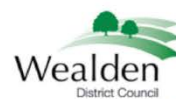


Better Beginnings

HOSC evidence pack 1

17th February 2014



Contents

1	Evidence from national bodies and other published evidence	
1.1	State of Maternity Services Report 2013; 2013 (The Royal College of Midwives) A report on the state of maternity services in the UK in 2013. The report details birth rates, increases in complex births, and the scale of the national shortage of midwives.	7
1.2	Birthplace programme overview: background, component studies and summary findings; November 2011 (Birthplace in England Collaborative Group) A report on the costs and outcomes of giving birth in different settings in the NHS in England.	23
1.3	Reconfiguration of Women's Services in the UK; December 2013 (Royal College of Obstetricians and Gynaecologists) A guide to understanding the principles that affect the reconfiguration of women's health services and to assessing the quality and standard of women's services following reconfiguration.	67
1.4	Good Practice No. 10: Labour Ward Solutions; January 2010 (Royal College of Obstetricians and Gynaecologists) A document highlighting the challenges and issues that arise from the process of expanding consultant presence on the labour ward and presenting facts and tips for those responsible for implementing changes.	79
1.5	Emergency Surgery standards for unscheduled surgical care; February 2011 (The Royal College of Surgeons of England) A report on the standards for the care of unscheduled adult and paediatric surgical patients.	103
1.6	Advice on proposals for changes to maternity, special care baby services and inpatient gynaecology services in East Sussex; July 2008 (Independent Reconfiguration Panel) The report by the Independent Reconfiguration Panel to the Secretary of State for Health on the Primary Care Trust's proposals for changes to maternity, special care baby services and inpatient gynaecology services in East Sussex in 2008.	187
1.7	NCAT Review: East Sussex Healthcare NHS Trust Maternity and Paediatric Services; January 2013 (National Clinical Advisory Team) A review of East Sussex Healthcare NHS Trust's (ESHT) proposals to temporarily change the configuration of maternity, gynaecology and paediatric services.	231

1.8	Review of the Obstetric and Neonatal Services of East Sussex Healthcare NHS Trust at Conquest Hospital; August 2013 (Royal College of Obstetricians and Gynaecologists) An independent review of ESHT's temporary reconfiguration of maternity services at the Conquest Hospital.	247
1.9	Service Review: East Sussex Healthcare NHS Trust; November 2013 (Royal College of Paediatrics and Child Health) An independent review of ESHT's temporary reconfiguration of paediatric services.	263
2	Evidence from the Clinical Commissioning Groups (CCGs)	
2.1	Better Beginnings: Proposals for the future of NHS maternity, in-patient children's services and emergency gynaecology in East Sussex; 2014 (Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG, & High Weald Lewes Havens CCG) The primary consultation document explaining the proposals for the future of NHS maternity, in-patient children's services and emergency gynaecology in East Sussex.	309
2.2	Pre consultation business case for maternity and paediatric services in East Sussex: Appendix 12 - Maternity and Paediatric Needs Assessment; December 2013 (Public Health) A maternity and paediatric needs assessment of East Sussex's population that was included as an appendix to the CCG's pre-consultation business case.	349
3	Media reports	
3.1	'Women's Experiences of maternity care have improved, but further progress is needed'; 12 December 2013 (Care Quality Commission)	411
4	Evidence from campaign groups and stakeholder groups	
4.1	Save the DGH Evidence: • Save the DGH campaign statement • Notes of meeting with Yeovil NHS Trust • Notes of meeting with Hinchingsbrooke NHS Trust • 'Homebirth and the Future Child'; 22 Jan 2014 (Lachlan de Crespigny, Julian Savulescu) • EDGH to Conquest by public transport	417
4.2	Maternity Services in the High Weald Locality: Not where...but how & by whom; February 2014 (Richard Hallett) An alternative viewpoint affecting maternity services for the people of	435

	Crowborough and the High Weald.	
4.3	Review of Obstetric Scanning at Crowborough; June 2012 (Crowborough Birth Centre Stakeholder Consultation Group) A review of Obstetric Scanning at Crowborough Birth Centre.	453
5	Evidence from members of the public	
5.1	Comments received by email from members of the public	465

Evidence from national bodies and other published evidence



State of Maternity Services report 2013



The Royal College of
Midwives

Executive summary

This is the third report in our annual *State of Maternity Services* series. Our two previous reports, the 2011 and 2012 editions, have set the standard as go-to points of reference for the latest numbers on NHS maternity services for each part of the UK. Over time the reports will serve as an evolving commentary on the changing state of maternity services; meantime they provide commentators and decision-makers with a snapshot of today's maternity care.

The report is not a review of, say, structural changes. It has a very specific focus: the collation and interpretation of some of the basic numbers that tell the story of the state of maternity services.

England remains the problem child. The number of births in England continued to rise in 2012, reaching its highest number (694,241) since 1971. This was 23 per cent higher than 2001. London (up 29 per cent) along with the South West and the East Midlands (both up 25 per cent) are the regions that have seen the biggest rises.

In Scotland, births fell for the fourth year in a row, although remained 10 per cent higher than in 2001. In both Wales and Northern Ireland the number of births fell in 2012 for the second year in a row, but in both cases the number remained 15 per cent higher than it had been in 2001.

The very latest figures, for the first half of 2013, may however suggest that the baby boom in England is over. In the first six months of the year the number of births in England fell by 18,000, compared to 2012. Smaller falls in the first six months of 2013 were seen across the rest of the UK.

Scotland, Wales and Northern Ireland have thankfully not used the tailing off of their baby booms to cut midwife numbers. Whilst individual units or areas in those parts of the UK may be understaffed, overall they employ broadly the right number of midwives.

The effect of this higher number of births in England is multiplied by the growing complexity of pregnancies. Indeed, the importance of complexity on the midwifery workload has often been overlooked.

One example of rising complexity is the continuing growth of births to older women. In 2012, for example,

there were 85 per cent more babies born to women in England aged 40 or over than there had been in 2001. In Scotland the rise for mothers aged 40 to 44 was 71 per cent over the same period, and 165 per cent for women older than that. In Wales the rise was 64 per cent for births to women aged 40 or over. And in Northern Ireland it was 64 per cent for women between the ages of 40 and 44, and 53 per cent to women above that age range.

Any falling away of the baby boom should not be seen as a reason to take a foot off the accelerator

Obesity is another area of growing complexity, which compounds the effect of the baby boom¹. The incidence of maternal obesity in the first three months of pregnancy in England, for example, more than doubled from 7.6 per cent to 15.6 per cent between 1989 and 2007. The result is an extra 47,500 women requiring more demanding care.

Our assessment of the shortage of midwives in the NHS in England in 2012, the latest full year for which we have both midwife and birth figures, is around 4,800. This is an improvement of 200 on last year. Indeed, this is the fourth year in a row in which the shortage has fallen, having stood at more than 6,000 in 2008.

This report also publishes for the first time a calculation, for England, of the difference between the number of births that took place in a year and the number of births for which the midwifery workforce during that year was suited. So, for example, in 2012 there were 694,241 babies born in England, but the number of midwives working in the NHS in that year was only really suitable for 565,245 births; meaning there were 128,996 more births than the service was designed to cope with. This puts any recent reduction in the number of births in context.

The total number of students studying midwifery has now topped 6,000 in England. That is good news, and needs to continue. The UK Government increased training places in England to a record level before letting them slip back in 2013/14; they should return the number of student places to their record level.

The fact that the NHS in England is thousands of midwives short of where it needs to be was confirmed in November 2013 by the publication of the National Audit Office (NAO) report, *Maternity services in England*. The report's findings largely confirmed what the RCM has been saying for some years now.

Outside of England, we need politicians to ensure that they keep putting into NHS maternity services the resources required to maintain everything on an even keel, particularly keeping an eye on the age profile of midwives so that retirees are replaced in good time by newly-qualified staff.

Within England we need to see an explicit commitment to maintain and speed up the elimination of the midwife shortage. A cut in the shortage of 200 midwives in a year is okay, but it is by no means fast enough.

We need to see training numbers maintained at their current levels and newly-qualified midwives given employment not least because of the growing dropout rate amongst student midwives, as referenced in the NAO report.

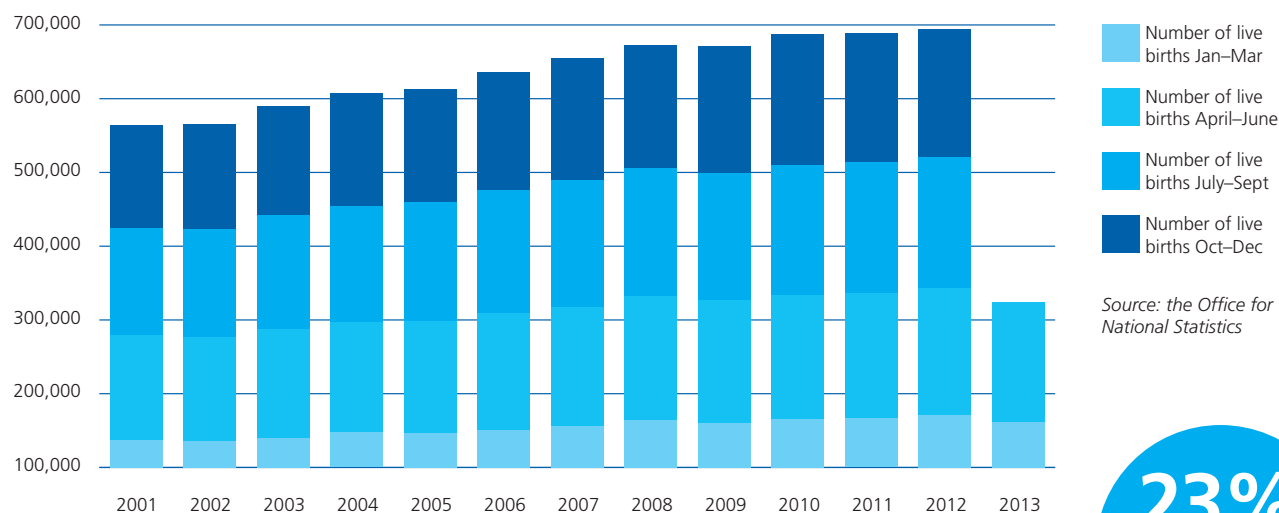
Above all it is important for the RCM to communicate the fact that any falling away of the baby boom should not be seen as a reason to take a foot off the accelerator; instead, it should be seen as an opportunity to eliminate the shortage much faster.

We remain hopeful for better days ahead. It would appear that the baby boom may have ended, although birth numbers remain high. With the pressure easing, the opportunity is now here finally to eliminate England's longstanding midwife shortage.

¹ Heslehurst, N. and Rankin, J. and Wilkinson, J.R. and Summerbell, C.D. (2010) 'A nationally representative study of maternal obesity in England, UK: trends in incidence and demographic inequalities in 619323 births, 1989-2007.', *International journal of obesity*, 34 (3). pp. 420-428.



Births



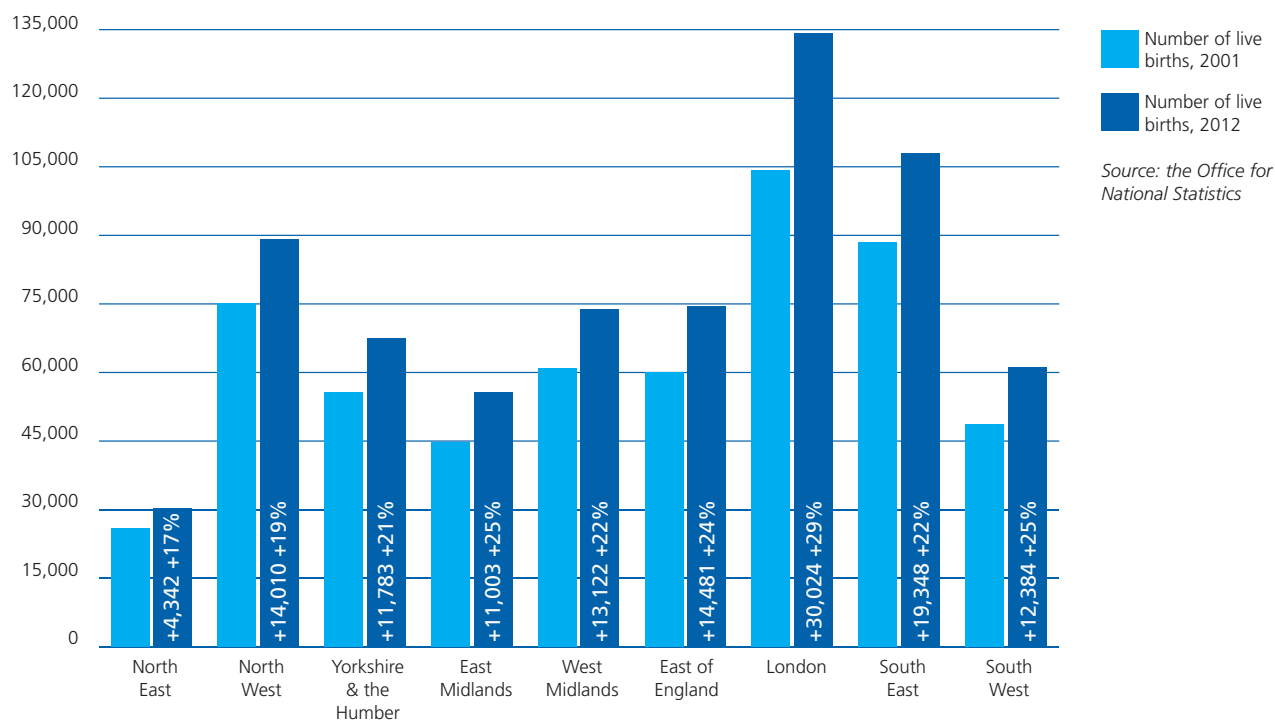
Source: the Office for National Statistics

Between 2001 and 2012 the number of births each year rose by 130,497 (or 23 per cent). Last year (2012) saw more babies born in England (694,241) than any year since 1971. Figures for the first half of

2013 however show that the number of births is beginning to fall, compared to the same period in 2012, suggesting that the decade-long baby boom may have come to an end.

23%
increase in babies
born between
2001 and 2012

Regional variation in births

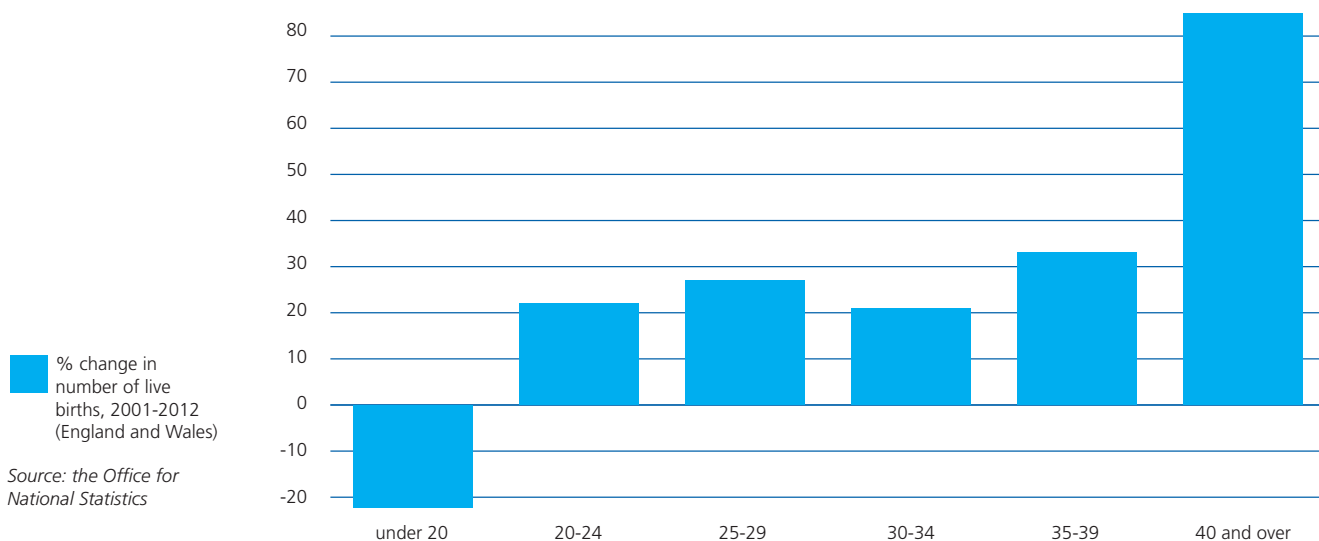


Source: the Office for National Statistics

All but two English regions saw rises of above 20 per cent between 2001 and 2012, with the biggest rises seen in London (up 29 per cent) as well as the South West and the East Midlands (both up 25 per cent). The largest rises in the number of babies born each year were in London (up 30,024) and the South East (up 19,348).

The lowest rises over those 11 years were seen in the North East and the North West, but those rises were still 17 and 19 per cent respectively.

Age profile of mothers



Previous *State of Maternity Services* reports revealed a trend towards women having babies later in life, and fewer giving birth in their teenage years. These trends are becoming more pronounced. Between 2001 and 2012, for example, the number of babies born in England to women aged 40 or over rose by 85 per cent (up 13,280).

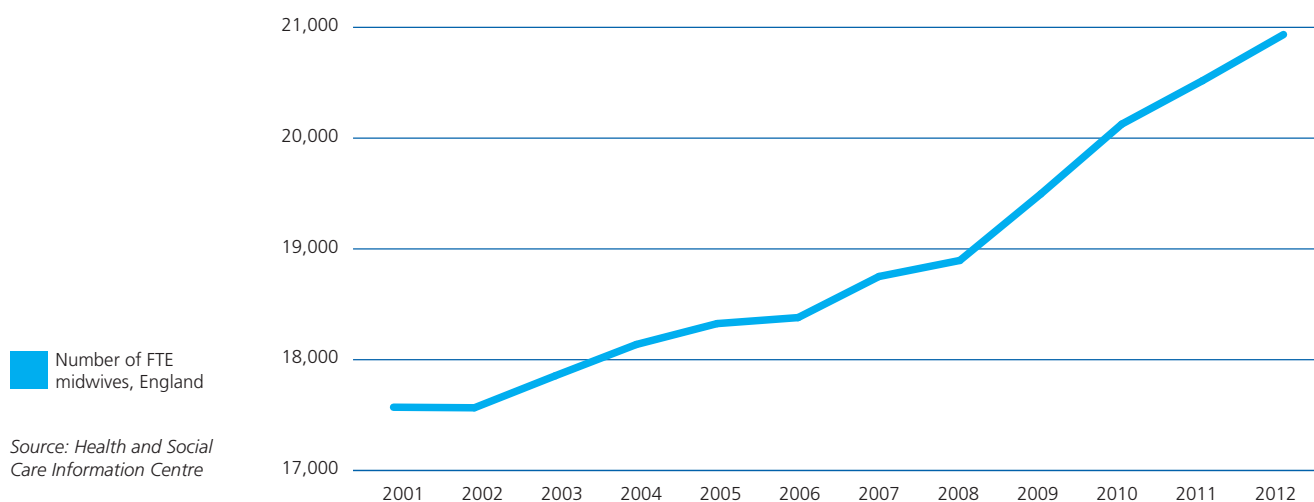
The second-highest rise amongst the age groups was to women aged 35 to 39, with babies born to

these women up 33 per cent. At the other end of the scale, babies born to women and girls aged under 20 fell 23 per cent during this period.

Older women require more assistance from midwives. They have a perfect right to all that additional care, of course, but it has an undeniable knock-on effect on workload, and that needs to be reflected in the number of midwives in the NHS overall.

85%
increase in births to women aged 40 and over between 2001 and 2012

Midwives

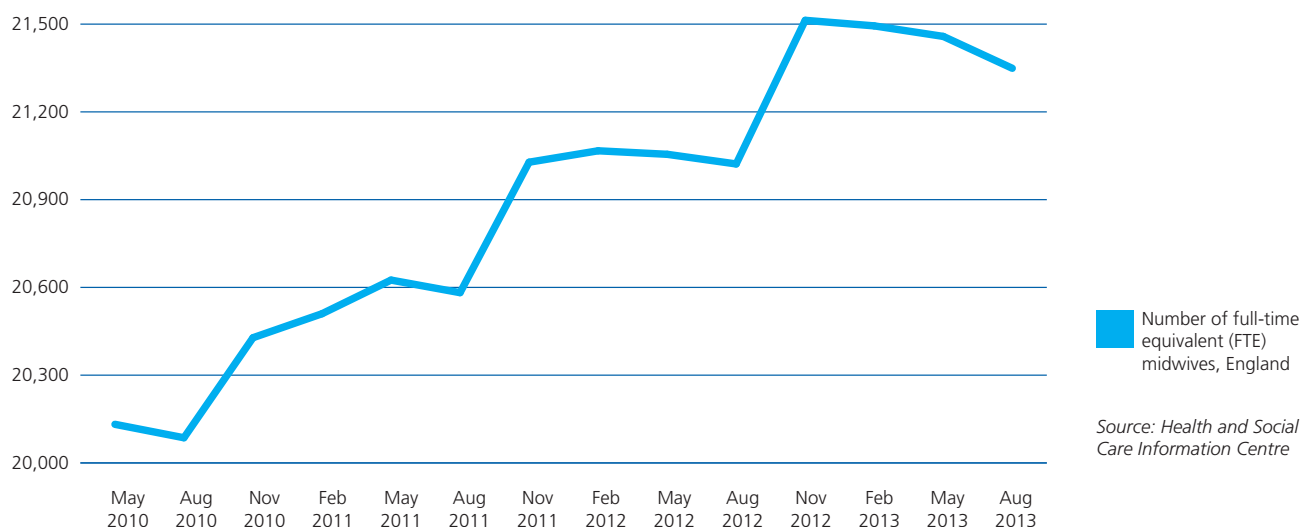


The number of midwives is up. In 2012, at the annual snapshot date of 30th September, there were the equivalent of 20,935 full-time midwives working in the NHS in England. This was up over

3,000 since the start of the baby boom in 2001. For most of the last decade, the midwifery workforce has risen slower than the number of births, though this has improved in recent years.



Midwives: the Coalition's record



The RCM is willing to criticise where it sees the Government getting things wrong, but equally we want to praise where we see the Government getting things right.

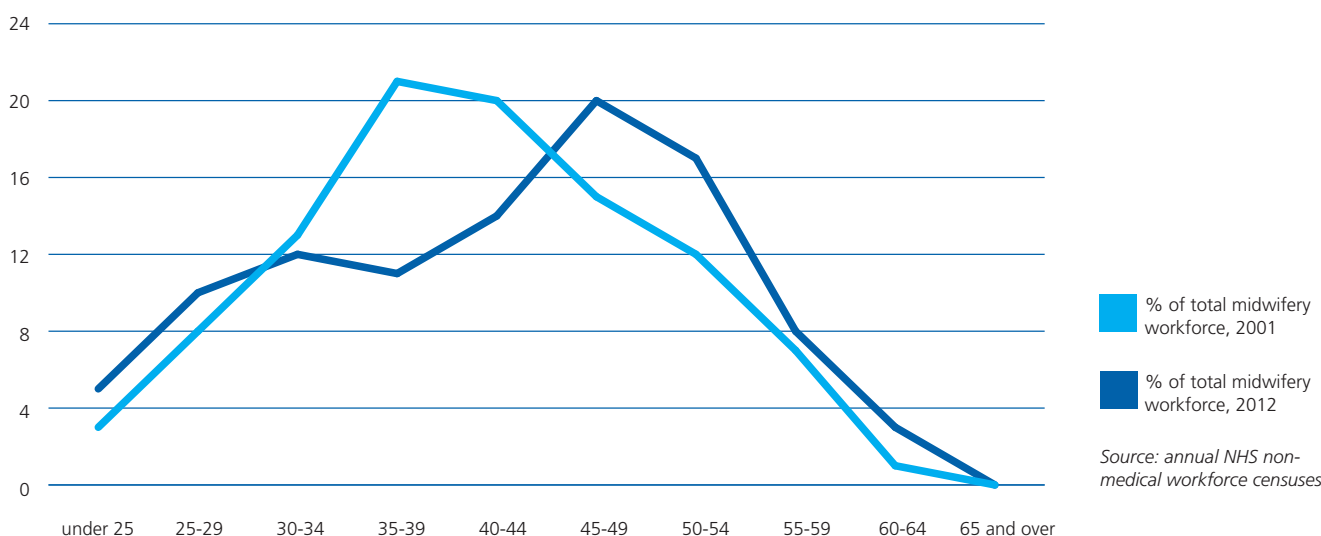
On midwife numbers the Government is moving things in the right direction. Despite cuts elsewhere, we have seen a continued rise in midwife figures since 2010, continuing a rise that started under

Labour. Indeed, there were 19 per cent (or 3,364) more midwives in 2012 compared to 2001.

The number of NHS midwives in England is up over 1,200 since the 2010 election, but has dipped slightly in recent months; with the desperate need for more midwives, we do hope that this drop will prove temporary.

19%
increase in
midwives between
2001 and 2012

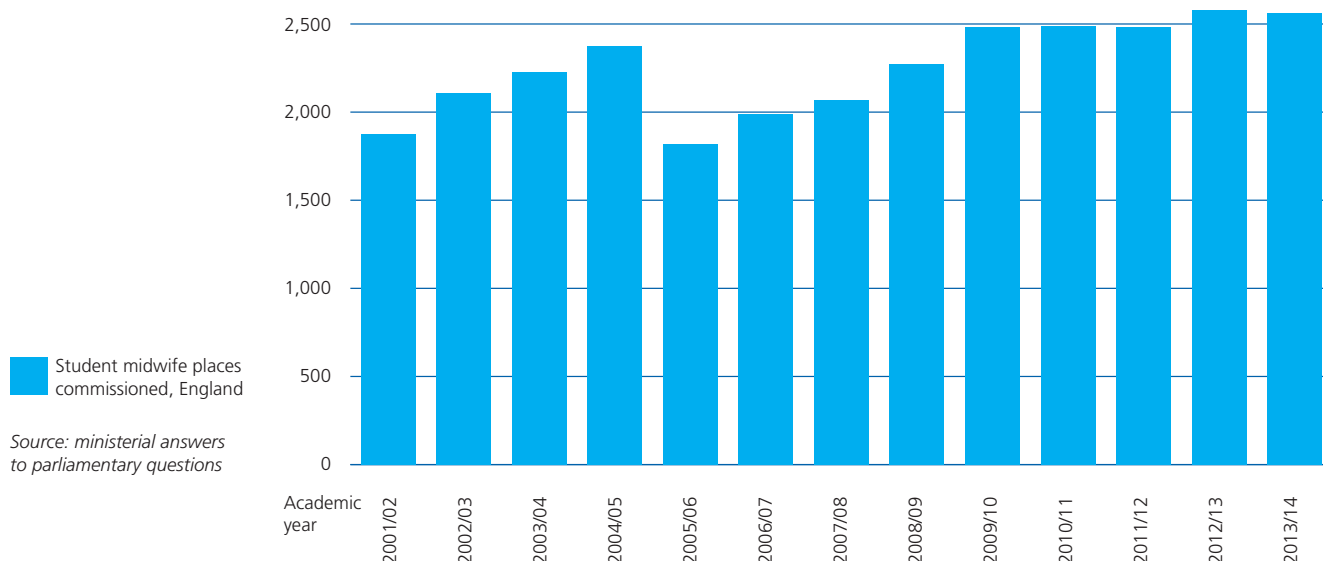
Age profile of midwives



NHS midwives in England are getting older. The largest age group in 2001 was midwives aged between 35 and 39; the largest age group in 2012 was those aged 45 to 49.

In other words, that large group is working its way through the system. Workforce planners need to ensure that this large group of midwives is replaced in advance of retirement.

Student midwives

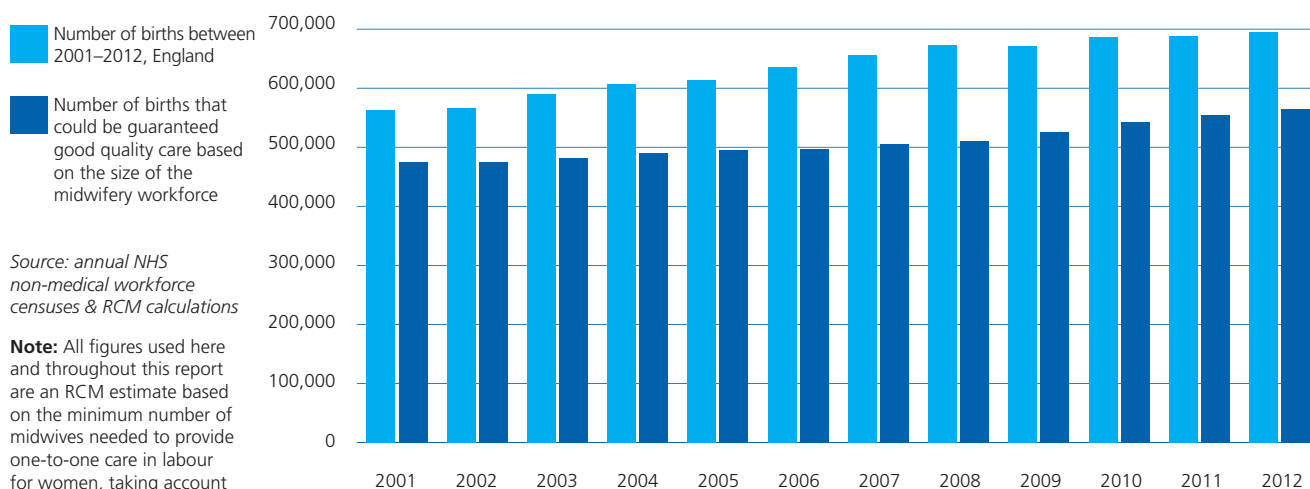


The Coalition deserves praise for increasing the number of training places for midwives. The total number of student midwives in 2012/13 topped 6,000, which is excellent news.

In the most recent year (2013/14) the number has dropped slightly, which is a shame.

As stated earlier, the work to eliminate the shortage must be maintained; the RCM wants to see the number of places for new student midwives restored to its earlier, record level. There is absolutely no shortage of applicants for midwifery courses.

How births outstrip midwife numbers



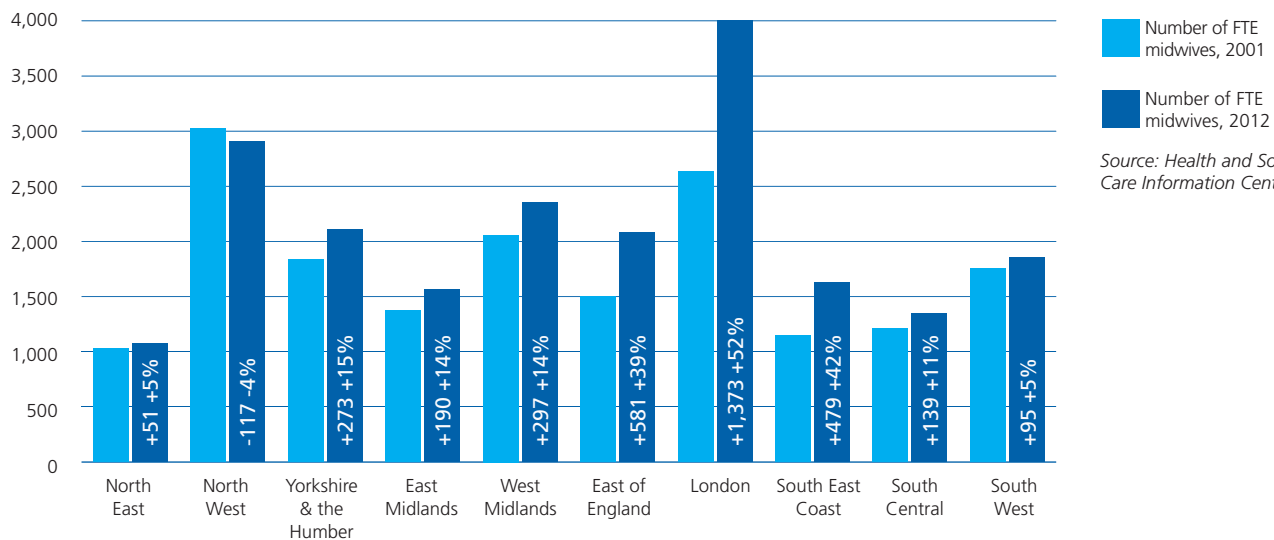
Note: All figures used here and throughout this report are an RCM estimate based on the minimum number of midwives needed to provide one-to-one care in labour for women, taking account of place of birth, antenatal and postnatal care, annual and sick leave, training, managerial and specialist roles and other factors. The estimates do not take into account the increasing complexity of birth.

This report introduces a new measurement: the difference between the number of births that take place each year and the number of births for which the midwifery workforce is suited. So, for example, in 2012 there were 694,241 babies born in England, but the number of midwives working in the NHS in that year was only really suitable for 565,245 births; meaning there were 128,996 more births than the service was designed to cope with.

So, even if the baby boom has ended and the number of births falls in 2013, it would need to drop by around 130,000 before the need for more midwives no longer exists. The end of the baby boom, if that is what we are seeing, does not mean the end of the need for more midwives.



Regional changes in number of midwives



There is a big variation in how different parts of England have responded to the baby boom. The NHS in London, for example, increased the number of full time equivalent midwives between 2001 and 2012 by more than half; up from 2,633 to 4,006.

NHS South East Coast increased their midwife numbers by 42 per cent, or 479 midwives, and the East of England witnessed a 39 per cent boost, up from 1,501 to 2,082.

The smallest rise was seen in the North East (up just 5 per cent), although to be fair it went into the baby boom in a far healthier state than any other region.

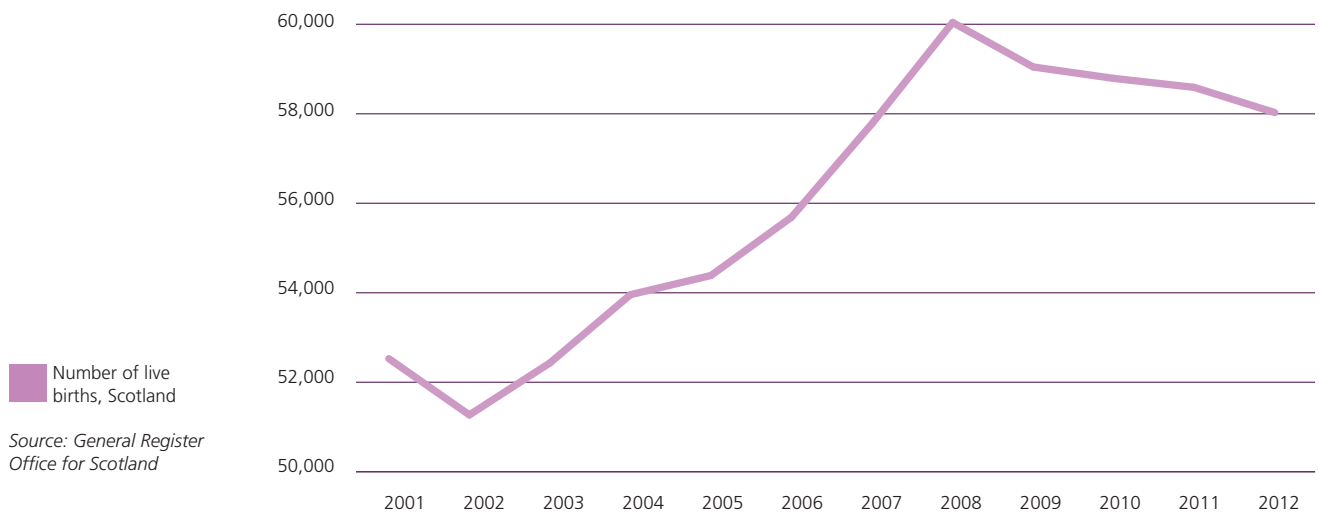
The worst performer was the North West, where the number of midwives was actually cut by 117 midwives between 2001 and 2012, despite the number of babies born in the region jumping by 14,010 over the same period.

4%
drop in the number
of midwives in
the North West
between 2001
and 2012



Scotland

Births

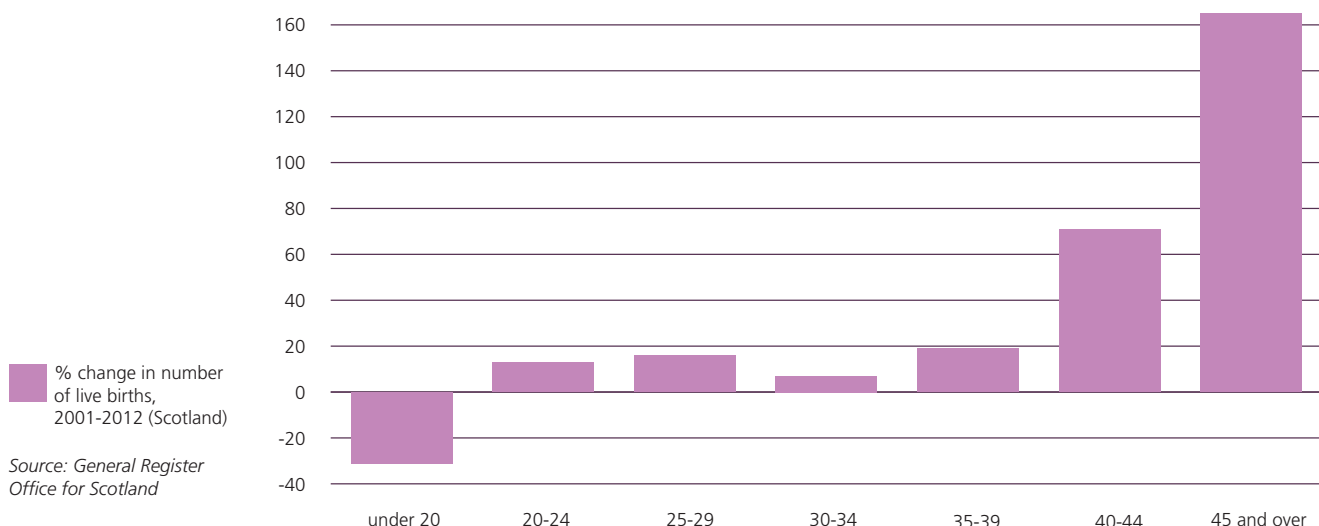


2012 was the fourth successive year in which the number of babies born in Scotland fell. The drop between 2008 and 2012 was not dramatic; the

2012 figure for births (58,027) was only 3.4 per cent off the 2008 peak (60,041), and the 2012 figure was still 10 per cent higher than 2001.

24%
fall in births to girls
under 20 between
2001 and 2011

Age profile of mothers

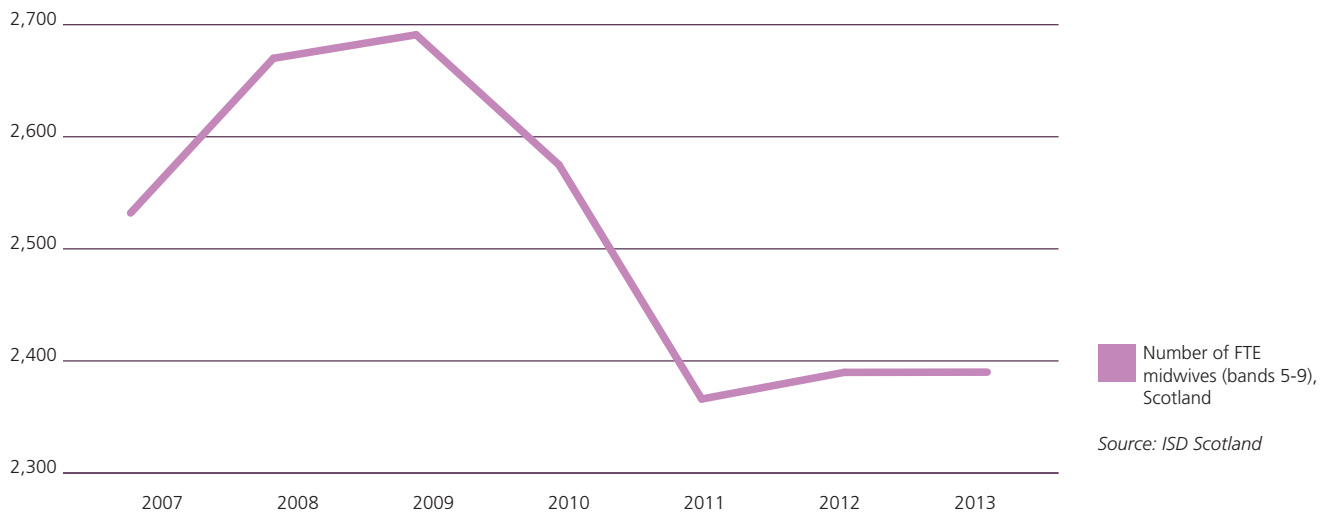


The changing age profile of women giving birth throughout the UK is perhaps at its most extreme in Scotland. The number of births to women and girls aged below 20, for example, fell 31 per cent between 2001 and 2012, from 4,444 to 3,074.

For older mothers, the care of growing numbers of whom is placing additional pressure on the NHS, rose dramatically in Scotland. The number of babies born to women aged between 40 and 44, for example, was up 71 per cent between 2001 and 2012; for the oldest age group (45+) the increase was 165 per cent, although for women of that age the numbers of birth are small (up from 40 to 106).



Midwives



Sensibly the Scottish Government has not exploited a small reduction (3.4 per cent over four years) in the number of births to slash midwife numbers. They have maintained them and we welcome the fact that they have taken that course of action.

We believe that the apparent fall in midwives shown in the chart is as a result of a large-scale data cleansing exercise, and that in recent months the figures have become much more accurate and trustworthy. The RCM believes that, when viewed as a whole, the NHS in Scotland employs enough midwives.

Student midwives



The number of training places for midwives in Scotland was cut. We accept that as reasonable however given that the NHS in Scotland employs sufficient numbers of midwives and the baby boom has tailed off.

The RCM will not simply call for more midwives, more student midwives and more funding whatever the circumstances. If we believe that a part of the UK employs enough midwives we will say so.



Wales

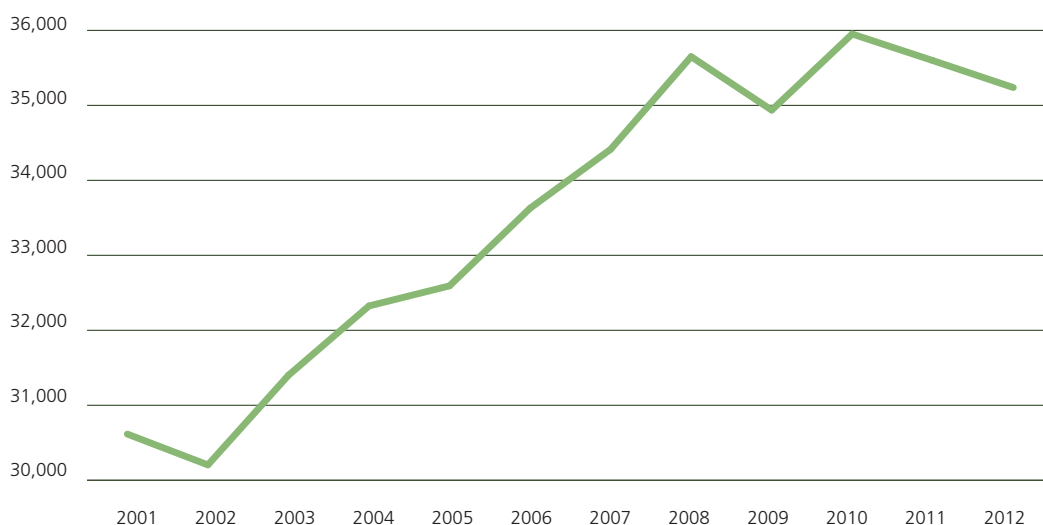
15%

rise in births in
Wales between
2001 and 2012

Number of live
births, Wales

Source: StatsWales

Births



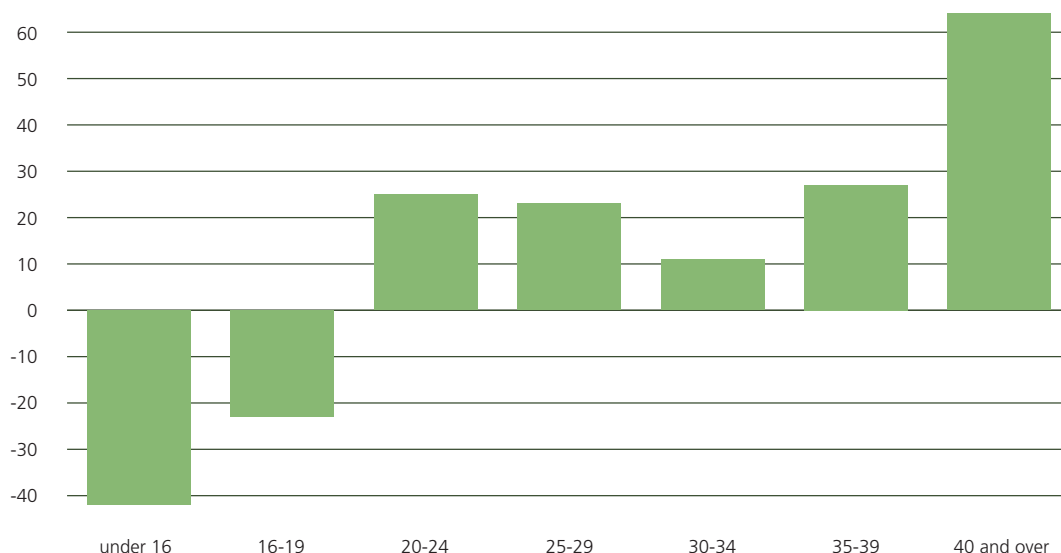
In 2012, the number of babies born in Wales fell; this was the second year in a row in which it had fallen. Between 2010 and 2012 however the

fall was only 2 per cent, down from 35,952 to 35,238. The 2012 figure was still 15 per cent higher than 2001.

Age profile of mothers

% change in number
of live births,
2001-2011 (Wales)

Source: StatsWales



Wales has witnessed the same changes in the age profile of mothers seen elsewhere in the UK, i.e. fewer younger mothers, and more older mothers.

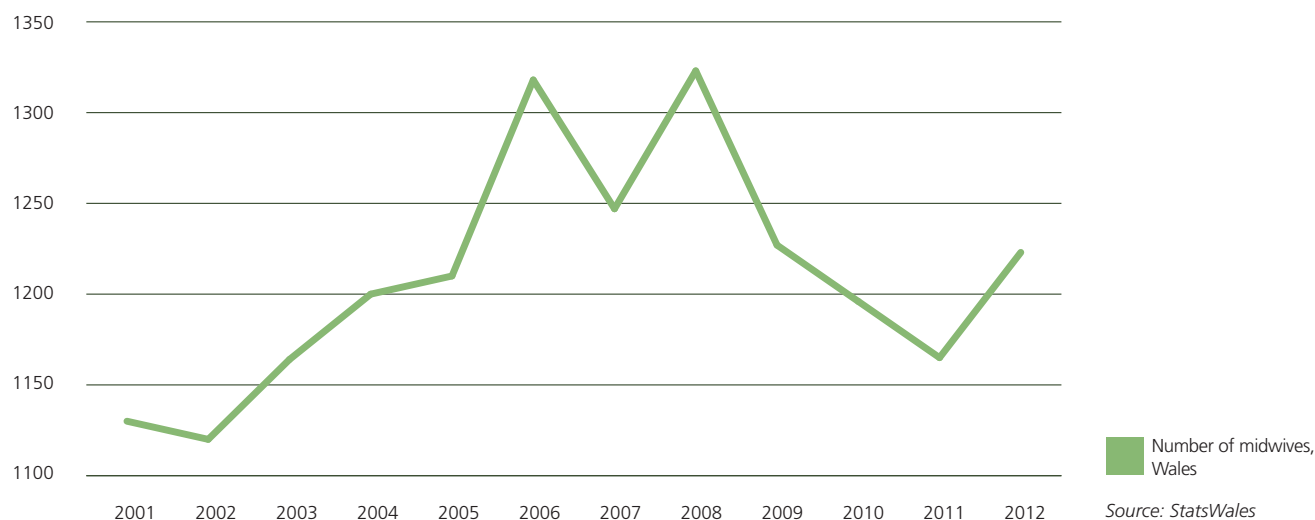
The small number of births to girls (those aged under 16) dropped 42 per cent between 2001 and 2011, from 93 to 54. There was a 23 per cent

fall in births to the remaining teenagers (ages 16-19) from 3,075 in 2001 to 2,365 in 2011.

The biggest rise was to the oldest age group, in Wales that is 40+. The number of births to these women in Wales rose 64 per cent.

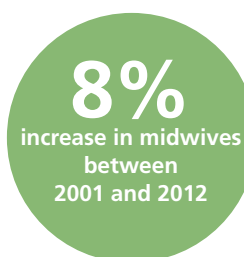


Midwives

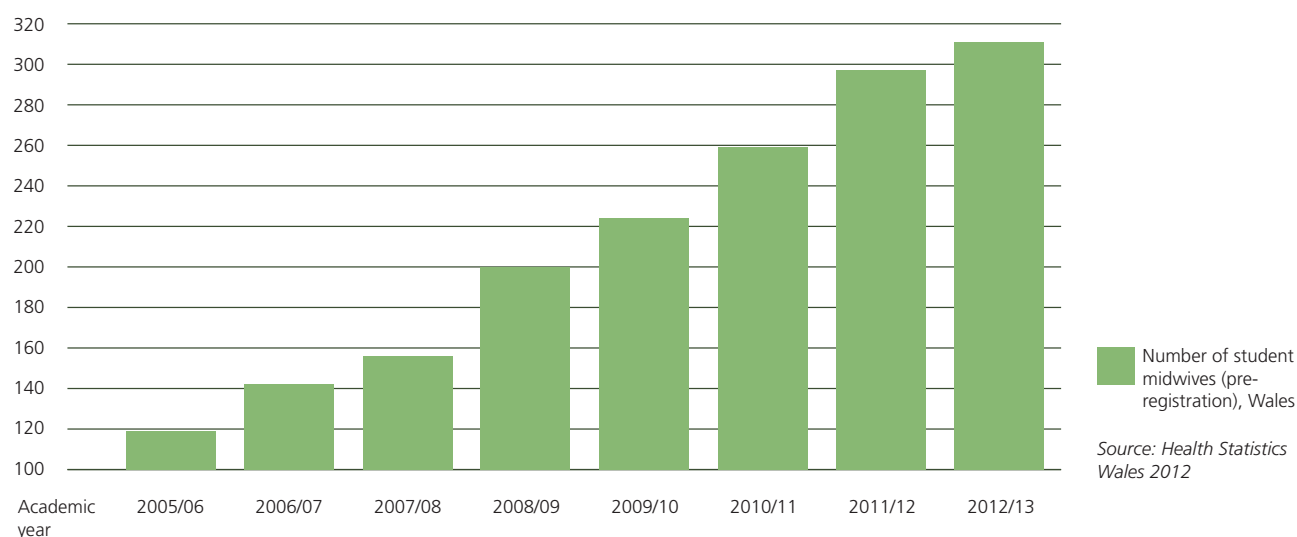


Since 2001 the number of midwives in the NHS in Wales has never been lower than 1,120 (in 2002) or higher than 1,323 (in 2008). In 2012 it stood at 1,223, up on the previous year and 8 per cent higher than 2001.

As with Scotland, we estimate that the NHS in Wales employs a sufficient number of midwives.



Student midwives



We are happy with midwifery training levels in Wales. The figures show a steady increase in places, which should ensure that those moving towards retirement are replaced long before they

leave the profession with newly-qualified midwives who have the time to develop their skills, confidence and experience.



Northern Ireland

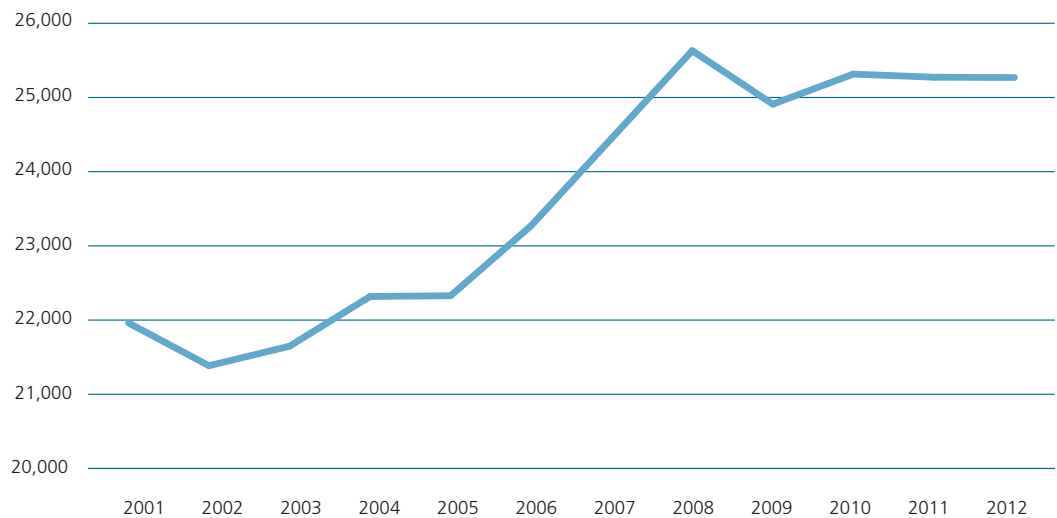
15%
increase in births
since 2001

■ Number of live births,
Northern Ireland

Source: Northern Ireland
Statistics and Research Agency

Note: As with the rest of the report, this includes only the number of live births to usually resident mothers. However, in large part due to Northern Ireland's shared border with the Republic of Ireland, a significant number of non-residents also give birth in Northern Ireland, increasing the pressure on maternity services.

Births



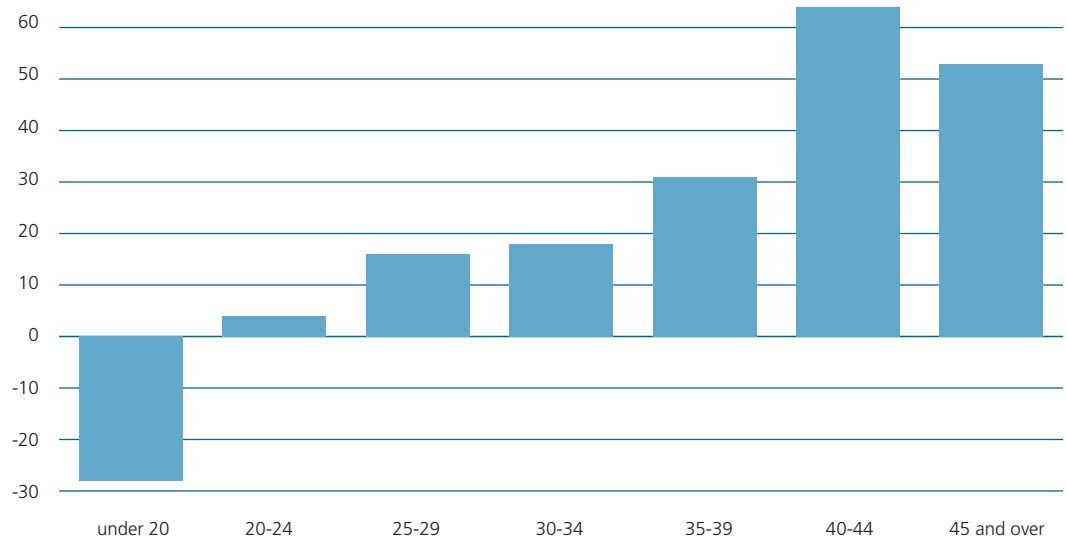
The situation with births in Northern Ireland is very similar to that of Wales. The number of babies born in Northern Ireland in 2012 (25,269) had fallen for the second year in a row, but by only a tiny amount (down 0.2 per cent in two years).

As with Wales, the 2012 figure was 15 per cent higher than the number of births in 2001. So, as with not just Wales but Scotland too, birth figures in Northern Ireland in 2012 were on a raised plateau compared to recent years, slightly off the peak but well above figures from the start of the century.

Age profile of mothers

■ % change in number
of live births, 2001-2012
(Northern Ireland)

Source: Northern Ireland
Statistics and Research Agency



The changes in the age profile of mothers in Northern Ireland between 2001 and 2012 were similar to other parts of the UK. Births to the youngest women and girls, those aged under 20,

fell by 28 per cent. The largest rises were to the oldest two age groups; births to women aged 40-44 jumped 64 per cent and for women aged 45+ the number was up 53 per cent.



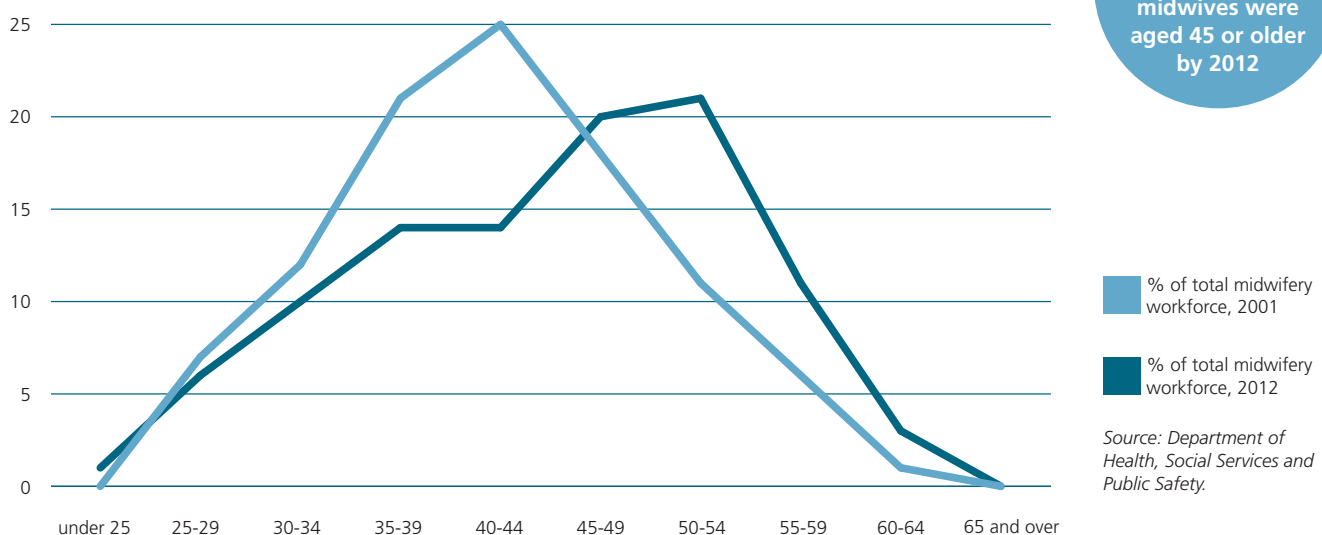
Midwives



The number of midwives working in the NHS in Northern Ireland in 2012 was its highest since at least 2001, at 1,040. That was up 7 per cent, or 65 full time equivalent midwives, between 2001 and 2012.

The RCM believes that the NHS in Northern Ireland employs a sufficient number of midwives.

Age profile of midwives

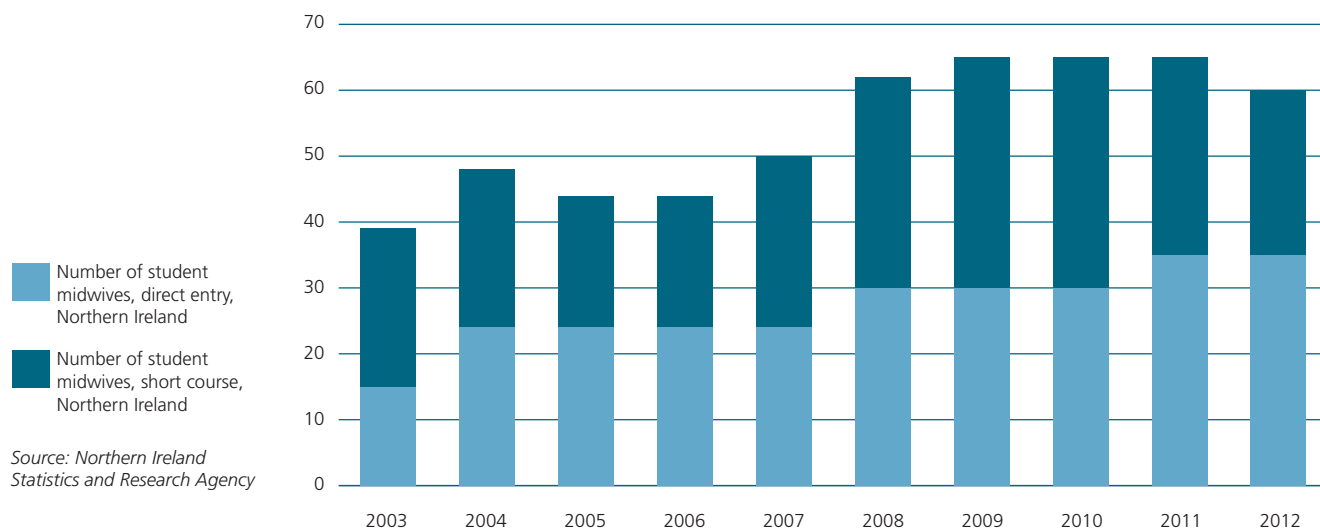


55%
Northern Ireland midwives were aged 45 or older by 2012

Midwifery in Northern Ireland is an ageing profession. Midwives falling into the following age bands – 25 to 29, 30 to 34, 35 to 39, and 40 to 44 – all formed a smaller proportion of the workforce in 2012 compared to 2001.

Interestingly the largest age group in 2001 was 40 to 44, whilst the largest age group in 2012 was 50 to 54, suggesting, possibly, that that represents a particularly large group within the profession in Northern Ireland who are all ageing together. That could present a workforce planning problem, and we would urge the Northern Ireland Executive to keep that under specific observation.

Student midwives



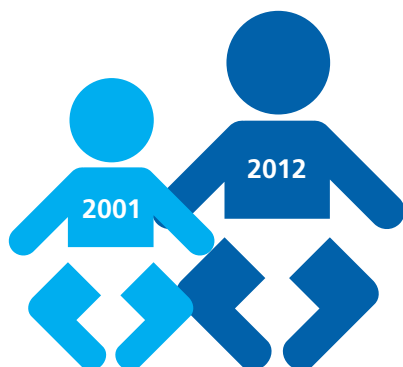
Whilst the latest – 2012 – student midwife figures are down on recent years, they are still higher than they were prior to 2008, and well above the levels seen at the start of the century.

As with Wales, we hope that this will ensure that new midwives can come into the profession in good time to replace those slowly heading towards retirement. This is something we may explore more in the preparation of the 2014 *State of Maternity Services* report.

Baby Boom 2001 & 2012

23%
increase

England saw more births in 2012 than any year since 1971



29%
increase in London



10%
increase in Scotland



15%
increase in Wales



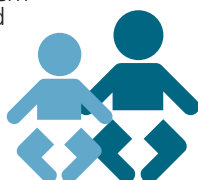
25%
increase in the South West



25%
increase in the East Midlands



15%
increase in Northern Ireland



Big rise in births to women over 40

71%
increase in births to women aged 40-44 in Scotland



165%
increase in births to women aged 45+ in Scotland



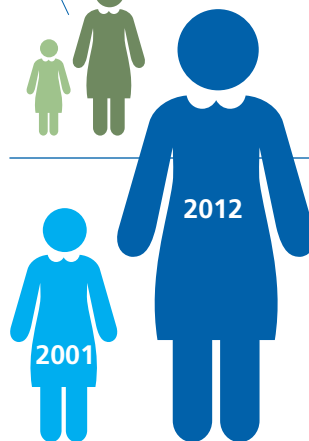
64%
increase in births to women aged 40-44 in Northern Ireland and Wales



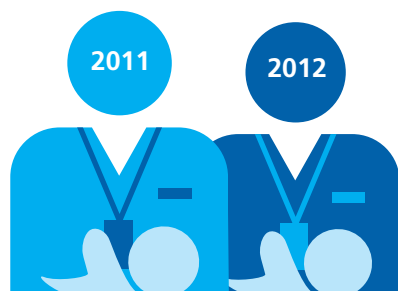
53%
increase in births to women aged 45+ in Northern Ireland



85%
increase in births to women aged 40-44 in England

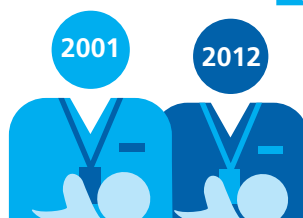
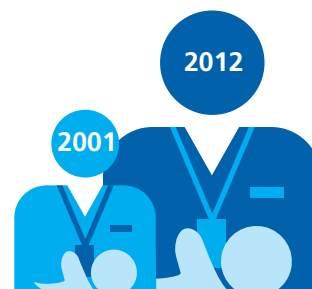


Not enough midwives to guarantee good quality care



In England, the shortage of midwives fell by only **200**, from **5,000** in 2011 to **4,800** in 2012.

52%
increase in midwives in London



4%
decrease in midwives in the North West



The Royal College of
Midwives



The Royal College of
Midwives

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Report compiled by Stuart Bonar

Birthplace programme overview: background, component studies and summary of findings

Birthplace in England research programme. Final report part 1

Prepared by Jennifer Hollowell on behalf of the Birthplace in England Collaborative Group

¹ National Perinatal Epidemiology Unit, University of Oxford

Published November 2011

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Project 08/1604/140

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Contents

Contents	3
Glossary of terms/abbreviations	5
Acknowledgements.....	6
1 Introduction	7
1.1 The purpose of this report	7
1.2 Background	7
1.2.1 Policy background.....	7
1.2.2 Research evidence.....	9
2 Overview of the Birthplace in England research programme	12
2.1 Aim	12
2.2 Objectives.....	12
2.3 Overview of the component studies	13
2.3.1 Terms and definitions consensus process.....	13
2.3.2 Mapping maternity care: the configuration of maternity care in England.....	14
2.3.3 National prospective study of planned place of birth.....	14
2.3.4 Cost-effectiveness analysis	15
2.3.5 Qualitative organisational case studies	15
2.3.6 National study of intrapartum related mortality	16
3 Overview of results	17
3.1 Terms and definitions	17
3.2 Mapping maternity care	17
3.2.1 Units and configuration	17
3.2.2 Workload.....	17
3.2.3 Capacity, occupancy and eligibility.....	18
3.2.4 Staffing	18
3.2.5 Intrapartum related services.....	19
3.2.6 Gaps in provision.....	19

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3.2.7	Recent and future changes in service provision	20
3.3	National prospective study of planned place of birth	20
3.3.1	Births to 'low risk' women	20
3.3.2	Births to 'higher risk' women	21
3.4	Cost effectiveness analysis	22
3.4.1	Socio-demographic characteristics	22
3.4.2	Costs	22
3.4.3	Cost-effectiveness	23
3.4.4	Sensitivity analyses	24
3.5	Qualitative organisational case studies	24
3.5.1	Choice of birthplace, information and access	24
3.5.2	Delivery of safe and high quality of care	24
3.5.3	Women's experiences of escalation and transfer	26
4	Key findings	27
4.1	The configuration of maternity care in England	27
4.2	The national prospective study of planned place of birth	27
4.3	Cost effectiveness analysis	28
4.4	Organisational case studies	28
5	Implications for policy and practice	30
6	Recommendations for future research	32
	References	34
	Appendix: Membership of the Birthplace in England Collaborative Group	37

Glossary of terms/abbreviations

AMU	Alongside Midwifery Unit
ANNP	Advanced Neonatal Nurse Practitioners
CI	Confidence Interval
CNST	Clinical Negligence Scheme for Trust
CQC	Care Quality Commission
DH	Department of Health
FMU	Freestanding Midwifery Unit
GP	General Practitioner
HCC	Healthcare Commission
HDU	High Dependency Unit
ICER	Incremental cost-effectiveness ratio
MWS	Maternity Support Workers
NCT	NCT (formerly National Childbirth Trust)
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NPEU	National Perinatal Epidemiology Unit
OU	Obstetric Unit
PSSRU	Personal Social Services Research Unit
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
RR	Risk Ratio
SHA	Strategic Health Authority
WTE	Whole Time Equivalent

Acknowledgements

This overview report was prepared on behalf of the Birthplace in England Collaborative Group which includes the wider group of co-investigators, advisors, researcher, project staff and coordinating midwives who contributed to the research programme, Members are listed in the Appendix to this report.

1 Introduction

The Birthplace in England research programme is an integrated programme of research, utilizing a range of methodological approaches, designed to address gaps in the evidence relating to processes, outcomes and costs associated with different settings for birth in the NHS.

1.1 The purpose of this report

The purpose of this report is to provide:

- the background to the Birthplace programme;
- an overview of the component studies; and
- a cross-study synthesis of:
 - key findings;
 - implications for policy and practice;
 - recommendations for future research.

The individual component studies are reported in detail in parts 2-6 of this report.¹⁻⁵

Two component studies are ongoing and will be completed in autumn 2011:

- Intrapartum mortality by planned place of birth (see section 2.3.6 below)
- Cost-effectiveness analysis part 2 (decision analytic model) (see section 2.3.4 below)

1.2 Background

1.2.1 Policy background

Since the early 1990s government maternity care policy has moved away from consultant-led care for women with straightforward pregnancies towards policies designed to give women a choice of settings for birth.⁶⁻⁸ The Maternity Standard of the *National Service Framework (NSF) for Children, Young People and Maternity Services* specified that 'Every woman should be able to choose the most appropriate place and professional to attend her during childbirth based on her wishes and cultural preferences and any medical and obstetric needs she and her baby may have' (p.27).⁸

This standard required that service providers and Trusts ensured that *'...options for midwife-led care will include midwife-led units in the community or on a hospital site'* and that care was to be provided in a *'...framework which enables easy and early transfer of women and babies who unexpectedly require specialist care'* (p28).⁸ *Maternity Matters* consolidated this policy direction for maternity care emphasising 'choice, access and continuity in a safe service' and setting out a 'national choice guarantee' for place of birth.⁹ In addition, the Public Service (PSA) Delivery Agreement challenged maternity service providers to ensure that services were accessible to all women, including the vulnerable and excluded, so that a risk assessment can be completed, women could make informed choices about their care, and appropriate care and services were put in place to help improve life chances for children.¹⁰

The more recently published White Paper confirmed and re-emphasised the principle of consumer choice.^{11 12}

Alongside this policy direction, a range of service specific and general NHS directed initiatives have also driven changes in the organisation and delivery of maternity care. Changes in workforce deployment such as the Changing Workforce Programme, revisions to medical training, the European Working Time Directive, maternity staffing standards and neonatal service reconfigurations have all altered professional practice boundaries, skill mix and relationships.^{13, 14} This has resulted in the introduction of support workers, of senior medical staff taking on direct care, extending the roles of nurses and midwives to include activities usually undertaken by junior doctors, and the promotion of midwifery led care.¹⁵ The implementation of these initiatives has taken place within a complex service, with care delivered in a wide range of organisational settings across the acute and primary care sectors and involving a wide range of caregivers in order to meet diverse needs ranging from promoting health and well-being in an essentially healthy population to high dependency care of sick women and babies.

In this context, 'midwife-led/midwifery units' or 'birth centres' and home birth services have become increasingly relevant to the configuration of maternity services currently under consideration in England. NHS midwifery units provide midwife-led care for women who are at 'low risk' of complications. There are two broad types of midwifery unit: 'stand-alone' or 'freestanding' units situated on a site geographically separate from a hospital obstetric or 'consultant-led' unit, and 'alongside', 'co-located' or 'integrated' midwifery units which are in the same building or on the same site as an obstetric unit. They have the potential to increase early direct access to community based maternity care, and deliver responsive and effective high quality care, that improves the quality and women's experiences of pregnancy and birth. However, the current development of

midwifery units and home birth services in England is ad-hoc and poorly evaluated, with a lack of agreed quality standards and benchmarks.¹⁶

1.2.2 Research evidence

Against this policy and organisational background, the Birthplace Research Programme was commissioned in order to fill a number of important gaps in the evidence supporting the provision of high quality intrapartum maternity care in England.

At the time there was little reliable evidence about the nature, geographical location and distribution of midwifery units. Evidence was also lacking about the number and characteristics of women planning birth in different settings, the staffing structures within midwifery units and their position within and relationship with the wider organisation and provision of maternity care, including obstetric and home birth services.

Reviews of research have also identified a lack of accurate quantification of the risk of adverse outcomes associated with births planned in these different settings. Furthermore, interpreting available evidence has been made more difficult because actual place of birth has often been used to make inferences about planned place of birth.^{6, 17-19}

Research on outcomes for women planning birth in midwifery units has been summarised in a Cochrane systematic review comparing birth in alternative birth settings with conventional institutional settings (obstetric units).²⁰ This review included nine randomised controlled trials and 10,684 women and the alternative birth settings studied were most similar to 'alongside' or 'co-located' midwifery units. Alternative birth settings were associated with an increased likelihood of spontaneous vaginal birth, increased maternal satisfaction and fewer interventions during labour and birth. There was no association between birth setting and severe perinatal morbidity or mortality (risk ratio (RR) 1.17, 95% CI 0.51-2.67). Also, there was no association between birth setting and serious maternal morbidity or mortality (RR 1.11, 95% CI 0.23-5.36). However, it is likely that the review was underpowered to detect any differences in rare but important severe adverse perinatal and maternal outcomes. No trials of 'freestanding' midwifery units were included in this review.

Prospective observational studies have shown a lower rate of intervention during labour for births planned in 'freestanding' midwifery units.^{19, 21}

Looking at home birth, a Cochrane systematic review of home versus hospital birth identified only one randomised controlled trial which included 11 women and was unable to detect any differences in safety or other outcomes between the two settings.²² A meta-analysis of six observational studies examined perinatal outcomes for 24,092 'low risk' women and their babies.²³ No difference was observed for perinatal mortality. There was

evidence that women planning birth at home had a lower risk of induction, augmentation, instrumental vaginal birth, caesarean section, episiotomy, severe perineal lacerations and that their babies were less likely to have low Apgar scores.

The results of several large observational studies comparing home births with birth in an obstetric unit have been published since the Birthplace Research Programme began in 2007. A retrospective cohort study from the Netherlands using routine data from over 500,000 women found no evidence of a difference in perinatal mortality or morbidity between 'low risk' women who planned to give birth at home and 'low risk' women who planned to give birth in hospital.²⁴ Canadian and Swedish studies of planned home births compared to planned hospital births for 'low risk' women also showed no difference in perinatal mortality.^{25, 26} Lower rates of obstetric interventions were observed in the planned home birth group for both studies. However, both studies included fewer than 20,000 births and lacked statistical power to demonstrate differences in rare but important adverse outcomes. A study using data from England and Wales attempted to quantify the intrapartum-related perinatal mortality rates for booked home births from 1994 to 2003 using routine statistics.²⁷ However, the data available were inadequate for this comparison and highlighted the need for a more rigorous quantification of the risks associated with each planned place of birth. A recent meta-analysis found planned home births, compared to planned hospital births, were associated with less medical intervention, had a similar perinatal mortality rate and an increased neonatal mortality rate.²⁸ This study has been criticised for failing to report the assessment of the quality of the studies included and for other methodological weaknesses.^{29 30}

It is difficult to draw clear conclusions about the effect of planned place of birth on outcomes due to differences in the health care systems in which studies were undertaken, the heterogeneity of studies, poor study design and the use of varied outcome measures. The National Institute for Health and Clinical Excellence's (NICE) clinical guidance on Intrapartum Care included guidance on planning place of birth and stated that "Of particular concern is the lack of reliable data, relating to relatively rare but serious outcomes such as perinatal mortality that is directly related to intrapartum events or serious maternal morbidity in all places of birth".³¹

Finally, given the complexity of maternity care provision, there is also a need for evidence about the features of maternity care organisations that are associated with high quality and safe care. High quality maternity care that crosses professional, institutional, geographical and temporal boundaries is predicated on developing effective pathways of care for a range of women. Research has highlighted communication barriers and a lack of collaborative working between health professionals as contributory factors to reduced safety.³² Successive confidential enquiries into maternal

deaths have also shown the contribution of poor interprofessional or interagency communication or teamwork to sub-standard care affecting outcomes.³³ There is a need to investigate how good communication and teamworking are pursued and achieved in different configurations of care.³⁴ It is also unclear to what extent midwifery unit care and home birth services can help meet the needs of individuals and communities that have been traditionally under-served, or where consultant obstetric services are no longer available locally. There is a need to investigate what kind of features work in practice to ensure equity of access and a high quality and safe service.

The Birthplace in England research programme was designed to fill these identified gaps in the research evidence and provide high quality evidence for use by policy makers, commissioners of services, health care professionals, women and their families to inform discussions and decisions about place of birth.

2 Overview of the Birthplace in England research programme

The main questions addressed by Birthplace are:

- How is intrapartum care organised?
- Are there differences in maternal and child outcomes between the various birth settings and, in particular, are there differences in safety for the babies of women at 'low risk' of complications according to current clinical guidelines?
- What is the comparative cost-effectiveness of the planned settings for birth?
- What are the features of maternity care systems that affect the quality and safety of care?

2.1 Aim

To provide high quality evidence about processes, outcomes and costs associated with different settings for birth in the NHS in England.

2.2 Objectives

Although conducted as an integrated research programme, the Birthplace in England research programme encompasses two separate programmes:

- Evaluation of Maternity Units in England, funded by the NIHR SDO Programme;
- Birth at Home in England study, funded by the Department of Health Policy research Programme.

Objectives of the Evaluation of Maternity units in England programme:

1. Determine the existing service configuration, system of care/network, process and outcomes of midwife-led units in England and to map changes over the three years of the project and describe the key drivers for change.
2. Describe women's choices, information needs, experiences and wellbeing associated with each type of clinical location for birth.
3. Evaluate the management and impact of transfer during labour from women's intended locations for birth at the time of onset of labour in relation to outcomes for mothers and babies.

4. Evaluate clinical outcomes, associated with location of birth, including safety, for woman and their babies at low risk of complications during labour and birth.
5. Evaluate the cost effectiveness of midwifery-led units and standard consultant-led units.
6. Identify valid and reliable woman-centred indicators and outcome measures for future benchmarking

Objectives of the Birth at Home in England study:

7. Determine the proportion of women in the England who plan to give birth at home.
8. Determine the proportion of women who transfer from home to another birth setting during labour.
9. Determine the clinical outcomes associated with planned birth at home in relation to maternal and neonatal morbidity, and to compare this with planned birth in freestanding midwifery units, alongside midwifery units and consultant-led units.
10. Determine the cost-effectiveness of planned birth at home compared with planned birth in freestanding midwifery units, alongside midwifery units and obstetric units.
11. Compare birth outcomes for women who plan birth at home and deliver at home with those who plan birth at home and who deliver in another birth setting

2.3 Overview of the component studies

The Birthplace in England research programme was planned as a series of six component studies, as outlined below.

2.3.1 Terms and definitions consensus process

This consensus study was undertaken to build on the existing literature review undertaken by the NPEU.³⁵ Current definitions and terminology associated with the settings in which birth takes place were synthesised and a consensus development process was undertaken to develop and agree terms and definitions to be used in the Birthplace programme.

Further details can be found in part 2 of the final report.¹

2.3.2 Mapping maternity care: the configuration of maternity care in England

The mapping study addressed the following key questions: How and where is intrapartum care organised? What role do midwifery-led units play in the current provision? How will changes in staffing influence the development of different settings of delivery. What are the future plans for midwifery-led unit development? How will changes in staffing in response to the European Working Time Directive (EWTd) influence the development of different settings for delivery?

The components study involved two questionnaire surveys of trusts and units providing maternity healthcare in England in 2007 and 2010. The first of the two surveys was a mandatory survey conducted by the Healthcare Commission in collaboration with Birthplace. The data used in the Birthplace analysis included details of midwifery and medical staffing, numbers of births/women delivered, planned and unplanned home births, eligibility criteria for planned AMU and FMU births, rooms and beds available, location and provision of specialist services, planned changes in capacity and staffing. The 2010 survey documented changes in configuration.

Further details can be found in part 3 of the final report.²

2.3.3 National prospective study of planned place of birth

This prospective cohort study of women using different models of intrapartum care addresses a number of questions: What are the maternal and child outcomes for the different types of care? What proportion of mothers and babies require transfer during labour or after birth from home, or a freestanding or alongside midwifery led setting to an obstetric led setting? How long do transfers take and is this acceptable in terms of safety? How can safe and effective transfer be ensured?

The cohort study was designed to compare outcomes by planned place of birth at the start of care in labour (Obstetric unit (OU), home, Freestanding Midwifery Unit (FMU), Alongside Midwifery Unit (AMU)). The primary objective was to compare intrapartum and early neonatal mortality and morbidity¹ by planned place of birth at the start of care in labour in women judged to be at 'low risk' of complications according to current national clinical guidelines. The study also compared a range of secondary outcomes (neonatal morbidities, 'normal birth', maternal interventions and maternal morbidities) by planned place of birth.

¹ Neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus or clavicle.

The cohort study aimed to collect data from the vast majority of midwifery units and NHS trusts providing home birth services across England and a stratified, random sample of OUs.

Further details can be found in part 4 of the final report.³

2.3.4 Cost-effectiveness analysis

The aim of this component study was to determine the cost-effectiveness of the four planned settings for birth (OU, home FMU, AMU) in women at 'low risk' of complications prior to the onset of labour. This component study is being undertaken in two parts:

- An initial cost-effectiveness analysis using individual level data on resource use/costs and outcomes (effectiveness) collected in the Birthplace prospective cohort study. Findings of this study are presented in this report.
- A decision analytic modelling study addresses the cost-effectiveness of each type of care. This study will use a decision-analytic modelling approach to synthesise data from Birthplace with published, clinical, epidemiological and economic evidence within a cost-effectiveness modelling framework. This work is ongoing: results will be available in autumn 2011.

In the individual patient analyses presented here:

- The analysis of costs takes account of costs attributable to the episode of intrapartum care and the additional costs of any higher level health care associated with complications arising during labour or immediately after birth.
- Three measures of the effectiveness of planned place of birth were examined: adverse perinatal outcomes averted (the cohort study primary outcome), maternal morbidity avoided (a composite of secondary outcomes from the cohort study), and 'normal birth'.

The study provides estimates of:

- the relative costs of planned births in each setting; and
- the cost-effectiveness of planned birth in each non-OU setting compared with a planned OU birth; cost-effectiveness is assessed separately for each of three effectiveness measures outlined above

Further details can be found in part 5 of the final report.⁴

2.3.5 Qualitative organisational case studies

The primary aim of the organisational case studies was to describe and explore features of maternity care systems that may affect the provision of

high quality and safe care in different birth settings. A secondary aim was to describe and explore professional and consumer perceptions regarding access to choice of place of birth, and experiences of escalation of care when complications occur during labour and birth in different birth settings.

The case studies used qualitative methods to explore issues that may affect risks and safety in different settings with a particular focus on systems of care. Data were collected in four 'best' or 'better performing' NHS Trusts as identified by the Health Care Commission Review of Maternity Services in England in 2007. Data collection focused on Trust policies and practice, and the experiences of women and birth partners in their journey through the system of care from March through to December 2010. Interviews were conducted with service providers, managers and other key stakeholders including user-group representatives (n=86), service users and their birth partners (n=72). Other data included document analysis (approximately 200 documents) and observation of key 'nodes' in the service (n=50 transcripts).

Further details can be found in part 6 of the final report.⁵

2.3.6 National study of intrapartum related mortality

Because intrapartum related mortality is rare in 'low risk' women, the prospective cohort study evaluated the effect of planned place of birth on a composite outcome designed to capture both intrapartum mortality and intrapartum related neonatal morbidity. This component study will use a modelling approach, incorporating data from the Birthplace prospective cohort study, routine birth statistics and data from the Confidential Enquiry into Stillbirths and Deaths in Infancy (CEMACH) to evaluate intrapartum related mortality by planned place of birth.

This work is ongoing: results will be available in autumn 2011.

3 Overview of results

The main findings of the component studies are summarised below.

3.1 Terms and definitions

The terms obstetric unit, alongside midwifery unit and freestanding midwifery unit and associated definitions were agreed for use in the Birthplace programme.

3.2 Mapping maternity care

3.2.1 Units and configuration

In 2007 data were returned from all 152 trusts providing maternity care in England (100%). Fewer trusts responded to the 2010 survey (63%) though these were representative in terms of configuration. Basic data were available for all trusts in 2010 (100%) on numbers and types of unit and trust configuration.

The configuration of maternity care within trusts changed over the course of the study: in 2007, two thirds of trusts (66%) contained only one or more obstetric units and by 2010 the proportion had decreased to half (49%); in 2007, less than a fifth of trusts contained at least one AMU and by 2010 the proportion had increased to 35%; in 2007, 18% of trusts contained an FMU and by 2010 the proportion was 24%.

By 2010 the overall number of maternity units had increased by 11%, with twice as many AMUs as in 2007 (53 compared with 26)

Based on 2007 data the geographical distribution of maternity units, particularly OUs and delivery beds reflects the centres of population.

There were marked differences in the numbers of midwife-led units in different areas of England in 2007: FMUs were most common in the South West and AMUs were more likely in London and South Central SHAs.

3.2.2 Workload

Intrapartum care in an OU was the most common form of provision, with staff in OUs caring for more than 95% of women giving birth in hospital in the year ending 31 March 2007 (1% in FMUs and 3% in AMUs).

Each type of unit provided intrapartum care for radically different numbers of women: a median of 192 in FMUs, 613 in AMUs and 3217 in OUs in 2007.

All types of unit varied in the numbers of women giving birth: over a quarter of OUs (29%) reported having fewer than 2500 women giving birth and a similar proportion (26%) delivered more than 4000 women

Based on the 2007 trust data the median proportion of births that took place at home was 2.5%, including both planned and unplanned home births.

3.2.3 Capacity, occupancy and eligibility

Data were returned from 262 units in 2007 with 2193 delivery beds or bed spaces, 6.2% in FMUs, 6% in AMUs and most (88%) in OUs.

There was considerable variation in capacity for care during labour and birth between and within the types of unit: the medium number of delivery beds ranged from 2 in FMUs, 5 in AMUs to 10 in OUs.

There was substantial variability in 'occupancy' (women delivered per bed) across all unit types and between geographical regions. Eligibility criteria for admission to FMUs and to AMUs were not consistent for either type of unit.

3.2.4 Staffing

A total of 19,415 whole time equivalent (WTE) midwifery posts were reported in March 2007 and 5263 WTE maternity support worker posts.

A total of 3864 WTE medical staff working in obstetrics were reported in March 2007, almost entirely in OUs: similar proportions were senior house officers (31%), registrars (30%) and consultants (30%) and 9% were staff grades or associate specialists.

General practitioner (GP) involvement in intrapartum care was widely distributed, but at low density with only 11% of maternity units reporting GP engagement with maternity care (2 FMUs, 1 AMU and 30 OUs).

Paediatric or neonatal staff were on-call for the delivery suites or theatres associated with all AMUs and FMUs and in 44% of OUs Advanced Neonatal Nurse Practitioners (ANNPs) took on this role.

Overall the largest components of the midwifery maternity workforce were midwives employed at Bands 6 (52%) and 7 (21%), followed by maternity support workers at Band 2 (14%); less than 3% of the workforce were employed above this level.

Midwifery staffing levels (midwives per 1000 births) were higher in FMUs (median of 35 midwives per 1000 women giving birth compared with 31 per 1000 in AMUs and OUs); the number of maternity support staff per 1000 births was also higher in FMUs (23 per thousand women delivered vs. 7 and 8 per 1000 in AMUs and OUs respectively).

Some units did not employ MSWs in 2007: 15% of FMUs, 35% of AMUs and 2% of OUs did not do so. Of those that did, OUs were most likely to use them in delivery suite (99%, compared with 79% of AMUs and 46% of FMUs).

There was considerable variation between OUs in the ratio of obstetric medical staff per 1000 women delivered per year (median 6.8 per 1000), obstetric consultants (median 2 per 1000) and obstetric anaesthetist staff (2.5 per 1000).

3.2.5 Intrapartum related services

Almost all units provided a telephone triage system for early labour assessment and half reported providing early labour assessment by a midwife at home, a service most commonly provided by FMUs (65%) and AMUs (58%) compared with 47% of OUs.

A large proportion of maternity units of all types had fixed birthing pools (79%).

Specialist medical services on site that included a 24 hour epidural service, dedicated obstetric theatres, adult intensive care units and neonatal units and obstetric high dependency beds were more likely to be associated with OUs.

Where adult intensive care and neonatal care were not available on-site, the distance to such a facility varied considerably (median distance 17 miles).

3.2.6 Gaps in provision

Gaps in provision occur as a consequence of staffing, capacity and other issues: 4% of midwifery posts and 11% of maternity support worker posts were reported to be vacant on March 31 2007.

Midwifery vacancy rates varied with geographical area and were highest in London and lowest in the Yorkshire and Humberside region.

A total of 39% of maternity units reported closing to admissions on one or more occasions in the year to 31 March 2007 (32% of FMUs, 35% of AMUs and 39% of OUs); while OUs were more likely to have closed at all, AMUs and FMUs were more likely to have closed more often or for longer.

The overall turnover rate of midwifery staff due to resignations and retirements in the year to 31 March 2007 differed little across the different types of unit (7% FMUs, 8% AMUs and 7% OUs); individual unit turnover which varied from 0-40% was not related to size of OU or FMU unit as reflected in the numbers of women delivered, though an association was indicated for AMUs.

In 2007 the proportion of midwives aged 50 years or more was 21% (26% in FMUs, 22% in OUs and 19% in AMUs).

3.2.7 Recent and future changes in service provision

In comparison with 2007 by 2010 over three quarters of trusts had increased their midwifery establishments (77%), increased the numbers of consultant obstetricians (80%) and obstetric cover (77%).

By 2010 a third or more of trusts had increased the overall number of delivery units (36%), delivery bed capacity (44%) and paediatric cover (32%).

In 2010 substantial proportions of trusts were planning yet further increases in the number of delivery units (54%), delivery bed capacity (57%), the midwifery establishments set (66%), the numbers of consultant obstetricians (64%) and obstetric cover (58%).

3.3 National prospective study of planned place of birth

In total, the cohort included 79,774 eligible women, of which 64,538 were classified as 'low risk'.

There was a high level of participation from all unit types: 97% of trusts providing home birth services, 95% of FMUs and 84% of AMUs. Five of the original sample of 37 OUs had to be replaced by resampling; 36 OUs participated.

74% of participating units/trusts achieved a response rate of 85% or more.

3.3.1 Births to 'low risk' women

Maternal characteristics varied by planned place of birth with the planned home birth group being most dissimilar to the OU group. The largest variation in maternal characteristics was for parity with 27% of the planned home birth group being nulliparous compared with 46%-54% in the other settings.

The incidence of adverse perinatal outcomes was low in all settings. After adjusting for differences in the characteristics of women planning birth in different settings, there were no statistically significant differences between settings in the incidence of the primary outcome for multiparous women. For nulliparous women, we found no difference in the primary outcome between midwifery units and OUs but adverse perinatal outcomes were more common in the planned home birth group (weighted incidence 9.3 per 1000 births, vs. 5.3 per 1000 births in planned OU births).

Instrumental and operative deliveries and other interventions were less frequent in planned home, FMU and AMU births. Women in these groups

were significantly more likely to have a 'normal birth', defined as a spontaneous vaginal birth without induction of labour, an epidural or spinal anaesthetic or episiotomy, compared with women in the planned OU group. Higher rates of 'normal birth' were seen in the non-OU groups for both nulliparous and multiparous women.

Babies in the planned home and FMU groups were significantly more likely to be breastfed at least once relative to babies born in the planned OU group.

Adverse maternal outcomes - third or fourth degree perineal trauma, blood transfusion or admission to a higher level of care – tended to occur less frequently in the planned home and FMU groups and blood transfusions were given less frequently in the planned FMU group relative to planned OU births. However, event rates for these outcomes were low and not all of these differences were significant at the 1% level.

Transfers during labour or immediately after birth occurred in over 20% of births in the three non-OU groups but transfer rates were markedly higher in nulliparous women. For nulliparous women, rates varied from 36% in planned FMU births to 45% in planned home births compared with rates of 9-13% in multiparous women.

3.3.2 Births to 'higher risk' women

For 'higher risk' women, comparisons with planned OU births are more difficult to interpret because the groups were not homogeneous in terms of risk. For example, induction of labour was recorded as a risk factor in almost half of the 'higher risk' women in the planned OU group. This both increases the risk of other interventions and, by definition, precludes a 'normal birth'.

Overall 5% of women in the three planned non-OU groups were classified as 'higher risk' and therefore, according to the NICE intrapartum care guideline should have been advised to give birth in an OU. The proportion of 'higher risk' women was 3% for planned FMU birth, 4% for planned AMU births and 7% for planned home births.

Findings were consistent with an increased risk of an adverse perinatal outcome for 'higher risk' women in the planned home birth group. Findings for other outcomes in 'higher risk' women – 'normal birth', receipt of interventions, maternal morbidities and breastfeeding – were broadly consistent with 'better' outcomes for planned non-OU births relative to the planned OU group.

3.4 Cost effectiveness analysis

3.4.1 Socio-demographic characteristics

A total of 62,036 women at 'low risk' of complications prior to the onset of labour were included in this analysis. Of these, 18,847 planned to give birth in an OU, 16,187 planned to give birth at home, 10,971 planned to give birth in a freestanding midwifery unit and 16,031 planned to give birth in an alongside midwifery unit.

The socio-demographic characteristics of women planning a birth at home were more similar to those planning birth in an FMU. The characteristics of women planning birth in an AMU were generally more similar to that of the planned OU group. The most marked contrast between the planned home birth group and the three other planned groups was in the distribution of parity: 27% of women planning a birth at home were nulliparous compared to 46%, 50% and 54%, respectively, in the planned FMU, AMU and OU groups.

3.4.2 Costs

Total costs captured all the resource use and the unit costs associated with intrapartum care and the immediate postnatal period after birth, including any higher level care for the mother or baby. The total unadjusted mean costs per 'low risk' woman at 'low risk' of complications prior to the onset of labour planning a birth in each setting were as follows: OU £1,631.2, AMU £1,461.2, FMU £1,434.9 and home £1,066.5. The total unadjusted mean costs per 'low risk' woman without complicating conditions at the start of care in labour were: OU £1,510.6, AMU £1,426.4, FMU £1,405.0 and home £1,026.9.

Adjusted cost differences were calculated for planned place of birth with birth in an OU as the reference group. The estimates were cost saving for all births planned in non-OU settings and this was statistically significant. The adjusted cost savings averaged £310 (home), £130.1 (FMU) and £134 (AMU). Adjusting for parity in a regression analysis on total cost resulted in sizable and significant cost differences, which overshadowed all other adjustments for confounding. The mean costs of care were substantially reduced for women who were parous compared to nulliparous. This cost-saving was accentuated for each previous pregnancy. The costs of care increased for a baby born above forty weeks gestation, representing a cost increment per additional week of gestation. A maternal age of thirty years and above was associated with an increase in the costs of care, and this was more apparent in women aged over forty years.

Mean differences in costs per woman for planned OU and non-OU births were weighted, adjusted and bootstrapped in an additional analysis. All

means costs of births in planned non-OU settings were cost-saving when compared with the mean cost of births planned in OUs, and the cost savings were as follows: £366.8 (home), £182.1 (FMU), £129.3 (AMU).

Additional subgroup analyses by parity were conducted. These identified that the total bootstrapped weighted mean costs per 'low risk' nulliparous woman was OU £2075.2, AMU £1,983.1, FMU £1,912.5 and home £1,793.7. In contrast, the total bootstrapped weighted mean costs per 'low risk' multiparous woman was: OU £1,142.4, AMU £991.3, FMU £968.9 and home £780.4.

3.4.3 Cost-effectiveness

Three sets of cost-effectiveness analyses were conducted; for the baby, the mother and for the outcome of 'normal birth'.

The incidence of adverse perinatal outcomes was low in all settings. The ICERs showed that, on average, births planned in non-OU settings would be cost saving when compared with births planned in an OU, and would lead to improved perinatal outcomes on average for births planned in the midwifery units, although considerable uncertainty surrounded the latter. Although the cohort study found no significant differences in the primary outcome by planned place of birth for 'low risk' women, analyses stratified by parity identified a significantly increased odds of an adverse perinatal outcome for 'low risk' nulliparous women in the planned home birth group. An additional cost-effectiveness analysis performed on nulliparous women who planned a birth at home resulted in a less-costly intrapartum maternity option but with increased adverse perinatal outcomes. This finding was repeated for nulliparous women of 'low risk' without complicating conditions at the start of care in labour where the economic evaluation showed planned home birth to be less costly but with statistically significantly worse perinatal outcomes. For multiparous women, there were no statistically significant differences between births planned in the different settings in rates of adverse perinatal outcome. For all bootstrapped replicates, the scatterplots of mean ICERs fell across the south east and south west quadrants of the cost-effectiveness plane, reflecting lower costs in planned non-OU settings accompanied by uncertainty surrounding changes to perinatal outcomes when compared to planned births in an OU.

The cost-effectiveness analyses conducted for maternal outcomes showed that planned births in non-OU unit settings led to improvements in maternal outcomes and reductions in costs to the NHS when compared to planned birth in an OU. All bootstrapped ICERs fell within the south east quadrant of the cost-effectiveness plane, confirming that births in planned non-OU settings would generate positive maternal health effects and less costly care.

All planned births in non-OU settings led to significant increases in 'normal birth' and significant reductions in costs to the NHS when compared to planned birth in an OU.

3.4.4 Sensitivity analyses

Uncertainty surrounded the modelled overhead costs and the midwifery costs, which included CNST charges. These were also seen to be generic cost drivers relevant to all settings of birth. We compared the effects of variations in these costs on all three incremental cost effectiveness measures. Results from the sensitivity analyses showed that the study findings were robust and the ICERs responded to changes in the cost variables in a manner consistent with expectations.

3.5 Qualitative organisational case studies

3.5.1 Choice of birthplace, information and access

There were variations in the number of women who had practical access to the full range of birth settings within their locality, as most women did not see travelling over a long distance in labour as a realistic choice. Choice was influenced by geographical, organisational, service culture and provider factors. Some women were not aware that choice of birthplace was possible, and lacked sources of evidence-based information on which to base choices. Women's views of safe care were influenced by what was locally on offer, their previous experience and that of other women that they knew. The prospect of intrapartum transfer was a major consideration when women made a decision around place of birth, and women often cited concerns about transfer distance as reasons for planning labour in hospital. Women who did exercise more agency had greater access to information, skills and confidence in asking for the choices they wanted, and had the support of family friends and health professionals in doing so.

There was considerable variation in service provision between and within sites due to geography, and the variation in the organisation of community midwifery services. In all sites, there were examples of service and information provision designed to reduce inequalities in access and choice for women with complex social needs, those from poorer socio-economic localities and women who needed English language support.

3.5.2 Delivery of safe and high quality of care

The design of the environment was tailored in the case study sites to positively support midwife-led and active birth care for low-risk women, but proximity of the AMUs created specific issues around blurring of spatial and professional boundaries in all sites. Competition over birth rooms and

staffing often overlapped with philosophical differences, which could undermine effective team working and safety. In contrast, FMUs although they appeared to have clear boundaries, were not viewed as financially viable. The cultivation of relatively positive and respectful relationships between and within professional groups, was the rule rather than the more 'embattled' relationships described in some studies.

Deployment of community midwifery staffing across distributed settings was a key challenge for managers in all sites. For example, coverage for women living in more rural areas, staffing free-standing units, and reducing variation in models and coverage of community midwifery services. Additional challenges at some time points were an increase in complexity of case mix resulting in some women finding difficulty accessing overcrowded units. These led to women and birth partners feeling psychologically unsafe, as well as posing potential clinical safety problems.

All sites demonstrated a commitment to multi-disciplinary training and included attention to emergency skills and escalation of care. However, more attention was given to the needs of FMU midwives and less attention to the needs of midwives working in AMUs or community midwives providing home births, some of whom attended very few births each year. Community midwives appeared to be less integrated in such processes, and some reported a sense of isolation and exposure when attending births at home.

In all sites this was mitigated in models of care where midwives worked across the continuum of care, and both in the community and hospital settings. For example within team/caseload models or where midwives rotated between community and the different units in order to maintain a range of skills as in the 'hub and spoke' model where an obstetric unit served a number of freestanding midwife units. Midwives working in FMUs indicated the value of their working relationships in the unit, including the role of maternity support workers.

Guidelines were generally used as support to knowledge and decision-making, rather than as substitutes for these, and were used to drive service improvement and appropriate levels of care. Positive organisational culture factors included a learning climate, which incorporated commitment to audit and review as sources of learning and improvement. When problems arose between professionals, these were tackled openly, rather than ignored.

The management of complications, escalation and transfer emerged as a key issue. These include the management of physical, geographical, professional and inter-personal boundaries, not only when transfers of women or staff were needed, but also in terms of information, knowledge and resources. Effective and safe transfer was contingent on good communication systems, clear guidelines that were used appropriately to support decision-making, trusting and respectful relationships between staff

groups, management of conflict over resources, and the confidence and competence of professionals.

3.5.3 Women's experiences of escalation and transfer

Although some women's experience of transfer and escalation was characterised by feelings of worry, disempowerment or disappointment, most women were prepared for the unpredictability of events in childbirth. Clear and careful explanation of events by professionals was a common theme that ran through women's *positive* narratives about escalation. Trust in professionals was an important aspect of feeling safe, physically and psychologically.

Some women described difficulty in being listened to when they raised concerns about complications they had noticed themselves, while concerns about medicalisation or previous negative birth experiences led women to avoid intervention in some cases, or request it in others. A few professionals viewed service users as both 'risky' and 'demanding' and consequently were less open to listening to their views, which were often not seen as relevant to safety.

