 or below. Despite these measures 4 SI's occurred in August and September and we were led to believe there have been at least another 4 SI's since.

We have not seen any gynaecological metrics for benchmarking.

There appears to have been a year on year increase in complaints from patients, serious incidents and patient diverts due to lack of beds and/or staff.

Medical staffing:
There are 5 consultants on each site providing obstetrics and gynaecology. The consultants Job Plans equate to 108PA's of which 23 are SPA's, 35 are described as Gynaecology and 25 PA's in Obstetrics. 20PA's are for on call and 10 PA's for management or administration. The consultants provide 40 hour presence on each site (ie 20PA's) but this is not prospective. Emergency measures were required in September 2012 due to middle grade vacancy of 37.5% and the retirement of 1 consultant and emergency leave for another at Easbourne.

There are16 "middle grade" staff, 8 on each site. Of these 4 are Specialist Trainees and 12 are non training grade doctors (mean age 52).

Midwifery staffing:
The present dashboard suggests that there is a Trust ratio of 1:31 (range 1:30 - 1:34) over the last 7 months against their target of 1: 28. In only 2 months during this period was the target reached. This should be RAG rated as Orange and at times Red. Turnover and vacancies are low. Midwifery absence runs at 13.3% (Range 11.4- 16.7%) and should be RAG rated as

Red. We were led to believe that a proportion of this is related to maternity leave running at 5-8%.

Current Issues:
There has been increasing difficulty recruiting and retaining adequate middle tier doctors. This has been compounded by legislation surrounding employment of overseas doctors, the availability of training grade doctors partly out of choice but also the national reduction in specialty trainee numbers and ST3 recruitment.

There has been difficulty in temporary recruitment of midwives to back fill maternity absence.. Specialist midwives are increasingly required in daily rota changes. This is due to resolve in January 2013 with many midwives on maternity leave due to return.
Use of bank staff to cover the acute care is particularly heavy at Conquest (150 hours/month) and surprisingly at Crowborough which will average 85 hours/month.

There have been a significant number of maternity related Serious Incidents over the last 7 months, some with tragic outcomes.

Paediatrics

Medical staffing: There are 11 consultants providing acute cover for children's and newborn services with no cross site cover (5 at Hastings one of whom also works within the community and 6 at Eastbourne). There is a single clinical lead for the service and a neonatal lead on each site. The majority have contracts with >10 PAs.

There are 16 middle grade doctors covering acute and community services; 2 are Specialist Trainees and the remainder non training grade staff including 3 'associate specialists' who do not contribute to the on-call rotas. The majority provide 13PA's of time and activity. At each site one middle grade doctor is working on the 'SHO' rota, this combined with maternity leave provides 6 for the on-call rota at Hastings and 5 at Eastbourne. The only middle grade posts recognised for training are at Hastings where there are 2 established posts one of which (in the community) is filled.

During the day the paediatric and neonatal services at each site have separate middle grade cover.

Nursing:
No information was provided about paediatric nurse staffing, but over the 2012/13 Christmas period it had not been possible to staff two acute children's wards and the paediatric service had been reduced to a single site. Neonatal nursing at each site was described as 'precarious' with dependence on staff providing over-time to cover gaps in the rotas and difficulty in recruiting staff with neonatal training.

Paediatric capacity: There is a 15 bed in-patient paediatric facility at each site supported by an assessment/observation area. Total admissions for all paediatric specialties including trauma and ENT average around 2,000 pa at one site (Kipling Ward) and around 2,400 at the other, around 50% of these stay overnight. This equates to two 'Small' hospitals in the nomenclature adopted in the RCPCH document 'Facing the Future' published in 2011 and

one medium size unit if combined. When the two wards merged onto one site over the Christmas period 2012/13 the maximum number of beds occupied at any one time was 21.

Neonatal capacity: There are 7 Level 1 neonatal cots at Eastbourne and 6 at Hastings. The local policy is if possible to transfer out ante-natally any woman expected to delivery at or below 32 weeks gestational age, in 2008 a total of 67 babies were transferred out postnatally and cot occupancy was around 80%.

Current Issues.

Medical staffing: The difficulty in maintaining middle grade rotas appears to be getting worse rather than easing, this is compounded by the recent changes in immigration regulations and the problems of clinical competence and communication skills of new recruits, necessitating their having initially to work under supervision. Rotas are only currently being maintained by excessive use of internal locums and consequently staff working excessive hours. This is unsustainable.