Sometimes speaking up was effective, and women's wishes were heard and acted upon, but the experience of speaking up and *not* being heard was also manifested as a safety issue. When women felt *unable* to ask about their options or challenge professional views they could experience feelings of frustration, self-blame or anger and felt this resulted in delay in the management of complications.

4 Key findings

4.1 The configuration of maternity care in England

- Options for place of birth have improved since 2007 but a substantial proportion of women are unlikely to have a full range of choices available locally.
- While midwifery units have increased in number, there are regional differences in availability and capacity is limited, such that most women will give birth in an obstetric unit.
- Future planned changes by NHS trusts include provision of more AMUs, more beds, more midwifery posts and more consultant cover.
- Marked variation is evident in almost all aspects of provision, yet the needs of mothers and babies during labour and birth are unlikely to vary in any fundamental respects.
- Staffing levels vary between units and regions of the country: an easily applied and validated method of matching staffing numbers to care requirements is needed that could assist in reducing this variation and planning appropriate staffing for maternity care.

4.2 The national prospective study of planned place of birth

- For 'low risk women', the incidence of adverse perinatal outcomes is low in all birth settings (4.3 primary outcome events per 1000 births).
- The benefits of planned birth at home or in a midwifery unit include fewer interventions, a substantially reduced incidence of intrapartum caesarean section and a higher likelihood of a 'normal birth'.
- For multiparous 'low' risk women there are no differences in adverse perinatal outcomes between settings but the risk of an adverse perinatal outcome appears to be higher for nulliparous women who plan to give birth at home (9.3 primary outcome events per 1000 births vs. 5.3 per 1000 births in an OU).
- For nulliparous 'low risk' women the intrapartum transfer rate is high in settings other than an OU (home 45%; FMU 36%, AMU 40%).
- A non negligible proportion (5%) of planned home and midwifery unit births are to women at 'higher risk' of complications who, according

to current clinical guidelines, should be advised to give birth in an obstetric unit.

4.3 Cost effectiveness analysis

- For 'low risk women', the cost to the NHS of intrapartum and related postnatal care, including costs associated with clinical complications, is lower for birth planned at home, in a FMU and in an AMU compared with planned birth in an OU.
- Cost differences between settings are partly attributable to differences in the characteristics of women planning birth in each setting; the three non-OU settings remain cost saving after accounting for these differences. Compared to a planned OU birth, home births cost £367 less, planned FMU births £182 less and planned AMU birth £129 less on average.
- The main cost drivers are unit overheads and staffing; there is substantial variability in costs between units.
- Planned birth at home, in a FMU or in an AMU generates cost savings per additional 'normal birth' and per adverse maternal morbidity avoided in comparison to planned birth in an OU. Planned birth at home, in a FMU or in an AMU generates cost savings per additional 'normal birth' and per adverse maternal morbidity avoided in comparison to planned birth in an OU. Analysis of the incremental cost per adverse perinatal outcome for the three non-OU settings was inconclusive for the reasons explained in the main report.
- When analysed by parity:
 - For nulliparous 'low risk' women, planned birth at home generated incremental cost savings compared to planned birth in an OU, but increased adverse perinatal outcomes.
 - For multiparous 'low risk' women, planned birth at home generated incremental cost savings compared to planned birth in an OU, but uncertainty surrounded adverse perinatal outcomes avoided.

4.4 Organisational case studies

- Access to good quality information often differed across social groups. Variations existed in how services and professionals provided such information in order to deliver equity of access and choice.
- Concerns around transfer distance meant that many women did not feel they had any realistic choice of place of birth. Travel distance to OUs was a concern for women living in more rural areas.

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- Out-of hospital birthplaces functioned best when they were embedded into the system of maternity services, supported by all staff, and not just seen as a midwifery concern.
- Variations existed at Trust level in support given to out-of-hospital births, including training for safety and teamwork across the maternity workforce. The deployment and resourcing of community midwifery was especially variable across Trusts, and those providing such support took a systematic approach to staff deployment to underpin women's choice of birth setting.
- Strong midwifery and obstetric leadership and a culture of mutually supportive professional teamwork appeared to be central features of Trusts where midwifery led and obstetric services functioned well.
- Audit and review were sources of organisational learning and improvement. These were promoted by leadership and staff involvement, and a 'learning and accountability' rather than a 'blame' culture, with attention to system processes and structures as well as individual professional practices.
- In some Trusts, community and birth centre midwives who had a low volume of births, and only attended 'low risk' births appeared to benefit from periodic rotation into settings in which they could gain experience of higher risk births. In well-integrated services, midwives working on obstetric units were also periodically rotated into low risk settings.
- The presence of an AMU sometimes highlighted contrasts in birth philosophies across units. There were also some cases of strong leadership for promotion of normal birth across the maternity system.
- The presence of an AMU appeared to intensify the workload in the adjoining obstetric unit where service providers struggled to support normal birth.
- Women's concerns about their safety and that of their baby (or babies) were expressed but not always listened to by staff. Being heard and receiving timely support was aided by continuity of carer and/or presence of a birth partner or relative.
- Early labour assessment at home appeared to provide an opportunity for accurate clinical assessment and women's informed decision-making about the safest place to give birth.

5 Implications for policy and practice

- Guidance given to women on planning place of birth should be updated to reflect the new evidence provided by this study. As a result of the cohort study, women can now be provided with more reliable information on outcomes in the available birth settings, and can also be given a more accurate estimate of the overall likelihood of intrapartum transfer.
- The evidence provided by the cohort study supports the policy of offering 'low risk' women a choice of birth setting:
 - Freestanding and alongside midwifery units appear to be safe for babies and offer benefits to both the mother (fewer interventions) and baby (more frequent initiation of breastfeeding). Nulliparous women should be informed of the relatively high probability of intrapartum transfer in these settings when choosing their planned place of birth.
 - For multiparous women, home births appear to be safe for babies and offer benefits to both the mother (fewer interventions) and baby (more frequent initiation of breastfeeding).
 - The substantially lower incidence of major interventions, including intrapartum caesarean section, in all three non-OU settings has potential future benefits to both the woman and the NHS in terms of avoiding surgical complications and reducing the need for repeat caesarean sections in future births. There is a need to address the higher frequency of major interventions and the relatively low proportion of 'normal births' in 'low risk' women in obstetric units
 - The continued provision of a home birth service is important so that multiparous women, and some nulliparous women who are aware of the additional risks to the baby and the high likelihood of transfer, can plan to have their baby at home.
 - Expansion of the provision of FMUs and AMUs would provide a choice of birth setting for 'low risk' nulliparous women who do not wish to opt for an OU birth
- A non negligible proportion of planned home and midwifery unit births are to women who, according to current clinical guidelines, should be advised to give birth in an obstetric unit. The reasons for this are not clear but some consideration needs to be given to the information and options offered to 'higher risk' women.

- Increased provision of home birth services and midwifery units is potentially cost saving but the evidence provided by the Birthplace studies indicates that the following issues may require consideration:
 - The higher midwife to birth ratio in non-OU settings – which women value – means that although such an expansion is potentially cost saving, it would be likely to require an overall increase in midwifery staffing numbers.
 - There is considerable variation between midwifery units in size, staffing levels, skill mix and throughput. These all affect costs, and may affect safety and other aspects of care, including women's experiences. Further work is required to determine whether particular 'models' are more cost-effective for the NHS and valued by women.
 - Strong midwifery and obstetric leadership and a culture of mutual professional respect appears to be a central feature of trusts where midwifery led and obstetric services function well alongside each other.
 - Attention needs to be given to the skills and training of midwives working in different settings. For example, community midwives who may assist at a low volume of births and only attend 'low risk' births may benefit from periodic rotation into settings in which they can gain experience of births, including higher risk births.
 - Attention needs to be given to staffing models in units with an AMU and OU.
- Intrapartum transfers from home and midwifery units into obstetric units occur relatively frequently and are potentially distressing for women. Further research into intrapartum transfers is recommended but maternity services could potentially use audit and review processes to identify actions that could already be taken to improve the experience and safety of women requiring intrapartum transfer.
- Discussion between maternity services and ambulance trusts may be needed to identify the most appropriate and effective protocols for intrapartum transfers.
- There is an urgent need for routine data collection systems to collect data on planned place of birth at start of care in labour so that outcomes can be monitored by planned place of birth.

6 Recommendations for future research

Key areas for further research arising from the Birthplace programme are outlined below. Additional details and further recommendations for research are given in the individual reports

- **Avoidable or remediable factors in adverse intrapartum outcomes which are specific to particular birth settings**
 - What are the aspects of clinical care and service delivery associated with adverse intrapartum related outcomes by planned place of birth?
 - What potentially modifiable aspects of current services are associated with poorer outcomes in particular birth settings.
- **'Out of hospital' births in women at 'higher risk'**
 - What factors influence 'higher risk' women to give birth outside an obstetric unit?
 - How should services be provided for women who wish to give birth outside hospital against professional advice?
- **Obstetric units**
 - How can the frequency of unnecessary interventions be reduced for 'low risk' women giving birth in obstetric units?
 - What is the impact of AMUs on intrapartum care in their adjoining obstetric units?
- **Choice and equity**
 - To what extent do less socially advantaged women have reduced access to choice of birth setting and what strategies might improve equity?
- **Intrapartum transfers**
 - How can the experience of intrapartum transfer be improved for women and their partners?
- **Broader economic evaluation encompassing both health impacts on the mother and infant and non-health effects**
 - Commonly used outcome measures in economic evaluations do not enable the value women attach to 'positive birth experiences' to be compared against values attached to different health outcomes. Methodological research is required to enable such

preferences to be incorporated in a broader economic evaluation framework.

- **Models of care**

- Do midwife-led models of care (team and caseload midwifery) that provide continuity of care across settings improve quality and safety of care?

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Appendix: Membership of the Birthplace in England Collaborative Group

The Birthplace in England Collaborative Group includes the wider group of co-investigators, researchers, project staff and coordinating midwives who contributed to the research programme:

Co-investigators

Professor Peter Brocklehurst, Professor of Perinatal Epidemiology, NPEU, University of Oxford

Professor Alison Macfarlane, Professor of Perinatal Health, City University London

Professor Neil Marlow, Professor of Neonatal Medicine, University College London;

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Professor Christine McCourt, Professor of Maternal and Child Health, City University London;

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Professor Stavros Petrou, Professor of Health Economics, University of Warwick

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Professor Jane Sandall, Professor of Women's Health and Programme Director (Innovations), NIHR King's Patient Safety and Service Quality Research Centre, King's College, London

Louise Silverton, Deputy General Secretary, Royal College of Midwives.

Birthplace Advisory group

Professor Cathy Warwick (Chair), King's College Hospital Foundation Trust, replaced by Kate Sallah, Tashie Consulting

Jill Demilew (Deputy Chair), Consultant Midwife, Kings College Hospital Foundation Trust

Professor Maggie Blott, replaced by Professor David Richmond, Vice President, Royal College of Obstetricians and Gynaecologists.

Sue Eardley, Children and Maternity Strategy and Safeguarding Care Quality Commission

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Addendum

The Birthplace in England Research Programme combines the Evaluation of Maternity Units in England (EMU) study funded in 2006 by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme, and the Birth at Home study in England, funded in 2007 by the Department of Health Policy Research Programme (DH PRP). This document is part of a suite of reports representing the combined output from this jointly funded research. Should you have any queries please contact Sdoedit@southampton.ac.uk



Royal College of
Obstetricians &
Gynaecologists

Reconfiguration of women's services in the UK

Good Practice No. 15

December 2013

1 Purpose

The purpose of this Good Practice Paper is to help Members and Fellows of the Royal College of Obstetricians and Gynaecologists (RCOG) to understand the principles that should be adhered to during the planning and process of reconfiguring women's health services and to assess the extent to which there is evidence that women's services are of a high standard and of good quality following reconfiguration.

2 Introduction

The RCOG has a major responsibility to define standards of care for maternity and gynaecological services. Decisions about configuration of services should be made by local commissioners and providers, cognisant of public demand where possible. In this Good Practice Paper, we discuss the standards needed to run high-quality and safe services. The Royal College of Midwives (RCM) will make its own recommendations from a midwifery perspective. Inevitably, such service-configuration decisions will be influenced by issues of patient safety, access, sustainability, skill mix, human resources and economic efficiencies of scale, together with the needs of the local population.

The 2011 RCOG report *High Quality Women's Health Care: a Proposal for Change*¹ describes a model that focuses on the needs of the woman and her baby by providing the right care, at the right time, in the right place, provided by the right person in order to enhance the woman's experience.

3 Context

The demands on women's services are increasing. There has been a year-on-year rise in new referrals for outpatient obstetrics and gynaecology,² which by 2011 accounted for the highest volume of outpatient attendances, at 11.4% of total annual referrals. In obstetric care, the number of births increased by 19% overall between 2000 and 2011.¹ However, this is not uniform throughout the UK (in Scotland, total births registered in 2009 showed a drop of 1.7% compared with 2008). This has been coupled with an increasing case complexity (Table 1) caused by changing demographic factors such as the increasing average age of first-time mothers, increasing rates of obesity and multiple pregnancy, and an increase in the number of women with existing comorbidities. This shift has added to the pressure on women's services in terms of both the volume of demand and the intensity and types of care required.¹

Table 1 Delivery outcome data for 1998/99 and 2009/10 by finished consultant episodes (England)

Delivery outcome	Finished consultant episodes		Percentage point change
	1998/99	2009/10	
Normal delivery with complications	17 211 (3.1%)	24 973 (3.8%)	+0.7
Normal delivery without complications	363 955 (65.6%)	385 765 (58.9%)	-6.6
Assisted delivery with complications	5 403 (1.0%)	9 968 (1.5%)	+0.5
Assisted delivery without complications	60 679 (10.9%)	74 917 (11.4%)	+0.5
Caesarean section with complications	15 788 (2.8%)	29 830 (4.6%)	+1.7
Caesarean section without complications	91 956 (16.6%)	129 170 (19.7%)	+3.2
Total	554 992	654 623	

Source: Hospital Episode Statistics

There are many policy drivers (all of which focus on similar issues):

- extending women's choice of type and location of maternity care (2010 NHS White Paper *Equity and Excellence: Liberating the NHS*³)

- the 2010 NHS White Paper *Healthy Lives, Healthy People: Our Strategy for Public Health in England*⁴
- the *Payment by Results*⁵ maternity pathway tariff
- the National Institute for Health and Care Excellence (NICE) *outcomes framework*⁶ and *quality standards*⁷
- extending patient choice of provider ('any qualified provider'; AQP)⁸
- shifting care from the hospital to the community⁹
- the 2009 Department of Health (DH) report *Delivering High Quality Midwifery Care: the Priorities, Opportunities and Challenges for Midwives*¹⁰
- the 2008 RCOG Working Party report *Standards for Maternity Care*¹¹
- the 2009 RCM report *Standards for Birth Centres in England*.¹²

Structural reforms also influence maternity services provision, particularly:

- **Commissioning:** transfer of commissioning powers and allocated funding from primary care trusts (PCTs) to clinical commissioning groups (CCGs), and the establishment of NHS England and the development of maternity and children's strategic clinical networks
- **Democratic/local accountability:** Health and Wellbeing Boards (HWBs) and local *Healthwatch* groups in England; the configuration of maternity services is often driven by the reconfiguration of neonatal and paediatric services.

The example of the reconfiguration in Manchester showed that when the obstetrics and midwifery heads of 12 Manchester maternity units met in 2000 they agreed 'almost from day one' they had too many sites.¹³ They feared that national shortages of specialist staff, increased clinical specialisation and EU restrictions on trainee doctors' hours would make it impossible to keep that many units adequately staffed. None, of course, particularly wanted their own units to close but, over time, they were able to agree that there should be eight at most, and to present a choice of possible configurations.

The guidance made in this document is based on the recommendations in several RCOG reports, most notably in *Safer Childbirth*¹⁴ and *Standards for Maternity Care*.¹¹ A summary of the key considerations for reconfiguration of services appears below.

4 Workforce planning

4.1 Obstetric staffing

The close working relationship between midwives and obstetricians, together with the support from other health professionals, is unique to the UK and emphasises the strength of our maternity services. It allows for:

- the development of differing modes of care
- choice of place of birth
- seamless escalation of care when required (and returning to the original carer when the risk has resolved).

Around one-third of women (often those with a previous uneventful birth) can be assessed as being at low risk of complications and a plan made for them to give birth at home or in a freestanding midwifery-led unit (FMU). Fewer than 5% of these women having their second or subsequent baby will require transfer to consultant care. This allows a significant number of women access to a low-risk environment of their choice with midwife support.

A further one-sixth of women will be classed as being at high risk of complications from previous events or medical problems in the current pregnancy.

In the remaining 50% of women, the level of risk is unknown. This is largely made up of women having their first baby and those women who had some complications in their first pregnancy but are not clearly high risk. Their antenatal care can start in a low-risk environment but one-quarter of them will require step-up care to specialist services prior to labour because of developing concerns such as fetal growth restriction or maternal hypertension.

Of those who continue as low risk and start labour in a low-risk environment, over 40% will need transfer to an obstetric unit in labour.¹⁵ These transfers from low risk to higher risk care need to be seamless. For ease of transfer, labour care in an alongside midwifery unit (AMU) or a mixed obstetric service allows quick, easy and safe escalation of care.

In any setting, the role of the midwife remains central as the main supporter and guardian of women in labour but in the obstetric unit there needs to be immediate access to senior medical obstetric staff. Appropriate obstetric cover to provide care for the number of anticipated births per year should in theory be possible with centralisation, in units with more than 6000 births per year. The 2005 report *The Future Role of the Consultant*¹⁶ suggested that delivery suites supporting large numbers of births (over 5000 a year) and/or a complex caseload should be moving towards a 168-hour-per-week consultant-based service.

Increasing the provision of community-based midwifery-led services would allow for this centralisation of obstetric services. More complex caseloads should be expected in centralised obstetric units and planning for consultant cover should reflect this.

Currently, most maternity services are struggling to provide adequately staffed low- and high-risk services. It is imperative that 24-hour consultant presence on the delivery suite results in improved decision making and healthcare organisations must ensure that these doctors have the appropriate team structures and support from their organisations and protected time to carry out their responsibilities. There is also the need for all consultants (excluding gynaecological subspecialists) to provide obstetric service and delivery suite presence as proposed in the 2009 report *The Future Workforce in Obstetrics and Gynaecology*.¹⁷

In smaller units (between 2500 and 4000 births per year), 24-hour presence may not be cost-effective and *Safer Childbirth*¹⁴ suggested a 60-hour-per-week presence as a minimum standard. Other circumstances such as geography and location of units must be carefully considered.

The RCOG believes that a 24-hour, 7-day-a-week consultant-led service for women requiring obstetric care improves patient safety and enhances women's experiences.¹ This results from enhanced clinical leadership and decision making with the added advantage of providing better supervision and mentoring of trainee doctors and increased support for midwifery colleagues. Similarly, women have stated that they prefer to be treated by specialists at any time of the day should they require this level of care.¹⁸

The RCOG recommends that there should be a lead consultant obstetrician on the delivery suite.¹¹

Recommendations on consultant presence can be found in the following documents:

- RCOG Good Practice No. 10 (2010) *Labour Ward Solutions*¹⁹
- RCOG Good Practice No. 8 (2009) *Responsibility of Consultant On-Call*²⁰
- RCOG Working Party report (2009) *The Future Workforce in Obstetrics and Gynaecology: England and Wales*¹⁷

- College of Operating Department Practitioners, Royal College of Midwives, and Association for Perioperative Practice (2009) *Staffing of Obstetric Theatres – A Consensus Statement*.²¹

4.2 Trainee doctor staffing

Organised shift handovers with the whole maternity team are needed to enable better continuity of patient care. Clearly defined roles (taking into consideration individual training needs and skill mix) for trainees are needed. Trainees at ST1–2 level should not be expected to provide the service unsupervised. Better mentoring and supervision for trainees is needed so that training occurs throughout the shift.

4.3 Anaesthetic care and support

Anaesthetists are an integral part of the maternity team and a lead obstetric anaesthetist is an essential requirement in the provision of safe services. In addition, an anaesthetist of appropriate seniority and experience, with appropriate operating department practitioner (ODP) support, should be on duty in an obstetric unit 24 hours a day.

Pain relief should be made available to women who want it and obstetric units must be able to provide regional anaesthesia on request at all times. There should be timely referral to doctors for women choosing epidural analgesia. The anaesthetic team's response time is crucial during emergencies and appropriate planning is needed to manage the response to elective procedures and to detect postoperative complications.

Recommendations on obstetric anaesthetic care can be found in the following documents:

- Royal College of Anaesthetists (2011) *Providing Equity of Critical and Maternity Care for the Critically Ill Pregnant or Recently Pregnant Woman*²²
- Royal College of Anaesthetists (2013) *Guidelines for the Provision of Obstetric Anaesthesia Services*.²³

4.4 Neonatal care

Obstetric services should include appropriate levels of staffing (paediatricians and specialist nurses) and facilities (neonatal intensive care unit (NICU)) to care for preterm or ill babies. In cases of suspected preterm labour, a neonatal consultant should be present. Where possible, arrangements should be made for the mother to be with her baby. In units where these services are unavailable, transfers to appropriate care must be planned in advance of birth. The current system to enable quick transfer arrangements exists within NHS Neonatal Networks (www.bapm.org/networks_info).

Recommendations on neonatal services can be found in the following documents:

- British Association of Perinatal Medicine (2010) *Service Standards for Hospitals Providing Neonatal Care*²⁴
- British Association of Perinatal Medicine (2008) *The Management of Babies Born Extremely Preterm at Less than 26 Weeks of Gestation: a Framework for Clinical Practice at the Time of Birth*²⁵
- Neonatal Expert Advisory Group (2013) *Neonatal Care in Scotland: a Quality Framework*.²⁶

4.5 Co-Surgical support

Every obstetric service must have close access to surgical backup for infrequent complications occurring during childbirth, which include damage to bladder, bowel or major blood vessels. In addition, major bleeding complications in obstetrics and gynaecology may need access to interventional radiology²⁷ and close proximity to laboratory services providing blood transfusion.

4.6 *Care of critically ill parturient women*

Commissioners of maternity and critical care services must design pathways at a local level which ensure that a critically ill parturient woman accesses equitable care for both components, irrespective of location. Such pathways should facilitate mother and baby remaining together unless precluded by a clinical reason. These arrangements should include defined escalation arrangements for bringing critical care, midwifery and obstetric competencies into the maternity or critical care unit. These arrangements also need to take into account local configuration, size and complexity of maternity and critical care services. Models may include:²²

- a suitable high-dependency area and equipment with medical input from anaesthetists and obstetricians, staffed by a team of midwives who have the necessary critical care competencies
- local multidisciplinary arrangements with appropriate escalation protocols should level 3 care be required
- appropriate arrangements with local critical care services for collaboration on the delivery suite
- transferring women to a general level 2 unit with local arrangements for providing obstetric and midwifery input and maintaining direct contact with their baby.

4.7 *A&E*

Admission to emergency gynaecology must be available. Emergency gynaecology departments must be staffed appropriately, with trained medical and nursing staff.

5 **Capacity and size of consultant-based obstetric units**

There is no published evidence on the ideal size for a maternity unit. Currently, there are nine units in England and Wales that have more than 7000 births per year²⁸ and the pressure continues to increase annually with the growth in the birth rate.²⁹ In very large units, more than one obstetric team at a time may be required to cover all responsibilities. Greater numbers of specialists are required during the daytime to service the elective caesarean section commitment.

6 **Geographical access to units**

Within large conurbations most women will have closer access and choice of provider in maternity services. Women who choose to give birth out of hospital must have access to ambulance services for quick transfer to hospitals in the event of emergencies. The Birthplace study conducted by the National Perinatal Epidemiology Unit (NPEU)¹⁵ has revealed that the transfer rates vary between 9% and 45%, depending on the mother's parity.

7 **Systems**

7.1 *Education and training*

Maternity services operate over a 24-hour period and should be staffed according to the size of the unit rather than the time of day. The educational and training needs of doctors must be borne in mind at all times of the day and night. They need to be supported with supervision and mentoring by senior staff.

7.2 *Other specialist services*

Births are getting more complex. There is a need for enhanced multidisciplinary teamworking in maternity services and this should include the availability of obstetric physicians and perinatal

psychiatrists to deal with a range of maternal morbidities and comorbidities. Arrangements should be made for adequate cover at all times. At least one, and sometimes two, dedicated co-located operating theatres for maternity services is a requirement.^{14,30}

8 Other considerations

Alongside the above standards is the need for NHS trusts, health boards and provider organisations (and, in future, the CCGs, working closely with local maternity services, local authorities, women and their families) through the HWBs, to anticipate regional population trends and to forecast future demand for services.

Within hospitals, this is already being done with the roll-out of the *Maternity Dashboard*³¹ but use of this is only meant to be for the short term. A more detailed analysis of demographic developments within the local population needs to take into account social and lifestyle changes (for example, increases in average maternal age and in maternal obesity) that will be likely to have an impact on maternity workload and service provision.

8.1 NHS reform and change

The RCOG believes that with growing provision from AQPs in the NHS, commissioners must ensure that non-NHS providers adhere to NHS standards and pathways so that high-quality care can be assured. This includes the use of national clinical guidelines produced by NICE and the RCOG.

The recent RCOG report *Tomorrow's Specialist*¹⁸ found a difference between what doctors perceive women need from healthcare services and what women actually want. There is therefore the need to ensure close working with women so that patient-centred care can be delivered. The new Healthwatch groups and HWBs should be able to advise CCGs on local requirements based on patient-reported outcome measures (PROMs).

NHS England has produced a *resource pack*³² to help CCGs make the appropriate decisions on the commissioning of maternity services in England. Similarly, the DH has published the NHS Mandate³³ which outlines the key outcomes for high-quality care and good outcomes in the NHS. During the consultation stage, draft guidance on the extent of patient choice in NHS maternity services was provided in the annexes.³⁴

The RCOG has published a resource (www.rcog.org.uk/commissioning) to assist CCGs in their commissioning decisions in obstetric and gynaecology services.

9 Tools for reconfiguration

Before embarking on wide-ranging reconfiguration of clinical services, potential clinical models will need to be considered. The following questions may be helpful to consider.

- a) What services could be best delivered within the community rather than on an acute hospital site?
- b) What services are required on all hospital sites? These services are likely to be those with a low complexity but high patient numbers.
- c) Which services would be better delivered on fewer hospital sites? These services are likely to be more complex or specialised services or those with smaller patient numbers.
- d) Are there any opportunities to provide local access to services for which patients currently have to travel out of the area?

With the introduction of AQPs, it is crucial to ensure that non-NHS providers comply with NHS standards of care, which should include measures for adherence to NICE and RCOG clinical guidelines.

Ensuring that integrated care is provided requires close working relationships to be formed between GPs, NHS maternity services and AQPs so that the care offered is seamless. Similarly, monitoring systems and information-sharing between providers of care are essential, especially in the case of high-risk patients. CCGs should ensure that these responsibilities are in place. It is not inconceivable that an NHS healthcare organisation may have to deliver follow-up care that was originally provided by an AQP and there are financial considerations involved in this scenario. Commissioners should also query the education and training commitments of the AQPs so that arrangements can be made by them and the NHS.

The evaluation criteria in Table 2, against which all potential models could be assessed before public consultation, were developed by the [Healthier Together³⁵](#) collaboration in the South East Midlands and published in their [Clinical Senate and Maternity Clinical Working Group Reports³⁶](#) in March 2013.

Table 2 Evaluation criteria for potential service models, developed by the [Healthier Together³⁵](#) collaboration

Criteria	Description
Quality/safety	Does the service model improve the clinical standards for quality and safety?
	Does the service model sustain or enhance the patient experience?
	Does the service model improve clinical outcomes?
	Does the service model meet national best practice guidelines?
	Does the service model enable patients to be transported safely by emergency vehicles?
Affordability	Is the service model achievable within current and future financial resources?
	Does it provide the best value for taxpayers' money across the health and social care economy?
	Is the capital expenditure affordable (including its revenue consequences)?
Deliverability	Will the proposed model receive support from NHS staff/clinicians as well as from local stakeholders?
	Does it meet clinical commissioners' strategies for the future shape of health services for their population?
	Are assumptions about transitional funding and capital funding realistic?
	Can the model be supported by a workforce/staffing model which is realistic?
	Can the model be effectively supported by education and training arrangements in the future?
Sustainability	Does the service model address the increased demands that will result from a growing and ageing population over the next two decades?
	Will it help organisations deliver their environmental sustainability responsibilities?
	Is it clinically sustainable over the foreseeable future?
	Are the medium-term workforce implications sustainable?
Equity of access	Does the model allow for equity of access for all sections of our diverse population, including vulnerable people and those with specific needs?
	Does the model enable patients to exercise their right to choice when considering treatment options?
Travel access	Are there sufficient transport options to allow all patients and their families to access relocated services within a reasonable time?

10 Future considerations

To improve women's services, the RCOG has made the case for the reorganisation of reproductive health services (including sexual health) in *High Quality Women's Health Care: a Proposal for Change*¹ and believes that women's health care provided within the structure of strategic clinical networks could offer better care to women, throughout their lives and to their babies.

This requires the reorganisation of care so that all maternity and gynaecological services are linked and services can then be concentrated where they are most needed. Women are willing to travel a little further to hospitals provided they know they will have access to appropriate levels of care throughout the day and night.¹⁸ In order to ensure that women continue to have a range of services closer to home, some care can be provided in community settings. CCGs must work with local hospitals on the services that can be provided outside secondary/tertiary settings.

In the case of maternity services, research has shown that women with low-risk pregnancies, having a second or subsequent baby, have good outcomes if they deliver in freestanding or alongside midwifery-led services or at home.¹² These options should be offered to these women. Strategic clinical networks must ensure that effective, swift and safe transfers to centres of obstetric care can occur where required for the health of mother and baby. The development of strategic clinical networks should ease planning and capacity development.

It must be noted that the birth rate in the UK is increasing year on year, as are the numbers of complex, high-risk pregnancies. Likewise, litigation related to maternity care is also on the rise. It is therefore wise for organisations to invest in more consultants and midwives for maternity services to help prevent serious untoward incidents.

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LABOUR WARD SOLUTIONS

1. Purpose

This document is aimed mainly at those responsible for implementing the Royal College of Obstetricians and Gynaecologists and Clinical Negligence Scheme for Trusts (CNST) maternity standards. It highlights the many challenges and issues that arise from the process of expanding consultant presence on the labour ward and presents facts, helpful tips and potential pitfalls that may be encountered by those responsible for implementing changes.

2. Background

*Safer Childbirth*¹ and *Standards in Maternity Care*² have clearly stated that one of the main principles for the provision of safe maternity services is that intrapartum care should be provided by appropriately trained individuals. Colleagues working in different parts of the country have used innovative ways of achieving some of the targets for consultant on-site presence in the labour ward. In response to repeated requests for advice, the College held a workshop on 17 March 2009 to examine models developed in different parts of the country to meet these objectives. These individual examples were examined carefully for features that enabled compliance with *Safer Childbirth*¹ and this guidance is based on the information collated for and presented at the workshop. It summarises the key messages of the day, describing what is required for the implementation of 40, 60 and 98 hours of prospective consultant presence on the labour ward.

3. Standards

The number of hours of consultant presence on the labour ward as set out in *Safer Childbirth*¹ and required by the NHS Litigation Authority³ are in broad terms greater in units that undertake more births (Table 1). The hours of consultant presence should be spread as evenly as possible throughout the working day to ensure that the times of increased consultant presence are used appropriately.

Table 1. Hours of consultant presence on the labour ward

Category	Definition (births/year)	Consultant presence (year of adoption)			Specialist trainees (n)
		60-hour	98-hour	168-hour	
A	< 2500	Units to continually review staffing to ensure adequate based on local needs			1
B	2500–4000	2009	–	–	2
C1	4000–5000	2008	2009	–	3
C2	5000–6000	Immediate	2008	2010	
C3	> 6000	Immediate	Immediate if possible	2008	

The RCOG would not recommend a pattern of work where the hours are ‘used up’ in large blocks of 24-hour resident on-call in units aiming for 60 or 98 hours of presence.

The RCOG believes that we should have a consultant-delivered service irrespective of where it is delivered or whether in a small or large unit. However, in acknowledging that this is not deliverable at present, the RCOG published the above standards as an interim measure. It also published Good Practice No. 8: *Responsibility of a Consultant on-call*.⁴

4. Terminology

To provide clarity, the terms ‘births’, ‘consultant’ and ‘consultant presence’ are defined here:

Births	The number of births a unit is responsible for in a year, including deliveries in co-located/stand-alone midwifery-led birthing units and home deliveries.
Consultant	Those appointed to a consultant post, including those doctors on the specialist register holding a Certificate of Completion of Specialist Training, providing labour ward cover on a sessional basis.
Prospective consultant presence	All consultant presence described in this document should be covered prospectively; that is, if a consultant has a timetabled regular session then there should be robust and demonstrable means to cover this at times of prearranged leave. This can be achieved by pairing consultants in teams who are strictly responsible for covering particular day of the week.

5. Expanding consultant presence: practical aspects

5.1 Roles

Consultant labour ward roles should be considered to be additional to junior doctors at most times. The provision of additional consultant time on the labour ward is to ensure that doctors in training are fully supported to maximise training opportunities. Furthermore, consultants will be involved in patient care directly and in enhancing quality of care.

An expected consequence of the recruitment of consultants to posts with a major commitment to obstetrics may be that they are filled with more newly appointed consultants. It is important that these posts are designed to demonstrate a degree of role progression and a sense of leadership. Other possible roles in addition to labour ward roles include: labour ward management support for risk management liaison with other staff groups education and training.

5.2 Rotas

Key principles:

1. Standard rate programmed activities (PAs) are from 7am to 7pm, approximately 12 hours (4 hours/PA, total 3 PAs).
2. Premium rate PAs are from 7pm to 7am, approximately 12 hours (3 hours/PA, total 4 PAs).
3. Rotas should have times for regular team ward rounds that fit in with the timings of midwifery handovers as per local requirements.
4. Many units use a system of ‘hot’ weeks (or days) where a consultant is allocated periods in advance that are part of a semi-fixed rota. These provide better continuity for both patients and trainees. Such arrangements require cancellation or alternative cover of commitments. Such interim arrangements are often effective for small to medium-sized units.

5. Some units have divided the departmental consultants into smaller teams (team of the day) who are strictly responsible for covering particular days of the week. This is an effective way of ensuring adequate prospective cover during holiday periods.
6. Some units have rostered resident consultants on-call at night, together with foundation or year 1 or 2 specialist trainees. This releases senior trainees for daytime elective surgical training opportunities.
7. Roles and responsibilities of the covering consultant must be agreed locally and must be clearly available to other healthcare professionals.⁴
8. If compensatory rest is negotiated into contracts then it should be taken immediately after periods of work, if possible, to compensate for tiredness. It would be inappropriate to pool rest into long periods of additional leave without taking most of it after working unsociable hours.
9. To help trust management to appreciate unit workload and numbers of doctors on duty, it may be appropriate to demonstrate the use of staff with a process similar to a British Medical Association junior doctors monitoring exercise or possibly with data from an external agency.

5.3 Calculation of hours

In calculating the required hours, it is important to first calculate the unit's existing labour ward commitment using a diary exercise (Table 2). It is then easier to calculate the additional PAs required to increase the labour

Table 2. Suggested work patterns (for units planning 48–98 hours of cover)

Hours	Mon	Tue	Wed	Thu	Fri	Sat	Sun
40	9am to 5pm	9am to 5pm	9am to 5pm	9am to 5pm	9am to 5pm	On-call after rounds	On-call after rounds
60 (example 1)	8am to 6pm	8am to 6pm	8am to 6pm	8am to 6pm	8am to 6pm	9am to 2pm	9am to 2pm
60 (example 2)	8am to 8pm	8am to 8pm	8am to 8pm	8am to 8pm	8am to 8pm	On-call after rounds	On-call after rounds
98 (example 1)	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm
98 (example 2)	24-hour starts 8am	24-hour starts 8am	8am to 10pm	8am to 10pm	8am to 10pm	9am to 1pm	9am to 1pm

NOTE: In **smaller units** where formal ward rounds at weekends do not routinely take much time, it would be inappropriate to count this time as consultant presence. In **larger units** where such rounds take long periods of time and are often punctuated with urgent labour ward work, it is appropriate to consider this work as consultant presence.

Table 3. Example PA calculations for prospective consultant presence

Consultant presence	Additional PAs required/week
40-hour non-prospective to 40-hour prospective	2.38
40-hour prospective to 60-hour prospective	7.23
40-hour prospective to 98-hour prospective	22.40

Table 4. Total PAs required to achieve 40 hours of prospective on-site consultant presence^a

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Work time	9am to 5pm	9am to 5pm	9am to 5pm	9am to 5pm	9am to 5pm	0	0
Standard PAs	2	2	2	2	2	0	0

^a 12.38 PAs/week (calculated using a 42-week year/consultant)

Table 5. Total PAs required to achieve 60 hours of prospective on-site consultant presence^a

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Work time	8am to 6pm	8am to 6pm	8am to 6pm	8am to 6pm	8am to 6pm	9am to 2pm	9am to 2pm
Standard PAs	2.5	2.5	2.5	2.5	2.5	0	0
Premium PAs	0	0	0	0	0	1.67	1.67

^a 19.61 PAs/week (calculated using a 42-week year/consultant)

Table 6. Total PAs required to achieve 98 hours of prospective on-site consultant presence^a

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Work time	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm
Standard PAs	2.75	2.75	2.75	2.75	2.75	0	0
Premium PAs	1	1	1	1	1	4.67	4.67

^a 34.78 PAs/week (calculated using a 42-week year/consultant)

ward presence (Tables 3–6; **Note:** the presented figures in all these examples are hours required and not suggested shift patterns, which will need to be separately designed).

6. The workforce

To plan an increase in consultant numbers, clinical directors will need to:

- ensure that expanding the consultant presence on the delivery suite does not lead to an overall adverse impact on other services, such as the provision of elective gynaecology activity
- demonstrate to the trust management the number of PAs currently provided by consultants (funded establishment) and the number of additional PAs required to increase delivery suite presence to the target level.¹ In these negotiations, the trust will also need to be aware that the new posts will also attract PAs for supporting professional activities
- consider redistribution of workload from incumbent consultants to new posts
- design appropriate jobs that will attract candidates
- be as open and transparent as possible during the process
- involve other appropriate members of the consultant team.

7. Contractual and job planning considerations

7.1 Existing consultants

- Offer changes in working patterns which could improve work-life balance.
- Suggest a more flexible working style.
- Meet regularly, consider the use of an independent facilitator.
- Reinforce that they will be paid for what they do.
- Be aware of the impact of changes on sessions outside the trust setting.
- Make sure that all job plans are up-to-date at the time of business plan.

7.2 New appointments

- Job plans should include flexibility as a backbone of their design.
- Illustrative timetables that include late evening working and the possibility of 24-hour working in the future.
- Avoid 'fixed session' style job plans; consider annualised job plans.
- Describe the number of sessions required per week in each role that the job entails.

7.3 *Funding*

7.3.1 *Business case*

The trust management will require a business case to be written, which should highlight the benefits to the trust other than improved labour ward presence; for example:

- improved flexibility
- leave cover
- better coverage of special interest areas
- achieving higher CNST levels
- improved risk management
- as part of solution to address challenges of WTD compliance
- better training and supervision.^{4,5}

7.3.2 *Potential risks to the trust*

- Cost of expansion if funds are not provided by the primary care trust.
- Potential impact on delivery of elective work if the expansion of consultant presence is not accompanied by employment of more consultants.
- Unlikely to achieve appropriate CNST level (if not already in place at the time of CNST inspection; you will need at least a business case with a definitive timeframe for implementation to meet their requirements).

7.3.3 *Potential sources of funding*

- Changes in intensity payments.
- Existing consultants reducing other commitments with an expansion of consultant numbers may increase PAs.
- Bidding for funding from the primary care trust.

7.4 *Recruitment*

To aid recruitment:

- job plans should adhere to national terms and conditions and to the RCOG template
- consider more attractive on-call accommodation options
- be more active in encouraging job share and part-time working
- emphasise flexibility in job designs
- be aware of the needs of doctors in training
- demonstrate a supportive environment with mentorship facilities
- show potential for improved work-life balance by using compensatory rest to increase days off
- encourage the development of special interests.

In areas where recruitment is particularly difficult, trusts may have to consider enhanced payments to attract suitable applicants and such payments may also need to be offered to consultants already in post.

7.5 *Governance*

With major changes in the consultant establishment, it is likely that there will be changes in relationships within units and it is important to observe closely the following:

- adverse impact on the functioning of the unit
- attendance of consultants at labour ward sessions⁴
- the performance of consultants returning to out-of-hours work⁵
- maintenance of practical skills in consultants may also require attention, especially if they return to labour ward practice after some time
- attendance at local obstetric 'drills and skills' sessions or national courses such as PROMPT (PRactical Obstetric MultiProfessional Training) or MOET (Managing Obstetric Emergencies and Trauma).

8. Examples

Many units have made a great deal of progress in increasing their consultant labour ward cover. Examples from some of these can be found in Appendices 1–6. If you wish to share your good ideas with others, please complete the template in Appendix 7 and send it to: Standards Coordinator, Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, London NW1 4RG, or email to: swhitear@rcog.org.uk.

Appendix 1: 40-hour consultant presence with prospective cover

Example from: Forth Park Hospital, Kirkcaldy, Fife

Appendix 2: 60-hour consultant presence

Example from: Birmingham Women's Hospital

Appendix 3: Aiming for 98-hour consultant presence

Example from: Liverpool Women's Hospital

Appendix 4: New-style job descriptions for three posts

Appendix 5: Sample job plan for a post incorporating resident on-call

Appendix 6: Options for increasing 60-hour to 98-hour labour ward cover

Example from Chelsea and Westminster Hospital

Appendix 7: Template to be completed by those willing to share their rota experiences for inclusion in this resource

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This good practice guidance was produced on behalf of the Safety and Quality Committee by Mr Edward Morris FRCOG, Norwich, Dr Tahir Mahmood FRCOG Vice President Standards, and Mrs Charnjit Dhillon, Director Standards, RCOG.

It was peer reviewed by the Safety and Quality Committee and those present at workshop, before being finally approved by the RCOG Standards Board.

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The RCOG will maintain a watching brief
on the need to review this guidance

APPENDIX 1

40-hour consultant presence with prospective cover: example from Forth Park Hospital, Kirkcaldy, Fife

1. Delivery numbers and design of the unit

The unit delivers 3950 women for a total population of 340,000. There are five outreach clinics a week to provide antenatal care for women at medium-risk of complications. All women classified as high-risk are seen at two clinics based at the obstetric hospital, supported by a fetal medicine team and a dedicated ultrasound scanning department. The obstetric suite has been physically divided into two parts: a consultant-led obstetric unit and a midwife-led unit comprising six delivery rooms and a birthing pool. All women classed as low-risk are offered an opportunity to deliver in the midwifery-led unit. About 1300 women deliver in the midwifery-led unit and there is an intrapartum transfer rate to the obstetric unit of approximately 15%. Our overall caesarean section rate is 21%, with an assisted delivery rate of 7%. We have five elective caesarean section lists a week; caesareans are performed by the on-call team. The cases are prioritised as either performed by the duty consultant or by specialist trainees (depending upon their experience) with direct supervision.

2. Consultant numbers

In 1999, we implemented the 'hot week' concept. At that stage, we had only seven consultants. The 'hot consultant' concept was designed to provide 40-hour consultant presence from Monday to Friday between 9am and 5pm each day and at 5pm the consultant on-call took responsibility for night on-call cover. The weekend was shared by seven consultants and the weekend on-call used to start on Friday 1pm and would end at 9am on Monday morning. Initially, during a 'hot week', all elective operating and gynaecology clinics were cancelled. There were also 14 outreach antenatal clinics which were covered by experienced registrars with consultant advice. Within six months, there was a significant increase in waiting times for elective operating which led to the development of a business case for the appointment of an eighth consultant.

In April 2000, eight consultants met with the clinical director, with the aim of revising their existing job plans. We agreed to be paired into four teams and each team was allocated to be responsible for covering one day a week. This meant that we had to organise our annual leave and study leave in such a way that only one person from each team could go away at a given time. Therefore, even during the summer holidays and half-term breaks, there were always four consultants available in the unit to provide cover from Monday to Thursday. The arrangements for weekend cover continues on a one-in-eight basis over a three-day weekend. A reorganisation of the outreach clinics into more midwifery-led clinics has also occurred.

We have now managed to appoint two more consultants to provide cover for Friday. At the moment, the unit has 48-hour prospective consultant presence. At the weekend, we conduct ward rounds of the labour ward and the obstetrics and gynaecology wards on Saturday and Sunday that start at 9am. Thereafter, telephone ward rounds are conducted at 9pm on Saturday and Sunday. Some of us like to spend more time at the weekend in the hospital, as it allows us to clear our desks and also gives us an opportunity to interact with the on-call team.

3. Funding issues

Currently, we have a Working Time Directive (WTD) compliant middle-grade rota which comprises eight specialist trainees and three staff-grade doctors. This arrangement gives a WTD-compliant rota with an in-built locum cover. While on-call, we have one foundation year 1/2 doctor, together with one specialist trainee. We are currently working on a business case for an eleventh consultant to extend the hours of consultant presence to 60 hours a week.

4. An outline of a typical week

A sample week rota can be found in Example 1.

5. Benefits to the unit

The unit has benefited from the consultants' presence, as we do not have any other commitments when looking after labour ward. We are all in theatre greens on the day of our on-call and assist our specialist trainees at difficult deliveries. We also manage emergency gynaecological cases. We have a very effective early pregnancy clinic and this has significantly reduced our emergency gynaecological admissions after 9pm. Currently, we are managing 80% of ectopic pregnancies laparoscopically.

6. Pitfalls

We had to make a convincing case to management regarding the 'hot week' labour ward concept, a process that took about nine months. During this process, we had difficulty dealing with waiting lists and waiting times which, at that time, was a good strategy to make a case for additional resources.

It did take time to convince team members to move their sessions around to set up the four-team concept. However, it has been functioning very effectively for the past seven years.

7. Top tips

- Work as a team and agree on one basic principle: that the management of labour ward emergencies should take a priority.
- Organise a day out away from the unit, with the help of a facilitator, to discuss the organisation of the job plans.
- Clearly agree that those who wish to undertake private practice do have a choice to do so and that they should agree in return to schedule their private practice work once they have delivered their commitment to the labour ward.
- Do not agree on one PA in a fragmented way. It is better to agree as a team of two for one day with no other commitment. The management, of course, would like to know what you do when you are not on call. That will be your administrative session, together with some elements of supporting professional activities for 42 weeks of the year.
- When calculating your PAs on the labour ward, always remember that there are only 42 working weeks in a year, so your one PA on the labour ward per week essentially becomes 1.3 PAs.
- Be careful when estimating your time commitment when you are consultant on call after 5pm. In our unit, we normally go home once we have sorted out all gynaecological emergencies and quite often this does not happen until 7pm. All this additional time spent while working in the labour ward needs to be factored in when agreeing your PAs for the on-call commitment.

Dr Tahir Mahmood FRCOG

Consultant Obstetrician, Forth Park Maternity Hospital, Kirkcaldy, Scotland

(see Example 1 on following page)

APPENDIX 2

60-hour consultant presence: Example from: Birmingham Women's Hospital

1. Delivery numbers and design of the unit

The unit is a tertiary referral teaching hospital and is a stand-alone women's hospital with foundation trust status. We had 7440 births in 2008/09. We provide care for women from our own area and also a significant number of women from outside our area, either because they require tertiary care or because they choose to give birth here. Twelve antenatal clinics are run in the hospital each week, of which five are high risk/subspecialist. There are currently no peripheral consultant-led clinics, although there are plans to develop these with consultant expansion.

The labour ward has 15 rooms (one pool room), including two high-dependency rooms (three beds). There is an alongside midwifery-led unit with five rooms (one pool room) in which 1163 births took place in 2008/09, with a transfer rate to the obstetric unit of approximately 34%. Our overall caesarean section rate is 23.7%, with an assisted delivery rate of 14.4%.

We have five elective caesarean section lists a week, all of which have a designated consultant and junior team. There are two dedicated theatres on labour ward, which allows emergency and elective procedures to be performed simultaneously, and a four bedded recovery area.

2. Consultant numbers

We currently have 15 consultants contributing to the obstetric service, of whom seven are obstetrics-only posts, and we are currently in the process of appointing a further two. At present, those who practice obstetrics and gynaecology cover both as the consultant on call but, with the pending new appointments, we are looking to split the rota entirely to ensure that both an obstetrician and a gynaecologist are on call each night. This would change the frequency of on call from the current 1:14 to approximately 1:10 but we feel it is important from a governance perspective.

To work towards 98 hours, two further posts are in the process of being appointed. Following this, job plans will be redesigned and the evening sessions in four consultant job plans will be removed. The on-call consultant will be present until 22.30 Monday to Friday and then will cover the remainder of the night from home, with the following morning being a non-clinical session.

At the weekends, there will be a further physical evening ward round (1 hour) in addition to the morning 3-hour presence, bringing the total to 78 hours. These changes will be appropriately remunerated. To achieve 98 hours will require further consultant expansion, as weekends will need to be split, and there is concern regarding work-life balance if the weekend frequency increases significantly. Alternatively, consultant expansion will allow us to appoint consultants to posts which contain a fixed resident night shift.

Working towards 168 hours will require significant further expansion following identification of funding, as we will need to split into teams to ensure appropriate daytime coverage to allow services, particularly tertiary services, to continue to run smoothly.

3. Funding issues

We have had major problems in trying to convince (so far unsuccessfully) the primary care trust that funding for consultant expansion does not lie within tariff and that money for consultant expansion has had to come from the trust. Among other reasons, as there are very few trusts in the country whose numbers of deliveries are such that they fall into the recommended 168 hours of consultant presence, it is difficult to see how this could possibly be in tariff. We have been successful in expanding the three junior tiers to ensure that all junior rotas are WTD-compliant for August 2009, again at a cost picked up by the trust for four of six posts, and two extra specialist trainee year 1-2 posts from the deanery. We have been clear that we will not substitute

consultants for junior doctors and that consultant presence on the labour ward must not diminish the junior staffing complement. This level of investment goes some way towards improving consultant presence on the labour ward and the WTD problem with juniors but difficult decisions have been made, as we also need to expand our midwifery numbers.

4. An outline of a typical week's labour ward presence

Our existing 65-hour cover involves daytime cover:

- 08.30 to 20.30 Monday to Friday (evening sessions from 17.00 to 20.30 constitute a PA in four consultant job plans; these consultants then have a half day during the week or are paid for the extra evening PA)
- 08.30 to 19.30 on Friday (on-call person paid to be present till 19.30 as part of predictable on-call)
- 09.00 to 12.00 Saturday and Sunday.

The only element that is not covered prospectively is the four evening shifts, although, if the consultant who takes the evening shift is away, the on-call consultant is paid to be present until 19.30, leaving only 1 hour not covered prospectively.

In the mornings, there are two consultants on for labour ward who cover each other for leave, so one is always present (who can then supervise the senior trainee indirectly for the elective list). To ensure cover for the afternoon if the usual consultant is away, the consultant in the antenatal clinic cuts the clinic and covers the labour ward and is physically present there. This does impact on the running of the antenatal clinics.

- Monday – Friday: prospective 12-hour day, daytime/evening shifts, with 11 of the 12 hours prospectively covered (afternoon sessions at the expense of antenatal clinics).
- Saturday – Sunday: 3 hours of consultant presence prospectively covered.
- Evening and weekend on-call consultant on a 1:14 rota.
- This provides 65 hours a week, 61 of which are prospectively covered.

5. Benefits to the unit

Increased consultant presence will expand our current consultant-based service and will significantly improve supervision and training of junior medical staff, as much of their time on labour ward is now out of hours, which impacts on the amount of direct supervision, training and assessment of skills they receive. Increased consultant presence will lead to improved leadership on the labour ward. We anticipate that the rates of unnecessary intervention will reduce and that appropriate intervention will be more timely, leading to a reduction in clinical incidents.

6. Pitfalls

The biggest hurdle has been funding. The primary care trust is not prepared to consider this as an issue pertinent to them. Without funding, there is nowhere we can go to address this matter and we have ended up funding posts at the expense of other equally important areas within the trust, such as midwifery staffing and service development.

Our current system impacts on the running of the antenatal clinics (not the specialist clinics) to ensure prospective cover for the afternoon sessions, which is not ideal.

There is always a concern regarding the availability of suitably qualified applicants. We are in a situation where we do not particularly need further expansion in the gynaecological workforce but we do need to expand the obstetric workforce. We have concerns about how attractive the new posts would be if they were obstetric only.

Some colleagues can be very resistant to change and this requires careful management and ensuring their full engagement in the process.

The age of the consultant workforce is important, as many obstetricians opt out of on-call after the age of 55

years but continue to work until 60 or 65 years. This means that they come off the rota but there is insufficient money released to appoint a replacement. In our own unit, many of us are of a similar age and may hit this problem around the same time.

7. Top tips

- It would be extremely useful if there was central guidance regarding funding for this that is explicit, so we all know where we stand to avoid the endless arguments.
- Keep your consultant workforce fully engaged with the process.
- Acknowledge their anxieties and explore different options.
- Ensure that the local negotiating committee/medical staff committee is involved at the beginning.
- Ensure that the rest of the unit's activities can continue without major disruption.
- Think laterally about working patterns – we do not all need to be doing the same work.
- Keep the funding issues on the agenda with the primary care trust.

Dr Tracey A Johnston MRCOG

Clinical Director, Birmingham Women's Hospital

APPENDIX 3

Aiming for 98-hour consultant presence: Example from: Liverpool Women's Hospital

1. Delivery numbers and design of the unit

The unit has 8000 births a year for a total population of approximately 708,000. Seventeen consultant antenatal clinics are performed each week, of which six are high risk/subspecialist.

The labour ward has 15 rooms, including four high-dependency rooms. There is an alongside midwifery-led unit with 13 rooms, where 2000 births take place annually, including a birthing pool.

We have seven elective caesarean section lists a week, two of which have a designated consultant. The remainder are covered by specialist trainees with supervision, either direct or indirect from the labour ward duty consultant. There are three dedicated theatres on the labour ward, which allows for emergency and elective procedures to be performed simultaneously.

2. Consultant numbers

Our existing 60-hour prospective cover involves a group of two to three consultants, between them providing a total of four PAs/12-hour weekday.

To achieve 98 hours, and keep contracts at the same number of PAs and maintain WTD compliance, the following solution was calculated:

- Three resident 12-hour nights at 4 PAs and weekend mornings, in addition to the 60 hours of prospective weekday presence would achieve 98 hours.
- This was preferable to the existing consultant body than seven times 14-hour days.
- It was considered that these hours were not feasible at the weekend without splitting shifts and therefore increasing the impact of weekend work on home life.
- WTD requires 11 consecutive hours rest in 24 hours and 14-hour shifts are non-compliant.
- Four daytime direct patient care PAs needed to be taken as time off to compensate for each night.
- Supporting professional activities (SPAs) should not be included in time taken off for nights: it should be like-for-like SPAs.
- We calculated that we needed four additional consultants on the rota to maintain work-life balance and preserve non-labour-ward work.

Working towards 168 hours:

- Adopting the same model, seven to nine more consultants are needed to maintain daytime non-labour-ward service and 24/7 presence on the labour ward.
- This means that we cannot make permanent appointments until funding issues have been dealt with.
- We are considering fixed-term appointments in conjunction with post-Certificate of Completion of Training fellows and trainees on a grace period.

3. Funding issues

We used income from research network, the National Institute for Health Research and other sources and achieved primary care trust funding to expand the consultant body to provide 98 hours on the labour ward and a number of consultant high-risk community antenatal clinics. The junior rotas are all WTD compliant.

4. Outline of a typical week's labour ward presence

- Monday – Friday: prospective 13-hour day daytime/evening shifts to allow personal handover by day consultant to night team, prospectively covered.
- Saturday and Sunday: 3 hours of consultant presence prospectively covered.

- Tuesday – Thursday 12-hour consultant resident night shifts (not prospectively covered) provided by three consultants undertaking a fixed night as part of their job plan. Non-resident cover for their leave provided by other consultants on 1:11 rota.
- Saturday – Monday nights and weekend afternoon and evenings: non-resident on-call consultant on 1:11 rota.

This provides 104 hours per week, 71 of which are prospectively covered:

Hours of consultant presence on labour ward		
Day of week	Day	Night
Monday	13	On call
Tuesday	12	12
Wednesday	12	12
Thursday	12	12
Friday	13	On call
Saturday	3	On call
Sunday	3	On call
Total hours	68	36

5. Benefits to the unit

- Increased consultant presence for training and supervision of junior doctors.
- Consultant-based service.
- Improved handover.
- Maintenance of other aspects of the service.

6. Pitfalls

We advertised twice and had no suitable applicants to make appointment to an obstetric post to reach 60 hours on the labour ward. We then had additional monies from the primary care trust to work towards 98 hours. We then advertised revised job plans, including gynaecology in two positions, and were able to recruit to three posts (job description for the three new posts can be found in Appendices 4–5). Applicants for obstetrics-only jobs were substantially lower than for the combined jobs and it was clear from application forms and interview that the majority still wanted some gynaecology, even if they had applied for an obstetrics-only post.

7. Contractual issues and payment

The obstetric tariff does not include any consultant presence outside 40 hours.

The primary care trust is reluctant to release any more of the £330 million for maternity services following the publication of the Healthcare Commission Survey.

There is little additional funding, as the tariff is based on 2006/07 reference costs that have funding for 40 hours of consultant presence.

The changes to the working patterns were put through our local negotiating committee, which considered that it was not in line with the British Medical Association (BMA) advice on the national consultant contract. The BMA guidance on premium PAs in the consultant contract explicitly states that they are to recognise the work needed to do a consultant's normal job, not resident on-call. It advises that this is not included within the contract. Existing consultants have no obligation to do this. If it is required, there must be local negotiations and 'substantial' additional payments over and above premium rate PAs. We were prepared to do some resident on-call but only by local negotiation of enhanced payments. We were concerned about being unable to recruit a suitable calibre of applicants for consultants if this was not in place.

The trust accepted that our proposals were in line with the national contract. We formalised this through the BMA and by ensuring that the enhanced payments were linked to future pay rises and seniority.

8. Impact on other areas of the maternity service

The cost of the additional payments left insufficient funds to recruit enough additional consultants. There were huge implications on the rest of the service as a result of rest requirements for resident nights.

9. Other issues

The consultant body initially felt strongly that the new appointees should have the same work pattern as existing ones, so as to be equitable. The protracted and difficult negotiations were extremely stressful and unsettling for the consultant body. Relationships between clinicians and managers were strained to the point that a complete rethink was needed. Refocusing on the aims of the service being to provide a high-quality and safe service for our population overcame the difficulties in considering alternative working patterns for individual consultants.

It was accepted that new consultants might actually find alternative working patterns attractive, with appropriate non-financial compensation in terms of a resident fixed night and no prospective cover and choice of developmental career progression sessions.

Our senior consultant requested to change to new-style working, as a lead into retirement. We have advertised two temporary consultant posts pending substantive appointments. This will achieve our aim of 98 hours, 60 of which are prospective.

10. Top tips

Do not underestimate how difficult the process will be.

Be imaginative with the options.

Take into account the specific requirements of your service.

Seek funding from Maternity Matters: £330 million of government investment from your primary care trust.

Dr Helen Scholefield MRCOG

Liverpool Women's Hospital

APPENDIX 4

New-style job descriptions for three consultants in obstetrics and gynaecology

These appointments are new posts to reflect significant increases in obstetric and gynaecological activity.

A candidate who is unable for personal reasons to undertake the duties of a whole-time will receive equal consideration. If such a candidate is appointed, the job content will be modified as appropriate, in consultation with consultant colleagues and local management.

We welcome all applications irrespective of age, disability, gender, sexual orientation, race or religion. Additionally, people with disabilities will be offered an interview, provided that they meet the minimum criteria for the post. The trust operates job share and flexible working.

Duties of the post

The appointment is to the trust, not to specific hospitals.

To recognise changes in consultant working practices within the specialty, the candidate will be expected to provide out-of-hours labour ward presence, with the support of a specialist trainee and a foundation trainee at times. Initially, this is expected to be until 10pm but, if national and local initiatives suggest that further consultant expansion is required, the candidate may be required to work in a rota that provides 24-hour cover with a physical presence on labour ward (resident on-call). At present, in addition to evening working, participation in the consultant on-call rota is expected (approximately one in nine prospective cover, with two mid-grade support staff at weekends and overnight). The three posts will be expected to provide presence for two evenings a week on a prospective-cover basis.

Post 1: Maternal medicine and general obstetrics

This post arises from the increasing numbers of obstetric patients with medical problems in pregnancy who require specialised care. The appointee will contribute to the outpatient and inpatient care of these women and will be encouraged, as a team member, to develop a special interest in managing a patient group. See below for further details of the maternal medicine team. It is considered essential that the appointee has subspecialty training in maternal medicine.

Posts 2 & 3: General obstetrics and gynaecology

These posts arise from a need to expand consultant presence on the labour ward and from an increase in the need for consultant input into outpatient and day case gynaecology. Post 2 is envisaged to have a predominantly obstetric bias, undertaking supporting senior roles in risk management and labour ward leadership. Medical school education, general outpatient diagnostic gynaecology and minor operative gynaecology will also be components of this post. Post 3 will be to take a lead on the provision and development of emergency gynaecology, to support ambulatory management of miscarriage and termination of pregnancy and to provide services in general obstetrics.

Successful candidates will be expected, when appropriate, to participate in the termination of pregnancy service provided by the directorate.

The fixed sessions of these posts will be arranged according to the expertise and wishes of the successful candidate and the needs of the directorate. The posts will have 7.5 fixed programmed activities (PAs) for delivery of clinical service. PAs allocated to labour ward cover will be flexibly allocated to cover for absent colleagues initially until directorate plans for reconfiguration of labour ward cover are complete.

Provisional timetables

The following provide suggested outlines of the expected clinical activity and clinically related activity components of the job plan which occur at regular times in the week. Agreement should be reached between the appointee and their clinical director with regard to the scheduling of all other activities, including supporting professional activities. Upon appointment, the consultant will be given a specific 'work programme' detailing, as a minimum, the direct clinical care (DCC) activities. Given the flexibility of this post, the appointee is required to ensure that PAs worked do not exceed a maximum of 60 over a 6-week period.

Post 1

Per week 1

1 General antenatal clinic	1 DCC/w
1 Maternal medicine clinic	1 DCC/w
Patient admin	1 DCC/w
On-call (1 in 9 non-resident)	1 DCC/w (0.8 predictable)
Protected teaching	1 SPA/w
National research projects	0.5 SPA/w
Teaching and educational supervision	0.5 SPA/w
CME, audit and guideline production	0.5 SPA/w

Alternate weeks

8am to 5pm labour ward presence	1 DCC/w
Diabetic antenatal clinic	0.5 DCC/w
Special interest antenatal clinic	0.5 DCC/w
Medical school education	0.5 DCC/w

Evening labour ward work

2 evenings/3 weeks (1.5 DCC/evening)	1 DCC/w

Totals	7.5 DCC/w
	2.5 SPA/w

Post 2

Per week

1 General antenatal clinic	1 DCC/w
1 General gynaecology clinic	1 DCC/w
Patient admin	1 DCC/w
On-call (1 in 9 non-resident)	1 DCC/w (0.8 predictable)
Protected teaching	1 SPA/w
Deputy labour ward/risk management lead	0.5 SPA/w
Maintaining operative skills	0.5 SPA/w
CME, audit and guideline production	0.5 SPA/w

Alternate weeks

8am to 5pm labour ward presence	1 DCC/w
Day procedure unit	0.5 DCC/w
Special interest gynaecology clinic	0.5 DCC/w
Medical school education	0.5 DCC/w

Evening work

2 evenings/3 weeks (1.5 DCC/evening)	1 DCC/w

Totals	7.5 DCC/w
	2.5 SPA/w

Post 3

Per week

1 General antenatal clinic	1 DCC/w
1 General gynaecology clinic	1 DCC/w
1 early pregnancy unit session	1 DCC/w
Patient admin	1 DCC/w
On-call (1 in 9 non-resident)	1 DCC/w (0.8 predictable)
Protected teaching	1 SPA/w
Early pregnancy unit lead	0.5 SPA/w
Maintaining operative skills	0.5 SPA/w
CME, audit and guideline production	0.5 SPA/w

Alternate weeks

8am to 5pm labour ward presence	1 DCC/w
Day procedure unit	0.5 DCC/w

Evening work

2 evenings/3 weeks (1.5 DCC/evening)	1 DCC/w

Totals	7.5 DCC/w
	2.5 SPA/w

DCC = Direct clinical care

PERSON SPECIFICATION

GRADE: Consultant SPECIALTY: O&G

JOB REQUIREMENTS	ESSENTIAL	DESIRABLE
Physical requirements	Good general health	Non-smoker
Qualifications	MRCOG or equivalent accreditation in obstetrics & gynaecology and on specialist register at or within 6 months of the AAC. Subspecialty accreditation in maternal medicine (Post 1).	Higher degree training and experience in delivering undergraduate education (Posts 1 & 2).
Aptitudes	Good communicator. Capable of working in a multidisciplinary team. Enthusiasm for service development and teaching. A flexible approach to delivery of service in a changing environment	Prepared to work in shared office space. Management skills.
Experience	Extensive experience in obstetrics and gynaecology, including ability and commitment to perform all roles within the job description. Applicants who are nationals from another European country or elsewhere overseas would have to show equivalence to the 5-year training period in the National Health Service required for the specialty.	Experience in research or published papers in area of special interest. Skills in intermediate laparoscopic surgery (posts 2 & 3). Experience in delivering and developing a first class early pregnancy service (Post 2).
Interests	Commitment to develop an appropriate special interest. Training. Audit/research.	
Circumstances	Flexible outlook on working hours. Must live within a 15-mile radius of the base trust or 30 minutes' travelling time. Full driving licence.	
Other	Flexible outlook on working practices. Full registration with GMC. Emotionally well balanced personality.	
Communications and language skills	Ability to communicate effectively with clinical colleagues, colleagues in pathology and support staff. Good knowledge of, and ability to use, spoken and written English. Ability to present effectively to an audience, using a variety of methods, and to respond to questions and queries.	Good presentation skills.

APPENDIX 5

Sample job plan for a post incorporating resident on-call

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Hysteroscopy	SPA 1			SPA 1
Afternoon	GOPD	SPA 0.5 ANC (alt weeks)			Operating theatre list (alt weeks)/clinical admin
Night (9pm to 9am)			12-hour resident on-call		

SPA	2.5
Resident on-call	4 PA (DCC)
Clinical admin	0.5 PA (DCC)
OP hysteroscopy	1 PA)
Gynae OP clinic	1 PA) = 3 PA (DCC)
Antenatal clinic	0.5 PA)
Operating theatre	0.5 PA)

Total = 10 PA

GOPD = Gynaecology outpatient clinic; OP = outpatient

APPENDIX 6

Options for increasing 60-hour cover to 98-hour labour ward cover

Rationale

For a unit with 4000–5000 births, the Royal College Obstetricians and Gynaecologists guidance specifies that there should be 60 hours of consultant presence on labour wards by December 2008 (achieved) and 98-hour cover by December 2009.

A business case was approved in 2008/09, for an additional 10PAs. It was intended that these would be shared across existing consultants, rather than recruiting to a new post. This was calculated on the basis of the additional hours required, as detailed below:

• Additional (antisocial) hours/week	30 hours
• Additional hours/year	1560 hours
• Additional PAs/year (3hours/PA)	520 PAs
• Additional PAs/week	10 PAs
• Cost at £10,000/PA	£100,000

Increasing consultant presence on labour ward is also a requirement of CNST level 3. As stated above, this will potentially improve quality of care and safety through having more experienced (consultant) medical cover on the labour ward, with less reliance upon junior staff. Weekend cover will be particularly improved, as currently there is only a consultant presence on labour ward for 3 hours each weekend day.

Current model of consultant cover

The consultant cover on the labour ward is currently 68.5 hours/week. This is achieved through fixed labour ward sessions 8am to 8.30pm (Monday to Friday) and 8am to 11am (Saturday and Sunday).

Weekday hours

There are currently 13 consultants contributing to labour ward cover. The team recently moved to a one-in-three labour ward cover model, to staff the five sessions a week required: 8am – 8.30pm (Mon – Fri). Each one-in-three session attracts one PA on a new consultant job plan.

Weekend working and on-call

Weekend on-call cover starts at 8.30pm on a Friday night and runs through to 8am Monday morning and is a different rota to the one-in-three trios. Part of the weekend on-call incorporates a 3-hour ward round on Saturday and Sunday mornings: 8am – 11am (Sat/Sun), Contributing to the on-call rota attracts 1 PA (0.5 PA for recently appointed consultants: this inequity needs to be addressed).

Labour ward trios

Day	Trio	Caesarean section list (am)
Monday	A,B,C	L
Tuesday	D,E,F	TBC
Wednesday	G,H,I	L
Thursday	J,K,L	O
Friday	M,N,O	Clinical fellow 1:2

Permanent staff/sessions contributing to labour ward rota

	Consultant	No. LW sessions/week	No. caesarean section list sessions/week
1	A	1	0
2	B	1	0
3	C	2	0
4	D	1	0
5	E	1	0
6	F	2	1
7	G	1	0
8	H	1	0
9	I	1	0
10	J	1	0
11	K	1	1 (locum: temp)
12	L	1	1 + 0.33
13	M	1	0
	Clinical fellows		0.66 + 0.5
	TOTAL	15	4.5 (3.5 perm)

The elective caesarean section list runs from 8am to 1pm on the labour ward, with a consultant or senior trainee (C, F) on the rota each day to run the list, separately from the labour ward consultant. There are gaps with the existing cover arrangement on: Tuesday morning and Friday afternoon. Currently, there is no prospective cover for any annual leave or study leave. There is a plan to use senior trainees on these occasions but this is not robust.

Any private sections can be scheduled at either 7am or at 1pm and are undertaken by the private consultant.

Gynaecology on-call service

This will be the subject of separate discussion.

Options for increasing to 98 hours

Increasing labour ward sessions to 12 hours/day for seven days/week

One option to meet the 98-hour cover requirement is to increase the existing labour ward sessions to 12 hours/day: 07:00 to 21:00 or 08:00 to 22:00.

It is recommended that one shift pattern is agreed on and consistently adhered to rather than individual consultants interpreting the times differently, so as to avoid confusion on the unit. This will change the on-call hours, with consultants on call reducing their hours to cover from 21:00 (or 22:00) to 07:00 (or 08:00) as opposed to taking on responsibility from 17:00.

The weekend on-call contribution would consist of providing 12-hour consultant presence on the unit and also retaining on-call responsibility throughout the night.

The length of shift is onerous and four rest periods will need to be factored in: 13:00–14:00, 17:00–18:00 and two half-hour breaks.

Consideration of compliance with EWTD working patterns for consultants may need to be discussed but because the days are one week in three and weekends one in 14, this should be more acceptable.

Labour ward hot-week

An alternative approach to the labour ward trios is to have a 'hot week', during which the consultant is

present for 14 hours each day. The hot week would be on a rolling one in 14 for all consultants and all other work would be cancelled for that week. Many hospitals employ this system outside London but currently not within the city.

Twilight shifts to enable EWTD compliance

The on-call consultant takes over at 17:00 and remains in the hospital until 22:00 before commencing on-call from home. Weekends would be split between two consultants, one providing resident day and one night out of hospital night time cover following a 2-hour ward round. This would overcome EWTD regulations also but would mean one in seven weekends on call.

Remuneration

It is suggested that consultants contribute to the resident rota a total of 1.5 PAs which includes on call. This is on the basis that, while the labour ward days have increased to 14 hours, the other elements of on-call commitments have reduced, with commitments now being one in 14 (previously one in 11). It is intended that this will redress the discrepancy of new consultants only receiving 0.5 PAs for on-call. Individuals who contribute to more than one labour ward session per week or do not have labour ward sessions will negotiate separate arrangements through the job planning process.

Next steps

- Consultants are requested to reach a decision at the awayday on 30 September, regarding how to meet the 98-hour cover requirements.
- Consultants are also requested to consider whether there is a need to staff separate caesarean sections five days per week or whether, in principle, lists could be consolidated into fewer sessions: i.e. three or four days per week.
- Further to agreement at the awayday, the next round of job planning should be planned for October/November in time to implement the changes at the end of the year.
- Colleagues are requested to consider the impact upon other disciplines and form a view about whether there is a need to increase the capacity of other disciplines i.e. anaesthetics.

Keith Duncan & Nicola Sprigens

Chelsea & Westminster Hospital

September 2009

APPENDIX 7

Please use the template below if you wish to share your good practice

Hours of consultant presence:

Name of clinical director/consultant:

Name of good practice unit:

1. Delivery numbers and design of the unit

2. Consultant numbers

3. Funding issues

4. An outline of a typical week (to include rota and on-call rota if available)

5. Benefits to the unit

6. Pitfalls

7. Top tips

Emergency Surgery

Standards for unscheduled surgical care

Guidance for providers,
commissioners and
service planners

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Contents

Contributors	ii
Foreword	1
Executive summary	2
About this document.....	4
Purpose.....	4
Context.....	4
Structure and content	6
Section 1: Background.....	7
1.1 What is emergency surgery?.....	7
1.2 How common is emergency surgical intervention?.....	7
1.3 How can outcomes and productivity be improved?	7
1.4 What are the common issues?	8
1.5 The case for change.....	12
1.6 Models of care	13
1.7 Planning and commissioning	16
Section 2: Standards for unscheduled surgical care (generic).....	18
2.1 Provision of the emergency surgical service.....	18
2.2 Leadership and governance	23
2.3 Patients and supporters	25
2.4 Education and training.....	27
2.5 Network cooperation	28
Section 3: Supporting unscheduled surgical care (specialty-specific standards)	29
3.1 Ambulance services	29
3.2 Emergency department	30
3.3 Acute medicine	32
3.4 Radiology	35
3.5 Pathology	37
3.6 Anaesthesia	42
3.7 Intensive Care	46
3.8 Discharge, ongoing care and rehabilitation	48
Section 4: Delivering unscheduled surgical care (surgical specialty standards	49
4.1 General surgery	49
4.2 Emergency surgery in children	53
4.3 Specialist paediatric surgery	56
4.4 Trauma and orthopaedic surgery.....	57
4.5 Plastic surgery	61
4.6 Urology.....	64
4.7 Neurosurgery.....	65
4.8 Oral and maxillofacial surgery	66
4.9 ENT	67
4.10 Cardiothoracic surgery.....	70
Glossary.....	71
Further reading.....	73
References.....	76

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Foreword

Those requiring emergency surgical assessment or operation are among the sickest patients in the NHS. Often elderly, frail and with significant co-morbidity, the risk of death or serious complication is unacceptably high. We, the professionals involved in delivering this care, believe that emergency surgical care can be delivered in a far safer and more efficient manner, bringing benefits to our patients and their families while also providing excellent training and an efficient use of resources.

I have had the pleasure of chairing a working group over recent months that comprised medical royal colleges and specialty associations, regulatory organisations and, importantly, patient representatives. We have sought to develop standards and guidance for commissioners and service planners so that they can ensure the provision of high quality surgical services for emergency patients across the UK. The specialty standards contained within this document are generic in nature – more detailed guidance is available from the relevant college or specialty association as indicated throughout.

In England, I hope that this document will be used to full effect as significant changes to the commissioning structure are introduced. While the details are as yet unclear, we can foresee that the commissioning of emergency surgical service provision may need to occur at a regional level via sufficiently sized consortia of commissioners to ensure adequate coverage, consistency and accountability. We wish to facilitate constructive working between service managers and clinicians in order to achieve the best possible outcomes for patients. We look forward to working with the Department of Health to ensure its proposals can be implemented in a safe and efficient manner.

I would like to thank the working group for bringing this work to fruition. I hope you will find this document useful. I certainly commend it to you as a vital tool to support the delivery of a high quality and efficient service that focuses entirely on the patient who, at the time of requiring emergency surgical management, will be at their most vulnerable.

Richard Collins

Vice President, Royal College of Surgeons
Chair, Emergency Surgery Standards Working Group

Executive summary

- › The delivery of emergency surgical care is currently sub-optimal. There has been a lack of investment in, and understanding of, the risks of this type of surgery and the associated workload.
- › Mortality varies two-fold between units for surgical emergencies. In general surgery alone emergency cases account for 14,000 admissions to intensive care in England and Wales annually, carrying a mortality rate of over 25% and intensive care costs of at least £88 million.¹
- › Commissioners, planners, providers and clinicians need to understand the specific requirements of patients receiving unscheduled surgical care and to ensure pre-, peri- and post-operative assessment arrangements are improved in order to secure better outcomes.
- › This report is the result of a working group comprising experts from all surgical and related specialties.
- › This report is aimed at commissioners, planners and service providers.
- › It provides standards for the care of unscheduled adult and paediatric surgical patients. The standards describe how a safe, responsive and high quality surgical service can be provided by prioritising the care of this group of patients.
- › The key elements of a high quality emergency surgical service are:
 - » Dedicated clinical and managerial leadership and effective multidisciplinary team working.
 - » The prioritisation of acutely ill patients over elective activity.
 - » A defined governance structure with a focus on outcomes, audit and regular review of practice.
 - » A consultant-led service across all specialties.
 - » Acknowledgement that care of acutely ill patients should be prioritised in the training of surgeons and other clinicians involved in unscheduled care.
 - » The availability of sufficient, suitably trained and competent staff throughout the patient's pathway.
 - » The presence of agreed protocols to assess and manage risk, matching the seniority of the attending clinician with the clinical needs of the patient.

- » Timely input of senior decision makers (Certificate of Completion of Training holders (CCT holders)) according to the needs of the patient.
- » Appropriate and adequate facilities, laid out in such a way as to provide safe and expeditious patient care in the acute setting.
- » Careful planning and provision of adequate resources to enable sufficient and timely access to emergency theatres.
- » Appropriate pre- and post-operative care arrangements, including the early involvement of anaesthetists and critical care specialists and resources where required.
- » A focus on patient-centred care, which involves consultant-led communication with patients and their supporters.

About this document

Purpose

This document aims to provide information and standards on emergency surgical service provision for both adult and paediatric patients. It is aimed at commissioners, planners, providers and others involved in the provision of emergency surgical care and seeks to ensure that:

- › Patients receive safe and high quality care and have the best care experience possible.
- › Services are delivered in a timely manner, with acutely ill patients prioritised over elective surgical care.
- › Services achieve the best possible clinical outcomes and follow established principles.
- › Services provide information and support to patients and their supporters at all stages of the pathway.
- › Services are provided by appropriately trained and competent healthcare professionals.
- › Services are structured to deliver training in an efficient manner and ensure that the competing demands of training and service provision are adequately balanced.
- › Services contribute towards the collection and collation of data to support evidence-based care.
- › Facilities and resources are adequate and easily accessible.
- › Services are efficient, effective and offer value for money.

Context

Patients requiring emergency surgical management are among the sickest patients treated in the NHS. Efficient and effective delivery of emergency surgical care is dependent upon the availability of experienced clinicians working together in teams to provide the best outcomes for patients and with adequate resources to do their work.

In the UK, outcome analysis has been focused on cardiac surgery, where specialist units carry out a range of predominantly elective procedures with intensive care support available routinely. Audit shows good results for this group of patients which continue to improve year on year, supported by high quality data. By contrast, emergency surgery in other specialties is carried out in almost all acute hospitals, encompassing a wide range of conditions and conducted with variable levels of intensive care support; there is a paucity of data to benchmark improvement in this group of patients.

Advanced age and significant co-morbidity are common in those requiring emergency surgery, yet these readily identifiable risk factors are not always given due consideration in the planning and delivery of this type of care. The pressure to meet targets for waiting times in the emergency department (ED) and for elective surgery often resulted in emergency surgical patients being de-prioritised.

Studies have shown that there is a distinct and measureable volume of admissions for emergency surgery, including both common/high volume and less common cases. It is possible therefore to predict, with reasonable accuracy, the demand for resources and to plan for it. This will allow the workload to be managed more efficiently.

Increasing sub-specialisation has led to difficulties in staffing emergency rotas and in defining protocols for transferring patients who do not require emergency intervention to the appropriate sub-specialty team working the next day.

The implementation of working time regulations has led to the fragmentation of on-call systems, an increased number of handovers and an over-reliance on junior doctors to support a wide range of acute services during the out-of-hours period. Increased shift working has led to a marked reduction in continuity of care, with patients reporting that they do not see the same doctor twice – ongoing observation and assessment of patients by different members of the team can, and does, result in miscommunication and missed opportunities to deliver safe patient care.

The reduction in training time has also resulted in changes to the competences and skills of doctors. There is a lack of balance between service provision and the requirement to ensure trainees can develop their emergency experience to achieve the required competences in emergency surgery defined by the Intercollegiate Surgical Curriculum Programme (ISCP). Trainees' working time must be arranged to maximise training opportunities rather than simply provide cover for service needs.

In the current financial environment, it is more important than ever to achieve an efficient service that offers value for money. Elective pathways are well defined and, as a result, offer less scope for further efficiencies. By contrast, the delivery of emergency surgical care can be vastly improved, providing better outcomes for patients and reducing costs by preventing or minimising complications and shortening the patient's length of stay. The changing structure of the NHS brings an opportunity for the colleges and professional organisations to reiterate standards of care.

There is a need to:

- › improve the priority given to patients requiring unscheduled surgical care
- › improve the timeliness of surgery
- › understand best practice in peri-operative care in order to reduce morbidity and mortality and achieve an efficient service

- › agree optimal pathways for patients requiring unscheduled surgical care
- › reallocate resources (in particular theatre availability and resource)
- › ensure training of the future generation of clinicians is appropriate, well resourced and delivered effectively
- › reorganise staffing to offer the best assessment, treatment and ongoing care to patients
- › develop quality indicators and performance measures through structured clinical audit
- › measure unit/region workload to plan for an appropriate emergency surgical service model.

Structure and content

These standards have been developed by an emergency surgery standards working group (see *Contributors*). The standards (covering paediatric as well as adult emergency surgical care) have brought together the wealth of expertise and knowledge from the key professional organisations involved in delivering acute care. Wherever possible, the standards are based on evidence. Where the evidence does not exist to support a standard, we have stated the consensus opinion of professionals experienced in delivering patient care. If implemented, these standards will lead to improved outcomes for patients and the more efficient use of scarce resources. The specialty standards are generic in nature; more detailed guidance can be obtained from the relevant medical royal college or specialty association.

The document has been written to highlight the essential standards required for a safe service and also to encourage excellence. *Sections 2–4* provide information on core and best-practice standards along with criteria for measuring performance against the standards.

This document is intended for use by providers (engaging in self-assessment), service planners and commissioners (to support planning and commissioning decisions against standards set by the professional organisations). As such, it is hoped this document will provide a tool for the assessment and benchmarking of the emergency surgical service provided across the NHS and will facilitate constructive working between service managers and clinicians in order to achieve the best possible outcomes for patients.

The professional organisations are well placed to set standards for the delivery of surgical and related care against which services can be assessed and benchmarked. This document is not prescriptive about how the standards should be met – that will be a decision for providers and commissioners at local level.

Section 1: Background

1.1 What is emergency surgery?

There is a tendency to consider the emergency surgical service as one that simply operates on patients in the out-of-hours period. In reality, the term ‘emergency surgery’ encompasses six main elements, outlined in *Box 1*.

This description is a simplification that masks the complex interdependency between staff, equipment and resources that must exist in order for all elements of the service to be delivered.

Box 1: Elements of emergency surgical provision

- › Undertaking emergency operations at any time, day or night.
- › The provision of ongoing clinical care to post-operative patients and other inpatients being managed non-operatively, including emergency patients and elective patients who develop complications.
- › Undertaking further operations for patients who have recently undergone surgery (ie either planned procedures or unplanned ‘returns to theatre’).
- › The provision of assessment and advice for patients referred from other areas of the hospital (including the emergency department) and from general practitioners. For regional services this may include supporting other hospitals in the network.
- › Early, effective and continuous acute pain management.
- › Communication with patients and their supporters.

1.2 How common is emergency surgical intervention?

Available data on emergency surgical care are incomplete and fail to demonstrate the variation between the specialties in terms of the complexity of surgery, the nature of teamworking, the time, resources and critical interdependencies required to deliver the service. Further work is required to ensure these data can be collected and analysed effectively.

Taking into account the six elements outlined in *Box 1*, it is estimated that the provision of emergency surgical care comprises 40–50% of the workload of most surgical specialties. In neurosurgery, for example, over half of admissions are non-elective and the resultant workload is substantially higher (70–80%) due to the complexity of unplanned admissions compared to elective cases.

1.3 How can outcomes and productivity be improved?

Poorly delivered emergency surgical services increase costs to the NHS (in terms of complications, returns to theatre and increased length of stay), to society more generally (in terms of rehabilitation costs and welfare support), and most importantly the personal costs to patients and their supporters (poor quality of life, morbidity and mortality).

Delays in treating emergency surgical patients result in additional complications and higher mortality.¹⁻³ As an example, in England and Wales, over 14,000 admissions per year to intensive care units are made from general surgical emergency admissions. Mortality rates are near 25% and the cost of intensive care provision alone is at least £88 million.¹ There is often a reluctance to provide adequate resources for emergency surgery (theatres and staffing), largely because of concerns that they will not be fully utilised. This leads to long delays in managing patients who languish in hospital instead of being treated quickly and discharged. It needs to be recognised that fast access to imaging and, where required, access to a fully staffed and resourced theatre for patients requiring immediate intervention will be cost effective in the longer term. Assessing, prioritising and rapidly treating patients requiring emergency surgery will result in reduced mortality, fewer complications, shorter lengths of stay and provide a more positive experience for patients.

1.4 What are the common issues?

1.4.1 Priority and timeliness of surgery

Emergency surgery is performed on patients who have an acute condition that threatens life, limb or the integrity of a body structure. Some emergency operations are time critical and need to be performed immediately (day or night). The majority of emergency procedures should be performed during the daytime but very often theatre space is unavailable or insufficient, meaning that surgeons are faced with the choice of delaying an emergency surgical patient's treatment or disrupting an elective list. Delaying emergency surgery until the end of the day creates difficulties in the pre- and post-operative care of patients.

There is evidence that delaying surgery for sick patients is detrimental both in terms of the patient's outcome and the immediate and longer term costs to the NHS and society in general.¹ It is therefore recommended that emergency surgical patients are prioritised according to their clinical need and this will usually mean prioritisation above elective patients. How this is managed is an issue of organisational efficiency for providers who will wish to maintain both services. The key deficiency is theatre access and this leads to multiple knock-on costs from increased length of stay, increased complications and interruption of elective throughput. There must be adequate access to emergency theatres across the specialties with additional, dedicated theatres for orthopaedic surgery and other specialties where necessary. Accurate auditing of workload across the specialties is required to define the number and type of theatres required.

There is a paucity of data to enable audit of the timeliness of surgical intervention. The time of decision to operate and the time of operation must be recorded in the patient's notes to enable effective audit.

1.4.2 Understanding quality and outcome issues

The outcomes of emergency surgical care are variable and poorly measured at present. They require greater ongoing scrutiny via clinical audit and the development of meaningful quality indicators and outcome measures, including those reported by patients. This will be essential to understanding the unit's workload and facilitating the planning of a safe and effective emergency surgical service model.

1.4.3 Teamworking

From assessment of the acutely ill patient through surgery and into rehabilitation, the provision of emergency surgical care is undoubtedly a team activity.

The initial assessment of patients with suspected surgical pathology should be completed by a senior clinician with the appropriate skills and competences to recognise when surgery may be required. This initial assessment may not only be undertaken by surgeons but also by senior doctors in emergency medicine, acute physicians or (for children's emergencies) paediatricians who may then refer to a surgeon for more in-depth assessment.

Surgery should be managed by a surgical team with the requisite skills and competences. In all cases, emergency surgery should be consultant-led to provide optimum care for the patient and maximise training opportunities.

All patients must have a clear diagnostic and monitoring plan on admission and the trust or health board must formalise pathways for unscheduled surgical care – this should include a risk grading strategy as envisaged in the National Institute for Health and Clinical Excellence (NICE) CG50 document.⁴ It is recognised that risk scoring mechanisms can be imprecise, however, an assessment of the patient must be made to ensure the competence of the surgeon/doctor is matched to the needs of the patient. The working group consider that:

- › Patients requiring emergency surgical opinion/intervention must be seen at an early stage by a surgeon with the required skills and competences. In most cases, this will be a specialty trainee (specialty trainee level 3 (ST3) or above) or a trust doctor with equivalent ability, ie Member of the Royal College of Surgeons (MRCS) with Advanced Trauma Life Support® (ATLS®) provider status. This doctor must be able to assess the patient and make an initial decision about the seriousness and urgency of their condition.
- › Emergency surgical cases may be managed appropriately by senior trainees or specialty doctors. This must be an active and audited consultant decision. All patients admitted as emergencies must be discussed with the responsible consultant if immediate surgery is being considered.
- › Those considered at high risk (eg patients with a predicted mortality of $\geq 10\%$ using the appropriate specialty risk scoring mechanism) must be discussed with the consultant and be reviewed by a consultant surgeon within four hours **if the management plan remains undefined and/or the patient is not responding as expected**. All patients in this group must have their operation carried out in a timely manner under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is also essential to optimise peri-operative care.
- › In cases with predicted mortality of $>5\%$, a consultant surgeon and consultant anaesthetist must be present for the operation except in specific circumstances where adequate experience and the appropriate workforce is otherwise assured.

- › As an **absolute minimum**, for patients not considered at high risk, all emergency surgical admissions must be discussed with the responsible consultant within 12 hours of admission. Active and continued monitoring of the patient must be carried out and the consultant should be notified immediately if a patient's condition deteriorates.
- › If a patient is admitted but not taken to theatre (ie they are admitted for observation and conservative treatment) he or she must be seen by a consultant surgeon within a maximum of 24 hours from admission. As above, active and continuous monitoring of the patient must take place and the consultant must be notified immediately if the patient's condition deteriorates.
- › In the recovery and rehabilitation phase of care there must be allied health practitioners and nurses working as part of the surgical team to plan and deliver the ongoing care of the patient at an appropriate location according to need and geography.

1.4.4 Organisation of staff

The six essential elements of emergency surgical care described previously in *Box 1* can all be required at the same time; some elements require many hours of high pressure work. It is essential that there is a surgical team available with the required range of competences to deal simultaneously with these demands and that sufficient support from colleagues in nursing and allied health professions is available to maintain continuity of care for patients.

Appreciating the scale of the change that has occurred in recent years is essential to developing safe emergency services. The reduction in working hours for trainees has led to a decrease in their level of experience and this now impacts critically on consultant workload and service provision. It is vital that providers, planners and commissioners recognise that these changes require more senior (consultant) input early in the patient pathway in order to maximise patient outcomes. In circumstances where resident doctors do not possess the required competences, consultants must be available to take responsibility and see that patients are treated according to their clinical needs.

Additional and complementary roles have been introduced to support continued service delivery. It is important that these roles are properly constituted and evaluated according to the standards set by the relevant professional organisations to ensure patient safety and efficiency.

1.4.5 Organisation of facilities

Hospitals receiving emergency surgical patients will need to consider the most appropriate facilities and layout. In many hospitals this is known as the 'emergency floor'. The area should be designed to ensure appropriate streaming of patients to the correct part of the service, avoiding duplication of assessment and of documentation. The ideal configuration would be a series of interlinked facilities where the skills of the emergency physicians, acute physicians, surgeons, anaesthetists (including the acute pain team), radiologists and critical care specialists work closely together to manage the early phases of acute illness.

Surgical units need ready access to acute medical services for patients with medical co-morbidities and for those who develop acute medical complications. Integrated acute medical

and surgical units may provide an ideal solution by increasing access to prompt cross-specialty opinion. Such units (when co-located with critical care facilities) play an important part in the assessment, stabilisation and optimisation of patients for surgery. High risk surgical patients may require input from multiple specialty teams with regard to resuscitation and optimisation. This should be conducted in an appropriate place and have early input from senior anaesthetists and critical care doctors.

Arrangements in many hospitals mean that sick surgical patients are often admitted to any available bed, with the potential for patients to be located in areas with limited surgical expertise available. The outlying of surgical patients on non-surgical wards leads to inefficient care and increases risk. Such occasions should be monitored and recorded. Emergency surgical patients should be co-located to ensure maximum surgical input to their care. An exception to this is in paediatric surgery, where it may be reasonable to admit emergency surgical patients to a general paediatric ward if no specific paediatric surgical beds are available.

The importance of recovery and rehabilitation are often ignored in discussions about emergency surgery. Both areas are of vital importance. It is essential that patients are assessed and have a coordinated, ongoing care plan implemented early in their admission. There must be adequate capacity to deliver the aspects of care planned in the service in order to maximise resources and optimise outcomes.

1.4.6 Clinical interdependencies

The working party agree that hospitals accepting undifferentiated patients via the ED must have access to 24-hour on-site surgical opinion (at ST3 level or above) or a trust doctor with equivalent ability (ie MRCS with ATLS® provider status), with a supporting team both senior and junior to this surgeon.

Where emergency general and orthopaedic services are provided, the following services are interdependent:

- › anaesthetics, critical care (intensive therapy unit/high dependency unit) and acute pain
- › acute medicine
- › interventional and diagnostic radiology
- › pathology
- › gastroenterology
- › cardiology
- › bronchoscopy
- › endoscopy

- › elderly care and rehabilitation medicine.

If children are admitted as emergencies, inpatient paediatrics and specialist children's facilities are required. Arrangements for other surgical specialties will be required as appropriate.

Where teams provide services across a wider geographical region in a network, adequate provision must be made for this in planning the service and modern communications methods (such as rapid image transfer and video conferencing) made available. Networks must liaise closely with ambulance services to develop agreed protocols for ambulance bypass and the transfer and repatriation of emergency surgical patients. Transfer of acutely ill patients has the potential to expose both transferring and receiving hospitals to inadequate resident personnel due to their required involvement in the transfer. This must be factored in to workforce and service plans.

1.4.7 Communication with patients and supporters

Communication with patients and supporters is a crucial activity which is both demanding and time consuming. It is an often overlooked element in the delivery of emergency surgical care and must be consultant-led. Adequate time for discussion with patients must be factored in to the schedule of work for the emergency team. This should include communication with patients undergoing major elective surgery who may return to the ward environment during the evening.

Effective communication is particularly important in relation to consent in an emergency situation^{5,6} and in making decisions about ongoing care. Poor communication is the prevalent cause of complaints.

The Patient Liaison Group of the Royal College of Surgeons is keen to improve effective communication both before and after emergency surgery and their specific recommendations have been included in the standards in *Section 2*.

1.5 The case for change

The focus on access targets for elective surgical care has been to the detriment of emergency surgery. There has been inadequate investment in staff and facilities, leading to poor access to diagnosis and treatment for acutely ill patients. Insufficient resources to facilitate access to theatres and an appropriately supported bed for non-elective patients, coupled with poor recognition within consultant job plans of emergency commitments, has led to a lack of understanding of the costs and how to achieve the best outcome for these patients.

In addition, training has suffered due to the enforced reduction in hours under working time regulations, coupled with the focus on service demands and throughput. There must be a balance within service provision to ensure surgical trainees can develop their emergency experience to achieve the required competences in emergency surgery as defined in the ISCP. This must be embedded within the system to ensure future service provision is safe and of high quality.

Providers, commissioners, planners, healthcare professionals and patients tell us that they would like to have defined standards for the delivery of the emergency surgical service in order that the service is better understood and prioritised.

There are many drivers for change:

- › Patients requiring emergency surgery are among the sickest treated in the NHS.⁷⁻¹⁰
- › Outcome measurement in emergency surgery is currently poor and needs to be developed further.
- › Current data show significant cause for concern – morbidity and mortality rates for England and Wales compare unfavourably with international results.
- › It is estimated that around 80% of surgical mortality arises from unplanned/emergency surgical intervention.⁸⁻¹⁰
- › The NHS has to reduce its costs significantly over the coming years – savings can only be delivered sustainably through the provision of high quality and efficient services. The higher complication rate and poorly defined care pathways in emergency surgery (when compared to elective surgery) offer much greater scope for improvement in care and associated cost savings.
- › The reduction in working hours for doctors and the focus on elective surgical care has changed the level of experience and expertise of trainees when dealing with acutely ill surgical patients.
- › Patients expect consultants to be involved in their care throughout the patient pathway.
- › Evidence from a survey of general surgeons indicated that only 55% felt that they were able to care well for their emergency patients.¹¹
- › At least 40% of consultant general surgeons report poor access to theatre for emergency cases.¹¹

1.6 Models of care

As described above, the critical interdependencies for emergency surgical service provision need to be observed. Within these interdependencies, a variety of models of care exist – some of which are listed below for information. This document does not seek to be prescriptive about the model of care to be adopted. Rather, it sets the criteria and standards for a high quality, responsive and efficient service. It will be for organisations and commissioners to decide how the standards will be achieved.

1.6.1 Consultant-based care

Studies have shown that the intervention of senior decision makers early in the patient's pathway improve outcomes for patients and make more efficient use of resources.^{12,13}

Careful consideration of the level of cover required both during daytime hours and in the out-of-hours period is vital. A consultant-delivered service is the optimum delivery method, although in some circumstances a consultant-led service may be all that can be achieved within current resources. The level of middle-grade and junior cover requires close attention – sufficient and competent doctors need to be available to provide advice, opinion and, if necessary, surgical intervention. It is inappropriate for a busy surgical unit to have only a single tier of resident cover.

It is important that patients are monitored actively during their admission so that the appropriate level of clinical support can be made available to them according to their clinical need. Each specialty has specified the level of consultant input required to support the service (*Sections 2–4*).

1.6.2 Separating elective and emergency care

The Royal College of Surgeons recommends a separation of emergency and elective surgical services (preferably on the same site due to imaging and equipment needs, particularly for highly specialised procedures) to improve the quality of care delivered to patients.¹⁴ In some specialties (eg general surgery, trauma and orthopaedics and neurosurgery) separating elective care from emergency pressures through the use of dedicated beds, theatres and staff can, if well planned and resourced, reduce cancellations and delays, achieve a more predictable workflow, and provide excellent, supervised training opportunities in both aspects of care. One of the key benefits of this approach is the ability to co-locate emergency patients, making dedicated patient care safer and more efficient. It should be noted, however, that the drive to provide single-sex accommodation within hospitals, while welcome, may limit the ability of the NHS to achieve this model of care.

1.6.3 Surgical assessment units

Dedicated surgical assessment units can provide a centralised area where acutely ill surgical patients can be assessed and monitored prior to being admitted and/or receiving treatment. Well-resourced and designed units can provide speedy access to assessment, diagnosis and treatment and avoid unnecessary delays and admissions. In this model, patients admitted at night can generally be managed on the unit under the care of the admitting consultant until the following morning when a referral to an appropriate sub-specialty team can be arranged (unless the patient's condition dictates that this should occur earlier). Assessment units facilitate the co-location of patients and can provide excellent training opportunities for surgeons and physicians when supervised by consultants.

It should be noted, however, that not all patients will be on dedicated surgical assessment units and that this model does not suit all specialties.

1.6.4 Clinical networks

Increasingly, services will need to be provided on a networked basis, that is via an interconnected system of service providers. This allows collaborative working (assisted by contractual agreements

where required), the development of common standards of care, flexible movement for clinical staff and robust patient transfer arrangements, according to clinical need. Expertise and resources will be drawn from the entire network, enabling patients to be treated at the most appropriate hospital depending on the complexity of the case, the resources available and the competence of staff at the receiving hospital. The network will also include the provision for appropriate continuing professional development and mentoring. Early and continued involvement of the ambulance service will be required when considering network arrangements to ensure the development and review of arrangements for ambulance bypass protocols, transfer and repatriation of patients.

To be effective, networking arrangements must have senior clinical and managerial endorsement and be supported by contractual arrangements, agreed, coordinated protocols of care and network-wide audit of both processes and outcomes.

Robust handover and transfer arrangements must be agreed within the network and audited for compliance. Standards for the transfer of critically ill patients must be adhered to. Adequate resources must be available to support this.

Bed availability across the network will require careful coordination and planning. High quality data transfer arrangements are also required to transport information from radiology, pathology etc to support the patient's care.

At a macro-level, networks need to be supported financially to ensure service sustainability.

1.6.5 Extending the working day

In some specialties, extending the traditional 'core hours' of service provides additional capacity, ensures more balanced staffing levels throughout busy periods and ensures senior clinician input during the service. While access to dedicated emergency theatres must be maintained across the working day, extending the staff, facilities and resources available across a longer period (for example, from 08.00–22.00, including weekend cover) offers the ability to complete more planned elective lists as well as many of the urgent cases which otherwise would compete for a slot on the next day theatre list and clog up true emergency theatre provision. This model allows patients to be treated expeditiously, avoids extended hospital stays, provides an efficient use of resources and can reduce pressure on the staff working in the hospital at night.

Providing adequate staffing and resources at the weekend will also ensure that patients receive good, safe care over this period. Currently, this is often not the case.¹⁵

For this model of care to work, all supporting services (eg radiology, pathology etc) and staff in the wider surgical team (eg anaesthetists, theatre nurses, recovery and ward staff) need to work in a similar pattern.¹⁶

1.6.6 Outcomes and quality indicators

The measurement of outcomes from unscheduled emergency surgical care is poorly carried out at present. It is essential to audit services closely to identify areas of best practice and areas where improvements can be made. Regular, systematic audit has been shown to improve outcomes.¹⁷

The standards in *Sections 2–4* have been written to focus on the structure and process of care which, if followed, will improve outcomes. We have sought to outline expected and best practice standards and to identify how providers and commissioners can assess progress against the standards.

Wherever possible we would suggest the use of existing data sources (for example, national clinical audit and routinely collected data, eg hospital episode statistics) to measure outcomes. This should enable organisations to benchmark themselves against others in the region and country. We would also expect that the revalidation standards for surgeons,¹⁸ which will require a focus on outcome measurement, are incorporated.

Participation in prescribed national clinical audits will be mandatory for surgical revalidation and organisations will need to consider how this will be managed and resourced. The government expects participation in audit to become a ‘professional norm’¹⁹ and this is to be welcomed.

Patient reported outcomes and patient experience measures are vital and individual organisations should ensure they have mechanisms in place to capture and monitor these and take action where reports suggest improvements could be made.

Underpinning the measurement of outcome is a clearly defined clinical governance framework that must exist within all provider units and networks. This will include regular morbidity and mortality review meetings, multidisciplinary working where indicated, the agreement and adoption of clinical guidelines and protocols, and regular detailed audit. Audits of practice, outcomes and untoward incidents must be discussed at trust board level and via the clinical quality review processes required by commissioners. There is a perception that the audit cycle is often not completed. Where problems arise, solutions must be identified, implemented and re-audited. This is a clinical governance issue that ultimately affects patient safety.

Outcomes should be published at organisation, hospital and unit-level in a way that is easily understood by patients but in a format that also contains the appropriate level of detail required to enable clinicians, providers and commissioners to identify concerns and seek improvements where necessary.

1.7 Planning and commissioning

The new arrangements for commissioning in England and for planning in Wales will embed over the next few years. We would recommend that for acute and essential services, such as emergency surgery, commissioning in England takes place across GP consortia to enable a sufficient catchment population size to ensure sustainability and best use of resources. Neighbouring commissioning consortia will need to collaborate in order to ensure high quality, safe emergency surgical services can be provided at scale. In Wales, local health boards should consider their population as a whole and should collaborate with others to support networks of care. It is hoped that these standards will assist in planning and purchasing high quality and efficient services.

1.7.1 Standards for unscheduled surgical care

The following three sections describe the standards that underpin the delivery of a high quality surgical service. They have been written by the relevant medical royal college or specialty association and should facilitate collaborative dialogue and assist service planners and commissioners to work together to ensure emergency surgical services are of the required standard. These standards apply to both paediatric and adult patients.

Section 2: Standards for unscheduled surgical care (generic)

It has been our intention to develop generic standards of care; more detailed standards will be available from the relevant college or specialty association.

2.1 Provision of the emergency surgical service

Rationale: The service is provided in the safest and most efficient manner possible. Patients are prioritised according to clinical need and provided with access to senior decision makers at each stage of the pathway to ensure best outcomes and best use of resources.

STANDARD	MEASUREMENT CRITERIA
Critically ill patients have priority over elective patients. This includes the delay of elective surgery to accommodate emergency surgical patients if necessary.	Regular departmental audit, reported to clinical governance committee.
The unit has the required resources and equipment to stabilise and resuscitate the patient at all times. This includes provision of 24-hour radiology, critical care, operating theatres including senior anaesthetic availability, full emergency theatre staffing and appropriate ward bed access. If the receiving unit is unable to provide these services, agreed protocols are in place for ambulance by-pass or transfer to a designated appropriate receiving unit. Best practice: Immediate availability of trained personnel, fully staffed and equipped resuscitation room.	Description of facilities and resources available. Audit
Assessment of patients is carried out regularly during their admission by competent personnel. Agreed escalation protocols are in place to deal with the deteriorating patient. Guidance contained within NICE CG50 ⁴ is adhered to. Best practice: Modified early warning score (MEWS)/paediatric early warning score (PEWS) are used. Acute response team is available 24/7.	Regular departmental audit, reported to clinical governance committee. Incorporated into morbidity and mortality meetings/clinical audit.
All patients undergo VTE assessment on admission and regularly thereafter. Appropriate steps are taken to manage risks. See <i>Further reading 3.8.1</i> and <i>3.8.2</i> .	Regular audit.
All services are consultant-led. Best practice: Services are consultant-delivered.	Description of department staffing, examination of rota

STANDARD	MEASUREMENT CRITERIA
As a minimum, a specialty trainee (ST3 or above) or a trust doctor with equivalent ability (ie MRCS with ATLS® provider status), is available to see/treat acutely unwell patients at all times within 30 minutes and is able to escalate concerns to a consultant. There is a surgical team available with the required range of competences in order to deal simultaneously with the six essential elements of an emergency surgical service at the same time (see <i>Box 1</i>, p7). Sufficient support is provided by colleagues in nursing and allied health professions in order to maintain continuity of care for patients.	Description of department staffing arrangements, examination of rota, departmental escalation guidelines.
In circumstances where a resident surgeon does not have the required competences to assess/treat the patient, consultants are available to take responsibility.	Examination of rota, written departmental escalation guidelines.
A consultant is available at all times for telephone advice.	Written policy/examination of rota.
The designated consultant is able to attend his/her base site within 30 minutes at all times.	Contractual arrangements/departmental policy.
There are agreed specialty risk scoring mechanisms in place and these are applied to all patients admitted as an emergency.	Written guidelines, adherence to NICE CG50. ⁴
Those considered at high risk (eg patients with a predicted mortality of $\geq 10\%$ using the appropriate specialty risk scoring mechanism) are discussed with the consultant and reviewed by a consultant surgeon within four hours if the management plan remains undefined and the patient is not responding as expected.	Departmental audit/review of practice.
All patients considered as 'high risk' have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.	Audit of outcomes. M&M review.
In cases with predicted mortality of $>5\%$, a consultant surgeon and consultant anaesthetist are present for the operation except in specific circumstances where adequate experience and the appropriate workforce is otherwise assured.	Audit of outcomes. M&M review.
As an absolute minimum, for patients not considered high risk, all emergency surgical admissions are discussed with the responsible consultant within 12 hours of admission. Active and continued monitoring of the patient is carried out and the consultant is notified immediately if the patient's condition deteriorates.	Audit of outcomes. M&M review.

STANDARD	MEASUREMENT CRITERIA
If the patient is admitted but not taken to theatre (ie they are admitted for observation and conservative treatment), as a minimum they are seen by a consultant surgeon within a maximum of 24 hours of admission. Active and continued monitoring of the patient takes place.	Audit of notes/outcomes. M&M review.
Consultants take an active decision in delegating responsibility for emergency surgical cases to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit. All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered.	Audit of notes/outcomes. M&M review.
In specialties with a high emergency workload, the surgical team is free of elective commitments when covering emergencies.	Description of rota arrangements.
In specialties with a high emergency workload, consultants do not cover (ie are expected to be available on-site) more than one site. In specialties provided over a defined regional network and with less onerous emergency workloads, consultants are on-call to provide cover at their base hospital, but also may be required to provide telephone advice to a number of units across the network.	Description of cover arrangements. Description of network arrangements.
Surgeons with private practice commitments make arrangements for their private patients to be cared for by another surgeon/team when they are on-call for emergency admissions.	Contractual agreements.
Wherever possible, emergency and elective surgical pathways are separated. Both services are managed effectively to minimise the adverse impact of one upon the other.	Description of service and audit arrangements.
The time from decision to operate to actual time of operation is recorded in patient notes and audited locally.	Local audit, at least annually.
Adequate emergency theatre time is provided throughout the day to minimise delays and avoid emergency surgery being undertaken out of hours when the hospital may have reduced staffing to care for complex post-operative patients.	Audit of theatre availability.

STANDARD	MEASUREMENT CRITERIA
Emergency theatres are staffed appropriately at all times. Accurate profiling of workload across the surgical specialties takes place to define the number and type of theatres required. In busy units with a heavy workload more than one emergency theatre is identified and available. There is a separate, dedicated theatre for orthopaedic surgery and, where necessary, for other specialties as defined by audit of the requirements of each specialty. In highly specialised areas, better outcomes are achieved if the emergency theatre team is familiar with the type of surgery to be undertaken. Best practice: A dedicated, separate team is established for the emergency theatre(s) 24/7.	Description of theatre availability and audit against unit workload. Avoidable delays in care are audited.
Patients admitted for unscheduled surgical care are nursed and managed in a surgical ward or critical care environment. Best practice: Bed occupancy rates are measured on ward-by-ward basis. Average occupancy rates should not exceed 82% and outlying should be exceptional and addressed as soon as possible by relocating the patient to the next available specialty bed.	The number of bed days that surgical patients are cared for in non-surgical environments is audited monthly and considered by service/ governance committees as potentially adverse events.
The provider unit has an appropriate procedure in place to enable it to 'scale up' provision, ensuring adequate resources and facilities to manage both 'business as usual' activity and increased emergency workload. This is separate from the provider's emergency preparedness/civil contingency procedure. Best practice: Agreed protocols to defer elective activity in order to give adequate priority to unscheduled admissions. Agreement within departments that an additional consultant might be called in by the on call consultant to assist (on an ad hoc but infrequent basis).	Agreed protocols in place.
Hospitals accepting undifferentiated medical patients have access to 24-hour, on-site surgical opinion (ie of ST3 or above or a trust doctor with equivalent ability (ie MRCS with ATLS® provider status). If on-site surgical opinion is not available, the unit does not accept undifferentiated patients. Where the first attender does not have the required skills and competences to assess the patient effectively, there are agreed protocols in place to enable contact with the responsible consultant without delay.	Description of services offered. Written policies and protocols.
All children are admitted and operated on in an environment and with facilities and staff that meet the standards for children's surgery.	The organisation has met the appropriate standards for children and young people's surgery.²⁰

STANDARD	MEASUREMENT CRITERIA
All admitted patients have an estimated discharge date as part of their management plan as soon as possible and no later than 48 hours post-admission.	Agreed protocols.
The maternity team is notified when a pregnant woman is admitted with a non-obstetric problem.	Agreed protocols.
Protocols are in place to manage end-of-life care and palliative support	Agreed protocols.
Suitable administrative support is available at all times for the emergency surgical team.	Description of service.
There is commitment to participate in appropriate clinical research. Best practice: Opportunities to engage in research are prioritised by the unit/network.	Research strategy for the unit/network.
All research programmes are subject to appropriate ethical approval.	Ethics committee approval for trials and research projects in place.

2.2 Leadership and governance

Rationale: The service is supported at board level and operates within a defined clinical governance framework. The service is recognised and prioritised appropriately in terms of workforce resources, equipment, facilities etc.

STANDARD	MEASUREMENT CRITERIA
The emergency surgical service has an identified medical and nurse lead (ideally separate to the leads for elective provision). Clinical leads have provision within their job plan to lead and develop emergency surgical service provision within the organisation.	Role identified in job plan and reviewed at appraisal.
There is commitment from the executive team and senior staff to the provision of a high quality emergency surgical service.	Demonstrated in the organisation's published plans, reports and the presence of a management structure to support the service.
There is a defined governance structure to assure the quality of the service and allow for continuous improvement.	Presence of governance structure and regular discussion at board level.
The service submits data to prescribed national audits.	Participation monitored via quality accounts. Outcomes monitored through governance systems.
There is a regular, multidisciplinary review of patient outcomes involving all relevant specialties at least monthly. Regular M&M/MDT reviews of individual cases take place to identify areas of good practice and areas for improvement. Processes for identifying critical incidents and monitoring action plans are in place, for example, engagement with clinical quality review processes of commissioners. Best practice: There is regular and systematic capture of patient-reported outcomes, including those admitted for unscheduled care. Risk and clinical governance groups review the outcomes of emergency surgery. Summary hospital-level mortality indicator (SHMI) data are reviewed within organisations for unscheduled surgical care at specialty level.	Regular M&M/MDT meetings. Board scrutiny of serious untoward incidents, SHMIs and other outcome-based information. Trust engages with quality review processes of commissioning organisations.
The WHO <i>Surgical Safety Checklist</i> (or a local variant thereof) is used for all surgical procedures in theatre.	Local arrangements and audit.

STANDARD	MEASUREMENT CRITERIA
Structured arrangements are in place for the handover of patients at each change of responsible consultant/medical team. Time for handover is built into job plans and occurs within working hours. Best practice: Electronic transfer of care documents to assist with handover arrangements	Handover processes and documentation.

2.3 Patients and supporters

Rationale: Patients and their supporters receive appropriate information about their treatment and are involved in decisions about their care and the delivery of the service. The following standards have been developed in collaboration with the RCS Patient Liaison Group.

STANDARD	MEASUREMENT CRITERIA
Arrangements are in place to ensure that guidance on consent for treatment and sharing information with supporters is followed. Patients and supporters are able to access, at all times, a dedicated member of staff on the ward with whom they can discuss (or arrange discussion with the relevant clinician) treatment options, diagnostic findings, expected recovery timescales, complications etc. Best practice: 'Customer service standards' for this role are in place.	Written policy in place. Role description/rota for this post. Customer service standards in place and audited.
Information is provided to patients and supporters at each stage of the care pathway. Communication with patients and supporters is consultant-led.	Presence of written information where applicable. Feedback from patients and supporters.
Before surgery, except in the case of acute, life-threatening situations, there are clear mechanisms in place, in the absence of patient records, to elicit information from supporters, particularly for unconscious/elderly/confused patients.	Written policy in place.
Immediately post-surgery a member of the medical/nursing team updates the patient's supporter(s) of the outcome of surgery.	Feedback from patients/supporters.
If the patient's supporter cannot visit, a member of the wider surgical team should make contact with the supporter within a set time period following the operation (ideally within 12 hours).	Feedback from patients/supporters.
Information about the patient and their condition is imparted in a sensitive manner and communicated in such a way as to preserve dignity and confidentiality. Adequate private space must be made available for this.	Provision of private facilities for discussion. Feedback from patients/supporters.
There is a system of communicating the name of the responsible consultant to patients and supporters, occurring on admission and at every change of consultant responsibility.	Monitored on a ward-by-ward basis.

STANDARD	MEASUREMENT CRITERIA
Patients and supporters are given clear information on discharge from the service and are able to make contact with a healthcare professional for advice and support following discharge. Primary care colleagues receive timely and accurate discharge information in order to support the patient in primary care. Best practice: The service offers a telephone follow-up service for patients and has defined links with general practice.	Standard written information is available. Evidence of telephone advice offered. Feedback from patients/supporters. Description of telephone follow-up service and GP links.
The service has mechanisms to receive feedback from patients and supporters. Best practice: The service has a rolling programme of capturing and auditing a sample of patient's experiences of the service and acts upon the results. The service has arrangements to provide support services such as translation, social care, interfaith relations and advocacy advice and support.	Feedback audited regularly.
The service has arrangements to provide support services such as translation, social care, interfaith relations and advocacy advice and support.	Description of services offered.
Printed patient information leaflets on common emergency surgical conditions are available.	Presence of information literature.
Mechanisms are in place to involve patients and supporters in decisions about the organisation of the service. This should include patient groups who are part of a network of regional or sub-regional services.	Evidence of patient involvement in decisions about service development.

2.4 Education and training

Rationale: The service supports the training and development of all staff involved in service delivery. This includes postgraduate medical training, nursing and allied health professionals. Resources and opportunities for CPD are also in place.

STANDARD	MEASUREMENT CRITERIA
There is a balance within service provision to ensure surgical trainees can develop their emergency experience to achieve the required competences in emergency surgery defined in the ISCP. Trainees' working time is arranged to maximise training opportunities rather than simply providing cover for the service rota.	Compliance with specialty guidance on training and education.
There is commitment to the provision of multi-professional training relevant to the provision of service (eg ALTS®, APLS, EPLS, EMSB, CCrISP®).	Training records.
Resources are available to support CPD (both in terms of contractual time for study leave and finance) Best practice: Opportunities for staff to rotate through different areas/organisations to gain breadth of experience and maintain skills.	Discussed at job planning and reviewed at appraisal.
All healthcare professionals have competences appropriate to their role in safeguarding and treating children and young people, vulnerable adults and vulnerable groups.	Training records.
The skills and competences expected of each role within the emergency surgical team are identified and there is a plan (a) to ensure these competences are available at all times and (b) to enable staff to achieve and maintain their competence.	Written plan in place. Training records and rotas.

2.5 Network cooperation

Rationale: Where units operate together in a network, there are good links with supporting services both within and outside the organisation.

STANDARD	MEASUREMENT CRITERIA
There is an identified network lead/director	Job plan and discussion at appraisal.
Agreed guidelines and protocols for managing the service are in place covering the full patient pathway. Best practice: There is a forum for sharing best practice and development of the service including all contributors. Methods of communicating with all those delivering emergency surgical services within the unit/network are established.	Protocols and guidelines in place.
Emergency surgical services delivered via a network have arrangements in place for image transfer and telemedicine and agreed protocols for ambulance bypass/transfer. Careful planning ensures adequate beds are available across the network to reduce delays for patients being transferred.	Arrangements agreed. Written policy on transfer/bypass, audited regularly.
Standards for the transfer of critically ill patients are adhered to and regularly audited (standards from ICS, RCS, SBNS and the AAGBI)	Regular (not less than annual) audit by critical care networks with involvement of relevant surgical teams.
There is regular network review of patient outcomes and experience.	Evidence of review.
Processes are in place to identify and monitor network risks and critical incidents.	Evidence of written processes.
Training takes place across the network and opportunities for learning and CPD are maximised.	Training and CPD policies.

Section 3: Supporting unscheduled surgical care (specialty-specific standards)

This section contains standards for those specialties supporting the delivery of unscheduled surgical care.

3.1 Ambulance services

The following provide generic ambulance service standards. For more specific guidance and support, please refer to the Chair of the National Ambulance Medical Directors Group.

STANDARD	MEASUREMENT CRITERIA
Agreed, regularly reviewed and audited protocols are in place covering ambulance by-pass, inter-hospital transfer and the repatriation of patients undergoing emergency surgery.	Protocols in place. Regular (not less than annual) review. Annual audit and feedback to providers/ commissioners.

3.2 Emergency department

The following provide generic emergency department standards. For more specific guidance and support, please refer to the College of Emergency Medicine (www.collemergencymed.ac.uk).

3.2.1 Request for an emergency surgical consultation made by an emergency medicine (EM) clinician

STANDARD	MEASUREMENT CRITERIA
In all hospitals receiving undifferentiated patients to their EDs, a patient for whom an emergency surgical assessment is required will receive the same within 30 minutes of referral being made in the case of a life- or limb-threatening emergency, and within 60 minutes for a routine emergency referral. The member of the on-call surgical team responding to the request is at ST3 level or above, or a trust doctor with equivalent ability (ie MRCS with ATLS® provider status). Should the designated first on-call surgeon be unable to attend due to other emergency duties (eg emergency theatre or dealing with a separate life-threatening emergency elsewhere in the hospital), protocols are in place for another member of the surgical team, of similar or a greater level of competence, to be available to attend the ED, within the above time scale. Best practice: All requests for an emergency surgical opinion to the ED are met with a prompt and appropriate response by a surgeon with the required level of competence. Where the required surgical specialty provision is 'off-site', strictly audited clinical pathways must be in place to ensure the necessary prompt response for life and limb threatening conditions is achieved 24/7.	Operational policy, including: › roles and responsibilities › facilities, staffing and establishment › competencies and training › rotas, job plans and cover arrangements › specialty liaison › meetings › guidelines, protocols and pathways.

3.2.2 Emergency theatre

STANDARD	MEASUREMENT CRITERIA
All hospitals receiving undifferentiated patients to their EDs have 24/7 emergency operating facilities available, on site, capable of being accessed and staffed to allow the timely management of a range of life- or limb-threatening surgical emergencies. Under certain agreed and published clinical circumstances, it may be necessary to undertake, in the ED resuscitation room or another clinical area, an emergency life- or limb-preserving procedure that would normally only be performed in a sterile operating theatre, eg emergency thoracotomy. Appropriate surgical instrumentation packs are immediately available to permit such a procedure to be undertaken by a practitioner of a suitable and agreed level of competence. Best practice: Hospitals accepting undifferentiated patients requiring immediate life- and/or limb-preserving surgery are equipped and staffed 24/7 to manage the likely range of surgical emergencies. Clinical audit of all emergency surgical procedures, whether undertaken in an operating theatre or in another area (eg ED resuscitation room), is regularly undertaken. Where such a procedure is undertaken outside an operating theatre, the specific circumstances and clinical outcome are formally reviewed as soon as practical after the event and findings acted upon as appropriate.	Operational policy, including: › roles and responsibilities › facilities, staffing and establishment › competencies and training › rotas, job plans and cover arrangements › specialty liaison › meetings › guidelines, protocols and pathways. Clinical audit.

3.3 Acute medicine

The following provide relevant generic acute medicine standards. For more specific guidance and support, please refer to the Royal College of Physicians (www.rcplondon.ac.uk).

3.3.1 Community/primary care

STANDARD	MEASUREMENT CRITERIA
The hospital admissions process for acute medical care is streamlined to allow the most direct and efficient patient access to an AMU. Patients recognised by a referring agency in the community to have an acute medical illness requiring hospital-based treatment have direct access to an AMU or alternative forms of urgent assessment when required.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.

3.3.2 Acute and local hospitals

STANDARD	MEASUREMENT CRITERIA
Local networks develop major acute centres to care for those with life-threatening illness, either presenting as undifferentiated acute illness or requiring access via specific pathways, for acute medical care. The ‘front door’ of major acute hospitals consists of an ‘emergency floor’ with properly equipped facilities staffed by a team of clinicians who are competent in managing patients suffering from illnesses requiring immediate resuscitation including acute medical, acute surgical, major trauma and minor injury problems.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.

3.3.3 Acute general surgery

STANDARD	MEASUREMENT CRITERIA
Access routes for emergency surgery are on the same site and co-located with the major AMUs within a network, where possible. Surgical units need ready access to acute medical services for patients with medical co-morbidities and for those who develop acute medical complications.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.

STANDARD	MEASUREMENT CRITERIA
Acute medicine has prompt access to senior surgical review of acutely ill patients and vice versa. Clear protocols and lines of responsibility are identified within the network.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.
Acute medical units (AMUs) have an augmented care area (up to level 2 care) and staff with competences to deliver this level of care. Safe transfer arrangements must be in place to ensure appropriate admission to this area and to level 3 care when required. Best practice: Surgical patients have similar access to level 2 beds whether shared with acute medicine in a combined unit or in critical care services. Clearly defined contact pathways for named senior clinical opinion (speciality trainee or consultant) are on a rota for all specialties likely to require regular interaction with the AMU. These include: geriatric medicine, gastroenterology, diabetes and endocrinology, dermatology, rheumatology, neurology, cardiology, respiratory medicine, infectious diseases, critical care and mental health teams.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.
The clinical team on the AMU is consultant led. Senior review of patients is available at all times and results in the early formulation of a clinical management plan. There is a twice-daily consultant-led ward round/review of all patients in the AMU, seven days a week, to support ongoing decision making and to review the management plans and results. These rounds include members of the nursing team to ensure proactive management and transfer of information.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.
The AMU has scheduled seven-day access to diagnostic and treatment procedures such as diagnostic GI endoscopy, bronchoscopy, echocardiography, diagnostic ultrasound, CT and MRI. Specialist opinion for patients on the AMU is provided promptly.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.

STANDARD	MEASUREMENT CRITERIA
Specialty teams develop rotas of clearly identified, adequately experienced staff who can provide advice or attend and review patients expeditiously on the AMU within a maximum of four hours of a request and ideally sooner.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.
There is 24/7 urgent access to 'life saving' interventions such as GI endoscopy, bronchoscopy, interventional radiology within the emergency care network, ideally located on the same site as the AMU.	Operational policy for unit, including: › staffing levels and rotas › competencies › clinical governance structure › multi-agency liaison › guidelines, protocols and pathways › audit programme.

3.4 Radiology

The following provide generic radiology standards. For more specific guidance and support, please refer to the Royal College of Radiologists (www.rcr.ac.uk).

3.4.1 Diagnostic radiology

STANDARD	MEASUREMENT CRITERIA
All imaging departments in hospitals that admit emergency surgical patients have access to appropriately staffed 24/7 plain films, ultrasound, CT and MRI. Where MRI is not available, clear patient pathways are in place to obtain the necessary imaging from a different provider. Best practice: Where imaging will affect immediate outcome, emergency surgical patients have access to CT, plain films and US within 30 minutes of request. When MRI is required and not available patients are transferred to the appropriate centre. Advice on appropriate imaging is available immediately. There is a system in place for ensuring that reports are received, understood and acted upon.	Delivery of emergency imaging should be audited at a minimum of twice per year.
When immediate outcome is dependent on imaging studies (ie the patient is to go directly to theatre after imaging) a provisional report is available within 30 minutes and a definitive report within 1 hour. Where the patient is to be placed on a NCEPOD list or is to be observed, imaging reporting may be delayed until the following morning. Best practice: A provisional report is issued by an appropriately trained radiologist and the definitive report by a consultant radiologist.	Delivery of emergency imaging should be audited at a minimum of twice per year.
Imaging departments ensure that imaging facilities are sited appropriately to minimise the transfer of acutely ill patients and are equipped to a standard that is safe for emergency patients. Best practice: Plain films, CT and US is available in, or close to, emergency departments and are designed to allow monitoring throughout imaging as well as the provision of gases and life-saving drugs and support.	Imaging rooms should be designed with input from radiologists, radiographers, surgeons, theatre staff, anaesthetists, emergency doctors and intensivists.
Teleradiology adheres to the existing standards, allowing rapid transfer of images of a suitable quality to allow management decisions to be made. Home monitors are one megapixel minimum with the facility to magnify to three megapixels. Best practice: Teleradiology complies with the standards set out by the Royal College of Radiologists.²¹	Any failures in the system should be reported to a named site and regular analysis of the reported failures should take place to ensure a robust network.

3.4.2 Interventional radiology

STANDARD	MEASUREMENT CRITERIA
Hospitals providing emergency surgical services have access to 24/7 interventional radiology. Interventional radiology services are staffed by fully trained interventional radiologists, interventional nurses and interventional radiographers. Best practice: Interventional radiology services are ideally on the same site as the emergency services. Where they are not, or where high end intervention is necessary, there are clear and unambiguous patient pathways to deliver those services through a network solution (see transfer of patients above).	Departmental and individual data on outcomes should be available for all interventional procedures. M&M meetings should be in the job plan of all interventional radiologists at a minimum monthly interval.
Vascular and interventional facilities are situated close to emergency room facilities. They are safe for emergency patients. Best practice: Vascular and interventional facilities are of theatre standard and accessible to emergency patients and the staff attending.	See design teams above.
Interventional radiology services have an identified consultant radiologist available 24/7. Best practice: Interventional radiology services for emergency patients are available within one hour of request.	Through M&M and audit as above.

3.5 Pathology

The following provide generic pathology standards. For more specific guidance and support, please refer to the Royal College of Pathologists (www.rcpath.org).

3.5.1 Pathology – generic standards for all disciplines

STANDARD	MEASUREMENT CRITERIA
There is a consultant-led, 24-hour laboratory service. Best practice: Repertoire of tests includes availability of core tests 24/7 based on types of sub-speciality emergency surgery within hospital. Guidance for appropriate use is jointly agreed between clinical and laboratory teams, supported by advice on interpretation of results.	Repertoire of laboratory tests. Audit of appropriate use of tests. Audit of turnaround times.
The laboratory service is accredited with Clinical Pathology Accreditation (UK) Ltd. Best practice: All laboratory services are compliant (see <i>Further reading 3.1</i>).	Accreditation certificates.
Point-of-care testing (POCT) facilities are developed jointly with laboratory services and compliant with POCT standards. Best practice: Service development includes SOPs, training, quality control monitoring. Compliance with CPA (UK), POCT standards and MHRA guidance (see <i>Further reading 3.2</i>).	Documentation including protocols, training logs and audit of use.
There is audit of provision of laboratory services for emergency surgery to key areas such as ED, theatres and ICUs. Best practice: Ongoing audit in collaboration between clinical and laboratory teams reviewing access, use and provision of laboratory services, eg turnaround times, sample labelling.	Evidence of audit and feedback of results.
Paediatric knowledge within relevant pathology laboratories is provided where children are treated. Best practice: Availability of appropriate laboratory facilities and relevant advice on result interpretation and liaison with clinical teams. Input of key laboratory disciplines in hospital.	Documentation, evidence of audit and feedback.
Major incident planning. Best practice: Major Incident planning with policy stating defined procedures and roles.	Documentation, evidence of involvement of laboratory disciplines in 'mock' major incident exercises.

STANDARD	MEASUREMENT CRITERIA
Input from laboratory staff on service developments within hospitals which impact on laboratory workload to inform appropriate planning. Best practice: Early involvement of clinical and business leads from laboratory disciplines when new services are planned.	

3.5.2 Pathology – discipline specific standards – haematology and blood transfusion

STANDARD	MEASUREMENT CRITERIA
24-hour test availability including FBC, sickle cell screen, coagulation screen, group and save, and availability of blood components. Best practice: Repertoire of tests, and guidance for appropriate use, to be jointly agreed between clinical and laboratory teams. Availability of paediatrics tests, where required, with relevant reference ranges and ability to interpret results.	Repertoire of laboratory tests. Audit of appropriate use of tests. Audit of turnaround times.
Clinical telephone haematology advice available 24/7. Best practice: Advice available to discuss abnormal results, further investigation and patient management where needed.	
POCT facilities developed and managed jointly with laboratory services. Best practice: Any POCT facilities, eg for haemostasis or FBC testing, to be compliant with relevant standards and guidelines (see <i>Further reading 3.1, 3.2 and 3.3</i>).	Documentation including protocols, training logs, quality control.
Prompt availability of blood components and massive haemorrhage protocol available in all key areas. Best practice: Protocols jointly developed between clinical and laboratory teams available in ED, theatres, ITU and relevant wards. Clear, agreed lines of communication to expedite urgent issue blood components (see <i>Further reading 3.4, 3.6.1 and 3.7.1</i>). Surgical representation on the hospital transfusion committee.	Availability protocols. Evidence of joint case review at M&M meetings. Audit of management of cases.
Protocol for reversal of warfarin prior to emergency surgery. Best practice: Protocol developed jointly between clinical and laboratory teams and stating use of PCC and Vit K where needed (see <i>Further reading 3.5</i>).	Availability of protocol. Audit of management of cases.

STANDARD	MEASUREMENT CRITERIA
Risk assessment for VTE. Best practice: Ensure compliance with NICE guidelines and quality standards (see <i>Further reading 3.8.1</i> and <i>3.8.2</i>) on reducing VTE risk in all patients admitted to hospital.	Documentation of patient management, including: › VTE risk assessment › provision of information on VTE prevention for patients/carers › implementation of VTE prophylaxis.
Training and competence assessment of relevant staff groups to ensure compliance with regulations and standards in blood transfusion. Best practice: Ensuring training and competence of staff taking blood samples and collecting and administering blood components (see <i>Further reading 3.6.2</i> and <i>3.9</i>).	Documentation of training and competence assessment.
Traceability of all blood components and adverse event reporting. Best practice: System to ensure compliance with Blood Safety and Quality Regulations 2005 (see <i>Further reading 3.9</i>).	Documentation of traceability. Adverse event reporting within hospital and to external haemovigilance schemes with further investigation and management where needed.
Availability of cell salvage. Best practice: Availability on call service for cell salvage where relevant eg aortic aneurysm surgery (see <i>Further reading 3.7.2</i>).	Documentation of use, protocols and training.

3.5.3 Pathology – clinical biochemistry

STANDARD	MEASUREMENT CRITERIA
24-hour availability of tests including urea and electrolytes, liver function, C-reactive protein, glucose, lactate, amylase, calcium, magnesium, blood gases and human chorionic gonadotrophin. Best practice: Repertoire of tests bases on sub-specialty surgery. Appropriate use of tests (including those to be available out of hours) to be jointly agreed between clinical and laboratory teams with stated turnaround times.	Repertoire of tests. Audit of turnaround and appropriate use.
Clinical telephone advice available 24/7.	
POCT for blood gases available in key areas (ED, theatres, critical care). Best practice: Service developed and jointly managed with laboratory team and compliant with CPA (UK) and MHRA standards (see <i>Further reading 3.1</i> and <i>3.2</i>).	Documentation, including: › protocols › training › quality control.

STANDARD	MEASUREMENT CRITERIA
Availability of paediatric tests if paediatric surgery service provided. Best practice: Ability to interpret paediatric clinical biochemistry, including knowledge of the different reference ranges for paediatrics.	

3.5.4 Pathology – medical microbiology and infection control

STANDARD	MEASUREMENT CRITERIA
24-hour availability of comprehensive infectious diseases and infection control advice. Best practice: Close liaison is required between the emergency surgeons and the microbiology/infectious diseases service to identify unusual infections and minimise the risk of transmission of infection within the hospital environment. Agreed protocols should be in place to take relevant samples before the administration of antibiotics for diagnostic and public health purposes.	
24-hour availability of emergency samples in cerebral spinal fluid, malaria films, meningococcal PCR, blood culture, smear for tuberculosis and an agreed virology service including, where appropriate, viral haemorrhagic fever. Best practice: Repertoire of tests bases on sub-specialty surgery. Appropriate use of tests (including those to be available out of hours) to be jointly agreed between clinical and laboratory teams with stated turnaround times.	

3.5.5 Pathology – histopathology

STANDARD	MEASUREMENT CRITERIA
Appropriate use of intra-operative frozen sections. Best practice: Very rarely used and only if unexpected/ suspected malignancy which may alter surgical intervention, eg at kidney harvest for renal transplantation. Appropriate preparation and fixation of any resulting surgical specimens (particularly obstructed or ruptured bowel cases). This should be covered by departmental SOPs	
M&M reviews in cases with poor outcome (including performance of coronial autopsy as appropriate). Best practice: The Royal College of Pathologists has extensive documentation on the conduct of autopsies (see <i>Further reading 3.10</i>).	

STANDARD	MEASUREMENT CRITERIA
For paediatric surgery, hospitals must ensure appropriate facilities available to expedite diagnosis of Hirschsprung's disease	

3.6 Anaesthesia

The following provide generic anaesthesia standards. For more specific guidance and support, including guidance for paediatric anaesthesia, please refer to the Royal College of Anaesthetists' *Guidelines for the Provision of Anaesthetic Services* document.²²

3.6.1 Anaesthesia –pre-operative assessment

STANDARD	MEASUREMENT CRITERIA
All patients undergoing emergency surgery requiring anaesthesia should be seen by an anaesthetist for assessment and pre-operative optimisation; the exact timing of this visit will be dependent upon the urgency of surgery. Best practice: This visit is carried out by the anaesthetist who administers the anaesthetic. Alternatively, a formal handover of all patients listed and assessed occurs at the end of each on-call shift.	Local audit.
Wherever general and regional anaesthesia is administered there is access to an appropriate range of laboratory and radiological services.	Local policy.
Pre-operative investigation complies with NICE recommendations.	Local audit.
Patients are optimally resuscitated before emergency surgery.	Local audit.
All patients should be assessed for adequacy of analgesia and appropriate care initiated.	Local audit.
Clear communication between surgeons, anaesthetists and intensivists with the common goal being the welfare and best interests of the patient.	Regular, local multi-disciplinary reviews, eg at M&M meetings.

3.6.2 Anaesthesia –peri-operative care

STANDARD	MEASUREMENT CRITERIA
An appropriately trained and experienced anaesthetist is present throughout the conduct of all general and regional anaesthesia for operative procedures.	Local audit. M&M meetings.
All deaths/serious morbidity should be reviewed formally by a senior member of the anaesthetic department. Best practice: Formal presentation of all deaths/serious morbidity to the department.	Local audit. M&M meetings.

STANDARD	MEASUREMENT CRITERIA
The level of anaesthetic service for emergency activities, including surgery, is provided by competent anaesthetists who are either consultants or, if non-consultants, have unimpeded access to consultants and consultant supervision. Best practice: Emergency anaesthesia in ASA3 and above patients should be provided by consultant anaesthetists	Local audit.
Named supervisory consultants are available to all non-consultant anaesthetists and those they are supervising know their identity, location and how to contact them.	Local audit.
In hospitals receiving patients with major injury and trauma, there is a sufficient level of appropriately experienced medical and non-medical staff to provide a 24-hour emergency service.	Local protocols.
Trained anaesthetic assistance is present at all times in all clinical areas where anaesthetics are administered, including the emergency and radiology departments.	Local audit. Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines (see <i>Further reading 4.2.3</i>).
All equipment used to provide anaesthesia, including monitoring equipment, complies with the recommendations of the AAGBI.	Local audit.
A high performance, blood warming system with a ready supply of disposables is readily available to allow rapid infusion of blood and fluids.	Local audit.
All consultant anaesthetists and anaesthetic trainees working in emergency surgery and trauma have specific training in the skills required for this area.	National guidance.

3.6.3 Anaesthesia – post-operative care

STANDARD	MEASUREMENT CRITERIA
Until patients can maintain their airway, breathing and circulation, they are cared for on a one-to one basis by competent and appropriately trained recovery staff.	Local policy.
Sufficient numbers of recovery staff are present until a patient is discharged to the ward.	Local policy.
All hospitals provide appropriate services for the relief of pain.	Local audit.

STANDARD	MEASUREMENT CRITERIA
Many patients presenting after emergency surgery require intra-hospital transfer; to the operating theatre, to radiology suites (for further investigation or haemostasis by embolisation) or to the critical care unit. Inter-hospital transfer to other specialist units may also be required (eg neurosurgical or cardiothoracic units for patients with serious head or intra-thoracic great vessel injuries). Trained anaesthetic staff, assistance and equipment are essential in the provision of these services.	Local audit.

3.6.4 Anaesthesia – immediate (within one hour)

STANDARD	MEASUREMENT CRITERIA
In some patients, particularly those with uncontrolled bleeding, surgery is regarded as part of resuscitation; anaesthetists, as part of the multi-disciplinary team, should ensure surgery is not delayed. Such patients require care from a consultant anaesthetist and one other anaesthetist – at least until they are stabilised.	Local audit.
Patient transfer is carried out to standards described by the AAGBI (see <i>Further reading 4.2.3</i>) and ICS.	Local audit.
The peri-operative anaesthetic care of ASA3 and above patients requiring immediate major surgery (and therefore with an expected higher mortality) is directly supervised by a consultant anaesthetist. Many ASA3 and above patients require post-operative care in a critical care area.	Local audit.
In situations where a trainee is remotely supervised, the trainee must contact their supervising consultant immediately who should attend as soon as is possible – no later than 30 minutes after being called.	Local policy/national guidelines.

3.6.5 Anaesthesia – urgent (within 24 hours)

STANDARD	MEASUREMENT CRITERIA
The time of surgery is determined by its urgency based upon the needs of the individual patient. Pre-operative anaesthetic assessment and optimisation is undertaken as soon as the patient has been referred for surgery.	Local audit.
The peri-operative anaesthetic care of all patients is, at all times, led by a consultant anaesthetist.	Local policy.
Clinical care may be delegated to a supervised, clinically competent trainee of sufficient seniority.	Local audit.

STANDARD	MEASUREMENT CRITERIA
All departments develop a risk assessment process to ensure that the postoperative care of patients occurs in an appropriately monitored and staffed area.	Local policy.
Consideration is given to critical care or extended recovery (Level 1) admission.	Local audit.
Critical care outreach services are involved if appropriate. Best practice: All emergency patients are reviewed by critical care outreach service.	Local audit.

3.7 Intensive Care

The following provide generic intensive care standards. For more specific guidance and support, please refer to the Intensive Care Society (www.ics.ac.uk)

STANDARD	MEASUREMENT CRITERIA
The intensive care service is consultant led.	Audit of activity.
There is 24-hour cover of the ICU by a named consultant with appropriate experience and competences.	
A consultant in intensive care medicine reviews all emergency surgical admissions to the ICU within 12 hours.	
Intensive care requirements are considered for all patients needing emergency surgery. There is close liaison and communication between the surgical, anaesthetic and intensive care teams peri-operatively with the common goal of ensuring optimal safe care in the best interests of the patient.	Case note review. Multidisciplinary audit meetings.
Level 2 and level 3 bed provision is sufficient to support the anticipated emergency surgical workload.	Regular audit of activity (not less than annual). Audit by critical care networks with involvement of relevant surgical teams. Continuous audit of patients not admitted, and managed at a lower level of care because of lack of capacity. Number of transfers required for lack of capacity
Units providing level 2 and level 3 support to emergency surgical patients are staffed and equipped to agreed standards. Best practice: Standards defined by the ICS. ²³⁻²⁵	Audit of facilities and staffing (not less than annual).
Critical care facilities are available at all times for emergency surgery. If this is not the case, agreed protocols for transfer are in place.	Local audit of critical care facilities Network agreed protocols in line with national guidelines (ICS and AAGBI) for transfer in place and audited.
Specialist intensive care services are matched to specialist surgical requirements, eg neurosurgery and cardiothoracic surgery. Specialist surgery that is likely to require specialist ICU support is not undertaken without appropriate intensive care support unless the patient's life is endangered by transfer prior to surgery. When specialist critical care services are not available following emergency surgery, or when the patient requires transfer to another facility for emergency surgery, the critical care team supports patient transfer in line with agreed transfer protocols. Where appropriate and available, specialist retrieval services, eg PICU, are used.	Transfer protocols agreed with appropriate specialist centres are in place and audited for compliance and problems.

STANDARD	MEASUREMENT CRITERIA
Critical care input is available either directly or through an outreach team to advise and support the management of emergency surgical patients on the wards. Agreed escalation protocols result in appropriate and timely critical care referral. Best practice: Clear defined parameters for monitoring and detecting deterioration in surgical ward patients are in place, with guidelines and defined responsibilities for escalation of care and involvement of senior staff from critical care and surgery.	Audit of patient deterioration on the ward. Use of early warning scores and appropriate use of escalation pathways.
M&M reviews of surgical patients admitted to intensive care facilities are undertaken with surgical teams with post mortem data available where appropriate. Critical care teams are also involved in review of surgical patients who died on the ward for lack of active management. Best practice: Regular multidisciplinary reviews of patient outcome.	Audit of frequency of meetings, outcomes reviewed, and actions taken.

3.8 Discharge, ongoing care and rehabilitation

STANDARD	MEASUREMENT CRITERIA
All emergency surgery patients are assessed early on in their admission to ensure an appropriate ongoing care, discharge and rehabilitation package is in place.	Audit.
Ongoing care and rehabilitation occurs in an appropriate place, as close to the patient's home as possible (and not necessarily where the admission took place).	Audit.
No patient is discharged without an appropriate care plan. Patients and their GPs are given adequate and timely information upon discharge to ensure ongoing care and rehabilitation can occur.	Audit. Feedback from patients and GPs.

Section 4: Delivering unscheduled surgical care (surgical specialty standards)

This section contains standards for the delivery of unscheduled surgical care from the surgical specialty associations.

4.1 General surgery

The following provide generic general surgery standards. For more specific guidance and support, please refer to the Association of Surgeons of Great Britain and Ireland (www.asgbi.org.uk).

In addition to operating, the emergency general surgical service plays a key hospital role in the assessment of emergency referrals and the management of critical surgical illness. Patients with complications of surgery and emergency surgical admissions who do not require surgery also require complex ongoing unscheduled care.

The emergency general surgical operations most frequently performed are incision and drainage of abscess, appendicectomy and cholecystectomy. Improved management systems (workforce, location of patients, access to investigations and access to theatre) would reduce the current considerable systemic delays and unnecessary bed occupancy thereby improving outcomes and reducing the burden of hospital care from its current level for these cases. Similar considerations apply to patients admitted for non-operative care.

Abdominal infections (including peritonitis) and bowel obstructions (with or without ischaemia) form the sizeable but mixed group which contribute the majority of major operations, deaths and complications. They utilise a disproportionate amount of healthcare resource and are, for example, the largest general user of level 3 critical care (intensive care).

STANDARD	MEASUREMENT CRITERIA
Patients requiring unscheduled inpatient surgical care are under the direct daily supervision of a consultant surgeon (CCT holder). Best practice: Identified consultant in administrative charge of emergency general surgery admissions with specific audit and managerial support	Job plans.
The urgent assessment of patients with emergency surgical illness or complication requires staff adequate in numbers and seniority for that service. For a typical major hospital, the emergency general surgical team will comprise a consultant surgeon (CCT holder), middle grade (MRCS holder), core trainee and foundation doctor. As major procedures often require three surgeons, the effect on other activities during major surgery should be anticipated. Best practice: Clear referral lines including cover arrangements for busy periods.	Examination of rotas, Audit Ensure all middle grade have MRCS or equivalent, ATLS® and if dealing with critically ill patients, CCrISP®. Ensure all CCT applicants in general surgery have ST8 competences as defined in the ISCP.

STANDARD	MEASUREMENT CRITERIA
Delivering an effective emergency general surgical service requires the entire team to be free of all other commitments, except in a few hospitals with low emergency workloads.	Job planning.
The location of emergency patients within a single area greatly facilitates an effective service and enhances patient safety.	Priority in hospital planning and bed management.
A modern, effective emergency general surgery service requires adequate theatre access, senior radiological support (including interventional radiology), senior anaesthetic support and critical care facilities.	Multi disciplinary audit and case review.
Vascular services are commissioned according to guidance from the Vascular Society of Great Britain and Ireland (VSGBI). ²⁶	Audit against VSGBI standards. ²⁶
In order to minimise avoidable harm, patients require definitive treatment by surgery or similar intervention (most commonly interventional radiology) with an urgency which is graded and escalated according to the degree of illness. Best practice: The timescale of intervention is defined and achieved. 1. Patients with ongoing haemorrhage require immediate surgery. 2. Patients with septic shock who require immediate surgery are operated on within three hours of the decision to operate as delay increases mortality significantly. 3. Patients with severe sepsis (with organ dysfunction) who require surgery are operated on within a maximum of six hours to minimise deterioration into septic shock. 4. Patients with sepsis (but no organ dysfunction) who require surgery should have this within a maximum of 18 hours. 5. Patients with no features to indicate systemic sepsis can be managed with less urgency but in the absence of modern and structured systems of care, delay will result in unnecessary hospital stay, discomfort, illness and cost. Specific surgical or medical considerations may demand a greater degree of urgency for given cases.	Audit of process and outcome data.

STANDARD	MEASUREMENT CRITERIA
Achieving timely definitive care of critically ill patients requires that due priority is given to urgency and leadership at each stage of the acute management pathway (assessment, senior input, investigation, anaesthetic review, critical care review, theatre scheduling, operation). Best practice: Hospital has agreed integrated pathway to facilitate the following within a defined timescale: › Urgent review by a surgeon with MRCS and ATLS® provider status. › Urgent access to imaging (CT). › Rapid senior (anaesthetic/surgical) review. › Adequate critical support. › Timely definitive treatment (surgery/radiology/medical).	Audit of key steps as per joint RCS/DH guidelines.¹
Management of critically ill patients requires assessment at MRCS level, critical care support and consultant surgeon (CCT) input within 30 minutes and rapid access to CT.	Examination of rota. Audit.
Resuscitation of patients follows NICE CG50⁴ and the joint RCS/DH guidelines.¹ The time taken to carry out definitive treatment is important and consultant (CCT) input is often required to ensure that it is achieved as above. Resuscitation should not delay surgery in patients in class 1 or 2. Resuscitation should be conducted in the anaesthetic room or similar. Adequate access to theatre, radiology and critical care is essential. Best practice: Surgeons with MRCS and ATLS® provider status and CCT holders are free from other duties when on call for emergencies.	Audit of delay to surgery. Audit of deferred urgent theatre cases.
Access to an operating theatre occurs within the timescales indicated above. If necessary, elective cases should be deferred to achieve this. Theatre access is free from predictable obstruction or restriction caused by over-running elective work or workforce shortage.	Audit of theatre availability/ utilisation.
Where patients in class 3 are resuscitated overnight, they must take first priority in theatre in the morning, if necessary ahead of elective surgery. Best practice: Evidence of close and collegiate emergency theatre working.	Audit of time from booking to surgery and of theatre cases continuing beyond midnight.
While patients are awaiting surgery, they are monitored in an environment with appropriate critical care support and appropriate surgical review. If deterioration occurs, intervention may need to be brought forward.	Description of peri-operative care monitoring and audit.

STANDARD	MEASUREMENT CRITERIA
A consultant surgeon (CCT holder) and consultant anaesthetist are present for all cases with predicted mortality $\geq 10\%$ and for cases with predicted mortality $>5\%$ except in specific circumstances where adequate experience and manpower is otherwise assured.	Audit of consultant presence. Examination of rota.
A consultant surgeon (CCT holder) should be present for all unscheduled returns to theatre.	Audit of consultant presence.
A consultant surgeon (CCT holder) should be present for all cases where the experience, practical or organisational skills of the duty trainee are liable to be exceeded or where the assistance available to them will otherwise be insufficient.	Audit of consultant presence.

4.2 Emergency surgery in children

Note: The following standards are applicable to all specialties providing emergency surgical care to children. Specialist paediatric surgery has its own standards at *Section 4.3*.

The following provide generic standards for the emergency surgical treatment of children. For more specific guidance and support, please refer to the British Association of Paediatric Surgeons (www.baps.org.uk).

STANDARD	MEASUREMENT CRITERIA
Development of a managed clinical network of care should be encouraged to underpin the local delivery of safe services, provide CPD and refresher training and to support clinicians if unexpected circumstances require that they act beyond their practised competences.	Managed clinical network established. Annual appraisal of network.
Consultants work within the limits of their professional competence and there are locally agreed guidelines which assist in deciding which cases are managed on site and those which require transfer with regard to age, co-morbidity, complexity of surgery and trauma.	Written guidelines with annual review. Audit of effectiveness of guidelines.
There is a written policy regarding the age range of children anaesthetised within the hospital (and for the out of hours period if the level of paediatric anaesthetic competences is different).	Written policy with annual review. Effectiveness of policy with audit of outcomes including transfers and untoward incidents.
Surgeons taking part in an emergency on-call rota which includes cover for emergencies in children have appropriate training and competence to handle the emergency surgical care of children, including those with life threatening conditions who cannot be transferred or who cannot wait until a designated surgeon or anaesthetist is available.	Evidence of child-specific training and CPD.
The trust/network/health board has a policy to support surgeons and anaesthetists undertaking life-saving interventions in children who cannot be transferred or who cannot wait until a designated surgeon is available.	Written policy in place. Notify such cases to the trust for audit purposes.
All hospitals admitting emergencies have the required resources and equipment to stabilise and resuscitate children, including infants, at all times. Best practice: Lead anaesthetist and board member for children take responsibility.	Adequacy of resources assessed annually.
Emergency surgery is only undertaken in hospitals with comprehensive paediatric facilities, 24/7 paediatric cover, paediatric nursing support and paediatric-competent anaesthetic support. Best practice: There is always at least one member of staff on site trained and competent in APLS/EPLS/pILS.	Description of service. Audit.

STANDARD	MEASUREMENT CRITERIA
Emergency theatres are staffed by a paediatric-competent theatre team. Best practice: All theatre staff have child-specific training.	Evidence in appraisals.
Access to paediatric critical care facilities is available at all times. Agreed protocols for transfer to these facilities are in place. Best practice: Fully staffed HDU beds available 24/7 on site. Formal arrangement with regional PICU for acceptance and transfer of the critically ill child, including retrieval.	Delays in acceptance and transfer of critically ill children audited.
Where children present to an ambulatory/day-case facility, there is a robust procedure in place for assessment and transfer. Best practice: Children are reviewed by a senior paediatrician and/or general surgeon. Written protocol for assessment and transfer of emergency surgical child.	Efficiency of assessment and transfer pathway.
The critically ill child with an immediate life-threatening condition is assessed by a senior clinician and the decision to operate or transfer is made promptly. Best practice: Consultant-led, multidisciplinary team resuscitation, assessment and decision of definitive management.	Audit of outcomes, untoward incidents and transfers.
For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery.	Audit of time intervals between admission, decision to operate and operation.
The ongoing care of inpatients/post-operative patients is managed by senior trainees (ST3 or above) or trust doctors with equivalent ability (ie MRCS with ATLS® provider status) and consultants on children's wards that have paediatric-trained nursing staff.	Description of service. Audit.
Written information on common emergency conditions is available for children and their parents/carers.	Printed information leaflets available and updated annually.
Parents/carers are allowed to accompany their child in the anaesthetic and recovery areas unless the child's condition is a contra-indication.	Feedback from patients and supporters.
There is a written policy for pain management in children.	Written policy reviewed annually.
All surgeons and anaesthetists caring for children undertake child-specific training, including paediatric life support, safeguarding and CPD requirements (which can usually be provided in house). Best practice: Provision in job plan.	Recorded in appraisal.

STANDARD	MEASUREMENT CRITERIA
Anaesthetists with no regular paediatric commitment but who have to provide out-of-hours cover for emergency surgery or stabilisation of children prior to transfer should maintain skills in paediatric resuscitation and an appropriate level of CPD in paediatric anaesthesia to meet the requirements of the job. Best practice: Provision in job plan.	Recorded in appraisal.
Training is organised so that the requirements of the general surgical syllabus, which requires all general surgeons to receive training in the management of common childhood surgical emergencies during training, can be achieved.	Recorded in appraisal.
There is trust/network/health board wide audit of emergency surgery in children.	Regular audit, outcomes discussed at board level.
Emergency paediatric surgical practice is audited annually using routinely collected data. For example: time between admission/decision to operate and operation; length of stay; morbidity and mortality. Audit should include paediatric surgical transfers and untoward incidents including unplanned re-admissions and unplanned admissions to a critical care unit.	Evidence of regular audit, outcomes discussed at board level.
Emergency children's surgery is included in inter-network audit of children's surgery. Best practice: There should be common and agreed methods of data collection which are easily comparable between trusts.	Regular audit discussed at board level.

4.3 Specialist paediatric surgery

The following provide generic paediatric surgery standards. For more specific guidance and support, please refer to the British Association of Paediatric Surgeons (www.baps.org.uk).

These standards apply to all settings where specialist paediatric surgical services are available to accept emergencies.

STANDARDS	MEASUREMENT CRITERIA
Neonatal intensive care facilities are available at all times. All transfers and their outcomes should be audited.	Description of facilities. Transfer protocols in place and regularly audited.
Paediatric-trained nurses, recovery and ward staff are available at all times. Emergency theatres are staffed by a paediatric-trained theatre team.	Description of service and available resources.
For the most immediate, life-threatening conditions, the patient is in theatre within two hours from the initial alert/decision to operate. Whenever possible, this is a dedicated children's theatre.	Description of facilities. Regular audit.
The ongoing care of inpatients/post-operative patients is managed by senior trainees (ST3 or above) or trust doctors with equivalent ability (ie MRCS with ATLS® provider status) and consultants, on paediatric surgical wards that have paediatric-trained nursing staff.	Examination of rota.
The outcomes of emergency specialist paediatric surgical practice is audited using routinely collected data. This should include: median length of stay; 30-day mortality; 28-day unplanned readmission and outcomes for patients transferred out.	As directed by the specialty association.
All units submit data to the British Association of Paediatric Surgeons' annual national audits.	Participation in audit recorded in quality accounts.

4.4 Trauma and orthopaedic surgery

The following provide generic standards for trauma and orthopaedic surgery. For more specific guidance and support, please refer to the British Orthopaedic Association (www.boa.ac.uk).

4.4.1 General trauma

STANDARDS	MEASUREMENT CRITERIA
A unit accepting orthopaedic surgical emergencies has daily access (including weekends) to routine trauma lists which are independent of general emergency theatres. Best practice: An additional theatre is immediately available for urgent and complex orthopaedic problems, such as open fractures and those with neurovascular compromise.	Inappropriate surgical delay.
Trauma patients are managed within a regional trauma network. Complex injuries are treated in centres with appropriate volumes within the region – this does not have to be the regional centre. Best practice: Appropriate triage by the ambulance service to minimise secondary transfers.	Secondary transfer rate.
A consultant leads the trauma team in all units receiving seriously injured patients. Best practice: Consultant-led trauma team in place 24/7.	Trust protocols. Audit.
If CT scanning is to be performed in patients with multiple injuries, routine use of 'top to toe' scanning is recommended in the adult trauma patient if no indication for immediate intervention exists. Best practice: Within 30 minutes.	Trust protocols. Audit.
There is standardised transfer documentation of the patients' details, injuries, results of investigations and management with records kept at the dispatching and receiving hospitals. This should include documentation for acute transfer and standardised documents for repatriation to the base hospital for continued therapy and rehabilitation. Best practice: The local receiving unit should be optimised for triage, critical resuscitation and rapid dispatch.	Trust protocols. Audit.

STANDARDS	MEASUREMENT CRITERIA
There is standardised transfer documentation of the patients' details, injuries, results of investigations and management with records kept at the dispatching and receiving hospitals. This should include documentation for acute transfer and standardised documents for repatriation to the base hospital for continued therapy and rehabilitation. Best practice: The local receiving unit should be optimised for triage, critical resuscitation and rapid dispatch.	Audits of transfers and protocols

4.4.2 Paediatric trauma

STANDARDS	MEASUREMENT CRITERIA
Care is in accordance with the British Orthopaedic Association's <i>Children's Orthopaedics and Fracture Care</i>.²⁷ The fracture care of children should be led by a consultant trained in children's orthopaedics. Best practice: Arrangements within a network of hospitals to treat complexity of injury appropriately. The majority of injuries should be treated in non-specialist centres.	Lead clinicians to be identified.
There is daily access for children to a dedicated orthopaedic emergency theatre.	
Each receiving unit has up-to-date guidelines for children which recognise the paediatric skills available on site and their limitations and include agreed guidelines for communication and transfer with specialised paediatric services within the local clinical network.	National service framework for children.

4.4.3 Hip fractures

STANDARDS	MEASUREMENT CRITERIA
Care is in accordance with the British Orthopaedic Association Standards for Trauma (BOAST 1)²⁸ aiming to achieve prompt surgery and appropriate involvement of geriatric medicine. Data is submitted to the National Hip Fracture Database Best practice: Compliance with the best practice tariff for fragility hip fracture care:²⁹ 1. Time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia. 2. Admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon. 3. Admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia. 4. Assessed by a geriatrician in the preoperative period: within 72 hours of admission. Postoperative geriatrician-directed multi-professional rehabilitation team. 5. Fracture prevention assessments (falls and bone health).	Performance in the National Hip Fracture Database.

4.4.4 Cervical spine

STANDARDS	MEASUREMENT CRITERIA
Care should be in accordance with BOAST 2³⁰ aiming to achieve appropriate spinal clearance in the trauma patient.	Compliance rates.

4.4.5 Pelvic and acetabular fracture management

STANDARDS	MEASUREMENT CRITERIA
Care is in accordance with BOAST 3³¹ aiming to achieve specialist care for displaced and unstable fractures. Best practice: Regional protocols for initial emergency management. Established pathways of care within a trauma network for definitive care.	Definitive surgery, where appropriate, within one week.
On identification of patients with a fracture of the pelvis or acetabulum in a non-specialist centre, referral is made within 24 hours. Best practice: Within an established trauma network, patients suspected of having sustained these injuries will be transported direct to the regional centre.	Definitive surgery, where appropriate, within one week.

4.4.6 Severe open lower limb fractures

STANDARDS	MEASUREMENT CRITERIA
Care is in accordance with BOAST 4 ³² aiming to achieve timely, specialist surgery rather than emergency surgery by less experienced teams. Best practice: Specialist orthoplastic care within a trauma network.	
Centres that cannot provide combined plastic and orthopaedic care for severe open tibial fractures have protocols in place for early transfer to an appropriate specialist centre.	Audit of transfers and protocols.

4.5 Plastic surgery

The following provide generic plastic surgery standards. For more specific guidance and support, please refer to the British Association of Plastic, Aesthetic and Reconstructive Surgeons (www.bapras.org.uk).

STANDARDS	MEASUREMENT CRITERIA
Arrangements are in place to provide senior telephone advice to colleagues in other hospitals within the network within 30 minutes and to transfer a patient to the admitting unit immediately if required, or at the appropriate time as determined by the referring and admitting consultants. Best practice: The admitting unit switchboard has the contact details of the on-call or covering consultant at all times. Priority is given to the emergency or urgent transfer of patients requiring specialist care	The switchboard has the contact details. There is a transfer protocol in place in the admitting hospital for specialist services. Patient transfer delays are regularly audited and reviewed at departmental and organisational level if adverse.
Any unit or centre that admits patients with burns is designated as a burns facility, unit or centre, and complies with the International Burn Care standards including the requirements for data collection through IBID and the audit of activity and outcomes. Best practice: Any patient with burns is cared for within a burns care network in an appropriate designated facility, unit or centre according to the UK burn care standards. All patients admitted are entered into the IBID. Any admitted patient is subject to audit of activity and outcome by the relevant UK burn-care network.	Admitting units are designated by DH through the National Network for Burn Care. Data returns and validation by IBID. Network level audit is in place.
Access to a staffed theatre that is suitable and equipped for microsurgery is available at all times of day and within 30 minutes of notification. Best practice: There is an emergency theatre equipped for microsurgery available within 30 minutes at all times.	A theatre with an binocular operating microscope suitable for plastic surgery. Appropriate instrumentation, equipment and environmental control can be made available within 30 minutes.
Sufficient capacity for unscheduled plastic surgical operating is available to allow patients to receive their operation within clinically appropriate timescales and in an appropriately staffed and equipped environment. Best practice: Unscheduled admissions or referrals already in hospital can be operated on during daylight or twilight hours with theatre staff familiar with plastic surgery and appropriate equipment and instrumentation. Limb- and life-threatening conditions can be operated on without delay at any time of day. This will usually require a dedicated theatre for unscheduled plastic surgery seven days a week.	

STANDARDS	MEASUREMENT CRITERIA
Arrangements are in place for unscheduled referrals with hand and other soft tissue injuries to be managed in an ambulatory setting if appropriate. Best practice: There is a protocol to divert appropriate unscheduled referrals into an ambulatory setting for semi-elective care and sufficient daycase theatre capacity is allocated for these patients.	The daycase rate for selected unscheduled referrals, eg single-digit hand injuries, displaced fractures of the nose, facial soft tissue injuries.
Specialist ortho-plastic centres meet the standards for open fractures of the lower limb including the provision of daytime ortho-plastic operating lists. Best practice: There are designated unscheduled ortho-plastic surgery lists during daylight hours at least twice a week to permit standard compliant care for open fractures, run by orthopaedic and plastic surgery consultants with specialist training in these injuries.	The BAPRAS/BOA standards are met. There are plastic surgery and orthopaedic consultants working in teams and with adequate beds and unscheduled daytime capacity. There are combined multi-disciplinary ward rounds and orthoplastic clinics.
The peri-operative care of patients is managed by senior trainees (ST3 or above) or trust doctors with equivalent ability (ie MRCS with ATLS® provider status) and consultants, assisted by other trainees and clinicians on surgical (or children's) wards that have qualified nursing staff, who have received plastic surgery or burns training. Best practice: All unscheduled patients are seen every day by at least an ST3 or above trainee, or a trust doctor with equivalent ability (ie MRCS with ATLS® provider status). Day-to-day management is directed by a consultant plastic surgeon. An ST3 or equivalent (as above) is available to review any patient at all times. Patients are cared for on dedicated plastic surgery (or burns) wards or on surgical or children's wards where the staff have specific plastic surgery training.	
Allied health professionals (AHPs) with appropriate specialist skills (physiotherapy, hand therapy, occupational therapy, speech therapy and dietetics) as well as psychology are available and resourced to support plastic surgery patient care. Best practice: There are adequate AHP's appropriate to the volume and scope of patients being cared for. This will vary between providers. Inpatients can access psychological support if clinically appropriate. Advice about psychological support in the community and third sector is available and offered to patients.	The value of AHPs in the outcome for patients is recognised and multi-disciplinary care teams are in place within the service. There is a psychologist or mental health liaison practitioner available for all patients that require such input.
The outcome of emergency specialist plastic surgical practice is audited using routinely collected data. Indicator procedures for unscheduled practice are agreed. Best practice: Indicator unscheduled procedures or conditions are agreed and outcome measures collected.	Consultants and trainees can demonstrate the outcome of indicator unscheduled care procedures or conditions in their annual appraisal. They may also be submitted to national audits.

STANDARDS	MEASUREMENT CRITERIA
Units and centres submit data to national audits where the opportunity to do so exists (BAPRAS and others) and partake in national or supra-regional benchmarking of performance and outcome. Best practice: Units are aware of all national audits or other benchmarking processes and submit data to them. This may include regional or supra-regional audit programmes.	A programme of audits is in place and all consultants support peer benchmarking and audit processes.

4.6 Urology

The following provide generic urological surgery standards. For more specific guidance and support, please refer to the British Association of Urological Surgeons (www.baus.org.uk).

STANDARDS	MEASUREMENT CRITERIA
A consultant urologist is available 24/7 for immediate advice and can be available on site within 30 minutes.	Rota and protocols in place.
All emergency cases, especially those where operative intervention is planned, must be discussed with the consultant on call.	Audit of activity.
A modern, effective emergency urology service requires adequate theatre access, senior radiological support (including interventional radiology), senior anaesthetic support and critical care facilities.	Multi disciplinary audit and case review.
There is immediate 24/7 availability of CT scanning and ultrasound scanning with the capacity for intervention in patients with suspected urosepsis.	Audit.
There is immediate 24/7 availability of CT scanning for patients with suspected urinary tract trauma.	Audit of availability/outcomes.
There is immediate 24/7 availability of a senior trainee (ST3 or above) or consultant urologists to manage the obstructed bladder, which cannot be managed by urethral catheterisation alone.	Rota and protocols in place.
There is immediate 24/7 availability of a senior trainee (ST3 or above) or consultant urologist to operatively intervene for suspected torsion.	Rota and protocols in place.
Where an operation is required, a theatre team with adequate experience of urological surgery must be available.	Local audit.
Outcomes of emergency treatment should be regularly audited.	Annually.
Patients with septic shock and evidence of obstructive uropathy require immediate intervention within three hours of the decision to operate as delay increases mortality significantly.	Local audit.
The ongoing care of inpatients/post-operative patients is managed by senior trainees (ST3 or above) or trust doctors with equivalent ability (ie MRCS with ATLS® provider status) and consultants, on appropriate urology wards with specialist-trained nursing care.	National audit.
Daily ward rounds carried out by senior trainees (ST3 or above) or trust doctors with equivalent ability (ie MRCS with ATLS® provider status) and/or consultants, including weekends.	Audit.

4.7 Neurosurgery

The following provide generic neurosurgical standards. For more specific guidance and support, please refer to the British Society of Neurological Surgeons (www.sbns.org.uk).

STANDARDS	MEASUREMENT CRITERIA
A consultant neurosurgeon is available 24/7 for immediate advice and can be available on site within 30 minutes.	Rota and protocols in place.
All emergency cases, especially those where operative intervention is planned, or where transfer to the neurosurgical unit is not appropriate, must be discussed with the consultant on call.	Audit of activity.
The unit has 24/7 theatre availability with an appropriately experienced neurosurgical team available within 30 minutes.	Examination of theatre availability and rotas.
There is immediate 24/7 availability of CT head scanning and MRI scanning for the spine within one hour.	Audit of availability/outcomes.
There are image link facilities between all referring hospitals within the network and to the consultant's home to allow immediate assessment and management decisions at a consultant level.	Facilities in place and monitored.
Neuroanaesthesia, intensivists and neuroradiologists are available at all times and consultant led.	Examination of rota.
Cases of traumatic intracranial haematomas requiring evacuation receive operative treatment without delay and after appropriate resuscitation.	Audit of surgeon activity and outcome.
Outcomes of emergency treatment should be regularly audited.	Annually.
There are agreed transfer protocols established between the neuroscience centre and referring hospitals for cases of trauma, spontaneous intracranial haemorrhage, acute hydrocephalus, spinal cord compression and other acute conditions.	Protocols in place, audited regularly.
Patients with treated hydrocephalus are given current, written details of their condition and relevant scan images, and have direct access to the neurosurgical unit.	Printed patient information. Audit of patient information.
All units submit trauma data to TARN and TARNlet	Participation noted in quality accounts.
All operative paediatric cases are submitted to the national BPNG database.	Participation noted in quality accounts.

4.8 Oral and maxillofacial surgery

The following provide generic oral and maxillofacial surgery standards. For more specific guidance and support, please refer to the British Association of Oral and Maxillofacial Surgeons (www.baoms.org.uk).

STANDARDS	MEASUREMENT CRITERIA
The ongoing care of inpatients/post-operative patients is managed by senior trainees (ST3 or above) or trust doctors with equivalent ability (ie MRCS with ATLS® provider status) and consultants, on appropriate specific head and neck wards or wards with specialist-trained nursing care. Best practice: There is a specific head and neck ward with all staff appropriately trained to manage such patients	National audit.
Daily ward rounds carried out by senior trainees (ST3 or above) or trust doctors with equivalent ability (ie MRCS with ATLS® provider status) and/or consultants, including weekends. Best practice: There are morning and evening ward rounds, daily, with one of these being consultant-led, including weekends.	National audit.
The outcome of emergency OMFS specialist surgical practice is audited using routinely collected data. These should include: › delays in patient care pathway › length of stay › 28-day unplanned re-admission › outcomes. Best practice: All of the working practice of an OMFS unit is subjected to regular audit to ensure the best patient care and to highlight appropriate change where necessitated.	Local audit.
All units submit data to the British Association of Oral and Maxillofacial Surgeons' annual national audits.	Audit.

4.9 ENT

The following provide generic ENT standards. For more specific guidance and support, please refer to the British Association of Otorhinolaryngologists, Head and Neck Surgery (www.entuk.org.uk).

STANDARDS	MEASUREMENT CRITERIA
Emergency and post-operative patients are nursed by ENT trained staff of sufficient number and seniority to conduct observations and detect variation from normal progress. Best practice: There is a dedicated ENT unit with immediate transfer to operating theatres.	Outliers to be recorded and incidence monitored.
Emergency admissions are admitted to the ENT unit. Best practice: Emergency beds are available in the ENT unit for acute admission of either sex.	Bed occupancy monitored to national targets.
The ward treatment area is equipped with rigid and flexible endoscopes, suction, headlight, microscope etc. Best practice: Endoscopic cautery, suction and irrigation are available 24/7.	Facilities audit.
Nursing staff are available to assist with emergency treatment. Nurse practitioner skills are utilised. Best practice: Training in emergency ENT incorporated into nurse training modules.	Monitor staffing and skill levels.
Paediatric ward staffing level is sufficient to escort children to adult treatment room if necessary (eg for removal of foreign body, use of microscope, where this cannot be provided on the ward/ED). Best practice: Adequate facilities on paediatric ward or ED.	Monitor against national standards for separation of paediatric and adult care.
Post-tonsillectomy discharge information specifies contact details for the patient's nearest centre. Centre requires skills and equipment to deal with arrest of haemorrhage, including blood transfusion capability, immediate theatre access and age-appropriate anaesthetist out of hours. The ambulance service is fully informed which ENT department is 'on take.' Best practice: Departmental protocols are in place detailing whether patients requiring resuscitation attend the ward or ED, with a clinically competent individual to be awaiting their arrival.	Use adverse incident reporting for any delays to identify communication problems plus root cause analysis to prevent repetition.

STANDARDS	MEASUREMENT CRITERIA
Patients with severe post-tonsillectomy bleed require immediate resuscitation and immediate discussion with a consultant or ST3/equivalent doctor (MRCS with ATLS® provider status). Returns to theatre are made within 30 minutes of decision to operate.	Audit unit transfusion rate and compare nationally.
Reduction of length of stay (LOS) for patients with oesophageal foreign body is achieved by early senior decision making; (ie within 30 minutes of admission). Best practice: There is a local, time- framed protocol detailing procedures from first contact to theatre, with or without flexible endoscopy referral. 90% of oesophageal foreign bodies are removed within 24 hours.	Audit adherence to protocol, LOS from HES data and incidence of complications.
Patients with sharp foreign bodies are fast tracked. The consultant is involved in their care within one hour of alert. Best practice: Existing theatre lists are utilised, along with consultant colleague expertise if appropriate. 90% of sharp foreign bodies are removed within six hours.	As above.
Admission of patients with epistaxis is supported by 24-hour transfusion and haematology opinion. Best practice: There is a written hospital protocol for initial management of ED or inpatient epistaxis prior to contacting ENT.	Audit use of protocol prior to referral/ transfer.
There is senior early review of patients to ensure epistaxis patients are only admitted when clinically necessary. Daily consultant management decision is recorded.	Quarterly LOS for epistaxis review from HES data. National comparison possible.
Admitted epistaxis patients have early assessment for anaesthesia to avoid crisis management and delays. Best practice: At admission or next morning endoscopic examination is performed by ST3 or above/equivalent doctor (MRCS with ATLS® provider status), patients are treated and discharged if possible. Daily consultant management decision is recorded.	Departmental protocol for epistaxis management. Audited locally and against national targets.
Persistent bleeding may require vessel ligation with or without referral for angiography. Best practice: Department has agreed written pathway for referral for angiography and embolisation including out of hours.	Pathway agreed with local or regional interventional radiology department. Audit.

STANDARDS	MEASUREMENT CRITERIA
Consultant paediatric opinion is available for joint care of ENT related sepsis in children. There is at least daily review by both teams. Cross-speciality referrals are made by ST3 level or above/equivalent (with MRCS and ATLS provider status). Best practice: Written guidelines of shared care between ENT and paediatrics are in place detailing provision of IV access, phlebotomy, daily review etc. There is joint ENT/paediatric post-graduate education.	Shared care guidelines agreed with review date. Paediatric antibiotic protocol on hospital IT system and wards.
Antibiotic treatment starts without delay once decision is made. Best practice: Standard IV regime drugs are available as ward stock.	Audit time from written opinion to treat (recorded, timed and dated as per GMC <i>Good Medical Practice</i>⁵) to administration of first dose.
Patients with orbital cellulitis require urgent ophthalmology opinion and CT scan with or without general anaesthesia available to manage complications. ST3 or above/equivalent doctor (MRCS with ATLS® provider status) to review patients within 30 minutes; there is immediate consultant verbal input to determine if local care appropriate. Immediate surgery is required if vision deteriorates. Twice daily review by ST3 or above/equivalent doctor (MRCS with ATLS® provider status) and at least daily by consultant. Best practice: There is an agreed procedure to ensure consultants are available immediately to review a patient, monitor clinical progress and the need for CT.	As above.
Paediatric anaesthetists are available out of hours for management of airway related sepsis, eg parapharyngeal or retropharyngeal abscess. Best practice: Ability to carry out CT scan under general anaesthetic and transfer to theatre for drainage.	Examination of rota and arrangements with anaesthetics department.
Established links and pathways to local (and more than one) tertiary paediatric ENT centre are in place Best practice: Written guidelines identifying responsibilities, including direct contact numbers where possible, are available on paediatric wards.	Audit time from decision to make tertiary referral to: 1. Patient verbally accepted. 2. Patient arrived in tertiary unit. 3. Root cause analysis of delays. Feedback to commissioning team if PICU bed shortages.

4.10 Cardiothoracic surgery

The following provide generic cardiothoracic surgery standards. For more specific guidance and support, please refer to the Society for Cardiothoracic Surgery (www.scts.org).

STANDARDS	MEASUREMENT CRITERIA
Patients are reviewed by an appropriate consultant within 12 hours of admission (or before if their condition dictates). Best practice: Out-of-hours electronic transfer of imaging investigations to consultant's home.	
Where an operation is required, a theatre team with adequate experience of cardiothoracic surgery must be available.	Theatre registries and local audit.
All units submit data to the relevant national database (congenital, adult cardiac and thoracic).	Compliance reported in annual database report.
All deaths are discussed at a multi-disciplinary audit meeting and standard of care graded by NCEPOD criteria.	Evidence of MDT/M&M meetings.

Glossary

AAGBI	Association of Anaesthetists of Great Britain and Ireland
AHP	allied health professional
AMU	acute medical unit
APLS	Advanced Paediatric Life Support
ASA	American Society of Anesthesiologists grading
ASGBI	Association of Surgeons of Great Britain and Ireland
ATLS®	Advanced Trauma Life Support®
BAO-HNS	British Association of Otorhinolaryngologists - Head and Neck Surgery (ENT-UK)
BAOMS	British Association of Oral and Maxillofacial Surgeons
BAPRAS	British Association of Plastic, Aesthetic and Reconstructive Surgeons
BAPS	British Association of Paediatric Surgeons
BAUS	British Association of Urological Surgeons
BOA	British Orthopaedic Association
BOAST	British Orthopaedic Association Standards for Trauma
BPNG	British Paediatric Neurosurgical Group
CCrISP®	Care of the Critically Ill Surgical Patient®
CCT	Certificate of Completion of Training
CPD	continuing professional development
CT	computerised tomography
DH	Department of Health
ED	emergency department
Elective	treatment or surgery that is planned
EMSB	Emergency Management of Severe Burns
ENT	ear, nose and throat
EPLS	European Paediatric Life Support
FBC	full blood count
HDU	high dependency unit
HES	hospital episode statistics
IBID	International Burns Injury Database
ICS	Intensive Care Society
ICU	intensive care unit
ID	infectious disease
ISCP	Intercollegiate Surgical Curriculum Programme
ITU	intensive therapy unit
IV	intravenous
LOS	length of stay
M&M	morbidity and mortality meetings

MDT	multidisciplinary team
MHRA	Medicines and Healthcare Products Regulatory Agency
MRCS	Member of the Royal College of Surgeons
MRI	magnetic resonance imaging
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
OMFS	oral and maxillofacial surgery
Orthoplastic	combined orthopaedic and plastic surgery management
PCC	prothrombin complex concentrate
PICU	paediatric intensive care unit
pILS	Paediatric Immediate Life Support
POCT	point-of-care testing
SBNS	Society of British Neurological Surgeons
SCTS	Society of Cardiothoracic Surgery
SOPs	standard operating procedures
ST3	specialty trainee level 3
TARN	Trauma Audit and Research Network
TARNlet	See TARN (for children)
US	ultrasound
Vit K	vitamin K
VTE	venous thromboembolism
WHO	World Health Organization

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This document aims to provide information and standards on emergency surgical service provision for both adult and paediatric patients. It is aimed at commissioners, planners, providers and others involved in the provision of emergency surgical care and seeks to ensure that:

- › Patients receive safe and high quality care and have the best care experience possible.
- › Services are delivered in a timely manner, with acutely ill patients prioritised over elective surgical care.
- › Services achieve the best possible clinical outcomes and follow established principles.
- › Services provide information and support to patients and their supporters at all stages of the pathway.
- › Services are provided by appropriately trained and competent healthcare professionals.
- › Services are structured to deliver training in an efficient manner and ensure that the competing demands of training and service provision are adequately balanced.
- › Services contribute towards the collection and collation of data to support evidence-based care.
- › Facilities and resources are adequate and easily accessible.
- › Services are efficient, effective and offer value for money.

IRP

Independent Reconfiguration Panel

*ADVICE ON PROPOSALS FOR CHANGES TO MATERNITY,
SPECIAL CARE BABY SERVICES AND INPATIENT
GYNAECOLOGY SERVICES IN EAST SUSSEX*

Submitted to the Secretary of State for Health
31 JULY 2008

IRP

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CONTENTS

Recommendations

1	Our remit	<i>what was asked of us</i>
2	Our process	<i>how we approached the task</i>
3	Context	<i>a brief overview</i>
4	Information	<i>what we found</i>
5	Our advice	<i>adding value</i>

Appendices (see separate document)

1	Independent Reconfiguration Panel (IRP) general terms of reference
2	Secretary of State for Health correspondence
3	Letter from IRP Chair to editors of local newspapers
4	Site visits, meetings and conversations held
5	List of written evidence
6	IRP membership
7	About the Independent Reconfiguration Panel

RECOMMENDATIONS

- 1. The IRP does not support the PCTs' proposals to reconfigure consultant-led maternity, special care baby services and inpatient gynaecology services from Eastbourne District General Hospital to the Conquest Hospital at Hastings. The Panel does not consider that the proposals have made a clear case for safer and more sustainable services for the people of East Sussex. The proposals reduce accessibility compared with current service provision.**
- 2. The Panel strongly supports the PCTs' decision to improve antenatal and postnatal care and associated outreach services. These improvements should be carried forward without delay.**
- 3. Consultant-led maternity, special care baby, inpatient gynaecology and related services must be retained on both sites. The PCTs must continue to work with stakeholders to develop a local model offering choice to service users, which will improve and ensure the safety, sustainability and quality of services.**
- 4. The PCTs with their stakeholders must develop as a matter of urgency a comprehensive local strategy for maternity and related services in East Sussex that supports the delivery of the above recommendations. The South East Coast SHA must ensure that the PCTs collaborate to produce a sound strategic framework for maternity and related services in the SHA area.**
- 5. The PCTs working with all stakeholders, both health providers and community representatives, must develop a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the Panel's recommendations.**
- 6. Within one month of the publication of this report, the PCTs must publish a plan, including a timescale, for taking forward the work proposed in the Panel's recommendations.**

OUR REMIT

What was asked of us

- 1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included at Appendix One.
- 1.2 On 31 March 2008, Councillor Sylvia Tidy, Chairman of East Sussex Health Overview and Scrutiny Committee (HOSC), wrote to the Secretary of State for Health, The Rt Hon Alan Johnson MP, exercising powers of referral under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. The referral concerned proposals developed by the two primary care trusts (PCTs) in East Sussex, namely East Sussex Downs & Weald PCT, and Hastings & Rother PCT, for reconfiguring maternity and special care baby services and inpatient gynaecology services provided by the East Sussex Hospitals NHS Trust (ESHT) from Eastbourne District General Hospital (Eastbourne DGH), and the Conquest Hospital, Hastings. The Birthing Centre at Crowborough was not part of this reconfiguration of services.
- 1.3 The Secretary of State asked the IRP to undertake a review of the proposals. Agreed terms of reference were set out in an Annex to the Secretary of State's letter dated 13 May 2008 to the IRP Chair, Dr Peter Barrett.
- 1.4 Copies of correspondence are included at Appendix Two.
- 1.5 The IRP was asked to advise the Secretary of State by 31 July 2008:
 - a) *whether it is of the opinion that the proposals for the reconfiguration of maternity and specialist baby care and inpatient gynaecology services provided by ESHT will ensure the provision of safe, sustainable and accessible services for local people and, if not, why not;*
 - b) *on any other observations the Panel may wish to make in relation to the proposals; and*

- c) on how to proceed in the interests of local people, in the light of (a) and (b) above and taking into account the HOSC's referral letter of 31 March 2008.*

It is understood that in formulating its advice the Panel will pay due regard to the principles set out in the IRP's general terms of reference

- 1.6 The advice offered in this report relates only to the provision of maternity, special care baby and inpatient gynaecology services provided by ESHT.

OUR PROCESS

How we approached the task

- 2.1 The South East Coast Strategic Health Authority (SHA) was asked to provide the Panel with relevant documentation for the review. In conjunction with the PCTs and ESHT, the SHA completed the Panel's standard information template, which can be accessed through the IRP website at www.irpanel.org.uk The HOSC was also invited to submit documentation.
- 2.2 The HOSC, SHA and PCTs were asked to suggest Panel visits and stakeholders to be involved in meetings and interviews. The Panel identified additional sites to visit and stakeholders to interview. The SHA was also asked to nominate a lead person to arrange site visits, meetings and interviews with the identified parties.
- 2.3 The Panel Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 13 May 2008 informing them of the IRP's involvement (see Appendix Three). The letter invited local people who felt they had new evidence that was not submitted during the consultation process or believed that their views had not been heard to contact the Panel. Press releases were issued on 14 May and 11 June 2008, providing information on the progress of the review. These can be accessed through the IRP website at www.irpanel.org.uk.
- 2.4 A sub-group of the full IRP carried out the review. It consisted of four Panel members, Nicky Hayes who chaired the sub-group, Cath Broderick, John Parkes and Paul Watson. Other Panel members attended on a number of days during the review. The sub-group was supported and accompanied on all visits by the IRP Secretariat.
- 2.5 Panel members visited East Sussex for nine days in total. Site visits were made to Eastbourne DGH, the Conquest Hospital and Crowborough Birthing Centre. The Panel met members of the HOSC, Public and Patient Involvement Forums (now replaced by a Local Involvement Network (LINK)), local authority representatives, local Maternity Services Liaison Committee, user representatives, representatives of 'Save the DGH' campaign group (Eastbourne) and 'Hands off the Conquest' campaign group (Hastings),

local NHS staff and trade unions representatives. The Panel also took oral evidence from various professionals and management groups from East Sussex Hospitals NHS Trust, East Sussex Downs & Weald PCT and Hastings & Rother PCT, South East Coast SHA and South East Coast Ambulance Services NHS Trust (SECamb). A list of all visits, details of the people seen and Panel members attending on these visits are included at Appendix Four.

- 2.6 Two oral evidence sessions, specifically to hear from local people who had responded to Dr Barrett's letter to editors, were held on the evening of 5 June and on 9 July 2008.
- 2.7 Meetings were held in July with four local MPs and a telephone conversation took place with a fifth (see Appendix Four).
- 2.8 A list of all written evidence received from the SHA, PCTs, ESHT, HOSC, MPs and all other interested parties is contained at Appendix Five. The Panel considers that the documentation received, together with the information obtained during oral evidence gathering sessions, provides a fair representation of the views from all perspectives.
- 2.9 Throughout the Panel's consideration of the proposals, the aim has been to consider the needs of patients, public and staff, taking into account the issues of safe, sustainable and accessible services for local people as set out in the IRP's general terms of reference.
- 2.10 The Panel wishes to record its thanks to all those who contributed to this process, to those who made time available to present evidence to the Panel, and to everyone who contacted the Panel offering their views.
- 2.11 The advice contained in this report represents the unanimous views of the Chair and members of the IRP.

THE CONTEXT

A brief overview

Historical context

- 3.1 Discussions about the future direction of maternity, special care baby and inpatient gynaecology services in East Sussex date back to a Clinical Services Review conducted by the PCTs in 2004. The review was prompted by the need to improve care and to ensure sustainability in the face of expected difficulties both in recruiting staff and in reduced junior doctors' hours as a result of the 2004 European Working Time Directive (EWTD). The review recommended that ESHT should strive to retain two all risk units but recognised that circumstances could arise where two all risk units could no longer be sustained. It also recognised that a transition to a single unit might need to be managed.
- 3.2 In spring 2005, the then Surrey and Sussex SHA commissioned a review from McKinsey¹ of healthcare across Surrey and Sussex to “*understand what is causing the NHS to overspend in some areas*” and “*to make recommendations about how the healthcare system could change to meet modern clinical standards within the available budget*”. This review reported to the SHA in July 2005 and shared with partners in February 2006 the discussion document *Creating an NHS Fit for the Future, First Steps for Improving Services in Surrey and Sussex*. The document concluded that:
- Surrey and Sussex SHA was financially and clinically unstable.
 - Lack of sustainability had more than one root cause.
 - Surrey and Sussex should implement an integrated transformational change programme to achieve sustainability which would result in a significant change in the number and location of healthcare providers across Surrey and Sussex, and a shift in activity from the acute setting to the community setting.

¹ McKinsey & Company is a management consulting firm

- 3.3 This was followed in May 2006 by a consultation document titled '*Creating an NHS Fit for the Future: Discussion Document*' as part of a Section 11² public consultation process. This document:
- covered the need for change
 - described new ways of delivering care
 - described ideas for service development in each area and asked questions of the public
 - set out what was happening, in terms of consultation, in the Surrey and Sussex localities

- 3.4 Wide professional and public engagement took place over the summer of 2006 and then, more locally, the East Sussex health community began detailed work on what sustainable health services could look like for its residents. This coincided with a 'handover' process from SHA to PCTs and the formation on 1 July 2006 of the South East Coast SHA. From summer 2006, the PCTs were responsible for taking the programme forward. At this stage, no specific services had been identified for reconfiguration. As part of this process, ESHT developed a clinical strategy which described the reasons why change was needed and noted that this was not driven by the need to achieve financial balance. Over the autumn and winter of 2006, these plans were the subject of SHA, PCTs and ESHT discussions which led to the East Sussex PCTs' formal public consultation, launched on 26 March 2007. The consultation period ended on 27 July 2007.

The proposals

- 3.5 *Creating an NHS Fit for the Future* set out four options, all proposing one consultant-led obstetric unit in East Sussex rather than two, supported by midwife-led care on both sites. It was proposed that antenatal and postnatal care should continue to be delivered locally. Additionally, it was proposed that the Special Care Baby Unit (SCBU) and inpatient gynaecology services should be provided on the same site as the consultant-led obstetric unit.

² The Health and Social Care 2001 Act places specific duties on NHS bodies in relation to consultation with overview and scrutiny committees and with the public. (now superseded by S.242 of the NHS Act 2006).

- 3.6 Before formal consultation began, a joint public meeting of the two PCT Boards expressed a preference for Options 3 and 4 which provided for a single site for consultant-led obstetric care open 24 hours a day, seven days a week at either Eastbourne DGH or the Conquest Hospital, with a SCBU and inpatient gynaecology care also at that hospital. The hospital without the consultant-led obstetric unit would have a midwife-led birthing centre. All options retained Crowborough as a midwife-led birthing centre.
- 3.7 The Joint Committee made up of the two Boards also indicated their willingness to consider other options generated during the consultation process, which would be assessed against the same criteria used to develop the proposed options. One of the specific objectives of the consultation process was:
“To see if there are any realistic, cost-effective and preferred alternatives to those outlined in this document.” (Creating an NHS Fit for the Future Public Consultation 2007)”
The invitation to generate alternative options was set out in both the summary and full consultation document.
- 3.8 To review emerging alternative options and to establish whether there was any common ground between clinicians, health service managers and the proposers or sponsors of alternative options, a New Options Assessment Panel was set up under an independent Chair, Professor Stephen Field³. A total of nine options were generated. The New Options Assessment Panel’s recommendation was that all except two options should be taken forward to the next stage.
- 3.9 In accordance with the Health and Social Care Act 2001, the East Sussex HOSC was formally consulted on the proposals. In response, it commented on the process employed by the PCTs and made 24 recommendations.
- 3.10 Following the end of the consultation process, the PCTs also produced or commissioned various pieces of work in advance of the Joint Board meeting on 20 December 2007. These included:
- Alternative Models Project

- Maternity Services Health Impact Assessment
- East Sussex Maternity Services Review of Costings

From the end of July to 20 December 2007, the two PCT Boards received further evidence. In November 2007, the Boards received short presentations from the proposers of each alternative option and conducted a formal (non-financial) appraisal of all the options remaining after the conclusion of Professor Field's work. Two Board to Board sessions took place between the SHA and the Joint PCT Boards on 18 December 2007.

3.11 Subsequently, the final decision reached at a meeting of the two PCT Boards on 20 December 2007 relevant to this review was to select Option 4 as the preferred option, namely:

- Provide a single site for consultant-led obstetric care open 24 hours a day, seven days a week at the Conquest Hospital, Hastings, with a SCBU and gynaecology care also at the Conquest Hospital.
- Provide a midwife-led birthing centre at Crowborough.
- Provide maternity outpatients service, antenatal care and community midwifery at both Eastbourne DGH and the Conquest Hospital.
- Provide gynaecological outpatients service, day surgery, investigative service and emergency pregnancy service at both Eastbourne DGH and the Conquest Hospital.

The minutes of the joint meeting recorded that several Board members voted against the recommendations.

3.12 The HOSC met on 28 January 2008 to consider the PCTs' decision on the outcome of the *Creating an NHS Fit for the Future* public consultation. Whilst it supported the PCTs' intention to improve antenatal and postnatal care and associated outreach services, it believed that the decision to establish a single obstetric unit on the Conquest Hospital site and a midwife-led unit on Eastbourne DGH site was not in the best interests of health services for East Sussex residents. It therefore gave notice that it would refer the PCTs' decision to the Secretary of State for Health, subject to the PCTs being given the opportunity to respond to the HOSC's agreed position.

³ Professor Stephen Field is Chairman of the Royal College of General Practitioners

- 3.13 The main reasons for the potential referral were as follows:
- a. *The divergence of clinical opinion on what configuration of maternity and obstetric services will be best for the residents of East Sussex.*
 - b. *Evidence that longer travel times to the obstetric unit could endanger the safety of women and babies.*
 - c. *Evidence that the distance of the midwife-led unit from the consultant-led unit could create undue risk to the safety of women and babies and questions over whether this is the best configuration for midwife-led care.*
 - d. *A lack of convincing evidence that patient outcomes will be improved with a single site configuration for consultant-led care.*
 - e. *Evidence that there may be a reduction in women's choice owing to the coastal location of both sites, the population distribution in East Sussex and the proposed configuration of services; all of which may be compounded in areas where there is significant deprivation.*
 - f. *Evidence that possible alternatives which could maintain services on two sites may not have been fully explored and considered.*
- 3.14 The PCTs responded on 20 February 2008 to the issues raised by the HOSC. The response stated that the PCTs had reviewed the reasons for reaching the original conclusion in December 2007 and that they were not aware of any previously unconsidered issues or fresh evidence that might lead them to question that decision. Therefore, there was agreement to proceed with the decisions made by the Joint Committee of the two PCT Boards *'in order to ensure long term safety and a better service for local women and their babies'*.
- 3.15 On 31 March 2008, the Chairman of the HOSC wrote to the Secretary of State for Health to refer the proposals. It highlighted the six reasons listed at 3.13 as not being in the best interests of the health service for East Sussex residents. However, the HOSC also stated its support for the PCTs' decision to improve antenatal and postnatal care and associated outreach services and that it had urged the PCTs to make rapid progress on these aspects of the consultation.

- 3.16 In May 2008, the Secretary of State for Health asked the IRP to undertake a review of the proposals for maternity, special care baby and inpatient gynaecology services provided by the East Sussex Hospitals NHS Trust.

INFORMATION

What we found

4.1 The evidence submitted to the Panel is summarised below and divided into the following sections:

- General background information
- An outline of the proposals
- Concerns raised
- Evidence gathered

The Panel received a substantial volume of written and oral evidence, which has been invaluable in enabling it to conduct an analysis and reach its conclusions and subsequent recommendations. It was clear from the evidence sessions that took place that everyone had put considerable thought into their presentations and this was very much appreciated by the Panel.

General Background Information

4.2 Services provided and activity⁴

4.2.1 ESHT provides DGH services for approximately 400,000 people in East Sussex from two general hospitals, the Conquest Hospital in Hastings and Eastbourne DGH, both with Accident and Emergency departments. The majority of healthcare is provided at these two hospitals, but services are also provided at Bexhill, Crowborough, Hailsham, Hawhurst, Rye, Seaford and Uckfield.

4.2.2 Eastbourne DGH and the Conquest Hospital each have four consultants who work jointly to provide obstetric and gynaecology services. Five acute consultant paediatricians provide acute paediatric and neonatal services at both sites. ESHT also provides community paediatric services.

⁴ This information is largely drawn from the standard IRP information template, ESHT and PCTs websites and background information supplied by SHA, PCTs, NHS Trust and local authorities

Women and Children's Services - Obstetric services

- 4.2.3 In 2007/08, 4,060 women delivered at ESHT a total of 4,121 babies. There are two consultant-led units, one based at Eastbourne DGH and the second at the Conquest Hospital. These units provide consultant-led obstetric and midwife-led care. Both sites also have consultant-led clinics, a day assessment unit and antenatal screening. In addition, there is a stand-alone midwife-led unit in Crowborough with six beds and a birthing pool that provided care for 317 women during childbirth in 2007/08.
- 4.2.4 ESHT provides a community midwifery service which incorporates antenatal, postnatal and parent education services. In 2007/08, 4.7 per cent of babies were delivered at home. There is a network of Children's Centres across East Sussex providing integrated services to children under five and their families.
- 4.2.5 At Eastbourne DGH, there are 28 antenatal/postnatal beds of which four are single rooms, with a further four bedded bay that can be used if all the beds are occupied. There are six delivery rooms and a separate birthing pool. There are also two admission rooms and a two bedded recovery/high dependency room. At the Conquest Hospital there are 20 antenatal/postnatal beds of which two are single rooms and eight delivery suites (all ensuite), one of which includes the birthing pool. There is also a recovery area.
- 4.2.6 The following table shows the 2008/09 midwifery budgeted establishment:

Table 1: 2008/09 midwifery budgeted establishment - whole time equivalents (wte)

	Area	Conquest	Crowborough	EDGH	Specialist
Qualified	Specialist				5.77
	Manager				1.00
	Delivery Unit	39.76	10.83	39.67	
	Day Unit	2.44		4.54	
	Community	18.30	3.80	16.90	
Unqualified	Delivery Unit	12.37	2.50	11.79	
	Day Unit	0.80		0.82	

S

Source: Hospital Information System

At the time of the review, all three sites had vacancies that were being actively recruited to and there were no long-term vacancies.

4.2.7 Maternity activity across ESHT in 2007/08 is shown in the following table:

Table 2: 2007/08 Maternity activity across ESHT

Site	Bookings	Number of mothers	Number of babies
Eastbourne DGH	2092	1975	2004
The Conquest Hospital	2029	1768	1800
Crowborough MLU	883	317	317
TOTAL FOR ESHT	5004	4060	4121

Source: Hospital Information System

4.2.8 If the MLU at Crowborough requires referral to a consultant-led obstetric unit, women are normally transferred to Eastbourne DGH, Princess Royal Hospital in Haywards Heath or Pembury Hospital near Tunbridge Wells.

4.2.9 2007/08 maternity diverts for ESHT are set out in the following table:

Table 3: 2007/08 Maternity diverts

	East Sussex Hospitals NHS Trust					
	The Conquest Hospital		Eastbourne DGH		Crowborough MLU	
Number of diverts	49	reason I 6 reason II 14 reason III 6 reason IV 21 reason V 2	25	reason I 4 reason II 6 reason III 3 reason IV 12 reason V 0	1	(reason: midwifery staffing)
Time bands of diverts	0-8 hours 15 8-16 hours 26 16-24 hours 6 over 24 hours 1 one duration not recorded		0-8 hours 8 8-16 hours 16 16-24 hours 0 over 24 hours 0 one duration not recorded		8-16 hours 1	

Source: Hospital Information System

Key: reason I Midwifery staffing/dependency
reason II Capacity
reason III Midwifery staffing/capacity

reason IV Midwifery staffing
reason V Medical staff

On two occasions during the year, the Conquest Hospital and Eastbourne DGH were on divert at the same time.

Women and Children's Services - Neonatal services

- 4.2.10 The Directorate has 13 level 1⁵ neonatal cots. There are seven at Eastbourne DGH and six at the Conquest Hospital (although at the latter there is room for expansion in the current location with minimal movement of other services). Critical Care provision - designated paediatric and neonatal intensive and high dependency care – is either provided by Brighton and Sussex University Hospitals NHS Trust or by one of the Kent or London hospitals.
- 4.2.11 The budgeted SCBU establishment for 2008/09 is as follows:
- Eastbourne DGH has 14.73wte qualified SCBU staff
 - The Conquest Hospital has 12.51wte qualified SCBU staff
- 4.2.12 Neonatal activity is set out in the following table:

Table 4: ESHT SCBU activity - calendar year 2006 and 2007

	SCBU level 1	
	2006 Activity SCBU admissions	2007 Activity SCBU admissions
Eastbourne DGH	271 (74 transfers, 196 discharged and 1 death)	257 (69 transfers, 188 discharged)
The Conquest Hospital	157 (27 transfers, 130 discharged)	145 (27 transfers, 118 discharged)
TOTAL FOR ESHT	428	403

Source: Hospital Information System

Women and Children's Services - Gynaecology services

- 4.2.13 ESHT provides both general and specialist gynaecology services for part of East Sussex. Gynaecological oncology is provided as part of the Cancer Network's hub and spoke model of care. The service has a full range of outpatient clinics and both sites have facilities for day surgery and inpatient gynaecology ward.

⁵ Units providing care for new-born babies fall into three categories from level 1 providing routine and special care to level 3 providing the most specialist intensive neonatal care. Report of the Neonatal Intensive Care Services Review Group, Department of Health April 2003.

4.2.14 Gynaecology activity across ESHT in 2007/08 is set out in the following table:

Table 5: ESHT gynaecology activity 2007/08

Site	Daycase	Elective	Non elective emergency	Outpatients
Eastbourne DGH	401	533	579	6108
The Conquest Hospital	527	612	753	6332
TOTAL FOR ESHT	928	1145	1332	12440

Source: Hospital Information System

4.3 Population and deprivation indices⁶

Population

4.3.1 In 2006, approximately 500,000 people were resident in East Sussex. This is expected to increase to around 545,000 by 2016 - the principal demographic change expected over the next 20 years is a large increase in the elderly population.

Deprivation

4.3.2 Indices of deprivation for 2007 show that problems of multiple deprivation appear to have increased in all parts of East Sussex since 2004, which was the last time the indices were published. Key findings are:

- Hastings remains the most deprived local authority area in the region
- Hastings SOA⁷s that are in the most deprived 10 per cent nationally are mainly concentrated in Central St. Leonards, Castle and Gensing, but also affect five other wards in the borough. The most deprived SOA in the county is in Baird Ward (Hastings)
- Eastbourne has one SOA in the most deprived 10 per cent nationally

4.4 Transport

⁶ All population statistics are sourced from ONS data on the East Sussex County Council and deprivation indices are national figures from the East Sussex County Council website.

⁷ Super output areas (SOAs) are sub ward level areas of deprivation published by the Office for National Statistics (ONS).

- 4.4.1 East Sussex has no motorways, few stretches of dual carriageways and main roads are relatively narrow. Eastbourne and Hastings are connected principally by the A259 coast road (see maps over page), but this is often congested. Eastbourne and Hastings are approximately 20 miles apart and the journey normally adopted by the South East Coast Ambulance Services NHS Trust (SECamb) uses a combination of 'A' and 'B' roads. Data provided by SECamb⁸ shows the average journey time by ambulance between Eastbourne DGH and the Conquest Hospital is 40 minutes (range 23 - 52 minutes), compared with an average journey time between the Conquest Hospital and Eastbourne DGH of 35 minutes (range 23 - 50 minutes).
- 4.4.2 There is no direct commercial bus service between Eastbourne District DGH and the Conquest Hospital. At least one change is required and the journey time often approaches two hours.
- 4.4.3 Trains run between Eastbourne station and Hastings station approximately every 20-30 minutes during the week (often more frequently). Trains run between Hastings station and Eastbourne station every 20 - 30 minutes during the day and every 45 minutes after 21.30. The last train returning from Hastings is at 23.13. The journey time is approximately 30 minutes. A bus link from Hastings station to the Conquest Hospital operates Monday to Saturday with a journey time of approximately 25 minutes.
- 4.4.4 ESHT provides the following support to patients accessing the hospital sites:
- Some free parking for disabled users at both Eastbourne DGH and the Conquest Hospital site
 - Free or reduced rate parking for patients / carers / family in particular circumstances
 - Patients who are on Income Support or some other benefits can claim back costs of parking or travel expenses (the Government Hospital Travel Costs Scheme)
 - Free non-emergency ambulance transport (ambulance / voluntary cars and taxis) for patients with a medical need

⁸ Data provided by SECamb from a small sample survey August – November 2007.