Nursing: There are problems recruiting trained staff and reliance on internal overtime.

The problems in recruiting both medical and nursing staff are probably made worse by the uncertainty about the long-term plans for the services and the delays in reaching conclusions.

Workload/ skill maintenance: The paediatric and neonatal services at each site are small and concern is expressed repeatedly in the documentation provided about its sufficiency to enable staff to maintain skills, particularly for resuscitation. Specifically there has been concern firstly that not all of the middle grade who are expected to run the paediatric arrest team have completed APLS and secondly about the immediate availability of staff competent to resuscitate an unexpectedly 'flat' newborn baby. We were told by the anaesthetists that they had been approached to become involved formally in arrangements for newborn resuscitation but they had resisted this taking the view that their primary role is to care for the mother and that they should not, except in exceptional circumstances, be distracted from this.

Standardisation of care across the two sites: Despite being a single trust the paediatricians seemingly operate as two separate teams using different guidelines and policies in both the paediatric and neonatal areas.

Training: Two middle grade posts at Hastings are recognised for training but these are not popular with trainees, only one community post currently being filled. Given the planning uncertainty and low activity this seems unlikely to change.

Outcomes: We were not provided with paediatric outcome data. The neonatal data contained on the Maternity Dashboard (provided in detail between April and November 2012) is difficult to interpret because of small numbers but is perhaps suggestive of excess unexpected admissions of full term babies to SCBU. Subsequent to the visit we have been provided with details of 3 paediatric SIs in 2012. One of these is a tragedy in the child's home with no implication in respect of the paediatric service, one of the others

relates to a delay in medical diagnosis and the other a failure of nursing observation, both with serious repercussions. It is not clear from the reports what remedial action has been taken.
Although the maternity SIs had serious implications for the babies it appears that there were no neonatal SIs as such during 2012.
The number of complaints about both the paediatric and neonatal services appears to have risen sharply since the beginning of 2011.

Other Specialties:

Acute surgery is likely to be placed at Conquest Hospital, Hastings. This and any proposal for altering the present maternity, gynaecology and paediatric services will have ramifications for the anaesthetic services. It is unclear what level of interventional radiology will be available at each site. We have assumed that Blood Transfusion Services are adequate and have been considered in the siting of other acute services.

Documents Received:
Appendix 1.

People met:
The NCAT Review Team met a range of Midwives, Nurses, Doctors, Managers and Commissioners – see Appendix 2. The majority were from Eastbourne. The consultant paediatricians we met (joined by 2 from Hastings by tele-conference in the afternoon) were predominantly community based, we met neither neonatal lead. Two consultants, one a paediatrician and one an orthopaedic surgeon, were seen separately seemingly because of the strength of their views and because of divergence of views from those of their colleagues.

Views expressed:
The overall view expressed was that acute in-patient maternity services across both sites are safe only because of emergency measures that are themselves unsustainable and that a decision about future configuration is needed urgently. The expressed view about paediatrics was less clear perhaps reflecting divergence between sites and individual team members.

The CEO and Trust Board have been notified by the clinical staff that the maternity service is unsafe and unsustainable.

We were given the impression that, although a Trust of two acute sites, the groups of doctors appeared to function more in isolation as two hospitals. There was lack of uniformity of clinical practice particularly amongst the paediatricians.

From the clinical maternity and gynaecological group the issues were those of constant fire fighting to maintain staffing levels. Increasing difficulties with locums, their assimilation into any team and the cover and support required. Experience and competencies were very variable and it was felt that the consultant obstetricians were increasingly being asked to attend delivery suite on occasion cancelling elective activity.

There was considerable anxiety surrounding recent tragic SI's, 6-7 since August 2012. We heard that 40 hour consultant presence was provided but this appears to be "cover" with local presence. The 40 hours are basically 9-5, Monday –Friday with significant on call requests. The midwifery team felt supported by the consultant staff but were conscious of the fragility of the system surrounding the competence, capability and availability of temporary midwifery and medical staff.

The paediatricians we met were somewhat defensive and reluctant to admit the failure of the teams to integrate that is reported in the documentation and by the other groups we met. While accepting that re-design of the service is needed they seemed to argue that this was obstetrically driven and didn't recognise problems within their own service. While it was not explicit, there appeared to be tension and the impression that there is a divergence of views amongst the paediatricians. This was explicit in respect of the consultant who we saw apart from the others who was critical of current consultant working patterns and argued that with change and a more consultant provided service the current two site pattern could work. We did not have access to consultant job plans but it is of note that the majority have contracts with more than 10PAs.

The CCG representatives were very supportive of the service as a whole but recognised that in patient service provision needed to change. The chosen site would have to take note of relevant specialties such as acute surgery, HDU-ITU and A/E services. They would not continue to support the £3.1 million contribution to the maternity service, probably beyond April 2013.

There was clinical support for alongside and free standing midwifery units as well as recognition that the present model was unsustainable and needed changing whilst maintaining choice with a full range of places for birth.

We heard that greater and possibly imaginative, flexible job planning may need to be considered whichever option is chosen to maximise efficient use of a finite consultant and junior workforce. 40 hour presence on delivery suite and the consultant support to paediatric assessment and observation areas may have to be more closely aligned with need and embrace elements of weekend working or late finishes to 8 or 10pm during the week. The breakdown of gynaecology and obstetric PA provision may need greater scrutiny perhaps with development of advanced roles for midwives and nurses, similarly the extension of paediatric and neonatal nursing skills should be considered.

There appears greater consensus for a single site option for obstetrics and paediatrics by the obstetric and gynaecological personnel than the paediatricians who we felt saw the maternity needs and risks as the primary drivers for change.

Finally, we heard repeated clinical requests for action and decisions to be taken about maternity and paediatric provision in East Sussex. The debate had been evident for at least 6 years.

We did not meet any patient groups or members of LINK during our visit.

Discussion and analysis.

The need for change is obvious and recognised by the NCAT team and the members of the clinical and managerial staff that we met. The services we were asked to consider are part of a broader strategic plan and the co dependencies remain crucial

to any conclusion. We were led to believe that acute surgery and trauma are to be placed on one site but that both hospitals would retain A/E services and acute medical admissions. There does not seem any appetite to remove all maternity and paediatric in patient beds to hospitals to the west and east of the region and therefore a safe and sustainable service needs to be established quickly for East Sussex. This is despite the obstetrics, gynaecology and sexual health services running at an effective loss of £4.2 million from income of £14.78 million with additional depreciation costs of 643k ie 33% deficit.

The focus of our discussions was around maternity and paediatrics and in particular in patient care. We recognised that outpatient and day care surgery should be considered separately.

The present configuration of maternity services in two small consultant led units provide the majority of the inpatient service. There are no alongside midwifery units. A combination of staffing issues, clinical competencies and availability of senior clinicians places the service at considerable risk. The increasing SI's, diverts and complaints would suggest a service that is under considerable strain and this increases the likelihood of governance issues for the Trust..
We were given little detailed information about paediatric services but the children's and newborn components share medical staff and clearly cannot be separated. They too are struggling with staffing and increasing complaints and attention is urgent. Both services have small neonatal units and low paediatric activity, while we understand that the road communications along the South Coast leave much to be desired the fact remains that small services such as this could only be justified in a very remote rural location which this certainly is not.

The maternity and paediatric service are interdependent and the in-patient units must be co located.

If obstetric care was to focus on one site (with ideally an adjacent midwifery unit) the remaining site could function as a stand alone midwifery unit for appropriately selected patients. The midwifery skills for resuscitation would have to be considered and transport facilities in emergency situations provided. The sustainability of the remaining stand alone unit (at Crowborough) would have to be addressed and a balance between choice and affordability reached.

The paediatric in patient unit must be on the same site as in patient obstetrics, both sites should retain out patient services . Whether or not a paediatric assessment and observation area is retained at the other site will need careful consideration. Such a unit would require on-site consultant presence, and in order for it to work efficiently and safely should be planned in the context of out-patient provision.

We suspect we did not see or hear the whole story as regards paediatric and neonatal services, we saw few acute clinicians, neither neonatal lead one of whom we hear is on sick leave and the other of whom is a recent appointment, and no junior doctors. There is reluctance to acknowledge the inevitability of re-design to achieve a single in-patient site and this attitude combined with failure to standardise practice across sites, will obstruct work towards redesigning a safe service, is a threat to the quality of care and ultimately to patient safety.