Location of maternity units in and around East Sussex



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Boundary map of East Sussex – main settlements



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ESIF
East Sussex in Figures

4.5 **Estate**

4.5.1 *Eastbourne DGH*

Eastbourne DGH consists of a 15.56 hectare estate located approximately two miles north of Eastbourne town centre. It comprises multi-storey buildings and includes accommodation for 522 inpatient beds. PEAT⁹ 2008 assessment ratings are excellent for environment, food, and privacy & dignity. The site provides 1,023 staff, 294 visitor, and 32 disabled parking spaces.

4.5.2 *The Conquest Hospital*

The Conquest Hospital site is a 14.02 hectare estate located four miles from Hastings town centre on the B2093. It comprises multi-storey buildings and includes accommodation for 486 inpatient beds. PEAT 2008 assessment ratings are good for environment and excellent for food, and privacy & dignity. The site provides 743 staff, 270 visitor, and 27 disabled parking spaces.

4.6 **Healthcare Commission annual assessment and Clinical Negligence Scheme for Trusts (CNST)¹⁰ status**

4.6.1 In January 2008, ESHT received the following assessments from the Healthcare Commission in its Maternity Review 2007, each score being out of 5, a score of 3 represents the acceptable level of performance where standards exist and an average performance otherwise:

- Overall assessment based on the question: “*Does the Trust provide a high quality value for money maternity service?*” was 3.199 which equated to “Better performing”
- Clinical focus : 2.625
- Women centred care : 3.75
- Efficiency and capability : 3.222

ESHT is working with the PCTs to address any area of concern identified by the Healthcare Commission.

⁹ Patient Environmental Action Teams carry out a self-assessment of every healthcare facility in England with more than 10 beds each year and give a rating from unacceptable to excellent.

¹⁰ The Clinical Negligence Scheme for Trusts is a scheme of risk pooling. It provides indemnity cover for NHS bodies in England which are members of the scheme against clinical negligence claims made by or in relation to NHS patients treated by or on behalf of those NHS bodies.

- 4.6.2 ESHOT is accredited at CNST Level 3 for maternity services, the highest level available. The new pilot maternity standards for 2009 onwards have recently been published on the CNST website and reflect the higher standards in recently published guidance.

4.7 **The proposals for maternity services**

- 4.7.1 Currently there are consultant-led maternity units at both Eastbourne DGH and the Conquest Hospital, plus a midwife-led service at Crowborough Birthing Centre. Both hospitals also run a full paediatric service including a level 1 Special Care Baby Unit (SCBU).

- 4.7.2 The PCTs' preferred option, Option 4 as described in *Creating an NHS fit for the future Public Consultation*, is detailed at 3.11.

4.8 **Concerns raised**

4.8.1 *Issues raised by the East Sussex HOSC*

In referring the matter to the Secretary of State for Health, the HOSC stated that it had submitted a report to the PCTs in October 2007 which made a series of recommendations about issues the PCTs should consider when coming to a decision. The HOSC's key recommendation was that several new options had arisen through the consultation process, including some which retained services on two sites, and that the PCTs should fully assess them before coming to a final decision. In December 2007, the PCTs took their decision to proceed with one of their original options, Option 4. However, the HOSC remained unconvinced that its key recommendation for the PCTs to assess the potential alternative options had been fulfilled. In addition, the HOSC considered that the PCTs' decision was not in the best interests of the health service for East Sussex residents as stated earlier at 3.13. These issues are discussed in detail in the HOSC's *Response to East Sussex Primary Care Trusts on Creating an NHS fit for the future Public Consultation* dated October 2007.

4.9 *Issues raised by others*

4.9.1 In reviewing the PCTs' proposals, many views and items of information were either presented or sent to the Panel by a wide range of contributors. These are summarised in key points below according to whether contributors were opposed to, or in support of, the proposals. The subsequent paragraphs describe issues relating to relevant service areas and key groups.

4.9.2 Those opposed to the proposals:

- Strongly believe that the two PCTs should have included a two site consultant-led obstetric service , SCBU and inpatient gynaecology service proposal
- Believe that the proposed service change is financially driven
- Believe that the PCTs had already decided on a single site option prior to the consultation process
- Are concerned about the potential implications of travelling from Eastbourne to Hastings, a distance of approximately 20 miles on roads which are subject congestion in terms of:
 - Emergency transfers of women in labour
 - Women, birthing partners and families being subjected to long travelling times
- Consider that the Government's declared aim of choice for women is being eroded
- Believe that a single site solution will contravene best practice guidance by the National Institute for Health and Clinical Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG)
- Do not believe that SECamb will be able to provide an effective rapid transfer service from Eastbourne to Hastings
- Are concerned that the loss of the consultant-led obstetric service from Eastbourne DGH will result in a 'domino' effect with other services being transferred from the site to other hospitals
- Consider that alternative options were not properly taken into account during the consultation process

4.9.3 Those in support of the proposals:

- Are concerned that, although the consultant-led obstetric service delivered by ESHT is currently safe, it is often stretched to the limit

- Are concerned about sustainability across two sites in view of the implications for consultant obstetricians in continuing to operate small units, for example, appropriate casemix, the effects of Modernising Medical Careers (MMC) and the European Working Time Directive (EWTD)
- Believe that operating a larger obstetric unit will result in a safer, more sustainable maternity service which will be more attractive professionally to medical and clinical staff
- Believe that locating the consultant-led obstetric unit at the Conquest Hospital will have a stabilising effect in terms of services, particularly in not jeopardising the long term emergency care at the Conquest Hospital
- Believe that the proposals would present an opportunity for a level 2 neonatal unit

4.10 *Maternity services*

4.10.1 In the proposals set out by the PCTs, the key issue is clinical sustainability of services and how best to develop high quality maternity services for the whole of East Sussex. The principal factor is that both Eastbourne DGH and the Conquest Hospital are classed as small units (that is, less than 2,500 births per year each). The supporters of the proposals, which include the SHA, PCTs (excepting the East Sussex Downs & Weald Professional Executive Committee), ESHT and East Sussex Downs and Weald Patient and Public Involvement Forum (Eastbourne area) believe that retention of the status quo is unsustainable for reasons of safety, recruitment, consultant presence, training status and meeting EWTD 2009. They consider that the adoption of a single site proposal with appropriate additional resource would give increased resilience and flexibility.

4.10.2 *Safer ChildBirth* (Royal College of Obstetricians and Gynaecologists' *et al* 2007) gives guidance for units with less than 2,500 births:

"...this document strongly recommends 40 hours of consultant obstetric presence and this should be mandatory if the unit accepts high risk pregnancies (2007)."

There is no requirement to increase beyond 40 hours but the document states that units should continually review their staffing to ensure adequate based on local needs.

For units with 2,500-4,000 births, the document states a requirement for 60 hours consultant presence by 2009. The SHA has set local guidance to increase to 60 hours presence by 2010 (*Healthier People, Excellent Care 2008*).

- 4.10.3 Currently, 15 hours per week per hospital is being provided by eight consultants, four on each site. The Women and Children's Service has estimated that 6.5 wte consultants would be required on each site to achieve 40 hours consultant presence on the labour ward. ESHT indicated that a further increase to 60 hours presence could be achieved in theory by increasing to ten consultants at each site. However, to retain their skills and be competent to be on call for gynaecology emergencies, the job plan would need to include both gynaecology operating lists and outpatient sessions. It was also the Service's view that the resulting job plan would not be attractive unless it made some provision for the postholder's special interest and that a job plan that consisted mostly of labour ward cover would be unlikely to receive RCOG approval. On a single site, the Service believes that the 60-hour standard could be achieved with 10 consultants.
- 4.10.4 The Panel heard concerns from consultants that small units are unlikely to have complex cases in sufficient numbers to maintain consultant skills, provide job satisfaction or to attract new applicants to Eastbourne DGH and the Conquest Hospital.
- 4.10.5 The Panel was also told of concerns over the provision of middle grade doctors for two reasons. First, the effect of MMC means that, in future, middle grade doctors will not have the breadth and depth of experience which presently exist. Secondly, the implementation of the EWTD means a further reduction in hours currently worked by doctors and, therefore, a need to increase the number employed to provide the same level of medical cover. The obstetricians consider that recruiting middle grade doctors for small units will be difficult. The Panel heard that there have already been problems with a shortage of doctors and frequent use of locums. Additionally, there is a lack of required skills amongst middle grade doctors for non-training posts. There is also a concern that, due to the small size of the units, ESHT would have difficulty in gaining training accreditation for middle grade doctor posts in the future.

- 4.10.6 Supporters of the proposals suggest that all the disadvantages stated above could be either overcome or largely ameliorated by centralising services on a single site and that these would outweigh the problems of distance and transfer times. Clinical protocols would be set up with SECamb and also within the MLU at Eastbourne DGH to strengthen the safety aspects of the proposals.
- 4.10.7 Opponents of the proposals argue strongly that a two hospital site option as well as single site options should have been included. There is substantial opposition in and around Eastbourne to the potential loss of the consultant-led obstetric unit at Eastbourne DGH as evidenced by a protest march in 2006, together with declared opposition by Eastbourne and Hailsham GPs, the Eastbourne MSLC, East Sussex Downs and Weald PCT PEC and East Sussex LMC, and local MPs. Opponents are particularly worried about the travel and transfer times to the Conquest Hospital, with perceived consequences for the safety of women and babies. They are unhappy at the prospect of a MLU at Eastbourne DGH that would only cater for low risk births, and of an obstetric unit being some 20 miles away in Hastings or Brighton. However, no concerns were expressed about the MLU model. For example, Crowborough Birthing Centre is well known and popular with women and their partners.
- 4.10.8 In giving evidence to the Panel, a group of midwives emphasised women-centred care and choice, believing that a reduction to one consultant-led obstetric unit at the Conquest Hospital would reduce choice, going against the direction of government policy as described in *Maternity Matters*. They too expressed concerns about the travel and transfer times to Hastings, which would result in additional stress for women. They also referred to the growing number of women of childbearing age from Eastern Europe, a matter which was elaborated upon in evidence to the Panel by representatives from a local organisation '*English in the Community*'. The Panel heard that local recruitment of midwives was satisfactory and that additional posts could be filled, if funded.
- 4.10.9 Concerns about the potential effect of moving the consultant-led obstetric unit from Eastbourne to Hastings were expressed by a group of GPs from Eastbourne and the surrounding areas. They believe that moving the unit will move the problem into the community. The GPs stated that safety was the key issue and that, in their view, many

women would opt to give birth in Brighton rather than Hastings. They were also already concerned over closures at Eastbourne and Hastings. A similar view was expressed by one of the two local PECs, which was also concerned about the proposed changes to maternity services in West Sussex. The PEC was further concerned about the effect of patients having to travel to Hastings in an emergency. Conversely, the other PEC supported a single site, principally because it had concluded that the status quo relating to two sites was only sustainable in the short term.

4.10.10 Trade union representatives expressed concerns about longer travel times and the effect on staff after long shifts, together with the extra cost involved.

4.11 *Special Care Baby Unit (SCBU)*

4.11.1 The proposals involve the transfer of the SCBU from Eastbourne DGH to the Conquest Hospital. A group of SCBU nurses acknowledged the challenges of maintaining two units and spoke of gaps being filled through goodwill. They saw the advantage of moving to a single site as providing an opportunity to develop a level 2 unit. A level 2 unit would reduce the need to transfer babies out of East Sussex who needed this level of care and would also enable them to be brought back from level 3 units earlier. The main concern of the staff on moving to one site was the potential impact of increased journey times on families living in the west of East Sussex.

4.11.2 Consultant paediatricians expressed mixed views about the proposals. Those in support thought that the potential increase in availability of middle grade doctors was a pressing reason to move to a single site. Concern was expressed that, with a MLU only site, there would be no neonatal cover and therefore any baby requiring SCBU care would need to be transferred to the SCBU at the Conquest Hospital. Those opposed to the proposals argued that it is possible to sustain the service on two sites and that development of level 2 neonatal services on a single site was dependent on a number of factors. These include birthing numbers and staffing, none of which are factored into the current proposals (which are for a level 1 unit on the single site) and which in reality may not be achievable.

4.11.3 The PCTs and ESHT confirmed that paediatrics would be maintained on both sites for three years. However, it was the view of some staff that, if consultant-led obstetrics were located on one site, then paediatrics would follow at some date in the future.

4.12 *Inpatient Gynaecology*

4.12.1 As with obstetrics and the SCBU, inpatient gynaecology is planned to move to the Conquest Hospital under the PCTs' proposals, with day surgery, outpatients and diagnostic testing remaining at Eastbourne DGH. ESHT stated that only a small number of patients would be affected by this change. However, the planned activity levels show that over 50 per cent of gynaecology surgery is inpatient care rather than daycase. Representatives of the gynaecology department also raised the issue that, without a gynaecology inpatient ward, the breadth of procedures undertaken in the day surgery unit may decrease. Under these circumstances, patients could only be operated on if they could be discharged within 12 hours of attending, as there would be no specialist ward to move patients to if they needed extended recovery. This issue could be resolved if the day surgery unit on the site without gynaecology inpatients was developed as a 23 hour day surgery unit.

4.13 *Anaesthetists*

4.13.1 In taking evidence from anaesthetists, the Panel was advised that a significant staffing change would be required to develop a dedicated obstetric tier of the anaesthetic rota if the obstetric unit exceeds 3,000 births per year, as would be the case with the adoption of any single site option. At present, anaesthetists cover both obstetrics and critical care but, should the 3,000 birth threshold be reached, then dedicated anaesthetic cover for obstetrics would be required. There is support for moving to a single unit in terms of safety and training, though some reservations were expressed about the ability to recruit suitably skilled staff.

4.14 *South East Coast Ambulance Services NHS Trust*

4.14.1 Various groups presenting evidence to the Panel expressed concern over the transfer time for an ambulance between Eastbourne DGH and the Conquest Hospital, with its safety implications for a woman and unborn baby. SECamb advised the Panel that its main priority was to ensure an effective service, and gave details of transfer times which varied

between 23 and 52 minutes. The decision regarding which hospital an ambulance would take a patient to would depend on the condition of the woman at the time and would be protocol driven. SECamb was commissioning a training programme to increase obstetric emergency skills by November 2008.

4.15 *Campaign Groups*

- 4.15.1 Two groups, namely the 'Save the DGH' and 'Hands off the Conquest', have campaigned jointly against the proposals and have done much to promote local support for their campaign, focussing on a specific two site solution. Two site solutions have the support of large numbers of the public. The campaign groups gave evidence to the Panel on five occasions, including two sessions devoted to 'new data', and one to the joint campaign groups' alternative option.

4.16 *National Childbirth Trust*

- 4.16.1 In written evidence, the NCT stated that the most important factors relating to where to give birth are choice, safety and access. The NCT was supportive of women having access to both antenatal and postnatal care closer to their homes, and welcomed the increase in MLUs under the PCTs' proposals. However, it saw the potential transfer of the obstetric unit at Eastbourne DGH as removing choice from some women. The NCT also expressed concerns over access and travel times.

4.17 *Local Authorities*

- 4.17.1 The Panel heard evidence from five local authorities which had produced much useful and carefully compiled information. Opinion was divided over the proposals, with the councils in and around Hastings being in favour, while those further to the west supported the retention of two consultant-led obstetric units. Comment was made about the potential impact on the East Sussex community of the maternity proposals in West Sussex.

4.18 *Alternative options*

- 4.18.1 The Panel heard evidence from the proposers of each of the alternative options which had emerged from the consultation process. The majority of presenters were dissatisfied with the process which the PCTs had employed to assess the options. Following the screening

of the alternative options by the New Options Assessment Panel, Professor Field in his report stated:

“Inevitably there is a little more work to be done on some of the options before the PCTs can fairly test them against each other but I am confident that work can easily be concluded during the month of August 2007 and that the PCTs will then be able to conduct an effective and robust option appraisal process in September 2007.”

A number of the proposers, together with others who gave evidence to the Panel, assert that this did not take place and that the alternative options were not fully explored before being discounted. The dissatisfied proposers were also unhappy that no two site consultant-led obstetric unit options were included in the PCTs’ consultation document.

4.19 *The Local NHS - Strategic Health Authority*

4.19.1 Early in the Fit for the Future process, the SHA modelled the impact of a wide range of potential scenarios across all of Sussex and Surrey. The mapping demonstrated that there was not a material and critical interdependency between East Sussex and Brighton, mid and West Sussex. The SHA recognised the benefits of all the Sussex proposals being consulted on at the same time but, early in 2007, it became clear that the West Sussex proposals required more time. Consequently, it was decided to allow the PCTs to proceed alone, a decision taken after confirmation by Brighton and Sussex University Hospitals NHS Trust that they could deal with an additional 1,000 births from the local area without major capital expenditure.

4.19.2 The SHA’s final view was that it accepted the arguments in favour of a single consultant-led obstetric unit. However, it had no view regarding the location, accepting the PCTs’ rationale for their preferred choice.

The local NHS - Primary Care Trusts

4.19.3 The PCTs, in describing the rationale for their decision to select Option 4, had identified a number of drivers for change:

- Urgent issues
 - Day to day realities, namely at the margins of safety; consultant staff being stretched across two sites; inadequate labour ward consultant cover; unplanned closures; difficulty recruiting middle grade doctors

- o Physical environment does not meet modern standards
- o Modernising Medical Careers
- o Safe working hours (EWTD)
- o High quality staff
- Future challenges
 - o Drive to improve safety
 - o Increased consultant labour ward cover
 - o SCBU: Network standards
 - o Maintaining CNST level 3
 - o Tackle inequalities
 - o Promote choice
 - o Local where possible, central where necessary
 - o Enhanced training

The local NHS - East Sussex Hospitals NHS Trust

4.19.4 In presenting evidence to the Panel, ESHT highlighted the clinical issues relating to both two site and single site options:

Clinical issues - two site options

- Do not provide sufficient patients to maximise training opportunities and enhancement and retention of skills
- Do not maximise the benefits of sub-specialisation
- Do not allow for upgrading of facilities
- Do not facilitate recruitment for consultants and trainees/non consultant career grades
- Do not allow potential upgrading to SCBU level 2

Clinical issues - single site option

- Provides 60 hours consultant presence and is affordable
- Gives maximum clinical experience and opportunity to retain skills in complex cases
- Allows maximum opportunity for sub-specialisation
- Permits upgrading of facilities

- Facilitates recruitment in consultants and trainees
- Allows for good training in obstetrics and anaesthetics
- Potential for upgrading to SCBU level 2

4.20 Other evidence

4.20.1 A number of documents and reports were taken into account by the Panel when reviewing the proposals, including:

- *Maternity Services: Future of Small Units RCOG (2008)*
- *Maternity Matters: Choice, access and continuity of care in a safe service (2007)*
- *Safer Childbirth: Minimum standards for the organisation and delivery of care in labour RCO, RCM, RCA, RCPCH (2007)*
- *The Safety of Maternity Services in England King's Fund Report (2008)*
- *Healthcare Commission review of Maternity Services (2007) & (2008)*
- *CEMACH: Saving Mothers' Lives – Reviewing maternal deaths to make motherhood safer 2003-2005 (2007)*
- *Safe Births: Everybody's Business – Report by the King's Fund (2008)*
- *High Quality Care For All: NHS Next Stage Review Final Report (2008)*

4.20.2 During the course of its review, the Panel spoke to a number of staff concerning the level of integration achieved between the two hospitals since ESHT was formed. Whilst formally integrated at the senior managerial and clinical level, with individuals undertaking cross site working, below this level the hospitals are generally viewed as separate entities although, as a single Trust, they both follow the same procedures and policies.

4.20.3 The Panel is aware from national policy and guidance that, together with recommendations regarding consultant cover for labour ward, maternity services are also to aim for one to one midwife to woman ratio during labour (*Safer Childbirth 2007*). Whilst the Panel did not receive any evidence of planning to meet this target, it noted that a reworking of Birthrate Plus was to be undertaken.

OUR ADVICE

Adding value

5.1 Introduction

- 5.1.1 Following the East Sussex HOSC's referral in 2008, the Secretary of State for Health asked the IRP to undertake a review of the East Sussex Downs & Weald and Hastings & Rother PCTs' *Creating an NHS Fit for the Future* proposals to reconfigure maternity and related services provided by ESHT.
- 5.1.2 In presenting evidence, the PCTs highlighted that the decision to opt for a single site solution was taken for reasons of safety, reliability and sustainability in terms of medical staff recruitment, consultant presence on labour ward, training status, developing the neonatal service to level 2 and meeting EWTB 2009.
- 5.1.3 The Panel considered the PCTs proposals under the headings of safety, sustainability and accessibility. It became clear during the taking of evidence that the safety of women and babies during transfer between sites was a predominant and recurring theme, and sustainability was clearly a major issue.

Safety

Safety of women and babies during transfer between sites

- 5.1.4 In both written and oral evidence to the Panel, safety of women in labour and babies during transfer between sites or in transport to hospital was clearly of paramount concern to a wide range of stakeholders, including MPs, members of the public, GPs and staff groups. The distance between Eastbourne and Hastings is approximately 20 miles, but there is currently no consensus on what constitutes 'safe' distances for transfer of women during labour. The Panel heard that the nature of the road network between the two locations frequently results in long journey times of an hour or more by private transport. Evidence was received from SECamb that the range of journey times is 23 - 52 minutes with consequent concerns regarding emergency transfer of women in labour. Many clinicians were concerned for the safety of a woman and unborn baby if an emergency transfer was required between Eastbourne DGH and the Conquest Hospital. The Panel heard from members of the public and clinicians of unforeseen emergency cases treated

at Eastbourne DGH. Had they needed to be transferred to Hastings, then there would have been fears for the woman and unborn baby or child. The PCTs have agreed to commission additional training places for SECamb to support clinical skills development of crews in managing obstetric emergencies. SECamb cites a very low level of emergencies encountered, although there is little national or local data available to boost the confidence of the public and many professional health workers. On balance, whilst recognising the efforts made by the PCTs and SECamb to reassure stakeholders that action would be taken to reduce risks, the Panel accepts the concerns raised by a number of stakeholders that there is an unquantifiable risk of incidents during transfer or transport of women during labour.

- 5.1.5 The Panel recognises that the condition of a woman and baby can change rapidly during the course of labour. When complications arise, urgent assessment by the attending clinician is required. Initial assessment is usually by the attending midwife with referral to an obstetrician as necessary. In a consultant-led unit or with integrated midwife-led maternity units, such referral can take place immediately. The Panel's attention was drawn to the '30-minute' rule, originally defined by the American Association of Anesthesiologists, as a possible yardstick for assessing maximum transfer times. However, the 30-minute rule is a specific clinical guideline for carrying out an emergency caesarean section once the decision has been made to operate and has not been published or endorsed as a guide to acceptable transfer to hospital times.

Staffing issues

- 5.1.6 The Panel noted that the PCTs had described the maternity services as being 'at the margins of safety' and this issue was raised with ESHT. These concerns were echoed by the consultant obstetricians from both sites who argued that, at current levels, they are overstretched and unable to deliver the current recommended level of cover for labour ward. ESHT stated that it believed the service to be safe, but that significant staffing problems will need to be addressed in order to meet the future standards and the EWTD. Currently, both hospitals are accredited at CNST level 3 and were assessed as 'better performing' at the last Healthcare Commission Maternity Review in 2007 as stated at 4.6.1. Ninety per cent of women during pregnancy, and eighty eight per cent of women during labour and birth, rated the care they received as 'excellent', 'very good' or 'good'.

- 5.1.7 The Panel heard that there have been a significant number of diverts and closures as detailed at 4.2.9. The majority of these are associated with midwifery staffing issues. The Panel was told by ESHT that it is currently addressing the matter.
- 5.1.8 The Panel recognises that concerns raised have some basis and that change needs to occur in order to sustain quality and ensure future safe medical staffing levels.

Sustainability

- 5.1.9 Currently, RCOG guidance advises 40 hours consultant presence on the labour ward for small units. The SHA's stated aim is for 60 hours consultant presence by 2010. ESHT considers that 10 consultants per site would be needed to achieve this, but the Panel heard evidence that this might be achieved with fewer. Since the end of the PCTs' consultation period, *Maternity Services: Future of Small Units* (RCOG) has been published which adopts a more flexible approach to staffing models. The Panel has considered this in detail in relation to the subject of required presence on labour ward. Furthermore, there are examples of innovative practices such as those implemented at other hospitals which demonstrate alternative approaches to maintaining small units which could be revisited in the light of guidance published since the consultation was carried out.
- 5.1.10 The Panel also noted that other hospitals are planning to provide greater consultant presence with a lesser enhancement of consultant numbers. For example, there are hospitals which are planning to provide 60 hours consultant presence per week with six to seven consultants on each site. These hospitals have higher delivery numbers than either the Conquest Hospital or Eastbourne DGH. However, the Panel also noted from *Safer Childbirth* (2007) that a minimum of 60 hours consultant presence is not stipulated for smaller units providing a service for less than 2,500 births.
- 5.1.11 The effect of the EWTD was discussed at length by the Panel, particularly in relation to clinical supervision. The result of MMC which will reduce the experience level and narrow the skill base of middle grade doctors in the future, together with the EWTD and its shorter weekly working hours, will mean that more doctors' hours are needed to deliver a comparable service. However, ESHT is concerned that recruitment of extra

doctors to compensate for the reduced working hours will be difficult to accomplish. The Panel heard that ESHT had calculated that a minimum of 10 middle grade staff was required on the proposed single site to provide appropriate cover. But, as with consultant staffing, the Panel noted that hospitals elsewhere in England have used different assumptions. For example, the hospitals referred to at 5.1.10 are planning to provide EWTD compliant cover with fewer than 10 middle grade staff for a site.

- 5.1.12 From the above analysis, the Panel questions ESHT's assumption for future medical staffing, considering it to be over-generous in the light of evidence received during the review. The Panel considers that alternative staffing models may be feasible which could still deliver a safe, sustainable service. However, the Panel acknowledges that the recruitment issues for middle grade staff are potentially the most challenging, regardless of the size of the unit, whereas recruitment of future consultants is less problematic
- 5.1.13 In terms of quality, *Safer Childbirth* recognises the central role of the midwife as lead autonomous practitioner in childbirth and also endorses the role of the consultant midwife. Yet the Panel considered that the medical staffing issues had, to an extent, eclipsed the concurrent issues relating to the future nursing and midwifery workforce. *Safer Childbirth* recommends that there should be a designated midwife per woman when in established labour for 100 per cent of the time. This issue was not raised during evidence sessions by the PCTs, but is clearly relevant to safety, sustainability and quality of services and must be actively addressed as part of the maternity strategy development. The Panel noted that the development of alternative models such as advanced midwifery practitioners to support junior and middle grade staff had not been considered either by the PCTs or ESHT. Exploration of the potential of these roles in both developing midwifery careers and supporting doctors' roles should be taken further locally.

Accessibility

- 5.1.14 In addition to safety concerns for women in labour who might require transfer to Hastings under the proposals, the Panel also heard that the journey to Hasting for those families who have to travel by public transport is very time consuming and costly. Furthermore, one of the principal reasons for choosing Hastings as the site for the single consultant-led obstetric unit was because of the higher levels of deprivation in and around Hastings and,

therefore, the Conquest Hospital would mean easier access for families from these areas. But the Panel heard evidence that Eastbourne also has a number of areas of deprivation whose residents would be particularly disadvantaged by the proposals because of their need to travel the extra distance to Hastings. The effect of travel time on staff should also not be underestimated, with many having to undertake much longer journeys to and from work.

- 5.1.15 Besides the physical reduction of consultant-led obstetric units from two to one, the Panel also heard evidence that transfer of the obstetric unit from Eastbourne DGH is likely to deter a number of women from having either a home birth or opt for the Eastbourne MLU, because of worries over accessibility of the consultant-led unit in Hastings. Paradoxically, this would conflict with the PCTs' aim to increase home births or encourage women to opt for intrapartum care in a midwife-led unit.

Drawing the discussion together

- 5.1.16 Taking all the evidence into consideration, the Panel made a judgement on the PCTs' proposals using the criteria of safety, sustainability and accessibility.
- 5.1.17 In terms of safety and sustainability, there was a divergence of opinion amongst clinicians as to whether implementation of the proposals would result in improved services. Consultant obstetricians and gynaecologists support the proposals overall, whereas some GPs and consultant paediatricians expressed reservations. These included that there would only be one, as opposed to two, SCBUs and therefore there would be no enhancement of care for neonates. Additionally, although paediatric cover would remain at Eastbourne DGH, this would not include cover for neonatal emergencies. In receiving evidence from the Anaesthetic Department, the Panel recognised the importance of appropriate anaesthetic cover for labour ward which, for a single site solution, would be provided by a dedicated obstetric rota. However, the Panel heard evidence that a two-site solution would be potentially sustainable from an anaesthetic perspective, provided the consultant-led obstetric units remained small.
- 5.1.18 The Panel concluded that the proposals were principally driven by the PCTs' attempt to address future medical staffing issues as perceived at the time of consultation. It also

concluded that, for the PCTs, the strength of this driver outweighed the issues of accessibility and choice. It formed a clear view that the PCTs had not given due weight to accessibility and that the reconfigured services would result in a real reduction in accessibility compared with current service provision for the people of East Sussex. Additionally, the IRP was not convinced by the arguments that there would be compensating improvements in safety and sustainability that could only be achieved through reconfiguration. Overall, whilst recognising that there does need to be some change in staffing the units in order to continue to deliver safe, sustainable services, the Panel does not accept that the single site solution is the only or best option to achieve this.

5.1.19 **Recommendation One**

The IRP does not support the PCTs' proposals to reconfigure consultant-led maternity, special care baby services and inpatient gynaecology services from Eastbourne District General Hospital to the Conquest Hospital at Hastings. The Panel does not consider that the proposals have made a clear case for safer and more sustainable services for the people of East Sussex. The proposals reduce accessibility compared with current service provision.

5.2 **Community maternity services**

- 5.2.1 The Panel commends the PCTs' proposals to improve antenatal and postnatal care and associated outreach services. The HOSC commented favourably on this proposal and requested that the PCTs implement the plans without delay. This is strongly supported by the IRP, as it will bring clear benefit to the East Sussex community. The Panel was impressed by the commitment to support home births, which is likely to be further enhanced by the retention of consultant-led maternity units at both sites.

5.2.2 **Recommendation Two**

The Panel strongly supports the PCTs' decision to improve antenatal and postnatal care and associated outreach services. These improvements should be carried forward without delay.

5.3 **Further work**

- 5.3.1 The Panel's view is that the PCTs must develop a local model that enables consultant-led maternity and related services to be retained at both hospital sites. As part of this process, they must examine emerging policy and practice examples and re-examine alternative models that emerged post consultation. This includes full consideration of options which promote choice for service users, including the feasibility of offering midwife-led units at both or either site.
- 5.3.2 While the IRP does not support the PCTs' proposals, it was nevertheless impressed by the thoroughness of aspects of the consultation and proposal development. It acknowledges that a great deal of hard work was put into both drawing up the consultation document and the subsequent follow-on work.
- 5.3.3 However, the Panel considers that the formal consultation was unsatisfactory in that the retention of a two-site arrangement was not included. A number of stakeholders put forward a variety of alternative options, some of which impressed the Panel by the detail included in their proposals. Whilst the initial screening process led by Professor Field provided support for further development of options, there is evidence that the formal post consultation option appraisal process was not able to give sufficient consideration and support for development of all alternative proposals.
- 5.3.4 Evidence from other reconfigurations demonstrates more open and transparent methodologies that may have been helpful in gaining support and trust for the process from the public, clinicians and others. For example, one approach involved two stages; the generation of a number of options at an early stage by a wide range of stakeholders, including clinicians, which were independently analysed to create a shortlist. A separate independent process generated criteria which were then used to assess the options. Only when this wider process had been undertaken did a joint committee of PCTs decide on which options to take forward to formal consultation.
- 5.3.5 The Panel disagrees with the PCTs' decision not to consult on a two site option. There is evidence that, in other parts of the country, reconfigurations of maternity services have taken place which retain small units such as those at Eastbourne and Hastings. The IRP nevertheless recognises that sustaining the two sites will require additional clinical staff,

but the staffing levels quoted of requiring ten consultants and ten middle grade staff per site for 60 hours cover is considerably higher than plans used in many other small units. The Panel recommends that the PCTs and ESHT revisit the Alternative Models Project work to benchmark their plans against other small maternity units.

5.3.6

Recommendation Three

Consultant-led maternity, special care baby, inpatient gynaecology and related services must be retained on both sites. The PCTs must continue to work with stakeholders to develop a local model offering choice to service users, which will improve and ensure the safety, sustainability and quality of services.

5.4 **Maternity services strategy**

- 5.4.1 Both Eastbourne DGH and the Conquest Hospital currently have a paediatric assessment unit which provides rapid assessment, observation and treatment under the care of experienced paediatricians. The PCTs have undertaken to maintain paediatrics on both sites for a period of three years. The general view expressed by ESHT's consultant paediatricians was that, logically, if obstetric and gynaecology services moved to one unit, then paediatrics should follow. Additionally, there were mixed views expressed by the consultants and other clinicians as to whether safety would be better or worse in a combined single site unit.
- 5.4.2 The Panel learned that no children's or maternity strategy presently exists within the PCTs and, therefore, was unable to judge the proposals against such a strategy. It heard that a maternity strategy group has now been convened to drive implementation of the reconfiguration proposal. The Panel considered that local proposals for change were not clear in the context of reconfiguration proposals in neighbouring West Sussex. It is the Panel's view that the implications of adjacent reconfiguration should be clear to all, particularly in relation to patient flows and the accessibility of midwife-led and consultant-led services for residents to the west of the catchment area/Downs and Weald PCT boundary. Additionally, it is considered that, in accordance with the *Department of Health's Operating Framework for 2008/09*, the PCTs will need to take particular action for maternity to improve access, as part of the wider *Maternity Matters Strategy* to deliver safe, high quality care for all women, their partners and their babies.

- 5.4.3 It was clear to the Panel that many stakeholders were concerned at an apparent lack of a ‘joined-up’ approach to service planning, particularly that affecting the population to the west of the area. Whilst the SHA had carried out impact assessments and projections of patient flows, and has more recently carried out some strategic review as part of the wider NHS review (*Healthier People, Excellent Care 2008*), the lack of an overall strategy in relation to maternity services across the area was of concern to the Panel.

5.4.4 **Recommendation Four**

The PCTs with their stakeholders must develop as a matter of urgency a comprehensive local strategy for maternity and related services in East Sussex that supports the delivery of the above recommendations. The South East Coast SHA must ensure that the PCTs collaborate to produce a sound strategic framework for maternity and related services in the SHA area.

5.5 **Future communication and engagement**

- 5.5.1 The Panel acknowledges that the consultation exercise has been a difficult time for many people, but recognises that the PCTs undertook a substantial programme of engagement with the public. Evidence from the campaign groups suggests that aspects of this were not universally perceived as successful. The Panel was disappointed by an unnecessarily adversarial attitude adopted throughout the review period by some members of the campaign groups. During their visits to East Sussex, the Panel became aware that relationships between the PCTs and some stakeholders had all but broken down. However, the Panel considers it essential in the long-term interests of the whole community that all stakeholders support the PCTs in the further work which they will be undertaking.
- 5.5.2 To ensure that services are informed by the needs and preferences of patients, the public and other key stakeholders, the PCTs should establish appropriate, rigorous and timely involvement and engagement. This must be used to inform commissioning decisions in respect of maternity, special care baby and gynaecology services. The Panel would wish to see the PCTs develop a strategy to ensure open and effective communication with the people of East Sussex in taking forward these recommendations.

5.5.3 Recommendation Five

The PCTs working with all stakeholders, both health providers and community representatives, must develop a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the Panel's recommendations.

5.6 Next Steps

- 5.6.1 The PCTs, SHA and ESHT should work together, linking with the East Sussex HOSC, to agree a plan for taking forward the recommendations in this report as a matter of high priority. The Panel noted that local workstreams have addressed Lord Darzi's Next Stage Review and expects that the ongoing local planning process should also take account of the final report by Lord Darzi.

5.6.2 Recommendation Six

Within one month of the publication of this report, the PCTs must publish a plan, including a timescale, for taking forward the work proposed in the Panel's recommendations.

NCAT review

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 are 16 “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 trial 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 clinicians. The 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 mitigations put in place, the risk to patient safety had not been fully 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.
11 February 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 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		

National Clinical Advisory Team - NCAT

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



Royal College of
Obstetricians &
Gynaecologists

CONFIDENTIAL

Review of the Obstetric and Neonatal Services of East Sussex Healthcare NHS Trust at Conquest Hospital

Undertaken by:

Mr Paul L Wood MD FRCOG (Lead Assessor)

Mr Andrea Galimberti FRCOG (Co-Assessor)

Professor Stewart Forsyth OBE MD FRCPCH (Co-Assessor)

On 8 and 9 August 2013

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CONTENTS

INTRODUCTION	3
Terms of Reference.....	3
BACKGROUND	3
Care Quality Commission (CQC) Inspection Reports (Maternity & Paediatric), Conquest Hospital, Eastbourne District General Hospital – Inspections (24–25 June 2013).....	8
RCOG EXTERNAL CLINICAL ADVISORY TEAM REVIEW, 8–9 August 2013	10
Interviewees.....	10
Other Information received in advance of the visit	10
Information supplied during the visit.....	10
Site visit.....	11
Clinical risk and service delivery assessments	11
Service management and clinical decision making	13
RECOMMENDATIONS	14
Risk Management Strategy	14
Service management and clinical decision making	15
CONCLUSION.....	16

INTRODUCTION

This review visit took place at the same time as a separate review visit undertaken by the Royal College of Paediatrics and Child Health (RCPCH).

Terms of Reference

1. Using case note review, interviews with staff and review of policies and procedures, identify areas for development in respect of Clinical Decision Making, Clinical Risk Assessment and Clinical Risk Management.
2. To make recommendations as to how these areas for development should be addressed.
3. Review the serious incidents that have occurred in Maternity and Paediatrics over the last twelve months and assess the clinical decision making processes, the root cause analyses, the incident reporting timeliness, and in particular identify any:
 - Learning points following serious incidents.
 - Failures to make the correct diagnosis.
 - Failures to perform an appropriate examination.
 - Failures to offer or perform appropriate treatment.
 - Failures to arrange an appropriate review strategy in relation to the condition for which referred.
 - Failures to take appropriate action in a timely manner.
 - Failures to comply with relevant Trust Clinical Guidelines.
 - Failures to identify or report a serious incident in a timely manner.
 - Failures to take appropriate action within a reasonable time frame to minimise the risk of a similar incident occurring and/or to address the root causes identified.
4. To make recommendations for actions that will ensure that there are robust and clinically led systems and processes in place to enable clinicians to critically appraise incidents, to identify root causes and implement actions so that learning and appropriate changes in clinical practice can be delivered and evidenced.

BACKGROUND

East Sussex Healthcare NHS Trust held an Extraordinary Trust Board Meeting in public on Friday 8 March 2013. Included in the Board papers was a document entitled 'Ensuring Safety for Obstetrics and Gynaecology and Neonatal Services'. The report provided the Board with information required to make a decision on the preferred option for improving the safety of the maternity and neonatal services. The paper sets out the reasons behind the view that for some patients some of the time the maternity and neonatal services operated by the Trust did not deliver the safety and quality standards expected and required. The paper was based on the views of the Trust's senior clinicians

and also those of the National Clinical Advisory Team (NCAT). The current dependency on mitigating actions meant that the cumulative risk of service failure was at an unacceptable level, and that the delivery of a safe service could become rapidly unsustainable, leaving the Trust with little time to implement effective mitigating actions. The preferred option presented to the meeting on 8 March 2013 was the provision of a consultant-led obstetric service, neonatal service, inpatient paediatric service and an emergency gynaecology service at the Conquest Hospital. A stand-alone Midwifery-Led Unit (MLU) with enhanced ambulatory paediatric care was to be established at Eastbourne District General Hospital.

The main risk factors identified were:

- Increased numbers of high risk pregnancies.
- Lack of 24/7 availability of medical and midwifery staff with the required competences.
- An ongoing dependency on temporary staff.
- Potential failure of the risk mitigations at short notice.
- The lack of availability of clinical leadership in a service delivered on multiple sites.

The requirement to act had been triggered by an analysis of increasing numbers of serious incidents (SIs). The NCAT attended in January 2013 and a Risk Summit had taken place in February 2013. Both concluded that the Trust was operating with unsustainable levels of risk and urgent action was deemed necessary. Prior to 2013 approximately 2000 women were delivered in each of two separate sites at Conquest Hospital and at Eastbourne District General Hospital. The Trust's number of SIs per calendar year from 2007 are summarised as follows:

Year	Obstetrics	Paediatrics
2007	1	2
2008	6	2
2009	1	0
2010	10	2
2011	7	1
2012	8	3
2013 (to 8 March)	8	1

The processes in place in relation to serious incidents were as follows:

- Root Cause Analysis (RCA).
- Discussion at weekly conference calls with the Primary Care Trust (PCT)/ Strategic Health Authority (SHA).
- Action plans for RCA discussed at the bimonthly Divisional Patient Safety and Clinical Improvement Group and at core team meetings.
- Each serious incident was also discussed at the fortnightly Trust Wide Serious Incident Review Group.

The themes identified from recent serious incidents were:

- Senior opinion not being sought in a timely manner.
- Women not being reviewed in a timely way.
- Poor care resulting in harm to babies at birth.
- Poor communication in relation to planning and communicating care plans.
- Poor liaison with senior colleagues.
- Care given by agency staff causing harm.
- Junior staff not recognising the deteriorating condition of a patient and escalating appropriately.
- Inadequate supervision of junior staff.
- Maternal risk factors.

The report referred to the Dr Foster Patient Safety Indicator Data and explained how the Trust was a significant outlier in 2010–11 and 2011–12 for obstetric trauma at caesarean section and this continued to be the case. The Trust's observed rate for 2011 was 20 against an expected level of 3.1. In 2011–12 this was 15 against an expected rate of 3.1, meaning the risk of harm to a woman undergoing caesarean section at East Sussex Healthcare NHS Trust was five-fold more than anticipated. The majority of the caesarean sections resulting in obstetric trauma were identified as having been undertaken by locum/agency doctors or more junior registrars without the presence or supervision of a consultant. Analysis demonstrated that there was a greater risk of harm at the Eastbourne site.

The Maternity Dashboard had identified:

- A consistent need to divert women in labour from one site to another.
- The birth to midwife ratio was above that expected.
- High midwifery absence rates.
- Low normal delivery rates.
- Higher than expected numbers of term babies admitted to the Neonatal Unit.

Key factors that were adversely influencing the quality and safety of service provision included the inability to provide consultant labour ward presence at levels above 40 hours per week, lack of suitable applicants to fill established posts with accompanying requirements to take unplanned action to address shortfalls, staff not always being able to operate at the skill levels required and lack of availability of experienced staff 24/7.

NCAT had concluded the following:

- A decision on the location of inpatient maternity care and paediatrics was needed as a matter of urgency.
- The manner in which the maternity and paediatric services were operating was neither safe nor sustainable.

- The siting of inpatient maternity services was dependent on appropriate arrangements with other relevant services.
- The maternity services were the main driver but separate inpatient paediatric services were felt to be too small to be sustainable.
- In the presence of two separate emergency departments the provision of emergency gynaecology needed to be managed on the remaining site in the absence of resident gynaecology staff.

NCAT's recommendations included:

- Co-location of maternity and paediatric inpatients on one site as a matter of urgency.
- A Trust-wide strategy for maternity and paediatric services to be developed.
- Consideration to the establishment of alongside and stand-alone MLUs.
- Maternity, gynaecology and paediatrics should be on the same site.
- The Trust to reconsider the overall strategy for delivering services to acutely ill patients in order to improve service delivery and reduce clinical risk.
- Need to urgently address local leadership of the paediatric team and improve cohesion.
- A paediatric group to take forward standardisation of clinical guidelines and practice within an agreed time frame.

The paper considered a risk assessment of the various options and the advantages of the preferred option was adopted. This involved the provision of a consultant-led obstetric service, neonatal service, inpatient paediatric service, an emergency gynaecology service on the Conquest site and establishing a stand-alone MLU as well as enhanced ambulatory paediatric care at Eastbourne General Hospital.

The advantages included:

- Ability to provide a minimum of 60 hours consultant labour ward presence.
- Consolidation of activity providing a wider range of experience for trainees, improving recruitment and retention.
- Improved medical cover at night.
- Improvement in staffing, flexibility of midwifery resources, improved midwifery skill mix, and provision of dedicated consultant-led teams.

NCAT referred to an external review of four cases which had taken place without the benefit of the clinical records, clinical guidelines, knowledge of the working practice and knowledge of the staff involved. However the external review concluded:

1. The Trust acted responsibly in requesting external reviews. NCAT noted that overall the reviews were well contributed and written but there were significant omissions.
2. There were delays in escalating incidents for risk review and identifying them as serious incidents.
3. There were delays in completing planned actions and a lack of robust assessment that actions had been achieved.

4. There was a lack of escalation by midwifery, neonatal nursing or theatre staff directly to the consultant when there were concerns about a middle grade doctor's actions raising concerns regarding the profile of the Labour Ward Co-ordinator and Labour Ward Lead Clinician.
5. There appeared to be significant issues around obstetric staffing including decision-making relating to delivery at full dilatation and trials of instrumental vaginal deliveries.
6. The RCAs did not demonstrate sufficient evidence of support being offered to medical staff, especially locums and paediatricians after adverse outcomes and a failure to adhere to local clinical guidance was a common theme in the incidents reviewed.
7. Poor communication within and between teams was a common feature.

Concerns raised by NCAT included:

- Delays in escalation.
- Lack of supervision of locum and middle grade staff.
- Validity of the interpretation of Serious Incident Reports.
- A very worrying culture of complacency in relation to risk within maternity and paediatrics.
- Poor record keeping.
- Poor communication.
- Lack of plan of care.
- Lack of documentation.
- Lack of appropriate level for opinion/planning.
- Inappropriate grades/level of staff undertaking or providing care.
- Where a serious incident involved a poor outcome for the baby there appeared to be a minimal review of obstetric care prior to the birth.

NCAT felt that the RCA Enquiry Team did not appear to have asked the appropriate questions and therefore they felt the conclusions were likely to be incorrect. The NCAT refer to the Edgecumbe Report which was 'truly shocking in its account of failure of clinical leadership and of the dysfunction within the Paediatric Team'. NCAT concluded that neither the maternity nor the paediatric services were safe or sustainable in their current shape and that the paediatric department especially appeared to be dysfunctional with little insight. Urgent steps were needed to address these shortcomings. This report was dated 11 February 2013.

Care Quality Commission (CQC) Inspection Reports (Maternity & Paediatric), Conquest Hospital, Eastbourne District General Hospital – Inspections (24–25 June 2013)

The assessors were provided with favourable Care Quality Commission reports (in draft) for both hospitals following inspections in June 2013. These reports were later issued in their final form by the CQC following correction of some minor factual inaccuracies.

Points to note within the reports include:

- The temporary reconfiguration of maternity and paediatric services was completed on 7 May 2013.
- There had been prior concerns registered by a team of consultant paediatricians at Eastbourne District General Hospital.
- Care and welfare, safeguarding, requirements relating to workers, staffing and assessing and monitoring the quality of service provision had been inspected and assessed as meeting the standards.

The reports noted that:

- Systems were reviewed at both the Conquest Hospital and Eastbourne District General Hospital.
- There had been a marked increase in the reporting of incidents during the second half of the financial year ending March 2013.
- Conclusions reached were that the Trust is providing a safe, effective, responsive, caring and well led maternity and paediatric service.
- Staff felt that centralisation of obstetric intrapartum care was safer.
- Staffing was obtained by the use of ‘familiar’ bank and agency staff.
- Colleagues had been supportive following the relocation.
- Obstetricians were now ‘present’ on the labour ward rather than ‘available’.
- The need for locum obstetric staff at night had been removed.
- There had been a reduction in clinical incidents since amalgamation.
- The Report referred to the computerised system for reporting incidents.
- Incident forms were reviewed daily with risk meetings Monday–Friday.
- Staff received feedback about incidents on a monthly basis.
- There had not been any clinical incidents regarding neonatal resuscitation since the reconfiguration.
- The Trust’s maternity services had been assessed as Level 3 at the last Clinical Negligence Scheme for Trusts (CNST) visit. (N.B. This was an incorrect typographical error and should have read Level 2).
- In the context of the paediatric concerns, if reassessed by CNST the Trust would be assessed as higher risk, but this would not make it uninsurable.

- The CQC was satisfied that, within maternity and paediatrics, the Trust had taken appropriate steps to mitigate risk and ensure that care and treatment was planned and delivered in a way that ensured people's safety and welfare.
- Maternity staff confirmed they received safeguarding training annually.
- Staff interviewed had a clear understanding of mental capacity assessments.
- Temporary staff (locums) were subject to the same level of checks and similar selection criteria to staff in substantive posts.
- The risk of employing locums was on the Risk Register and specific controls had been put in place.
- The Trust compared its SIs with others and the national mean.
- The Trust may not be able to find evidence when consultants were on the ward on the basis of the attendance diary.
- All locums were directly supervised re decision-making and instrumental and operative deliveries.
- The Maternity Dashboard had been reviewed.
- Each clinical unit had a risk register and monthly risk meeting.
- The high-level risk register was reviewed.
- Minutes of the Serious Incident Review Group had been inspected for 29 May and 12 June. Contradictions in report were questioned by the Inspectors. The controls in place for locum staff were deemed to be 'adequate'
- Escalation was to the Divisional Risk Meeting, Health and Safety Group, Patient Safety Group, Clinical Management Executive, Quality & Standards Committee and Patient Safety and Clinical Improvement Group and finally the Trust Board.
- Six SI reports and their RCAs were examined in detail and, in general, the CQC found that the reports and reviews had been completed to a high standard.
- Some staff had been made personally accountable following RCA.
- Generally the action plans were relevant and had been completed, but not all.
- There has been a South Coast Audit that had only been able to provide limited reassurance that action plans were being completed. One recommendation was that actions were implements and monitored. Auditing of the quality of case notes had been incomplete.

RCOG EXTERNAL CLINICAL ADVISORY TEAM REVIEW, 8–9 August 2013

Interviewees

- Coordinator – Ms Paula Smith, Acting Associate Director, Women and Children – Integrated Care, East Sussex Healthcare NHS Trust, who facilitated the review
- Ms Amanda Harrison – Director of Strategic Development and Assurance
- Dr David Hughes – Medical Director (Governance)
- Mr Jamal Zaidi – Divisional Director – The Divisional Director has joint accountability for governance including risk, along with the Associate Director of Nursing
- Ms Marie Foreman – Matron Delivery Suite
- Dr Sebastien Adamson – ST4 Obstetrics and Gynaecology
- Mr Dexter Pascall – Clinical Unit Lead, Obstetrics. The Clinical Unit Lead has responsibility for the implementation of the Maternity Risk Management Strategy, this responsibility being shared with the Head of Women's Reproductive and Sexual Health Services
- Ms Anne Watt – Divisional Clinical Governance Manager
- Dr Noka Sadete – Middle Grade Trainee in Neonatology
- Dr Graham Whincup – Paediatrician
- Ms Lindsey Stevens – Head of Midwifery and Associate Nurse for the Division
- Ms Wendy Thompson – Neonatal Matron
- Ms Cathy O'Callaghan – Acting Clinical Services Manager

Other Information received in advance of the visit

- Maternity Risk Management Strategy
- Copy of notes and correspondence relating to serious incidents:
 - 2013/10044,
 - 2013/5108,
 - 2102/22311,
 - 2012/23709,
 - 2012/23168,
 - 2012/23709,
 - 2012/24174,
 - 2013/10830,
 - 2013/10040.

Information supplied during the visit

- Clinical records of 47 sets of notes relating to mothers and babies admitted to the Neonatal Unit by way of a random review of case notes.
- Maternity Dashboard April to July 2013.
- Risk Management Meeting Minutes dated 21 June 2013 and 26 July 2013.
- Adverse incidents by category and incident August 2012 to May 2013.
- Maternity Staffing Audit Report December 2012.

- Guidance for Maternity Unit Staffing Levels for all care settings relating to obstetrics and midwifery.
- Obstetrics and Gynaecology weekly rota.
- Daily reporting tools for Maternity Services, Gynaecology and Paediatrics.
- Complaint status as of 10 June 2013.

Site visit

The visit included a brief tour of the Neonatal and Obstetric Unit at the Conquest Hospital during which the labour ward staff were able to demonstrate familiarity with the Datix Incident Reporting System.

Clinical risk and service delivery assessments

Review of serious incidents

The documents relating to eight serious incidents during 2012–2013 were reviewed and a detailed analysis of these cases has been provided to the Trust.

The case reviews identified serious failures in clinical decision-making and service management including delays in escalation of level of care, excessive use of locum doctors, poor communication, inadequate supervision of middle grade doctors, inappropriate care, misinterpretation of CTGs, misleading documentation, and substandard clinical skills including neonatal resuscitation.

The review of the RCAs of each of the incidents revealed that they were invariably undated with no recognisable authorship. Review of the statements shows that these are not consistent in terms of their format or presentation.

These incidents predate the reconfiguration of services and it is vitally important that these serious risks to patient safety are rigorously audited in the new service configuration to ensure the quality of care provided within the new structure is at an acceptable level.

Review of case notes

Time constraints limited the number of case notes reviewed on a random basis but the Review revealed a good standard of neonatal note keeping and in particular the value of combined medical and nursing notes was observed.

Within the obstetric records the risk profiles were often not completed and the reviewers support the need for an ongoing random audit of case notes which has not been carried out within the Trust despite previous recommendations.

Staff were generally good at signing the booklets and the obstetric cases appear to have generally been well managed overall. Incomplete documentation relating to antenatal, labour and postnatal risk factors were evident despite provision of a well structured risk assessment form. Many important clinically relevant fields were not completed. It was gratifying to see that early warning scores had been acted upon appropriately. Not all medical entries were signed.

Maternity risk management strategy

The current version of the Maternity Risk Management Strategy (V1.0) was ratified in November 2012 and issued in January 2013. We were advised that this strategy was in place at the time of the SIs that have been reviewed. The previous strategy version V7 2011017 was dated January 2011.

The Strategy refers to cross-site Obstetric Risk Management and Labour Ward Leads. The document was apparently made available to all staff within the organisation, partner organisations and the public. Key objectives were to ensure that staff had an understanding of the risk management structure via mandatory training sessions and to encourage participation in the risk management process. Other objectives included undertaking audit of practice at three yearly intervals or six to nine months after a practice change, and regular review of the maternity service and labour ward dashboards.

There is no obvious convergence between the Trust's Risk Management Strategy and that for the maternity unit. Furthermore the existing Risk Management Strategy document (V1) is limited in what it provides with obvious gaps as listed below. As a document it is not user friendly and pre-dates obstetric working on a single site.

Root cause analyses

RCAs were generally of a satisfactory standard but hampered by the absence of forensic analysis typified by acceptance of statements without any interviews or meetings with the clinicians concerned where there were apparent conflicts between statements or when the clinical description of the sequence of events was not entirely credible. In addition there was a lack of clarity over outcomes following on from the conclusions reached as a result of the RCAs in relation to clinical governance. These outcomes should be clearly documented, monitored and developed, e.g. SUI 2013/10830. There was clear substandard care on behalf of the consultant and the registrar in this case but, in contrast to midwifery supervision, all that was noted was that the clinical director would have a conversation with the clinicians concerned. The outcome of this conversation or indeed whether this conversation ever took place has never been documented but should have been.

In addition there is a need to strengthen the responses to situations where good medical practice is potentially compromised, e.g. SUI 2012/20174 when the registrar's actions were entirely inappropriate as indeed were his subsequent comments. Under these circumstances there was no attempt to escalate concerns about this individual within the Trust itself and no mechanism to ensure that there was accountability for the responses to this inappropriate clinical behaviour.

Furthermore it became apparent to us that whereas a number of cases involved locum staff there appeared to be a tendency to apportion inappropriate blame on the locum/junior staff in comparison to situations where similar criticisms could be made of the more senior staff in substantive posts.

Daily Datix reporting meetings

The daily Datix reporting meetings appear to be extremely successful and reflect good practice. It would probably be helpful to attempt to involve the neonatal team in these daily meetings.

Service management and clinical decision making

The evidence from the clinical risk assessment highlights serious service delivery issues with significant risk to patient safety. It is acknowledged that these are the drivers for the change in service configuration within the service. However, a robust operational plan to address these issues within the new structure needs to be developed and implementation will require effective clinical and managerial leadership.

The operational plan should include a knowledge and skills review that ensures that at all locations within the maternity and neonatal services care is being provided by staff that are appropriately skilled to deliver safe and effective patient care.

It is clear that the Senior Management Team has trust in the obstetric team and the introduction of a management rota for the maternity unit has been a good move forward. There remain issues with paediatric clinical staff where two clinicians are currently restricted in their clinical work. It is noted that a review team from the RCPCH is providing advice on these issues.

There should be an identified Labour Ward Midwifery Manager Lead rather than a system of rotating the Band 7 coordinators. This will allow for accountability and continuity of responsibility in respect of clinical risk and day to day management of the unit.

Consultant presence on the labour ward involves a system of signing in and out, with which there is limited compliance. Trainees have reported that their supervision on the labour ward tends to amount to consolidation of skills rather than learning, raising the need for a greater degree of direct supervision by the labour ward consultant than is currently provided. There is a need to ensure progress is made in this respect to avoid the risk of poor practice.

Routine auditing of case notes has not been taking place on a regular basis and this should be reintroduced in order to maintain standards and reduce risk.

There would appear to be some additional work in terms of the understanding and implementation of existing guidelines.

RECOMMENDATIONS

Risk Management Strategy

The reviewers had sight of individual pages from a revised draft version of the strategy (V2) but before this is published we recommend the following:

- a) The Risk Management Strategy should be targeted beyond the Maternity Department itself.
- b) Titles are not necessarily appropriate and roles and responsibilities need to be clearly defined.
- c) There need to be references to guidelines, risk management coordination processes and responsibility for Root Cause Analyses.
- d) There should be separate sections on incident reporting, serious incidents and links to the Trust Risk Management Board.
- e) There should be references to the Maternity Dashboard, mechanisms for minimising risk and future risk management planning.
- f) There should be evidence of compliance monitoring and audit and hyperlinks to related documents.
- g) There are no references and there is a need to include links to external bodies.
- h) It seems unclear to us why there are separate lists relating to the type of incidents to be reported and we recommend that these are put together under one heading rather than for instance a separate supervisory list.
- i) The manner in which incidents are categorised should be reviewed with emphasis on breaking down incidents relating to antenatal, labour and postnatal care. This is especially important given the marked increase in incidents reported even prior to single site working. The increase in reporting has continued thereafter and the reasons for this should be explored and clarified.
- j) Root Cause Analyses should be more 'forensic' with detailed interviews with key members of staff corroborating the written information.
- k) Root Cause Analyses should have ownership and be dated appropriately with adequate evidence of closure of the process.

Service management and clinical decision making

- a) In keeping with previous recommendations, routine random audit of case notes should be regularly performed and viewed as an essential component of good practice.
- b) The merger provides the opportunity to ensure that the service provided at each of the locations is supported by staff with appropriate knowledge and skills. This will require a comprehensive review of staff numbers, knowledge and skills.
- c) Delivery of the recent service changes will require strong and effective clinical leadership and a review of service management structures should be considered.
- d) Continuing professional development of all clinical staff should focus on the deficiencies in service delivery highlighted in the reviews of the serious untoward incidents, for example, escalation of levels of care, interpretation of CTGs, record keeping, supervision of junior/locum clinical staff and neonatal resuscitation.
- e) There should be an identified Labour Ward Midwifery Manager Lead rather than a system of rotating the band 7 coordinators. This will allow for accountability and continuity of responsibility in respect of clinical risk and day to day management of the unit.
- f) The consultant presence and role within the labour ward requires consolidation. There is a need for clarity in respect of the role of the consultant, more robust monitoring of consultant presence and specific guidance as to when consultants should be supervising trainees directly.
- g) It is unusual for a hospital with over 3000 deliveries per annum to provide only Level 1 neonatal intensive care and the option of the neonatal unit operating as a Level 2 Unit should be achievable working in collaboration with a tertiary centre.

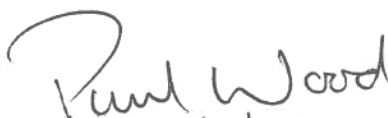
CONCLUSION

The interim arrangements for obstetric and neonatal services at the Conquest Hospital have had positive outcomes for clinical governance and these should be monitored and developed. The Trust appears to be generally risk averse and there is much to build on. Our recommendations will hopefully provide clear guidance on mechanisms to strengthen risk management and clinical governance. Working on one site since 7 May 2013 has resulted in increased opportunities for senior staff, improving the workforce, increasing the resilience of middle grade staff and increasing the workload and as a result staff appear to be happier, more confident and feel better supported. As a result the hospital is seen as a more attractive place to work and hopefully this will improve recruitment of both junior and senior staff. There is an incidental benefit of an enormous potential for reducing the numbers of staff in middle grade posts and potentially expanding consultant numbers to increase labour ward presence, supervision and training.

We note that the changes since the interim arrangements have been mainly operational and there is now an opportunity to consolidate governance arrangements.

Mr Paul L Wood

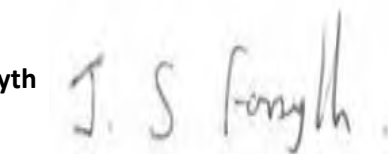
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Mr Andrea Galimberti


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Date: 10/9/2013

Professor Stewart Forsyth

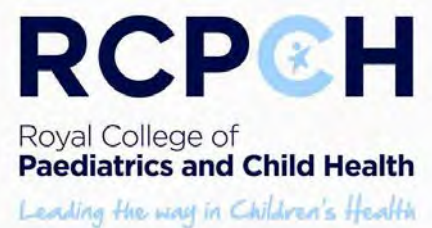

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Date: 4 September 2013

RCPCH Invited Reviews Programme

Service Review

East Sussex Healthcare NHS Trust

November 2013



RCPCH Invited Reviews Programme
November 2013

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Contents	Page
1 Introduction	3
2 Terms of Reference	3
3 Background Information	4
4 Context of the Review	5
5 Analysis of the Operational Policy	7
6 Summary and Recommendations	13
7 Conclusion	17

Appendix 1	Information sources and reference documents
Appendix 2	List of abbreviations

1 Introduction

1.1 The RCPCH was approached in June 2013 by Dr Andrew Slater, Joint Medical Director to conduct an invited review following reconfiguration of the paediatric service. This report provides an independent critique of the arrangements, and specifically the Operational Policy, against agreed terms of reference, based upon information provided to the reviewers and evidence gathered through a one-day site visit. .

1.2 The services are considered against published policy and standards documentation from the RCPCH and other professional bodies, where these are available, together with the objective workforce and service design experience of two senior reviewers representing the views of the College.

1.3 The report is the property of East Sussex Healthcare NHS Trust through the medical director. It remains confidential between the Trust and those appointed by the RCPCH to produce the report unless there are serious concerns that justify the RCPCH sharing it directly with regulatory authorities. This would in any case be discussed beforehand with the Trust.

1.4 The RCPCH encourages wider dissemination of this review report amongst those involved in the service but the RCPCH will not itself publish or comment on review reports without the permission and agreement of the review client.

2 Terms of reference

The RCPCH invited reviews team will conduct a review of the above service including studying advance materials, interviews with key individuals and a visit to the site(s) in question. This will follow the process set out in the “RCPCH Guide to Invited Reviews” dated April 2013 and include:

a) Consideration of safety concerns raised about the service following the recent reconfiguration with specific reference to emergency attendance and the ambulatory care model,

b) This will include

- Assessment of compliance with national guidance and standards for care and treatment of children and young people
- Referral pathways and links between paediatric services on the two acute sites (Eastbourne District General Hospital and the Conquest Hospital Hastings) and other acute services
- Information sharing and links with primary care and community services
- Staffing and workforce arrangements
- Child protection arrangements
- Involvement and patient feedback
- Clinical governance including accountabilities and quality improvement
- Benchmarking of services with equivalents elsewhere where possible and highlighting good practice

c) To make recommendations for the consideration of the Medical Director of the Trust as to: -

- Whether there is a basis for concern about the service in light of the findings of the review.
- Possible courses of action which may be taken to address any specific areas of concern which have been identified.
- Suggested indicators and approaches to inform and implement any changes to the short term transitional arrangements.

Note: This review will refer to and build on the Invited Review conducted by RCPCH across the Trust and published June 2012

3 Background Information

3.1 The acute paediatric service was until May 2013 configured across the two main hospital sites, namely Eastbourne DGH and the Conquest Hospital, Hastings which are 20.8 miles apart (40 minutes by car, 1hr 30mins by public transport)¹. Each site included a 15 bed paediatric inpatient ward, a 6-bed ambulatory care/ assessment unit and a Special Care neonatal unit. The service was funded for 5 consultant acute paediatricians supported by 8 Tier 2 paediatric posts at each site plus 7 Tier 1 doctors at Eastbourne and 8 at Hastings.

3.2 Further to the RCPCH report in 2012, there had continued to be difficulties with staffing of the middle grade posts – there are three vacancies and three doctors are not yet able to fulfil all the duties of the post and at times up to 50% of shifts are covered by locum doctors. Only two posts at Hastings are training grade, one being based in the community.

3.3 Since the merger of the two hospitals into one trust 10 years ago, the Trust has struggled to combine the paediatric teams as one service across the sites despite joint management and governance at senior level. The clinical lead is

¹ Source: Transport Direct - showing peak daytime journey

allocated 2PAs for the role; he is based in Hastings and works with the general manager to lead and support the medical staff across both sites.

3.4 The Trust is included within the pan-Sussex children and maternity commissioning review “Sussex Together” initiated by the Strategic Health Authority (SHA) in 2011. Clinical Commissioning Groups are developing their proposals for the future provision of Maternity and Paediatric services. This is likely to involve significant service change and therefore formal public consultation which is expected to take place in January 2014..

3.5 Neighbouring acute units include the Royal Alexandra Children’s Hospital (part of Brighton Hospitals NHS Trust) which is 23 miles (36 minutes) to the west of Eastbourne DGH and provides specialist paediatric services including NICU and paediatric critical care. The new Pembury Hospital in Tunbridge Wells (part of Maidstone and Tunbridge Wells NHSFT) is 25 miles (38 minutes) from Hastings.

3.6 Activity and admissions were similar across both sites prior to the reconfiguration. Total admissions for all paediatric specialties including trauma and ENT averaged around 2,400 per year at Eastbourne and around 2,000 at Hastings, around 50% of these stay overnight and around 95% are non-elective or emergency. 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 RCPCH reviewed the service in spring 2012 there were concerns that activity numbers and the level of demand appeared to be insufficient to support two inpatient and neonatal units and enable doctors to maintain their skills.

3.7 Eastbourne DGH has a small day surgery unit covering ENT and general surgery. There are no specialist paediatric anaesthetists although a small group of anaesthetists conduct most of the procedures on children. Outpatient surgical clinics are also hosted on the site for Brighton doctors.

3.8 The Friston ward on the first floor of the Eastbourne comprises a purpose built 16-bedded ward, plus four consulting rooms for Children’s outpatients and community child health services within a bright and spacious environment. Safeguarding Non-accidental injury reviews can take place either on Friston or at the Scott Unit for community paediatrics on a floor below on the hospital site. CSA medicals can take place on Friston and the unit functions as a paediatric SARC. At the Conquest Hospital, Kipling ward provides a purpose built 21 bedded unit which is in the process of being expanded to 28 beds to meet the increased demand of the single sited service.

3.9 There is a consultant community paediatric team based at each of the two trust hospital sites, with onsite cover from 8-6 weekdays supported by the community paediatric nursing team. A community neonatal nurse practitioner who supports parents with babies discharged from Special Care is being considered as a service development. The team is developing an epilepsy service and has already established a diabetes service across the sites, benefitting from the Best Practice tariff. There is also one day per week CAMHS input.

4 Context of the review

4.1 Longstanding concerns about the safety and staffing of the maternity service across the two sites, together with a review in January 2013 by the National Clinical Advisory Team (NCAT) led to the Trust Board agreeing in March 2013 to consolidate obstetric and neonatal services onto the Hastings site, with a midwife-led unit remaining at Eastbourne. This was implemented in May as a temporary measure on safety grounds following a discussion with key stake holders including the Commissioners and HOSC but without formal consultation.

4.2 At the same time reconfiguration of the paediatric service was proposed to create a single inpatient ward and expanded special care neonatal service at Hastings and a 12-hour short-stay paediatric assessment unit (SSPAU) at Eastbourne. The plans included integration of the paediatric medical staffing, with cross-site working and specifically the on-call rota for the extended Hastings service including consultants from the Eastbourne team. There had been no specific safety-related incidents in paediatrics, but long standing difficulties in filling middle grade posts, increased neonatal activity at Hastings and compliance with the 'Facing the Future' standards were cited as the basis for including acute paediatrics alongside the changes to SCBU and maternity.

4.3 The reconfiguration of both services has been announced as a temporary solution with an expected duration of around 18 months, during which time analysis of the viability of the arrangements, exploration of alternative options and a public consultation on a permanent arrangement could be carried out. This requires the contracts and facilities to remain reversible until that is complete.

4.4 The move has largely been supported by the obstetric and midwifery teams, who were found by CQC to be much happier working in the new configuration, and the Paediatricians based at the Conquest site. However those paediatricians, based on the Eastbourne site have remained consistently unhappy with the arrangement. Concerns have been raised with the medical director who leads in this area and the Eastbourne consultant paediatricians presented management with a 10-point list of safety concerns about the new arrangements but these proved difficult to evidence and quantify in order to resolve them.

4.5 The Consultants have continued to raise concerns internally and externally, including to local politicians, regulators and the media, The Care Quality Commission discussed the issues with the doctors when it conducted an unannounced visit to the obstetric and paediatric services at both sites in June 2013 but did not uphold the concerns and the Medical Directors are confident the arrangement is fit for purpose pending a wider review and consultation towards permanency.

4.6 The RCPCH was invited to visit as an independent external source to examine the safety and viability of the model, benchmark the service against similar models and national standards and provide an opinion on the longer term arrangements.

4.7 In parallel with the RCPCH's involvement, all 3 local CCG's (Eastbourne, Hailsham and Seaford, Lewis Havens and High Wield, Hastings and Rother) have commenced the development of proposals for the future provision of maternity

and paediatric services, including 'the case for change' and a set of locally-defined standards, against which a self-assessment has been carried out by four units, including Brighton and the Princess Royal in Haywards Heath.

5 Analysis of the Current Service

5.1 Overview and compliance with national guidance and standards

5.1.1 Since 7th May 2013, the Friston inpatient ward at Eastbourne has changed to a 15-bed SSPAU, open from 9am to 9pm weekdays and 10-6pm at weekends and bank holidays. Consultant cover is available weekdays from 9-5pm with middle grade cover and consultant on-call availability to 9pm and at weekends and bank holidays. This does not meet the requirement² for consultant presence at times of peak activity which were stated to be 6pm to midnight. Nursing staff commence at 7am weekdays to welcome day case and surgery patients and there are at least two nurses available throughout the day to 9.30pm. Last weekday admission is 7pm (4pm weekends). During the SSPAU opening hours, agreed GP referrals may be brought by ambulance, and on rare occasions where a child deteriorates, emergency resuscitation and stabilisation may be carried out at Eastbourne. The review team were told that nurses on the ward are proactive and will seek out consultants if needed although several nurses are trained to carry out cannulation, immunisation and glucose monitoring.

5.1.2 The SSPAU at Eastbourne is currently located on the old children's ward and is not co-located with ED but the feasibility of co-location prior to the outcome of a public consultation on the future configuration of paediatric services is being considered.

5.1.3 The Eastbourne Emergency Department (ED) sees around 50,000 patients per year, with around 17% of them children. There is a small visually and audiologically separate waiting area, but this is cramped and in effect a corridor space. There is a dedicated cubicle in the minors area and separate paediatric and neonatal bays on the 6-bed resuscitation area. All children are seen by an Emergency Nurse Practitioner (ENP) and either referred to the Friston SSPAU when it is open or to the middle grade paediatrician if medical advice is required out of hours. Pain scores and pain management is audited regularly and usually benchmarks as good.

5.1.4 There are no paediatric-trained consultant emergency physicians and just two of the ED nursing staff are children-trained. Since the change to paediatric inpatient arrangements, senior medical cover is no longer available from the paediatric team after 9pm and paediatric emergencies are wherever possible diverted to neighbouring acute hospitals in Hastings, Pembury or Brighton. For those sick children brought in to ED out of hours, a middle grade short-term paediatric post had been established by the ED team. This role was designed as a six-month post to work alongside ED staff to manage paediatric demand out of hours as the new arrangements bedded in and also provide on-job training,

² Facing the Future standard 6

supervision and confidence building in children's emergency care to existing ED staff.

5.1.5 In practice a considerable amount of the out of hours activity by ED nurses and doctors is spent dealing with adults and members of the ED staff cannot always be present when the paediatrician is reviewing a child. This post is being filled by a series of locum doctors, and has not worked effectively as a source of training. The six months were complete in August but there is a commitment to continue this role for up to 18 months.

5.1.6 Since implementation of the new arrangements, activity has not notably reduced and in July there were 770 attendances by children and young people aged under 16. Of these 23 arrived by ambulance, 31 were admitted and 24 transferred to another hospital. The peak period for paediatric emergency and urgent attendance is between 6pm and midnight which does not align to the opening hours of the SSPAU, however paediatric expertise remains on site in the form of a paediatric middle grade doctor in ED out of hours with support from the on-call consultant. Despite publicity through schools and other public media there has been a small increase in parents bringing children in by car and some concerns were expressed that the GP Out of Hours service (IC24) was not fully fluent with the arrangements.

5.1.7 There have been no serious incidents since the reconfiguration. Paediatricians feel however that they do not 'own' the Operational Policy and raised concerns about high dependency transfer, cover for maternity, safeguarding / SUDI process and support for ED out of hours.

5.1.8 Amongst concerns raised by the Eastbourne paediatricians included the absence of resuscitation equipment except ambibags on the midwife led birthing unit. The lead midwife however confirmed that the unit operated as a stand alone MLU with operational policies that did not include an expectation for the paediatricians to attend in the event of an emergency even when the SSPAU open and they would themselves commence basic life-support and call for emergency support via a 999 call. Appendix 3 of the Standards for the Care of Critically Ill Children³ (Paediatric Intensive Care Society, 2004) lists the resuscitation equipment required in such facilities.

5.1.9 Throughout the review and report sections below reference has been made to relevant national and professional standards for the care of children and young people. The specific standards cited are detailed in Appendix 1

5.2 Referral pathways and links with the Hastings site and other acute services

5.2.1 Three of the Eastbourne paediatricians provide daytime Consultant of the Week cover at Hastings (two others are on restricted duties) and Hastings paediatricians also cover the Friston SSPAU on a rota basis with an aim of full joint working across the sites.

³ See http://www.ukpics.org.uk/documents/PICS_standards.pdf

5.2.2 The Review Team did not visit the Conquest hospital site in Hastings. Concerns were however raised about the ability of Eastbourne-based consultants to attend the Conquest at Hastings within 30 minutes when on call out of hours due to travelling distance. This particularly related to new-born care and the CNST minimum requirement for availability⁴ but there was no data or analysis available to the Review Team that indicated the intensity of the on-call duty. The Trust has made available hospital-based on-call rooms or hotel accommodation for consultants on call who have a greater travelling distance but this does not confer resident status to the shifts. Despite the reduction in on-call commitment due to more consultants on the single rota, more negotiation is required for the short term arrangement to be workable.

5.2.3 The focus of the Operational Policy and changes made were to transfer all out of hours or complex paediatric urgent and emergency attendances to Hastings but it is likely that a proportion attending Eastbourne would be more conveniently (for them) be redirected to Brighton Hospital subject to parental choice. It was not clear that this alternative which would benefit the patient experience had been considered.

5.3 Information sharing and links with primary care and community services

5.3.1 The community children's nursing team is based within the Trust but aligned with the community paediatric service. Increasingly in other organisations the role of community children's nursing (and in some areas GPs) is extended to minimise attendance at ED, particularly by those with long term conditions, and there is an opportunity within the current consultation to explore similar development of this service,

5.3.2 Some work has been proposed to upskill primary care to be able to improve initial assessment and refer appropriately, particular out of hours.

5.4 Staffing, training and workforce arrangements

5.4.1 There are only two children-trained nurses within the ED establishment at Eastbourne and only 4 at the Hastings site. The intercollegiate guidance requires at least one children trained nurse to be available at all times that children may attend, which would require at least six nurses at each site for one to be present on every shift. All ED staff are trained in Paediatric Immediate Life-Support (PILS) and around 50-60% are EPLS with all middle grades being APLS certified. Three nurses are undergoing Sick Child training in September and all ENPs have completed the paediatric module. A useful chart detailing the training required for ED and anaesthetic consultants can be found in Appendix 5 of the PICS standards.

⁴ Reference NHSLA CNST Maternity standards page 133 Standard 5 criterion 2

a. The maternity service has [approved documentation](#) for newborn life support, which as a minimum must include....c) deliveries to be attended by a clinician (doctors, advanced neonatal nurse practitioner, midwives) with [newborn life support skills](#)

5.4.2 The nursing team from Friston Ward have struggled to adapt to the changed arrangements of rotating across the two sites but although there was some difficulty integrating initially the teams are now starting to work well together with action learning sets for the matrons and improved communication.

Six Generic Skills

These skills can reasonably be expected of all personnel involved with the care of acutely or critically sick or injured ill children in the DGH

- To recognise the critically sick or injured child
- To initiate appropriate immediate treatment
- To work as part of a team
- To maintain and enhance skills
- To be aware of issues around safeguarding children and
- To communicate effectively with children and carers

Ref: The acutely or critically sick or injured child in the DGH – a team response

5.4.3 Nursing leadership is developing and staff feel listened to by the Chief Nurse, There is more to be done in terms of integration and team working, for example the matrons consider themselves to be responsible for a ward rather than being the lead or 'champion' for children across either of the sites. The clinical service manager is however encouraging wider thinking. The Trust clinical strategy aims among other plans to extend the community nursing team and employ more Advanced Nurse Practitioners (ANP) for ED and the SSPAU as well as nurse specialist's for the community, e.g. epilepsy nurse specialist. There is enthusiasm to develop extended role nurse-led clinics for review work and more follow-ups in patients' homes.

5.4.4 There are no ACNPs at present and no arrangements for SSPAU staff and ACNPs to rotate through the emergency service. In the short term a paediatric nurse rotation could be established between ED and the SSPAU in Eastbourne with, perhaps inclusion of the Kipling ward at Hastings. There are plans now to rotate SSPAU staff though the ED with ED staff also rotating to SSPAU.

5.4.5 Trainees are currently rostered across both sites to ensure benefit from all educational opportunities, and providing a single site for the IP service has enabled the middle grade rota to be fully and consistently staffed.

5.5 Child protection arrangements

5.5.1 There are three named nurses across the Trust – one each West and East for the community with a third covering the hospital sites. The named doctor only overs the Eastbourne site and there are concerns that the medical safeguarding roles are not working effectively together.

5.5.2 Staff are all trained to Level 2 or 3 depending on their role, and there is a liaison health visitor at each hospital site. Concerns were raised with the Review Team about the availability of medical staff to carry out statutory functions following child deaths, and the consequences of children and young

people from Eastbourne being diverted to Hastings which was 'out of area' in terms of liaison with social services.

5.6 Involvement and patient feedback

5.6.1 There is limited engagement with young people or families to seek feedback and involve them in designing improvements to the service although the Trust-wide Meridian service was reported to be in operation to gather views and feedback. The PREM tool developed by the RCPCH and partners was not in place and leaflets and posters were mainly aimed at young children and not attractive for adolescents. Adolescent care was however reported to be good at Hastings hospital although this location was not visited as part of the review.

5.6.2 Brighton has some examples of good patient leaflet and information (e.g. head Injury)

5.7 Clinical governance

Medical Management

5.7.1 The review team consider that the trust has serious problems with the management of its medical staff at Eastbourne and swift, visible action is required to restore the confidence and enthusiasm of other staff. There are some team and behaviour issues that have been internally and externally identified (including in a review by Edgecombe in January 2012) yet have not been effectively dealt with over several years. There is a risk of these issues provoking long term unhappiness and insecurity amongst the rest of the consultant body. This is also likely to affect all other staff groups.

5.7.2 The operating policy and changes to the service appear to have been imposed on the consultant body too swiftly with a failure to engage them fully in the rationale and consideration of the operational feasibility. There were reported difficulties with consultant attendance at the strategic meetings which were often convened at relatively short notice. It is acknowledged that SCBU had to move at the same time as maternity services and that the organisation made a decision to move inpatient paediatric services at the same time due to a lack of confidence in the sustainability of the middle grade workforce, the need to provide a consistent high quality service and the need for clear communication to the public. However in retrospect moving inpatient paediatrics could have been considered separately from obstetrics and SCBU and more time taken to iron out the issues with the acute paediatric personnel given the historical difficulties in managing change.

5.7.3 Although implementation of the agreed changes was managed through a programme approach this was run internally by the Trust's Programme Management Office. Given the long history of difficult relationships across and between the sites, it would have been prudent to have had an externally recruited project manager to oversee communications and full stakeholder engagement and ensure decision making and timescales are rational and adhered to. However it is acknowledged that the trust had to make decisions within a short timescale due to the pressing safety issues within the obstetric service.

5.7.4 Although the review team did find a number of areas where the Operating Policy needs strengthening these did not directly correlate to the concerns raised by the consultants at Eastbourne. The Review Team felt that some clinicians were expressing considerable discomfort about the changes to working practice and that this must be recognised in order to move forward; consultants need to be reassured and supported to move across to this new model but also recognise the expectations of the organisation and medical management in terms of their behaviours and activity.

The Operational Policy

5.7.5 The Operational Policy governs the procedures and arrangements for managing paediatric attendances, primarily at Eastbourne. It was developed using equivalents from neighbouring trusts such as Maidstone and Tunbridge Wells and Haywards Heath and although the ambulance service and other external stakeholders were involved, and the managers 'took time to ensure a safe solution' the review team heard that some paediatricians within the service did not feel engaged with the process or the need for such urgency in agreeing a way forward. Whilst there was general agreement about the benefit operationally of running paediatric inpatients from a single site, the doctors reported that whilst they had been invited to some of the meetings their clinical timetables and short notice made it impossible for many of them to attend and there appeared to be no other mechanisms or for a for discussion and understanding of the new policies.

5.7.7 The operational policy marked 'final 7th May' was reviewed by Dr Ryan Watkins (a Brighton neonatologist and clinical director for the Maternity, Newborn, Children and Young People Strategic Clinical Network, Kent/Surrey and Sussex) against the RCPCH Intercollegiate standards shortly after implementation and a number of recommendations were made which have not been formally implemented, apparently pending the RCPCH visit. These points address many of the concerns picked up by the RCPCH during the visit and feedback and indeed could be built on to fulfil guidance such as the Tanner report⁵.

5.7.8 The operational policy covers The Women and Children's Division, but due to the service delivery model it relies very heavily on the ED department in Eastbourne identifying and managing sick children when the assessment unit is closed. This should therefore also be covered in the strengthened operational policy to include issues over staff training, policies and procedures. The RCPCH identified issues at both sites with the level of staffing, particularly children's trained staff and the lack of additional training to try and counteract this.

5.7.9 There are differences in standards and procedures between the two acute sites, for example in staff training and competencies and the policy for medical assessment and treatment of babies under one year. Information management is poor at Eastbourne and the informatics system is inadequate. The trust is implementing SystmOne for the community but this will not be operational for at least a year.

⁵ The sick and injured child at the DGH – a team response DH 2009

5.7.5 The paediatricians at the Eastbourne site, together with some of the nursing and support staff, had proposed an alternative model of a 23hr 'rolling' SSPAU at the Eastbourne site to more fully support ED and address, in their opinion, the 'five key safety concerns' with the current model. The status of this proposal was unclear; the RCPCH would not usually support such a model but it is important that such proposals are properly considered by management as part of genuine engagement with the clinicians involved.

5.8 Benchmarking of services with equivalents elsewhere where possible and highlighting good practice

5.8.1 The Review Team did not see hard data such as clinical audit, critical incident, mortality information and were not offered examples of good practice other than a comment that there had been a Best Practice initiative that had secured additional funding for diabetes care in children

5.8.2 The arrangements that have been put in place are similar to reconfigurations that are being planned or implemented around the country. Each setting is different in its approach but most changes are triggered by difficulty in recruitment of middle grade doctors and compliance with the standards set out in 'Facing the Future'. Some equivalent models are further advanced than East Sussex, particularly the 'making it better' redesign project in Manchester where Salford operates with a single SSPAU supporting ED without inpatients.

6 Summary and Recommendations

6.1 The Review Team is aware that the current arrangement is temporary in terms of paediatric services, and, building on the June 2012 review, considers that restoration of an inpatient unit is not appropriate or sustainable.

6.2 The opportunity being taken by the CCG and 'Sussex Together' programme to design a networked model of service that would be best for children, unbounded by constraints of the Trust's own facilities is positive, but in the meantime the Trust must prioritise strengthening the Eastbourne ED's paediatric expertise in line with the Tanner report and other standards for urgent care and SSPAUs and agree shared policies and procedures within the Operating Policy.

6.3 It is important during the temporary phase that staff on both sites continue to develop their competencies in assessing and treating children and young people and that trainees are offered an appropriately rich experience. Current concerns about lack of training opportunities and the provision of cover on the Eastbourne site are counterbalanced with the higher quality of training experienced on a fuller inpatient ward at Hastings, and the potential to enhance the roles and experience of nursing staff should be recognised and exploited.

6.4 The unit at Eastbourne relies quite heavily upon senior paediatric trainees. In terms of "future proofing" the RCPCH has two concerns with this arrangement. The first is that trainee numbers will be reduced in the fairly near future leaving the model unsustainable in the longer term and the second that this activity is inappropriate for paediatric trainees if they are spending a considerable amount

of their time in working in a relatively quiet SSPAU; this may not be viewed as positive placement in terms of their training experience.

6.5 The Review Team believes that implementing the recommendations below will enable the provision of an appropriately safer service for infants, children and young people at the Trust's two sites. However this will not be safer unless there is engagement and buy-in from the consultant body. They must be led effectively and encouraged to contribute their professional judgement and expertise to developing policies and risk assessments on the basis of hard evidence and data about the service and activity levels.

6.6 The following recommendations reflect information detailed in the sections above together with conclusions and priorities identified in the CQC report and other correspondence available to the review team.

Recommendations

Short Term

- a) Establish a formal mechanism for review of the operational policy and address the areas identified below including the recommendations made by Dr Ryan Watkins by e-mail on 10th May 2013 and specific amendments communicated by the RCPCH shortly after the visit. It is important to fully involve the paediatricians as long as there is an agreement to cooperation at the outset and a very clear and tight deadline.
- b) Take positive steps to tackle the longstanding difficulties within the paediatric consultant team and the relationship with senior Trust management. It is suggested that professional, independent external advice is engaged swiftly to facilitate restoration of a positive working environment and tackle issues around behaviours and communication.
- c) Assess the current arrangements against the 'Tanner' report and the PICU standards relating to the model of 'some children's services but no onsite inpatient facility' to provide assurance that the service at Eastbourne is safe round the clock for children. For example for transfer of children from Eastbourne requiring inpatient care for whom there is a risk of requiring resuscitation including airway support. (PICS⁶ standards B1 and B2).
- d) Consider appointment of an 'independent' project manager to oversee the continued implementation and monitoring of the new operational arrangements.
- e) Recruit / commit to develop up to four further children-trained nurses to cover ED at Eastbourne (and consider requirements at Hastings to meet the standard for presence in ED), perhaps using existing nurses from SSPAU and/or Hastings inpatient wards on a rotation.
- f) Ensure there is at least one APLS-trained nurse or doctor on each shift in ED and that staff are familiar with spotting the sick child⁷. This is not happening as

⁶ Paediatric Intensive Care Society http://www.ukpics.org.uk/documents/PICS_standards.pdf

⁷ See Department of Health DVD *Spotting the Sick Child* available from <https://www.spottingthesickchild.com>

intended through the middle grade doctor so specific training should be arranged for ED staff, including anaesthetists⁸ until the team has gained paediatric skills and is confident that the locum is no longer needed. Regular team moulages led by the resuscitation team should be implemented to allow all professionals to practise their skills and working together.

f) Identify clinical champions for children throughout the Trust- these could be the ward managers/matrons. There should also be an identified executive lead for children and young people and a non-executive lead. Many hospitals have established a Children and Young People's board chaired by an executive which enables strategic and operational cross-trust issues around children's and young people's services to be discussed appropriately.

g) Review current communications and develop further clarification to ensure staff, parents, GPs and young people know what conditions the Eastbourne site does and does not assess and treat. .

h) Ensure policies and procedures are agreed and implemented on a Trust-wide basis – for example using NICE guidelines including patient leaflets and implementation tools, and the policy for treating Under 1 year olds in ED.

i) Continue to invest in community children's nursing to allow development of a comprehensive children's community nursing team that can be available for extended hours 7 days a week and deal both with specialist conditions and support acute care by supporting early discharge and admission

j) Agree an immediate course of action between the local unit and transport team to manage the occasional child who is unsafe to transfer but does not require intubation and ventilation. This may mean keeping the child in ED for observation until a safe plan can be made which may require a children's nurse to stay on site.

k) Agree arrangements for a consultant to attend a child death. The RCPCH notes that attempts were made to instigate 2 on-call rotas whilst issues were addressed but this did not prove viable as there are a number of consultants not participating in the on-call rota.

l) Increase evening consultant presence during the opening hours of the SSPAU and at least part of the day at weekends to help with decision making and ensure more patients are discharged and transfers are appropriate and safe.

m) Review urgently the availability of resident or on-call consultant paediatric expertise local to the Hastings site, including for new-borns to ensure compliance with National and RCPCH standards. This will have a short and long term solution as workforce is expanded or renewed and will depend on the final configuration of paediatric services as determined by the public consultation.

Longer term

n) Consider alternative models for the SSPAU with the consultants and commissioners as part of the work on the future of maternity and paediatric

⁸ See PICS standards appendix 5

services– the RCPCH have concerns that the activity may be insufficient for the proposed 23hour unit to be a feasible option but discussion about indicators and rationale for alternative should take place with those who will be operating them.

o) Consider moving the assessment and observation unit adjacent to ED to enable sharing of paediatric skills and staffing. This would be best practice to be considered for both sites.

p) Review medical and nursing workforce and consider the need for adjustments based on the future configuration of the service and published standards⁹ to enable consultant presence at both sites during peak periods of activity and development of extended roles of nursing staff to include children's advanced nurse practitioners and children's emergency nurse practitioners.

7 Conclusion

The review team would like to thank all staff for contributing helpfully and openly to the review, and it is encouraging that the Trust has openly requested the RCPCH to assist in resolving some of the differences of views between paediatricians and senior managers. We hope that this provides an opportunity to move forwards and ensure the continued safe care of children

The operational policy will only be fully effective if health professionals understand, support, and most importantly, comply with it. We do not underestimate the challenge of new ways of working but shared, open engagement in development and agreement of standards alongside adherence to contractual obligations is important for all involved to ensure that the team is providing the safest and most effective care in all situations.

This independent review and critique of the proposed model of paediatric services was commissioned by the Medical Director of East Sussex Hospitals NHS Trust. It was carried out by Dr Edward Wozniak FRCPH and Dr Melanie Clements FRCPH with additional Quality Assurance input and verification from Dr Stephanie Smith and Dr David Shortland, members of the RCPCH Invited Review panel.

It satisfies the terms of reference set out in section 2 above and we hope provides useful information and rationale for future decisions by the partners over the structure and design of paediatric services in East Sussex

⁹ See Facing the Future (RCPCH, 2011)

Appendix 1 Information sources and reference documents

A1.1 The following standards are referenced in the review

Intercollegiate Standards for care of CYP in emergency care settings (RCPCH 2012) covers staffing, training, facilities, communications and interfaces set out in a clear style and agreed by all professional colleges involved with urgent and emergency care.

Good medical Practice (GMC 2013) sets out the principles and values on which good practice is founded; which together describe medical professionalism in action.

The acutely or critically sick or injured child in the district general hospital – a team response (DH and intercollegiate 2006 – “Tanner report”) details issues around anaesthesia and other services available. It has 42 clear service and competence recommendations and provides a clear checklist when reviewing urgent care services.

Short Stay Paediatric Assessment Units advice for commissioners and providers (RCPCH 2009) sets out models for provision of observation and assessment facilities to complement emergency care and reduce pressure on inpatient services.

Guidance on the role of the consultant paediatrician in the acute general hospital (RCPCH May 2009) offers models of paediatric care including consultant of the week, resident on call and includes information on job planning, rotation and competencies for acute care

Standards for the Care of Critically Ill Children (Paediatric Intensive Care Society, 2010) sets out measurable standards for care from arrival at hospital ED through reception, assessment, inpatient, HDU/ITU and general care across services. Sections on anaesthesia, retrieval and transfer complete the pack

Appendix of guidance to the Standards for care for Critically Ill Children (Paediatric Intensive care Society, 2010) supports the standards with checklists and tools to enable clinicians and managers to establish effective arrangements are in place. These include details of knowledge and skills required, guidance on resuscitation training, referral information, and support for families.

Children and Young People Assessment Service Standards (EoESHA 2012) Developed locally by the SHA to support a peer review programme these achievable standards are based on operational practicality and set out with indicators and examples to demonstrate compliance.

Maternity Clinical Risk Management Standards 2011/2 (NHSLA/CNST 2011) define the thresholds for achievement of assessed levels of risk management and consequently reduced premiums payable to CNST. These standards are currently not being updated pending review of the NHSLA function and approach but provide a basis for assessment of safety and risk reduction.

A1.2 The following staff were interviewed as part of the review

Interviewee	Role & Responsibility
Dr Jamal Zaidi	Divisional Director – Integrated Care
Dr David Hughes	Joint Medical Director Clinical Governance
Richard Sunley	Chief Operating Officer
Paula Smith	Acting Associate Director Women’s & Children’s
Dr Maggi Wearmouth	Consultant Paediatrician
Dr Graham Whincup	Consultant Paediatrician
Dr Keith Brent	Consultant Paediatrician
Dr Tracy Ward	Consultant Paediatrician
Dr Geeta Gopalkrishnam	Consultant Paediatrician
Dr Imad Boles	Consultant Paediatrician
Dr Padmani De Silva	Consultant Paediatrician
Dr Nadia Muhi-Iddin	Consultant Paediatrician
Dr Sarah Hall	Emergency Medicine Consultant
Liz Vaughn	Ward Matron, Friston Ward EDGH
Lindsey Stevens	Consultant Midwife
Caroline Stephenson	Ward Matron, Kipling Ward CQ
Stephanie Kennett	Non-Executive Director
Amanda Philpott	Accountable Officer (Interim), Eastbourne, Hailsham and Seaford CCG/COO, Eastbourne, Hailsham and Seaford and Hastings & Rother CCGs
Martin Writer	Head of Quality, EHS & H & R CCGs
Jo Thomas	Chair, Eastbourne, Hailsham & Seaford CCG
Anne Singer	General Manager CYP Services – Integrated Care
Christine Craven	Deputy Director of Nursing
David Fox-Dossett	Senior Charge Nurse, ED

A1.3 Documents were provided by the Trust relating to the following areas:

Minutes of meetings including
Trust Board seminar 23rd February, Public meeting 8th March
Operational Policy
Activity records and reports
CQC visit reports

Appendix 2 – List of Abbreviations

ADHD – Attention Deficit Hyperactivity Disorder
ANP – Advanced Nurse Practitioner
ASD – Autistic Spectrum Disorder
CCG – Clinical Commissioning Group
CDOP – Child Death Overview Panel
CYP – Children and Young People
ED – Emergency Department
EDGH – Eastbourne District General Hospital
ENP – Emergency Nurse Practitioner
GP – General Practitioner
SHA – Strategic Health Authority

East Sussex Healthcare NHS Trust

THE Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans. November 2013

RAG Rating:

All recommendations completed – no further action	
Some recommendations completed - further action required	
Few recommendations completed – action required	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Review of the Risk Management Strategy.	Risk management strategy in place; met with CNST approval at Level 2 assessment in 2013.	Roles and responsibilities need to be clearly defined. Needs to be referenced to guidelines; risk management co-ordination processes and responsibilities for Root Cause Analysis.	A Watt	L Stevens & P Smith	Re-drafted risk management strategy	End February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		Need to separate sections on incident reporting; serious incidents and links to the Trust Risk Management committee. Should be references to the maternity dashboard; mechanisms for minimizing risk and future risk management planning. Should be evidence of compliance monitoring and audit and hyperlinks related to documents.					

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		References need to be included. Lists of incidents need to be put together under one heading rather than separate lists. Needs to be reviewed to ensure it is user friendly. Ensure maternity risk management strategy is linked to Trust's risk management strategy.					
Review the incident categorisation within the maternity Risk Management	Risk management strategy in place; met with CNST approval at Level 2 assessment in 2013.	Break incidents into categories relating to antenatal; labour; and postnatal care.	A Watt	L Stevens & P Smith	Re-drafted risk management strategy	End February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Strategy		The reasons for increase in incidents should be explored and clarified.					
Root Cause Analysis needs to be more forensic.	RCAs carried out in line with Trust policy.	There is currently a Trust wide review of how RCAs are undertaken to ensure consistent processes across all areas. To include introducing a process of undertaking interviews with key members of staff involved to corroborate their written statements.	A Watt & Emily Keeble	L Stevens & P Smith & A Webster	Re-drafted risk management strategy	End February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		Need to ensure robust processes to evidence closure after a Root Cause Analysis is completed.					
Case note audits to be carried out	Monthly audit of 40 (random) case notes undertaken	Ensure random case note audit is undertaken and presented to the multi-professional team	D Pascall	M Nair – Audit lead	Presented at audit meetings to the multi professional team with documented learning points	In progress by February 2014	
		Introduction of an annual Supervisor of Midwives random audit of 100 sets of notes			Presented to Supervisors of Midwives; senior midwives; at consultant meetings and audit	By April 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
					meeting		
To ensure staff have appropriate knowledge and skills.	Staff undertake annual Trust mandatory training and annual mandatory obstetric related study days to include management of obstetric emergencies. Attendance is monitored by the practice development midwife and kept on an comprehensive Training Needs Analysis (TNA). Data also maintained within	Ensure a comprehensive review of staff numbers, knowledge and skills via the TNA to include medical staff. Ensure this references and reviews work being undertaken nationally regarding appropriate workforce numbers.	D Pascall; L Steven s & G Clarke	P Smith	Workforce numbers as agreed with HR Knowledge in accordance with grade – appraisal for consultants and specialty doctors/ e portfolio for trainees Knowledge for midwifery by ongoing assessment of clinical	Baseline – April 2014/ then ongoing assessment	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	the Trust's Electronic Staff Records (ESR)				knowledge and skills using a clinical competency framework via supervision; line management and peer review Skills – Mandatory training		
Ensure appropriate service management.	Currently have a management structure for Women's health but this has not been reviewed since the temporary reconfiguration of	Undertake a review of service management structures to ensure strong and effective clinical leadership – the Trust will commence a programme of	Senior Trust managers	HR	Appropriate management structure in place	End April 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	services	organisational structure review in April 2014. Continue to support clinical leaders via the clinical leaders forum that commences in 2014.					
Continuing Professional Development (CPD) for all clinical staff should focus on deficiencies in service delivery.	Skills training in relation to interpretation of CTGs; record keeping; neonatal resuscitation is offered within the mandatory obstetric study days that staff are required to attend annually Learning through complaints; incidents and SIs		D Pascall; L Steven s G Clarke & A Watt	P Smith	Mandatory training / Remedial training as necessary	Baseline by March 2014 then rolling	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	is taken forward on a one to one basis with individuals as appropriate.	the governance team on an add hoc basis this needs to be formalised with attendance at sessions mandatory					
Accountability and continuity of responsibility in respect of clinical risk and day-to-day management by a Band 7.	Every shift (day and night) is supported by a band 7	Advert out to appoint an identified labour band 7 lead rather than rely on a system of rotating the Band 7 co-coordinators.	C O'Callaghan	L Stevens	Appointment of band 7 matron as labour ward lead	End January 2014	
Consolidation of consultant presence on labour ward.	The role of the consultant on labour ward has been clearly clarified and consolidated since the temporary reconfiguration Consultants' are	Robust monitoring of consultant presence on labour ward needs to continue.	D Pascall	All consultants	Continued robust evidence of consultant availability by use of 'consultant daily sign in' on labour ward	Ongoing	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	required to sign in x3 times daily to monitor labour ward presence	Further audit of presence of consultant on labour ward through the maternity documentation audit – audit to ask the question 'did the consultant see the woman' (applicable to high risk women only)	L Steven s & A Watt	Supervisors of midwives	Evidence in maternity records of consultant presence and involvement in care of the high risk women	Commence in the March Supervisor of midwife audit	
Supervision of trainees.	72 hour labour ward cover allows appropriate support and supervision of trainees. There needs to be specific guidance as to when consultants	Continued monitoring	D Pascall	All consultants	Completion of recommended assessments	In place	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	should be supervising trainees that is shared with the whole multi-disciplinary team.						
Review the level at which the SCBU is functioning at.	Currently level 1	Work in collaboration with a tertiary centre to review if SCBU should be a Level 2. This will require discussions with commissioners and the network as to the service that they wish to commission and is required by the network locally.	P Smith & F Edmunds	L Stevens	Report from tertiary centre	June 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Ensure staff are trained in statement writing	There is a Trust wide review of how statements are written to ensure consistent processes across all areas. This will include a robust process to ensure statements are consistent in terms of format and presentation.	Training to continue Monitor attendance at training	C Howath A Watt & E Keeble	P Smith & L Stevens & A Webster	Improved statement writing by all staff	By April 2014	
Neonatal presence at daily incident reviews.	Paediatricians and SCBU staff are invited to join the daily incident review meetings.	Monitor attendance to ensure there is always a paediatrician available for any incident that involves a poor outcome for a neonate	D Pascall	S Mansy	Attendance log	January 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
All staff to have a understanding of current guidelines.	A variety of systems in place to ensure that staff are aware of guidelines, that they understand these and can implement them	Monitor current process and ensure staff have a good working knowledge of guidelines	G Clarke & D Pascall as this require s Drs to be cognisa nt of these as well	L Stevens & J Crowe & C O'Callaghan	Evidence of understanding at appraisals; SOM reviews Improvement in management of care and decrease in dataix/ changes in trends of incidents	ongoing	

East Sussex Healthcare NHS Trust

THE RCPCH ESHT Service Review Recommendations Action Plans

November 2013

RAG Rating:

All recommendations completed – no further action	
Some recommendations completed - further action required	
Few recommendations completed – action required	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Establish a formal mechanism for review of the operational policy.	Policy is being revised to reflect the comments made. A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes	Address the areas identified in the report including the recommendations made by Dr Ryan Watkins. Agree and ratify policy	Anne Singer/ Andy Slater	Jane Sumner. Salah Mansy Fran Edmunds	Policy ratified	Jan 31 st 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Take positive steps to tackle the longstanding difficulties within the paediatric Consultant team and the relationship with senior Trust management.	New Clinical Lead has been recruited who is not an integral member of the paediatric Clinical Unit. He has identified a Paediatric Consultant to act as operational lead for the day to day management of the service	Commitment by the Consultant body to engage in these actions; groups and meetings	Andy Slater/ Anne Singer	Salah Mansy	Regular attendance and contribution at the Consultant meetings where majority decisions are made and then adhered to by whole consultant body.	Ongoing	
	A monthly cross site face to face Consultant meeting has been set up There are three paediatric taskforce groups overseen by an external facilitator - Acute, Community and Long Term Conditions.						

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Assess the current arrangements against the 'Tanner' report and the PICU standards	Ensure all areas of non compliance are addressed Policy is being revised to reflect the comments made A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes.	Agree and ratify policy	Anne Singer/ Andy Slater	Salah Mansy	Policy ratified	Jan 31 st 2014	
Consider appointment of an 'independent' project manager to oversee the continued implementation and monitoring of the new operational arrangements.	Since the new management structure was implemented this has facilitated majority decisions within the paediatric unit	No action required	N/A	N/A	N/A	N/A	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Recruit / commit to develop up to four further children-trained nurses to cover the Emergency Department at the non acute site	Nurses have always been seconded from the Emergency department to undertake their paediatric training This will be a rolling programme	There needs to be Internal rotation of nurses between the SSPAU and the ED	Sarah Wilmer/ Fran Edmunds	Jenny Darwood	Successful recruitment Sufficient paediatric trained nurses available in ED.	ongoing	
Ensure there is at least one APLS-trained nurse or doctor on each shift in the ED who are familiar with spotting the sick child.	It is mandatory for all nurses to undertake annual basic life support training	Specific training should be arranged for the ED staff, including anaesthetists until the team has gained paediatric skills and there is confidence that the locum is no longer needed.	Paul Cornelius/ Utham Shanker/ S Wilmer	Jenny Darwood	Successful training of staff in paediatric settings	ongoing	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
	Nurses from the ED are routinely offered APLs training	There needs to be a rolling programme until all ED nurses have completed APLs			A rolling plan is in place to maintain training		
Identify clinical champions for children within the Trust	Within the Paediatric clinical unit the clinical services manager/ HoN is the link between paediatric and ED Services and there are ED/Paediatric meetings held regularly on both sites.	Clinical champions need to be identified at executive and non executive level	The Trust Board need to identify the leads	Andy Slater	Confirmation of Board leads	April 2014	
There should also be an identified executive lead for children and young people		Consider establishing a Children and Young People's board chaired by an executive					

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		lead to enable strategic and operational cross-trust issues.					
Review current communications and develop further clarification to ensure staff, parents, GPs and young people know what conditions the Eastbourne site does and does not assess and treat.	Policy is being revised to reflect the comments made. A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes	Once ratified the operational policy needs to be widely distributed across partner agencies to clarify the model for East Sussex	Andy Slater	Anne Singer, Fran Edmunds, Jane Sumner, Salah Mansy	Operational policy distributed and also available on the GP intranets	February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Ensure policies and procedures are agreed and implemented on a Trust-wide basis for treating Under 1 year olds in ED.	All policies currently in place have been distributed to their authors for review.	The operational lead will be responsible for ensuring that the policies have been updated and reviewed appropriately to meet Trust policy. CU considering a Policy review sub group	Salah Mansy	Andy Slater Fran Edmunds	All policies updated, reviewed and archived when appropriate	March 2014	
Continue to invest in community children's nursing to allow development of a comprehensive children's community nursing team that can be available	The current strategy developed by the CCGs in conjunction with representatives from Pan Sussex services features the development of community children's services	Work needs to continue across the clinical network to discuss the future model of children's acute and community service Pan Sussex.	Commissioners/ Fran Edmunds	Andy Slater/ Anne Singer/ Jane Sumner	Development of a 7 day community service	ongoing	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
for extended hours 7 days a week							
Agree an immediate course of action between the local unit and transport team to manage the occasional child who is unsafe to transfer but does not require intubation and ventilation.	On occasions a child may need to be kept in ED for observation until a safe plan can be made which may require a children's nurse to stay on site Policy is being revised to reflect the comments made. A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes	Agree and ratify policy	Anne Singer/ Andy Slater/ Paul Cornelius/ Utham Shanker/ SECAMB	Salah Mansy	Ratified policy	February 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Agree arrangements for a consultant to attend a child death.	Currently there is a middle grade paediatric doctor working in ED when the SSPAU is closed. Policy is being revised to reflect the comments made. A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes	To consider developing a community on call rota	Andy Slater	Salah Mansy	Ratified policy and introduction of an on call rota	April 2014	
Increase evening consultant presence during the opening hours of the SSPAU and at least part of the day at weekends to help with	Currently there is an on-call Consultant for the SSPAU during opening hours	Need to assess requirements for consultant presence	Andy Slater	Anne Singer/	Children are assessed; discharged or transferred appropriately	April 2014	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
decision making and ensure more patients are discharged and transfers are appropriate and safe.							
To urgently review the availability of on-call consultant paediatric expertise to the acute unit to ensure we are compliant with national standards that suggest 24-hour availability of a consultant paediatrician (or equivalent non-consultant career-grade doctor)	ESHT are compliant with this as they have resident trained middle grade doctors 24/7.	No further action required	N/A	N/A	N/s	N/A	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
trained and assessed as competent in advanced neonatal life support, who can attend within 30 minutes”.							
Consider alternative models for the SSPAU with the consultants and commissioners as part of the work on the future of maternity and paediatric services.	The CCGs have announced their proposals for the future model of acute paediatrics across Sussex which has gone out for public consultation in January 2014	No further action for the Trust	N/A	N/A	N/A	N/A	

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Consider relocation of the SSPAU to be adjacent to the ED on the non acute site.	The CCGs have announced their proposals for the future model of acute paediatrics across Sussex which has gone out for public consultation in January 2014.	No further action for the Trust until outcome of consultation	N/A	N/A	N/A	N/A	

Evidence from the Clinical Commissioning Groups (CCGs)

Better Beginnings

Proposals for the future of NHS maternity, in-patient children's services and emergency gynaecology in East Sussex



**Have
your say**

January 14 to
April 8 2014

Public consultation

*Give us your views on the future of health
services for local women and children*

Foreword

As local GPs, we feel passionate about providing the best possible NHS care for women and children. Local people deserve services that are safe and high quality.

Most of the women and children using maternity and in-patient paediatric services in East Sussex receive excellent care from dedicated nurses, midwives and doctors.

But we need to do much better. In many areas we have been failing to meet local and national standards for safety and quality.

This consultation document presents six options for the future of maternity, in-patient paediatric and emergency gynaecology services in East Sussex to ensure they can be provided in a safe and high-quality way in the long term.

Why we need to change

Over recent years it has become more and more difficult to maintain high standards of safety and quality in our local hospitals, particularly in consultant-led maternity services. Too many women and children have been placed at risk of serious harm in childbirth. That has to change.

Since 2008, the NHS locally has worked hard and invested more money to keep consultant-led maternity services in both Eastbourne and Hastings. We have seen some improvements but have not seen safe, high quality services delivered consistently.

This consultation has developed from an in-depth clinical study of all maternity and paediatric services across Sussex, which identified an urgent need to improve safety and quality in East Sussex.

We are not unique. Many other smaller maternity and paediatric services across the country are facing the same challenges.

In May 2013, East Sussex Healthcare NHS Trust (ESHT) temporarily located all consultant-led maternity services and in-patient paediatrics to the Conquest Hospital, Hastings, in response to a trend of worrying safety problems.

We agreed that this temporary arrangement would need to be properly reviewed with ESHT, local partners, patients and the wider community to develop and agree a safe and high-quality long-term solution.

In this document, we describe six options for providing these services across hospital sites at Eastbourne, Hastings and Crowborough. The options have been developed by leading local GPs in partnership with hospital clinicians and informed by widespread public engagement.

All other documentation referred to in this consultation is available on our website www.betterbeginnings-nhs.net. Paper copies can also be requested. See page 39 for details.



What are we consulting on?

All of the options include:

- A consultant-led maternity unit in East Sussex
- Two midwife-led birthing units in East Sussex
- An in-patient paediatric ward in East Sussex
- A short-stay paediatric assessment unit at both Eastbourne and Hastings
- An emergency gynaecology service on a single site in East Sussex.

The main difference from the services as they were provided before the temporary changes is that the options do not include the provision of consultant-led maternity and in-patient paediatric services on two hospital sites.

There is a wide range of clinical evidence that has led clinicians in East Sussex to conclude that we cannot maintain safe consultant-led maternity services on two small sites. We cannot move forward with options that we do not believe are safe.

Have your say

Please read the options carefully (page 24 onwards). These six options are the only ones we believe can ensure the high standards in safety and quality we expect as local GPs.

We want to know what you think. This is an opportunity for us to work together to reshape your local NHS maternity, in-patient paediatric and emergency gynaecology services to ensure safe and high quality care for the future wellbeing of women, babies and children.

What are CCGs?

- Clinical Commissioning Groups are new NHS bodies, led by local GPs, which since April 2013 have been responsible for planning and buying the majority of local health services. There are three CCGs in East Sussex:
- Eastbourne, Hailsham and Seaford CCG
- Hastings and Rother CCG
- High Weald Lewes Havens CCG



Dr Martin Writer

Eastbourne GP

Chair of Eastbourne,
Hailsham and Seaford CCG



Dr Roger Elias

Bexhill GP

Chair of Hastings and
Rother CCG



Dr Elizabeth Gill

Buxted GP

Chair of High Weald Lewes
Havens CCG



Which services are being considered for change?

This consultation relates to maternity and in-patient paediatric services in East Sussex provided at our local hospital sites before the temporary changes made in May 2013, plus emergency gynaecology.

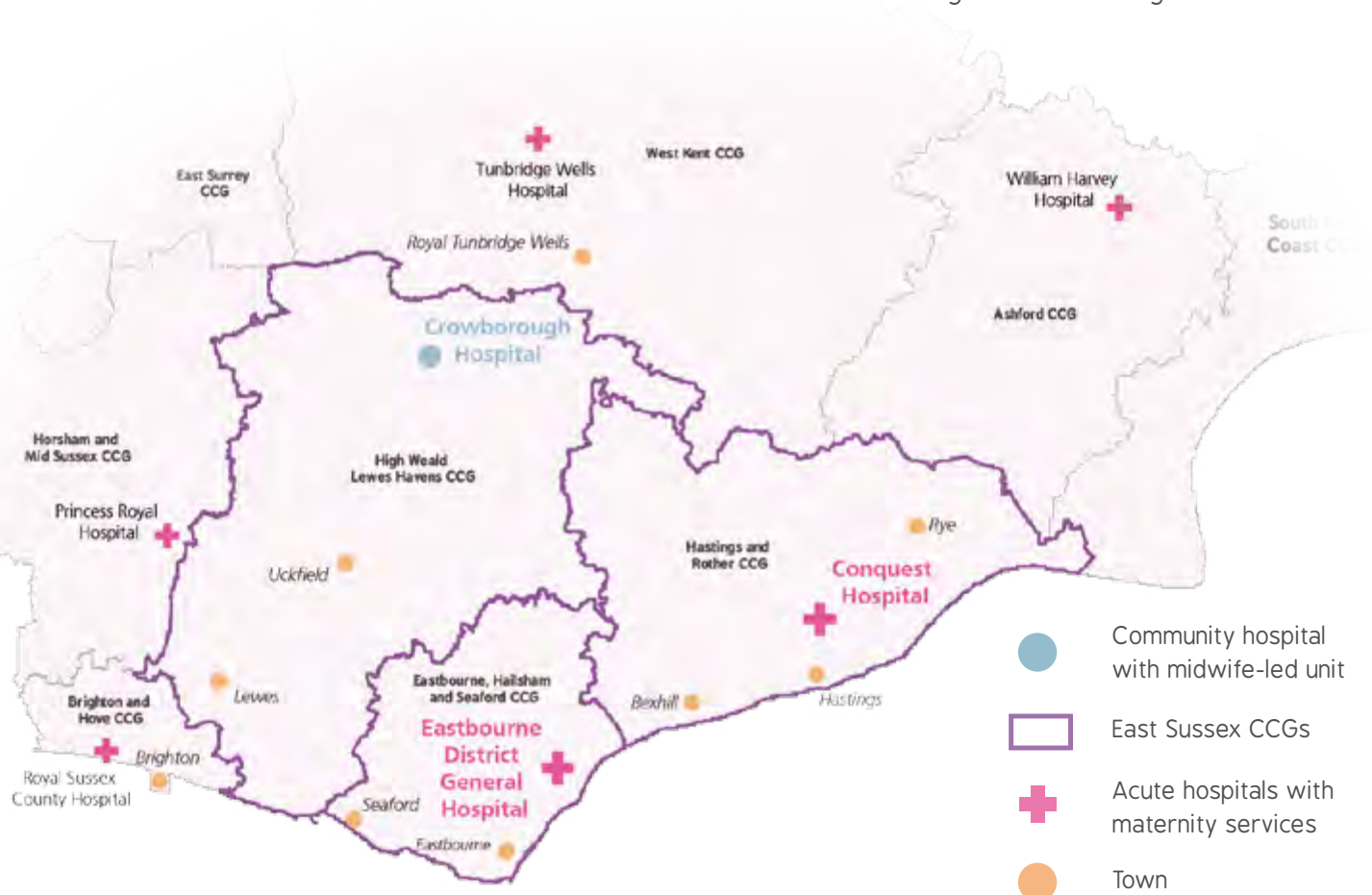
For maternity services, we are considering birthing services offered at Eastbourne District General Hospital (DGH), the Conquest Hospital, Hastings and Crowborough War Memorial Hospital.

For paediatrics we are considering in-patient children's services provided at EDGH and the Conquest Hospital.

For gynaecology we are considering only emergency gynaecology provided at the Eastbourne DGH and the Conquest Hospital. We are not considering other gynaecology services such as outpatients and planned in-patient surgery.

What were the temporary changes?

In May 2013 East Sussex Healthcare NHS Trust (ESHT) made temporary changes to maternity and paediatric services at the Eastbourne DGH and Conquest Hospital on the grounds of safety. Services at Crowborough were not changed.





Under the temporary changes, both main hospital sites continued to provide the following services:

MATERNITY	PAEDIATRICS	GYNACOELOGY
Day assessment unit, antenatal clinic, ultrasound, early pregnancy unit	Outpatients, day surgery	In-patient beds, outpatients, in-patients elective surgery, low risk day surgery

The following table shows which of the services were temporarily changed in May 2013:

CURRENT	Eastbourne DGH		CONQUEST	
	Pre 7 May 2013	From 7 May 2013	Pre 7 May 2013	From 7 May 2013
MATERNITY				
Consultant-led (obstetric) care	✓	✗	✓	✓
Freestanding Midwifery Led Unit	✗	✓	✗	✗
PAEDIATRICS				
Paediatric in-patient beds	✓ 15 beds	✗	✓ 15 beds	✓ 21 beds (28 max)
Short stay paediatric assessment unit	✓	✓	✓	✓
Special Care Baby Unit	✓	✗	✓	✓
GYNACOELOGY				
Emergency gynaecology surgery	✓	✗	✓	✓

Numbers of people using these services:

	Eastbourne DGH	CONQUEST	CROWBOROUGH
Births 2012/13	1973	1865	253
Paediatric emergency in-patient admissions for East Sussex children 2012/13	3048	2843	NA *
Emergency gynaecology in-patient admissions for East Sussex women 2012/13	458	516	NA *

* not applicable



Description of services

Consultant-led maternity service (obstetrics)

Consultant-led services are staffed by doctors (obstetricians) and midwives in a hospital environment and provide care to women who require more specialist support to give birth. They are supported by doctors specialising in pain relief (anaesthetists) and care of babies (neonatologists /paediatricians).

Obstetricians are able to provide care for women who have medical conditions or pregnancy-related problems that place them at a higher risk of experiencing complications that need medical supervision or intervention.

Specialist support available in consultant-led units includes:

- Interventions such as caesarean section and induced labour
- Epidural pain relief
- Forceps and vacuum-assisted (ventouse) birth if needed
- Special care for sick babies.

Special care baby unit

All maternity units have responsibility for the safe care of new born babies. Babies who require continuing support after birth will be looked after in a special care unit at a hospital site. Staff who work in these units have additional skills to provide expert care for babies.

Midwife-led unit

Midwife-led units (MLUs) are maternity units where care is provided by midwives.

They offer care to women with a straightforward pregnancy who are at low risk of developing complications.

Midwife-led units can be in a community setting (known as a 'freestanding unit') or on the same site as a hospital providing obstetric services (known as an "alongside" unit). There is no difference in the service provided by an alongside unit in a hospital setting or a freestanding unit in the community. If a woman during labour needs obstetric care, they will be transferred from the midwife unit to a consultant-led unit.

Debbie Gowers

Midwifery Matron,
Crowborough
Birthing Centre

"Midwife-led units provide a home from home environment and are offered as an alternative place of birth for low risk women. They offer the woman continuity and one-to-one care throughout their pregnancy, birth and postnatal period.

"A major benefit of midwife-led units is that women feel in control of their birthing experience. Midwife-led units' breastfeeding rates are outstanding, intervention rates are much lower than in an obstetric unit and staff and client satisfaction is high."





Short stay paediatric assessment unit (SSPAU)

A SSPAU is staffed by paediatric doctors and nurses who assess and treat children who have been referred to a paediatrician by a GP or through A&E.

In the vast majority of cases children can be assessed, treated and allowed to go home without an overnight stay. Those children with more complex medical needs who need to stay overnight will be transferred to an in-patient paediatric unit.

Liz Vaughan: Paediatric matron, East Sussex Healthcare NHS Trust

"The modern philosophy in children's nursing is to minimise the time a child spends in hospital. Short stay paediatric assessment units allow us time to assess a child's needs, treat them and if possible, get them home again to sleep in their own beds which is good for the child, their parents and the rest of the family."



In-patient paediatric unit

These are resourced and equipped to look after children who are very ill and need to stay in hospital overnight or longer.

Children admitted for emergencies and who are likely to require overnight care would typically be taken directly to an in-patient unit, or transferred from an SSPAU.

Emergency gynaecology

The emergency care of problems occurring in the female genital tract. It also includes treatment for problems occurring in early pregnancy such as miscarriage and ectopic pregnancy.



Why we need to change

Background

The challenge to provide consistently safe and high quality maternity services in East Sussex has a long and complex history.

Problems recruiting and retaining staff to maintain these services across our local hospital sites date back at least ten years.

In 2007, local NHS bodies proposed to address these problems by reconfiguring consultant-led maternity, newborn and in-patient gynaecology services. Following public consultation, a decision was made to situate these services at the Conquest Hospital, Hastings.

This decision was overturned by the Secretary of State in 2008. A body called the Independent Review Panel made recommendations about how these services should be provided in the county.

An extra £3.1 million was invested per year over and above normal and a number of service improvements were made by East Sussex Healthcare NHS Trust as a result.

As a result of this:

- More doctors and midwives were recruited
- Early pregnancy services were established and women were given direct access to midwives
- Training for medical staff was improved
- Assessment and treatment of maternal mental health was improved.

Despite these and other achievements, concerns about the safety of these services remained, mainly because there have been ongoing difficulties recruiting and retaining enough medical staff.

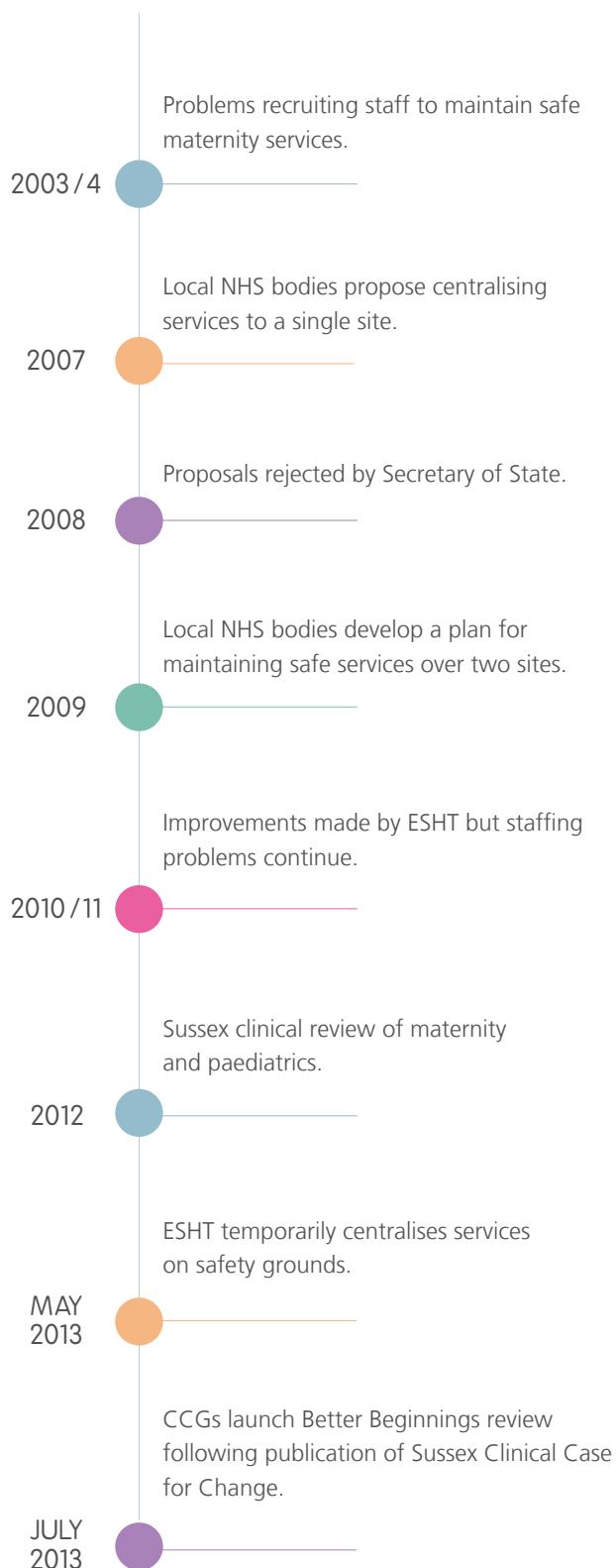
In 2012 clinicians from NHS organisations across the whole of Sussex began a year-long study of maternity and children's services to look at the continuing problems.

This resulted in the publication in July 2013 of the **Sussex Clinical Case for Change** for maternity and paediatric services and the launch in East Sussex of the **Better Beginnings** review.

The **Sussex Clinical Case for Change** can be read at our website www.betterbeginnings-nhs.net.



TIMELINE



Case study

Tracey Jenner, from St Leonards, gave birth to baby Aiden at Eastbourne midwife-led unit just before 5am on Wednesday 31 July 2013. Aiden weighed 7lbs 7ozs.

Tracey said: "With this being our first baby, I wanted to give birth somewhere that had a homely feel where the experience could be as relaxing as possible. We came to have a look round the unit beforehand and I just felt it would be the perfect place for me to give birth.

"For me, travelling for the birth just wasn't a problem and I'm so glad that I was able to come here. It has been lovely. I would recommend it to anybody."

Husband David added: "I would sum up our experience on the unit by saying we've felt like guests here, not just a patient and her husband."





The evidence

The **Sussex Clinical Case for Change** confirmed that consultant-led maternity units in East Sussex were having particular difficulties meeting agreed standards and had major challenges maintaining patient safety and quality of care.

The main problems were:

Size

The **Sussex Clinical Case for Change** indicates that consultant-led units with annual birth rates of less than 2,500 faced particular challenges in maintaining safety and quality. Birth rates at both the Conquest Hospital and EDGH were significantly below this. Birth rates in East Sussex are projected to fall over the next ten years.

Staffing

There are significant national and local problems in recruiting and retaining obstetric doctors and midwives. Across the UK, many maternity units are struggling to recruit medical staff. This is particularly hard in smaller units, such as ours, as most medical staff wish to work at large busy units where they will increase their skills and assist in more births.

In East Sussex there were particular problems maintaining staffing levels in two consultant-led (obstetric) units.

This has had a major impact on the ability to provide a safe and high quality service. Doctors and midwives in smaller units do not see enough volume and range of births to maintain their skills.

The low number of births at the two smaller consultant-led units in East Sussex made it very difficult to attract trainees. There was widespread use of temporary staff who were not familiar with the way things work in our local hospitals.

4,000-5,000

The optimum number of annual births in East Sussex at a consultant-led unit.

Less than 2,500

The annual birth rate at which units may have challenges maintaining safety and quality.

1,865

Number of births at Conquest Hospital in 2012/13.

1,973

Number of births at EDGH in 2012/13.



MYTH

East Sussex Healthcare NHS Trust has not tried hard enough to maintain these services.



FACT

There has been huge effort and investment to maintain these services over the years, but despite this, the safety of mothers and babies has remained at risk.



Case study

Danielle Ward, from Battle, gave birth to baby Isla at Eastbourne midwife-led unit on Sunday 18 August 2013. Isla is Danielle and husband Rob's first baby and weighed 7lbs 5ozs.

Danielle said: "I really wanted to be able to use the birthing pool during labour, and I also wanted Rob to be able to stay with me throughout, which was why we went to the midwife-led unit.

"The journey took us half an hour and for me it was worth it for the benefits of the midwife-led unit. The care we had throughout was second to none - just brilliant. The food was nice and it was a big plus to have our own private room after Isla had been born."

Husband Rob added: "We were treated like royalty. We really couldn't have asked for better care."



MYTH

This is all about saving money.



FACT

Better Beginnings is about improving the safety and quality of services for local women, babies and children and is not financially driven.



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

– National Clinical Advisory Team, January 2013

Risks to women and babies

Although ESHT worked hard to maintain safe services, these issues continued to place women and children at risk in several areas:

- Too many **Serious Incidents**: ESHT had significantly more incidents resulting in death or serious harm to women or babies in maternity than any other Sussex hospital trust in 2012/13.
- Too many **Transfers**: ESHT had significantly more women transferred to another hospital out of area during labour than anywhere else in Sussex in 2012/13. Transfers usually occur if the unit does not have enough staff to provide the necessary care for the mother or child or if complications occur which cannot be managed at the hospital.
- High numbers of **Diverts**: The result of a divert is that women who phone to say they are in labour or have a planned admission are asked to go to another consultant-led or midwife-led unit within the same trust. The main reason for this locally was insufficient staffing.

In January 2013 an expert independent body called the National Clinical Advisory Team reviewed East Sussex maternity and paediatric services. The review recommended that consultant-led maternity and in-patient paediatric services should be located on one site for safety reasons.

Serious Incidents are those where the incident has resulted in death or permanent /serious harm to a mother or baby.

Serious Incidents	2012 /13
East Sussex Healthcare NHS Trust	17 out of 4091 births
Brighton and Sussex University Hospitals NHS Trust	5 out of 5761 births
Western Sussex Hospitals NHS Foundation Trust	4 out of 5624 births
Surrey and Sussex Healthcare NHS Trust	4 out of 4285 births

Transfers	2012 /13
Conquest Hospital, Hastings	12
Eastbourne DGH	25
Princess Royal Hospital, Haywards Heath	3
Royal Sussex County Hospital, Brighton	2
Worthing Hospital	4
Surrey and Sussex Healthcare NHS Trust	3

Source: Sussex Clinical Case for Change



What good maternity services look like *	Did we have this in East Sussex prior to May 2013?	
All labour wards should have the medical workforce required to ensure safe care for women.	ESHT had particular difficulties recruiting staff, leading to increasing use of temporary doctors and midwives.	
Units are able to ensure a ratio of one midwife to 30 births for hospital birthing services.	ESHT achieved this ratio in most months of 2012/13 but this was only made possible through reliance on temporary and/or agency staff.	
All women are to be provided with 1:1 care during established labour from a midwife, across all birth settings.	In 2012/13 this was achieved - In 86 per cent of cases at the Eastbourne DGH - In 88 per cent of cases at the Conquest - In 100 per cent of cases at Crowborough	
Women should be given a choice of where to give birth – at a consultant-led unit, a midwife-led unit or a home birth.	Yes. Women have always had a choice of giving birth at home, a midwife-led unit or an obstetric unit. However prior to May 2013 there was only one midwife-led unit in the county (at Crowborough).	
Women and their families will be treated as individuals with dignity, kindness and respect.	Complaints received showed concerns about lack of information given to women and the attitude of the staff. Concerns were raised about the standard of care in both obstetrics and neonatology.	
There is a threshold of 2,500 births per year, below which consultant-led services should be scrutinised closely due to the additional challenges of maintaining safety and quality.	Both units had significantly fewer. - Eastbourne DGH: 1973 in 2012/13 - Conquest Hospital: 1865 in 2012/13	
The on-call consultant should attend in person in a number of high-risk situations eg: eclampsia, major bleeding and other serious complications.	Themes identified from serious safety incidents showed that the level of supervision provided to medical staff was not always adequate, which may have resulted in harm to babies at birth.	
Obstetric units should have a dedicated anaesthetist available on call 24 hours a day, 7 days a week to provide anaesthetic relief and assist in complex deliveries.	Responsibilities of anaesthetists on call were split between obstetrics and intensive treatment units. Relatively low birthing numbers on both sites meant ESHT could not maintain full-time on-call obstetric anaesthetic cover.	

* "Sussex Intrapartum Care Standards", July 2013. This can be found at www.betterbeginnings-nhs.net



The lack of senior paediatric doctors is so acute that the safety of treatment cannot be guaranteed at every unit.

– Dr Hilary Cass, Royal College of Paediatrics and Child Health (2011).

Why does the paediatric service need to change?

Whilst the **Sussex Clinical Case for Change** found that local paediatric services did not have the same degree of safety or quality concerns as maternity, it did highlight a number of challenges to address.

There is a national shortage of children's doctors, as highlighted in the Facing the Future report published by the Royal College of Paediatrics and Child Health (RCPCH) in 2011. In order to cope with these shortages, the (RCPCH) report says the NHS needs to make radical changes to ensure safety, including reducing the number of hospitals with in-patient children's wards.

Some of these pressures were beginning to be felt locally with two in-patient units prior to the temporary changes of May 2013. For instance, ESHT was reliant on temporary (locum) staff to maintain safe levels of staffing.

The full **Sussex Clinical Case for Change** can be read in full at the Better Beginnings website www.betterbeginnings-nhs.net.

In January 2013 an expert independent body called the National Clinical Advisory Team (NCAT) reviewed East Sussex maternity and paediatric services and recommended that in-patient paediatrics should be situated at the same location as consultant-led maternity services.

This is because there are critical links between consultant-led maternity services and paediatrics in respect of the care of sick babies.

Why does emergency gynaecology need to change?

The medical staff who provide emergency gynaecology services are normally the same as those providing consultant-led maternity services.

Bringing this service onto the same site as the consultant-led (obstetric) care will increase the amount of time that senior consultants are available on the ward. This increases the safety and quality of services. This change is only for emergency gynaecology. Planned surgery, daycase surgery and outpatient gynaecology services would continue to be provided on both sites.

Dr Salah Mansy :

Consultant paediatrician,
East Sussex Healthcare
NHS Trust

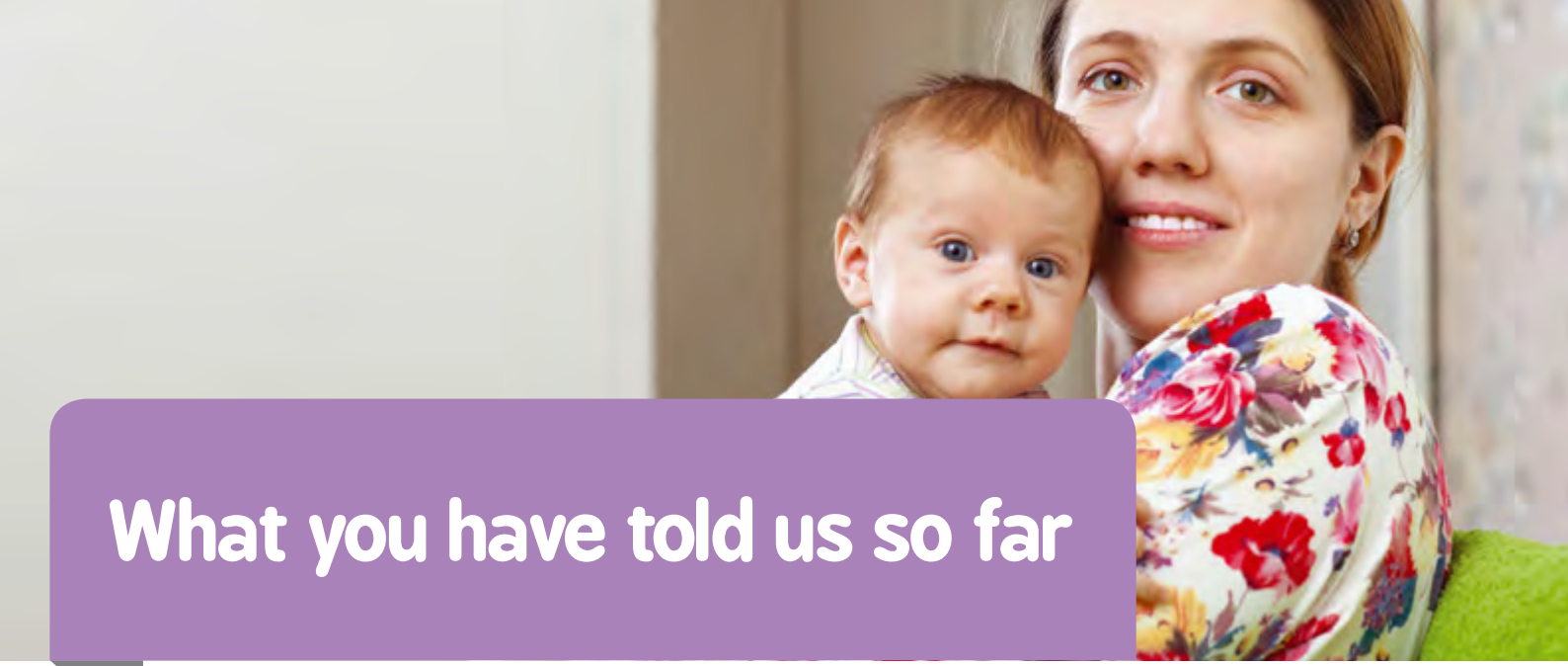
"The care of the newborn baby and the requirement for some babies to be admitted to the special care baby unit means that neonatal services have to be where the obstetric unit is. As a consequence of this, all the paediatric services need to be under the same roof because the doctors who care for the newborn babies also care for sick children who need to stay overnight in hospital. While some families may have to travel further it will improve the outcome for children and mean better quality care."





What good paediatric services look like *	Did we have this in East Sussex prior to May 2013?	
Children's clinical services should meet the Royal College of Paediatrics and Child Health (RCPCH) Facing the Future standards (2011). There are 10 standards mainly concerning the ability of consultants and other paediatric medical staff to respond directly or provide advice.	While ESHT met 9 out of the 10 standards, it could not always ensure a consultant paediatrician was on duty at peak times.	
Children's clinical services should meet the Standards for Children and Young People in Emergency Care, which are designed to improve the outcomes and experience of patients.	While ESHT met most standards, there were not always enough children's nurses to provide cover for shifts across two sites.	
All trusts providing children's surgery will meet the Royal College of Surgeons of England (2013) Standards. These aim to ensure children can receive surgery in safe, appropriate environments, as close to their homes as possible.	The trust was meeting most standards, however surgery was not always carried out by consultant surgeons and anaesthetists. The trust also needed to put in place an annual audit of the transfer of children from the inpatient ward.	
All trusts should meet national standards for the care of children with epilepsy.	ESHT met these standards.	
There should be clear protocols in place to support access to hospital care for children with complex care needs who are normally cared for at home.	These were in place at ESHT.	
Clear guidance should be developed and implemented for managing common childhood conditions and for long-term conditions.	Guidance was developed but not implemented in East Sussex.	

* "Sussex Intrapartum Care Standards", July 2013. This can be found at www.betterbeginnings-nhs.net



What you have told us so far

Since the beginning of the Better Beginnings review we have been speaking with local people, particularly current and recent users of maternity and paediatric services, to understand what local people across East Sussex want, need and expect from these services. Two reports that capture what we learned through focus groups, one-to-one interviews, individual patient case studies and an online survey can be found at www.betterbeginnings-nhs.net

	What you told us	What we're doing about it
Maternity	Women want a choice of midwife-led or consultant-led care during childbirth.	All our options include a balance of midwife and consultant-led care, enabling choice.
	Many women want a natural birth where possible.	We support natural birth and will continue to offer the choice of a home birth to low risk women as well as midwife-led units.
	Others who would choose a midwife-led birth also want the reassurance of consultant-led care.	Four of our options include consultant-led care on the same site as a midwife-led unit. Arrangements are in place to quickly and safely transfer women and babies to a consultant-led unit where necessary.
	Many women want to give birth at a stand-alone midwife-led unit.	All our options include two midwife-led units, at least one of which will be stand-alone.
	Many women want a midwife-led birthing facility in the north of the county.	Four of the options include a midwife-led unit at Crowborough.
	Women are concerned about travelling to the consultant-led unit and then being advised to go home because their labour is not far enough advanced.	We will ensure that under all of our options, women are able to stay at the hospital where appropriate, reducing the need for repeat journeys.
Paediatrics	People want to access paediatric care as close to home as possible.	All the options include short-stay paediatric assessment units (SSPAU) at both Eastbourne and Hastings.
	Parents would prefer to be discharged and take their child home rather than stay in hospital overnight, providing this is safe and appropriate.	We agree and believe that having a SSPAU on both sites will enable more children to go home on the same day unless they are very ill and require an overnight stay.



Concerns you raised about travel

	What you told us	What we're doing about it
Maternity	Women are concerned about the prospect of travelling from a midwife-led unit to an obstetric led unit during labour or immediately after childbirth.	We understand the anxieties that women have about travelling further to access consultant-led care. In a few cases women giving birth in a midwife-led unit may transfer during labour, due to complications or by choice. This is discussed with women and arrangements are in place to quickly and safely transfer women and babies to a consultant-led unit where necessary. Since the temporary changes in May 2013, no women have given birth in an ambulance during transfer. On average women give birth three hours after arrival following transfer.
Paediatrics	Parents have told us that they are concerned about how they might manage the challenges of additional travel with an in-patient unit on just one site.	It is normal for some children who are very ill to require transfer to an in-patient unit or another hospital out of area for specialist treatment. We want to ensure that children are only admitted as in-patients where necessary, so we are reviewing the opening hours of SSPAUs. This will allow more children to be treated and discharged on the same day.
General	Some people were concerned around the perceived risk of additional travel to access consultant-led maternity and in-patient paediatric care.	We have been carefully monitoring the safety of women and children using the services. Local and national evidence has shown us that it is safer to provide services on a single site; even if that means that some people will travel further.

We will continue to explore any impact of service changes throughout this consultation. Please use the survey attached to this document to give us your views. You can also complete the survey online at www.betterbeginnings-nhs.net.

In average driving conditions, a patient anywhere in East Sussex can reach an obstetric unit within 45 minutes. This journey can be even quicker by ambulance.

– South East Coast Ambulance Service, January 2014



How your feedback will continue to influence the design of these services

This section gives a flavour of what people told us during our initial engagement period in 2013.

We asked for suggestions on how we might make changes to services easier for people. We continue to welcome your feedback during consultation.

Among other things, you suggested:

- Have a system where women can be assessed locally to see if labour is sufficiently advanced to travel to the place of birth. This would avoid people being sent back home.
- If it is difficult to recruit staff to a unit with lower birth rates, or in a coastal location, then do something to attract trainees and consultants. Maybe create a fertility clinic or a teaching unit.
- Development of a “staff village” to enable staff to live together – even if this is between the two main sites.
- Ensure staff work across both sites to increase the range of their experience.
- Offer tours of the different birthing units.
- Improve information about different choices of birth. Promote the benefits of natural birth and provide better information on the internet and social media.
- Provide information about what happens in emergency situations. This would relieve anxiety.



Choice is great but I spent a lot of my time in and out of hospital. Location is important to me.

– maternity focus group

Jane McFaite: Midwife-led unit matron, East Sussex Healthcare NHS Trust:

“The quality of care and birthing experience offered to women with low risk births is excellent in a midwife-led unit. We are able to provide one-to-one care in labour for women and we know that this level of support reduces women’s need for additional pain relief, interventions in the labour process as well as increasing the rate of normal birth, maternal satisfaction with their birth experience and breastfeeding rates.

“We are trained to give care to women who have low risk pregnancies in their ante-natal, labour and post-natal period.”



MYTH

The consultant-led maternity service cannot cope since the temporary changes. The unit keeps closing and women are being turned away.



FACT

There have been no closures of the consultant-led (obstetric) unit since the temporary changes.

Babies were at risk in the old model and it was unsustainable.

– maternity focus group



What we have learned from the temporary changes

We have very closely monitored the impact of the temporary changes and analysed key safety and quality data and patient experiences.

The CCGs' lead nurse and governing body GPs have regularly visited the hospitals to talk to staff and patients about how the changes have affected them. There have also been reviews by expert national bodies such as the Care Quality Commission, the National Clinical Advisory Team, the Royal College of Obstetricians and Gynaecologists and the Royal College of Paediatrics and Child Health.

Maternity

What changed?

Consultant-led maternity services were centralised at the Conquest Hospital, Hastings, with midwife-led units at Eastbourne DGH and Crowborough Hospital.

What was the impact on safety and quality?

There have been major improvements to safety. Most significantly there has been a sharp decline in Serious Incidents – those causing death or serious harm to patients. Since May 2013 there has been increased consultant presence and more time for training and supervision. Feedback from trainees and consultants has been very positive.

A review by the Royal College of Obstetricians and Gynaecologists noted that the temporary changes had a positive impact on safety.



MYTH

Local clinicians don't support the centralisation of these services.



FACT

These options have been developed by GPs and leading doctors, nurses and midwives. We have engaged widely with local GPs and hospital staff in developing these options.



How things have improved in maternity services

We compared key safety data from the seven months before and seven months after the temporary changes

	Before temporary changes *	Since temporary changes #	
Consultant hours on labour ward.	Average 56 hours per week	Average 72 hours per week	There has been a big increase in consultant cover on the labour ward. More senior clinical supervision has resulted in increased quality and safety.
Serious Incidents resulting in death or serious harm to maternity patients.	14	4	There was a very significant reduction in Serious Incidents, mainly as a result of greater consultant presence on the labour ward and less pressure on staffing levels.
Babies born before arrival at a maternity unit or before the assistance of a midwife.	28	26	No real change. Most incidents involved women from Hastings and due to give birth at the Conquest Hospital
Transfers Women transferred from one hospital to another during labour. ESHT had significantly more than any other Sussex hospital trust in 2012/13.	10	5	The number of transfers has reduced which represents improved safety and a better experience for women.
Diverts The result of a divert is that women who phone to say they are in labour or have a planned admission are asked to go to another consultant-led or midwife-led unit within the same trust.	16	4	The main reason this was happening before May was because the two smaller sites had insufficient staffing levels. There have been far fewer diverts since May 2013 because the single consultant-led site has had more capacity. This has contributed towards increased safety for women and babies. The divert number is the number of times that units have been on divert, not the number of women affected.
Midwife to birth ratio Achieving a ratio of one midwife to every 30 births.	1:29 monthly average	1:27 monthly average	ESHT continued to consistently meet this national standard and has shown a steady improvement since the temporary changes, contributing to safer care for women in labour.
Caesarean-sections	533	473	A reduction in caesarean sections can be linked to the increased presence of senior consultants on the labour ward. This has allowed more women to have a natural birth.

* October 2012-April 2013. # May 2013-November 2013

Data provided by East Sussex Healthcare NHS Trust



Case study

Sarah Blake gave birth to her son at Crowborough midwife-led unit in 2010.

She said: "I've always heard such good things about the midwife-led unit and, as a first time mother, I wanted that home-from-home experience to help me to relax.

"All through my pregnancy, labour and birth, the staff were incredible - from my regular appointments with my midwife to the lady who brought me the most amazing toast I've ever tasted! I had a wonderful experience and Crowborough midwife-led unit is a wonderful place, I can't wait to go back one day."



MYTH

There has been a big increase in babies being born before arriving at the hospital since the temporary changes in May 2013.

FACT

There has been no change in the number of babies being born before arrival in this time and no babies have been born in ambulances.

Case study

"I went into labour four weeks early in May 2013. Baby wasn't due until the end of May and because I'm classed as high-risk, I knew I'd have to travel from home in Eastbourne to the Conquest to have her. To begin with I was really upset and worried about what it would be like, but the staff and facilities here are amazing and I'm so pleased I had my baby here.

"It took us about half an hour to get here which was fine. I had a lovely room to give birth in and it all felt so clean and spacious, I was worried that with all the changes they might not be ready for me, but I felt safe as soon as I walked in the door.

"I've got friends who are pregnant and I know they're worried about having to travel to give birth, but I can reassure them that they really have nothing to worry about. The staff here have been fantastic and couldn't have looked after me and my baby any better."



Paediatrics

What changed?

In-patient paediatric services (for sick children needing an overnight stay) were centralised to the Conquest Hospital, Hastings, with a short stay paediatric assessment unit still provided at both hospitals.

What was the impact on safety and quality?

While we did not have safety concerns about paediatric services, changes were made owing to the very close links with maternity, especially in the care of sick babies.

It is important for us to understand any impact this has had on safety and quality and we have been closely monitoring these services.

Since locating the paediatric in-patient unit on a single site, ESHT is no longer reliant on



temporary (locum) staff. This has resulted in improved quality of service.

The Care Quality Commission conducted a review of safety and quality in the paediatric service since the changes, and found East Sussex Healthcare NHS Trust was meeting all the required essential standards inspected. We are confident that the single-siting of in-patient paediatrics has had no negative impact on the safety and quality of services.

“The restoration of two in-patient units (at ESHT) is neither appropriate nor sustainable.”

– Royal College of Paediatrics and Child Health, 2013



The options



How we arrived at the options

We agreed the standards

The standards, known as models of care, were tested widely with all GPs across East Sussex, with hospital doctors and with other clinicians from surrounding areas in Sussex.

We created a long list of potential options

We worked out every possible option that the group should consider. The full list can be found at our website www.betterbeginnings-nhs.net.

We compared the list of options to the models of care

The working group took out several options that they agreed would not meet the models of care (for example, if women would have no choice of where to give birth, or if there would be no paediatric service in East Sussex).

We spoke to other smaller units across the country and looked at national and local evidence

We had access to a wealth of evidence including population data and information about the safety and quality of local services both before and after the temporary changes.

We visited and studied other smaller maternity units across the country to understand what we could learn from them.

We asked local people and clinicians for input

We carried out extensive public and clinical engagement to raise awareness and seek views on the Sussex Clinical Case for Change (see from page 8), and to better understand the challenges and opportunities that each option may bring. Full reports outlining what you told us can be found on our website www.betterbeginning-nhs.net.



What we have learned from the process so far

We believe:

- That East Sussex currently needs an in-patient paediatric unit within the county.
- That women in East Sussex should have the choice of whether the birth of their babies was supported by midwife-led or consultant-led (obstetric) care.
- That East Sussex should have an additional midwife-led unit (prior to the temporary changes, there was only one midwife-led unit in East Sussex).
- That we should continue to commission a short stay paediatric assessment unit at both Eastbourne and Hastings and that we should review their opening hours.
- That we should increase the number of hours that consultants are present on the labour ward.
- That we cannot offer safe and sustainable services across two consultant-led maternity and in-patient paediatric sites.

What is not changing?

Whilst the purpose of this document is to consult with you about the changes that we are proposing to maternity, in-patient paediatric and emergency gynaecology services, much of these services will not change and will continue to be provided at both of the main hospital sites. These include: maternity day assessment unit; antenatal clinics; ultrasound; early pregnancy unit; paediatric outpatients; gynaecology outpatients; paediatric day surgery; gynaecology day surgery. Community services (including health visitors and home births) will continue.

What do you think?

Fill in the survey attached to this document or complete the survey online at www.betterbeginnings-nhs.net.



Why can we not have consultant-led maternity services at both Eastbourne and Hastings?

We knew that before the temporary changes it was becoming difficult to consistently maintain safe services across two sites (as explained from page 8).

We spoke to other smaller units across England, looking for innovative practice that we could use in East Sussex. We did not find a way that would help us improve services so that they could be safely run at both Eastbourne and Hastings. Many smaller units were experiencing similar difficulties in staffing consultant-led units. Several units were either going through, or about to go through, a review like this one. This tied in with national evidence, which shows that there are fewer and fewer smaller units, as larger units tend to be safer for women and babies.

We know that there have been major improvements to safety in East Sussex following the temporary changes (as explained on page 20).

Because of all these reasons we believe it would be unsafe to run consultant-led services on both sites, and the safety of patients is not something that we are prepared to risk.

To test this, we took the evidence to two different clinical groups which included clinicians from outside of East Sussex and discussed our findings with them. They supported the findings.

Their reports can be found as appendices to our Pre-Consultation Business Case, which can be downloaded at www.betterbeginnings-nhs.uk.



MYTH

It is safer to maintain two smaller consultant-led maternity units than one larger one.



FACT

It is much more difficult to sustain safe services over two consultant-led sites because they require more staff and birth rates are not high enough for doctors and midwives to maintain skills.

Nicky Roberts: Consultant obstetrician, East Sussex Healthcare NHS Trust, said:

"As an obstetrician and mother of young children my overriding priority is to have safe, high quality maternity and children services across East Sussex. We can provide good quality, safe obstetric care from a single sited consultant-led unit. It gives us more consultant time on the delivery suite to be directly involved with complicated births and we can attract a higher calibre of doctor to work in a busy unit offering greater safety to mothers and babies."







Why do in-patient paediatrics need to be on the same site as consultant-led maternity?

The clinical working group very carefully considered whether in-patient paediatrics could be safely maintained at both hospital sites in the future. The Royal College of Paediatrics and Child Health (RCPCH) have stated that there are “too many small (paediatric) units and not enough specialist centres” in the U.K. The RCPCH is warning that unless a radically different model of care is developed, there will be serious safety risks to children and the system will be unable to meet demand.

In a review of the temporary changes at ESHT carried out in August 2013, the RCPCH recommended “the restoration of two in-patient units was neither appropriate nor sustainable”. There are clinical links between obstetrics, paediatrics and the special care baby unit (SCBU) and to provide the best care for babies they all need to be located together.

Why does emergency gynaecology need to be on the same site as consultant-led maternity?

The medical staff who provide obstetric care are normally the same staff who provide gynaecology care, so for the same reasons that we propose centralising obstetric services on one site, we propose to centralise emergency gynaecology on the same site. This is so we can provide the safest and best quality of emergency gynaecology services for local women. Planned surgery and outpatient appointments would still continue on both sites.



MYTH

You are attempting to downgrade my local hospital.



FACT

We want two vibrant hospital sites in our two major towns and there is no hidden agenda to downgrade either site. Better Beginnings is about improving the maternity and paediatric services we provide in East Sussex and improving the safety and quality of care for women, babies and children.





OPTION 1

Eastbourne DGH

- Midwife-led unit
- Consultant-led maternity service (obstetrics)
- Emergency gynaecology
- In-patient paediatrics
- Level 1 special care baby unit (SCBU)
- Short stay paediatric assessment unit (SSPAU)

Conquest Hastings

- Short stay paediatric assessment unit (SSPAU)

Crowborough

- Midwife-led unit

OPTION 2

Eastbourne DGH

- Short stay paediatric assessment unit (SSPAU)

Conquest Hastings

- Midwife-led unit
- Consultant-led maternity service (obstetrics)
- Emergency gynaecology
- In-patient paediatrics
- Level 1 special care baby unit (SCBU)
- Short stay paediatric assessment unit (SSPAU)

Crowborough

- Midwife-led unit

Summary of options 1 and 2

- These options provide birthing services on two of the three current sites.
- These would provide a consultant-led maternity service in either Eastbourne or Hastings, with no birthing service at the other main hospital site.
- There would be a midwife-led unit on the same site as the obstetric service. Women who choose to give birth at this midwife-led unit would have rapid access to obstetric care, should they require it.
- A midwife-led unit would continue to be provided at Crowborough.
- In-patient paediatrics would be provided on the same site as the obstetric care.
- There would be a short stay paediatric assessment unit at both Eastbourne and Hastings.
- Emergency gynaecology would be provided on the same site as obstetric care.



OPTION 3

Eastbourne DGH

- Midwife-led unit
- Consultant-led maternity service (obstetrics)
- Emergency gynaecology
- In-patient paediatrics
- Level 1 special care baby unit (SCBU)
- Short stay paediatric assessment unit (SSPAU)

Conquest Hastings

- Midwife-led unit
- Short Stay Paediatric Assessment Unit (SSPAU)

Crowborough

- No maternity service

OPTION 4

Eastbourne DGH

- Midwife-led unit
- Short stay paediatric assessment unit (SSPAU)

Conquest Hastings

- Midwife-led unit
- Consultant-led maternity service (obstetrics)
- Emergency gynaecology
- In-patient paediatrics
- Level 1 special care baby unit (SCBU)
- Short stay paediatric assessment unit (SSPAU)

Crowborough

- No maternity service

Summary of options 3 and 4

- These options provide birthing services on two of the three current sites.
- These options would provide a consultant-led maternity service in either Eastbourne or Hastings, with a midwife-led service at the other main hospital site.
- There would be a midwife-led unit on the same site as the obstetric service. Women who choose to give birth at this midwife-led unit would have rapid access to obstetric care, should they require it.
- There would be no maternity services at Crowborough.
- In-patient paediatrics would be provided on the same site as the obstetric care.
- There would be a short stay paediatric assessment unit at both Eastbourne and Hastings.
- Emergency gynaecology would be provided on the same site as obstetric care.



OPTION 5

Eastbourne DGH	Conquest Hastings	Crowborough
• Consultant-led maternity service (obstetrics) • Emergency gynaecology • In-patient paediatrics • Level 1 special care baby unit (SCBU) • Short stay paediatric assessment unit (SSPAU)	• Midwife-led unit • Short stay paediatric assessment unit (SSPAU)	• Midwife-led unit

OPTION 6

Eastbourne DGH	Conquest Hastings	Crowborough
• Midwife-led unit • Short stay paediatric assessment unit (SSPAU)	• Consultant-led maternity service (obstetrics) • Emergency gynaecology • In-patient paediatrics • Level 1 special care baby unit (SCBU) • Short stay paediatric assessment unit (SSPAU)	• Midwife-led unit

Summary of options 5 and 6

- These options provide birthing services on all three current sites.
- These options would provide a consultant-led maternity service in either Eastbourne or Hastings, with a midwife-led service at the other main hospital site.
- The site providing obstetric services would not also have a midwife-led unit.
- A midwife-led unit would continue to be provided at Crowborough.
- In-patient paediatrics would be provided on the same site as the obstetric care.
- There would be a short stay paediatric assessment unit at both Eastbourne and Hastings.
- Emergency gynaecology would be provided on the same site as obstetric care.



How maternity services will look



Pregnant woman



Community midwife appointment

At this appointment your history, risk factors and general health will be assessed to see if you are at risk of complications. Risk assessments continue throughout pregnancy until after the baby is born.



Low risk

You can choose from:



Home birth



Midwife-led unit



Consultant-led unit



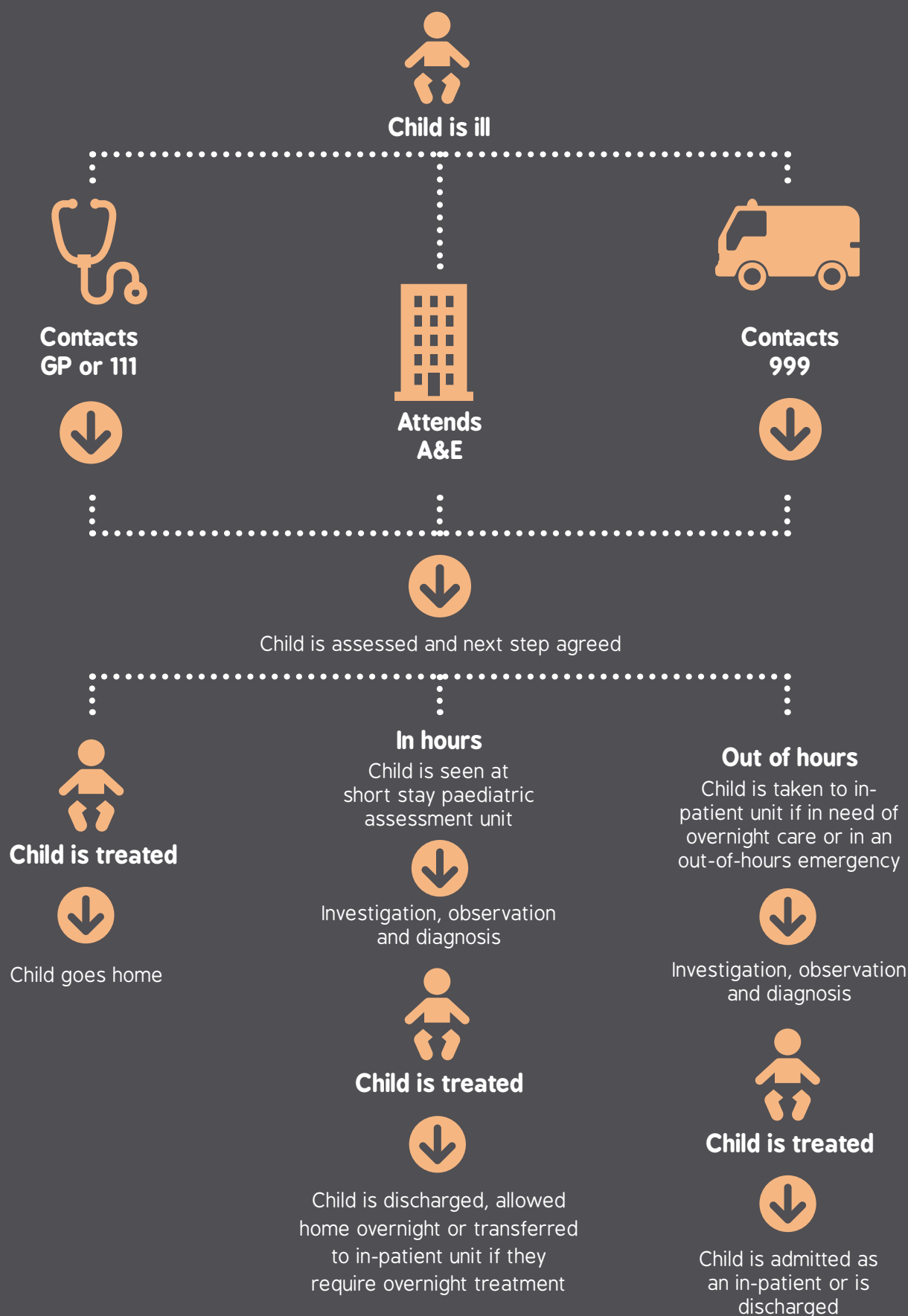
High risk



During labour or after childbirth women can be transferred to a consultant-led unit for additional support if necessary



How paediatric services will look





How emergency gynaecology services will look



Woman is ill



Contacts
GP or 111



Attends
A&E



Contacts
999



Non Emergency



Advice /treatment can be given on the spot, at home or in the community.

(Available across East Sussex)

Hospital treatment or surgery is required, but not urgently. Appointment made and patient treated.

*(Available on **2 sites** in East Sussex)*



Emergency

Patient is automatically transferred by ambulance to hospital providing 24/7 emergency gynaecology service, unless already attending that site.



Hospital treatment or surgery is urgently required. Patient is admitted and treated.

*(Available on **1 site** in East Sussex)*



What happens next?

After the consultation has closed on 8 April 2014, an independent third party will analyse all the responses and publish a final report which we will consider as one of the pieces of information when making a final decision. They will also review the effectiveness of the consultation process.

How will the options be assessed?

Each of the options will be assessed and scored against five weighted criteria (as outlined in the table below). This is called an options appraisal.

The options appraisal ensures that we take all relevant information into account when thinking about the best way of delivering services. In this document and in the Pre-Consultation Business Case (which can be found at our website www.betterbeginnings-nhs.uk) we have extensively outlined the information we have in relation to these criteria.

More information on how the options will be assessed and scored can be found on our website www.betterbeginnings-nhs.net or contact 01273 403563.

Weighting

A weighting is a way of measuring the importance of the criteria. For example, we know that access is important but that quality and safety is paramount. We also know that finance is a key consideration, but not the most important factor.

The options appraisal criteria and their weightings have been informed by what patients, the public and clinicians have told us is important. We will publicly share more information on finance and deliverability as it becomes available during the consultation.

Equality

We have a duty to comply with equalities legislation as well as duties to reduce health inequality and promote integrated health services where this will improve quality.

These have all been taken into account in the development of the proposed options. We have also undertaken an equality analysis (EA) to help us understand any potential impacts on particular communities as a result of these proposals. The EA can be found on our website www.betterbeginnings-nhs.net. This will be updated once the consultation has closed and used as one of the pieces of information to inform our decision. Information from public health about the needs of our local populations will also be used to support this. You can find out more about these needs at www.eastsussexjsna.org.uk.

Criteria	Weighting	Considerations
Quality and Safety	25%	Would this option provide care that is safe, effective and focused on high-quality patient experience? Would it meet national and locally agreed quality standards and best practice guidance?
Clinical Sustainability	25%	Will this way of delivering the service continue to meet national and local clinical standards on a long-term basis? Can we recruit and retain enough staff to operate this option?
Access and Choice	20%	Does this option meet the needs of local people? Do people have a choice of services? Are these services accessible? Can pregnant women access all maternity services - homebirth, delivery in a midwife-led unit or a consultant-led-obstetric unit? Is there access to all paediatric services?
Financial Sustainability	15%	Can we afford to deliver this option on a long-term basis and does it make best use of the available resources?
Deliverability	15%	Can we realistically achieve this option? How much will it cost? Can we do it on time? What impact will it have on other local services?

Financial Sustainability

Whilst our prime consideration is improving the safety and quality of these services, we will also need to consider the cost of implementing and sustaining each of these options as part of the consultation process.

The total value of the contract for all services the three CCGs have with East Sussex Healthcare NHS Trust is £250.4 million for 2013/14.

In 2013/14 we expect to spend £13.3 million on obstetrics and midwifery, £6.3m on gynaecology and £7.4 million on paediatrics.

The cost of services covered by these proposals reduces to £19.6m because planned and outpatient gynaecology and outpatient paediatrics are not included in the consultation.

These costs are determined by our expected activity and the national and local tariffs.

In addition we are paying the trust £2.6 million in 2013/14 to cover the costs of having to potentially revert to a two site consultant-led maternity service during the period of the temporary reconfiguration.

During consultation the trust will provide costings for both revenue and capital to enable the CCGs to assess the level of resource needed to sustain each option and best meet assumptions about resources, tariffs and activity. Once this is received, we will make this information publicly available during the consultation.

Financial breakdown

		2013/14 Forecast Expenditure by CCG			
Service	Description	EHS £m	H&R £m	HWLH £m	TOTAL £m
Obstetrics and Midwifery	In-patient obstetrics and midwifery	2.8	3.1	0.4	6.3
	Other Obstetrics and Midwifery	3.2	3.3	0.6	7.1
	Total	6.0	6.4	1.0	13.4
Gynaecology	Emergency In-patients	0.4	0.4	0.0	0.8
	Total	0.4	0.4	0.0	0.8
Paediatrics	Emergency & Elective In-patients	2.5	2.6	0.3	5.4
	Total	2.5	2.6	0.3	5.4
All Services	Total	8.9	9.4	1.3	19.6

EHS - Eastbourne, Hailsham and Seaford

H&R - Hastings and Rother

HWLH - High Weald Lewes Havens

Have your say

This consultation is your chance to have a say on the future of these services. We want as many people as possible to respond, and everyone's view will be considered. All responses must be received no later than **8 April 2014**. What is important to you? Is there anything else you think we should have considered? You can help us get these decisions right.

There are a number of ways you can find out more and respond to our consultation.

Online

The Better Beginnings website includes all the information in this document plus all other evidence referred to. The site will be regularly updated with the latest Better Beginnings news and details of events. You can ask questions and complete our online questionnaire.

www.betterbeginnings-nhs.net

Social media

Follow us on Twitter @BetterBeginsES or Facebook www.facebook.com/betterbeginningseastsussex

Events

We will be holding lots of events across the county which are open to everyone and will give you the chance to talk to clinicians and others about the proposals and give your views.

Details of these events will be on our website and will be publicised in the local press. Posters advertising them will also be displayed in the local area.

By email

You can send your comments to:
hrcgg.betterbeginnings@nhs.net

By post

Complete the questionnaire attached to this document, and return it to the FREEPOST address below (this has no charge for you).

Better Beginnings
East Sussex CCGs
FREEPOST SEA2474
BN8 2ZZ

By phone

You can phone the consultation team on 01273 403563.

If you would like further copies of this consultation document, or any other information, please call 01273 403563 or email hrcgg.betterbeginnings@nhs.net.

How and when will the decision be made?

The CCGs will make a final decision this summer (2014). The decision will be based on:

- An appraisal of the options
- The needs of the population for each CCG area and for East Sussex as a whole
- The independent report on the consultation
- A report on the consultation produced by the East Sussex County Council's Health Overview and Scrutiny Committee (HOSC). More information about the role of HOSC can be found www.eastsussex.gov.uk
- The equality analysis

The CCGs will meet in public to make their decisions and each CCG will separately record the decision they have made. The outcome from the options appraisal and the information mentioned above will be published.

Information available in other formats:

- Translated into another language
- Easy read
- Large print
- Braille
- Audio recording
- DVD in British Sign
- Language or another assisted language (for example Sign Assisted English, Makaton)

Please contact: **01273 403563**

Если Вам необходима эта информация в другом формате, например:

- перевод на другой язык,
- версия для упрощенного чтения,
- крупный шрифт,
- шрифт Брайля,
- аудио версия,
- диск DVD с записью на британском языке жестов (British Sign Language) или другом языке со вспомогательными средствами (например английский со вспомогательными знаками (Sign Assisted English), Макатон (Makaton)).

пожалуйста, обращайтесь: **01273 403563**

Si vous souhaitez obtenir ces informations sous une autre forme, c'est-à-dire :

- traduites dans une autre langue ;
- présentées sous une forme facile à lire ;
- présentées en gros caractère ;
- écrites en braille ;
- présentées dans une version audio ;
- sur un support DVD avec langage par signes anglais ou toute autre langue assistée (à l'exemple de l'anglais assisté par signes, le Makaton)

Veuillez contacter : **01273 403563**

Si desea esta información en otro formato, por ejemplo:

- traducida a otro idioma
- versión EasyRead
- impresa en caracteres de gran tamaño
- Braille
- versión audio
- DVD en lenguaje de signos British Sign Language o cualquier otro lenguaje asistido (por ejemplo Sign Assisted English, Makaton)

Contacte, por favor, con: **01273 403563**

Gdyby chcieli Państwo otrzymać te informacje w innej formie, np.:

- Przetłumaczone na inny język
- W formie łatwej do przyswojenia (easy read)
- Wydrukowane dużym drukiem
- Zapisane alfabetem Braille'a
- W wersji audio
- Na DVD prezentowane Brytyjskim językiem migowym lub w innym języku wspomaganym (np. Angielskim uzupełnianym znakami czy w tzw. Makaton)

Prosimy o kontakt: **01273 403563**

如果您希望得到本資料的其他版本，比如：

- 譯成其他語言
- 易讀的版本
- 大字體
- 盲文
- 音頻版本
- 英國手語或其他輔助語言（比如帶手勢的英語、默政插手語等）的 DVD

請聯繫：**01273 403563**

إذا كنت ترغب في الحصول على نسخة من هذه المعلومات في شكل آخر، كالمصنوع عليها:

- مترجمة إلى لغة أخرى
- كنسخة سهلة القراءة
- مطبوعة بأحرف كبيرة
- بطريقة برايل للمكفوفين
- كنسخة صوتية
- كقرص فيديو رقمي مضغوط بلغة الإشارات البريطانية للصم أو غيرها من الوسائل اللغوية المساعدة (كلغة الإنجليزية المدعومة بالإشارات، (Makaton) (ماكاتون))

الرجاء الاتصال على: **01273 403563**

ଆମେନି ଯଦି କଣା ଏକଟି ରୂପେ ଏହି ତଥା ଦେଖେ ଚଳ, ତଥାହେବବ୍ୟବହାର:

- କଣା ଏକଟି ଭାଷା ଅନୁସାରେ
- ସହଜପାଠୀ ଭାଷା
- ବଡ଼ ଛାପର ହରଫ
- ଗ୍ରେଇଲ
- ଅଭିନିତ ଭାଷା
- ବ୍ରିଟିଶ ସାଇନ ଲାଂଗୁଏଜ୍ ବା ଅନ୍ୟାନ୍ୟ ସହାୟତାଯୁକ୍ତ ଭାଷା (ଉଦାହରଣସ୍ୱରୂପ ସାଇନ ଆସିଷ୍ଟେଡ୍ ଇଂଲିଶ୍, ମାକାଟନ) ଡିଭିଡି

ତାହାଙ୍କୁ ଅନୁରୋଧ କର ଯୋଗାଯୋଗ କରନ୍ତୁ: **01273 403563**

اگر تمایل دارید این اطلاعات را به صورت دیگری دریافت کنید، برای مثال در یکی از فرمت‌های زیر:

- ترجمه به زبان دیگر
- نسخه ای با قابلیت خواندن آسان
- چاپ درشت
- خط بریل
- نسخه صوتی
- دی وی دی به همراه زبان اشاره ناتوانان یا زبانهای توانبخشی دیگر (مانند زبان اشاره انگلیسی، (Makaton) (ماکاتون))

لطفاً تماس بگیرید با: **01273 403563**

Maternity and Paediatric Needs Assessment

Public Health, December 2013

Contents Page

Item No.	Section	Page
	Executive Summary	3
	Section 1: Maternity	3
	Summary of findings in relation to districts and boroughs	5
	Summary of findings in relation to maternity units	6
	Section 2: Paediatrics	8
	Summary of findings in relation to districts and boroughs	9
	Section 1: Maternity	10
1	East Sussex population	10
1.1	Fertile females (15-44 years)	10
1.2	Deprivation	12
1.3	Households with no car or van	13
1.4	Sole registrations	13
2	East Sussex births	13
2.1	General Fertility Rate (GFR) (birth rate) and number of births	13
2.2	Total Period Fertility Rate (TPFR)	14
2.3	Birth projections	15
2.4	Age specific fertility rates	15
2.5	Number of births by maternal age	19
2.6	First time mothers	20
2.7	Births to women born outside the UK - trend	20
2.8	Births by provider unit	22
2.9	Home births	23
2.10	Place of birth by area of residence	27
2.11	Maternal age profile by place of birth	30
2.12	Deprivation by place of birth	30
3	Risk Factors	31
3.1	Smoking	31
3.2	Obesity	32
3.3	Substance misuse and alcohol	33
3.4	Domestic violence	33
3.5	Perinatal mental health	33
3.6	Teenage pregnancy	33
3.7	Maternal morbidity	34
4	Outcomes	34
4.1	Caesarean sections	34

4.2	Gestation at birth	35
4.2	Low birth weight	37
4.3	Multiple pregnancies	38
4.4	Infant mortality	38
4.5	Perinatal mortality	39
4.6	Still births	40
Section 2: Paediatrics		41
1	East Sussex population	41
1.1	Current population	41
1.2	Population projections	41
1.3	Income deprivation	42
1.4	Looked after children	42
2	Child Health	43
2.1	Breastfeeding	43
2.2	Immunisations	44
3	Risk Factors	45
3.1	Exposure to second-hand smoke	45
3.2	Substance misuse	45
3.3	Obesity	45
4	Outcomes	45
4.1	A&E attendance	45
4.2	Emergency admissions	47
4.3	Emergency admissions for diabetes, epilepsy and asthma	55
Appendix 1		57
Appendix 2		59

Executive Summary

Section 1: Maternity

	Page
Fertile female population - Wealden has the highest number of 15-44 year olds (23,522) and Rother the lowest (12,502). The fertile female population is predicted to decline by 6% between 2012 and 2021; the largest decline is in Eastbourne (9%) and the smallest in Lewes (4%).	10
Ethnicity - The proportion of non-White British females in East Sussex is highest in Eastbourne, followed by Hastings, and lowest in the more rural areas of Rother and Wealden.	11
Deprivation - Of the Districts and Boroughs in East Sussex Hastings has the most deprived population and Wealden the least deprived. The map of households with no car or van shows the link with deprivation.	12
General Fertility rate (birth rate) - The general fertility rate (live births per 1,000 females aged 15-44 years) in East Sussex is lower than that of England and Wales, which has been the case for a number of years. The rate in Hastings has been consistently higher than England and Wales since 2003; whilst the rate in Eastbourne has exceeded the national rate since 2009.	13
Births - There were around 5,450 births in East Sussex in 2012: Hastings has the highest birth rate, followed by Eastbourne; Wealden has the highest number of births and Rother the lowest.	13
The Total Period Fertility Rate (TPFR) – The TPFR increased from 1.69 live births per woman in 2002 to 2.01 in 2012. It now appears to be reducing or stabilising. The highest rate tends to be in Hastings and the lowest in Eastbourne, although in 2012 the lowest rate was in Wealden. It is the TPFR together with the size of the 15-44 year old female population that is used to predict the likely number of future births.	14
Birth projections – Projections to 2021 suggest that from 2012 the number of births in Eastbourne will decrease by 24%, the number in Hastings and Lewes by around 10%, with the numbers in Rother and Wealden remaining fairly static.	15
Age specific fertility rates (birth rates) – East Sussex rates are lower than England for all age bands, except 20-29 year olds where they are higher. Birth rates in younger women (under 29 years) tend to be higher in Hastings and birth rates in older women (30 years and over) tend to be higher in Wealden and Lewes. Fertility rates in the under 20s have been decreasing; in the 20-29 yr olds they have increased but are beginning to stabilise; in the 30-39 year olds and 40+ age groups they are still increasing. Hastings has the highest number of births in younger women and Wealden the highest number in older women. Rother has the lowest number of births for all age groups apart from for the under 20s where numbers are similar to Lewes and Wealden.	15
Births by maternal age – around 90% of East Sussex births are born to women aged 20-39 years. Hastings has the highest number of births in the younger age groups (<20 yrs and 20-29 yrs) and Wealden the highest number in the older age groups (30-39yrs and 40+ yrs)	19
First time mothers - the average age of first time mothers in East Sussex is 28 yrs, ranging from 26 years in Hastings to 29 years in Lewes and Wealden. Lewes has the	19

highest percentage and Rother the lowest.	
Births to women born outside the UK - the proportion of births to women born outside the UK has been increasing over the last decade; it is particularly apparent in Eastbourne and to a lesser extent Hastings, the areas with the highest non-white British fertile female populations. In 2012 the largest proportion of births in non-UK born mothers was to women from the New EU (see Appendix 2) followed by the Middle East and Asia.	20
Births by provider unit – In 2011, the largest proportion of live births were in Eastbourne District General Hospital (EDGH) (36%) followed by the Conquest (33%), Royal Sussex County Hospital (RSCH) (11%), Princess Royal Hospital (PRH) (8%) and Tunbridge Wells Hospital (TWH) (5%); 3% of births in 2011 occurred at home and 3% in Crowborough Birthing Centre(CBC). There has been a gradual increase in the number of East Sussex births between 2006 and 2012. The Conquest and EDGH have seen some increase but the numbers appear to be stabilising. The number of births in RSCH and TWH is increasing; there has been little change in CBC and PRH, and the number of home births has decreased.	22
Place of birth by district and borough Between 2010 and 2011: • 92% of Eastbourne residents gave birth at EDGH • 92% of Hastings residents gave birth at the Conquest • 81% of Rother residents gave birth at the Conquest • 47% Lewes residents gave birth at RSCH, 24% at PRH and 18% at EDGH • 47% Wealden residents gave birth at EDGH, 16% at TWH and 15% at PRH. Home births - Home births made up around 3% of births in 2012; rates are highest in Lewes and Rother (5%).	27
Maternal age profile of unit • CBC, PRH, TWH and home births have an older age profile; these providers account for 22% of all deliveries. • The Conquest, EDGH and RSCH have a younger age profile; these providers account for 75% of all deliveries. •	30
Deprivation profile - Conquest has a higher proportion of births to women from the more deprived areas than EDGH.	30
Risk factors • Smoking rates at booking (24%) and at the time of delivery (22%) are highest in Hastings; rates at the 6 week health visitor review, for both mothers and fathers, are highest in Hastings. • Women who live in more deprived areas have higher levels of obesity than those in less deprived areas. • Poor mental health is more common in more deprived groups. • The teenage pregnancy rate in East Sussex is generally declining and is lower than the England average. Rates are highest in Hastings and lowest in Wealden.	30
Caesarean section rates - Caesarean sections made up 23% (940) of all deliveries in ESHT in 2012/13: 9.6% elective and 13.4% emergency. Rates are higher in EDGH than the Conquest, particularly for emergency caesareans; this has been the case for a number of years. Elective caesareans were similar on the two sites until 2012/13, when the rate in EDGH increased.	34
Low birth weight - Across the county, 6% of babies are born at low birth weight (under	37

2,500 grams) and 1% at very low birth weight (under 1500 grams).	
Multiple pregnancies – Between 2008 and 2011 there were 83 multiple pregnancies per year; the highest number is in Wealden which accounts for around a third of multiple births.	37
Infant mortality – The main causes of infant mortality are immaturity related conditions and congenital abnormalities. East Sussex has a similar infant mortality rate to England; around 22 children under one year die each year. The rate in Rother was significantly higher than England in 2012/13, but numbers are small and very variable and this is not expected to persist.	38
Perinatal mortality (after 24 wks gestation but before 7 days of life) – There are no significant differences between Districts and Boroughs.	39
Stillbirths – Stillbirths account for around 20 deaths each year in East Sussex; the still birth rate is generally below the England average.	40

Summary of findings in relation to districts and boroughs

Hastings (compared to other districts and boroughs in East Sussex) • Most deprived of the districts and boroughs. • Highest birth rate (higher than England and Wales since 2003) and highest total period fertility rate. • Number of births predicted to decrease by around 10% by 2021. • Has higher birth rates in younger women and highest number of births in younger women. • Higher teenage conception rates and births to women under 20 years. • Second highest non-White British population after Eastbourne. • Increasing percentage of births to women born outside the UK (after Eastbourne). • 92% of births to women living in Hastings are at the Conquest. • Risk factors generally higher as associated with deprivation i.e. smoking, obesity, mental health.	Rother (compared to other districts and boroughs in East Sussex) • Lowest number of 15-44 year old women (fertile females). • Lowest number of births. • Number of births projected to 2021 expected to remain fairly static. • Lowest number of births for all age groups apart from under 20s where similar to Lewes and Wealden. • 81% births to women who live in Rother are at the Conquest. • Highest home birth rate, together with Lewes (5%). • Significantly higher infant mortality rate in 2012 (which is though unlikely to persist – rates are very variable from year to year as numbers are small).
Eastbourne (compared to other districts and boroughs in East Sussex) • Second highest birth rate after Hastings. • Higher birth rate than England and Wales since 2009. • Percentage of fertile females predicted to decline by 9% by 2021. • Lowest total period fertility rate. • Number of births predicted to decrease more than the other districts and borough (by around 24%) by 2021. • Highest percentage of non-White British females. • The percentage of births to women born outside the UK is increasing.	Wealden (compared to other districts and boroughs in East Sussex) • Least deprived of the districts and boroughs. • Highest number of 15-44 year old women (fertile females). • Highest number of births. • Lowest total period fertility rate in 2012. • Birth projections to 2021 show that the number of births is predicted to remain fairly static. • Lowest teenage conception rate. • Higher birth rates in older women (>30 yrs). • Highest number of births in older women. • Highest percentage of multiple births

• Prior to the changes, 92% of births to women living in Eastbourne were at EDGH.	(around a third). • Lowest number of non-White British females. • Prior to the changes, 47% of births to women who live in Wealden were at EDGH.
Lewes (compared to other districts and boroughs in East Sussex) • Number of births expected to decrease by 10% between 2012 and 2021. • Tends to have higher birth rates in older women (>30years). • Prior to the changes, 47% gave birth at RSCH. • Has the highest home birth rate (5%), together with Rother.	
East Sussex • Lower birth rate than England and Wales. • TPFR increased from 1.69 live births per woman in 2002 to 2.01 in 2012 but is now stabilising. • Age specific fertility rates are lower than England for all age bands, except 20-29 year olds where they are higher. • Fertility rates have been declining in under 20 year olds; they have increased but are now stabilising in the 20-29 year olds; they are still increasing in the 30-39 year olds and 40+ year olds. • The percentage of births to women born outside the UK is increasing: the highest percentage is to women from the new EU; the second highest percentage is to women from Middle East and Asia. • The percentage of low birth weight babies is 6% (1% of which are very low birth rate). • Has a similar infant mortality rate to England (around 22 deaths per year). • Around 20 stillbirths per year. • Around 81 multiple births per year.	

Summary of findings in relation to maternity units

Conquest • A third of all East Sussex live births in 2011. • Younger age profile (compared to CBC, TWH, PRH). • Highest percentage of births to women from more deprived areas (70% in the most deprived areas).	EDGH (compared to other maternity units) • 36% of all East Sussex live births in 2011. • Second highest percentage of births to women from more deprived areas (51% in quintiles 1 and 2). • Younger age profile (compared to CBC, TWH, PRH). • Higher caesarean section rate than the Conquest, particularly emergency caesareans. • Elective caesarean section rate is the same on both sites.
Crowborough (compared to other maternity units) • 3% of all live births in 2011. • Older age profile (compared to Conquest, EDGH and RSCH). • Least deprived population (74% in quintiles 4 and 5).	Home (compared to other maternity units) • 3% of all live births in 2011. • Older age profile (compared to Conquest, EDGH and RSCH).
RSCH (BSUH) (compared to other maternity units) • 11% of all live births in 2011.	PRH (BSUH) (compared to other maternity units) • 8% of live births in 2011. • Older age profile (compared to Conquest, EDGH and

• Younger age profile (compared to CBC, TWH, PRH).	RSCH). • High percentage of 1st time mothers.
Tunbridge Wells • 5% of live births in 2011. • Proportion is increasing. • Older age profile (compared to Conquest, EDGH and RSCH).	

Section 2: Paediatrics

	Page
Current population: Children make up 22% of the East Sussex population; the largest age group is the 10-14 year old population (5.9%). Wealden has the highest number of children, which is the case across all five year age bands, and Hastings the lowest number, followed by Rother. Hastings has the highest percentage of children under five year olds of all the districts and boroughs and Rother the lowest.	41
Population projections: The number of children is predicted to decrease by 4% by 2021: largest decrease in Lewes (6%), followed by Eastbourne (5%), then Hastings (3%) Rother (3%) and Wealden (3%). • Under 5s decrease by 7% - largest in Eastbourne (15%) and Lewes (11%). • 5-9 year olds increase by 5% - largest in Hastings (9%) and Rother (13%). • 10-14 year olds increase by 5% - largest in Lewes (6%). • 15-19 year olds decrease by 17% - largest in Rother (26%) and Hastings (21%); lowest in Eastbourne (10%).	41
Income deprivation: Across the county, around a fifth of children are living in poverty. Low income families are more likely to be living in urban than rural areas; the highest numbers living in Hastings followed by Eastbourne.	42
Social care: Looked After Children, children on child protection plans and referrals to social care are all highest in Hastings.	42
Child health: Breastfeeding rates increase with the age of the mother. Breast feeding rates at 6-8 weeks are lowest in Hastings and are below the national average. Whilst vaccination rates in East Sussex are generally better than the national average, uptake rates fall short of the national target of the 95% required for herd immunity.	43
Risk factors: Children from poorer households are more likely to be exposed to risk factors for ill-health, resulting in higher use of health services.	45
A&E attendance: There were over 30,000 A&E attendances for children (0-18 yrs) in 2012/13, of which about a third were for 0-4 year olds. Around 40% of A&E attendances for the under fives were for accidents and injuries. The highest rates of A&E attendance (per 1,000 population) across all five year age bands are in Hastings and the lowest in Wealden, although Wealden, with the largest population of children, has the highest number of attendances. Attendances have been increasing over the past few years, with the highest rate of increase seen in Lewes.	45
Emergency admissions: There were more than 15,000 emergency admissions for children in the two years 2011/12 and 2012/13; almost two thirds of which were for the under fives. The highest numbers of emergency admissions in the under fives are in Hastings and Eastbourne.	47
Reasons for admission: The main reasons for emergency admission in under fives are respiratory causes and infections. The main reason for 5-18 year olds is injuries and poisoning. Respiratory problems in children tend to be higher in more deprived communities, as do childhood accidents.	48
Length of stay: The majority of admissions for children aged 14 years or younger are for less than one day; almost 60% of these 'zero length of stays' are for the under fives. Eastbourne has the highest percentage of stays of zero days in all age groups.	53
Prevention: One of the indicators in the NHS Outcome Framework (NOF) focuses on enhancing quality of life for children with long-term conditions: <i>to reduce the proportion of children admitted to hospital as an emergency admission with a primary diagnosis of asthma, diabetes or epilepsy</i> . The highest rates in East Sussex are in Hastings and the lowest in Lewes; both the number and rates of emergency admission are highest in the under fives, particularly in Hastings.	55

Summary of findings in relation to districts and boroughs

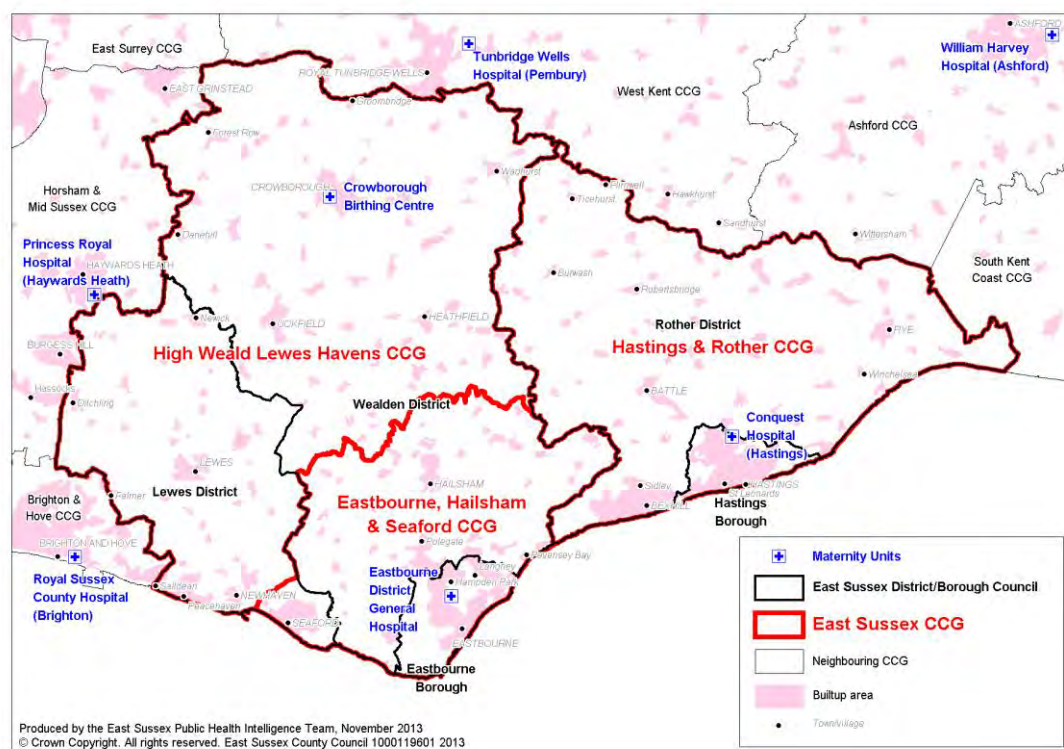
Hastings (compared to other districts and boroughs in East Sussex) • Lowest number of children across all five year age bands. • Most deprived of the districts and boroughs. • Highest number of children living in income deprived households. • Lowest breastfeeding rates. • Highest smoking rates among parents. • Highest A&E attendance rates and second largest percentage of A&E attendance in children after Wealden. • Highest rate of emergency admissions for asthma, diabetes and epilepsy, particularly for the under fives, which could be effectively managed in primary care.	Rother (compared to other districts and boroughs in East Sussex) • Second lowest population of children after Hastings. • Lowest percentage of under fives.
Eastbourne (compared to other districts and boroughs in East Sussex) • Predicted to have the second largest decrease in number of children (5%) between 2012 and 2021. • Second highest number of children living in income deprived households (after Hastings). • Highest percentage of emergency admissions with 'zero length of stay'.	Wealden (compared to other districts and boroughs in East Sussex) • Highest number of children across all five year age bands. • Lowest percentage of children living in income deprived households. • Lowest A&E attendance rate (per 1,000) but highest number of attendances.
Lewes (compared to other districts and boroughs in East Sussex) • Largest predicted decrease in number of children (6%) between 2012 and 2021.	
East Sussex • 4% decrease in the number of children in the county between 2012 and 2021, although an increase is predicted in some age bands (5-9 year olds and 10-14 year olds). • Around a fifth of children live in income-deprived households. • 30,000 A&E attendances and 15,000 emergency admissions for children in the two years between 1 April 2011 and 31 March 13. • A&E attendances have been increasing; the highest rate of increase has been in Lewes. • Around a third of A&E attendances and almost two thirds of emergency admissions are in the under fives.	

Section 1: Maternity

1. East Sussex population

Figure 1 shows the boundaries for the districts and boroughs of East Sussex, the boundaries for the three East Sussex CCGs and the maternity units serving East Sussex.

Figure 1: East Sussex map with Districts and Boroughs and CCG boundaries and maternity and paediatric provider units



1.1 Fertile females (15-44 years)

Size: The population of fertile women (15-44 yrs) in East Sussex is 87,087. Table 1 shows how this is broken down across the Districts and Boroughs in five year age bands. Wealden has the highest number of 15-44 year olds (23,522) and Rother the lowest (12,502); this is the case across all five- year age bands.

The 40-44 year age band (21%) is the largest group amongst 15-44 year olds; however, the birth rate to women over 40 years tends to be low compared to women in younger age cohorts.

Table 1: Number and percentage of fertile females in East Sussex Districts and Boroughs, by five year age bands, 2012

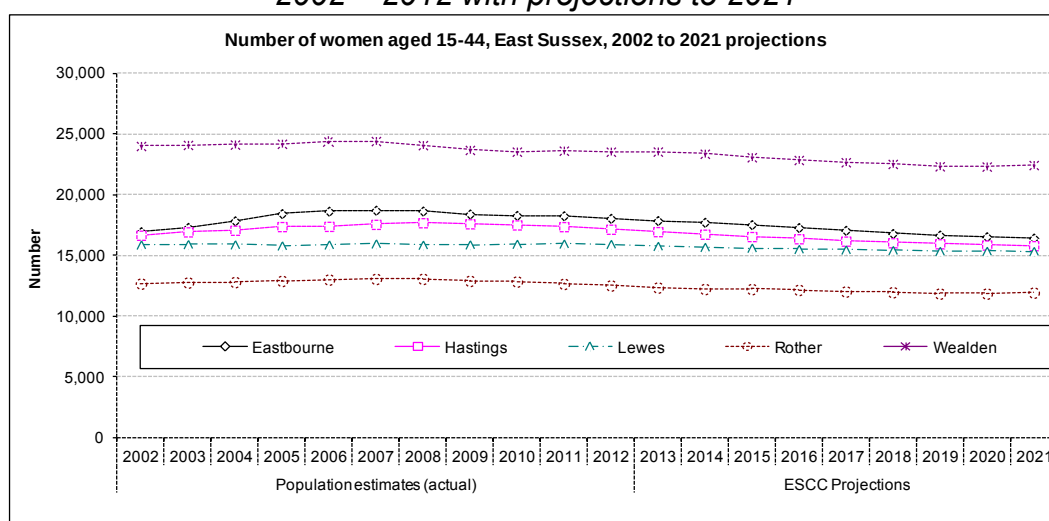
	15-19 yrs	20-24 yrs	25-29 yrs	30-34 yrs	35-39 yrs	40-44 yrs	15-44 yrs total
Eastbourne	2,915	2,936	2,908	3,059	2,935	3,274	18,027
Hastings	2,813	2,975	2,830	2,715	2,576	3,226	17,135
Lewes	2,695	2,194	2,225	2,419	2,844	3,524	15,901
Rother	2,499	1,739	1,665	1,765	1,991	2,843	12,502
Wealden	4,220	3,203	3,048	3,392	4,162	5,497	23,522
Total	15142	13047	12676	13350	14508	18364	87087

	15-19 yrs	20-24 yrs	25-29 yrs	30-34 yrs	35-39 yrs	40-44 yrs	15-44 yrs total
Eastbourne	16%	16%	16%	17%	16%	18%	100%
Hastings	16%	17%	17%	16%	15%	19%	100%
Lewes	17%	14%	14%	15%	18%	22%	100%
Rother	20%	14%	13%	14%	16%	23%	100%
Wealden	18%	14%	13%	14%	18%	23%	100%
<i>Total</i>	17%	15%	15%	15%	17%	21%	100%

Source: ONS Mid Year estimates 2012

Population projections: The East Sussex 15-44 years female population is predicted to decline by 6% between 2012 (87,087) and 2021 (81,837).¹ . Figure 2 shows that this decline is predicted for all Districts and Boroughs, with the largest decline in Eastbourne (9%) and the smallest in Lewes (4%).

Figure 2: Trend in number of women aged 15-44 by district and borough in East Sussex, 2002 – 2012 with projections to 2021



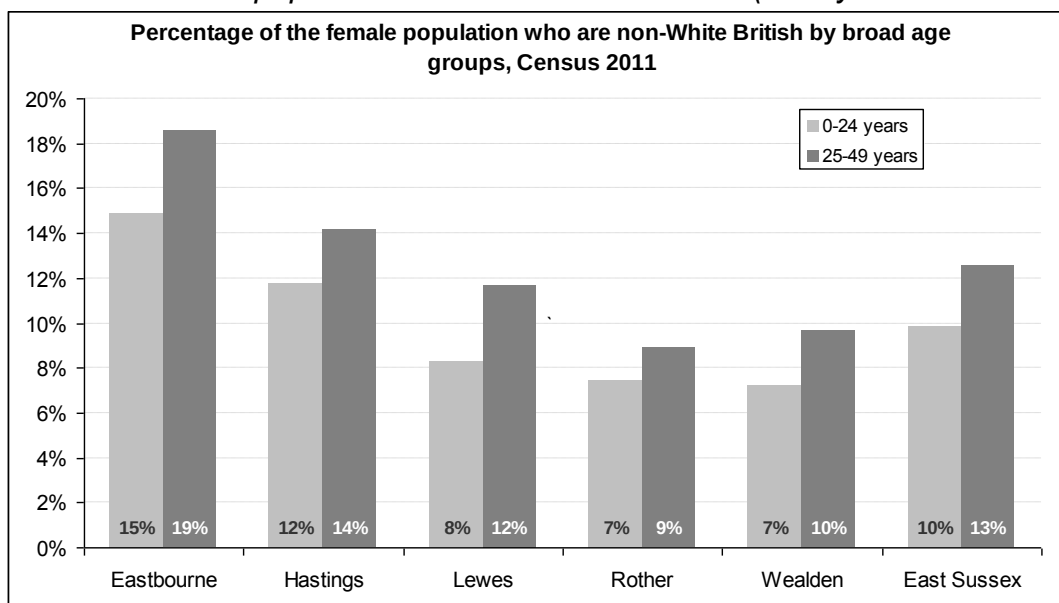
Source: ESCC Policy based 2012 Population Projections, July 2013

The East Sussex policy based population projections estimate future population change based on: 2011 Census results; fertility and mortality data; migration and local housing plans.

Ethnicity profile: It is not possible to assess the size of the BME 15-44 year old female population in East Sussex as data is not available by this age band. However Figure 3 shows that 10% of 0-24 year old females, and 13% of 25-49 year old females, are non-White British. The proportions of non-White British females are highest in Eastbourne (15% 0-24yrs; 19% 25-49yrs) followed by Hastings (12% 0-24 year olds; 14% 25-49 yr olds) and lowest in the more rural areas of Rother and Wealden.

¹ ESCC Policy based Population Projections, July 2013

Figure 3: Fertile female population other than White British (0-24 years and 25-49 years)



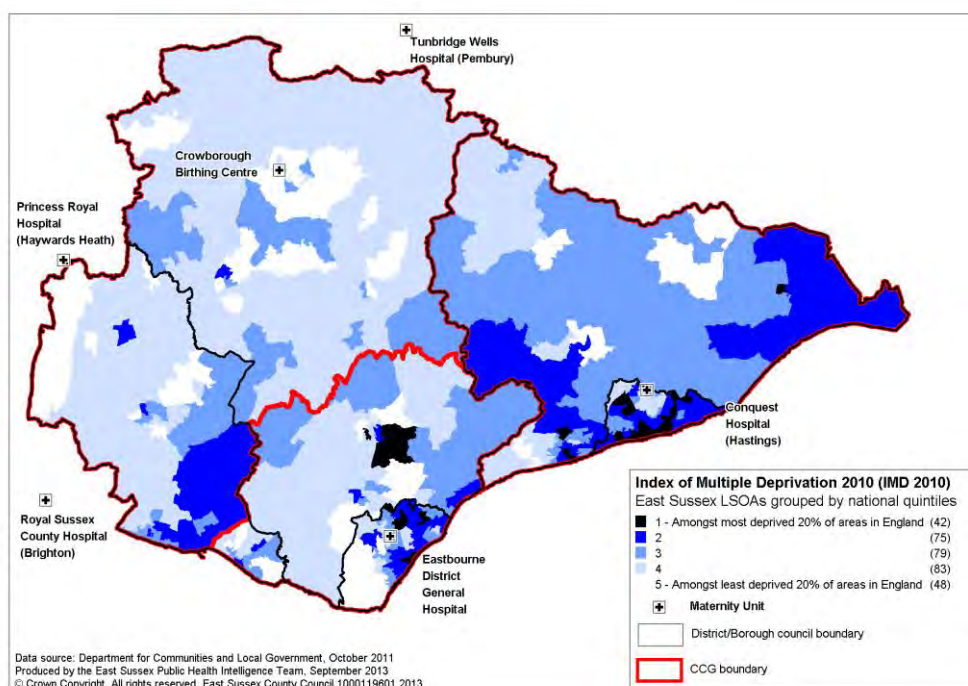
Source: Census 2011

1.2 Deprivation

Figure 4 maps deprivation across East Sussex. The darker the area the more deprived the population, although it needs to be recognised that whilst the overall populations in Lower Super Output Areas (LSOAs) are of similar size, the size of the fertile female population may vary.