If two A/E units are to be maintained, then some sort of triage or surgical facility needs to be provided for the care of acute haemorrhage and/or ectopic pregnancy when transfer to the acute unit becomes unsafe. It would help to identify the total number of such gynaecological emergencies and the timing of presentation in 2012.

There does appear to be an opportunity to develop more flexibility in consultant job planning perhaps with external advice and extending roles of midwives and nurses.

Conclusions.

1. A decision on the location of in patient maternity care and in patient paediatrics needs to occur as a matter of urgency.

2. The maternity service and to a lesser extent paediatrics appears to be fire-fighting on a regular basis. This is neither safe nor sustainable.

3. The siting of in patient maternity services will depend on the Trust making appropriate arrangements with other relevant services such as acute surgery, HDU/ITU and interventional radiology.

4. While it is likely that maternity will be seen as the main driver within the services we were asked to consider we believe that the separate in-patient paediatric services are too small to be sustainable and should be considered with the same urgency. Gynaecological services would then follow.

5. If there are two separate A/E departments the provision for Emergency gynaecology (haemorrhage and ectopic pregnancy) needs to be managed on the remaining site in the absence of resident gynaecological staff.

6. An analysis of the efficiency of the Crowborough site needs to be undertaken urgently.

A job planning review needs to take place at the earliest opportunity to provide greater flexibility and cover at greatest times of activity. This must be considered an interim solution only until single site working has been achieved. As maternity appears the service at risk, then immediate solutions need to be found, possibly at the expense of elective gynaecology to maximise safety and reduce risk.

Recommendations.

1. That maternity and paediatric in-patient care be located onto one site as a matter of urgency.

2. A Trust wide strategy for maternity and paediatric services is developed.

3. Consideration be given to the establishment of an alongside midwife led unit on the site where in-patient obstetrics is provided. A stand alone midwife led unit be established on the other hospital site possibly with a paediatric assessment unit and short-term observation area.

4. That the affordability of the Crowborough site be reviewed such that it should not detract from the ability to provide equitable facilities across East Sussex.

5. Maternity, gynaecology and paediatrics in patients should be on the same site and ideally alongside acute surgery and HDU/ITU.

6. In the light of the decision about obstetrics and paediatrics, the Trust will need to reconsider the overall strategy for delivering services to all acutely ill patients. Ideally all acute services (and that includes obstetric and paediatric inpatient services) should be co-located on the same site as this will improve the service delivered and reduce clinical risk. The Trust, with its partners in the health economy, will need to develop a long term strategy for this population which will deliver a safe, sustainable acute service within the resources available. There is an immediate job plan review of the obstetricians and gynaecologists which focuses upon the demands of the emergency care needed.

7. That the local leadership of the paediatric team is addressed urgently and a project developed to increase the cohesion of the paediatric team.

8. That pending final decision and re-design, the paediatricians set up a group to take forward the standardisation of clinical guidelines and practice within an agreed time-frame, given the lack of cohesion within the paediatric team this process may need independent guidance.

9. We recognise that there is a parallel review of pan-Sussex services underway but the potential for calamity in East Sussex is such that decisions should not await the outcome of that review.

Postscript

On Monday 4 February the NCAT team received details of the Serious Incidents at East Sussex including the Root Cause Analysis(RCA) reports of 4 cases.
The dashboard provided to us on 4 January describes:

- 4 SIs in September
- 1 SI in November
- 1 SI in December.

The Excel spreadsheet provided on February 4 describes 9 SIs as follows:

- 2 SIs in August
- 1 SI in September
- 1 SI in December
- 5 SIs in January 2013.

We also have the RCA reports of 3 of these 9 cases together with an additional RCA report (2012/22311) relating to a case missing from the most recent Excel spreadsheet. The Incident dates/reporting dates vary.

Therefore, there appear to have been 10 SIs at this Trust in the 7 months between August 2012 and end January 2013. We are led to believe that at least 8 of these relate to Eastbourne DGH.

Furthermore there has been an External Review of the 4 RCAs, BUT without the benefit of the clinical records, guidelines, a knowledge of the working practice at ESHT and a knowledge of the staff involved and as they say may not be representative of practices generally across the service at ESHT.

They concluded that:

1. The four clinical incidents investigated by the RCA's occurred over a 7 week period. Statistically it would sometimes happen that incidents occur in a cluster with no related factors whatsoever. However, ESHT have acted responsibly in requesting external reviews of the investigations for completeness and to add an independent overview to their internal investigations. Overall the reviews are well contributed and well written, however there are significant omissions.
2. There are delays in escalating incidents for risk review and identifying them as serious untoward incidents.
3. There is a delay in completing planned actions and a lack of robust assessment that actions have been achieved.
4. There is a general lack of escalation by midwifery, neonatal nursing or theatre staff directly to the consultant when there are concerns about a middle grade doctor's actions raising concerns regarding the profile of a labour ward coordinator and labour ward lead clinician.
5. There appear to be significant issues around Obstetric staffing especially at middle grade level and the challenges of providing a safe service when locums are required at this grade. This includes decision making relating to delivery at full dilation and the relative merits of a caesarean section and trail of instrumental vaginal delivery.
6. The RCA's did not demonstrate sufficient evidence of support being offered to medical staff especially locum doctors and paediatric doctors after adverse outcomes.
7. A failure to adhere to local clinical guidance was a common theme in the incidents reviewed.

8. Poor communication within and between teams was a common feature in all incidents.

In addition to the conclusions from the External Review team we (the NCAT Team) have reviewed the 4 RCA investigation reports and have identified the following themes.

- All 4 incidents occurred on a Thursday.
- All 4 incidents occurred during the night shift.
- All 4 incidents involve locum obstetric staff.

Delays in doctor handover from the evening to night shift - but no reason identified. There appears to be a difficulty in identifying serious incidents and consequently a delay in investigations. Including:

- Delays in escalation.
- Lack of supervision of locum & middle grade staff.
- Accurate interpretation of serious incident reports is questionable.
- There appears to be a very worrying culture of complacency in relation to risk within the maternity and paediatric services.
- Poor record-keeping.
- Poor communication.
- Lack of plan of care.
- Lack of documentation.
- Lack of appropriate referral for opinion/plan.
- Inappropriate grades / level of staff undertaking/providing care.
- Where the serious incident involves a poor outcome for the baby there
- appears to be minimal review of the obstetric care prior to birth.

Of the 4 RCAs 2 have neonatal components. Re case 2012/22311; we do not agree that neonatal care was acceptable, the probability of a diagnosis of severe septicaemia in this baby is obvious from birth, and antibiotics should have been commenced sooner.

Similarly the management of the baby in case 2012/7414 raises serious concerns about the quality of neonatal care, these are noted in the RCA. Two venous gases were taken in the hour after admission to the neonatal unit which showed severe and deteriorating abnormalities which appear not to have been recognized or understood, particularly by the consultant.

These failures of management in what are standard neonatal emergency situations raise questions of the competence of the staff and safety of this unit. It is an absolute requirement of a neonatal service however small that the staff are competent to assess and stabilize an unexpectedly ill infant. These problems echo the recommendation made in our main report about the urgency of the neonatal teams in the two hospitals collaborating to discuss and agree clinical protocols.

The dashboard describes only 1 baby with HIE all year (September 2012). Clearly this baby and probably also SI reference 2012/24174 had HIE.

The RCA enquiry team do not appear to have asked the appropriate questions and therefore conclusions are likely to be wrong. We presume they have been based on perusal of the RCA proformas rather than an in depth examination of each case.

Furthermore we have now seen the Edgcombe report which is truly shocking in its account of failure of clinical leadership and of the dysfunction within the paediatric team - it was received in April 2012. We understand that the Trust management has taken steps to try and rectify the problems, working with the paediatric cliniciansThe Obstetric team also described a number of occasions where they have raised concerns to senior management about clinical performance and clinical safety and stated that, although a number of actions had been taken and risk mitigantions put in place, the risk to patient safety had not been fuilly mitigated and serious incidents were still occurring.

In summary, we do not believe that either the maternity or the paediatric service is safe or sustainable in its current shape. The paediatric department particularly appears dysfunctional with little insight. Urgent steps need to be taken to address these shortcomings.

David Richmond on behalf of the NCAT team.
11February 2013.