Hastings is the most deprived district/borough in East Sussex (IMD score 34.49) and Wealden is the least deprived (IMD score 11.81). From an NHS perspective, H&R CCG is the most deprived CCG in East Sussex and HWLH CCG is the least.²

Figure 4: Map of deprivation in East Sussex

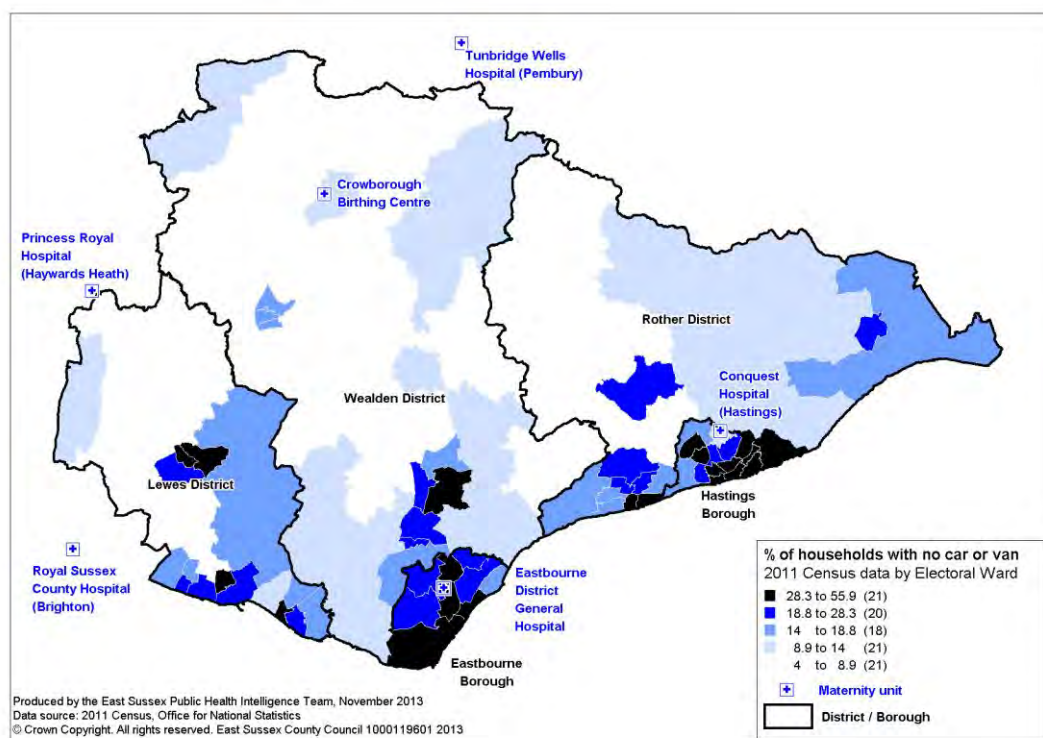


² JSNA scorecards, East Sussex Commentary 2013, Local Authority view. East Sussex JSNA web site.
<http://www.eastsussexjsna.org.uk/scorecards/2013authorityview>

1.3 Households with no car or van

Figure 5 maps households with no car/ van. These are concentrated in the Boroughs of Hastings and Eastbourne, and in Hailsham within Wealden District. A comparison with the map in Figure 4 illustrates the link with deprivation.

Figure 5: Map of households with no car or van



1.4 Sole registrations

Sole registrations, where the father is not recorded on the birth registration, are likely to be lone mothers. In 2011, 6% of the East Sussex live births that occurred outside of marriage were sole registrations. As expected, the proportion was highest in the under 20s where 23% were sole registrations (see Table 2).

Table 2: Percentage of live births that are sole registrations, by maternal age, 2011

	Under 20s	20-29 years	30-39 years	40+ years
East Sussex	23%	7%	3%	4%
Eastbourne	16%	7%	3%	3%
Hastings	27%	9%	4%	7%
Lewes	22%	7%	2%	8%
Rother	28%	8%	3%	8%
Wealden	20%	5%	1%	0%

Source: Vital Statistics 2011, ONS

2. East Sussex births

2.1 General fertility rate (birth rate) and number of births

Table 3 shows that there were around 5,450 live births in East Sussex in 2012. The highest birth rates are in Hastings (70.5 per 1,000 females aged 15-44) and Eastbourne (66.2 per 1,000 females aged 15-44). The highest number of births is in Wealden, which has more 15-44 year old females than the other districts and boroughs. Rother, with the fewest 15-44 year old females, has the lowest number of births (see Table 1 for population of 15-44 year old females).

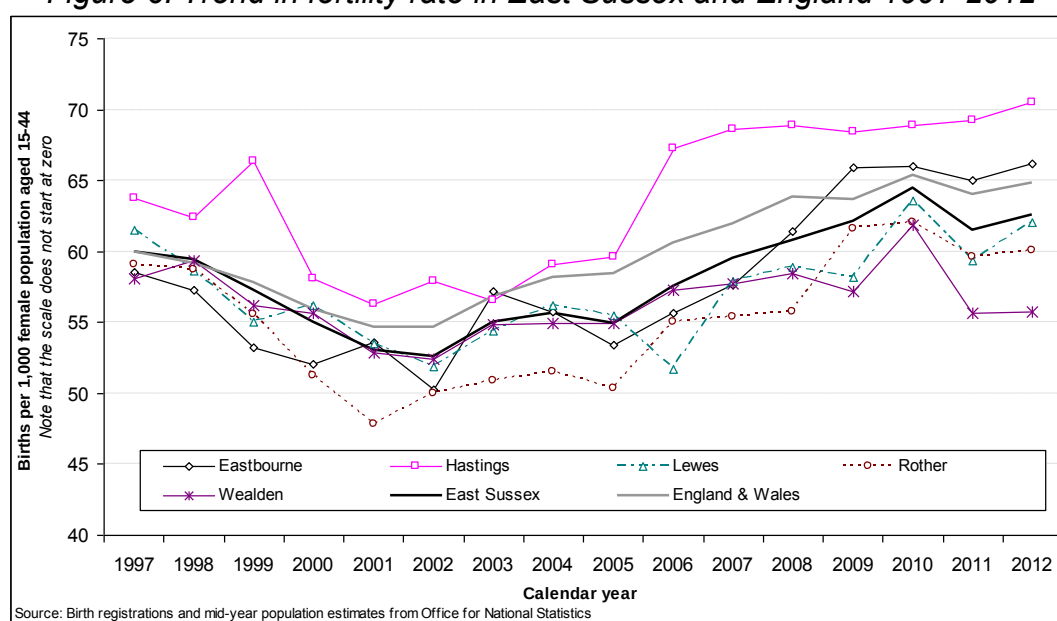
Table 3: Live births and general fertility rates, 2012

Area	Live births	General fertility rate
Eastbourne	1,193	66.2
Hastings	1,208	70.5
Lewes	987	62.1
Rother	751	60.1
Wealden	1,312	55.8
East Sussex	5,451	62.6
England	694,241	64.9

Source: Birth summary tables 2012, ONS

The General Fertility Rate (GFR) (births per 1,000 females aged 15-44 years) has been increasing over the past 10 years both nationally and locally (Figure 6).

Figure 6: Trend in fertility rate in East Sussex and England 1997-2012



Source: Birth registrations and mid-year population estimates, ONS

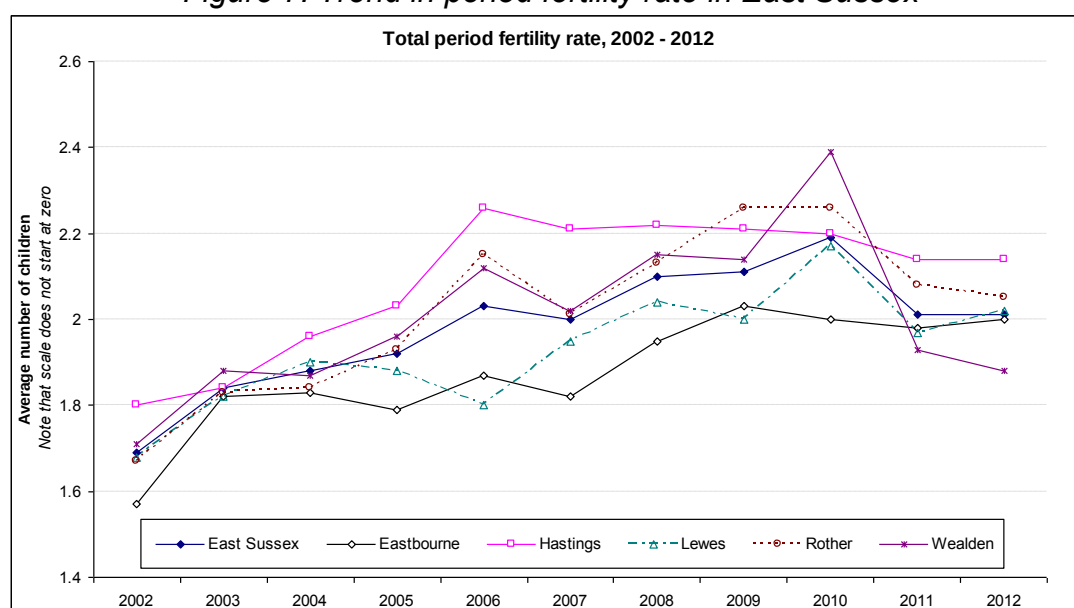
The GFR/birth rate in East Sussex (62.5 per 1,000 females aged 15-44) is lower than that of England and Wales (64.8 per 1,000), which has been the case for a number of years. The GFR varies between districts and boroughs. The birth rate in Hastings has been consistently higher than England and Wales since 2003; whilst the rate in Eastbourne has exceeded the national rate since 2009. The birth rates in Lewes, Rother and Wealden District Councils are all below the East Sussex and England averages (Figure 6).

2.2 Total Period Fertility Rate

The Total Period Fertility Rate (TPFR) is the average number of live births per woman if the current age-specific fertility rates were experienced throughout their childbearing lives. It is a hypothetical measure but provides a reasonable summary of current fertility levels. Changes in the TPFR can result from changes in the timing of childbearing within women's lives as well as any changes in completed family size.

The TPFR in East Sussex has increased from 1.69 live births per woman in 2002 to 2.01 in 2012, but now appears to be reducing or stabilising. The highest rate tends to be in Hastings and the lowest in Eastbourne, although in 2012 the lowest rate was in Wealden (Figure 7).

Figure 7: Trend in period fertility rate in East Sussex

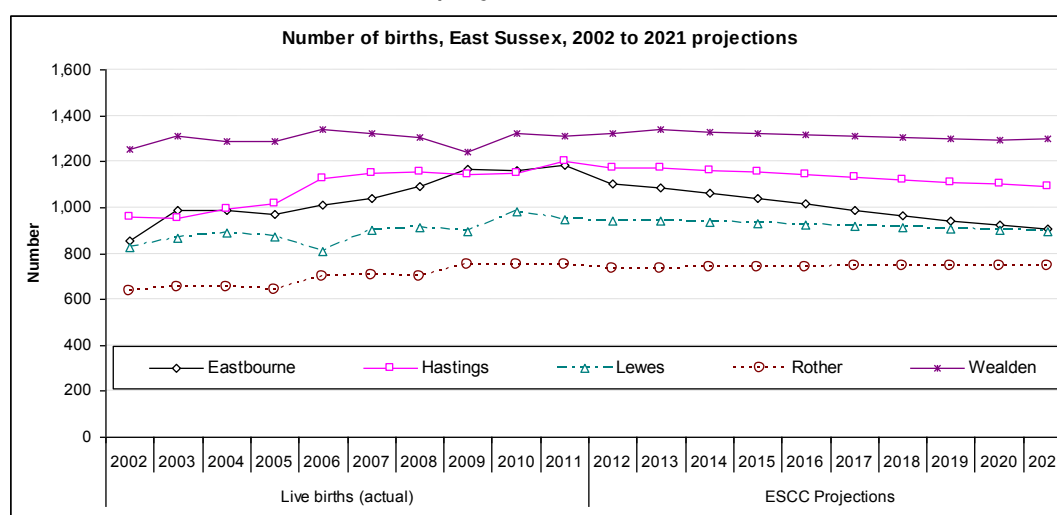


Source: Vital statistics, ONS

2.3 Birth projections

The TPF, together with the size of the 15-44 year old female population, is used to predict the likely number of future births. Birth projections to 2021 suggest that from 2012 the number of births in Eastbourne will decrease by 24%; the number in Hastings and Lewes by around 10%, with Rother and Wealden remaining fairly static (Figure 8). As well as having the lowest TPF, Eastbourne is predicted to see the largest decline in 15-44 year old females (see Figure 2).

Figure 8: Trend in number of live births by district and borough in East Sussex, 2002 – 2012 with projections to 2021



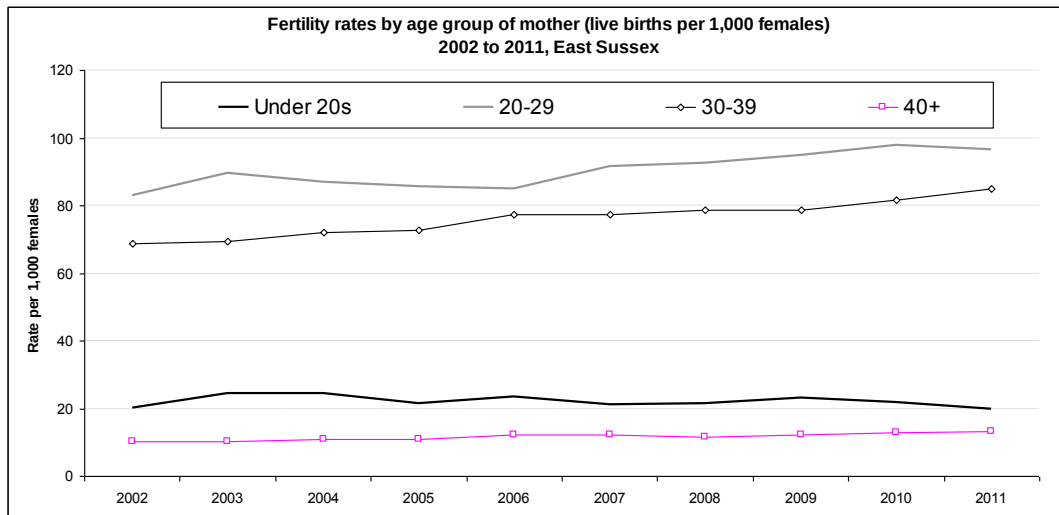
Source: ONS births data and ESCC Policy based Population Projections, July 2013

Note: At the time the projections were calculated 2012 actual live births were not available.

2.4 Age specific fertility rates

Figure 9 looks at the trend in age specific fertility rates in East Sussex: the rate is highest in the 20-29 year old age group and lowest in the 40+ age group. Between 2002 and 2011 rates have increased in all age bands except in the under 20s where they decreased by 2%: in 20-29 year olds they increased by 16%; in 30-39 year olds by 24% and in 40+ year olds by 29%.

Figure 9: Age specific fertility rates in East Sussex, 2002-2011

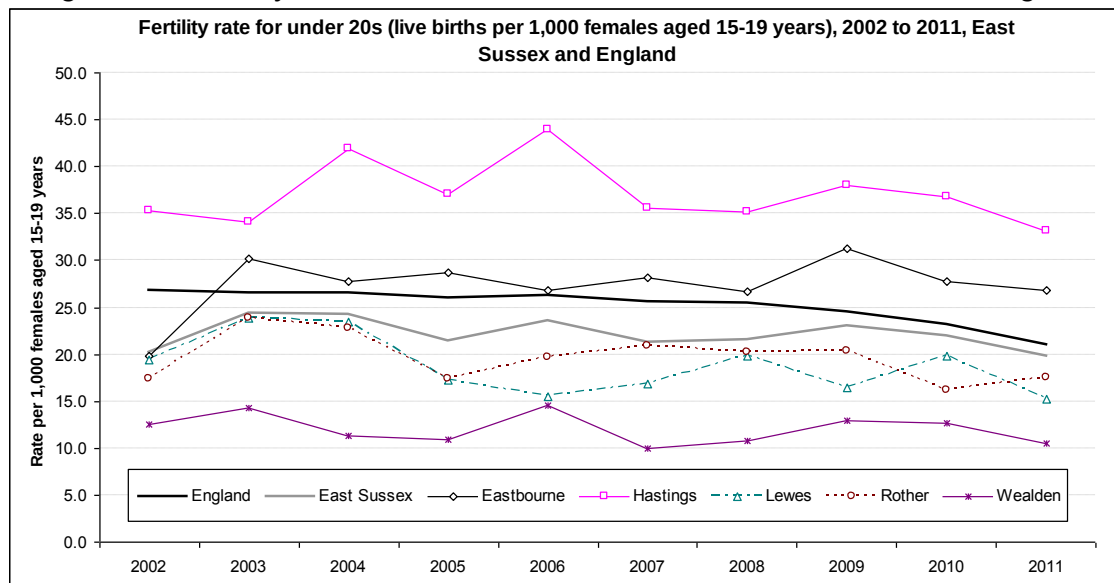


Source: Source: ONS Vital Statistics and Mid-year estimates

Birth rate in under 20s

The East Sussex birth rate to women under 20 years (19.8 per 1,000) is lower than the England average (21.0 per 1,000); rates are consistently highest in Hastings and Eastbourne and lowest in Wealden. In 2011 there were 305 live births to women under 20 years: the highest numbers were in Hastings (95) and Eastbourne (80) and the lowest in Lewes (41) [Figure 10 and Table 4].

Figure 10: Fertility rate for under 20s, 2002-2011 East Sussex and England



Source: ONS Vital Statistics and Mid-year estimates

Table 4: Number of live births to mothers aged under 20 years, East Sussex, 2002 to 2011

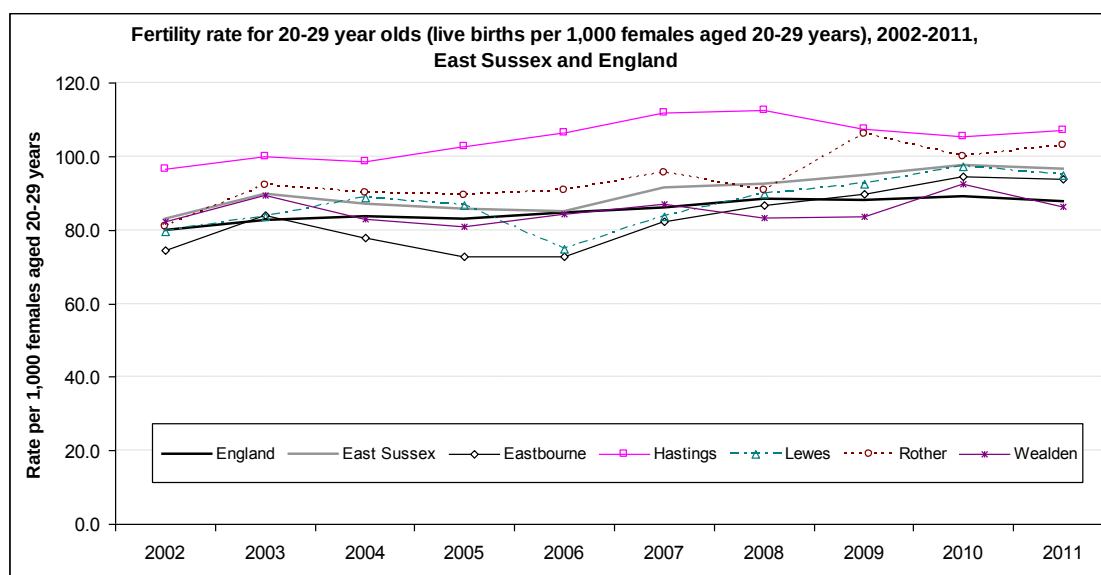
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
East Sussex	277	347	360	329	365	333	336	360	340	305
Eastbourne	52	82	78	84	77	81	75	90	81	80
Hastings	90	93	120	109	133	109	108	117	109	95
Lewes	49	62	62	47	42	46	54	45	54	41
Rother	37	53	53	42	48	52	51	51	40	43
Wealden	49	57	47	47	65	45	48	57	56	46

Source: ONS Vital Statistics and Mid-year estimates

Birth rate in 20-29 year olds

The East Sussex birth rate to women aged 20-29 years (96.4 per 1,000) has been increasing since 2006, since which time it has been higher than the England average (87.8 per 1,000); it now appears to be stabilising. Rates tend to be highest in Hastings and Rother Districts. In 2011 there were 2,477 live births to women aged 20-29 year; the highest numbers were in Hastings and Eastbourne and the lowest in Rother [Figure 11 and Table 5].

Figure 11: Fertility rate for 20-29 year old females, 2002-2011 East Sussex and England



Source: ONS Vital Statistics and Mid-year estimates

Table 5: Number of live births to mothers aged 20-29 years, East Sussex, 2002 to 2011

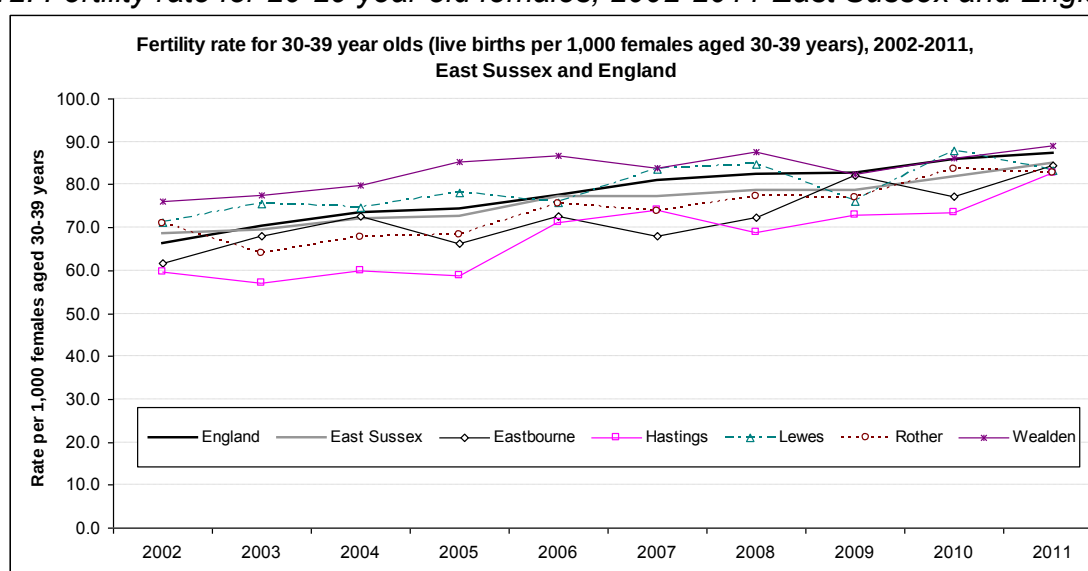
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
East Sussex	1820	1973	1941	1962	2012	2227	2286	2361	2470	2477
Eastbourne	390	446	439	436	450	518	546	554	577	562
Hastings	462	472	478	515	533	584	604	591	597	624
Lewes	307	321	341	329	294	340	373	389	420	416
Rother	232	263	252	256	273	295	289	346	337	352
Wealden	429	471	431	426	462	490	474	481	539	523

Source: ONS Vital Statistics and Mid-year estimates

Birth rate in 30-39 year olds

As nationally, the East Sussex birth rate to women aged 30-39 years has been increasing; rates tend to be highest in Wealden and lowest in Hastings. In 2011 there were 2,370 live births to women in this age group; the highest numbers were in Wealden and Hastings, and the lowest in Rother [Figure 12 and Table 6].

Figure 12: Fertility rate for 20-29 year old females, 2002-2011 East Sussex and England



Source: ONS Vital Statistics and Mid-year estimates

Table 6: Number of live births to mothers aged 30-39 years, East Sussex, 2002 to 2011

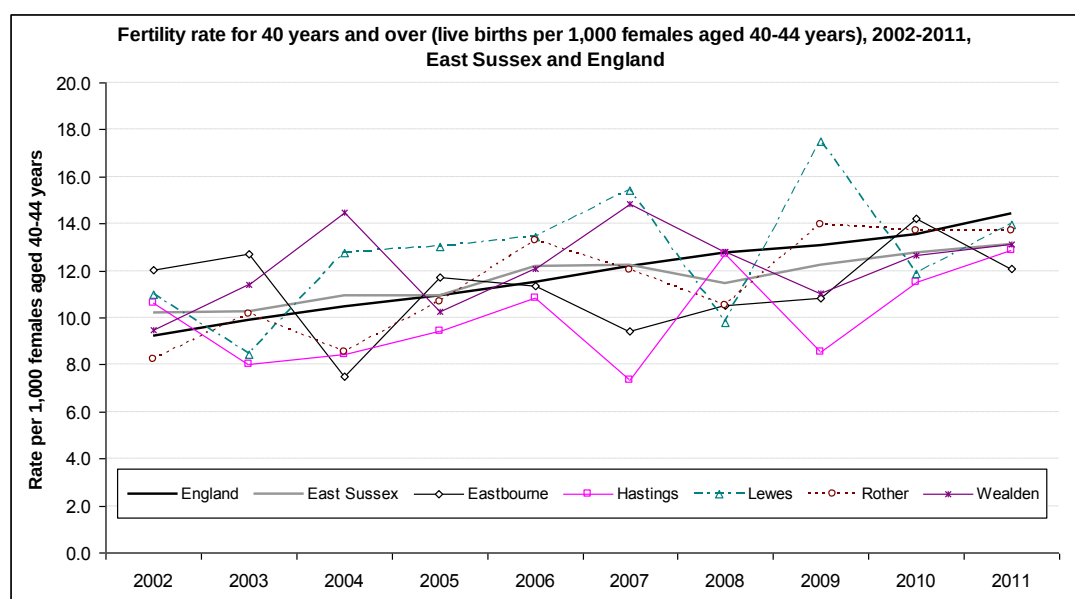
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
East Sussex	2254	2266	2309	2285	2377	2320	2310	2246	2312	2370
Eastbourne	375	421	448	409	445	409	434	486	458	503
Hastings	376	362	368	359	427	433	397	409	402	440
Lewes	434	454	442	448	427	461	447	400	463	438
Rother	345	308	320	314	336	318	325	310	334	318
Wealden	724	721	731	755	742	699	707	641	655	671

Source: ONS Vital Statistics and Mid-year estimates

Birth rate in females of 40 years and over

The East Sussex birth rate to women aged 40 years and over is very variable from year to year but as nationally it appears to be gradually increasing albeit at a slower rate than nationally. Rates tend to be higher in Lewes and lower in Hastings. In 2011 there were 247 live births to women in this age group; the highest numbers were in Wealden and the lowest in Rother and Eastbourne [Figure 13 and Table7].

Figure 13: Fertility rate for 20-29 year old females, 2002-2011 East Sussex and England



Source: ONS Vital Statistics and Mid-year estimates

Table 7: Number of live births to mothers aged 40 years or over, East Sussex, 2002 to 2011

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
East Sussex	179	185	201	207	235	240	225	236	242	247
Eastbourne	36	39	24	39	39	33	37	37	47	40
Hastings	32	25	27	31	36	25	44	29	39	43
Lewes	37	29	44	46	48	56	36	64	43	50
Rother	23	29	25	32	41	38	33	43	41	40
Wealden	51	63	81	59	71	88	75	63	72	74

Source: ONS Vital Statistics and Mid-year estimates

Table 8 provides a summary of age specific fertility in East Sussex. Age specific fertility rates (birth rates) are lower than England for all age bands, except in 20-29 year olds where they are higher.

Table 8: Births in East Sussex by age of mother: relative picture in Districts and Boroughs

Age of mother	Number of births in 2011	E Sussex rate compared to England	Rates in Districts and Boroughs - trend		Numbers in Districts and Boroughs in 2011	
			Highest Rate	Lowest Rate	Highest Number	Lowest Number
< 20 yrs	305	Lower	Hastings	Wealden	Hastings (95)	Lewes (41)
20-29 yrs	2,477	Higher	Hastings	Wealden - since 2007	Hastings (624)	Rother (352)
30-39 yrs	2,370	Lower	Wealden	Hastings	Wealden (671)	Rother (318)
40+ yrs	247	Lower	Lewes	Hastings Eastbourne	Wealden (74)	Rother (40) Eastbourne (40)

Source: ONS Vital Statistics and Mid-year estimates

Trend data (see Figures 8-11) shows that birth rates in younger women (under 20s and 20-29 years) tend to be higher in Hastings than in the other districts and boroughs and birth rates in older women (30-39 years and 40 years and over) tend to be higher in Wealden and Lewes. In East Sussex, as for England, fertility rates in the under 20s have been decreasing; in 20-29 yr olds they have increased but are beginning to stabilise; in 30-39 year olds and 40+ age groups they are still increasing - although rates in 40+ age group are low.

2.5 Number of births by maternal age

Hastings has the highest number of births in the younger age groups (under 20s and 20-29 years), and Wealden the highest number in older age groups (30-39 years and 40s and over). Rother has the lowest number of births for all age groups apart from for the under 20s where numbers are similar to Lewes and Wealden. The majority of births are to women between 20 - 39 years of age with only 6% of births being to women under 20 years and 5% to women over 40 years (Table 9).

Table 9: Births by maternal age in Districts and Boroughs (2011)

	<20 yrs		20-29 yrs		30-39 yrs		40+ yrs		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Eastbourne	80	6.8%	562	47.4%	503	42.4%	40	3.4%	1185	100%
Hastings	95	7.9%	624	51.9%	440	36.6%	43	3.6%	1202	100%
Lewes	41	4.3%	416	44.0%	438	46.3%	50	5.3%	945	100%
Rother	43	5.7%	352	46.7%	318	42.2%	40	5.3%	753	100%
Wealden	46	3.5%	523	39.8%	671	51.1%	74	5.6%	1314	100%
East Sussex	305	5.6%	2477	45.9%	2370	43.9%	247	4.6%	5399	100%

Source: ONS Vital Statistics

2.6 First time mothers

In 2012/13 the average age of first time mothers in East Sussex was 28 years, ranging from 26 years in Hastings to 29 years in Lewes and Wealden. Lewes (56%) has the highest percentage of first time mothers and Rother the lowest (41%) (Table 11).

Table 11: Average age and percentage of first time mothers in districts and boroughs

Local Authority	Average age of first time mother	Percentage of maternities first time mothers
Eastbourne	28	47%
Hastings	26	45%
Lewes	29	56%
Rother	27	41%
Wealden	29	46%
East Sussex	28	47%

Source: East Sussex Child Health systems, children born between 19/02/2012 to 17/02/13 (children due 6 week check in 2012/13)

The average age of first time mothers at the Conquest and EDGH was 27 years compared to 30 years at TWH, and 31 years at PRH and for home births. The percentage of first time mothers varies by provider: 76% of East Sussex women giving birth at PRH were first time mothers compared to 32% at CBC and 25% of those giving birth at home (Table 12).

Table 12: Average age and percentage of first time mothers by provider unit

Place of birth	Average age of first time mother	Percentage of maternities first time mothers
Conquest	27	44%
EDGH	27	46%
Crowborough	29	32%
PRH	31	76%
RSCH	28	50%
Tunbridge Wells	30	54%
Home	32	25%

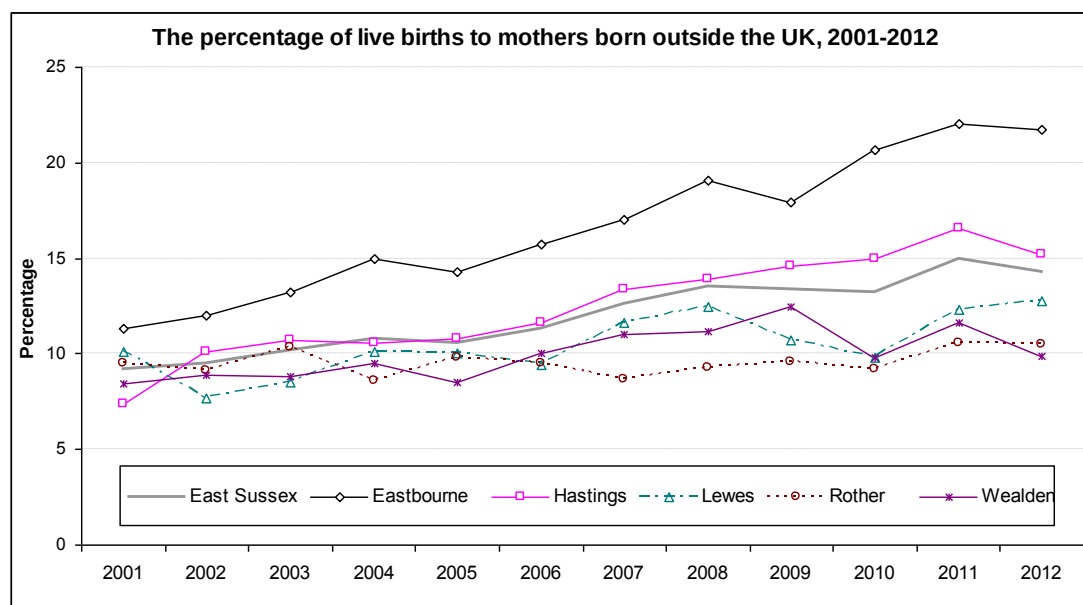
Source: East Sussex Child Health systems, children born between 19/02/2012 to 17/02/13 (children due 6 week check in 2012/13)

2.7 Births to women born outside the UK - trend

In East Sussex, as nationally, the proportion of births to women born outside the UK has been increasing over the last decade. This is particularly apparent in Eastbourne and to a lesser extent Hastings, where the non-White British fertile female population is greatest (see Figure 14).

In 2012, 14.3% (778) of all live births in East Sussex were to non-UK born mothers compared with 25.9% in England and Wales as a whole. The percentage was highest in Eastbourne (21.7%, n=259) followed by Hastings (15.2%, n=184) and lowest in Wealden (9.9%, n=130); the lowest number of births to non-UK born women was in Rother (10.5%, n=79) [see Tables 13 and 14].

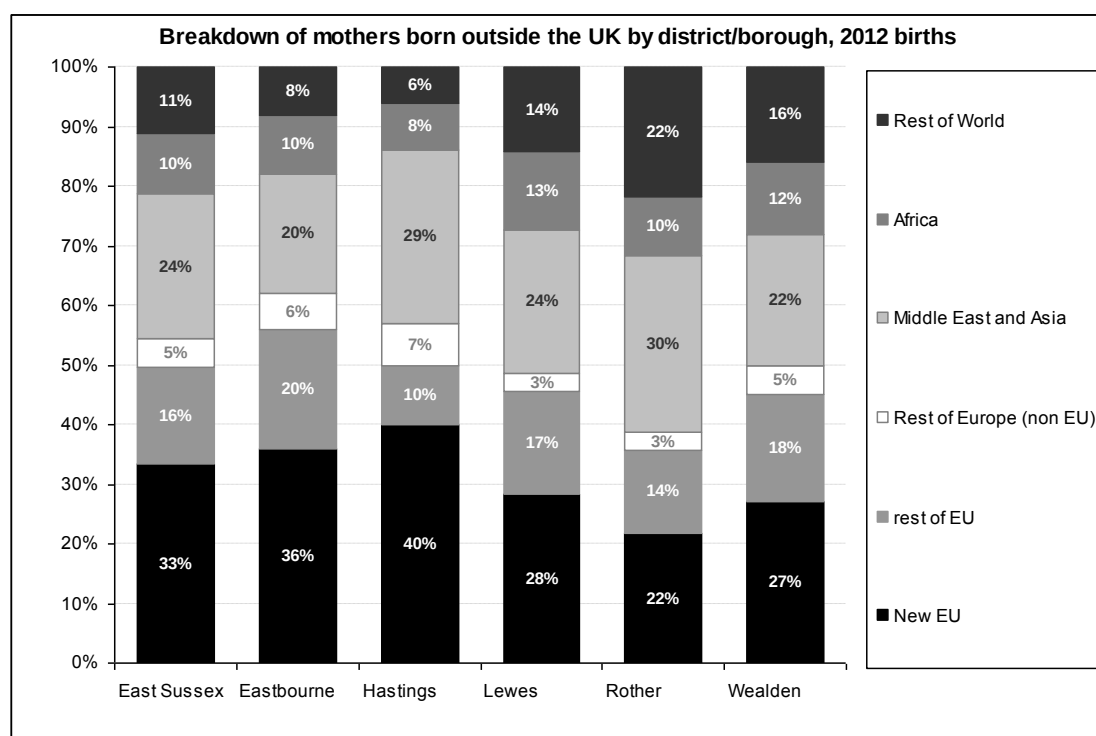
Figure 14: Percentage of live births to women born outside the UK



Source: ONS

In 2012 the largest percentage of births in non-UK born mothers was to women from the New EU (33%, n=253)³ followed by the Middle East and Asia (24%, n=188). This was the case in all Districts and Borough except Rother where the percentage from the Middle East and Asia was higher than from the New EU countries (see Figure 15).

Figure 15: Births to mothers born outside UK by East Sussex districts and boroughs, 2012



Source: ONS

³ New EU includes Estonia, Latvia, Lithuania, Czech Republic, Hungary, Poland, Romania, Slovakia, Malta, Bulgaria, Cyprus (EU), Cyprus (not otherwise stated), Slovenia, Czechoslovakia not otherwise stated

Table 13: Number of babies born to non-UK born mothers, E Sussex resident births 2012

	New EU	rest of EU	Rest of Europe (non EU)	Middle East and Asia	Africa	Rest of World	All
East Sussex	253	128	40	188	80	89	778
Eastbourne	92	52	16	52	25	22	259
Hastings	74	19	12	53	15	11	184
Lewes	35	22	4	30	17	18	126
Rother	17	11	2	24	8	17	79
Wealden	35	24	6	29	15	21	130

Source: ONS

Table 14: Percentage of babies born to non-UK born mothers, E Sussex resident births 2012

	New EU	rest of EU	Rest of Europe (non EU)	Middle East and Asia	Africa	Rest of World
East Sussex	33%	16%	5%	24%	10%	11%
Eastbourne	36%	20%	6%	20%	10%	8%
Hastings	40%	10%	7%	29%	8%	6%
Lewes	28%	17%	3%	24%	13%	14%
Rother	22%	14%	3%	30%	10%	22%
Wealden	27%	18%	5%	22%	12%	16%

Source: ONS

2.8 Births by provider unit

The main maternity units serving East Sussex (see Figure 1) are:

- Royal Sussex County Hospital (RSCH) in Brighton
- Princess Royal Hospital (PRH) in Haywards Heath
- Eastbourne District General Hospital (EDGH) in Eastbourne
- The Conquest hospital in Hastings (Conquest)
- Crowborough Birthing Centre (CBC) in Crowborough
- Tunbridge Wells Hospital (TWH) in Pembury.

There has been a gradual increase in the number of East Sussex births between 2006 and 2012. The Conquest and EDGH have seen some increase but the numbers appear to be stabilising. The number of births in RSCH and TWH is increasing; there has been little change in CBC and PRH, and the number of home births has decreased (Figure 16 and Table 15).

Until the recent changes, the largest percentage of East Sussex live births were in EDGH (35% in 2012) followed by the Conquest (33%), RSCH (11%), PRH (8%) and TWH (6%); 3% of births in 2012 occurred at home and 3% in Crowborough birthing centre (Table 12). In the first nine months of 2013/14, the percentage of births in EDGH has reduced to 20% and the percentage at the Conquest has risen to 45%; there has also been an increase at TWH (8%) (see Table 15).

Figure 16: Number of East Sussex live births by place of birth, 2006-2012



Source: 2006 to 2011 ONS Annual birth files; 2012 to September 2013 East Sussex Child health Systems * 2013 9 months of data only

Table 15: Number and percentage of live births, by place of birth, East Sussex resident births

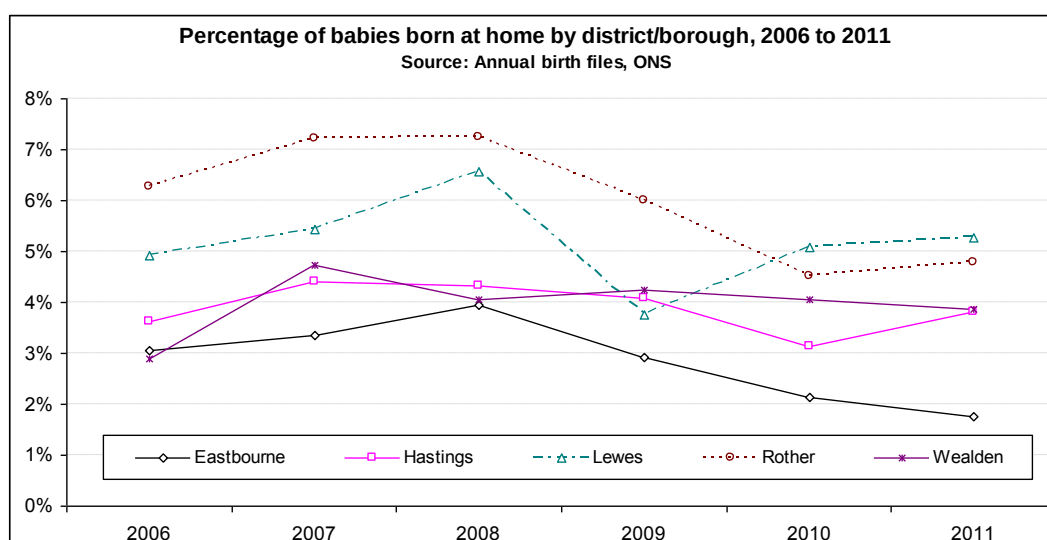
	2006	2007	2008	2009	2010	2011	2012*	2013* (9mths data only)
EDGH	1823	1801	1880	1892	1981	1933	1919	792
Conquest	1652	1650	1675	1765	1747	1799	1790	1817
RSCH	411	467	475	479	485	514	584	421
PRH	367	426	412	412	453	419	425	344
Tunbridge Wells	258	254	197	213	233	296	356	359
Home	193	249	257	212	198	203	167	125
Crowborough	188	167	170	161	175	151	178	134
Other	97	108	88	69	92	84	82	63
Total	4989	5122	5154	5203	5364	5399	5501	4055
Percentage of births								
EDGH	37%	35%	36%	36%	37%	36%	35%	20%
Conquest	33%	32%	32%	34%	33%	33%	33%	45%
RSCH	8%	9%	9%	9%	9%	10%	11%	10%
PRH	7%	8%	8%	8%	8%	8%	8%	8%
Tunbridge Wells	5%	5%	4%	4%	4%	5%	6%	9%
Home	4%	5%	5%	4%	4%	4%	3%	3%
Crowborough	4%	3%	3%	3%	3%	3%	3%	3%
Other	2%	2%	2%	1%	2%	2%	1%	2%
Total	100%	100%	100%	100%	100%	100%	100%	100%

Source: 2006 to 2011 ONS Annual birth files; 2012 to September 2013 East Sussex Child health Systems * 2013 9 months of data only

2.9 Home births

Figure 17 identifies home births by district and borough between 2006 and 2011. It shows that home birth rates tend to be highest in Lewes and Rother and lowest in Eastbourne and Hastings. The highest numbers of home births tends to be in Wealden and Lewes (Table 16).

Figure 17: Home births to East Sussex women, 2006-2011



Source: 2006 to 2011 ONS Annual birth files, 2012 to September 2013 East Sussex Child health Systems*

Table 16: Number of home births by Districts and Boroughs (2006-2011)

	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2006	31	41	40	44	39	195
2007	35	51	49	51	63	249
2008	43	50	60	51	53	257
2009	34	47	34	45	53	213
2010	25	36	50	34	54	199
2011	21	46	50	36	51	204
Total	189	271	283	261	313	1317

2.10 Place of birth by area of residence

Figures 18 to 23 map the births at each provider unit according to Lower Super Output Area (LSOA)⁴ of residence; the darker the colour the greater the number of deliveries in that LSOA.

- Births at the Conquest are predominantly from Hastings and Rother (Figure 18)
- Births at EDGH are predominantly from Eastbourne and Wealden (Figure 19)
- Births at Crowborough come from all parts of East Sussex, but are predominantly from the Wealden area; there are very few births from Eastbourne and Hastings (Figure 20).
- Births at RSCH are predominantly from Lewes district (Figure 21)
- Births at Princes Royal are from the West of Wealden and the North and North-west of Lewes district (Figure 22).
- Births at TWH are predominantly from the North-east of Wealden and the North-west of Rother (Figure 23).

⁴ Lower super output areas (LSOAs) are geographical areas used for the collection and publication of small area statistics

Figure 18: Births at **Conquest Hospital** by East Sussex LSOA, 2010 and 2011

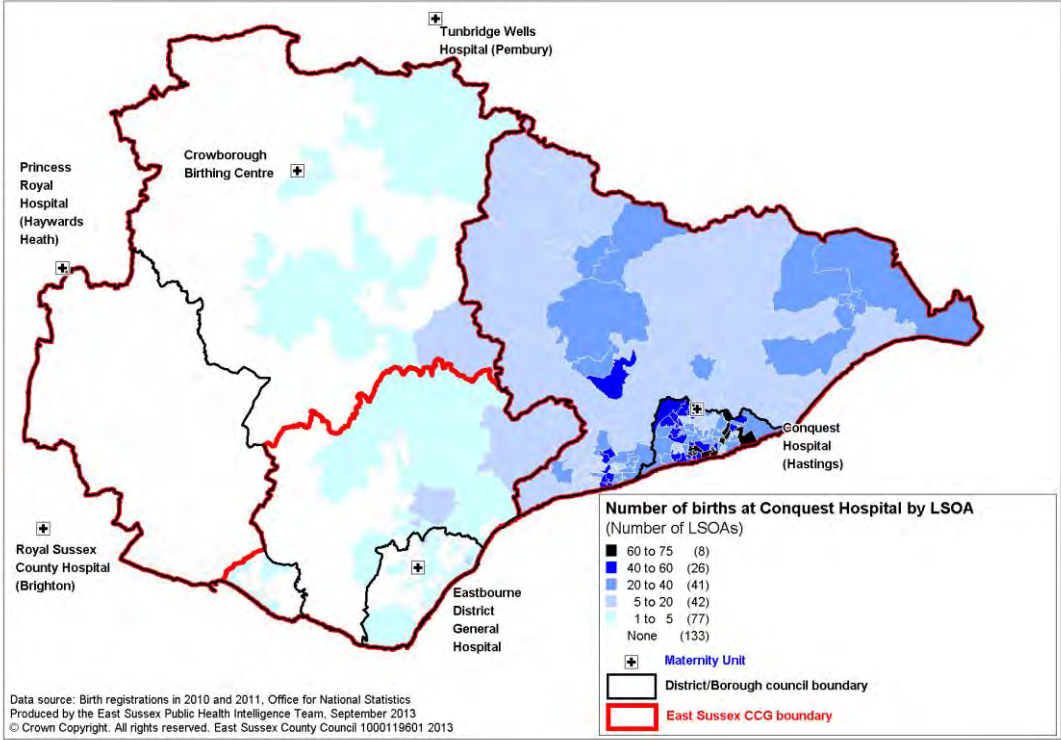


Figure 19: Births at **Eastbourne District General Hospital** by East Sussex LSOA, 2010 and 2011

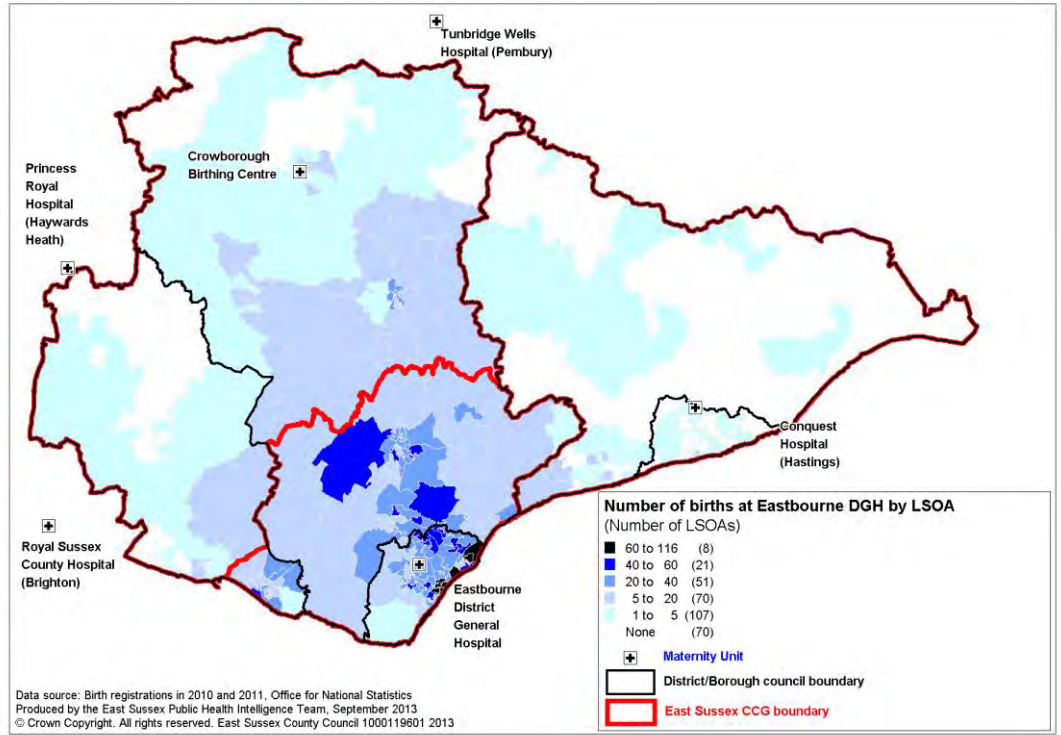


Figure 20: Births at **Crowborough Birthing Centre** by East Sussex LSOA, 2010 and 2011

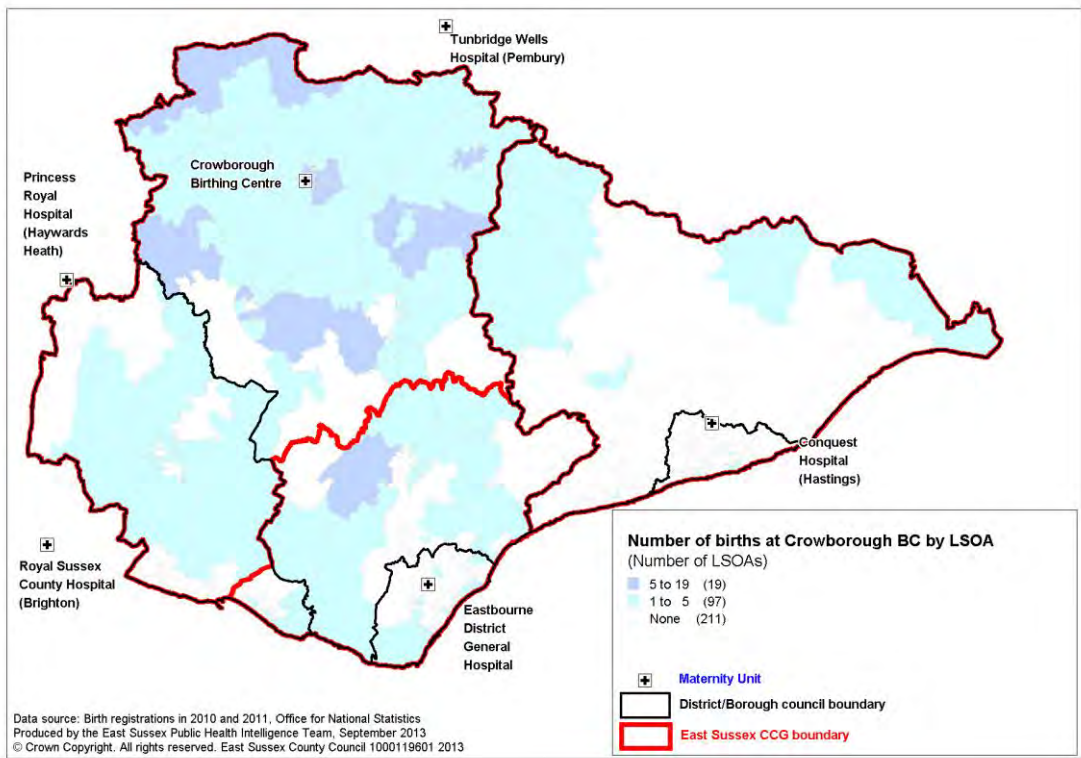


Figure 21: Births at **Royal Sussex County Hospital** by East Sussex LSOA, 2010 and 2011

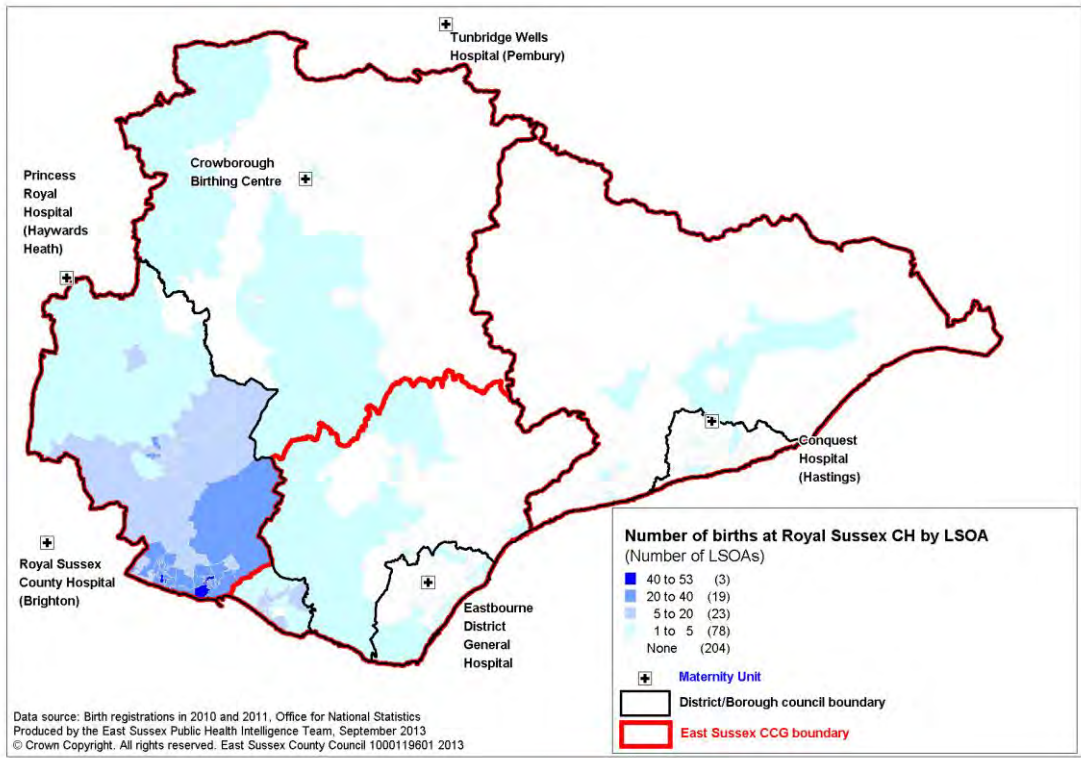


Figure 22: Births at **Princess Royal Hospital** by East Sussex LSOA, 2010 and 2011

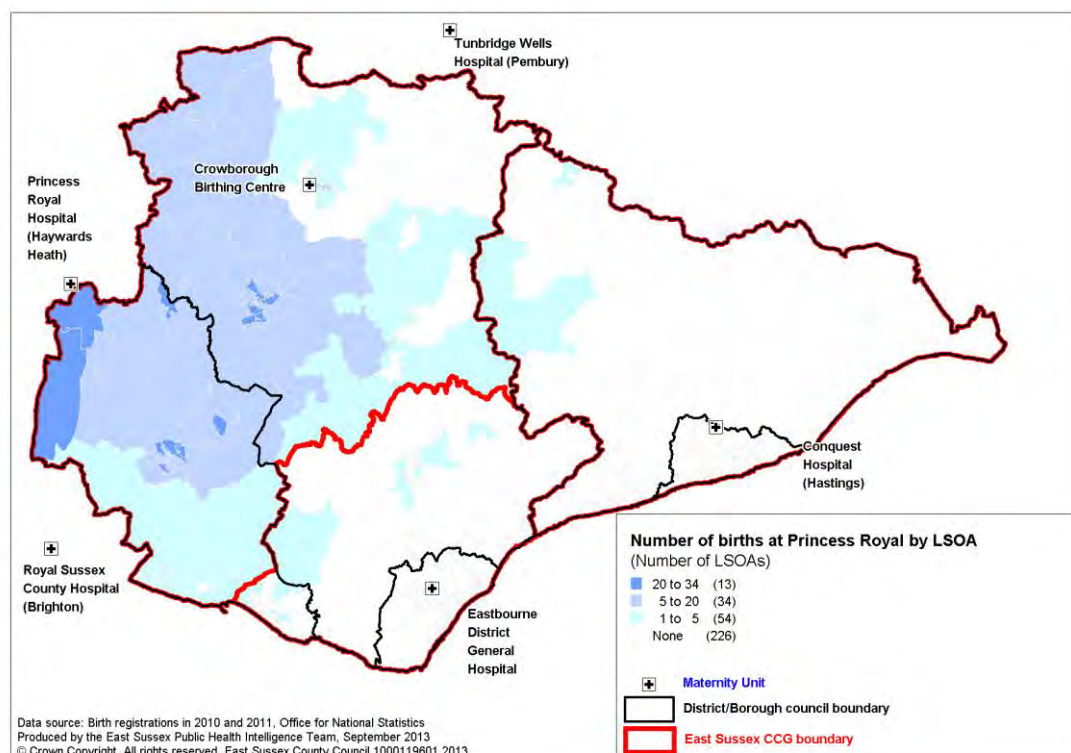
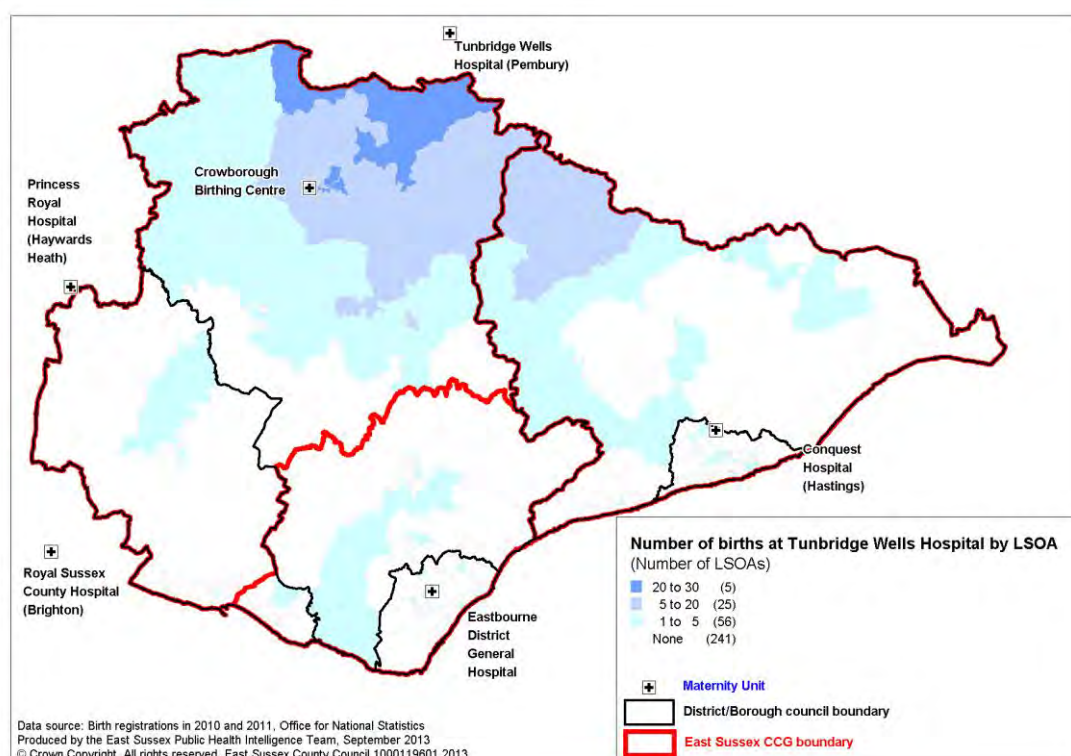


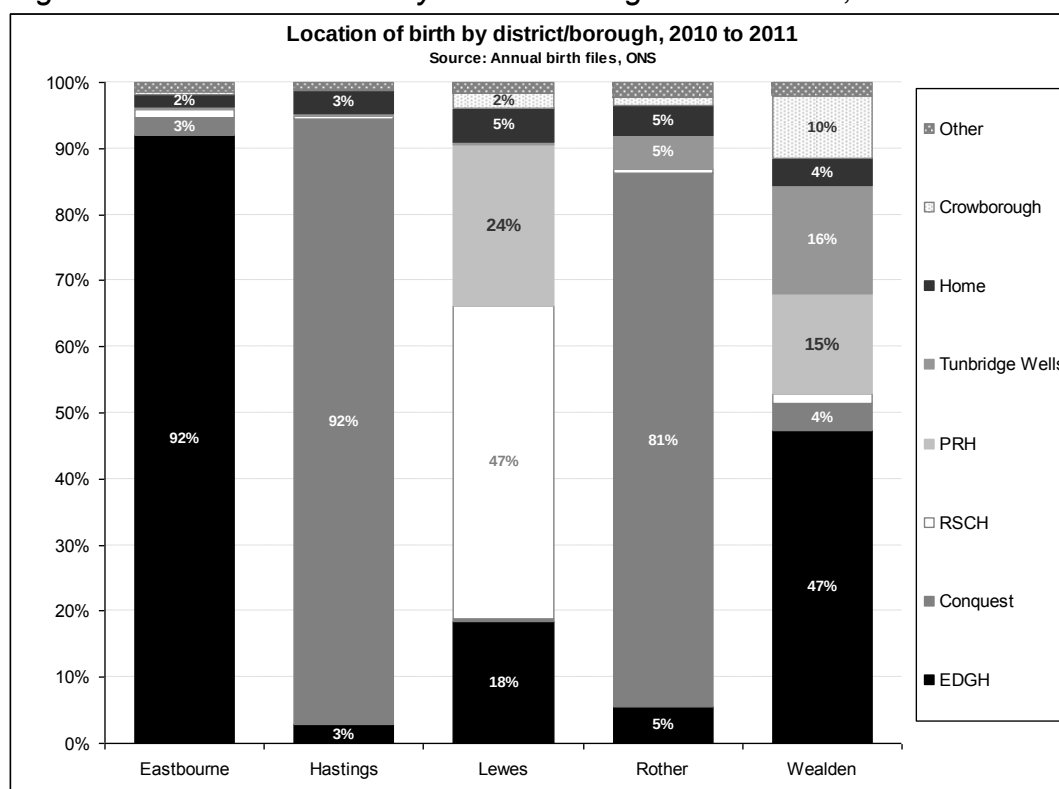
Figure 23: Births at **Tunbridge Wells Hospital** by East Sussex LSOA, 2010 and 2011



2.11 Place of birth by area of residence

Figure 24 looks at the maternity unit of birth by district and borough. Figure 25 maps the dominant maternity unit for each geographical area (CCGs and District and Boroughs) by allocating each Lower Super Output Area (LSOA) to the maternity unit where most births in that LSOA occur.

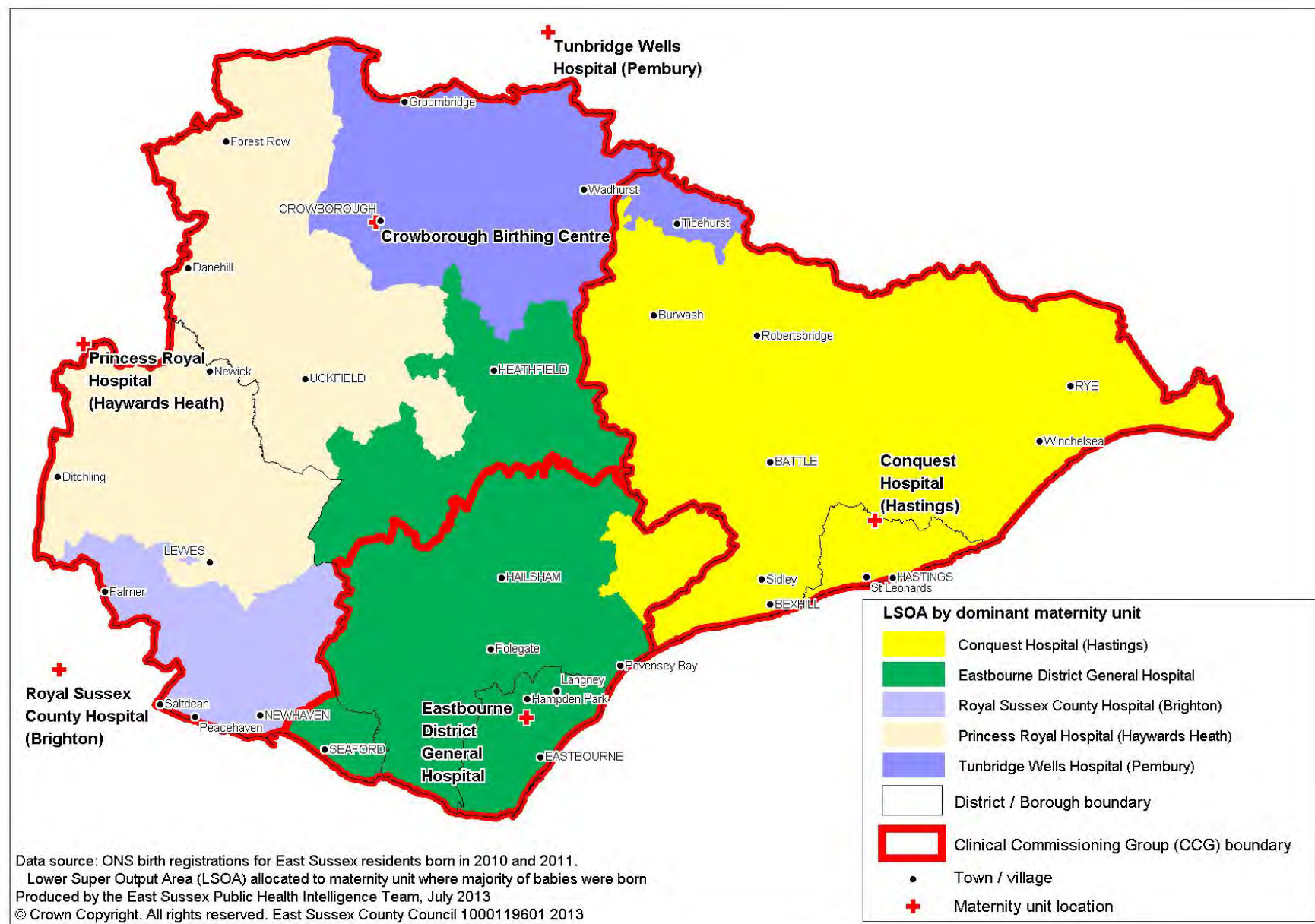
Figure 24: Location of birth by district/borough of residence, 2010 and 2011



Source: Annual birth files

- Those residing in Hastings and Rother CCG area generally give birth at the Conquest in Hastings with a proportion from the north- west going to Tunbridge Wells Hospital in Pembury (Figure 25). Analysis by districts and boroughs shows that 92% of Hastings residents and 81% of Rother residents gave birth at the Conquest during 2010 and 2011 (Figure 24).
- Those residing in Eastbourne Hailsham and Seaford CCG area generally give birth in Eastbourne DGH with a proportion from the north-east going to the Conquest (Figure 25). Analysis by districts and boroughs (Figure 24) shows that 92% of Eastbourne residents gave birth at EDGH in 2010 and 2011 (Figure 24).
- In High Weald Lewes and Havens CCG area the picture is more mixed: those in the north-east mainly go to TWH in Pembury (TWH); those in the south-east to Eastbourne EDGH; those in the west to PRH (BSUH); and those in the south to the RSCH (BSUH) (Figure 25). Analysis by districts and boroughs shows that in 2010 and 2011, 47% of Lewes residents gave birth at RSCH, 24% at PRH and 18% at EDGH (Figure 24). Newhaven, Peacehaven and Saltdean residents generally give birth at RSCH; (as mentioned above Seaford residents generally give birth at the EDGH); and Lewes town, Ditchling, Newick and Ringmer residents at PRH (Figure 25).
- In the Wealden area, during the same period, 47% residents gave birth at EDGH, 16% at TWH and 15% at PRH (Figure 24): Polegate, Hailsham and Heathfield residents generally give birth at EDGH; Crowborough residents at TWH; and Uckfield, Danehill and Forest Row residents at PRH (Figure 25).

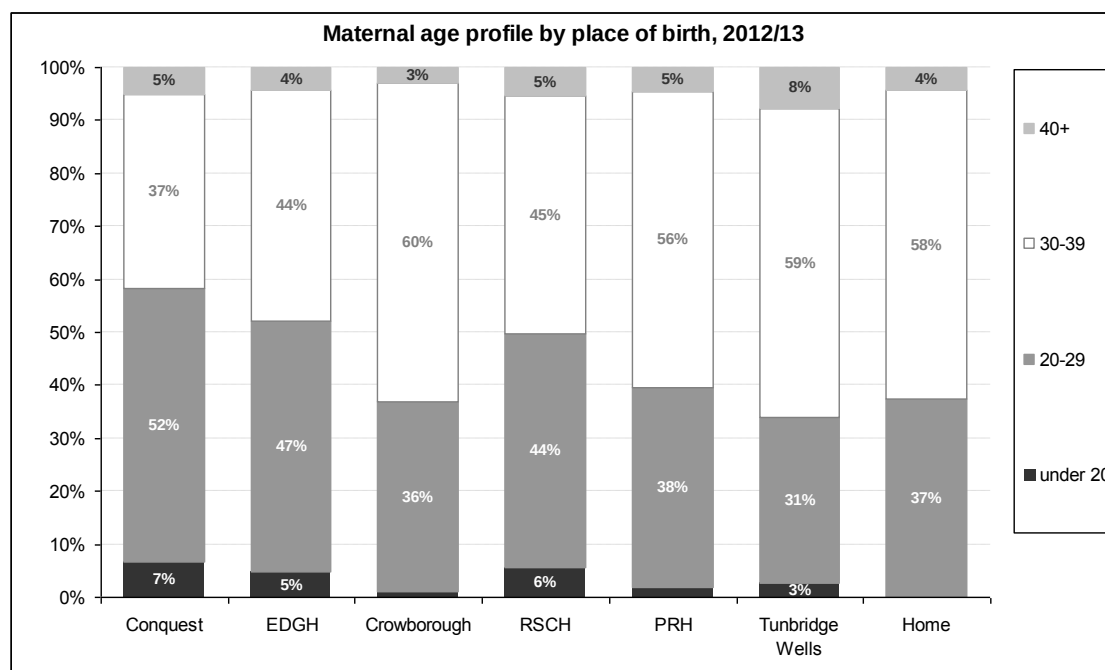
Figure 25: East Sussex Lower Super Output Areas by dominant maternity unit for births registered in 2010 and 2011



2.12 Maternal age profile by place of birth

A comparison of the age profile of East Sussex residents by place of birth in Figure 26 shows that Crowborough, PRH, Tunbridge Wells and home births (accounting for around 22% of deliveries) have older profiles than the Conquest, EDGH and RSCH. However the Conquest, EDGH and RSCH account for 75% of all deliveries in 2012/13. And whilst Tunbridge Wells has the highest proportion of deliveries to women over 40 years (8%), this equates to only 25 deliveries in 2012/13.

Figure 26: Maternal age profile by place of birth, 2012/13



Source: ESHT, BSUH and MTW maternity unit 2012/13 delivery data

2.13 Deprivation by place of birth

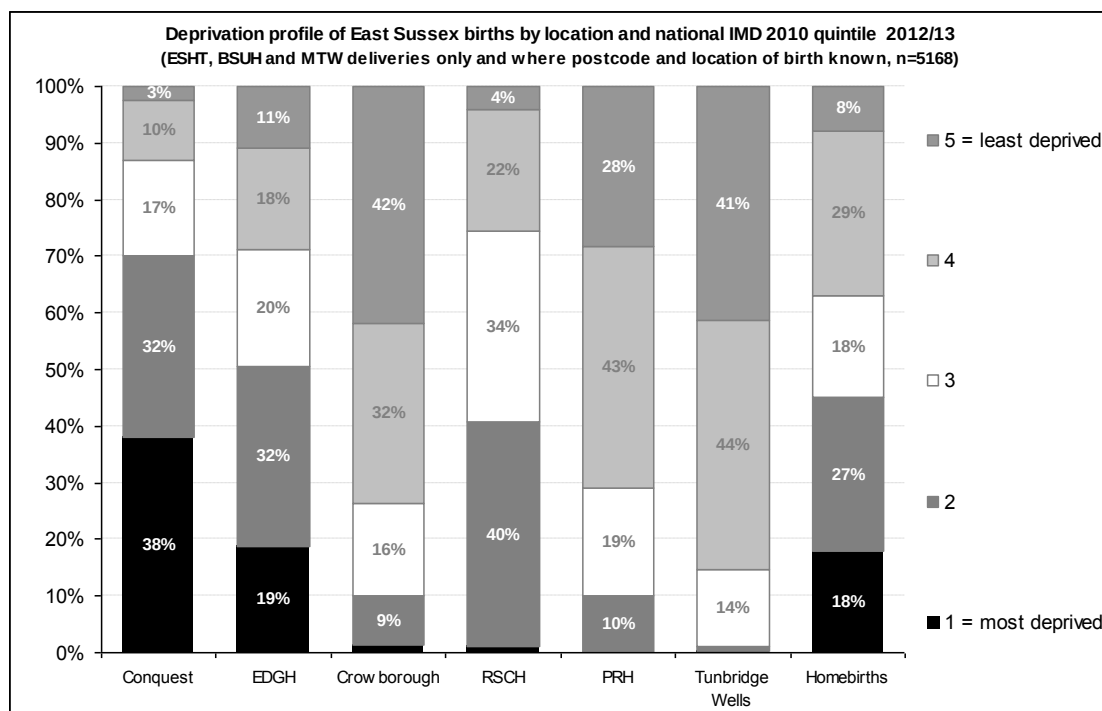
Figure 27 shows that the Conquest has a higher proportion of births to women from the more deprived areas [(70%, n=1,254) in quintiles 1 and 2] than EDGH [(51%, n=958) in quintiles 1 and 2]. In contrast women delivering in Crowborough, PRH and Tunbridge Wells Hospital are predominantly from the less deprived areas [with 74% (167), 71% (226) and 85% (264) respectively in quintiles 4 and 5]. Forty five percent of home births (68) in 2012/13 were to women resident in the more deprived areas (Table 17).

Table 17: Number of East Sussex births by location and national IMD quintile, 2012/13

	1 = most deprived	2	3	4	5 = least deprived	Total
Conquest	681	573	303	188	46	1791
Crowborough	3	20	37	72	95	227
EDGH	356	602	387	341	206	1892
PRH	0	32	61	136	90	319
RSCH	5	190	162	103	19	479
Tunbridge Wells	1	2	42	136	128	309
Homebirths	27	41	27	44	12	151
Total	1073	1460	1019	1020	596	5168

Source: ESHT, BSUH and MTW maternity unit 2012/13 delivery data

Figure 27: Deprivation profile of East Sussex births by location, 2012/13



Source: ESHT, BSUH and MTW maternity unit 2012/13 delivery data

3. Risk Factors

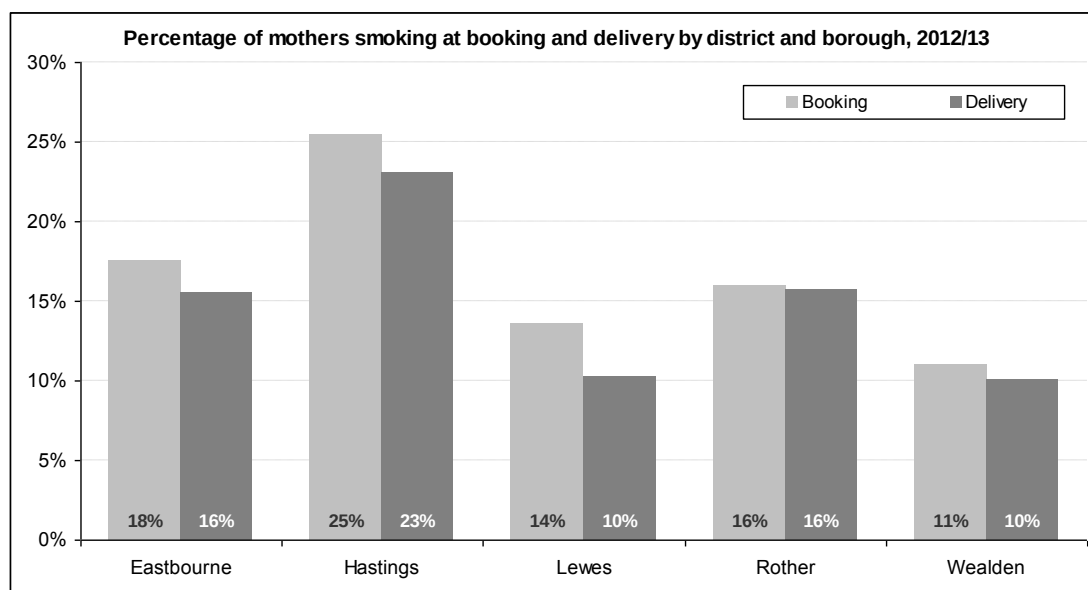
Several factors can adversely affect the developing foetus and increase the likelihood of adverse outcomes including maternal smoking, alcohol and drug use, domestic violence, mental health problems, and maternal diet – all factors that tend to be more common in more deprived areas and households.

3.1 Smoking

Women who smoke in pregnancy are at higher risk of miscarriage, premature birth, low birth weight babies and stillbirth. Smoking during pregnancy increases the risk of infant mortality by an estimated 40%.

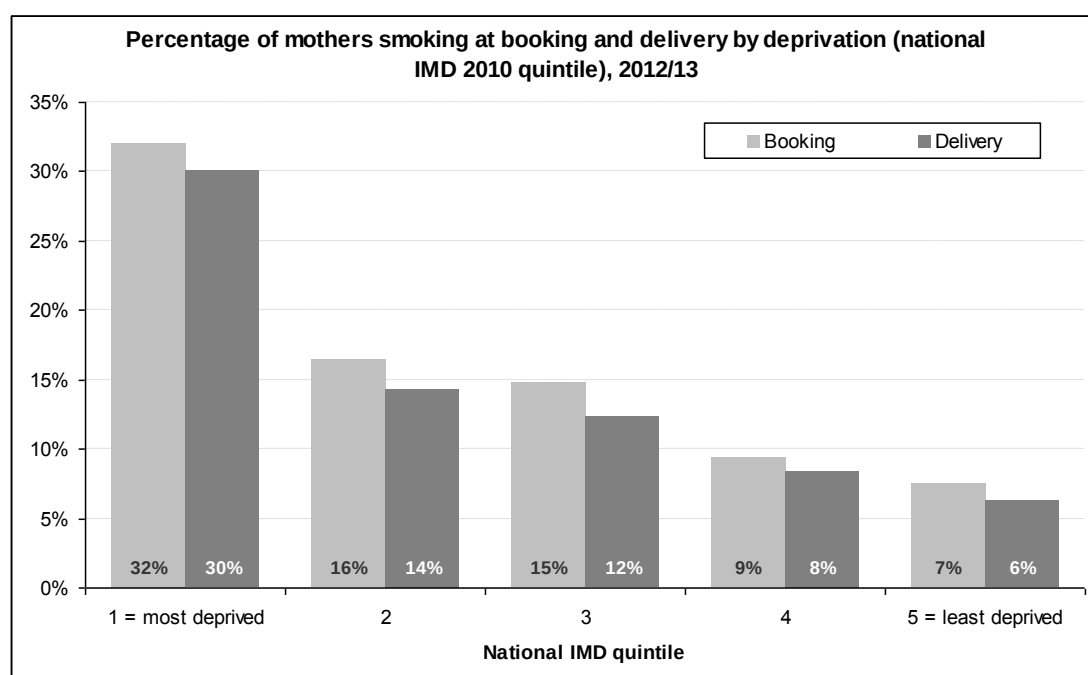
In East Sussex 18% of women are smoking at the time they book with the midwife at 10-12 weeks of pregnancy; 16% are still smoking at delivery. Smoking rates at booking (25%) and at the time of delivery (23%) are highest in Hastings. They are lowest at booking in Wealden (11%) and at delivery in Lewes and Wealden (10%) (see Figure 28). At the 6 week health visitor review the smoking status of both parents is identified. The highest rates for mothers and fathers are in Hastings (Figure 29). There is a clear socioeconomic gradient across East Sussex with rates being highest in the most deprived quintile and lowest in the least deprived.

Figure 28: Percentage of mothers smoking at booking and delivery by district and borough



Source: ESHT, BSUH and MTW maternity unit 2012/13 delivery data

Figure 29: Percentage of mothers smoking at booking and delivery by deprivation



Source: ESHT, BSUH and MTW maternity unit 2012/13 delivery data

3.2 Obesity

Maternal obesity is associated with greater health risks to the mother (in terms of maternal death, cardiac disease, gestational diabetes, caesarean section rate, post caesarean wound infection, admission to hospital for complications, longer length of stay post delivery) and also the baby (in terms of stillbirth, congenital abnormality and prematurity). There are technical issues in caring for obese women, including difficulties performing ultrasound examination and foetal monitoring, and implications for anaesthesia. Women who are living in more deprived areas have higher levels of obesity than those in less deprived areas.⁵

⁵ National Obesity Observatory data briefing, Adult obesity and socioeconomic status, October 2010.

Currently, data on maternal obesity is not routinely collected in the UK. Local data from ESHT suggests that, year on year, there is a slight increase in maternal obesity rates (women with a Body Mass Index (BMI) of over 35), with the rate rising from 6.5% in 2009/10 to 8.0% in 2011/12.

3.3 Substance misuse and alcohol

Substance misuse is associated with poor pregnancy outcomes. Women misusing substances are likely to experience other social disadvantages as well as being reluctant to access or stay in contact with maternity services.

It is estimated that around 4.5% of births in England are to women who misuse substances (alcohol and other drugs) which equates to 245 East Sussex births to women with substance misuse problems.⁶

3.4 Domestic violence

It is estimated that around 7% of births in England are to women who are victims of domestic violence, which equates to 380 East Sussex births to women who are experiencing domestic violence.⁵

3.5 Perinatal mental health

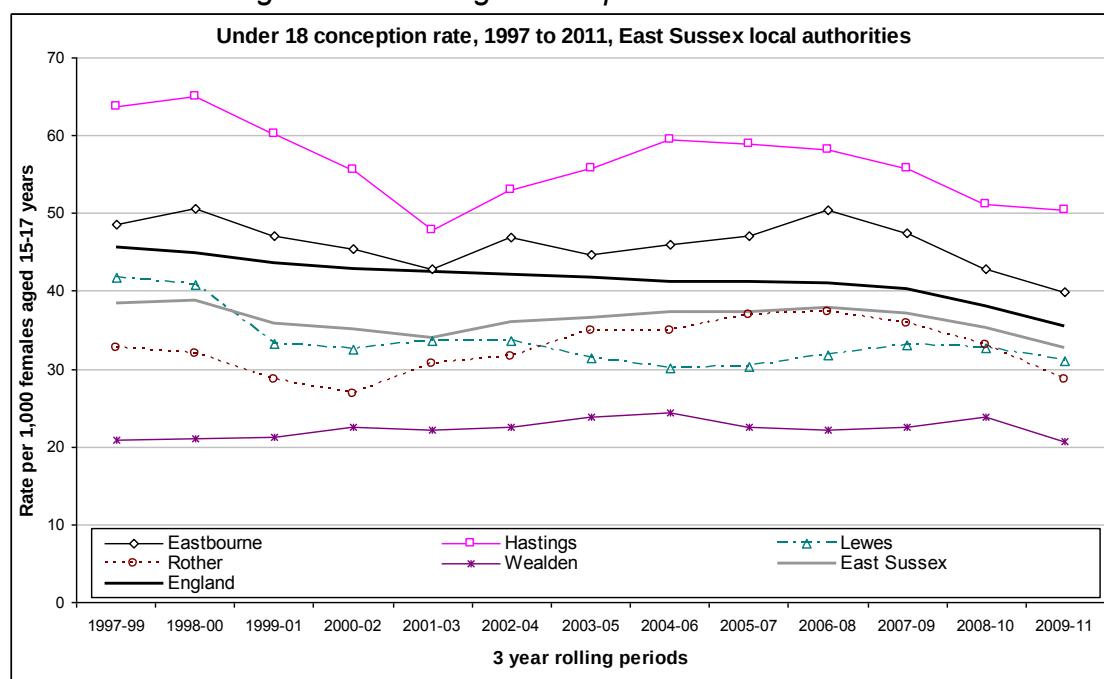
There is good evidence that postnatal depression affects the mother-infant relationship and children's cognitive and emotional development. Poor mental health is more common in more deprived groups and may be linked to poor housing, unemployment, low income and domestic violence. It is also more common in people who misuse alcohol and drugs. Depression and anxiety are the most common mental health problems in pregnancy affecting 10-15% of women, around 550-800 East Sussex mothers per year.

3.6 Teenage pregnancy

Teenage pregnancy and early motherhood are associated with poorer health and social outcomes for mothers and children. The East Sussex teenage conception rate (includes terminations and births) is generally declining and is lower than the England average. Rates are highest in Hastings the most deprived area and lowest in Wealden the most affluent area (Figure 30).

⁶ National Institute for Health and Clinical Excellence. Costing Statement: Pregnancy and complex social factors, September 2010.

Figure 30: Teenage conception rate 1997-2011



Source: ONS

3.7 Maternal morbidity

Pregnant women with long-term conditions such as heart disease and diabetes will generally be identified as high risk at booking. Others who develop pregnancy-related disorders, such as Gestational diabetes or Pre-eclampsia, will be identified as high risk during their pregnancy. Modelling used for the development of the maternity tariff assumes that 30% of women are 'high risk'. This equates with around 1,100 East Sussex women in 2012.

4. Outcomes

4.1 Caesarean sections

A Caesarean section is usually performed when a vaginal delivery would put the baby's or mother's life or health at risk, although more recently it has also been performed upon mother's request. It is conducted, either as a planned or emergency procedure, by an obstetrician.

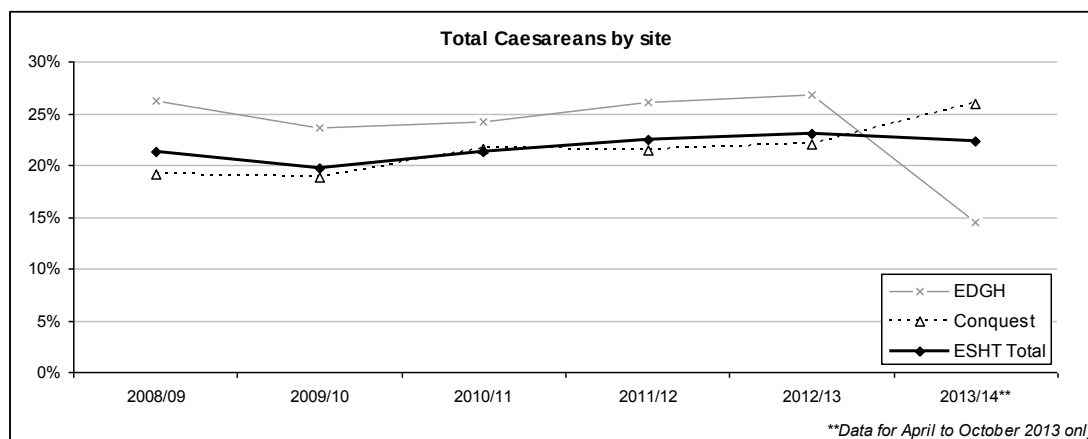
The data in Figures 29-31 is taken from monthly data tables provided by ESHT from their Euroking maternity system. Data for 2013/14 only covers the period April 2013 to October 2013.

In 2012/13, 23.0% (940) of all deliveries within ESHT were caesarean sections: 9.6% (393) elective and 13.4% (547) emergency. The overall rate for the EDGH (26.8%, n=528) was higher than that of the Conquest (22.1%, n=412); this applied to both the elective rate (EDGH 10.8%, n= 213; Conquest 9.7%, n=180) and emergency rate (EDGH 16.0%, n=315; Conquest 12.4%, n=232).

Trend in caesarean section rates

The overall caesarean section rate in Eastbourne DGH has been higher than that of the Conquest for a number of years. Since the temporary reconfiguration was introduced in May 2013 caesarean sections at EDGH have ceased (Figure 31).

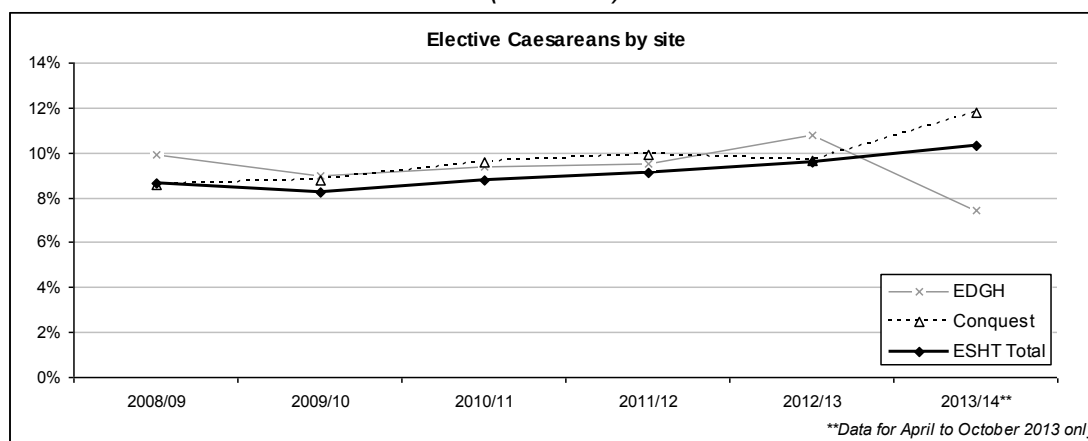
Figure 31: Trend in caesarean section rates within ESHT, 2008/09 – 2012/13 (October)



Source: ESHT Euroking maternity system **Data for 2013/14 only covers the period April 2013 to October 2013

The elective caesarean section rates in the Conquest and EDGH were similar between 2009/10 and 2011/12, but in 2012/13 the rate in EDGH increased from 9.5% to 10.8% (see Figure 32).

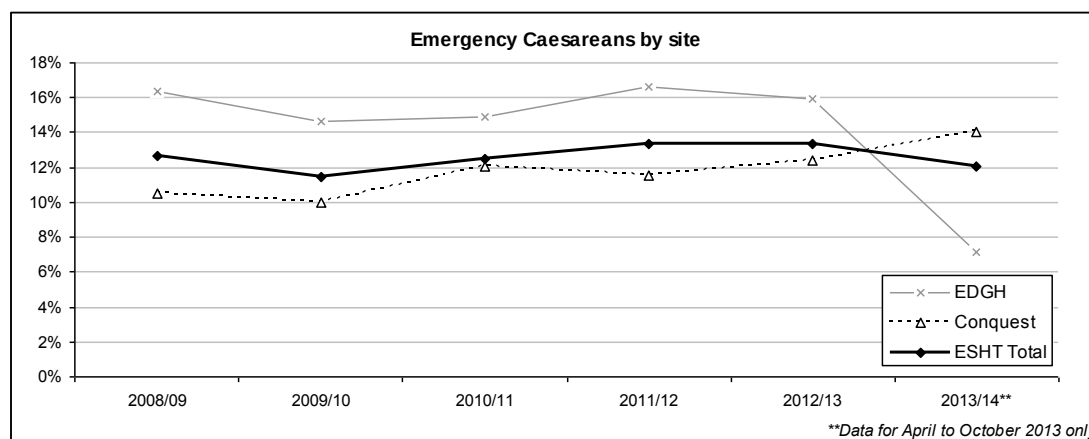
Figure 32: Trend in elective caesarean section rates within ESHT, 2008/09 – 2012/13 (October)



Source: ESHT Euroking maternity system **Data for 2013/14 only covers the period April 2013 to October 2013.

Figure 33 shows that the emergency caesarean section rate has been higher in EDGH than the Conquest for a number of years; in 2012/13 it was around 4% percentage points higher. From what is known of the catchment populations this is unlikely to be related to differences in case mix at the two sites.

Figure 33: Trend in Emergency caesarean section rate within ESHT, 2008/09 – 2012/13 (October)



Source: ESHT Euroking maternity system **Data for 2013/14 only covers the period April 2013 to August 2013.

4.2 Gestation at birth

In 2012/13, 7% (353) of births to East Sussex residents were preterm births: 12 were extremely preterm (<28 weeks); 26 very preterm (28 -31weeks); 315 moderate to late preterm (32-36 weeks). Table 18 looks at the gestation period of East Sussex births by maternity unit. RSCH had the highest percentage of preterm births (11%), followed by TWH (10%); 7% of births at the Conquest, 6% of births at EDGH and 5% of births at PRH were preterm. The highest percentage of post term births were at TWH (8%) and RSCH (7%); 3% of births at the Conquest and EDG were post term.

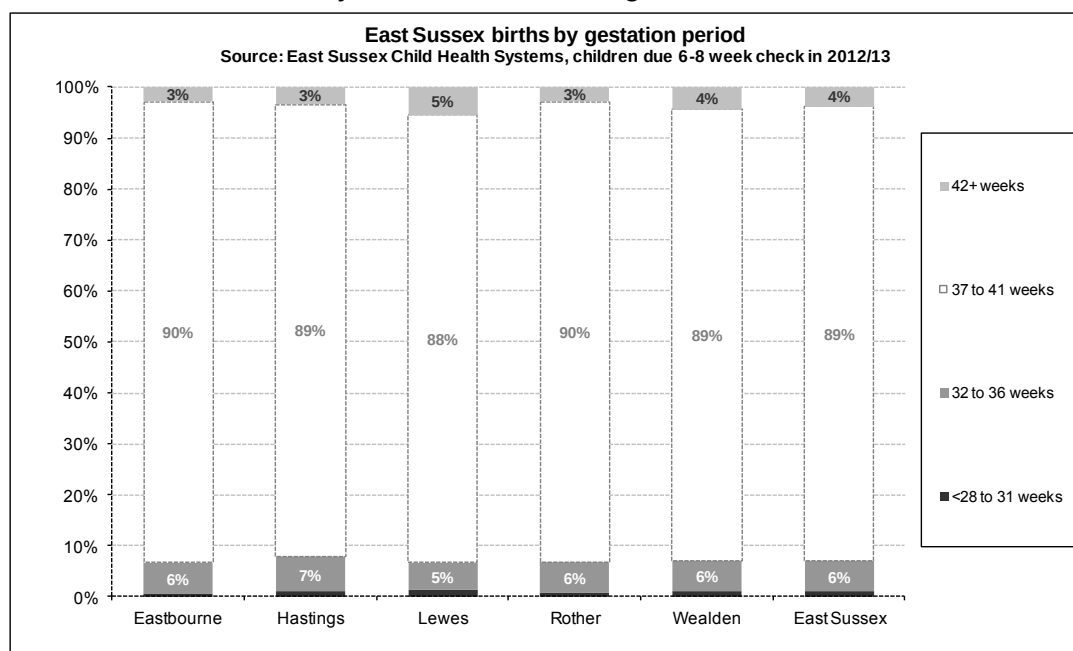
Table 18: Gestation at birth by maternity unit for East Sussex residents, 2012/13

Main providers	<28 to 36 weeks	37 to 41 weeks	42+ weeks
Conquest Hospital	7%	90%	3%
Eastbourne District General Hospital	6%	91%	3%
Royal Sussex County Hospital	11%	82%	7%
Crowborough Birthing Centre + Home births		97%	
Princess Royal Hospital	5%	91%	4%
Tunbridge Wells Hospital (Pembury)	10%	82%	8%

Source: East Sussex Child Health System

Figure 34 looks at gestation at birth by districts and boroughs for the same period (2012/13). One percent of births in East Sussex in 2012/13 were extremely/very preterm (1% < 28-31 weeks) and there was little difference between districts and boroughs; 6% of births were moderate to late preterm (32-36 weeks) ranging from 5.3% in Lewes to 7.0% in Hastings. The percentage of post term births was highest in Lewes (5.4%) followed by Wealden (4.3%); it was 2.8% in Eastbourne and 3.3% in Hastings.

Figure 34: Gestation at birth by districts and boroughs for East Sussex residents, 2012/13



Source: East Sussex Child Health System

4.3 Low birth weight

Low birth weight is associated with neonatal and infant mortality as well as being a strong predictor of health outcomes in childhood and adulthood. It is caused by a short gestation period or retarded intrauterine growth.⁷ Some of the factors associated with low birth weight are prematurity; smoking; multiple pregnancy; inherited medical conditions; pre-eclampsia; high blood pressure; maternal depression.⁸

The women at higher risk of low birth weight are:

- Lone mothers
- Non-White ethnic groups
- Women with limiting long-term illness
- Women living in deprived circumstances

Across the county, 6% (296 in 2011) of babies are born at low birth weight (under 2,500 grams) and 1% (60) at very low birth weight (under 1,500 grams). Rates vary by district and borough from year to year as numbers are relatively small (Table 19).

⁷ Health Development Agency, July 2003. Prevention of low birth weight: assessing the effectiveness of interventions.
http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/prevention_of_low_birth_weight_assessing_the_effectiveness_of_interventions_evidence_briefing.jsp

⁸ The Baby Centre. Low birth weight in babies, February 2013. <http://www.babycentre.co.uk/a1033196/low-birth-weight-in-babies#ixzz2mRA1a4kM>

Table 19: Numbers and percentages of low birthweight and very low birthweight live births

Numbers	Low birthweight (<2500g)			Very Low birthweight (<1500g)		
	2009	2010	2011	2009	2010	2011
East Sussex	311	320	296	58	51	60
Eastbourne	61	77	67	6	16	14
Hastings	81	70	67	13	7	6
Lewes	54	70	51	20	12	13
Rother	41	37	55	7	5	14
Wealden	74	66	56	12	11	13
Percentage	Low birthweight (<2500g)			Very Low birthweight (<1500g)		
	2009	2010	2011	2009	2010	2011
East Sussex	6%	6%	6%	1%	1%	1%
Eastbourne	5%	7%	6%	1%	1%	1%
Hastings	7%	6%	6%	1%	1%	1%
Lewes	6%	7%	5%	2%	1%	1%
Rother	6%	5%	7%	1%	1%	2%
Wealden	6%	5%	4%	1%	1%	1%

Source: ONS Vital Statistics

4.4 Multiple pregnancies

There were 87 multiple pregnancies in East Sussex in 2011. The highest number in each of the four years between 2008 and 2011 was in Wealden (Table 20).

Table 20: Number of multiple maternities

	2008	2009	2010	2011
Eastbourne	13	21	19	18
Hastings	20	14	17	16
Lewes	15	10	20	12
Rother	<5	5	11	12
Wealden	27	26	23	29

Source: Vital Statistics, ONS

4.5 Infant mortality (*deaths in the first year of life*)

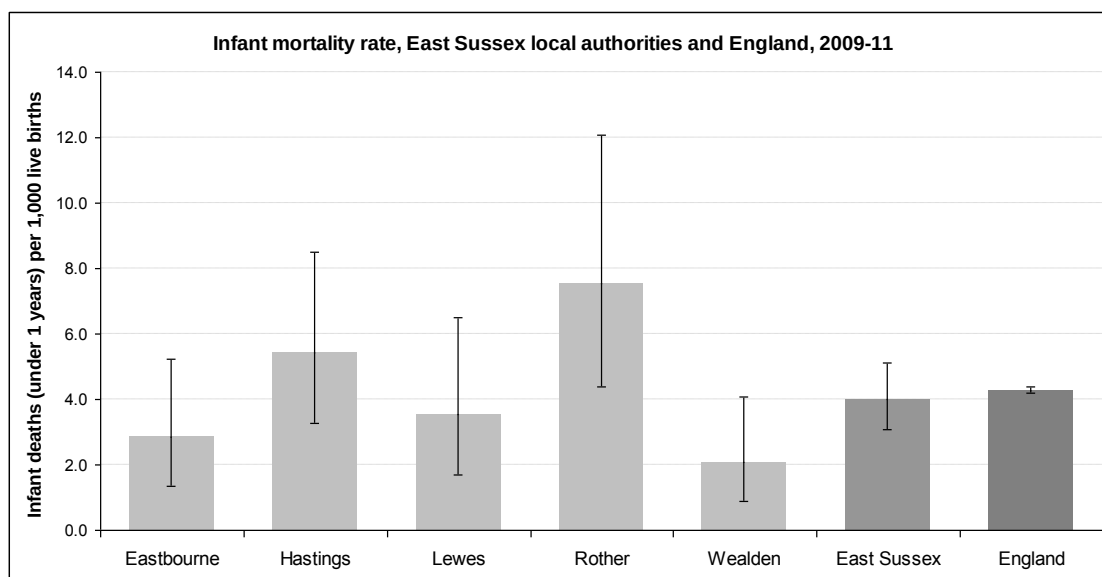
Nationally the main causes of infant mortality are immaturity related conditions and congenital anomalies accounting for three quarters of infant deaths in England and Wales in 2007.⁹ Smoking during pregnancy increases the risk of infant mortality by an estimated 40%. Around a third of all perinatal deaths in the UK are thought to be caused by smoking.¹⁰

The infant mortality rate in East Sussex in 2009-11 was 4.0 per 1,000 live births, similar to the England rate of 4.3 per 1,000, equivalent to an average of 22 deaths a year. Rates vary between districts and boroughs but the differences are not statistically significant except that the rate in Rother is significantly higher than that of England. However it is important to consider that rates fluctuate from year to year due to the relatively small number of deaths; hence this difference is unlikely to persist, although it does require monitoring (Figure 35).