Appendix 1

Documents Received prior to visit

IRP Report 2008
Review of maternity services September 2011
East Sussex Maternity Services Strategy 2009-2012
RCPCH Service Review
Updated Service Review 4-9-11

Activity
Maternity Risk Register 31-8-11
SI's in maternity
Letter to CE from O&G Consultants
Risk Paper August 2012
Summary of Current Risks Dec 2012
Updated for CE 22-10-12

Maternity PID
Sussex Together MN - Why we need to change version 8
Strategic options to be considered to deliver the model of care 12-9-11
The Need for Change in Services for Sick Children in Sussex July 2012
Sussex together – Maternity and Paediatric Clinical Summit Summary

.Appendix 2

NCAT Review Friday 4th January 2013
Maternity & Paediatric Services
Interview Schedule

St Mary's Board Room Eastbourne DGH 9am onwards /Room 1 Education Centre Conquest 11am onwards

NCAT Working Group:
Standards for Reconfiguration of Maternity & Children's services

David Richmond **Vice President for Standards, Royal College of Obstetrics & Gynaecology**
Suzanne Truttero **Midwife**
Kate Costeloe **Consultant Neonatologist**

Session	Time	Interviewee	Role & Responsibility	Room/Phone Number
	09.00	**Pre-Meeting – Tea & Coffee x11**		**St Mary's Board Room EDGH**
1.	**09.30**	Darren Grayson Amanda Harrison Andy Slater Jayne Phoenix Jamal Zaidi Dexter Pascal David Scott Paula Smith David Hughes Malcolm Stewart Alice Webster	CEO ESHT Director of Strategic Development & Assurance Joint Medical Director Associate Director of Integrated Care Divisional Director of Integrated Care Consultant Obstetrician Consultant Paediatrician Assistant Director Integrated Care Joint Medical Director Medical Advisor to NHS South of England Director of Nursing	**St Mary's Board Room EDGH** **13) 5653** **14) 8972** **14) 8049** **13) 3754** **14) 6527** **14) 6434** **14)2730** **13) 5812** **14) 8049** **07974348175** **14) 6302**
2.	**10.30**	**Obstetrics & Midwifery Group Meeting** Dexter Pascal Mini Nair Tim Arnold Mo Faris Paula Smith Yousef Waleed Chris Cowling Anne Watt	Consultant Obstetrician Consultant Obstetrician Assistant Director Integrated Care Midwifery Clinical Services Manager Clinical Governance Manager Integrated Care	**St Mary's Board Room EDGH** **V/C at Conquest from 11am** **Room 1. Education Centre** **14) 6434** **14) 6527** **13)5812** **14) 4164 until 11.15** **13) 4795 until 11.30**
	13.00	**LUNCH x6**		

3.	**13.30**	**CCG Meeting** Martin Writer Greg Wilcox Roger Elias		**St Mary's Board Room EDGH**
4.	**14.30**	 Keith Brent Scarlett McNally	 Consultant Paediatrician Orthopaedics Consultant	**St Mary's Board Room EDGH** **13) 3709** **13) 5809**
	15.00	**Tea & Coffee x6**		
5.	**15.30**	**Paediatrics Meeting** David Scott Melanie Liebenberg Nadia Muhi Iddin Nursing Staff via Paula Smith Paula Smith Wendy Thompsett Jayaram Pai	 Consultant Paediatrician Consultant Paediatrician Consultant Paediatrician Assistant Director Integrated Care Ward Matron SCBU Consultant Paediatrician	**St Mary's Board Room EDGH** **14)2730** **13)8277** **14)8945 via V/C Conquest** **13)5812** **14) 6307** **14) 8459**
6.	**17.00**	**Emerging Findings** Darren Grayson Amanda Harrison Andy Slater Jayne Phoenix Jamal Zaidi Dexter Pascal David Scott Paula Smith David Hughes Malcolm Stewart	 CEO ESHT Director of Strategic Development & Assurance Joint Medical Director Associate Director of Integrated Care Divisional Director of Integrated Care Consultant Obstetrician Consultant Paediatrician Assistant Director Integrated Care Joint Medical Director Medical Advisor to NHS South of England	**St Mary's Board Room EDGH** **13) 5653** **14) 8972** **14) 8049** **13) 3754** **14) 6527** **14) 6434** **13)5812** **14) 8049** **07974348175**