⁹ National Perinatal Epidemiology Unit. Infant mortality overview and context. March 2013. <https://www.npeu.ox.ac.uk/infant-mortality>

¹⁰ National Institute for Health and Clinical Excellence (2010) Quitting smoking in pregnancy and following childbirth NICE public health guidance 26 www.nice.org.uk

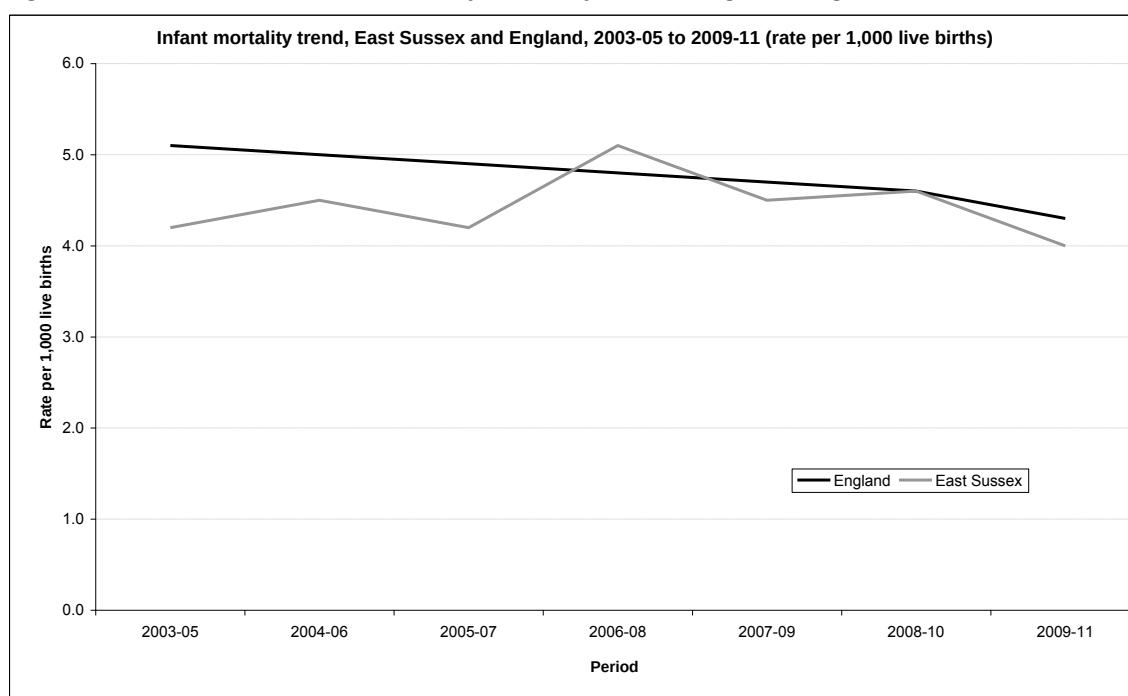
Figure 35: Infant mortality rate across districts and boroughs, 2009-11



Source: Public Health Outcomes Framework, www.phoutcomes.info

There has been a gradual decline in the national infant mortality rate since 2003-05; this trend has not been seen in East Sussex, although the 2009-11 average was lower than that for England (Figure 36).

Figure 36: Trend in infant mortality, three year rolling averages 2003-5 to 2009-11

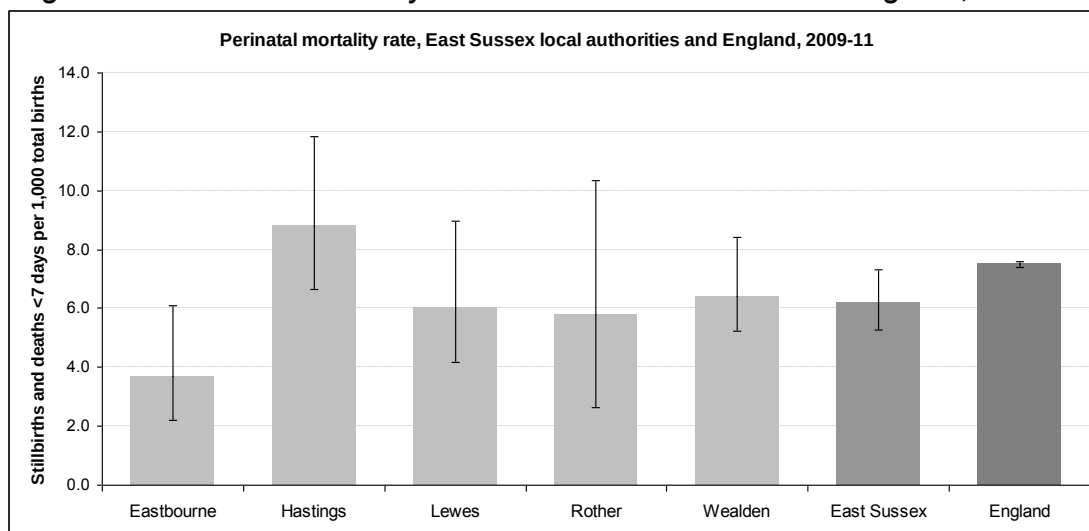


Source: ONS Vital Statistics

4.6 Perinatal mortality (deaths after 24 weeks and before 7 days of life)

The perinatal mortality rate is a key outcome indicator for newborn care and directly reflects prenatal, intrapartum, and newborn care. There are no significant differences in perinatal mortality rates between the Districts and Boroughs in East Sussex (Figure 37).

Figure 37: Perinatal Mortality rate in East Sussex LAs and England, 2009-11

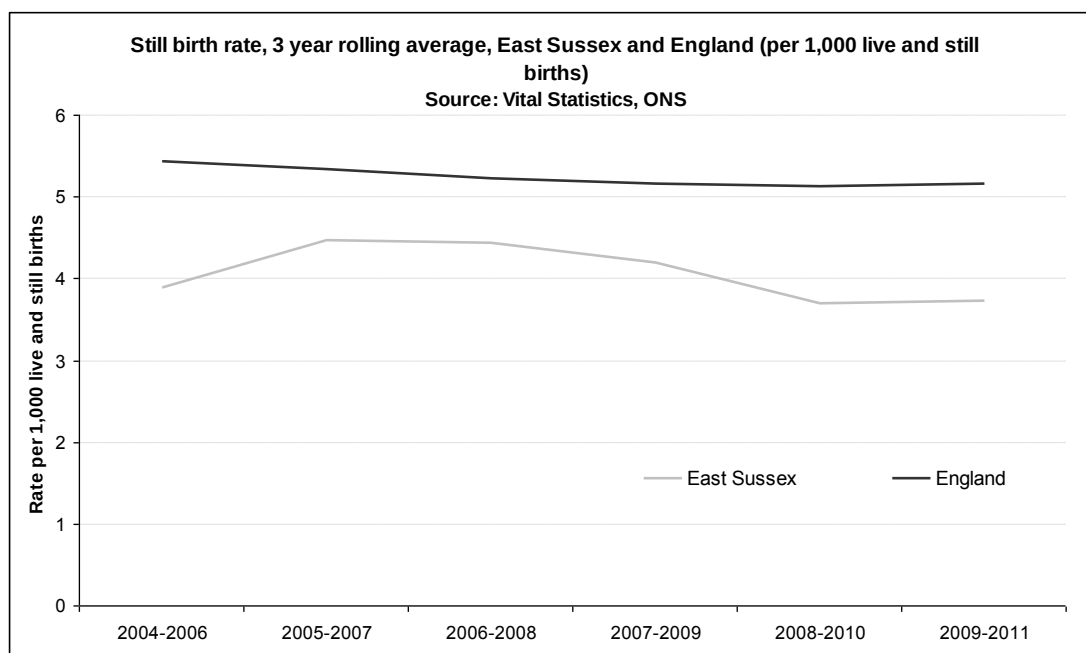


Source: *Compendium of Population Health Indicators, Health and Social Care Information Centre*

4.7 Still births

The still birth rate in East Sussex is generally below the England average. Figure 35 shows the three year rolling averages between 2004-06 and 2009-11. In 2011 it was 4.2 per 1,000 live births compared to 5.2 per 1,000 in England. Between 2008 and 2011 there was an average of 20 stillbirths per year in East Sussex. The number is highest in Hastings (the most deprived area) and Wealden (the area with the most births) and lowest in Rother (Table 21).

Figure 35: Stillbirth rate for East Sussex and England, 3 year rolling averages, 2004-06 to 2009-11



Source: *ONS Vital Statistics*

Table 21: Number of still births, 2008 to 2011

Area	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
Number	12	24	13	8	24	81

Source: *Vital Statistics, ONS*

Section 2: Paediatrics

1. East Sussex population

1.1 Current population

Table 1 shows that there are 116,691 children (0-19 years) in East Sussex making up 22% of the total population: 5.3% 0-4 years; 5.3% 5-9 years; 5.5% 10-14 years and 5.9% 15-19 years. Wealden has the highest number of children (151,029), which is the case across all the five year age bands, and Hastings the lowest number (90,345), followed by Rother (91,088). Hastings has the highest percentage of under 5s (6.3%) of all the districts and boroughs, and Rother the lowest (4.3%) (Table 1).

Table 1: Population estimates for children and young people aged 0-19, mid 2012

	All ages	0-4		5-9		10-14		15-19	
		n	%	n	%	n	%	n	%
England	53,493,729	3,393,356	6.3%	3,083,582	5.8%	3,007,871	5.6%	3,286,306	6.1%
South East Region	8,724,737	545,710	6.3%	507,365	5.8%	502,658	5.8%	536,186	6.1%
East Sussex County	531,201	28,141	5.3%	27,906	5.3%	29,430	5.5%	31,214	5.9%
Eastbourne	100,049	5,515	5.5%	5,041	5.0%	5,273	5.3%	6,027	6.0%
Hastings	90,345	5,656	6.3%	4,937	5.5%	5,028	5.6%	5,652	6.3%
Lewes	98,690	5,225	5.3%	5,408	5.5%	5,455	5.5%	5,606	5.7%
Rother	91,088	4,092	4.5%	4,213	4.6%	4,812	5.3%	5,227	5.7%
Wealden	151,029	7,653	5.1%	8,307	5.5%	8,862	5.9%	8,702	5.8%

Source: Mid-2012 resident population estimates, Office for National Statistics

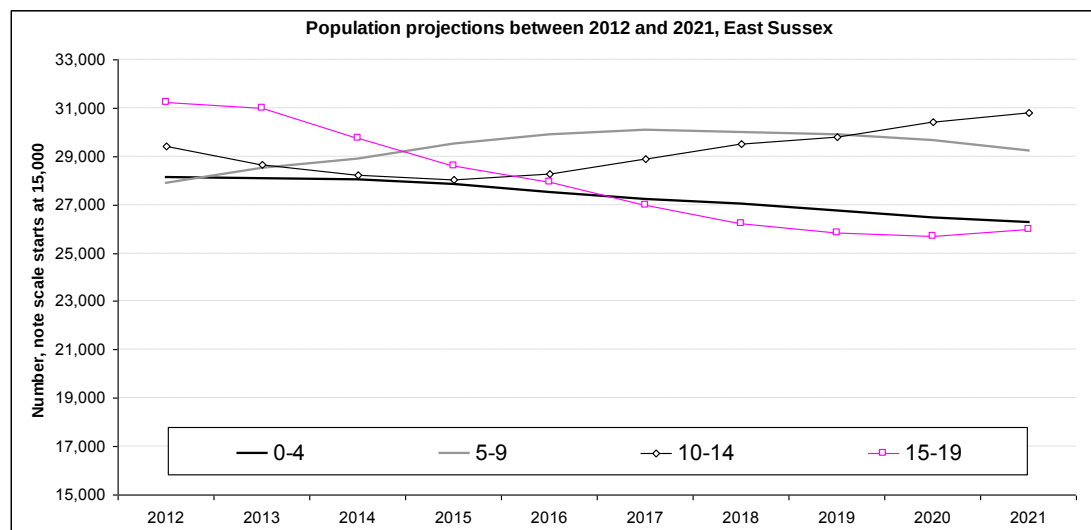
1.2 Population projections

Population projections from 2012 to 2021 predict a 4% decrease in the number of children across the county with the largest decrease in Lewes (6%), followed by Eastbourne (5%), Hastings (3%) and Rother (3%), and Wealden (3%).

However examination of the predicted changes by age band shows that across the county the number of children decreases in some age bands but increases in others:

- 0-4 year olds is predicted to decrease by 7% - with the largest decrease in Eastbourne (15%) and Lewes (11%);
- 5-9 year olds is predicted to increase by 5% - with the largest increase in Hastings (9%) and Rother (13%);
- 10-14 year olds is predicted to increase by 5% - with the largest increase in Lewes (6%);
- 15-19 year olds is predicted to decrease by 17% - with the largest decrease in Rother (26%) and Hastings (21%) and the lowest in Eastbourne (10%).

Figure 1: Population projections in East Sussex for children and young people aged 0-19, 2012 to 2021



Source: 2012 Policy-based (Dwelling-led) Demographic Projections (2012-2027), ESCC.

1.3 Children in low income families

Families with low incomes are more likely to live in deprived neighbourhoods with poorer housing, higher rates of crime, poorer air quality, lack of green spaces for children to play and more risks to safety from traffic all of which impact on their health.

Around one in five (18.1%) children in East Sussex is living in a low income family. The highest number and percentage of children living in low income families is in Hastings (29%) followed by Eastbourne (20.6%); the lowest percentage is in Wealden (10.3%) (Table 2). Analysis in 2010 found almost a six-fold difference in the number of children in urban areas (21.6%; n=14,055) compared with rural areas (10.5%; n=2,420)¹¹

Table 2: Number and percentage of children in low-income families, districts and boroughs in East Sussex in 2011

	Number	%
Eastbourne	3,440	20.6%
Hastings	4,865	29.0%
Lewes	2,480	15.3%
Rother	2,600	19.0%
Wealden	2,575	10.3%
East Sussex	15,960	18.1%
England	2,026,465	20.6%

Source: HMRC

1.4 Looked after children

Looked After Children are vulnerable to a range of poor health outcomes, and can face particular inequalities in accessing health services.¹² At the end of March 2012 there were 618 Looked After Children in East Sussex: Hastings (266; 43%) had the highest number followed by Eastbourne (144; 23%). In addition there were 674 children on a Child Protection

¹¹ Director of Public Health Annual Report 2012/13. Reducing health inequalities among children and young people.

¹² National Children's Bureau Presentation: Delivering health needs of looked After Children: How the new NHS will work from April 2013

Plan (agreed to be at risk of abuse by a Child Protection Case Conference): 235 in Hastings, 178 in Eastbourne, 105 in Rother, 91 in Lewes and 65 in Wealden.

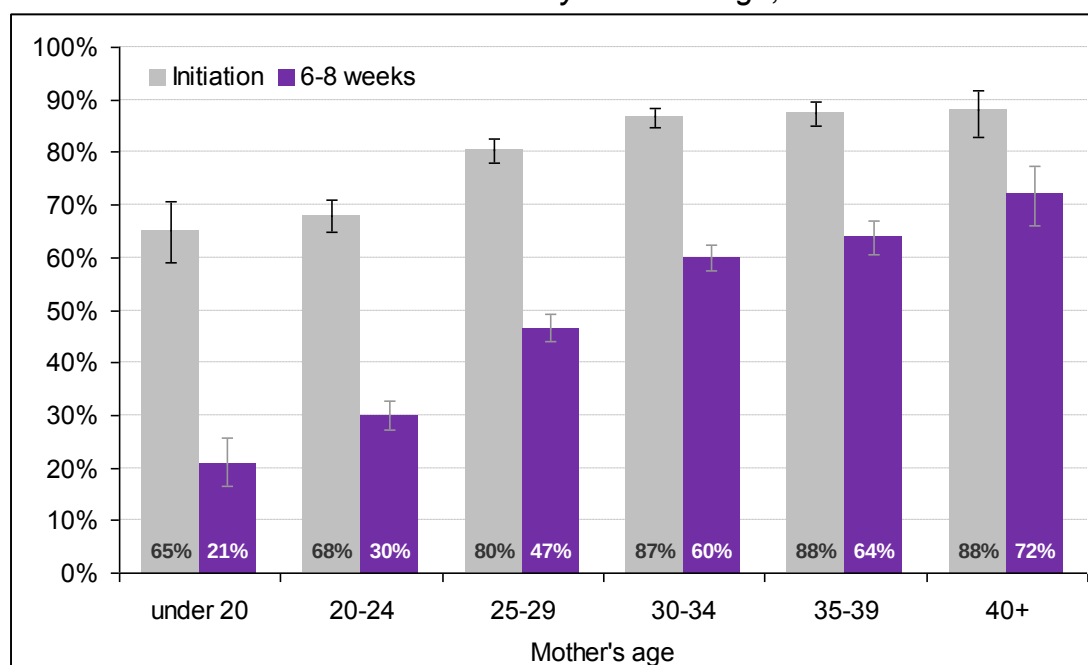
East Sussex had 15,104 referrals to children's social care in 2011/12, a rate of 150 per 1000 population under 20 years. Hastings and Rother CCG had the highest rate of referral, at 200/1000, followed by Eastbourne, Hailsham and Seaford CCG at 149/1000 and High Weald Lewes Havens CCG at 97/1000.¹³

2. Child Health

2.1 Breastfeeding

Exclusive breastfeeding for up to 6 months has been shown to benefit both the baby and the mother. Breastfeeding at 6-8 weeks is linked more with the mother's age than with the level of deprivation. Figure 2 shows that in East Sussex the breastfeeding initiation rate and the rate at 6-8 weeks increase with the age of the mother with drop off rates being highest for younger women (Figure 2). Overall East Sussex breast feeding rates at 6-8 weeks are in line with the England average with the highest rates being in Wealden and the lowest in Hastings. In both Hastings borough and Rother district rates are below the national average (Figure 3).

Figure 2: Prevalence of breastfeeding initiation and breastfeeding at 6-8 weeks amongst babies of known status by maternal age, 2011/12

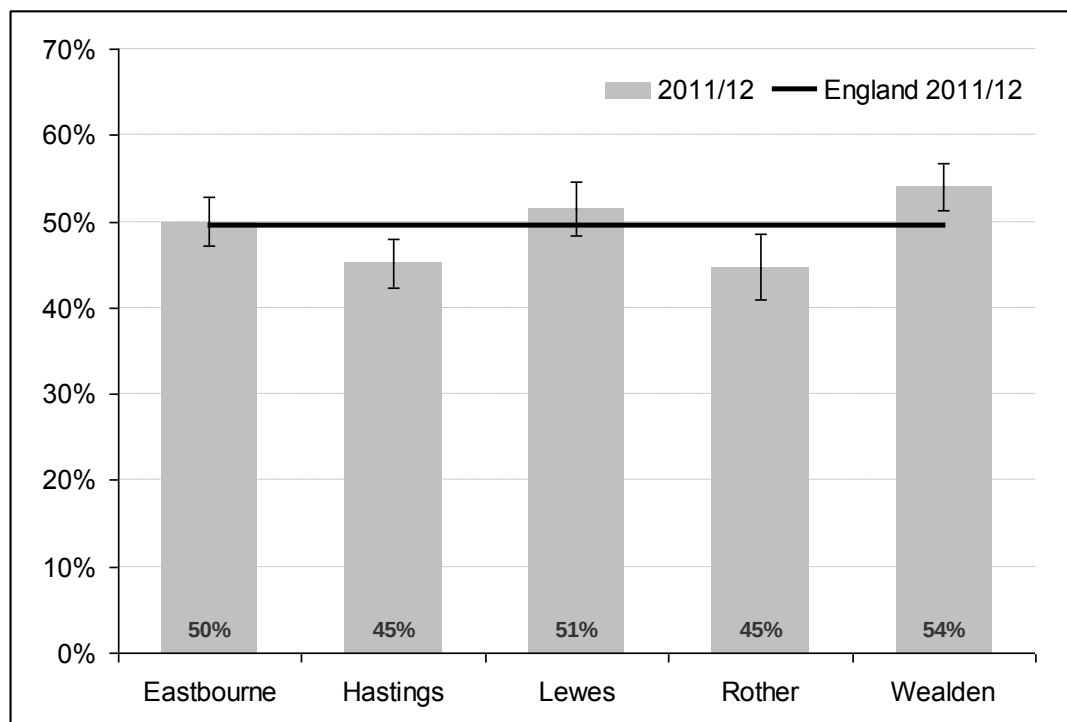


Source: East Sussex Joint Strategic Needs Assessment (JSNA), Local Briefing - Breastfeeding at 6-8 weeks in East Sussex 2011/12, November 2012.

www.eastsussexjsna.org.uk/briefings

¹³ JSNA Scorecard 2013. <http://www.eastsussexjsna.org.uk/scorecards/2013nhsvi>

Figure 3: Percentage of mothers breastfeeding at 6-8 weeks by East Sussex local authorities with 95% confidence intervals, 2011/12



Source: East Sussex JSNA, Local Briefing - Breastfeeding at 6-8 weeks in East Sussex 2011/12, November 2012. www.eastsussexjsna.org.uk/briefings

2.2 Immunisations

Immunisation protects babies and children from a number of illnesses thus reducing ill health and admission to hospital. Whilst vaccination rates in East Sussex are generally better than the national average, uptake rates fall short of the national target of the 95% required for herd immunity. Table 3 shows immunisation uptake at second and fifth birthdays in 2012/13. At second birthday the uptake rates in East Sussex were 93% for MMR (*which protects against measles, mumps and rubella*), 93% for PCV (*which protects against pneumococcal pneumonia*), and 93% for Hib and Meningitis C booster (*which protect against meningitis*). At fifth birthday the uptake rate for MMR was 88%. Uptake rates vary across the districts and boroughs (Table 3).

Table 3: Childhood immunisations, 2012/13

Local Authority	By 2nd birthday			By 5th birthday
	% MMR	% PCV booster	% Hib MenC booster	% 2nd MMR
Eastbourne	95	94	93	91
Hastings	93	92	92	88
Lewes	94	93	93	87
Rother	92	91	92	86
Wealden	93	93	93	86
East Sussex	93	93	93	88

Source: East Sussex child health systems

3. Risk Factors

3.1 Exposure to second-hand smoke

Children from poorer households are more likely to be exposed to second hand smoke.¹⁴ This causes ear infections, more frequent and severe asthma attacks, respiratory symptoms (e.g., coughing, sneezing, shortness of breath), respiratory infections (i.e., bronchitis, pneumonia), and a greater risk for sudden infant death syndrome (SIDS). In 2012, 42% of East Sussex Year 10 pupils reported that at least one person smokes on most days indoors at home. 12% said that at least three people do.¹⁵

3.2 Substance misuse

There are strong links between high levels of youth alcohol consumption and other risk factors such as youth offending and teenage pregnancy, truancy, exclusion and illegal drug misuse.¹⁶ A&E attendance of children under 17 years for alcohol intoxication is monitored by the paediatric liaison nurses: In 2011/12 there were 72 attendances at EDGH and 65 at the Conquest. In the same year there were 44 admissions for East Sussex residents aged under 18 years for alcohol specific conditions; the rate was above the national average in Hastings, but numbers are very small.¹⁷

In 2011/12, there were 317 East Sussex residents aged under 18 years in treatment for substance misuse. The majority declared sole use of cannabis (47%) or alcohol (42%).¹⁸ Hospital admissions for 15-24 year olds due to substance misuse were significantly lower in East Sussex (54.9/100,000) than the England average (69.4/100,000) in 2009-12.¹⁹

3.3 Obesity

Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults. Nationally, obesity prevalence increases between Reception Year and Year 6 which is also the case in East Sussex. In Reception the prevalence of overweight and obesity are highest in Hastings and Eastbourne areas, and in Year 6 they are highest in Hastings, Rother and Eastbourne. There is a clear link between deprivation and obesity for both Reception and Year 6. The percentage of pupils who are obese in the most deprived areas is almost double that of the least deprived (based on national IMD 2010 quintiles).²⁰

4. Outcomes

4.1 A&E attendance

Table 4 shows A&E attendance numbers and rates by five year age bands. There were 30,713 attendances for children (0-18 yrs) in 2012/13 of which: 32% were for 0-4 year olds, 17% for 5- 9 year olds, 23% for 10-14 year olds and 29% for 15-18 year olds. Attendance rates (per 1,000 population) in all age bands were highest for Hastings residents and generally lowest for Wealden residents. However, of all A&E attendances in East Sussex children 24% were from Wealden residents, 23% Hastings, 21% Eastbourne, 18% Lewes and 14% Rother.

¹⁴ Comprehensive Needs Assessment for Children and Young People in East Sussex, June 2008.

¹⁵ Health related behaviour survey 2012.

¹⁶ Safe, sensible, social: the next steps in the National Alcohol Strategy 2007. <http://www.dh.gov.uk/en/>

¹⁷ ESCC Public Health Department. Alcohol related health harm. February 2013.

¹⁸ East Sussex Drug and Alcohol Action Team, Young People's Specialist Substance Misuse Treatment Needs Assessment.

¹⁹ East Sussex Child Health Profile 2012

²⁰ East Sussex JSNA, Local Briefing - East Sussex National Child Measurement Programme 2011/12, October 2012. www.eastsussexjsna.org.uk/briefings

Table 4: Rate of A&E attendances for 0-18 year olds, 2012/13

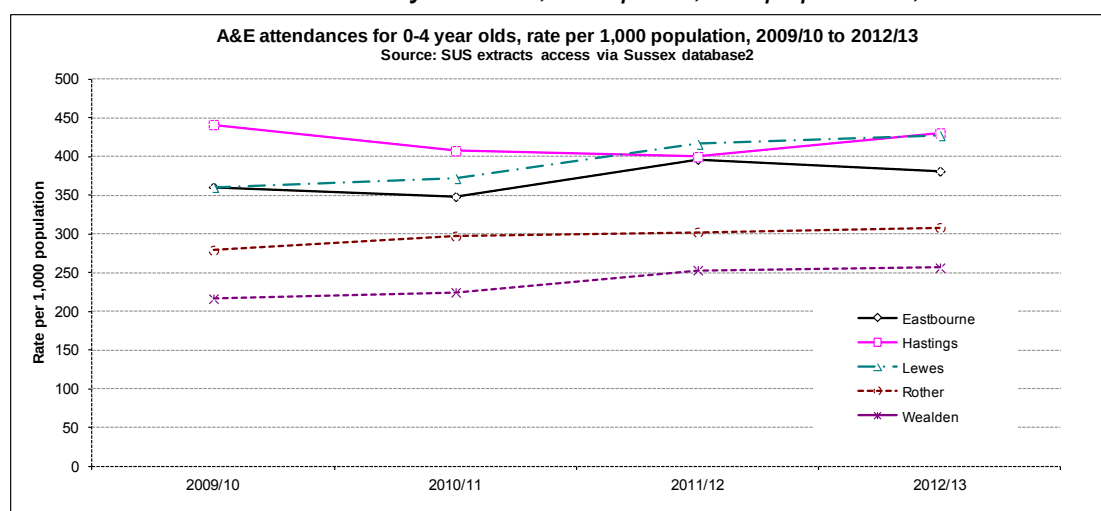
	Numbers of attendances					Rate per 1,000 population			
	0-4 yrs	5-9 yrs	10-14 yrs	15-18 yrs		0-4 yrs	5-9 yrs	10-14 yrs	15-18 yrs
Eastbourne	2029	1089	1385	1943		381.0	223.8	257.4	310.8
Hastings	2396	1179	1499	1912		430.0	247.1	281.9	332.0
Lewes	2156	895	1070	1406		427.0	171.2	192.8	252.0
Rother	1231	760	1119	1299		308.0	185.5	218.6	257.8
Wealden	1923	1320	1887	2215		256.0	163.0	209.1	251.5
East Sussex	9735	5243	6960	8775		355.0	193.7	229.0	279.1

Source: local SUS extracts accessed via Sussex Database 2

Attendance for the under fives are looked at in more detail as many of these could be prevented. Across the county, the rate of Accident and Emergency (A&E) attendances for the under fives is 355 per 1,000 population. At district and borough level the highest rates are in Hastings (430 per 1,000) and Lewes (427 per 1,000) and the lowest in Wealden (256 per 1,000). These figures do not include attendances at Crowborough, Lewes and Uckfield minor injury units (Table 4).

Figure 4 (and Table 5) shows that between 2009/10 and 2012/13 there has been an increase in A&E attendances for the under 5s in all the districts and boroughs except Hastings, although the rate in Hastings has increased in 2012/13 following a decrease in the previous two years. The highest rate of increase since 2009/10 is in Lewes.

Figure 4: A&E attendances for 0-4 year olds, rate per 1,000 population, 2009/10 to 2012/13



Source: SUS extracts access via Sussex database2

Table 5: Rate of A&E attendances for persons aged 0-4 years, per 1,000 population, 2009/10 to 2012/13

Area	2009/10	2010/11	2011/12	2012/13
Eastbourne	360	348	396	381
Hastings	441	407	400	430
Lewes	360	371	416	427
Rother	279	297	302	308
Wealden	216	224	253	256
East Sussex	324	323	348	355

Source: local SUS extracts accessed via Sussex Database 2

Thirty nine percent (n=3807) of East Sussex attendances at A&E for the under 5s are for accidents and injuries (Table 6). The highest number of attendances and the highest rates are for Hastings residents (175 per 1,000; n=976) and Eastbourne (171 per 1,000; n=917); the lowest rates are for residents of Wealden (111 per 1,000; n=832) and Lewes (113 per 1,000; n=573). Again these figures do not include attendances at the minor injury units (MIUs) in Crowborough, Lewes and Uckfield.

Table 6: A&E attendances due to accidents and injuries for persons aged 0-4yrs, 2012/13

Local Authorities	Number of attendances	Rate per 1,000 population
Eastbourne	917	171
Hastings	976	175
Lewes	573	113
Rother	509	126
Wealden	832	111
East Sussex	3807	138

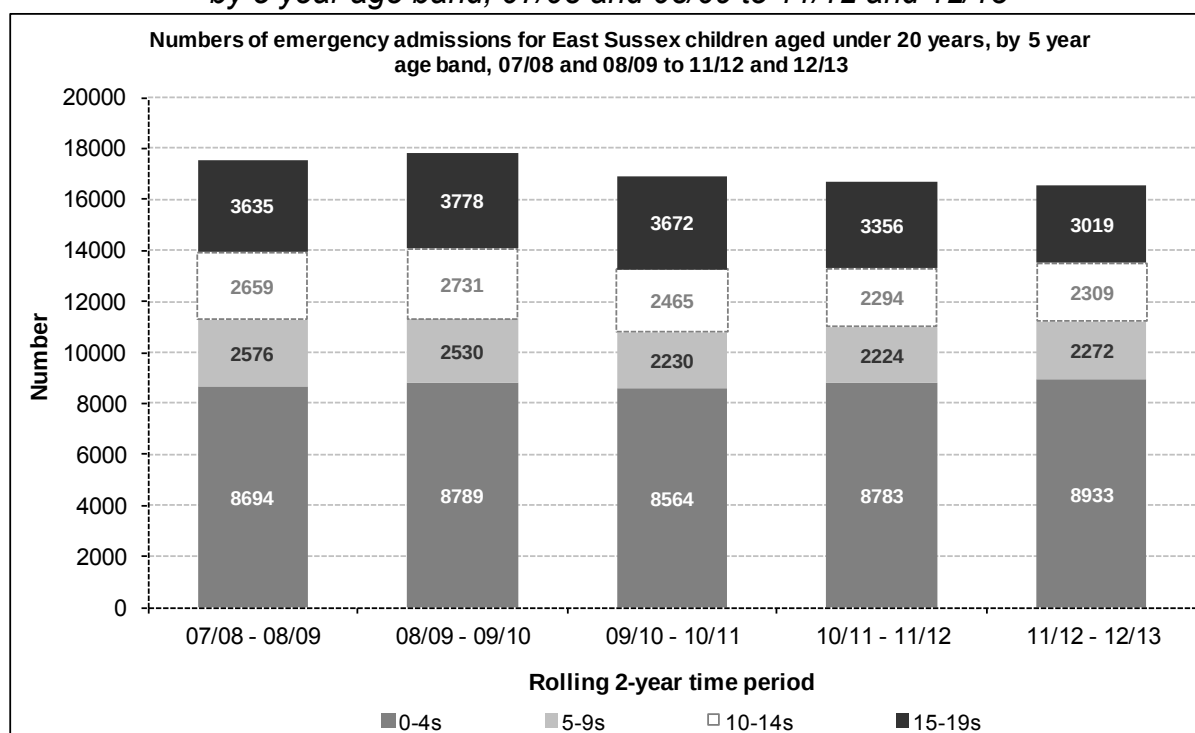
Source: local SUS extracts accessed via Sussex Database 2

Note: A&E patient group = 10,20,30,40,50,60 (road traffic accident, assault, deliberate self-harm, sports injury, firework injury, other accident)

4.2 Emergency admissions

During 2011/12 and 2012/13 there were 15,650 emergency admissions of East Sussex children (0-18 years). Figure 5 identifies the number of emergency admissions in two year time periods from 2007/08 and 2008/09 to 2011/12 and 2012/13. This shows that the overall numbers of emergency admissions have decreased and that this decrease is seen in all age bands except in the under fives where there has been an increase.

Figure 5: Numbers of emergency admissions for East Sussex children aged under 20 years, by 5 year age band, 07/08 and 08/09 to 11/12 and 12/13



Source: Local SUS extracts accessed via Sussex Database

Table 7 provides an overview of the trends in emergency admissions rates across the districts and boroughs by five year age bands during the same five year period. This shows that in:

- in Eastbourne rates have increased across all five year age bands;
- in Hastings rates have reduced in all five year age bands although the rate in the under fives is starting to increase again;
- in Lewes rates have increased in all five year age bands;
- in Rother rates have decreased in the older age bands but increased in the 5-9 year olds and remain stable in the under fives
- in Wealden rates have decreased in all five year age bands but remain stable in the under fives.

Table 7: Trend in emergency admissions across districts and boroughs by five year age bands: 07/08 and 08/09 to 11/12 and 12/13

	0-4 yrs	5-9 yrs	10-14 yrs	15-19 yrs
Eastbourne	↑ small increase	↑	↑	↓
Hastings	↓ now increasing	↓	↓	↓
Lewes	↑	↑	↑	↑
Rother	→	↑	↓	↓
Wealden	→	↓	↓	↓

Source: Local SUS extracts accessed via Sussex Database

Tables 8 to 11 show the numbers of admissions and the admission rates by five year age bands in 2011/12 and 2012/13; Figures 7-10 show the primary diagnosis of emergency admission for each of these five year age bands during the same time period.

Under 5s

The highest emergency admission rate is in the under 5s (163 per 1,000 population, n=8,933) equivalent to 57% of all emergency admissions in children. The highest number of emergency admissions for the under 5s are in Hastings (n=2,318) and Eastbourne (n=2,214) which also have the highest admission rates (208 per 1,000 population); the lowest rate is in Lewes (110 per 1,000; n=573) (Table 8). Whilst the rate in Wealden is relatively low (130 per 1,000), the numbers are relatively high (1,958) as Wealden has more children than the other districts and boroughs (See Table 8).

Table 8: Emergency admissions for 0-4 year olds, 2011/12 and 2012/13

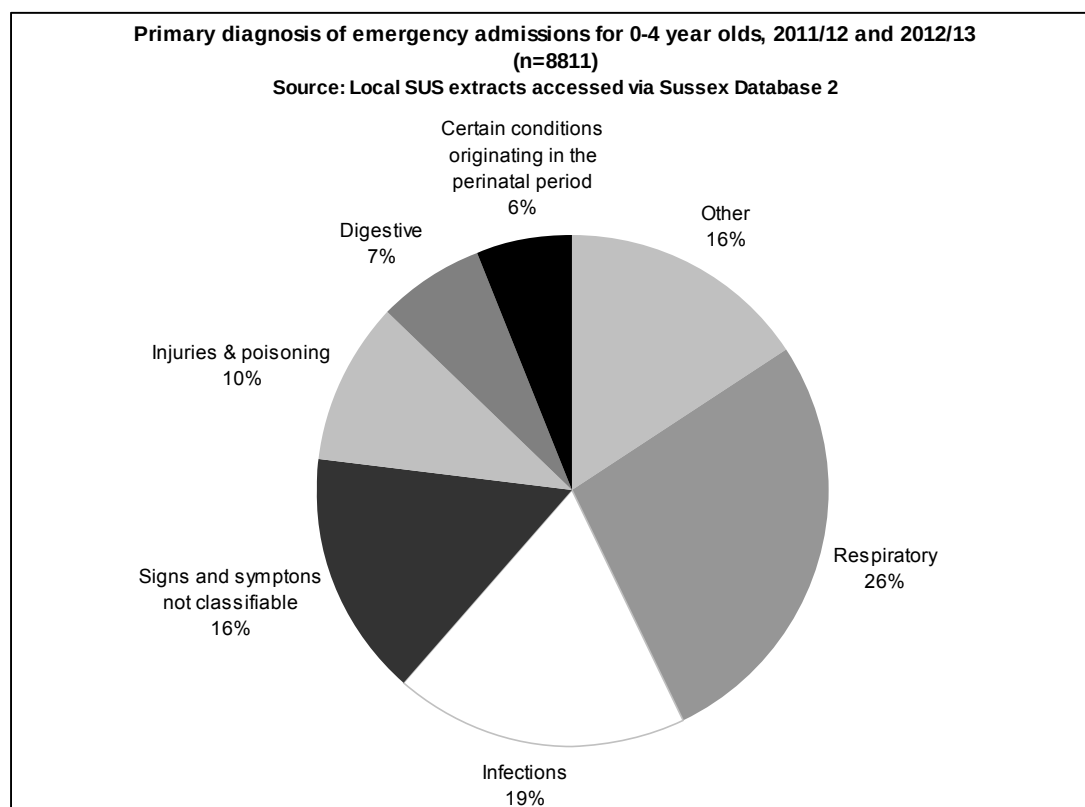
Local Authorities	0-4 year olds	
	Number of admissions	Rate per 1,000 population
Eastbourne	2214	208
Hastings	2318	208
Lewes	1109	110
Rother	1334	167
Wealden	1958	130
East Sussex	8933	163

Source: local SUS extracts accessed via Sussex Database 2

The primary diagnoses for emergency admissions in the under 5s are respiratory conditions (26%) and infections (19%). Other reasons for admission are injuries and poisoning (10%),

digestive (7%) and certain conditions originating in the perinatal period (6%). 'Other' and 'signs and symptoms not classifiable' each make up 16% (See Figure 6).

Figure 6: Primary diagnosis of emergency admissions for 0-4 yr olds, 2011/12 and 2012/13



Source: Local SUS extract accessed via Sussex Database 2

5-9 years

The emergency admission rates in the 5-9 year old age band is 42 per 1,000 (n=2,272), around a quarter of the rate for the under 5s (Table 8). The highest rates are in Eastbourne (54 per 1,000; n=526) and Hastings (51 per 1,000; n=484). The highest numbers are in Wealden (533) which has the greatest number of children (see Table 9).

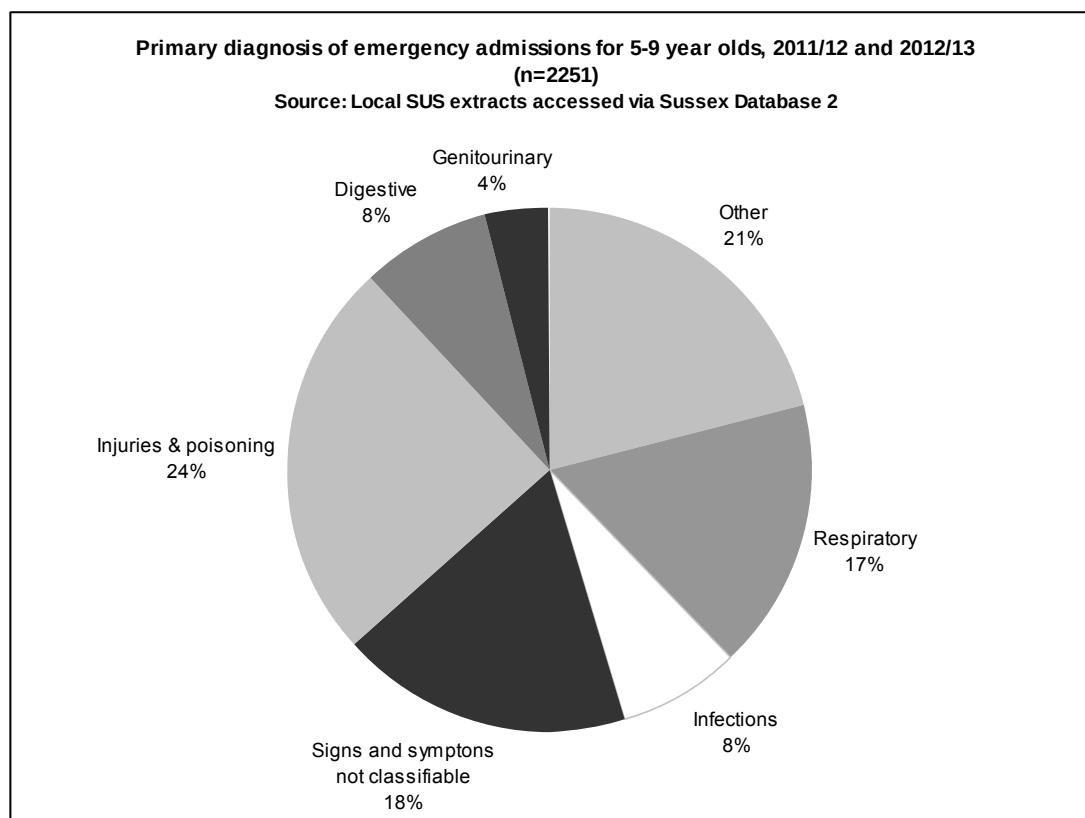
The primary diagnoses for emergency admission in the 5-9 year olds are injuries and poisonings (24%) and respiratory conditions (17%); 'other' makes up 21% and 'signs and symptoms not classifiable' 18% (see Figure 7).

Table 9: Emergency admissions for 5-9 year olds and 10-14 year olds, 2011/12 and 2012/13

Local Authorities	5-9 year olds	
	Number of admissions	Rate per 1,000 population
Eastbourne	526	54
Hastings	485	51
Lewes	385	37
Rother	343	42
Wealden	533	33
East Sussex	2272	42

Source: Local SUS extract accessed via Sussex Database 2

Figure 7: Primary diagnosis of emergency admissions for 5-9 yr olds, 2011/12 and 2012/13



Source: Local SUS extract accessed via Sussex Database 2

10-14 years

The emergency admission rate in the 10-14 year old age band is 38 per 1,000 (n=2,309) (Table 10). The highest rate is in Eastbourne (48 per 1,000; n=519) and the lowest in Wealden (31 per 1,000) although Wealden has the highest number followed by Eastbourne (563 and 519 respectively) (Table 10).

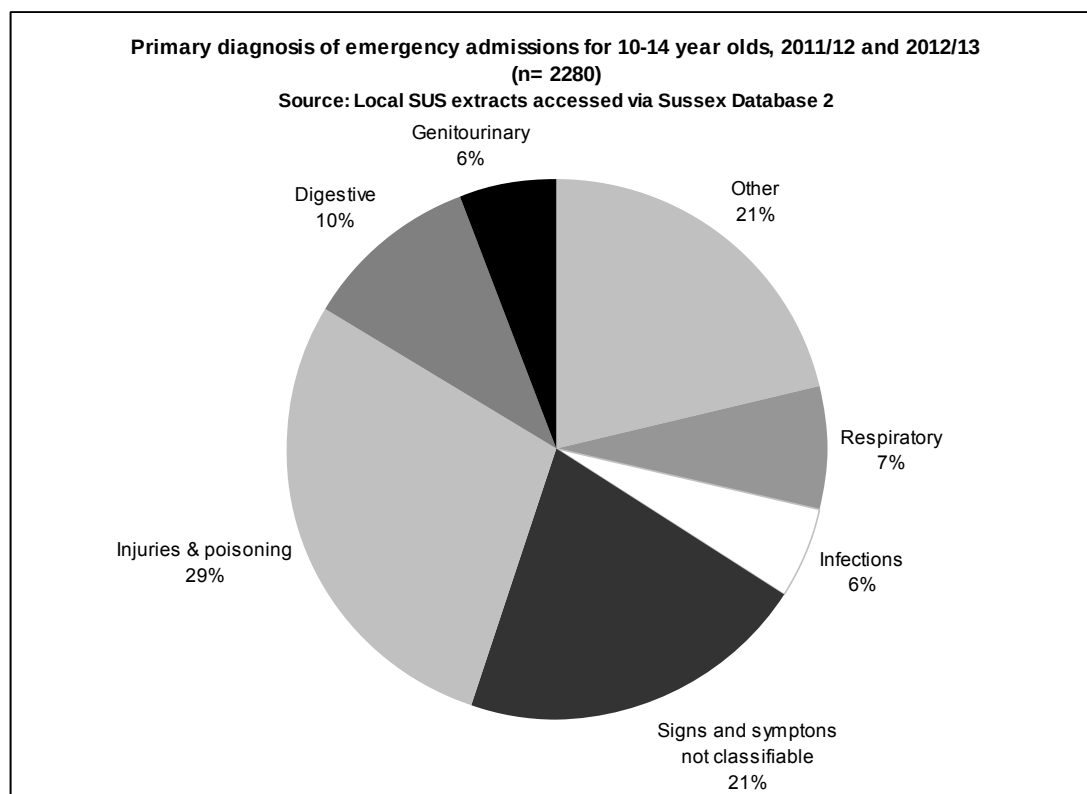
The primary diagnoses for admission in the 10-14 year olds are injuries and poisonings (29%), digestive (10%); 'other' and 'signs and symptoms not classifiable' each make up 21% (Figure 8).

Table 10: Emergency admissions for 10-14 year olds, 2011/12 and 2012/13

Local Authorities	10-14 year olds	
	Number of admissions	Rate per 1,000 population
Eastbourne	519	48
Hastings	413	39
Lewes	418	38
Rother	396	39
Wealden	563	31
East Sussex	2309	38

Source: Local SUS extract accessed via Sussex Database 2

Figure 8: Primary diagnosis of emergency admissions for 10-14 yr olds, 2011/12 and 2012/13



Source: Local SUS extract accessed via Sussex Database 2

15-18 years

The emergency admission rate in the 15-18 year age band is 45 per 1,000 (n=2,280). The highest rate is in Lewes (49/1,000) and the lowest in Wealden (41/1,000). The highest numbers are in Wealden and the lowest in Rother (Table 11).

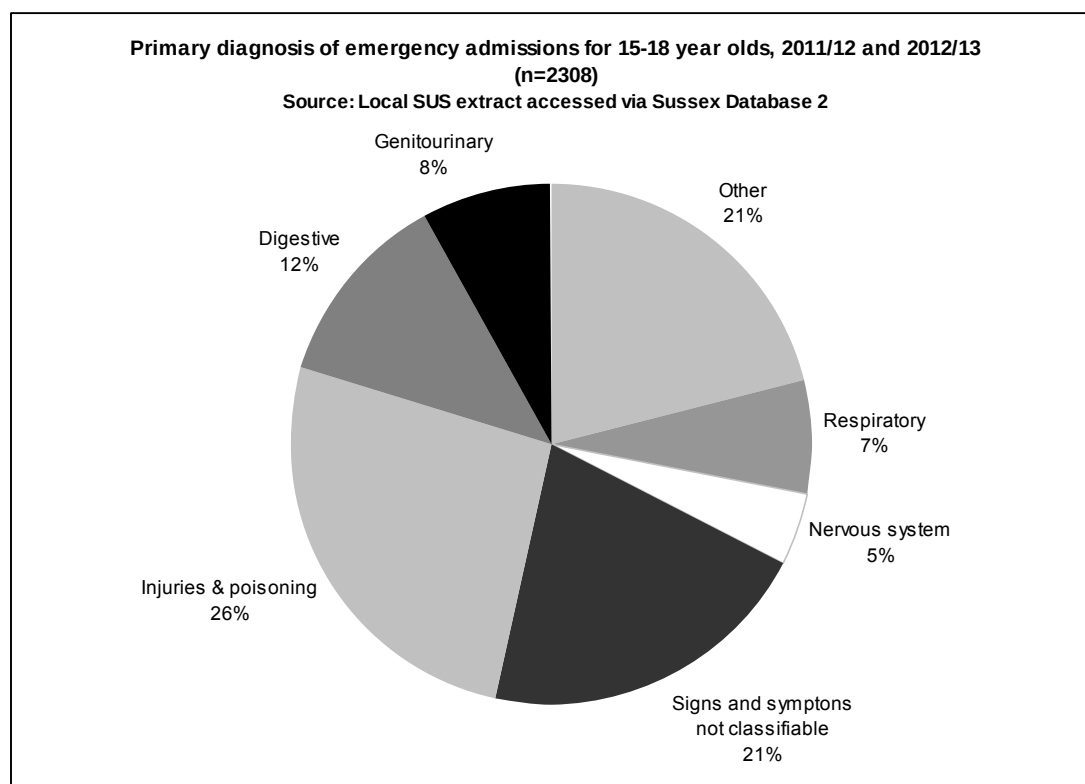
The primary diagnoses for emergency admissions in 15-18 year olds are injuries and poisonings (26%), digestive (12%), genitourinary (8%) problems; 'signs and symptoms not classifiable' make up 21% and 'other' 21% (Figure 9).

Table 11: Emergency admissions for 15-18 year olds, 2011/12 and 2012/13

Local Authorities	15-18 year olds	
	Number of admissions	Rate per 1,000 population
Eastbourne	454	47
Hastings	412	45
Lewes	453	49
Rother	378	45
Wealden	611	41
East Sussex	2308	45

Source: Local SUS extract accessed via Sussex Database 2

Figure 9: Primary diagnosis of emergency admissions for 15-18 yr olds, 2011/12 and 2012/13



Source: Local SUS extract accessed via Sussex Database 2

Table 12 provides a summary of emergency admissions in the 0-18 year olds in East Sussex by five- year age band. Respiratory causes and infections are the primary diagnoses for the under 5s - who have the highest rates of admission - and injuries and poisoning for the 5-18 year olds. Respiratory problems in children tend to be higher in more deprived communities as do childhood accidents.

Table 12: Summary table of emergency admissions by age band in 2011/12 and 2012/13

	0-4 yrs	5-9 yrs	10-14 yrs	15-18 yrs
<i>Number</i>	8,811	2,251	2,280	2,308
<i>Rate per 1,000 population</i>	163	42	38	45
Primary diagnosis				
Respiratory	26%	17%	7%	7%
Infections	19%	8%	6%	-
Injuries and poisonings	10%	24%	29%	26%
Digestive	7%	8%	10%	12%
Certain conditions originating in perinatal period	6%	-	-	-
Nervous system	-	-	-	5%
Genitourinary	-	4%	6%	8%
Signs and symptoms not classifiable	16%	18%	21%	21%
Other	16%	21%	21%	21%

Respiratory admissions

In 2011/12 – 2012/13 there were 796 emergency admissions for lower respiratory tract infections in the under 19s, a rate of 0.76 per 1,000 population. The rate is highest in Eastbourne (1.08 per 1,000) followed by Hastings (0.95 per 1,000) and lowest in Rother (0.52 per 1,000) (Table 13).

Table 13: Emergency admissions for lower respiratory tract infections in under 19s, 2011/12 and 2012/13

Local Authorities	Number of admissions	Rate per 1,000 population
Eastbourne	214	1.08
Hastings	171	0.95
Lewes	128	0.66
Rother	94	0.52
Wealden	189	0.63
East Sussex	796	0.76

Source: local SUS extracts accessed via Sussex Database 2

As per NHS outcomes framework definition: primary diagnosis = J10.0, J11.0, J11.1, J12 - J13, J14, J15, J16.0, J18.0, J18.1, J18.9, J21

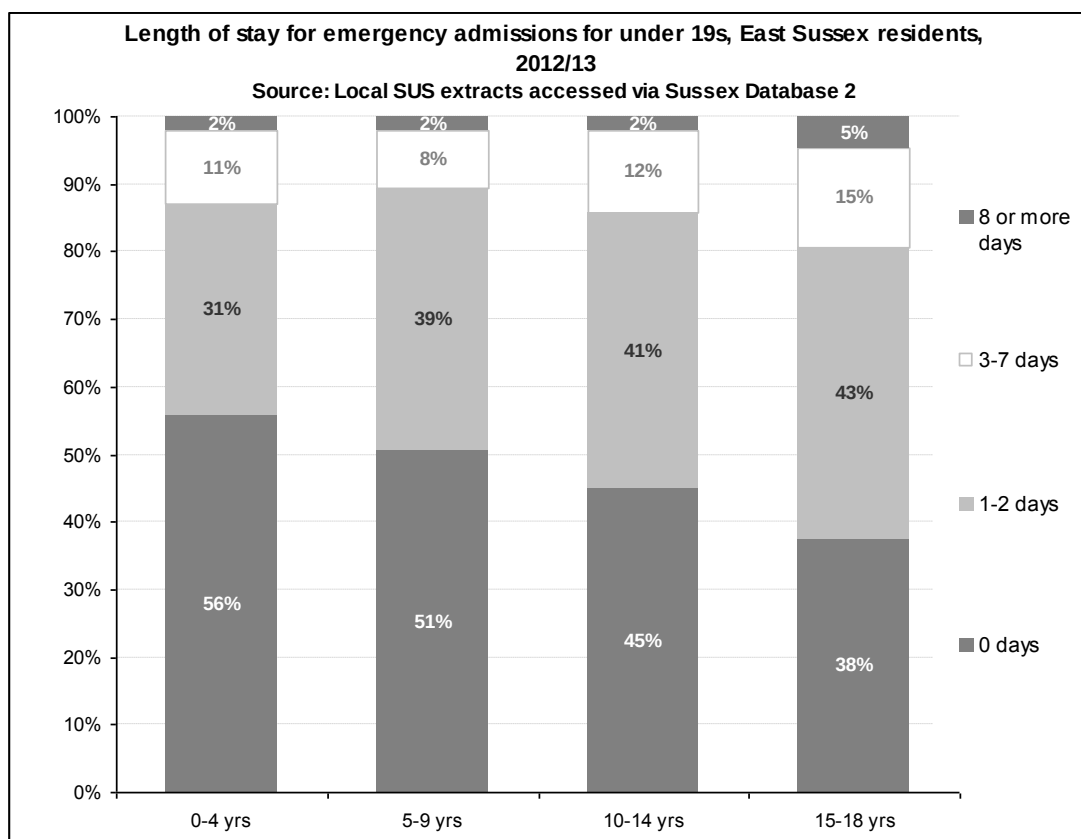
Length of stay

Emergency admissions for children have increased by 28% over the last decade. A recent review of emergency admissions for children under 15 years of age found that a small decline in stays of 1 day or more was offset by a two-fold increase in admissions of less than one day, many of which were for common infections which could be managed in the community.²¹

Figure 10 looks at emergency admissions by length of stay for East Sussex children in 5- year age bands. The majority of admissions for children aged 14 years or younger are for less than one day and only a small percentage stay for more than two days. Zero length of stay is highest in the under 5s (56%) and lowest in the 15-18 year olds (38%); conversely stays of longer than 2 days are highest in the oldest age group.

²¹ Gill PJ et al., Increase in emergency admissions to hospital for children aged under 15 in England, 1999–2010: national database analysis. *Arch Dis Child* 2013;98:328-334 doi:10.1136/archdischild-2012-302383

Figure 10: Length of stay for emergency admissions, East Sussex resident children, 2012/13



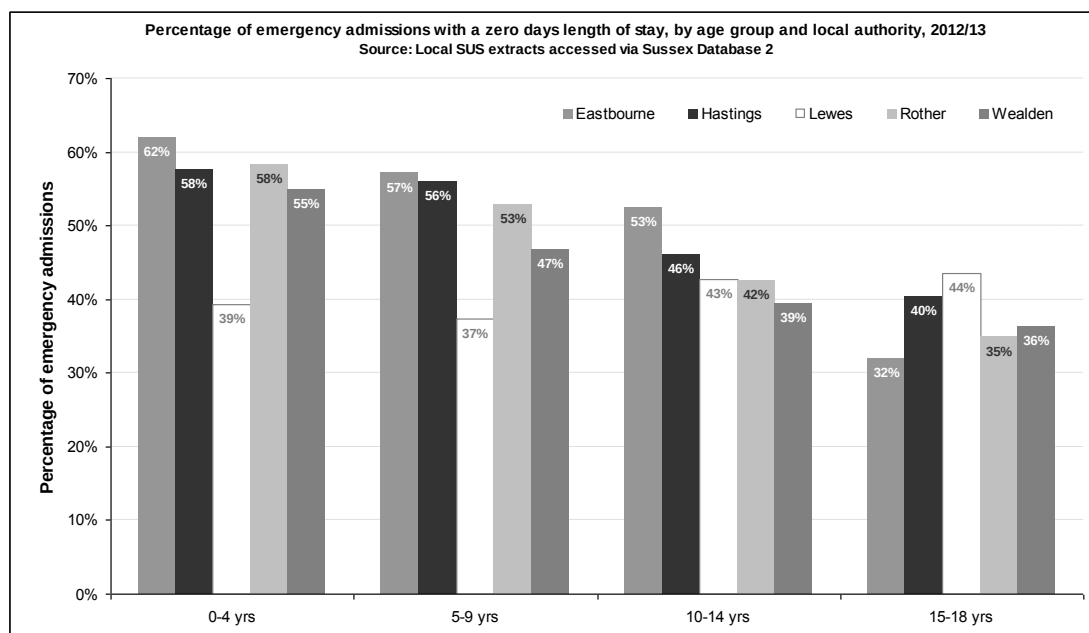
Source: Local SUS extract accessed via Sussex Database 2

Figure 11 shows the percentage of emergency admissions for East Sussex resident children that have a zero length of stay, by age group and local district and borough of residence. The majority of stays for the under 5s are for less than one day apart from for the Lewes children.

Eastbourne has the highest percentage of stays of zero days in all age groups apart from the 15-18 year olds where the percentage is highest in Lewes. Hastings has the second highest percentage in all of the five-year age bands.

Lewes has the lowest percentage of zero length of stays in the under 10s; Wealden has the lowest percentage in the 10-14 year olds and Eastbourne in the 15-18 year olds.

Figure 11: Percentage of emergency admissions with a zero length of stay



Source: Local SUS extract accessed via Sussex Database 2

4.3 Emergency admissions for diabetes, epilepsy and asthma

One of the indicators in the NHS outcome framework, that focuses on enhancing quality of life for people with long-term conditions, is to reduce the proportion of children (0-18 yrs) admitted to hospital as an emergency admission with a primary diagnosis of asthma, diabetes or epilepsy. Ideally such conditions should be managed effectively in primary care, hence admissions indicate where improvements might be made.

Table 14 shows that the emergency admission rate for these three conditions in East Sussex is 0.75 per 1,000: the highest rate is in Hastings (0.94 per 1,000) and the lowest in Lewes (0.56 per 1,000).

Table 14: Emergency admissions for diabetes, epilepsy or asthma in under 19s, 2011/12 and 2012/13

Local Authorities	Number of admissions	Rate per 1,000 population
Eastbourne	173	0.88
Hastings	168	0.94
Lewes	109	0.56
Rother	131	0.73
Wealden	198	0.67
East Sussex	779	0.75

Source: local SUS extracts accessed via Sussex Database 2

As per NOF definition: primary diagnosis = J45, J46, E10, G40, G41

Table 15 shows the numbers and rates of emergency admission for asthma, diabetes and epilepsy by five-year age bands. The number of admissions and the rates are both highest in the under fives, particularly in Hastings.

Table 15: Number and rate of emergency admissions by five year age bands

	Numbers of admissions				Rate per 1,000 population			
	0-4 yrs	5-9 yrs	10-14 yrs	15-18 yrs	0-4 yrs	5-9 yrs	10-14 yrs	15-18 yrs
Eastbourne	57	59	36	21	5.4	6.1	3.3	2.2
Hastings	90	39	18	21	8.1	4.1	1.7	2.3
Lewes	36	28	23	22	3.6	2.7	2.1	2.4
Rother	55	23	27	26	6.9	2.8	2.6	3.1
Wealden	66	40	35	57	4.4	2.5	1.9	3.8
East Sussex	304	189	139	147	5.5	3.5	2.3	2.9

As per NOF definition primary diagnosis = J45, J46, E10, G40, G41

Appendix 1

Population projections

Population projections for 15-44 year olds, 2012 - 2021

	ESCC Projections									2012-2021 change	
	2013	2014	2015	2016	2017	2018	2019	2020	2021	Change	%
Eastbourne	17,845	17,701	17,509	17,270	17,039	16,779	16,648	16,514	16,401	-1,626	-9%
Hastings	16,938	16,725	16,532	16,352	16,157	16,022	15,938	15,834	15,781	-1,354	-8%
Lewes	15,739	15,658	15,591	15,489	15,439	15,395	15,324	15,330	15,319	-582	-4%
Rother	12,333	12,211	12,206	12,138	12,005	11,947	11,835	11,833	11,914	-588	-5%
Wealden	23,533	23,354	23,064	22,837	22,654	22,515	22,319	22,298	22,422	-1,100	-5%
East Sussex	86,388	85,649	84,902	84,086	83,294	82,658	82,064	81,809	81,837	-5,250	-6%

Population projections for 0-19 year olds in East Sussex by District and Borough, 2012-2021

											2012 to 2021	
East Sussex	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Change	% change
0-4	28,141	28,077	28,040	27,848	27,509	27,246	27,036	26,729	26,481	26,273	-1,868	-7%
5-9	27,906	28,527	28,895	29,532	29,877	30,072	29,971	29,886	29,634	29,247	1,341	5%
10-14	29,430	28,642	28,206	28,014	28,284	28,881	29,491	29,821	30,441	30,783	1,353	5%
15-19	31,214	31,004	29,742	28,618	27,918	26,987	26,238	25,838	25,680	25,971	-5,243	-17%
Total 0-19	116,691	116,250	114,883	114,012	113,588	113,186	112,736	112,274	112,236	112,274	-4,417	-4%

											2012 to 2021	
Eastbourne	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Change	% change
0-4	5,515	5,538	5,495	5,436	5,337	5,141	5,026	4,904	4,787	4,676	-839	-15%
5-9	5,041	5,095	5,135	5,253	5,316	5,384	5,414	5,367	5,307	5,210	169	3%
10-14	5,273	5,061	5,053	5,039	5,055	5,198	5,257	5,294	5,415	5,480	207	4%
15-19	6,027	6,105	6,037	5,866	5,848	5,662	5,430	5,415	5,400	5,418	-609	-10%
Total 0-19	21,856	21,799	21,720	21,594	21,556	21,385	21,127	20,980	20,909	20,784	-1,072	-5%

											2012 to 2021	
Hastings	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Change	% change
0-4	5,656	5,622	5,620	5,638	5,628	5,574	5,538	5,486	5,446	5,397	-259	-5%
5-9	4,937	5,116	5,213	5,348	5,356	5,407	5,389	5,388	5,406	5,399	462	9%
10-14	5,028	4,816	4,734	4,689	4,742	4,854	5,039	5,135	5,270	5,279	251	5%
15-19	5,652	5,536	5,325	5,109	4,966	4,735	4,544	4,470	4,434	4,493	-1,159	-21%
Total 0-19	21,273	21,090	20,892	20,784	20,692	20,570	20,510	20,479	20,556	20,568	-705	-3%

											2012 to 2021	
Lewes	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Change	% change
0-4	5,225	5,163	5,065	4,964	4,886	4,784	4,755	4,705	4,667	4,633	-592	-11%
5-9	5,408	5,427	5,461	5,502	5,528	5,493	5,438	5,329	5,209	5,122	-286	-5%
10-14	5,455	5,467	5,470	5,530	5,524	5,664	5,681	5,705	5,734	5,756	301	6%
15-19	5,606	5,481	5,240	5,081	5,015	4,918	4,924	4,917	4,962	4,955	-651	-12%
Total 0-19	21,694	21,538	21,236	21,077	20,953	20,859	20,798	20,656	20,572	20,466	-1,228	-6%

											2012 to 2021	
Rother	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Change	% change
0-4	4,092	4,102	4,159	4,173	4,107	4,164	4,171	4,154	4,153	4,153	61	1%
5-9	4,213	4,333	4,454	4,576	4,742	4,781	4,806	4,849	4,843	4,755	542	13%
10-14	4,812	4,614	4,443	4,345	4,379	4,493	4,629	4,741	4,859	5,025	213	4%
15-19	5,227	5,135	4,832	4,664	4,456	4,225	4,052	3,887	3,816	3,860	-1,367	-26%
Total 0-19	18,344	18,184	17,888	17,758	17,684	17,663	17,658	17,631	17,671	17,793	-551	-3%

Wealden	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Change	% change
0-4	7,653	7,651	7,701	7,638	7,551	7,581	7,545	7,479	7,429	7,413	-240	-3%
5-9	8,307	8,556	8,631	8,854	8,935	9,007	8,922	8,953	8,868	8,761	454	5%
10-14	8,862	8,685	8,504	8,411	8,585	8,673	8,884	8,945	9,163	9,243	381	4%
15-19	8,702	8,746	8,308	7,897	7,634	7,447	7,288	7,149	7,068	7,245	-1,457	-17%
Total 0-19	33,524	33,638	33,144	32,800	32,705	32,708	32,639	32,526	32,528	32,662	-862	-3%

Source: 2012 Policy-based (Dwelling-led) Demographic Projections (2012-2027), ESCC July 2013

Appendix 2

Country code listings

Country grouping	Countries included
UK	England, Northern Ireland, Scotland, Wales, England and Wales, Alderney, Sark (little and great), Guernsey, Jersey, Channel Islands not otherwise specified, Isle of Man, Great Britain not otherwise stated, United Kingdom not otherwise specified.
New EU	Estonia, Latvia, Lithuania, Czech Republic, Hungary, Poland, Romania, Slovakia, Malta, Bulgaria, Cyprus (EU), Cyprus (not otherwise stated), Slovenia, Czechoslovakia not otherwise stated.
EU	Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Sweden, Cyprus (EU), Cyprus (not otherwise stated), Spain (except Canary Islands), Spain not otherwise stated, Aland Islands, Vatican City, Czechoslovakia not otherwise specified, Canary Islands.
Rest of Europe	Europe not otherwise stated, Albania, Bosnia and Herzegovina, Croatia, Cyprus (non EU), Kosovo, Macedonia, Montenegro, Serbia, Turkey, Serbia and Montenegro not otherwise specified, Andorra, Gibraltar, San Marino, Armenia, Azerbaijan, Belarus, Georgia, Moldova, Russia, Ukraine, Faroe Islands, Iceland, Norway, Svalbard and Jan Mayen, Liechtenstein, Monaco, Switzerland, Union of Soviet Socialist Republics not otherwise stated, Yugoslavia not otherwise stated, Commonwealth of (Russian) Independent States.
Africa	North Africa, Western Africa, Central Africa, Eastern Africa, Southern Africa, Africa not otherwise stated.
North Africa	Algeria, Egypt, Libya, Morocco, South Sudan, Sudan, Tunisia, Western Sahara.
Western Africa	Benin, Burkina, Cape Verde, Ivory Coast, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, St Helena Ascension and Tristan da Cunha, Senegal, Sierra Leone, Togo.
Central Africa	Angola, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon, Sao Tome and Principe.
Eastern Africa	Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mayotte, Mozambique, Reunion, Rwanda, Seychelles, Somalia, Tanzania, Uganda, Zambia, Zimbabwe.
Southern Africa	Botswana, Lesotho, Namibia, South Africa, Swaziland.
The Americas and the Caribbean	North America, Central America, South America, The Caribbean.
North America	Bermuda, Canada, Greenland, Saint Pierre and Miquelon, United States of America, North America not otherwise stated.
Central America	Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Central America not otherwise stated.
South America	Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Falkland Islands, French Guiana, Guyana, Paraguay, Peru, Surinam, Uruguay, Venezuela, South America not otherwise stated.

The Caribbean	Antigua and Barbuda, Anguilla, Aruba, The Bahamas, Barbados, Bonaire Sint Eustatius and Saba, British Virgin Islands, Cayman Islands, Cuba, Curacao, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Montserrat, Netherlands Antilles not otherwise stated, Puerto Rico, Sint Maarten (Dutch Part), St Barthelemy, St Kitts and Nevis, St Lucia, St Martin (French Part), St Vincent and the Grenadines, Trinidad and Tobago, Turks and Caicos Islands, United States Virgin Islands, Caribbean not otherwise stated.
Middle East and Asia	Middle East, Central Asia, Eastern Asia, Southern Asia, South East Asia, Asia not otherwise specified.
Middle East	Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, United Arab Emirates, Occupied Palestinian Territories, Yemen, Middle East not otherwise specified.
Central Asia	Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan.
Eastern Asia	China, Hong Kong, Japan, North Korea, South Korea, Macao, Mongolia, Taiwan.
Southern Asia	Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka.
South East Asia	Brunei, Burma, Cambodia, East Timor, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand, Vietnam.
Antarctica and Oceania	Antarctica, Australasia, Other Oceania.
Antarctica	Antarctica, Bouvet Island, French Southern Territories.
Australasia	Australia, Christmas Island, Cocos (Keeling) Islands, New Zealand, Norfolk Island, South Georgia and the South Sandwich Islands.
Other Oceania	American Samoa, British Indian Territory, Cook Islands, Fiji, French Polynesia, Guam, Heard Islands and McDonald Islands, Kiribati, Marshall Islands, Micronesia, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Pitcairn, Henderson, Ducie and Oeno Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, United States Minor Outlying Islands, Vanuatu, Wallis and Futuna, Caroline Islands, New Hebrides.

Media reports

Women's experiences of maternity care have improved, but further progress is needed

Care Quality Commission

FOR IMMEDIATE RELEASE: Thursday 12 December 2013

Women's experiences of maternity care have improved over the last three years, but progress is needed in some critical areas, the findings of a survey published by the Care Quality Commission (CQC) show.

The 2013 survey of women's experiences of maternity care in England shows some improvements since the 2010 survey but highlights concerns around continuity of care, support during labour and birth, cleanliness and other issues.

The survey received responses from more than 23,000 women who had a baby in February this year and it covers all aspects of maternity provision; antenatal care, care during labour and birth, and postnatal care.

One hundred and thirty-seven acute NHS trusts took part and their individual reports will help them compare their labour and birth services with those elsewhere in the country to identify good and poor performance*.

The findings include:

More women than in the 2010 survey felt they were always involved in decisions about their care, both antenatally (77 percent) and during labour and birth (74 percent)

More women than in the 2010 survey said that most of the time they were able to move around and find a position that made them most comfortable during labour and birth (71 percent)

More women said they definitely had confidence and trust in the staff caring for them during labour and birth, up from 73 percent in 2010 to 78 percent

More women than the 2010 survey reported that they were left alone at a time that worried them during labour and birth, up from 22 percent to 25 percent

Almost one in five women said their concerns during labour and birth were not taken seriously (19 percent)

The survey also explored continuity of care. For both antenatal and postnatal care, women who saw the same midwife each time tended to report more positively on areas of the survey. Those women who saw different midwives and said that they didn't mind, tended to have also had quite positive experiences of care. More negative responses came from women who had not seen the same midwife but wanted to.

Some questions can be compared with results from the previous surveys but others, such as those on cleanliness were new in the 2013 survey. Just over half (52 percent) felt that toilets were 'very clean', over a third (38 percent) fairly clean and almost a tenth (nine percent) not very or not at all clean.

Women were able to provide comments at the end of the questionnaire and 10,000 did so; the majority of comments were analysed and grouped into key themes such as access to care, continuity of care, and quality of care.

In the comments some women:

reported experiences of poor pain management with some feeling they were not able to access pain relief quickly or that they were given insufficient quantities to control the pain

said they felt 'bullied' into breastfeeding and that the pressure to breastfeed made them feel isolated and guilty.

One comment received as part of the survey reported:

"The most upsetting part though, was that midwives and health visitors make you feel bullied into breastfeeding... I was desperate to breastfeed during my pregnancy, and I was devastated when I couldn't, but the comments and the way you are made to feel guilty is totally unacceptable."

Although many comments noted the poor quality of care there were also positive comments, which highlighted professional and competent staff, and staff who were attentive to women, for example:

"My midwives during labour were fantastic. They allowed my mum to lead me through pushing and they really involved my little sister who was present".

CQC Chief Inspector of Hospitals, Professor Sir Mike Richards said: "This survey is critical because it tells us what is important to women, what they feel is working and what needs to improve.

"I'm encouraged there are improvements but in too many cases, the quality of care delivered is just not good enough. Women and their partners are being left alone when it worries them, toilets and wards are described as unclean, and some women are not given the pain relief they had expected or planned to use in their birth plan.

"Further findings of note include those about continuity of care, these suggest to me that women do not mind seeing different midwives if the information and messages they receive is consistent.

"Feedback in the comments shows at times, a truly shocking picture of experiences that should be the most joyous time in a woman's life, not the most frightening."

The results from the survey will be fed into CQC's new Intelligent Monitoring Tool.

Ends

For social media please use #maternitysurvey.

For media enquiries, call the CQC press office on 020 7448 9401 during office hours or out of hours on 07917 232 143. For general enquiries, call 03000 61 61 61.

Notes to Editors

Some trusts with a small number of women delivering in February would have also included women who gave birth in January 2013, one NHS trust included women who gave birth in March. The national patient experience programme is managed by CQC on behalf of NHS England.

The Picker Institute Europe coordinates the survey programme on behalf of CQC.

Forty-six percent of women eligible to complete the survey did so.

The proportion of women responding to the survey who were first time mothers has increased from ten percent to 13 percent. It is likely that some of the experiences of women will be different if they have previously had children, and so some of the changes since 2010 could be explained by there being a different proportion of first time mothers responding to the survey.

*Some trusts could not offer an adequate sample size and were consequently not included in the survey. NHS Trusts in England took part in the survey if they had a sufficient number of eligible women that give birth at their NHS trust during the sampling time frame.

The survey was run in 2007 and 2010, with results available on the survey co-ordination centre website here: <http://www.nhssurveys.org/surveys/299>

The questionnaire was extensively reviewed for the 2013 survey and amendments were made to improve the insight collected. The redevelopment included analysis of the data, involvement from women about their experiences, from stakeholders and from NHS trusts. The changes made between years have limited the number of comparisons available to 2010.

Results are available for trusts on the labour and birth questions, as all women would have definitely received care from the trust they were sampled from. More information on the attribution exercise that was completed as part of the survey is available here: www.nhssurveys.org/

Evidence from campaign groups and stakeholder groups

Save the DGH Evidence

Introduction by Liz Walke, Chair of the Save the DGH Campaign

Since 2006 I have had the privilege of leading a campaign group of highly respected, skilled and professional people.

We work together on a voluntary basis to defend our local core emergency health services.

We know that we have the backing and mandate from the vast majority of local people.

We want the safest service, not just a safer service!

The safest service must take into consideration accessibility – time and distance.

We do have limited resources and time available to us, so please also bear this in mind.

Some Background History

Since 2006, East Sussex Healthcare (Hospitals) Trust has failed to provide a sustainable maternity and paediatric service despite the EDGH Maternity unit being rated the highest it could be at CNST Level 3. When we produced Option 5 in 2007, we made it clear that the units could not continue as they were and different staffing models were needed to provide a safe sustainable service. The European Working Time Directive was known about in 2008 and so was the lack of middle grade doctors. In our view, the only thing that has changed since then is the reputation of ESHT which now makes it increasingly difficult to recruit staff - not just staff for maternity. Eastbourne has always been a very popular and attractive town to live in.

We are in the same situation as in 2007 when the local NHS refused to include a two site option saying they could not include anything which was not deliverable. Yet even when the local NHS said it was not possible and presented that view to the IRP, the Secretary of State for Health decided that keeping both units was possible and that single siting the service would reduce choice, reduce accessibility and increase the risk for women giving birth.

IRP Decision

The local NHS, whether it be the PCT, ESHT or the local CCGs, have all failed to implement the directive to keep both maternity units. There was no appeal to the decision made in 2008 and indeed the local NHS publicly accepted the decision to implement it.

The right course of action before any changes to the IRP decision would be for an appeal to the decision to be made to the Secretary of State for Health and go through due process. If there is the will to provide a safe service on two sites, this can be done and we said in 2008 our Option 5 was the safest not safer option for women in East Sussex. Option 5 has never been considered or implemented.

'Temporary' Removal

This is the most cynical move that we have seen. This is no 'temporary' arrangement as ESHT by their actions are making permanent changes and have no intention of bringing back a consultant unit to Eastbourne DGH. Despite massive financial problems, they have spent more money on this 'temporary' arrangement to try and ensure they deliver their desired single site option.

Can we point out that the reason given for changes to maternity came as a result of a number of Serious Untoward Incidents (SUI's) due to the failure of ESHT. So why were staffing changes not immediately implemented on both sites, as a temporary measure, rather than single siting which was the exact opposite of what the IRP had demanded?

Who is responsible for safety?

From the recent RCOG report the SUI's were as a direct result of failure of ESHT management to keep women safe. The report was dated August 2013 and the incidents took place many months previously, yet why are there only RCA's (Root Cause Analysis) done on four SUI's and not all of them? Have the staffing issues produced a gap in the risk register which then immediately resulted in the multiplying of SUI's resulting in the change for 'safety' reasons? Both the RCOG and the RCPCH reports included in the latest ESHT Board meeting papers make for scary reading and yet this same management team are still in post! Surely the consultants should have been present on labour wards and not left to trainees, locums, agency or newly qualified doctors to cope on their own without support? Perhaps this is why, as unpopular as it is, a consultant-delivered service should be considered. But why are other ways of staffing not being explored as requested by the IRP?

Number of births

Not all the units in the UK with under 2,500 births are closing or branded as being unsafe. East Sussex has continued to see a rise in the number of births now up to nearly 5,500. Would it not be possible to plan to keep 5,000 of those births within East Sussex at ESHT and relieve the pressure on neighbouring Trusts such as BSUH (Royal Sussex County) and MTW (Pembury)? If ESHT plans proceed and the temporary arrangement be made permanent, it is possible that one third of East Sussex women will give birth outside of their home county!

There are a number of Trusts that do provide a Consultant Maternity unit with under 2,500 births and the CCG say they have made enquiries. Where are their reports? We have visited units in Hinchingsbrooke and Yeovil and enclose details of these visits. This shows it is feasible to provide safe maternity services for their local population. We are hoping to produce our own option but really this should be the work of the CCG and not us. The problem has always been that there has not been the will of the local NHS to do this.

The Case for Change

The reports supporting the Case for Change may not be as robust as it appears as, for example, some with vested interests repeatedly are included as interviewees and/or panel members etc. Furthermore, in the Sussex Case for Change Appendix 1 (p.87-90), headed up Sussex Intrapartum (childbirth) Standards of Care, there is reference to 'evidence' in the case for change. However, the Sussex Maternity and Newborn Clinical Reference Group is not a 'national standard' but a 'view' of this group and thus not evidence based. The RCOG do not mention that 2,500 births is the standard requirement for a unit, and furthermore they have not said that you cannot have a safe unit with under 2,500 births. Doesn't this undermine the Case for Change?

Accessibility

There are few dual carriageways and no motorways in East Sussex. The new Bexhill link road is predicted to make less than 5 minutes difference to the journey times.

The Conquest in Hastings, the Royal Sussex County in Brighton or Pembury Hospital cannot be accessed within thirty minutes from EDGH. Thirty minutes is an important obstetric standard for unforeseen emergencies and was noted in the recent ESHT RCOG report querying transfers from the Crowborough Birthing Centre (run by ESHT) going to Pembury Hospital (run by MTW) which is down to transfer times. It takes about 10 minutes travel time to get to Pembury hospital but 40 minutes to EDGH.

The travel time between EDGH and the Conquest is at least 40 minutes or even longer depending on traffic and road conditions. Just a few days ago on 5th February 2014, there were three road closures on the A259, two of which were between Bexhill and Hastings. It is quite likely that to the west and north of Eastbourne travel time may be quicker to the Royal Sussex County Hospital in Brighton, Pembury or the Princess Royal rather than the Conquest.

What if you don't have a car? Even if you get to hospital by ambulance you rarely get a lift back. The cost of a taxi is about £30 to Hastings and taxis will not take women in labour. What about difficulties for family and friends wanting to support loved ones? What would have been a quick visit is now likely to take nearly two hours travelling time.

Better Beginnings

This document is completely flawed with the basis being the Case for Change – see earlier paragraph. The challenges surrounding staffing and size of unit can be addressed if there is the desire to do this. Choice would be reduced if consultant maternity services are not provided at EDGH.

During public engagement at all the focus groups in the Eastbourne area, women explained the difficulties of the reduced services and said they could not contemplate not having consultant Maternity or Paediatric services at EDGH. This has not been adequately stated in the public consultation document – Page 16 states “Others who would choose a midwife-led birth also want the re-assurance of obstetric care”, and, “Many women want to give birth in a stand-alone midwife-led unit.” In fact the reverse is true for those who would give birth at EDGH. The statement should read “Many would choose a midwife-led birth if obstetric care was available at the same site (or within 30 minutes) should an emergency arise.”

Interestingly, Crowborough birthing Centre has been closed recently due to their staff being transferred to the Conquest. This has created outrage amongst the locals and has resulted in a challenge to ESHT as current provider of the service be changed and MTW (Maidstone Tunbridge Wells NHS Trust, which runs Pembury Hospital) now provide this service.

ESHT

ESHT as an organisation has failed to deliver a safe maternity service by their own admission and yet have managed to use this failure to single site the service. We do not have information on the SUI's but we do know that locums, trainees and agency staff have been used and consultants and management have presided over this. Why did they not address the staffing issues and staff the unit differently as we suggested in our Option 5 in 2007 and

as stated by the Secretary of State for Health? All the pressures stated in the CCG case for change were known and stated in the PCT documents in 2007, so it's not new!

Conclusion

The arguments made in 2006 – 2008 are documented in the HOSC papers which we hope you will read as they bear a striking resemblance to the current argument. We must have the safest service for women and that means accessibility has to be considered in addition to having the staff to meet that need and not to succumb to the desires of consultants, management or anyone else with a vested interest. The independent IRP decision confirmed that only the two site option could deliver the safest service and a single-site Option could not proceed.

Please carefully consider the future healthcare and well being of the people of East Sussex. Changes to single siting the consultant maternity service will have far reaching repercussions and are already impacting on other core and emergency services.

Liz Walke

On behalf of the Save the DGH Campaign Team

Addendum

Although not mentioned in the above, we remain committed to the belief that what is safest and best for Eastbourne area at EDGH is what should be provided for the Hastings area at the Conquest – hence a two-site solution. To salami slice essential services between the two hospitals has caused havoc to our hospitals and those who use them, therefore we believe action to rectify this should be taken as soon as possible.

NOTES FROM MEETING WITH GAVIN BOYLE CHIEF EXECUTIVE YEOVIL DISTRICT HOSPITAL NHS
FOUNDATION TRUST 19TH JANUARY 2012
VINCENT ARGENT & RICHARD BOOTH

EXECUTIVE SUMMARY

Core services can be retained if the desire and will exists. Starting from the premise that core services are the key offering to the local community, it is then just a question of how to achieve that goal. Yeovil fights to create surpluses from other sources to support core services and structure themselves to minimise the costs of providing all services. Gavin Boyle was an impressive individual with energy and vision who thinks outside the usual NHS box.

In terms of Foundation Trust Status, the strategy adopted to cope with the funding issues to maintain core services is a mindset; an ethos. It requires an understanding of accountability to the local community and a rigour of approach in the handling of the funding issues. The strategy and actions adopted by Yeovil are by Gavin's reckoning, all possible within a conventional NHS Trust. It just requires a state of mind. Perhaps the conversion to Foundation Trust status is the enabler which can bring about this state of mind. Perhaps the key lays in the recruitment of the right Chief Executive.

DETAILED NOTES

- Introductions – VA & RB working with Stephen Lloyd on options for health provision in Eastbourne & East Sussex
- Yeovil had financial problems up to 2003/04 – gradually recovered financial position so that by 2006 it could convert to Foundation Trust in ^{2nd} wave
- Yeovil is about half size of Eastbourne. It has an annual income of £106.5m (ES NHS Trust £360m), 2200 staff (7500 ES), serves a population of 185,000 (500,000 ES), has 345 beds (1023 ES)
- It is therefore a small hospital but provides the core services of obstetrics, paediatrics, maternity, acute surgery, acute medicine including E M (A & E)
- It has near neighbours of Taunton & Somerset NHS Hospital (29 miles), Dorchester County & Exeter General Hospital (21 miles) & Exeter (49 miles)
- How has Yeovil survived pressure to merge or be acquired? By providing other answers.
- Answer 1.
 - o The ethos is that core services are essential to the local community but they do not generate a surplus. Core services are not sustainable in isolation because the national tariffs generally are not high enough for these services. (The extent of the loss changes year on year as the national tariff for each service changes).
 - o The hospital undertook and continues to undertake an analysis of its portfolio of services so that it balances the losses made by core services with profits made on other services. It has even developed a clinical specialism to sell to other hospitals to make a profit.

- Answer 2.
 - Partnership. The hospital is not sustainable in isolation.
 - An appreciation that the hospital is part of the town not simply part of the NHS. It is the third largest employer in Yeovil and hence a key player in the local community. Links with the community are therefore key. The hospital is a member of the chamber of commerce. The chief executive regularly meets local employers and funds from those firms assist the hospital develop its infrastructure and hence its services. Currently the hospital is raising £2.4m for re-development of its 42 year old Womens' Hospital Unit under a banner of "Flying Colours" is involving the local business community to assist.
 - For certain services it has created network links with the other local hospitals mentioned above. For example:
 - an E M (A & E) consultant has been on secondment from Exeter because of short term recruitment issues;
 - Pathology. The path service to local GP's made a profit but the hospital cases made a loss as more complicated. Whilst retaining path labs at Yeovil and Taunton & Somerset, these two hospitals have set up a new lab on an M5 site to handle their more complex path issues. This shares the costs for more complex cases. They hope to add other hospitals as partners hence the choice of the M5 site.
 - Pharmacy. Joint bid with Boots for community pharmacy services (e.g. prisons etc) and won contract away from Lloyds.
 - Sterile Services Dept offers services to outside parties such as doctors, dentists etc in Somerset & Dorset. The cost of a new state of the art unit is effectively paid by this external income.
 - Redevelopment of onsite staff accommodation to another adjacent site will free up a large areas for re-development which will be undertaken with a private developer. The Trust as the ability to borrow but has no borrowing currently. Some borrowing may be considered as the project will generate income which in turn will assist in the repayment of any debt. A Housing Association delivered the new accommodation.
 - Lots of meeting with the other hospitals to build up relationships with them so they are prepared to work together.
 - Retaining key staff. Many senior managers have been with the Trust for long periods of time and hence provide stability and continuity. The Trust recognises its intellectual capital e.g. by retaining all their student nurses even when there were seemingly too few places at that moment in time. They know that there will be leavers and it is better to have someone who learned in the organisation than pay to recruit someone at this level from outside.
- Answer 3.
 - Staff and team management & attitude.
 - "Icare" - effective COMMUNICATION, positive ATTITUDE, RESPECT for patients, carers and colleagues, and an ENVIRONMENT that is conducive to care and recovery. Borne out of a clinical complaint, the system involved training all staff over an 18 month period about respect & caring, setting up weekly monitoring through simple questions about the items that if they went wrong could cause issues with immediate allocation of resource to any department with a potential weakness. Links quality agenda and staffing agenda. Indicative of a clinically led organisation.
 - Clinical led management at a practical level. For example the head nursing officer heads the procurement committee and is able to challenge consultants on the use of cheaper alternatives which a non clinical manager could not.

- o Equipment library. An area where commonly used items of equipment are returned to after every use rather than standing awaiting use on wards. This has reduced the number of items required (e.g. pumps), enables maintenance to be undertaken immediately as required whilst always having a stock of items available ready for use.
 - o Staffing management. Though staff are allocated to departments, there is a system in place which allows staff with common skills to be shared between departments when required by pressure of work (e.g. theatre nurses). This has significantly reduced agency & bank staff costs.
 - o A can do approach. For example, to keep within guidelines as to timescales for release of patients, the systems may highlight the need for a few extra hours of work to be required on a Saturday. The income loss through breaching the guideline outweighs the additional wage cost. They have systems which recognise such issues, short communications channels to allow the matter to be taken up at clinical level and the willingness of staff to do the extra hours.
 - o Accessibility of chief executive and directors to clinical staff. Staff ideas for changes and savings are encouraged, listened to & taken on. The pharmacy idea above came from within the hospital from seeing an advert.
- Answer 4.
 - o Keeping the commissioning body close. Obstetrics was a worry as the numbers are not high. The relationship with the PCT is key to taking a long term view. The risk of removal of the service has been mitigated by the quality of the service. This in turn leads to awards & accolades making it difficult for the PCT to make a change. The women's service combines a number of related activities including breast surgery which is a profit generator and hence helps support losses. (Breast surgery is normally part of general surgery).

**SAVE THE DGH CAMPAIGN GROUP
NOTES OF THE HINCHINGBROOKE VISIT
MADE ON 24 JUNE 2013**

PRESENT

Liz Walke; Robert Smart; Stephen Lloyd MP; Sandy Medway and Vincent Argent

MEETING WITH

Hisham Abdel-Rahman (Consultant Obstetrician; Clinical Chairman & CEO, Hinchingsbrooke)

Mark Cammies (Estates/Facilities Director, Hinchingsbrooke)

Tom Muir (Head of Communications, Circle Partnership)

Jenny Raine (Finance Manager)

Massoud Fouladi (Consultant Ophthalmologist; Clinical Chairman & Co-Founder, Circle Partnership)

Chris Davison (Trust Board Non-Executive Chair)

INTRODUCTIONS & FIRST SESSION

Massoud introduced himself and explained his interest in contributing to UK healthcare. His vision is for a network of 28 small DGHs to come together. In his view an increase in managers has seen a decline in quality. Small hospitals can be efficient and he is excited by the possibilities at Eastbourne's DGH. Mergers don't solve problems. Circle has introduced a clinical leadership model with a focus on community tailored to the population of a local area. There will be a need to win hearts and minds.

Hisham introduced himself. Change is a long-term and hard road to travel. There was initial support for what they wanted to do but it soon waned and morale dipped. Their small unit has turned around from a £2m deficit to a £500k surplus. The hospital is run by an elected Clinical Leadership team alongside a mini-board of 3 non-executive directors who act as an NHS scrutiny committee. Power was put into Circle's hands who delegated this to the Clinical Leader. The hospital has kept all its core services and believes that a DGH must keep them. The hospital has centres of excellence for Older People and Acute Medicine. They only keep what they feel we can be excellent at and core services that are viable, eg they have kept diagnostics for cancer but cervical treatment is done elsewhere. They see any lost opportunities that can't make work now as opportunities they can win back in the future as they prove ourselves. 13 units have been amalgamated to 11 with 7 divisions. However they have kept and emphasised the need to keep all core services and think what you would like the hospital to look like in five years.

The Clinicians are not above the Managers who are enablers. They meet weekly as follows:-

Week 1 Finance

Week 2 Strategy

Week 3 Integration

Week 4 Quality

Units also meet weekly and there are sub-unit meetings but a key aspect is the detection of failure, which they call "Stop the Line". Any serious incident is reported to the CEO (Hisham) within the hour and then followed up as in the handout.

Hisham ran through the presentation document we had been given.

We then did a brief tour to several areas, visiting the A&E Short Stay Ward (which has been expanded) and also met with the Senior Midwife and the Lead Emergency Clinician. He stressed how important it is having a Senior Clinician on call/on duty to make decisions about admissions to hospital and care pathways. This has stopped unnecessary admissions.

SECOND SESSION

Chris Davison is Chair of the Trust Board and is the franchise manager appointed by the Department of Health as Ops Director. The NHS Trust Development Authority (TDA), an arm of the Dept of Health, is the organisation which looks into Trusts who are unlikely to meet the Foundation Status – ESHT likely fitting the bill. The Dept of Health is looking at solving the problem of those Trusts like Hinchingbrooke (DGH size) and had the vision to bring in Circle Partnership for a management franchise, wanting to offer a solution for DGHs. They also need to look at value for money and safety. They have reserve powers re the state. We knew we needed someone with vision and foresight and Stephen Dunn of the TDA (the Trusts Development Authority) was the main person involved. Chris will be on the phone to Stephen after we leave to see if there is any political will on our patch in Eastbourne. Indicators re Foundation Trust status will be important. TDA have good relations with Circle via Dept of Health and Monitor. This franchise is groundbreaking and innovative and builds on the best of private with the values of the NHS. It is a John Lewis model with staff ownership of shares. Hinchingbrooke/ Circle see it as a window of opportunity for smaller DGHs. You can't argue with the results. Circle made a £3.7m investment in this hospital for its future and put in place robust governance arrangements. The old Board went and that whole process took about 2 years. All staff have a ten year contract. There were originally 26 bidders, reduced to 5 private providers. Staff didn't want merger nor acquisition.

Jenny explained at one time they couldn't recruit Consultants but with job security and a 10 year plan they now get 30 per position and can pick high calibre people. Some Consultants have contracts with Hinchingbrooke and also other nearby hospitals. Their (Circle) future plan is for Hinchingbrooke to become an integrated Trust and have networked hospitals.

They recommended Stephen Lloyd first go and see David Florrie, CEO of the TDA and test the atmosphere. At Hinchingbrooke there was an appetite for this. Don't contact the CCG too soon. They work well with the CCG and have regular contract and monitoring meetings so there is trust and confidence. Chris deals with all the external environments and if he has any concerns he has a direct line to the local HOSC and Dept of Health. There is a sense of common purpose.

There was some regional resistance via the Unions but not from staff nor local unions. The checks and controls mean that the Trust board has public accountability and we really need to stress this. Hinchingbrooke hospital Clinicians wrote to the Prime Minister to get the change they wanted so getting them onside is very important. They've not made one single redundancy and staff who left some time ago are now returning to work with at Hinchingbrooke because they can see a future.

PAPER

Homebirth and the Future Child

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ABSTRACT

Debate around homebirth typically focuses on the risk of maternal and perinatal mortality and morbidity – the primary focus is on deaths. There is little discussion on the risk of long-term disability to the future child. We argue that maternal and perinatal mortality are truly tragic outcomes, but focusing disproportionately on them overshadows the importance of harm to a future child created by avoidable, foreseeable disability. The interests of future children are of great moral importance. Both professionals and pregnant women have an ethical obligation to minimize risk of long-term harm to the future child; harm to people who will exist is a clear and uncontroversial morally relevant harm. The medical literature does not currently adequately address the risk of long-term disability, which is at least as relevant as other outcomes.

The choice of place of elective birth (home, hospital or other) may only be justified if it does not expose the future child to an unreasonable increased risk of avoidable disability. Doctors' duty of care for the life of the pregnant woman and her fetus may be overridden by the woman's choices. But further research is required to document the prevalence of long-term avoidable disability associated with different birth place choices. Couples should be informed of this risk and doctors should attempt to dissuade couples when they elect a place of birth that puts the health and well-being of the future child at risk.

INTRODUCTION

"The fact itself, of causing the existence of a human being, is one of the most responsible acts in the range of human life. To undertake this responsibility—to bestow a life which may be either a curse or a blessing—unless the being on whom it is to be bestowed will have at least the ordinary chance of a desirable existence, is a crime against that being"¹

"I fully admit that the mischief which a person does to himself may seriously affect, both through their sympathies and their interests, those nearly connected with him ... When, by conduct of this sort, a person is led to violate a *distinct and assignable obligation* to any other person or persons, the case is taken out of the self-regarding class, and becomes amenable to moral disapprobation ... If, for example, a man, through intemperance or extravagance, becomes unable to pay his debts, or, having undertaken the moral responsibility of a family, becomes from the same cause incapable of supporting or educating them, he is deservedly reprobated, and might be justly punished..."¹

"It still remains unrecognised, that to bring a child into existence without a fair prospect of being able, not only to provide food for its body, but instruction and training for its mind, is a moral

crime, both against the unfortunate offspring and against society; and if the parent does not fulfil this obligation, the State ought to see it fulfilled, *at the charge*, as far as possible, of the parent."¹

On 4 September 2012, a UK Coroner's Court heard that a mother died within hours of giving birth at home.² According to reports, the woman had previously delivered twins by emergency caesarean section, one later dying, a history which, according to The Royal College of Obstetricians and Gynaecologists, is a strong indication for hospital birth.

While this tragedy affected the mother, more commonly serious complications during birth affect the baby. Homebirth perinatal deaths of infants who would have survived if they had been born in hospital are reported more commonly than maternal deaths. In Australia, the New South Wales coroner recently determined that a woman's decision to deliver at home unsupervised 'cost the baby her life'.³ A South Australian coroner found that three fatal homebirths would not have occurred if the births had taken place in hospital.⁴

But the fetus has few ethical or legal rights; maternal autonomy includes the right to risk perinatal death as well as her own death. The cases above have reignited the debate over maternal autonomy in the national press of Australia and the UK. However, one silent tragedy is the long-term disability that can result from homebirth. And it is this risk that we will argue weighs heavily against homebirth. In this paper, we will argue that both professionals and pregnant women have an ethical obligation to minimise risk of long-term harm to the future child. Harm to people who will exist is a clear and uncontroversial morally relevant harm. Consistent with this, antenatal care focuses on minimising the risk of harm to the future child with measures such as advocating alcohol abstinence in pregnancy, folic acid supplementation to reduce the chance of neural tube defect and minimising teratogenic risks of medications in pregnancy. These all aim to minimise the risk not to the fetus or the pregnant woman, but to the long-term health and well-being of the child.

RISKS OF DISABILITY FROM HOMEBIRTH

What kind of disability may be associated with homebirth? When a labour is obstructed or a baby is born with hypoxic brain injury, the immediate treatment is crucial in the outcome for the baby. Delay in transferring to a tertiary hospital may result in permanent severe disability that will persist for the rest of that person's life. Vital delays are inevitable in some cases. These can lead to disability, which was avoidable if the delivery had



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occurred in hospital, especially in a large country or when support services are suboptimal.

To take an extreme example, the lack of equipment to deal quickly when such events occur at home might result in avoidable quadriplegia.

We will argue that the choice to have a homebirth might only be justified if it exposes the future child to a near-zero increased risk of avoidable disability.

We will conclude by arguing that perhaps less than the best standard of care can be provided to patients on grounds of distributive justice—society cannot afford to offer everyone the best obstetric care possible. But couples should be warned of avoidable and foreseeable risks of future child disability.

RISK OF DISABILITY: BRIEF REVIEW OF EMPIRICAL LITERATURE

Although future harm and disability is of great moral significance in deliberating about reproductive choice, there are few good data on risk of longterm disability after homebirth, partly because documenting disability requires difficult, expensive and very large long-term follow-up studies. Reliable data are also hard to come by as many homebirths where complications are experienced transfer to hospital and are recorded as hospital births.

Some studies may also be unhelpful for those seeking data on significant morbidity following birth. A recent UK study reported that ‘multiparous women planning birth at home experience fewer interventions than those planning birth in an obstetric unit with no impact on perinatal outcomes’.⁵ Morbidity was assessed by a ‘composite primary outcome measure’ of conditions ranging from a clinical diagnosis of neonatal encephalopathy to a fractured clavicle and even delayed breastfeeding initiation. The authors noted that a weakness of their study is the use of a composite primary outcome measure because of the low event rates for individual perinatal outcomes. But it is problematic to bundle fractures and delayed breastfeeding initiation, which are correctable, with encephalopathy. If individual perinatal outcomes were examined, the study was apparently underpowered to assess these major morbidities. Many studies similarly fail to distinguish between severity of outcomes.

In another study, caesarean section rate was lower for intended out-of-hospital births, but risk of 5-min Apgar <7 and neonatal seizures higher. The study concluded, ‘This trade-off between maternal benefit and neonatal risk of deliveries outside of hospital should be weighed in the decision regarding birthing facility preferences’.⁶

Nevertheless, there are strong data to show that there are significantly worse outcomes for the fetus in homebirths. A meta-analysis included 12 studies and 500 000 planned homebirths in healthy low-risk women showed neonatal mortality tripled.⁷ This suggests that we could expect increased risk of future child morbidity—perinatal mortality and morbidity may be surrogate markers for future child risk. Surrogate markers can be objectively measured and evaluated as indicators of pathogenic processes.⁸

Intrapartum events

Homebirth is expected to cause a delay in diagnosis, delivery and/or transfer following an acute intrapartum event with rapidly developing hypoxia, acidosis and asphyxia. Such a delay will necessarily result in a prolonging of asphyxia.

The best intrapartum fetal heart rate parameter for predicting newborn acidemia is minimal or absent variability, with or without the presence of late decelerations.⁹ This is difficult to

detect with intermittent auscultation alone, and even if diagnosed there will be the inevitable delay in expediting hospital delivery, which may be time critical. Even within a major tertiary hospital, both perinatal mortality and 5-min Apgar <7 are higher in a birth centre model of care (where only low-risk women are permitted, intervention rates are minimised and cardiotocography monitoring is unavailable) compared with a collaborative model.¹⁰

Intrapartum factors associated with an increased risk of neonatal encephalopathy include infection, intrapartum haemorrhage, cord accidents, prolonged labour¹¹ and severe shoulder dystocia. Some of these complications will be amenable to timely intrapartum hospital transfer, others less so. Inability to expedite delivery in the face of severe fetal compromise will worsen outcome.

It has been demonstrated in the hospital setting that training all disciplines in management of obstetric emergencies (such as shoulder dystocia, neonatal resuscitation and fetal heart rate abnormalities) can significantly reduce the incidence of both 5-min Apgars <7 and hypoxic ischaemic encephalopathy (HIE) and therefore their attendant long-term consequences.¹¹ Consistent with this is the finding from the Netherlands that infants of ‘low-risk’ women who were referred by a midwife (primary care) to an obstetrician during labour had a 2.5 fold higher risk of neonatal intensive care unit admission than did infants of women who started labour supervised by an obstetrician.¹² Of great concern is the fact that this study showed infants of low-risk pregnant women who started labour in primary care had a higher risk of delivery related perinatal death plus the same risk of admission to the neonatal intensive care unit as infants of high-risk pregnant women who started labour in secondary care.¹²

These data confirm what might be expected intuitively—the inability to achieve timely access to emergency obstetric care (to expedite delivery in the setting of fetal compromise) and paediatric care (to optimise neonatal resuscitation and implement neuroprotection) will impact on the rate of HIE and subsequent disability. In support of this are further data from the Netherlands, confirming that where travel time from home to hospital is greater than 20 minutes, there is a significantly increased risk of neonatal mortality and adverse outcome.¹³

Resuscitation

An infant delivering following an asphyxial insult may require oxygen, bag and mask ventilation, intubation, chest compressions and resuscitative medications,¹⁴ which cannot be optimally provided in a homebirth environment. It would be expected that in some cases inadequate neonatal resuscitation will not only convert potential future normality to survival with morbidity, but may also convert potential normality or mild morbidity to survival with major morbidity.

Access to hypothermia

Transfer of an infant who has suffered a severe asphyxial insult from home to hospital may delay the commencement of neuroprotective strategies, particularly therapeutic hypothermia. This will worsen outcome. The therapeutic window can be too short for infants requiring transfer to a tertiary referral centre.¹⁵

HIE occurs in approximately 1–6 : 1000 term infants with a mortality of 20% and the risk of neurodevelopment consequences in the survivors is 25%.¹⁶ Long-term consequences of HIE may include cerebral palsy, motor, perceptual-motor and cognitive impairments detectable by school age.^{17–20} Even infants who have required resuscitation at birth but remain

asymptomatic for encephalopathy may be at risk of developing low IQ at 8–9 years of age.²¹

REFRAMING CURRENT DEBATE: FUTURE HARM AND DISABILITY

Homebirth press focuses on potentially avoidable maternal and perinatal deaths, while pro-homebirth advocates tend to focus on the risks of interventions.^{2 3 22} There is little discussion by either on the risk of long-term disability to the child. We believe that highlighting maternal and perinatal mortality and morbidity can overshadow the importance of future harm to the child through infliction of avoidable, foreseeable disability. The interests of children who will exist in the future are of great moral importance, and need to be given priority.²³ Debate should focus on foreseeable, avoidable disability.

There is an established and lively literature on disability—its nature and moral significance.^{24 25} Some of this has focused on the use of genetic or other testing for selection of healthier embryos or fetuses to avoid disability.²⁶ However, comparatively less has focused on actions that cause a future child to be harmed (see²³ for an overview) but are not lethal.

It is obviously wrong to injure a child or fetus in such a way that it will be severely disabled in the future. Courts award enormous payouts when obstetric mismanagement is found to contribute to a child's subsequent disability. An independent Sydney midwife was found to have been negligent in both recommending and carrying out a home birth. She has been ordered to pay \$6.6 million in damages. The child has quadriplegia, cerebral palsy and intellectual disabilities.²⁷ There is a reluctance to prescribe drugs to pregnant women, even those for which there are no data suggesting ill-effects to the fetus. Pregnant women are strongly discouraged from even low doses of alcohol, smoking or recreational drugs. Yvonne Kelly, the lead author of a recent study, stated that their findings raise questions as to whether current recommendations for complete alcohol abstinence during pregnancy are merited.^{28 29} Despite this, the head of science and ethics at the British Medical Association (BMA), said that the BMA still believes the simplest and safest advice is for women not to drink alcohol during pregnancy.²⁹

Maternal and perinatal deaths are obvious adverse outcomes that must be recorded. But when a baby is injured during childbirth, the full extent of the harm is often not obvious until years later. Psychologically, these harms are less weighty in and present to moral consciousness. Human beings are biased to the present and near future. We do not accord the weight we should to harms that are largely manifest in the distant future.

Yet, in moral philosophy, there is a basic principle of temporal neutrality with respect to harm: when a harm occurs is morally irrelevant.^{30–33} Actions taken today that cause harm in the future are as wrong as if that harm were realised today.

Consider an example. Imagine a doctor gives a 3-year-old child, John, a drug that makes the child deaf. This is a terrible wrong. Another doctor gives a pregnant woman a drug. Her child, James, is diagnosed as being deaf 3 years later as a result of being given the drug now. This is as wrong as the action of the doctor in the case of John, even though the full magnitude of the harm to James is not realised until 3 years later.

Homebirth, as the data above suggest, may be associated with an increased risk of disability to the future child. Yet homebirth is enthusiastically promoted by some healthcare professionals and organisations,^{34 35} while maternal consumption of any alcohol is strongly discouraged despite such a recommendation being questioned. It seems inconsistent to demonise low doses

of alcohol during pregnancy but endorse homebirth. At very least, we need better data on each.

At home deliveries, there are few resources to detect and manage complications. What risk of disability in the future child is reasonable to satisfy a mother's personal desires? The answer according to temporal neutrality is the same risk of present harm that she would be justified in exposing a child to.

WOMEN'S CHOICE?

Homebirth is said to be about the ability of women to make a fundamental choice about their own bodies.³⁶ Homebirth advocates often wish to keep birth free from medical interventions. Homebirth decisions may also be influenced by what is fashionable or the latest cause célèbre.³⁷

Benefits of homebirth include lower intervention rates. Women have less pain at home and increased satisfaction, plus fewer episiotomies, lacerations, postpartum haemorrhages, retained placentae and infections.^{34 35}

There are also risks attached to hospital birth such as medicalisation of pregnancy, hospital acquired infections and higher intervention rates considered by some as unnecessary. There are possible long-term effects of instrumental and operative deliveries, and even, in the case of caesarean section, possible effects on the health of a next child.

Most women will deliver at home with good outcomes for both the mother and child. Nonetheless, because of the increased risks, it has been argued by some that planned homebirth does not meet current standards for patient safety in obstetrics and to regard these risks as ethically acceptable relegates pregnant and fetal patients who experience adverse events to the category of 'collateral damage'.³⁸

There are plenty of horror stories available arising from both hospital and homebirth experiences. However, it is important to compare all the risks and benefits of homebirth versus hospital birth when both are competently and effectively supported. Despite homebirth having some advantages, what we do know about the risk of long-term disability suggests that competent hospital birth must be of lower risk to the future child than competent homebirth.

It is right that women can choose management options and behaviours that result in risk of maternal and fetal mortality (where abortion is accepted), maternal morbidity and even short-term perinatal morbidity. Professionals should try to persuade them to act differently and reduce these. But ultimately women ought to be, and are, free to make their own decision regarding whether to take such risks.

However, it is important to distinguish ethically between risks of perinatal death (mortality) and risk of disability (long-term morbidity). Perinatal death involves the death of a late fetus or newborn. If one accepts that abortion is permissible because the fetus is not a person, one could consistently hold that maternal choices that increase the risk of perinatal mortality are morally equivalent to a choice to have an abortion or late abortion. One might accept perinatal mortality on the grounds that the late fetus is not a person.

However, we need not take a position on the moral status of the fetus. Choices that do not cause the death of a fetus or newborn but raise the chances of severe long-term disability are different in kind because they involve harm to people who will exist. This is a clear and uncontroversial morally relevant harm, regardless of views of moral status. It is wrong to put a future child at an unnecessary risk of a life of disability. This is true whether one is prochoice or prolife.

It is considered reasonable for a mother or father to satisfy some of her or his personal desires even if it imposes some risk on her or his children. She or he may go to a movie, thereby exposing her or his child to the (low) risk of travelling by car despite the child having little to directly gain from the trip. The risks of a car accident are low and going to the movie gives them pleasure. However, labour and delivery is a time of high risk and homebirth exposes the future child to unreasonable risk of potentially life-changing disability for benefits that may be comparatively small.

Imagine that I like boxing. I decide to let my child take boxing lessons which, in this hypothetical case, carry a 50% chance of permanent learning disability. This is clearly wrong. Yet severe HIE may have just such a chance of permanent brain damage.

Now imagine there is only a 1/10 000 risk of a 50% chance of causing permanent brain damage (1/20 000) from my child doing boxing. I still should not allow boxing unless I have a very good reason of sufficiently superior weight and probability compared with the alternative.

The point is that even if there is a very low probability of some bad outcome, if the outcome is very bad and there is another alternative with an even lower probability of that outcome, it may be rational to take the latter course, that is, the hospital rather than the homebirth (even if homebirth has quite a low overall morbidity).

THE LAW

Few jurisdictions are likely to deny women the right to homebirth. The United Nations statement on the Rights of Women³⁹ asserts that women 'have the right to have control over and decide freely on all matters related to their sexual and reproductive health'. There is, in addition, clear legal justification for a mentally competent patient to be free to choose an option that seems irrational or wrong to clinicians, even if the consequences are potentially fatal.⁴⁰

The UK Court of Appeal ruled that a mentally competent patient has an absolute right to refuse medical treatment even where that decision might lead to her death or the death of her baby, for any rational or irrational reason or for no reason at all.⁴¹

There have been over 50 cases in the USA of court-ordered caesarean sections since 1980.⁴² However, the Court of Appeal stated that 'a foetus cannot have rights ... superior to those of the person who has already been born'.²³

Women in most jurisdictions have the right to freely make decisions that may cause fetal death, including access to late termination in at least some circumstances in most western jurisdictions. Women are also usually allowed to refuse recommended medical treatment, even at full term.

Medical vigilance has helped to reduce maternal and perinatal morbidity and mortality but it sometimes rests uneasily with a woman's enfranchisement in her own care. Legal decisions tend to focus on death of the pregnant woman or her baby and not future child disability. It is the risk of harm to the future child that is also ethically significant, yet we believe this has been neglected in consideration of decisions about homebirth. While the clear message is that respect for women's autonomy is enshrined in law and overrides the risk presented to a future child, it is by no means clear that ethically parental autonomy should extend this far.

SHOULD HOMEBIRTH BE BANNED?

Banning is sometimes a morally justified state restraint of risky behaviour. Thalidomide was banned worldwide in the interests

of future people rather than informing women of these possible effects and allowing them to choose whether to take this sedative.²³ If the extra risks of homebirth did make it unethical should it be banned? However, for reasons discussed in the previous section, we do not propose legal sanctions against any women who choose homebirth. Given that the excess risk of "low risk homebirth" is likely to be low, *we suggest that any moral obligation to lower risk to the future child should be a moral rather than legal requirement.*

Moreover, a legal ban is unlikely to prove necessary. Carers should recommend strongly against planned homebirth,³⁸ provide information about the risks and try to persuade women to have better obstetric management. Limiting patient access to health funding for homebirth may be appropriate in some countries. Of course perhaps the best solution is to make hospital-based delivery more acceptable to women and to better educate people about the risks of birth (and perhaps also the ethical principle of temporal neutrality).

CONCLUSION

Birth is an inherently risky time for mother and baby. Through most of human history, around 1% of mothers have died while giving birth.⁴³ At the beginning of the 20th century, for every 1000 live births, six to nine women in the USA died of pregnancy-related complications and approximately 100 infants died before age 1 year.⁴³ From 1915 through 1997, the infant mortality rate declined greater than 90% to 7.2 per 1000 live births, and from 1900 through 1997, the maternal mortality rate declined almost 99% to less than 0.1 reported deaths per 1000 live births (7.7 deaths per 100 000 live births in 1997).

Modern obstetrics has been one of the great advances of modern medicine. Yet today, some people wish to return to the past.

There is a need to reconcile respect for a woman's autonomy with the duty of care that practitioners have to the woman, but also and separately to the baby.⁴⁴ The baby is most plausibly interpreted as the future child. Doctors' duty of care to the woman and for the life of her fetus may be overridden by the woman's choices. But doctors should use all their powers of persuasion when the health of the future child is at risk. If 'future child' is substituted for 'baby' then we agree that 'women have the right to choose how and where to give birth, but they do not have the right to put their baby at risk'.²²

We do not argue that doctors should accept without question their patients' plans to risk maternal or fetal mortality or morbidity. Doctors should explain the risks and encourage women to act safely. But ultimately, within current law, it is the patient's decision. When there is risk to the child, however, professionals have an additional responsibility to explain to the pregnant woman our collective responsibility to minimise the risk of disability to our children. We do not prohibit alcohol and cigarette smoking during pregnancy, we merely strongly discourage them.

Having a homebirth may be like not putting your child's car seat belt on. The risk of being injured in a single trip by not wearing a seat belt is extremely low. Still, we expect people to wear a seat belt to make the risks as low as possible, despite some inconvenience and diminution of driving pleasure. Most children will be unharmed. Some trips are very safe. And wearing a seat belt will not remove all risk of injury or death. Indeed, wearing a seat belt in an accident will, on rare occasions, cause greater injury than not wearing a seat belt. But on balance it is much safer with a seat belt. And if one child is permanently brain damaged because she/he did not wear a seat belt, that is one child too many.

Professional organisations in some countries may judge that homebirth can be carried out safely for low-risk women if geographical factors, staff and training, equipment and service organisation allow it. But it is unrealistic to think that most medical services can provide optimal care to women in their homes; even highly regarded homebirth services may be associated with increased perinatal mortality and morbidity.¹³ Labour out of hospital, with staff who may be professionally and geographically isolated, is unlikely to produce neonatal outcomes as good as the best quality obstetrician-led hospital care. We have argued that in most situations the risk of disability may be elevated and unjustified.

Homebirth appears to be a risk factor for the future child, or at least so uncertain, that it should be discouraged, pending further research. Doctors and midwives often do not currently tell patients that there are predictable avoidable risks of future child disability with homebirth. They should do so. Potential homebirth patients should be told that it is usually wrong to knowingly allow such a risk. We agree with Chervenak *et al*³⁸ who argue that professionals should not support planned homebirth when there are safe and compassionate hospital-based alternatives.

There is one consideration that speaks ethically in favour of homebirth—distributive justice. Low-tech midwife-led health-care may be considerably cheaper than the best obstetric management. There are simply not enough resources to allow every woman to deliver in a tertiary care institution no matter how much more beneficial that would be. Part of the enthusiasm for homebirth is related to cost-cutting and perhaps distributive justice. However, we agree that real costs, including sometimes those of a lifetime of institutional care, must be taken into consideration in economic analyses.⁴⁵ Even if homebirth must remain an option within a publicly funded healthcare system in the 21st century, couples should be clearly informed of the excess risk of future child disability that this might present. Only then can they rationally reflect on whether to seek hospital care to reduce these risks.

We will finish with an important qualification. We have not argued definitively that homebirth is immoral. We lack sufficient evidence to establish such a claim. What we have argued is that a neglected ethically relevant outcome is serious avoidable, foreseeable disability to a future child. The ethical ranking of home or hospital birth will depend significantly on future child disability. It is theoretically possible that high tech hospital care might be worse in relation to this outcome. This would be a reason to believe that homebirth is in one way preferable. But we will not know whether homebirth is better, worse or equal to hospital birth until we accurately know the rates of future child disability. Risk in life is never eliminable. Pregnancy and childbirth are inherently risky. What matters is that we try to make risk reasonable.^{46 47} This includes understanding its magnitude and causation. This requires much larger long term studies of disability from different birthing choices. It also requires balancing risk against benefit. And importantly it requires that risk be minimized. One important determinant of risk during birth is the place of birth and the competence of the person assisting birth (“accoucheur”), be that midwife in hospital or out, or obstetrician, or GP and the support available to them both prior to and during birth. Outcome for the mother and future child will be determined by training, experience, skill, knowledge, support and oversight of all those involved in the pregnancy and childbirth, together with the availability of intervention should mishap occur. One thing is clear is that there will always be future children who are left disabled because of events in pregnancy and during the birth process. We should seek to

predict and avoid these. Foreseeable, avoidable disability in a future child is a great tragedy.

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Start **Eastbourne District General Hospital**
 King's Dr, Eastbourne, East Sussex BN21 2UD, United Kingdom
 End **Conquest Hospital**
 The Ridge, St Leonards-on-sea, East Sussex TN37 7RD, United Kingdom
 When 15/01/2014 after 15:10
 Duration 1 hour 22 mins total



Eastbourne District General Hospital
 King's Dr, Eastbourne, East Sussex BN21 2UD, United Kingdom



Walk to Upperton, opp Burton Road

About 5 mins



Upperton, opp Burton Road (Stop ID: esuadgwi)

15:25 - 15:33

Bus - Eastbourne Loop - Eastbourne - Langney - Hampden Park - Eastbourne towards Eastbourne Town Centre, Terminus Road Arrivals

(8 mins, 7 stops)



Eastbourne Town Centre, Terminus Road Arrivals (E-bound, Unmarked) (Stop ID: esudjgpa)

About 1 min

Walk to Eastbourne



Eastbourne (Stop ID: EBN)

15:40 - 16:12

Train - Brighton to Ore towards Ore

(32 mins, 8 stops)



Hastings (Stop ID: HGS)

About 1 min

Walk to Hastings Town Centre, Railway Station (Stop F)



Hastings Town Centre, Railway Station (Stop F) (Stop ID: esuajptj)

16:17 - 16:39

Bus - 340 - Hastings - Conquest Hospital - Northiam - Tenterden towards Tenterden, The Vine

(22 mins, 18 stops)



St Helens, o/s Conquest Hospital (Stop ID: esuajptj)

About 3 mins

Walk to Conquest Hospital



Conquest Hospital
 The Ridge, St Leonards-on-sea, East Sussex TN37 7RD, United Kingdom

A Submission
to
East Sussex County Council
Health Overview & Scrutiny Committee
on

Maternity Services in the High Weald Locality

Not where...

...but how & by whom?



Contents

Executive Summary 3

1 Background 5

1.1 Role of CBC Midwife Team of Midwives 5

1.2 Trend of Maternity Services Reduction by ESHT in High Weald 6

2 High Weald Maternity 7

2.1 De facto access to local Scanning & Obstetrics in High Weald. 7

2.2 The maternity disconnect in High Weald 8

2.3 2013 mapping & analysis of service usage 10

3 Midwife Led Units 11

3.1 The wider picture on “MLU demand” & “midwife staffing” 11

3.2 Midwife-led Unit Demand 12

3.3 Midwifery Staffing 12

4 A Robust Locality Solution for High Weald Maternity 13

4.1 Continuity of Care from a Maternity Team 14

4.2 Re-shaping Maternity with a Local Obstetric Provider 14

4.3 Next Steps in Reshaping Maternity in High Weald 15

References 15

Appendix – Comments from Women 16

Executive Summary

Crowborough Birth Centre in High Weald is a local maternity care centre for all women, regardless of their clinical risk classification, for whom the midwife team provide ante-natal & post-natal care, and with those women deemed to have “low-risk” pregnancies able to plan to give birth there. The centre is open 24 hours-a-day and acts as a ‘help-line’ source of advice to all pregnant women in High Weald and further afield.

“Actual births” are in reality the smaller part of the activity with 70% of the CBC midwife team work load being antenatal care during pregnancy for the 800 women who are pregnant each year in High Weald. This integrated team working is an efficient and cost-effective model of maternity care.

A midwife-led birth centre does not operate in isolation. Pregnant women being cared for by the midwife team require maternity scans, blood tests & analysis, the opportunity for a consultant clinic if potential complications arise, and a seamless pathway to local obstetric care if complications of pregnancy are confirmed. Since 2010 these maternity support services, provided by ESHT, have moved further away from the High Weald.

Now, fewer than 4% of women in High Weald use the obstetric services of ESHT for the birth of their baby. As the maternity support services provided by ESHT in High Weald have reduced, women have progressively turned to other maternity providers to access local maternity care. By default, Pembury has become a major provider of maternity care for High Weald women and the overall effect is that High Weald Women receive disjointed maternity care with different parts of their care provided by different trusts and midwife teams.

The current public consultation for East Sussex maternity focuses almost entirely on the locations of maternity units and when applied to High Weald, this totally misses the real maternity issues and the main concern of local women.

The consultation fails to take account of actual maternity demand in the localities and that, historically, demand for an MLU in High Weald has come from both East Sussex & West Kent, with potential for at least an additional 100 births per year.

The current arrangement for maternity in High Weald is not clinically robust, is not financially sustainable and fails to provide a good quality of maternity service to local women. A variation on Option 4 is available that meets all of these requirements, and involves re-joining the local community midwifery to the local obstetric providers.

Maternity in the High Weald

Not where...but how & by whom?

1 Background

The Crowborough Birth Centre has been a midwife-led local maternity-care centre in High Weald since 1997 from which time the midwives running the unit were employed by the then Eastbourne Hospitals Trust. They are now employed by East Sussex Healthcare Trust.

The unit functions as a local maternity care centre for all women, regardless of their clinical risk classification, for whom the midwife team provide ante-natal & post-natal care. Women deemed to have low-risk pregnancies are able to plan to give birth there. The centre is open 24 hours-a-day and acts as a ‘help-line’ source of advice to all pregnant women in High Weald and further afield.

Crowborough Birth Centre functions as a local maternity care centre for all women, regardless of their clinical risk

Over the last 10 years, each year around 300 women have given birth at the centre, and in 2010/2011 this increased to 322 births in the year. In 2012 the Care Quality Commission’s overall judgment was that Crowborough Birth Centre was meeting all the essential standards of quality and safety expected.

There were temporary closures of the Crowborough Birth Centre in November and December 2013 due to staff shortages at the obstetric unit at Conquest Hospital in Hastings. These closures attracted local media attention and appear to have significantly undermined local women’s confidence in booking at the CBC in case it is closed at short notice just when they need it.

1.1 Role of CBC Midwife Team of Midwives

The Crowborough Birth Centre community midwifery catchment area shown on this map corresponds closely to the High Weald CCG area.

In this area approximately 800 women give birth every year and this has been a relatively steady number for several years.

All these 800 High Weald women receive their antenatal care (i.e. during pregnancy up to the birth) and their post-natal care from the CBC midwife team.

Actual births (which grab the activity headlines) are in reality the smaller part of the midwife workload. 70% of the CBC midwife team work-load is antenatal care during pregnancy for these 800 women.



The midwife team based at Crowborough Birth Centre care for around 800 pregnant women every year

Actual births are in reality the smaller part of the midwife workload

70% of the CBC midwife team work-load is antenatal care during pregnancy for 800 women in High Weald each year

Integrated team working at CBC is an efficient and cost-effective model of maternity care

The CBC midwife team work as an integrated team, between them providing antenatal community midwifery care, intra-partum (birth) care, and postnatal care in the High Weald area. This integrated team working is an efficient and cost-effective model of maternity care. The recent birthplace study shows that costs of straightforward births in midwife-led units are lower than straightforward births in obstetric units [Ref 1].

1.2 Trend of Maternity Services Reduction by ESHT in High Weald

A midwife-led birth centre does not operate in isolation. All local pregnant women being cared for by a midwife team will require:

- a 12 week maternity scan
- a 20 week maternity scan
- blood tests & analysis,
- the opportunity for a consultant clinic if potential complications arise,
- a seamless pathway to local obstetric care if complications of pregnancy do develop.

Maternity support services provided by ESHT have moved further away from High Weald

Since 2010 these maternity support services provided by ESHT have moved further away from the High Weald, which has left the midwife team isolated from such services that they require for their pregnant women.

1.2.1 ESHT Maternity Scanning Cessation 2010

Up until 2010 maternity scanning was provided by ESHT at Crowborough, so that all High Weald women (and their partners) had ease of access to a maternity scan as part of their maternity care from the midwife team at the Crowborough Birth Centre.

In May 2010 maternity scanning at Crowborough was unilaterally ceased by ESHT without notice or consultation. A new, fully funded, state-of-the-art scanner (entirely suitable for maternity scanning) was provided by the Friends of Crowborough Hospital, but despite this ESHT have been unwilling or unable to restart maternity scanning at Crowborough [Ref 2].

Most High Weald women opt out of the Crowborough ESHT maternity pathway and refer themselves to an alternative provider that has local facilities for maternity scanning

Therefore, since 2010 the midwife team in High Weald (employed by ESHT) have been required to refer local High Weald women to EDGH for their scan – a round trip of up to 60 miles. Most High Weald women decline this referral, many because they wish to have their partner present at the scan and excessive time off work can be difficult (and costly) for partners.

As a result most High Weald women opt out of the Crowborough / ESHT maternity pathway and refer themselves to an alternative provider that has local facilities for maternity scanning. As part of this women have to be booked onto that provider's information notes system and be 'intending' to have their birth with that alternative provider.

1.2.2 ESHT Obstetric Care Retrenchment since May 2013

Then in May 2013 obstetric services were removed from Eastbourne DGH on a temporary (but at least 18 months) basis. Therefore since May 2013, when local women ask the midwife team in High Weald (employed by ESHT) about the obstetric unit to which they will be referred should they require consultant-led obstetric care, these women are told that it would be the obstetric unit at the Conquest Hospital in Hastings.

For most High Weald women the risk of referral to consultant-led care at Hastings is sufficient to prevent them booking with the ESHT midwife team at CBC, and as a result the number of bookings for birth at CBC has gone down.

It is not lost on High Weald women and their partners that the AA route planner recommended quickest route from Crowborough Birth Centre (TN6 2HB) to Conquest Hospital (TN37 7RD) directs the traveller via Pembury and the A21. The AA route planner shows it as a journey of 34.7 miles and 53 minutes in off-peak traffic! [Ref 3].

For most High Weald women the risk of referral to consultant-led care at Hastings is sufficient to prevent them booking with the ESHT midwife team at Crowborough Birth Centre.

The AA route planner recommended quickest route from Crowborough Birth Centre to Conquest Hospital directs the traveller via Pembury

2 High Weald Maternity

The current public consultation for East Sussex maternity focuses almost entirely on the locations of maternity units. For the South Coast CCGs that is, to some extent understandable, with the major questions focussed on “one obstetric unit or two?” and if just one obstetric unit, then is it at “Eastbourne or Hastings?”.

This focus on locations for maternity units, when applied to High Weald, totally misses the real maternity issues, and the main concern of local women. As the maternity support services provided by ESHT in High Weald have steadily reduced, women have progressively turned to other maternity providers to access local maternity care.

The current public consultation, when applied to High Weald, totally misses the real maternity issues and the main concern of local women

2.1 De facto access to local Scanning & Obstetrics in High Weald.

During 2010, only 192 out of 800 High Weald women went to Pembury for their birth. By 2012 over 250 women of those 800 were using Pembury for their birth, and since mid-2013, when obstetrics were removed from EDGH, over 400 women of the 800 High Weald women will have used Pembury for their maternity scanning and births.

In the six months from June to December 2013 fewer than 4% of women in High Weald used the obstetric services of ESHT for the birth of their baby. Women are voting with their feet to avoid being sent to the South Coast for their maternity scans, and to avoid the risk of being referred to consultant care in Hastings.

Therefore, by default, Pembury has become a major provider of maternity care for High Weald women, but are only able to provide part of the total care pathway because they do not employ the community midwife team.

Of course it has always been the case that, in the event of complications during labour at Crowborough, an urgent transfer in labour will almost always be to Pembury as the nearest obstetric unit.

Fewer than 4% of women in High Weald now use the obstetric services of ESHT for the birth of their baby

By default, Pembury has become a major provider of maternity care for High Weald women

In the event of complications during labour at Crowborough, an urgent transfer will almost always be to Pembury

High Weald women receive disjointed maternity care

This is not a seamless, flexible care pathway, especially as regards continuity of midwife care

I'd like my partner to be with me, but Eastbourne is too far and takes too long for that.

So if I still really want to birth at Crowborough and have a local scan I'll have to pretend?

2.2 The maternity disconnect in High Weald

The overall effect of the situation described above is that High Weald women receive disjointed maternity care with different parts of their care being provided by different trusts and midwife teams.

Almost every woman in High Weald has to deal with two different trusts, two different information systems, and two different sets of midwives. This is not the seamless, flexible care pathway, especially as regards continuity of midwife care, that should be the hall-mark of a modern good quality maternity service.

2.2.1 Women's Experiences (see also Appendix)

The examples below illustrate the type of conversations that regularly take place between High Weald women and the midwife team based at Crowborough.

Typical Low Risk Woman in High Weald (since 2011)

HW Woman:

I'm pregnant and I want to book for birth at Crowborough.

Midwife:

By all means. We will book you for your 12 weeks scan at EDGH.

HW Woman:

Oh! I'd like my partner to be with me, but Eastbourne is too far and takes too long for that. Why can't I have my scan at Pembury?

Midwife:

You can, but you need to be booked by Pembury. We'll tell Pembury. You will get a letter in the post inviting you to a scan, and then a second letter inviting you to a booking appointment.

HW Woman:

But does that mean I'll be booked at Pembury?

Midwife:

Yes.

HW Woman:

Well you are my named midwife. Why can't you book me in?

Midwife:

It's a different system, in a different trust and we don't have access.

HW Woman:

When I go for a scan at Pembury should I tell them that I want to come to Crowborough for my birth?

Midwife:

No. They will only provide a scan for women booking on to their system and planning to give birth there

HW Woman:

So if I still really want to birth at Crowborough and have a local scan I'll have to pretend?

Midwife:

I mustn't comment on that?

Low Risk Woman in High Weald (since May 2013)

HW Woman: I'm pregnant and I want to book again for birth at Crowborough.

Midwife: By all means. We will book you for your 12 weeks scan at EDGH.

HW Woman: Oh! I had my scan at Crowborough last time. Well I guess I can manage Eastbourne, though it's difficult because it means more child-minding for the time it takes.

Midwife: OK then. If you can get to Eastbourne for your scan, we'll book you in here at Crowborough.

HW Woman: For my first baby I was quite late compared to my due date. I'm a bit worried about that. What happens if I am overdue again and go further over the date?

Midwife: If that happens you might need an induction.

HW Woman: Can that still be here at Crowborough?

Midwife: No, we can only provide inductions in an obstetric unit.

HW Woman: I see. Can I go to Pembury for that?

Midwife: No, You'd have to go to Hastings for that if you are booked with us here at Crowborough.

HW Woman: Oh I wouldn't want that! Perhaps I'd better book at Pembury after all.

Oh I wouldn't want to go to Hastings! Perhaps I'd better book at Pembury after all

2.2.2 A Midwife's Experience

"If a local woman contacts CBC at the beginning of her pregnancy wanting to give birth at CBC, she is offered scan appointments for 12 & 20 weeks at either Eastbourne or Conquest Hospitals. Often these women will ask if they can have their scans at Tunbridge Wells (Pembury).

Pembury will accept these women for scans but women will need to have their initial booking appointment, 12 week blood tests and scan, 20 week scan and 28 week blood tests at Pembury. They then have Pembury notes in which we record all her pregnancy care. Pembury would not provide the scans to an East Sussex woman without first doing a booking appointment.

Although these women are free to choose CBC for the birth while their pregnancy remains low risk, what we have seen in recent times is that women are not changing from their original place of booking,

The motivating factor for women choosing to book at Pembury is access to scans

and Pembury have seen a rise in the number of East Sussex women booking with them.

My contact with local women at the pre-booking stage tells me that the motivating factor for women choosing to book at Pembury is the access to scans.

Even though there is a modern ultrasound scanner at Crowborough Hospital, women who would prefer to have their scans at CBC can no longer make that choice. Local women now have to 'opt in' to a CBC birth rather than 'opt out' in a manner of speaking.

As a midwife I want to be able to offer the women safe, timely and accessible appointments throughout their care with us, and at the moment this includes having to regularly offer Pembury. This is even more frustrating now that the Birthplace study in 2011 shows that midwife led care settings provide the safest care for women with uncomplicated pregnancies."

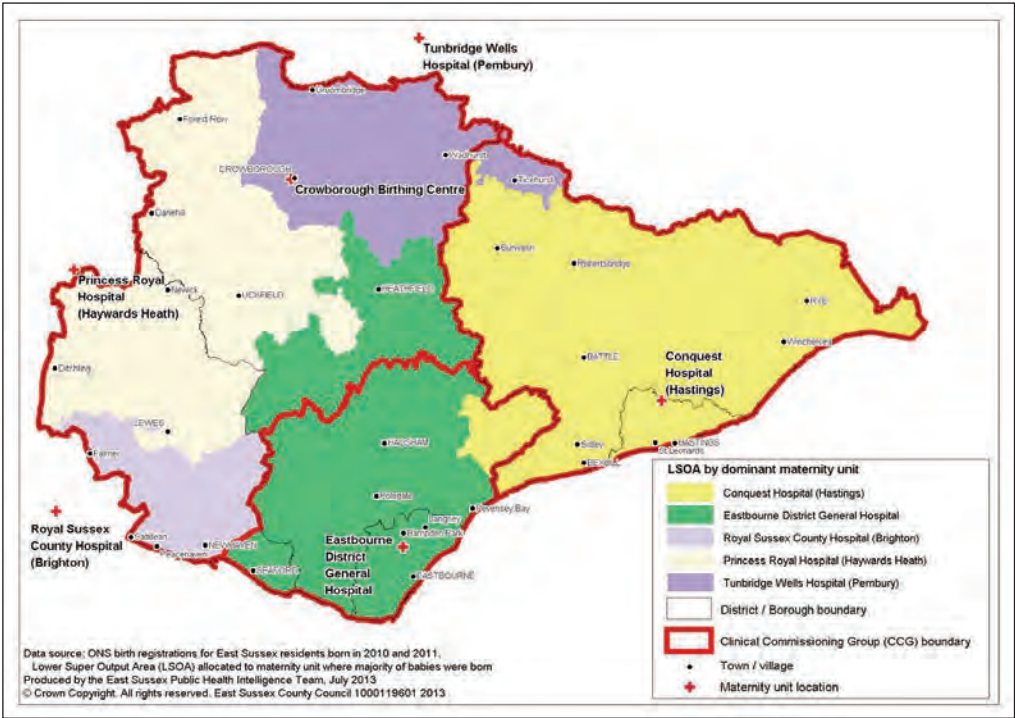
A Crowborough Midwife

2.3 2013 mapping & analysis of service usage

The map below in the “Better Beginnings” Public Consultation is out-of-date (births registered 2010 & 2011) and fails to take into account the changes in 2013 which have had a significant impact on maternity in High Weald.

Figure 25: East Sussex Lower Super Output Areas by dominant maternity unit for births registered in 2010 and 2011

This map fails to take into account changes in 2013 which have had a significant impact on maternity in High Weald



[REDACTED]

[REDACTED]

[REDACTED]

3 Midwife Led Units

3.1 The wider picture on “MLU demand” & “midwife staffing”.

Underlying in the Better Beginnings Consultation document in relation to midwife-led units is the statement that there is insufficient demand to sustain 3 midwife-led units. This leads to a situation in Option 4 (for example) where the provision of an along-side midwife-led unit at Hastings is assumed (without any real justification) to affect the demand for midwife-led care in High Weald.

This false reasoning then results in Option 4 indicating “no maternity service” at Crowborough because the Option includes an alongside midwife led unit in Hastings.

However, the Better Beginnings review process itself started with a limiting assumption in relation to the localities of East Sussex. As is neatly summarised in the executive summary of the Pre-Consultation Business Case

The Better Beginnings review process started with a limiting assumption in relation to localities

“A working group that was established as a sub-committee of the Better Beginnings Programme Board developed and agreed models of care for the services that was based on the Sussex-wide clinical consensus.”[Ref 5]

A viable option that interacts with adjacent obstetric providers to the north has been prejudicially excluded from the consultation

While this might be a reasonable basis for considering various options for Coastal Sussex it is not good enough as a basis on which to generate all the potentially viable options for localities on the margins of the county. As a result a viable option that interacts with adjacent obstetric providers to the north has been prejudicially excluded from the consultation without proper consideration.

3.1.1 Benefits to Hastings from an along-side Midwife-led Unit

The mapping and analysis of service usage, as above, shows that the demand from women in High Weald for midwife-led care is not impacted by the existence, or otherwise, of an along-side midwife-led unit in Hastings.

However, an alongside midwife-led unit in Hastings would be likely to have a beneficial effect on the quality of maternity care in Hastings itself.

- a) low-risk Hastings women would be encouraged out of the obstetric unit in Hastings and benefit from access to local midwife-led care.
- b) the busy obstetric unit at Hastings would be less crowded, with some 400 low risk women each year likely to use the along-side midwife-led unit. This lesser crowding will thus be a benefit to all high risk women from across Coastal East Sussex.

3.2 Midwife-led Unit Demand

The limiting effect of relying only on this “Sussex-wide clinical consensus” is apparent in the assessment on the potential demand for midwife-led units used in the consultation proposals.[Ref 4]

Historically, demand for an MLU in High Weald has come from both East Sussex & West Kent

The short-coming of the midwife-led unit demand analysis is precisely because it is limited to an East Sussex Health Care perspective. It fails to take account of demand dynamics in the margins of the ESHT provider area, and that historically, demand for an MLU in High Weald has come from both East Sussex & West Kent.

Maidstone & Tunbridge Wells NHS Trust estimate that there is a latent Tunbridge Wells demand for the Crowborough Birth Centre of some additional 100 births per year, especially from the parts of West Kent they serve that are less accessible to Maidstone.

This demand, combined with a re-integration of maternity services in High Weald would swiftly raise birth numbers at Crowborough to around 400 per annum

This additional demand, combined with a re-integration of maternity services in High Weald would swiftly raise birth numbers at Crowborough to around 400 per annum without any impact on a possible Hastings MLU. In addition to this, the Crowborough midwife team would continue to provide antenatal & postnatal community midwifery care to the 800 women in High Weald whether low or high risk.

3.3 Midwifery Staffing

As part of the pre-consultation business case the Sussex Collaborative Clinical Reference Group (SSCRG) also concluded that 3 midwife-led units would not be sustainable in East Sussex due to the midwife staffing requirement this creates. This concern gave rise to “Maternity Exclusion Criteria 4” which states that only 2 midwife-led units can be included in the options available.

As with the demand analysis, this is an East Sussex Healthcare Trust-centric view, similarly driven solely from the basis of the “Sussex-wide clinical consensus”. It fails to recognise the obvious alternative that if midwifery staffing in High Weald was provided by Maidstone & Tunbridge Wells Trust then that concern about East Sussex staffing would be fundamentally resolved.

Without recognising this, the underlying business case continues to assert that:

“all options including one or three MLUs were excluded from further analysis.” [Ref 5]

This is a prejudicial exclusion of a clearly viable alternative maternity arrangement that would bring significant benefit within High Weald.

Recent events with staff shortages at Hastings leading to un-announced closures at Crowborough Birth Centre in November & December 2013 and January 2014 suggest that it might indeed be easier for East Sussex Healthcare Trust to focus on staffing just the two coastal maternity units in a more concentrated management structure.

They should stop trying to provide maternity services in a locality that is beyond their effective reach, and make way for a maternity provider that has the necessary support services in place locally.

There is a prejudicial exclusion of a clearly viable alternative maternity arrangement that could bring significant benefit within High Weald

4 A Robust Locality Solution for High Weald Maternity

The public consultation does not offer a “two obstetric site” option on the South Coast because the combined CCGs have been clear they will not offer options for public consultation that they do not believe are deliverable against the criteria of:

- a) Clinically Safe & Robust
- b) Financially Sustainable
- c) Provide a good quality service

However, the current arrangement for Maternity in High Weald fails on all three criteria.

The current arrangement for Maternity in High Weald fails on all these three criteria.

- a) It is not clinically robust for a maternity service to have a built-in disconnect between community midwifery service provided by ESHT and local acute services, (including maternity scanning and access to consultant obstetric care), that High Weald women choose.
- b) The current service subsidy is costing the HWLH CCG an additional £400,000 over tariff each year. This is not financially sustainable. Maidstone & Tunbridge Wells Trust has indicated that it could operate the maternity service in High Weald (including the birth centre at Crowborough) at or close to tariff. This would provide the locality with a more cost-effective maternity service.
- c) Local women have quite clearly articulated that there is deep seated dissatisfaction with the quality of the maternity service provided in High Weald. They are dissatisfied by the fragmented nature of the maternity pathway from different providers and uncertainty over closures of the local birth centre. [See Appendix]

4.1 Continuity of Care from a Maternity Team

The CCG's Pre-consultation Business Case quotes approvingly the Intercollegiate Report (2007) entitled "*Safer Child Birth*" [Ref 6], which outlined minimum staffing and training requirements for midwives and doctors. This report also identified the importance of team working, as well as the respective roles of midwives, obstetricians, anaesthetists, paediatricians, support staff and managers as part of the local maternity care team.

Continuity of care for pregnant women from a maternity team requires easy access to local scanning, pathology services, consultant clinics and obstetric care if required. In High Weald this maternity team work is currently impossible to deliver, and local women have articulated quite clearly in their feedback to the CCG their 'on the ground' experience of this lack of joined-up working.

Feedback has been ignored, as despite a number of High Weald engagement meetings, none of the consultation options outlined address these women's concerns.

This feedback has been ignored, as despite a number of High Weald engagement meetings, none of the consultation options outlined address these women's concerns. Nor for High Weald, do any of the options address the "Safer Child Birth" aspirations for a joined-up local maternity care team.

4.2 Re-shaping Maternity with a Local Obstetric Provider

It is not difficult to see that there is a variation on Option 4 for High Weald that meets all three of the required criteria of clinical robustness, financial sustainability, and providing a good quality maternity service for women.

This variation on Option 4 would be the provision of a comprehensive maternity service in High Weald by Maidstone & Tunbridge Wells Trust. This would include community midwifery, local maternity scanning, local pathology services, easy access to consultant clinics, obstetric care, and a local midwife led unit. The creation of maternity pathways linked to the obstetric service at Princess Royal Hospital would also be required to accommodate women's choice.

At a recent Tunbridge Wells Borough Council Overview & Scrutiny Meeting, the Maidstone & Tunbridge Wells Trust were questioned about their ability to provide a clinically robust, cost-effective and good quality maternity service in High Weald including the Crowborough Birth Centre. They confirmed that they did indeed have the ability to provide exactly such a service.

Maidstone and Tunbridge Wells Trust would welcome the opportunity to provide a more complete and joined-up maternity service to the majority of High Weald women

Indeed, they would welcome the opportunity to provide a more complete and joined-up maternity service to the majority of High Weald women who are already accessing significant parts of their service for the scanning and obstetric care which is not available locally from ESHT.

They were confident that they could operate the Crowborough Birth Centre as a midwife-led facility for both East Sussex & West Kent women. They have sufficient feedback from High Weald women for whom they already provide significant maternity care to be able to make substantive proposals to commissioners, if invited so to do.

4.3 Next Steps in Reshaping Maternity in High Weald

The current review and consultation process needs to settle the shape of maternity care, not just in respect of single obstetric siting on the South Coast, but also to deal with issues that now exist within various localities. High Weald women and their families would consider it unacceptable for these unsatisfactory maternity pathways issues and disjointed care in their locality to be left unresolved at the end of this review.

For this reason we believe that the High Weald Lewes & Havens CCG should be asked by this HOSC to:

- 1) identify new locality arrangements for maternity that are appropriate to the changed provider landscape in High Weald. These arrangements should deal effectively with the maternity pathways issues so clearly identified by High Weald women & midwives.
- 2) conduct some engagement and informal consultation within High Weald specifically focussed on the locality. In the remaining 7 weeks from this HOSC meeting of 17th February, this informal consultation should engage on the maternity pathway issues highlighted in this submission and consider solutions to these issues involving alternative maternity providers.

The High Weald Lewes & Havens CCG should be asked by this HOSC to identify new locality arrangements for maternity, and conduct some engagement and informal consultation within High Weald

References

- [1] The Birth Place Study 2011 showed that the "mean cost for women at 'low risk' without complicating conditions at start of labour (2009/2010 prices)" was £1510 per birth in an obstetric unit, and £1405 per birth in a free-standing midwife-led unit. (*Birthplace cost-effectiveness analysis of planned place of birth*. Birthplace in England research programme: final report part 5. Schroeder L, et al. National Perinatal Epidemiology Unit, University of Oxford. November 2011)
- [2] See supporting document; *Review of Obstetric Scanning at Crowborough*, CBC Stakeholder Consultation Group, June 2012
- [3] Route planners vary slightly as to the 'quickest' route, but all show a journey of at least 53 - 54 minutes in off peak traffic whether via Pembury or cross country.
- [4] *Better Beginnings: Pre-Consultation Business Case*. Page 61. Paragraph 10.48-50
- [5] *Better Beginnings: Pre-Consultation Business Case*. Page 62. Paragraph 10.54
- [6] Royal College of Obstetricians & Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, Royal College of Paediatrics & Child Health. *Safer Child Birth Report 2007*.

Appendix – Comments from Women

I had my daughter in Jan '12 and had decided that I wanted to have her at CBC, all being well. When I found out that my scans would be in Eastbourne, I booked in at Tunbridge Wells so that my scans could take place there (I live in Crowborough and work in Tunbridge Wells). At about 30 weeks I 'changed my mind' and booked in at CBC. I did labour at CBC before being transferred to Tunbridge Wells in the end but would absolutely want to deliver at CBC in the future.

Lu Martin

I am due to give birth in April. I was initially deemed high risk and told I couldn't give birth at CBC but now looking like I may have the option after all. However, much as I really want to support this fantastic place - I think I will continue to go to Pembury (where I booked in) purely because I do not want to have to risk transfer to Hastings.

I have had my scans at Eastbourne and at Pembury but would have loved to have had them at Crowborough – as I did with my first son. I believe there is still a scanner at Crowborough but no-one to operate it.

I have also found there to be some differences in clinical protocol between the two Health Trusts - for example – I am Rhesus Negative and have been told that if I do want to have the baby at Crowborough then I will have to have my Rhesus tests repeated as at CBC the East Sussex Healthcare Trust will not accept the paperwork from Pembury – this seems like a real waste of resources – as these tests have already all been done! Also, as a needle phobic I am reluctant to have them repeated!

I would be very happy to give birth at the Birthing Centre – if it was partnered with Pembury but I don't feel happy to go there at present due to the risk of being transferred to Hastings. I do really value being able to use the CBC for pre and post-natal support and have been really impressed whenever I have been in there – just wish it was affiliated with Pembury!

Ruth Clark

"I was booked in to come in to CBC. After speaking with various midwives during the day as my contractions had started, I was shocked to get a answer-phone message in the evening to say you were shut. I wanted to come in to get checked as my contractions had been going on all day. Nobody had mentioned in the day that you maybe shut. I ended up calling Pembury and went in there and had my little boy the next day. Pembury didn't even know you were shut when I called them, which was a little disconcerting."

Marie Kennedy

"I'm due to have my baby in February, I was really looking forward to planning a birth at CBC but due to the chance of the centre not being open when I am in my moment of need, I'm now not sure I want to get my hopes up of a CBC delivery to then have to go to hospital. The situation makes it a very hard decision."

Ellie Lear

"I'm due in Feb and if I have to go elsewhere just for the fact CBC is closed I shall be so upset."

Kirsty Williams

"I'm due in March and have had to also book into Pembury (where I really don't want to go!!) just in case."
Victoria Heart

"I am due in March and going to change from CBC to Pembury as I don't want to take the risk of Crowborough being closed"
Stephanie Richardson

"I am due in May and have always planned to have my baby at CBC even before I was pregnant as I knew I didn't want to deliver in an acute hospital. However I am getting very concerned about the frequent closures of CBC that I am very sadly having to think about changing to Pembury. I was so excited and reassured about the prospect of having my baby at CBC as I knew it would be a calm atmosphere and close to my home. I am very reluctant to change to Pembury but I am finding the thought of being sent to Hastings too stressful."
Heathfield Mum

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Crowborough Birth Centre Stakeholder Consultation Group

Review of Obstetric Scanning at Crowborough

Prepared for: East Sussex Healthcare 

NHS Trust

Jayne Boyfield, Associate Director Integrated Care.

June 2012

- 1 Introduction to the Review
- 2 Developments in Obstetric Scanning
- 3 Cessation of Obstetric Ultrasound Scanning at Crowborough
- 4 Local Impact on Birth Centre Activity
- 5 Clinical Requirements
- 6 Obstetric Scanning in Midwife-led Units
- 7 The Business Case for Obstetric Scanning at Crowborough
- 8 Local GP Support
- 9 Local Community Support
- 10 Recommendations
- 11 Proposed Trial Period & Review
- 12 Implementation

Notes

Appendix 1: *The Impact of Loss of Obstetric Scanning at Crowborough*

Appendix 2: *Obstetric Ultrasound Scanning in Low-risk Settings*

CBC Stakeholder Consultation Group:

<i>Dr Katie Stokes</i>	<i>Crowborough GP</i>
<i>Alison Ledward</i>	<i>Chair, Mid-Sussex MSLC</i>
<i>Chantal Wilson</i>	<i>Friends of Crowborough Hospital</i>
<i>Cllr Diane Phillips</i>	<i>Wealden District Council (HOSC)</i>
<i>Richard Hallett</i>	<i>Chair, East Sussex MSLC</i>

1	Introduction to the Review In 2010 a review was commissioned by the (then) East Sussex Maternity Services Development Panel to evaluate the cost-effectiveness of Crowborough Birth Centre and to recommend means by which activity levels at the centre might be increased in order to enhance financial viability. The review report was published in February 2011. At the same time as the review was underway maternity scanning that had taken place at Crowborough stopped due, primarily, to concerns about the age and quality of the equipment. It is a cause of some regret within ESHT that there was no advance notice of this cessation to local GPs (and other stakeholders) and no preparation of plans to deal with the age and quality of the ultrasound equipment. This issue of the age of the ultrasound scanner at Crowborough was identified by the 'Local Antenatal Screening Group' in March 2009, and although included on the 'Combined Screening Action Plan' it appears there was no action taken to resolve any potential ultrasound equipment issues in a timely manner. The CBC Working Group expressed concern in their report of February 2011 about the adverse impact of this cessation of scanning on birth centre activity, and recommended that maternity scan clinics should be urgently restarted. They noted that local funding for new equipment was made available in June 2010. The East Sussex HOSC scrutiny officer proposed a stakeholder group be set up to provide local consultation for the Associate Director of Integrated Care of ESHT who had been nominated by the ESHT CEO to progress the matter.	Notes (1) (2)
2	Developments in Obstetric Scanning The UK National Screening Committee (UK NSC) was given responsibility by the Department of Health (DH) to oversee the implementation of a national strategy for Down's syndrome screening which would improve the standard of local services and provide uniformity. Two Health Technology Appraisal (HTA) reports were pivotal in shaping future policy for Down's syndrome screening, and provided the base evidence for the first national Down's syndrome screening policy called a 'Model of Best Practice' in 2003. All Trusts were expected to provide a universal screening programme which met a 60% detection rate (DR) for a 5% or less false positive rate (FPR) during 2004 to 2005. Additionally, Trusts were also expected to work towards improving their baseline programmes by improving the detection rate to 'greater than 75% with an FPR of less than 3%' by April 2007.	(3) FPR False Positive Result

	The next iteration of the national Down's syndrome screening policy was published in 2008 and set out that Trusts would be expected to improve on their programme standards. It stipulated a 'detection rate of equal to or greater than 90% of affected pregnancies with an SPR equal to or less than 2%' by April 2010, which required the introduction of more sophisticated technologies to be employed in order to reach the standard. Key requisites for the combined test are the linear fetal measurement of the crown rump length (CRL) to estimate fetal gestational age (dating scan), measurement of the nuchal translucency (NT) space at the back of the fetal neck and maternal blood to measure the serum markers of pregnancy associated plasma protein A (PAPP-A) and human chorionic gonadotrophin hormone (hCG).	SPR Screen Positive Result
3	Cessation of Obstetric Ultrasound Scanning at Crowborough By 2009, East Sussex Hospitals Trust was in the position of being the only trust in the South East Coast region that had not introduced combined screening. Therefore, a working group was convened to rapidly implement combined screening. By February 2010 the lack of provision of combined screening had been put on the PCT and Divisional ESHT risk register, though funding was still not resolved. Implementation of combined screening had become a 'must do' and 'extraordinary' meetings of the steering group were held in February and March 2010 to try and find solutions to deliver the combined screening programme with an implementation date of 6th April 2010. In mid-March 2010 it was reported to the steering group that combined screening would create a scan capacity problem at EDGH to provide all the Nuchal Translucency scans prior to 2.30 pm (50 scan slots were required). One of the solutions identified was to cease obstetric scanning at CBC to maximize sonographer time, and it was also noted that the scanner at CBC was not 'fit for purpose' particularly with new NSC guidelines. On this basis the group decided to propose that CBC should stop offering obstetric scans. Combined screening was therefore implemented on the two acute hospital sites and the sonographer resource was transferred from CBC. Sadly e-mails at the time (May 2010) from ESHT to ESDW PCT (Frank Powell – Beacon Surgery) show that not only was there no consultation with local GPs and stakeholders, but that local GPs were not even informed that obstetric scanning had stopped until after the event.	

	At the time it was envisaged that decisions relating to extending combined screening to CBC would be taken once a new scanner was in place, because without combined screening, scanning at CBC would be more limited as it would now exclude NT. It does seem that, in June 2010, ESHT gave every indication to local stakeholders that a new specification ultrasound scanner was being sought for both obstetric and general radiology. Funding was confirmed. However, for a variety of reasons, there was extended delay in the purchase of a new scanner and the work to introduce combined screening at Crowborough was never undertaken.	
4	Local Impact on Birth Centre Activity There are good reasons to accept that the lack of obstetric ultrasound has an adverse effect on the number of women who are booking to give birth at the Birth Centre. Ultrasound services for women who book with ESHT and plan to have their babies at CBC are at Eastbourne District General Hospital, and women travel there for obstetric scans at 12 and 20 weeks. Many women who live around the northern part of the Trust 'catchment area' may have to travel up to 60 miles for this and are choosing instead to have their ultrasound scans at nearby Pembury Hospital (Tunbridge Wells) or Princess Royal Hospital (Hayward's Heath). In order to access scans in these Hospital Trusts, women have to initially book with those Trusts. Although, in theory, women can subsequently change their booking to the CBC, many apparently tend not to do so. Local women (at a LINK meeting in 2011) explained their own experience that as soon as they had to attend a local acute unit for their first scan they were effectively 'booked-in and signed-up' to give birth in that unit. At a pre-booking session held at Crowborough in August 2011, some 5 out of 6 North Wealden women expressed a wish to book for birth at Crowborough, but were put off doing so because they would be required to go to Eastbourne for their scan. All wanted to have a scan more locally and therefore chose either PRH or Pembury. In the event none of those women was determined enough to "shake-off the system" and subsequently change her booking from the acute unit to Crowborough. Analysis of CBC statistics shows that in the six months from April – Sept 2010 on average 75 women per month were booked to birth at CBC (having had a 12 week scan at Crowborough by the end of March 2010).	

	During the next six months as women were sent to Eastbourne for scans the average dropped to 58 bookings per month (a 20% fall). As more women realised (and midwives acquiesced) that they were entitled to request scans at Pembury or PRH there was a further decline to 48 bookings per month in each of the two following six month periods up to March 2012. The conversion rate for bookings to births has remained unchanged. Within ESHT we should acknowledge that this situation also creates considerable frustration for the Crowborough midwife team who are tasked with improving activity levels at the birth centre. There will have been a 2 year gap in local obstetric scanning at a crucial time for the wider use of the Birth Centre as part of the East Sussex Strategy to implement Maternity Matters with its birth choice guarantees and with the aim of extending midwife-led care and capacity. This (inadvertent) 2 year gap in local service provision is especially regrettable in view of the recent NPEU Birthplace Study that confirms birth in a midwife-led unit as both safe and cost-effective. A re-start of local obstetric scanning at Crowborough could be seen as a timely and proactive response by ESHT to this significant national maternity report.	(4) (5)
5	Clinical Requirements The clinical requirements for the re-start of obstetric scanning at Crowborough should not be underestimated as outlined in section 2 above. However, an expert evaluation of the requirements has been undertaken that reached this conclusion below. <i>“Provided that robust and secure IT links are in place to support electronic archiving and reporting of ultrasound images within all radiology units within the Trust, I can see no practical reasons why obstetric ultrasound scanning could not be redeveloped at Crowborough. Investment may be needed in the infrastructure such as computers, printers and possibly licenses for the Viewpoint database, and maintenance contracts and consumables for the ultrasound machine.</i> <i>Consideration would need to be given to possibly having midwifery / MSW support for times when obstetric scanning was taking place, to support parents in the event of a problem, and to coordinate Downs syndrome screening and venesection services.</i> <i>Unless a local sonographer can be recruited the Trust would need to consider the practical and financial implications of a sonographer having to travel to CBC for 3-4 sessions a week. This might also have an impact on the main ESHT scan department at Eastbourne District General Hospital, but could be expected to result in more women from the Wealden part of East Sussex in particular choosing to book with ESHT and have their babies at CBC.”</i>	(6)

	The Trust has now been able to recruit a sonographer for Crowborough who is both highly experienced (previously Grade 8A) and well qualified. The existing ultrasound business case relates to general diagnostic radiography on referral from local GPs. This, therefore, provides an opportunity for the Trust to undertake a trial of obstetric scanning at Crowborough without disruption to any other sonographer work load.. Crowborough Hospital already has a designated radiology department that is located close to the Birth Centre, and has facilities for X-ray and ultrasound, with changing cubicles. The Clinical Services Midwifery manager with responsibility for the CBC is confident that a robust pathway can be put in place that will deal sensitively with any referrals that are required due to suspect scan results. <i>“Scanning - there is an issue around abnormality if found with no doctor on site, but there is a robust pathway for this. There have not been previous problems, and women are aware that there are no doctors here. There was also a previous agreement with Pembury that we would scan those local women who were booked for Pembury.”</i>	(7)
6	Obstetric Scanning in Midwife-led Units Other midwife-led units in the UK do manage to offer obstetric scanning. 2 midwife-led units in Shropshire offer obstetric scanning, and midwives from the same trust (Shrewsbury & Telford Hospital NHS Trust) provide a visiting obstetric scanning service to some of the small central Wales midwife-led units. A local PCT has also funded an ultrasound scanner in a Children’s Centre to ensure wider scanning provision in the community. Within Angus (Scotland) the midwife-led unit at Arbroath offers a full obstetric scanning service including Nuchal Translucency, and the current consultation underway in Grampian plans to extend this ‘one-stop-shop’ approach to the 3 free standing Community Maternity Units proposed. Andover Birth Centre offers obstetric scanning and hosts regular consultant clinics. In Huddersfield the previous obstetric unit has been converted to a midwife-led birth centre. Obstetric scanning is provided locally for all Huddersfield women irrespective of whether they opt to go to the obstetric unit in Halifax Royal Infirmary or intend to use the birth centre in Huddersfield. Births in Huddersfield are heading towards 700 per year because the birth centre effectively provides a ‘one-stop-shop’ maternity service and only refers-on women who need or choose consultant obstetric care.	

	Obstetric scanning in low-risk settings is also supported by the recent RCOG Expert Advisory Group who published “ High Quality Women’s Health Care: A proposal for change ” in July 2011. They include a case study from Clevedon, 15 miles from Bristol where weekly antenatal clinics for low-risk women take place at the community hospital and routine ultrasound scans are performed by sonographers. (See Appendix 2)	
7	The Business Case for Obstetric Scanning at Crowborough The evaluation of obstetric scanning at Crowborough also considered the potential workload in relation to ‘critical mass’ for both cost-effectiveness and skills maintenance. The conclusion was that with the Downs Syndrome screening scan at 12 weeks now in addition to the ‘traditional’ dating scan at 20 weeks there is sufficient workload for obstetric sonography to be viable at Crowborough. <i>“From GP surgery data there is the potential for up to 800 women in the area to give birth each year. Obviously some of these women would not be suitable to birth in CBC because of risk factors, but they may be able to have their scans in Crowborough. With a minimum of 2 scans per woman, this would equate to about 1600 scans per year, i.e. approximately 32 scans per week for 50 weeks a year, 16 scans a day – each lasting 30 minutes. This is equivalent to at least 2 days of ultrasound scans per week. National recommendations are that any individual sonographer performs obstetric scans for at least ½ day per week to maintain competencies.”</i> This additional workload, as a supplement to the existing general radiography workload, strengthens the overall business case for ultrasound scanning at Crowborough Hospital. In isolation, the funding required for obstetric scanning is self-financing. The PbR payment for ultrasound scanning is set at £63 for scans of more than 20 minutes, and at £47 for scans of less than 20 minutes. The 12 weeks Downs Syndrome scan falls in the first category and the 20 week growth scan falls (probably) in the second category. Thus for each woman receiving both scans at Crowborough the payment is £110. The Crowborough community midwifery sector has around 450 women per year on caseload, while the middle sector (Heathfield & Uckfield) has around 350 women per year on caseload. If some 350 women per year (<i>ie: equivalent to just three-quarters of the Crowborough caseload</i>) receive their scans, locally then the PbR income is £38,500 for which approximately 1 day of ultrasound scanning per week is required. This is easily cost-effective as incremental income supplementary to general radiology, and is income that is mostly being lost to out-of-area providers at Pembury & Princess Royal Hospitals. Significant additional income is also likely to be available by offering local ultrasound scans to women on other caseloads who wish to book at Crowborough.	See note (6) (8)

	Clearly, the overall business case for obstetric scanning also rests on the future viability of the birth centre itself, so that the two commitments are inter-twined. Ultimately the long-term business case for obstetric scanning rests on increased birth centre activity levels, but without local obstetric scanning increased birth centre activity will be discouraged. Without a purposeful trial of obstetric scanning to provide a 'one-stop-shop' midwife-led unit it will be difficult for ESHT to avoid the impression that the birth centre has been 'undermined' and that we have failed to implement the working group recommendations and provide a pathway for local midwife-led care that is 'user friendly' and easy to access.	
8	Local GP Support There is clear support from local GPs for the continued viability of the Crowborough Birth Centre and they believe that it is important for the birth centre to provide holistic maternity care in the ante-natal period for all local women, even if some will need to plan delivery in an obstetric unit due to recognised risk factors. They recognise the deterrence factor for local (North Wealden) women of being required to make a nearly 60 mile round trip to Eastbourne or Conquest for each scan if they wish to book at the Crowborough Birth Centre. This is especially so when there are many natural links to acute services at PRH and Pembury in many other specialities. One of the local Crowborough GPs (Dr Katie Stokes) has offered to act as lead GP for the birth centre. She will facilitate effective liaison with the local GP Commissioning Group and this is an important step in ensuring good partnership working between ESHT and primary care in the North Wealden part of East Sussex.	
9	Local Community Support There is active support from the local community for the birth centre and wider maternity services that should be seen as valuable to ESHT. In addition to the provision of ultrasound equipment, innovative local community support has been provided for specialist perinatal mental health support in the North Wealden area. This has funded (through the Sussex Partnership) an additional Community Psychiatric Nurse working in the North Wealden area and providing clinics in Crowborough, Heathfield and Hailsham. This has relieved pressure on the (busiest) Eastbourne SPMH service and has significantly enhanced the overall maternity care offered to women through East Sussex.	(9)

	Beyond the provision of modern ultrasound equipment, there are substantive offers of financial support to help restart the obstetric scan clinics at Crowborough. This could include any start-up costs, service contract, training, blood courier costs, and other reasonable ancillary requirements that may occur in the development and transitional stage. In addition to this, there is financial and active participation in publicity and marketing for the birth centre and the local maternity care that it provides. It is a good opportunity for the Trust to test out the longer term viability of the Crowborough Birth Centre without risking existing Trust resources.	
10	Recommendations The recent recruitment of a fully qualified sonographer and the purchase of modern sophisticated ultrasound scanning equipment make it possible to plan a re-start of obstetric scanning at Crowborough that meets the new clinical requirements and follows robust and sensitive pathways. This should be, initially, on a trial basis and include regular review of clinical quality, effectiveness of care pathways, sonographer workload, adverse incidents, and overall activity levels and cost-effectiveness. The new sonographer starts in early July 2012 on a three-day-per-week contract, having previously had a full time role with the previous employer trust. This provides an excellent opportunity to schedule 1 - 2 days of additional obstetric sonography to facilitate this trial period. A provisional target of 1st September would allow for the bedding-in of general radiography, training needs, pathway development and local communication in advance of the planned start date.	
11	Proposed Trial Period & Review The stakeholder group propose that a trial period should run from September 2012 for two years. This acknowledges the fact that any increased birth activity stemming from increased bookings is subject to a 'gestational delay' of six months. The two year period will allow sufficient time for proper evaluation. Notwithstanding this trial period, a review of operation should be held after 12 months in order to retain confidence on issues of clinical quality, effectiveness of care pathways, sonographer workload, and any adverse incidents as noted above.	
12	Implementation A "job & finish" implementation team should be established for obstetric scanning that includes representation from radiology, midwifery, local GPs, users and community stakeholders.	

Notes:

- 1) **Local Antenatal Screening Steering Group, ESHT**
Combined Screening Action Plan – Sabine Turpin 11th March 2009
- 2) **Crowborough Birth Centre Working Group Report - February 2011**
Section 12.3 “Service Enhancement”

“The cessation of local ultrasound scanning at Crowborough in mid-2010 has had an adverse impact on the number of women choosing to use CBC. It decreased the ability of CBC to offer truly local ante-natal care to women in the catchment area. (It also affects bookings within ESHT because some women in North Weald will book at Pembury rather than travel to the Conquest or EDGH).

At the time cessation was explained as due to the age and quality of the equipment available. There was an immediate (June 2010) offer by the local Friends of Crowborough Hospital to provide a thoroughly modern Ultrasound Scanner (at a cost of £80,000) to the specification recommended by the East Sussex Hospital Trust's radiography department. This offer has not been taken up, and lack of local scanning continues to have an adverse impact on activity levels at Crowborough Birth Centre. We recommend purchase of the funded scanner and an urgent re-start of this service. “

- 3) **NHS Fetal Anomaly Screening Programme**
Screening for Down's syndrome:
UK NSC Policy recommendations 2011–2014 Model of Best Practice
- 4) **See Appendix 1** (*The Impact of loss of obstetric scanning at Crowborough*)
- 5) **‘Birth Place’ National Perinatal Epidemiology Unit. 2011**
The Birthplace in England Research Programme.
- 6) **Obstetric Ultrasound Services at Crowborough Hospital**
An Evaluation – March 2012. Sally Boxall
Consultant Nurse in Prenatal Diagnosis and Family Support,
Wessex Fetal Medicine Unit,
University Hospitals Southampton NHS Foundation Trust.
- 7) **Jenny Crowe**
Crowborough Implementation Group Minutes of Meeting 14 March 2012
- 8) **Direct Access Services (PbR Tariffs 2012-2013)**
Department of Health 27th March 2012
- 9) **Specialist Perinatal Mental Health Service - East Sussex**
Quarterly Report 2011-12, Quarter 4.
Rachel Denny, Perinatal Team Leader, Sussex Partnership Foundation Trust
- 10) **High Quality Women's Health Care: A proposal for change.**
RCOG Expert Advisory Group Report July 2011

Appendix 1: The Impact of loss of Obstetric Scanning at Crowborough

If a local woman contacts CBC at the beginning of her pregnancy wanting to give birth at CBC, she is informed that we can arrange all of her antenatal care including blood tests and scanning. She is offered appointments that involve scanning at either Eastbourne or Conquest Hospitals (these would be at 12 and 20 weeks).

If she does not wish to travel to either of those venues, her other options will be explained. Often these women will ask if they can have their scans at Tunbridge Wells (TWH). We can refer the women to any hospital for their scan, the most commonly chosen is TWH, although some may opt for Haywards Heath (PRH).

TWH will accept these women for scans but this means the women will need to have their initial booking appointment, 12 week blood tests and scan, 20 week scan and 28 week blood tests at TWH. The women would then have TWH notes in which we record all her pregnancy care. ***TWH will not provide the scans to an East Sussex woman without first doing a booking appointment, nor will PRH.***

As we know, these women are free to choose CBC for the birth all the while their pregnancy remains low risk. However, what we have seen in recent times is that women are not changing from their original place of booking.

We have a very good working relationship with the midwifery team at TWH and recently had confirmation from Gillian Duffey, Head of Midwifery at TWH, that they have seen a rise in the number of East Sussex women booking with them.

My contact with local women at the pre-booking stage tells me that the motivating factor for women choosing to book at TWH is the access to scans. Women who would prefer to have their scans at CBC can no longer make that choice. ***Local women now have to 'opt in' to a CBC birth rather than 'opt out' in a manner of speaking.***

As a midwife I want to be able to offer the women safe, timely and accessible appointments throughout their care with us, and at the moment this includes having to regularly offer TWH. This is even more frustrating now that the results of the Birthplace study in 2011 have been published and show that midwife led care settings provide the safest care for women with uncomplicated pregnancies.

A Crowborough Midwife

January 2012

Appendix 2: Obstetric Ultrasound Scanning in Low-risk Settings



*The RCOG published an 'Expert Advisory Group Report' on **High Quality Women's Health Care** in July 2011. ⁽¹⁰⁾*

That report noted that while many consultants will continue to practice exclusively within a hospital setting, an increasing number will be expected to develop services in the community in partnership with GPs. In this role the consultant will lead a multi-professional team, acting as an advisor to clinical colleagues.

On page 38 the report provides a case study as reproduced below.

Case study 5.3: General gynaecology clinics and routine antenatal care for women at low risk in GP surgeries or community hospitals

- Provides care nearer home for women.
- Provides opportunities for primary care education and involvement of GPs with a special interest in women's health to work alongside consultants.
- Provides a one-stop service for most women where supporting services such as ultrasound are co-located.

Mr A, a consultant obstetrician and gynaecologist, is based in a major teaching hospital in Bristol. Once a fortnight he provides a clinic in Clevedon, a small town 15 miles from the base hospital. The clinic takes place in the outpatient department of a community hospital, which has co-located radiology and physiotherapy and also provides clinics in medicine of the elderly, general medicine and surgery.

Mr A has an ultrasound scanner available for his clinic and is supported by nursing and clerical staff. If surgery is needed, women are admitted to the base hospital in Bristol, but otherwise all women from Clevedon have their outpatient appointments in Clevedon.

The community hospital is also used for weekly community-based antenatal clinics for low-risk pregnant women. The care is midwife led and the routine ultrasound scans are performed by sonographers who divide their time between the base hospital and community clinic.

Evidence from members of the public

Contents

Comments received by email from members of the public.....	4
Comments about Eastbourne DGH and Conquest Hospital	4
16/12/2013 Eastbourne District General Hospital	4
16/12/2013 Eastbourne DGH	5
16/12/2013 SAVE DGH . keep full services	6
16/12/2013 No subject line.....	7
16/12/2013 Eastbourne DGH	9
16/12/2013 EBDGH Public Consultation	10
16/12/2013 EBDGH Public Consultation (Attachment)	11
16/12/2013 downgrading of eastbourne DGH.....	16
16/12/2013 Eastbourne DGH Downgrade.....	17
16/12/2013 Eastbourne DGH maternity services	18
17/12/2013 Written from my daughters bedside at the Conquest Hastings	19
20/12/2013 Eastbourne DGH Maternity transfer	20
21/12/2013 Maternity and Paediatric Services at Eastbourne District General Hospital	21
05/01/2014 Maternity & paediatric services at Eastbourne DGH	22
07/01/2014 FW: Your daughters Case.....	23
07/01/2014 FW: Your daughters Case (Attachment)	24
09/01/2014 D.G.H	28
09/01/2014 Bringing Services back to Eastbourne.....	29
10/01/2014 Concerned Resident of Eastbourne	30
15/01/2014 EDGH downgrading	31
17/01/2014 Consideration of CCG Options for Maternity and Paediatric Services in East Sussex by the ESCC HOSC	32
17/01/2014 Bringing Services back to Eastbourne.....	34
22/01/2014 Comments to HOSC re: maternity and paediatric services	35
06/02/2014 Liz Walke Personal Statement	36
07/02/2014 Re:- East Sussex Maternity & Paediatrics 2014.....	39
Comments about Crowborough Birthing Centre	42
05/01/2014 Closure of Crowborough Birthing Centre.....	42
07/01/2014 Crowborough birthing unit	43
08/01/2014 Crowborough birth centre.....	44

15/01/2014 Crowborough Birthing Centre Closure.....	45
Index of comments from members of the public	47

Comments received by email from members of the public

Comments about Eastbourne DGH and Conquest Hospital

16/12/2013 Eastbourne District General Hospital

From: [REDACTED]
Sent: 16 December 2013 09:12
To: Health Scrutiny
Subject: Eastbourne District General Hospital

As a resident of East Sussex, formerly Newick, and now Seaford my extended family has made significant use of the full services of DGH over the years, with the birth of two grand-daughters, life-saving treatment of my wife and emergency surgery on my son-in-law, together with a range of out-patient services too.

Initiatives to reduce the standard of service, be it maternity or A&E, are unacceptable: for central East Sussex Royal Sussex County and Princess Royal are over-stretched and perennially functioning under budgetary constraints and the Conquest Hospital is too far for this geographical cluster.

As a Chartered Accountant of over forty years' standing I am alarmed that any of these hospital trusts can operate in a way that seems to ignore the core function and objectives under which they have been created and for which the establishments have been built.

One of the maxims oft repeated is 'safety' which seems to stem from a report on the wider NHS. I cannot ascertain whose safety is deemed to be uppermost in the thinking of many of the proposals to down-grade but it is obvious that the safety of the poor patient seems to be at the lowest point of consideration and his/her requirements placed at the back of other determinants.

May I request that common sense is applied to maintain core standards and services at DGH? Also that the feud between clinical, nursing and administrative factions is eradicated and management changes implemented to ensure that whatever Board emerges is both accountable and aware of its responsibilities and acts in wider and commensurate interests rather than relying on theoretical fiction going forward.

Regards

Colin Andrews
[REDACTED]

16/12/2013 Eastbourne DGH

Dear Sirs,

I am writing as a concerned individual to express concern that the Paediatric and Maternity services for Eastbourne are not all at the DGH. We are a community of over 80,000 and should have these services at hand.

Please ensure these services go back where they belong.

Yours faithfully,

Dr K Smethers

16/12/2013 SAVE DGH . keep full services

From: [REDACTED]
Sent: 16 December 2013 14:01
To: Health Scrutiny
Subject: SAVE DGH . keep full services

I have lived In Eastbourne for over ten years. My husband works at DGH.

Its not about protecting his job. DGH is important to the community and Eastbourne has new housing , more youngsters as well as the older community. It is not practical for many to travel to Conquest., people visiting over there and in case of emergency how do many get back.

My son almost 16 this year had a severe reaction to nuts at night. DGH wouldn't take him and the ambulance had to in bad weather have to travel to Conquest. I had to get my elderly mother to go in the ambulance while I drove so that we would be able to get home. The journey took almost an hr due to severe weather (wins and heavy rain) The ambulance was therefore out area for some time. This year the main A259 has been closed many times due to accidents or bad weather. What happens then!

regarding maternity. Its seriously is NOT sensible to downgrade this unit. Before long incidents will occur and when the NHS is then sued adding to the cost. My daughter had a baby at DGH thankfully before the changes. She gave birth just 20 mins after arriving! had she had to go to Conquest she would have given birth on the way! Many of her friends do not drive, they are similar ages and planking to have a family they want the safety of obstetrics if needed but Conquest is not practical.

Not all staff drive either.

Its crazy to downgrade the services. A vast amount of money was spent on the helicopter pad what for, to have the unit downsized. Endoscopy has whole new building but surgical is moving. what is there is an emergency situation. Conquest is a lengthy journey away. someone cant just be wheeled to theatre.

ambulances of road longerNot practical for staff visitors and the patients.

many elderly wouldnt be able to drive or make way.

we need to keep all the services for the expanding population of Eastbourne

Eastbourne is expanding with many more young families its important for the whole community Clearly Hastings are not coping with the changes otherwise Eastbourne MLU would not be closing sometimes and the staff sent to Hastings to help cope, Crowborough has also been shut some times to help other areas.

The wider community needs to voice option as many are unaware of how these changes affect them , maybe not directly now but maybe in years to come .

D Chapman
[REDACTED]

16/12/2013 No subject line

Sent: 16 December 2013 14:15
To: Health Scrutiny

Dear Sir/Madam,

I have a newborn baby and a dog so would find it very difficult to get them both looked after to come and discuss my experience direct with you. However I wanted to let you know of my recent experience at Eastbourne DGH and Hastings.

I went to Eastbourne DGH on Monday 21st October after labouring at home for 8 hours. Eastbourne is a 10 mile journey from our house in Herstmonceux. After being in active labour for 2 hours it was decided by the midwives that I needed to be transferred to Hastings. The midwives were excellent at Eastbourne and that is why I wanted to have my baby there. I also wanted to be close to my family and friends and also have the option of my partner staying with me and our baby after the birth.

The journey by ambulance to Hastings was horrendous. I was told not to push while we were in the ambulance and I felt every bump. It was the worst journey of my life. Although the journey was only 28 minutes it was extremely painful and made the whole birthing experience terrifying. I was also worried and anxious about how my partner would get back to Eastbourne as that is where his car was. We were just advised that he could get a taxi or the train which wasn't very reassuring as Hastings hospital is far away from the station and I was worried about him travelling alone.

When we arrived at Hastings it was decided that I should have a forceps delivery and within a couple of hours my baby boy Leo was born. Due to the circumstances I was told that I would have to stay the night. My partner wasn't allowed to stay so he had to leave us at 9pm. I was left lonely and miles away from home.

As Leo wasn't feeding well one of the paediatricians said that he had to stay in until he put on weight so in total we were kept in for 4 days. I was very emotional throughout this time as I had very few visitors as my parents are elderly and couldn't come for very long and it was a long way for my partner to keep travelling. It was a very lonely and upsetting time and has probably contributed to Leo not feeding properly.

I also got moved twice while I was at Hastings both times happened at 9pm at night which was very disruptive. The first time I was moved I was put in the induction ward with my baby which wasn't ideal. It also meant I wasn't offered any breakfast, lunch or dinner and I had to survive on food that my partner had brought in. This made me feel worse and I was very far away from the kitchen where the microwave was that I needed to warm Leo's milk. This meant I had to keep leaving him for 15 minutes while I went to prepare his milk.

I found the midwives at Hastings stressed and not able to devote any time to my needs. They didn't help me try and feed Leo as they are too understaffed. I asked for help with my breast pump but they said they couldn't help. I felt totally isolated and couldn't wait to leave so that I could go home for support from my partner.

I wish I could have had my baby at Eastbourne and then I would have had more support from my family as my experience at Hastings has put me off having future children. Please do not hesitate to contact me if you require further information.

Kind regards,

Jessica Norton-Hill

16/12/2013 Eastbourne DGH

From: Barbara Davies [REDACTED]
Sent: 16 December 2013 17:37
To: Health Scrutiny
Subject: Eastbourne DGH

I would like to register my concerns as a member of the public, who has lived in Eastbourne all her life (55 years!).

I saw St Mary's Hospital and the Princess Alice, which I remember well, replaced with the bright and shiny Eastbourne District General Hospital. A huge improvement for the town, services all in one place, which with a town that has grown as ours has, vitally important.

Now piece by piece this asset is being stripped away and lives are being put at risk. Families are going through desperately worrying times due to these changes, which I am very aware of through speaking to Mums and Dads at my nursery school in Eastbourne.

Families getting stranded at The Conquest late at night without transport, young children having to get in ambulances late at night when they are too poorly to go home but unable to stay in a ward in Eastbourne overnight. Mum's in labour being forced to endure a wait for an ambulance followed by the journey to Hastings, whilst in serious pain and stress.

Eastbourne has become a very busy town, with more residents than ever, so where is the sense in reducing the care available to our residents?

The decision to reduce options from two to one must be re-visited and changed, before there is a death as the result of this dreadful mistake in planning and organisation.

Yours sincerely

Barbara Davies
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

16/12/2013 EBDGH Public Consultation

From: Kirsty Peyton-Lander [REDACTED]
Sent: 16 December 2013 21:40
To: Health Scrutiny
Subject: EBDGH Public Consultation
Attachments: NHS Birth Complaint.pdf

To Whom it May Concern,

Please find attached my letter of complaint and details of 'my story' further to the alleged temporary downgrade of the maternity services at Eastbourne DGH.

I am still suffering the effects of what happened to me and wouldn't wish on anyone the experience I had giving birth to my son and the hell I've lived through everyday since. It's not just the physical, it's the psychological effects. More and more women will suffer from PND and that in itself will place more pressure on the NHS and it's mental health service/team.

You have to bring back the services to Eastbourne DGH. The sadness I've felt hearing parents' stories on how they did had open access to Friston for their child (in some cases more than one child) and the pressure and struggles those poor families are now suffering at the hands of this decision.

Please actively seek out members of staff who have left their jobs since the changes were made and ask them why? How it can be said that staff are happier in their jobs since the changes is beyond me! Don't speak to [REDACTED] - they are 'yes' people' and will tell people what they have been told to say by powers that be so they don't lose their jobs. Sheer bullying tactics have gone on and are still going on - it's outrageous. The brave members of staff who spoke out at the extraordinary meeting are the staff you should be speaking to!

I hope that you will use what happened to me as a reason why maternity and paediatrics have to be brought back to our local hospital. The people of Eastbourne and their children need to be safe and had the hospital been staffed properly in the first place, the closure wouldn't have been sold on 'safety'. Someone will die as a result of these changes and there will be blood on certain people's hands.

Yours sincerely,

Kirsty Peyton-Lander

16/12/2013 EBDGH Public Consultation (Attachment)

Mrs Kirsty Peyton-Lander

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

18th October 2013

Dear Darren Grayson,

RE: Archie Henry Nigel Peyton-Lander born May 10th 2013 in car due to maternity downgrade at Eastbourne DGH 7th May 2013

As I know you are aware, I had my baby son in the back of my 3 door car at the side of the Queensway road at 07.44 on the cold morning of 10th May 2013 just 3 days after the downgrade to the maternity unit at Eastbourne DGH. Please accept this letter as a formal complaint at both how I was forced to deliver and events following the delivery involving both Eastbourne DGH & Hastings Conquest.

Please take into consideration that there has been a catalogue of events prior to Archie's conception. Allow me to explain my history, what happened on the day and also what happened following that day since one would assume that you should be conducting an internal investigation you should have the facts. I have heard nothing from yourself or a representative from the Trust which quite frankly is disgusting and shameful.

I fell pregnant with my daughter Lexie in February 2006 after some treatment in 2005 for severe endometriosis and ovarian cysts. My Husband (Leigh) and I weren't married when we had our daughter so wanted to wait to have the Wedding in September 2008 before we thought about any more children. I discovered I was pregnant after a scan I had requested following some bad pain and unfortunately was told the pregnancy was ectopic. I was managed in the women's health ward on/off for weeks as my case wasn't as straight forward as just ectopic. To cut a long story short and after hours of investigative surgery in May 2009, the pregnancy could not be found within my fallopian tube and it was labelled a 'missed miscarriage' so I then have to have more surgery. The surgeon himself said my case was mismanaged. Directly after that in June 2009, I had to have treatment under a general anaesthetic for CIN 3 cells. I then couldn't fall pregnant and was told due to the extensive treatment received in June 2009 it was highly unlikely I would be able to have any more children. After all this, I'm sure you can imagine just how elated I was to discover I was pregnant in August 2012. Due to my history, my pregnancy was considered 'high risk' and I was under the care of [REDACTED] (who is a fantastic consultant) throughout my entire pregnancy. I had suspected premature rupture of membranes at 27 weeks and was admitted for observation and treatment. I was then required to visit the day unit once a week for monitoring until I delivered my baby. I was required to 'keep an eye on' my

temperature and at one point my bloods had a raised CRP level and there was concern I had an infection. I also had regular scans to check liquor volume.

Once it was 'officially' confirmed that the downgrade was going ahead and it would be 7th May, I knew that as my pregnancy was high risk and I was told I needed to deliver with consultants and surgeons to hand (in case there were complications) that I would be having my baby at the Conquest Hospital in Hastings. Understandably I was annoyed as Eastbourne DGH is 4.6 miles (11 minutes no traffic) from my home and Conquest Hospital Hastings is 16.9 miles (35 minutes no traffic) from my home.

I had months of Braxton hicks so when I awoke at 05.50 on 10th May I knew this was a real contraction as the pain was horrific. I went to the toilet and came back to bed thinking the next one would be at least an hour away. I drifted off to sleep again quickly but was awoken again at 06.10 with another. I woke up my Husband and said we needed to call the hospital and his Mother (to come look after our 6 year old daughter) immediately.

I was in too much pain to make the call myself so Leigh telephoned the Conquest at approximately 06.15 (I'm sure your call logs would have the correct timings) to tell them that the contractions were already 20 minutes apart. After Leigh gave a brief overview of my history (mentioning that we live in Eastbourne), the midwife at the other end of the phone [REDACTED] asked whether my waters had broken or whether I had had a show. The answer was no to both questions and with that [REDACTED] said 'we've got plenty of time' and to 'call back when they are 5 minutes apart'. He mentioned again that we live in Eastbourne and she was adamant there was time and she would have heard me having another contraction whilst they were speaking. She didn't ask about my first labour (which was quick), we had to volunteer that information. I went to get myself changed to get ready to go knowing that Leigh's Mother was en-route. By approximately 06.30, I had another contraction and they were becoming more painful as the gaps between them grew closer. I shouted at Leigh that they were 10 minutes apart already and could he call her back as we needed to go by which point Leigh's Mother had arrived. On this attempt nobody even answered the telephone! When Leigh got through on the next attempt a few minutes later, I had a very painful contraction and I shouted again that they were getting close to 5 minutes and we needed to come in now. Leigh was on the phone to [REDACTED] again and she said that we should make our way to the Conquest Hospital. We left the house 06.50. We left the North Harbour and took the A259 heading toward Bexhill and Hastings.

My Husband had to drive at speed, overtaking cars the entire way (which essentially put us in further danger and also other road users). When we reached Little Common, I was yelling that I needed to push and I could feel the baby coming. I literally had to hold him in! We finally saw the signs to The Ridge and the Conquest hospital to then get stuck in traffic in temporary traffic lights on the Queensway. By some stroke of luck, there was an Ambulance in the queue ahead of us that my Husband drove up alongside and basically forced them out of the Ambulance (where they had to leave a patient that they were transporting to the Conquest) to see me. They called for another ambulance but by the time that arrived I had already given birth lying down with a Paramedic crouching in the back of my car and my Husband watching through the window. I feel I should point out that at no point did my waters break before the birth and the 'show' didn't happen until minutes before my son was born. I then held my son still lying in the back of the car with my Husband driving the car and a Paramedic in the front passenger seat. I was told to rub my son's back the entire time to keep his circulation going as it was so cold. Upon arrival at the hospital no one knew what they should be doing. Archie was still attached to me and the midwives dithered in the car park with the door to the car wide open. The cord needed to be cut which

they said they would do in the hospital then decided they would do it in the car. A midwife (no idea on name unfortunately) then went off to find the instrument etc required and came back to the car. She didn't even ask my Husband whether he wanted to cut the cord just forced herself in to do it at which point he got quite annoyed and said he wanted to do it. The instrument was blunt, it took ages and there was no blood left in the cord to test. I then had to pass Archie to a midwife who ran inside with him and I had to get out the car with nothing but a thin blanket around my modesty (with all sorts falling out of me) and get myself onto the trolley.

At this point, I was still to deliver the placenta and could see the two midwives clock watching the entire time, looking at each other, massaging my belly trying to help things along. Archie was under the heat lamp as his body temperature wasn't where it should have been. I couldn't hold him again for over an hour. I was visited in quick succession by a few Hospital representatives, one being [REDACTED] who's bedside manner leaves a lot to be desired. She was rude, arrogant and non-sympathetic to what had just happened to me. She was clearly spouting from a script about the changes being made at the DGH due to safety, but pray tell, what exactly was 'safe' about what happened to me?! Have you given any thought to what could have happened had the Ambulance not been in the same queue of traffic? Because I have, it literally haunts me every day when I have to take that same route to take my daughter to school in Gunters Lane, Bexhill.

Archie and I were allowed home early evening that day which (although I was asked what I wanted to do) I do not believe should have happened further to some information explained to me the following day. That night Archie struggled to breathe and anytime we laid him down he sounded to be fighting for his breath. He didn't have a proper cry, it was a squeak and we had to keep him upright the entire night to ensure he could breathe. When visited by the midwife the following day (Saturday 11th May) it was explained to me in a 'normal' labour as a baby is gently squeezed down the birth canal and ultimately delivered, anything they may have taken into their mouths is squeezed out through their nose but as Archie was a quick delivery, this would not have happened and with that alone in mind, I believe that it should have been heavily suggested that Archie and I stay in on the day of the ordeal. I noticed that I hadn't been losing a lot of blood following the birth and on the evening of 11th May, I took a bad turn, developing a high temperature, shaking and almost delirious and was taken to A & E at Eastbourne DGH (initially I was refused treatment there and told to 'make my way to the Conquest' but I was far too ill to endure that journey again) where it was decided that I had an infection of 'some sort, possibly urinary' but it was too early to tell what type of infection and was sent on my way with antibiotics. I did point out that I was concerned about the very small amount of blood I was losing. I started to feel slightly better in 2-3 days on the 5 day course of antibiotics but couldn't look after Archie properly myself (as I felt so weak and still unwell) that entire first week and had to have my Mother to stay. Archie was averaging sleep of just 4/5 hours in a 24 hour period, cried continually and was barely feeding. On Saturday 18th May for the first time since delivering Archie, I started to bleed heavily with a lot of pain and pass very large clots. I felt very ill so after discussing my symptoms with 111 an ambulance was called. An ambulance wasn't available so an ambulance car arrived to assess me whilst we waited for the ambulance. The attending paramedic looked at the clots and blood loss we had left in the toilet said I would need to be taken to the Conquest Hospital as it was a substantial loss (I asked if I should take the clots with me and was told 'no need') and I was taken to the Conquest in an ambulance (that had travelled from Newhaven to get to me) where it was suggested I may have had ragged membranes which HAD I delivered Archie in a hospital I would have been examined properly and that may not have happened. It has recently been reported within

local and national media that lives are lost due to sepsis not being recognised and treated appropriately. I wonder why (especially given the inappropriate and unclean conditions of Archie's birth) I wasn't treated with more caution after this being my second visit to a Hospital within a week with symptoms of sepsis.

It transpired that my discharge paperwork had not been completed correctly and when [REDACTED] arrived to examine me he was forcibly trying to get me to confirm that my placenta was delivered within an hour of Archie which of course I couldn't confirm due to my state of complete shock of what had happened! When they checked the computer system miraculously the answer presented itself (it stated the placenta was delivered 58 minutes after Archie's delivery) even though it wasn't detailed on my paperwork. I was given IV antibiotics plus two separate antibiotics in tablet form to take home with me to take for 7 days. I didn't start to feel better until almost a week later.

I have spent the first four months of Archie's life with a very upset and unsettled baby which if you research into traumatic labours you will see that in cases where the baby is born in situations such as mine, is a direct result of what happened. He barely slept, was scared to be left alone (and not in 'I'm trying it on way') which was verified by my Health Visitor [REDACTED] and also the various midwives that visited us in our home. I took him for cranial osteopathy appointments every week from week 4 of his life reducing to fortnightly visits from week 8 of his life. I have tried baby massage at the suggestion of the health visitor which whilst I appreciate the suggestion was pointless as you are not 'allowed' to massage a baby whilst he/she is in a state of upset which Archie always was. I have had to seek help from the 'afterthought' support service (I am not in the financial position to fund private counselling) to try process exactly what happened to me and am struggling but am yet to receive an appointment.

You have ruined my birthing experience and months following it by downgrading the unit. I would have made it to the DGH and delivered Archie in a 'safe' environment had you not done this. You have caused me months of heartache and feelings of failure as I have been unable to console to my son. You took away those first amazing moments that I should have felt skin to skin contact with my such longed for baby. You turned what should have been one of the happiest moments in my life into one of sheer terror, unnecessary pain, humiliation and shock. My Husband filmed the midwife handing Archie to me after his body temperature was back up to normal and I cannot remember it as I was in total shock. I watched the film and cried because I don't remember doing it. I will never get over it. I can still feel the pain and feeling of being petrified whenever I think about that day and am in tears now as I relive it again. Archie was not just a 'BBA', I am not just 'that Mother' as so cruelly referred to by [REDACTED] when interviewed for Meridian Tonight, he was a baby, my baby and I am a woman, we are people not just statistics. When you look at my history and what I went through to become pregnant and hold onto him, I don't honestly know how you and any of your team can be so blasé about what we went through. Would you feel happy if this happened to a woman within your Family...?

Furthermore, Archie's Father suffers with severe depression and doesn't deal well in high stress situations. Following the trauma of the delivery and my emergency admittance to hospital he spiralled into a deep depression and had to be signed off work for one month. I had to call on other Family members to help me with Archie and also our daughter Lexie. So not only was I physically and emotionally affected by what happened, but my Husband was heavily effected which caused me further stress and upset I didn't need. Not to mention the stress placed on our relationship and our Family.

The fact remains which needs to be acknowledged, I live 10 minutes away from my local hospital and would have made it even with a quick labour as I did with my daughter in 2006. If I wanted to live 45 minutes away from a hospital of actual use to me and my Family, I would live in the countryside somewhere where I used to live before I had my children. I chose Eastbourne for a reason. Birth is meant to be about 'choice'. I had NO choice; the choice was taken away from me. According to the Birth Place Choices Project it was deemed "...that women should receive convenient, high quality services that offer greater choice and flexibility." Where was my convenient choice?

I request that you investigate what happened to me and respond in accordance with the NHS complaints procedure. I specifically would like the following questions answered;

- Why knowing there was ALWAYS a risk this could happen to a labouring woman when you made the decision to downgrade did you (clearly) not have a plan in place?
- Will what happened to me be documented with the review as a cause for concern if the temporary downgrade is proposed to be permanent?
- Following the midwife not actually listening to my history and taking the massive distance to the Hospital into account, has anything changed/further training been given since Archie was born? Also given that I was high risk (which the midwife was made aware of), was it correct for her to advise me to wait until the contractions were just 5 minutes apart or should she have advised me to make my way over sooner - particularly as the contractions started off so close together?
- With me not having the correct information on my discharge maternity notes, and the time of the delivery of the placenta being absent – is this against procedure? Also, was the condition of the placenta documented? Why did the community midwife NOT pick this up and question it herself?
- Was the delivery of the placenta adequate or did something go wrong that was possibly realised after the fact and I was not made aware of it?
- Am I able to obtain a copy or at least view my handwritten notes to clarify what information was/wasn't documented?
- Following what happened to me, have you implemented an 'action plan' so people do know what to do in the event this happens again to some poor woman and her baby and to avoid further stress and confusion as I did upon arrival to the Conquest? If so, may I have a copy?

I look forward to your response and in the meantime, please acknowledge receipt of this letter.

Yours sincerely,

Kirsty Peyton-Lander (Mrs)

Electronically signed

CC – Care Quality Commission

CC - NHS Trust Development Authority

CC – PALS – Conquest Hospital (via email)

CC – PALS – Eastbourne DGH (via email)

CC – Lindsey Stevens (via email)

16/12/2013 downgrading of eastbourne DGH

From: SIMON HUGHES [REDACTED]
Sent: 16 December 2013 22:03
To: Health Scrutiny
Subject: downgrading of eastbourne DGH

Dear sir ,

As a resident of Eastbourne I really have to show my disgust at the removal of not only consultant led maternity but of children`s services! its awful to shut the door and turn off the light in a children`s ward - especially the size of the area the ward serves! if the last count is correct - its something around 200,000 people and rising!

We read weekly , the number of car or ambulance births on the road to hasting's (at least 30 minutes on a good day) , and with recent closures of Crowborough birthing centre , and at least twice , Hastings itself shut to new admissions (a family was driven over 100 miles to find a bed). you really have to stop this appalling situation.

get rid of the over paid senior managers - why pay the wages of £250k + for 1 person , when quite frankly that would run the ward!

too many senior managers not enough real staff, and sadly those managers , were rated `poor` in the last CQC.

please , heed the word of those who live here (before anyone actually takes legal action) and stop this stupidity

Simon Hughes

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

I include my address as im not anonymous and you can reply in writing.

16/12/2013 Eastbourne DGH Downgrade

From: Lucy Hancock [REDACTED]
Sent: 16 December 2013 22:23
To: Health Scrutiny
Subject: Eastbourne DGH Downgrade

Dear Sirs,

I writing in complete disgust as to how the people of Eastbourne are being treated with the current downgrading of our hospital the DGH. Around 7 years ago Liz Walke undertook a huge campaign to save the maternity services at Eastbourne which were in threat of being lost. It was a hard fought battle resulting in victory when the IRP overturned the decision based on safety grounds.

In light of this recent decision I am at a complete loss as to how the Maternity & Paediatric services have been stripped from Eastbourne along with other important services. How was this able to happen ?

Whilst I appreciate that the Trust have to look at their budget to reduce their costs surely putting people's lives at risk has no amount of monetary value placed on it. Women going into labour at one of their happiest times with a commute of an hour and the stress. Women having children born at the side of the road. Women in labour at Eastbourne with complications having to be transferred to Hastings. Hastings has been unable to cope with this influx and closed their doors to admissions. Crowborough has been closed with staff transferred to Hastings to try and keep up with the demand.

Children having to be transferred to Hastings as no beds. Ambulances are being needlessly used as a taxi service when their expertise and resources should be there for emergencies. Why are children being transferred to Hastings when there is a perfectly good and able hospital in Eastbourne which is able to serve its constituents.

Eastbourne is a growing town , with the population average falling year by year and birth rate and amount of children living here increasing. You only have to contact East Sussex County Council as Eastbourne is struggling and is unable to cope with primary school places due to influx to this coastal town and increasing birth rates.

I, along with thousands of Eastbourne residents are strongly opposed to the temporary downgrading of maternity and paediatrics and demand a return to full services at Eastbourne and Hastings as two growing towns with immediate effect. Do not wait until there is a death to ensure that both towns are serviced!

Yours faithfully,

Lucy Hancock

16/12/2013 Eastbourne DGH maternity services

From: Louise Burrluck [REDACTED]
Sent: 16 December 2013 22:38
To: Health Scrutiny
Subject: Eastbourne DGH maternity services

I am writing to register my concern over the future of maternity and paediatrics at Eastbourne DGH.

I had my son via emergency c section at the DGH in July 2012, everything was progressing well but the situation changed very quickly. My son was delivered and was unresponsive for 4 minutes, fortunately he recovered well within a couple of days but it gives me great concern to think what would have happened in that situation today at the DGH. There was nothing to suggest my labour was going to take such a dangerous turn and I can't understand why a town the size of Eastbourne can't support it's many expectant mothers with a full maternity unit. I've spoken to many expectant women and most of those women are upset that they have to travel so far and be so far away from their families at a time when they need love and support. It adds an unacceptable amount of worry to a situation which is already daunting to women.

I also had to spend a night at the conquest with my son when he was 9 months old, as he contracted pneumonia. We had to wait at the DGH for nearly two hours for an ambulance to take us while the paediatric unit was waiting to close its doors for the night. When we got to the conquest another ward had to be opened for all the people who had been transferred from Eastbourne.

My husband spent hours travelling to and from the conquest and Eastbourne to bring us things we needed and to visit us.

We were told we'd be in hospital for at least 48 hours but were discharged the next morning. My son's condition then deteriorated so we went back to the DGH where we had to go over the entire case again as the notes were not shared between the hospitals and were still at the conquest. The DGH staff couldn't understand why we were back and had been discharged. The whole system adds unwarranted anguish at a time when young children are ill and deserve better care and support from their home town health care provider.

I hope that someone will come to their senses and see that Eastbourne needs better support for its expectant mums and young ill children.

Yours sincerely
Louise Burrluck

17/12/2013 Written from my daughters bedside at the Conquest Hastings

From: Erica Simmonds [REDACTED]
Sent: 17 December 2013 08:43
To: Health Scrutiny
Subject: Written from my daughters bedside at the Conquest Hastings

My family have first hand experience of the transfer of services from Eastbourne to Hastings. We have had open access for over 11 years now (my daughter is 13) and our length of stay at Eastbourne has always been 3-4 days. Since transferring to Hastings this has increased to 7 days. How much extra is this costing the NHS? There is no medical reason for this increase just the extra stress of the travelling, the lack of knowledge of the new doctors and nurses, the unfamiliar environment and the lack of visitors due to the distance from home. In addition as a family we are struggling, the journey takes an hour each way so it is impossible for family to help out or for us to juggle work. I am seriously having to consider whether or not I can continue my job of 25 years due to the amount of time off I now need.

Our first visit to Hastings was the day services transferred. Despite being assured that the open access records had been transferred this was not the case. I had to ask my family to scan the protocol to me so that I could e-mail it to the doctor, ridiculous!! I was assured that this wouldn't happen again and even our consultant assured me that our records had all been transferred and this wouldn't happen again. I was therefore shocked to find out last Tuesday that this wasn't the case, yet again no file, no protocol and again I had to e-mail this to the doctor myself. The treatment plan states that medicine must be given within an hour of symptoms, by the time treatment was written up and given 5 hours had passed. Obviously this caused immense distress to my daughter and has increased her recovery time.

The ward is over crowded, staff have been unable to give us space and privacy (through no fault of their own) and my daughter, who is autistic, has been placed in a 6 bed room despite her shouting out, swearing and generally being very disruptive. Unfair on her, unfair on us and unfair on the others in the room.

Please consider reversing this decision.

20/12/2013 Eastbourne DGH Maternity transfer

From: Ken Davies [REDACTED]
Sent: 20 December 2013 10:15
To: Health Scrutiny
Subject: Eastbourne DGH Maternity transfer

Dear Sir

It amazes me that at a time of rising birth rate, maternity services at Eastbourne's DGH have been transferred out of the town. East Sussex Local Education Authority are increasing school pupil sizes in the town in response to the birth rate rise, despite Eastbourne already having one of the largest Junior schools in Europe.

It astounds me that anyone would consider moving maternity services from a Hospital that is well served by road links to one on the top of a hill that is particularly arduous to get to from Eastbourne, even with the benefit of flashing blue lights. When one considers the nature of the patient in labour with a definite time limit before giving birth, then a local maternity unit is clearly the best option for all apart from the bean counters who appear to be able to over rule any semblance of care or logic.

The demand for Maternity services in Eastbourne has always been manifest, I and my siblings were born at the Maternity hospital in Upperton Road. My children were born at the DGH, my grand children were born at the DGH. I hope that my next grand child will be born in Eastbourne without the worry and danger of a blue light dash to Hastings that it will bring for the parents.

Although when we married we had the opportunity to move closer to my work we chose to settle and remain in Eastbourne, not only because of our family roots but also because it has good schools and a well provisioned local Maternity and Paediatric hospital. As it transpired we went through a long period of time when at least one of our four children needed day or overnight Paediatric care, principally from asthma related conditions. Since I commuted to work and was also often required to stay away from home, I was not able to instantly respond to a health crisis at home. A children's ward a few minutes away became essential and proved the value of locating in Eastbourne.

Without the local Paediatric care at Eastbourne's DGH it would not have been possible to maintain our family unit or possibly even my employment.

Taking away the Maternity and Paediatric services downgrades not only the Hospital but also the community, making the town a less attractive place for families to settle and stay. Without the families and their income, employment falls away. Less children means less vibrancy, less money being spent in the local economy and inevitably a decline into stagnation. Reviewers of Public Services must look at the greater effect on society of their decisions and consider if any short term financial gain in one community service is in the best long term interest of the local community of which the reviewers are as much a part as everyone else. I believe that that HOSC has a greater understanding of that than maybe the Health Service CCG's and hope that due consideration of the bigger picture is taken into account in your discussions.

Sincerely Mr K Davies

21/12/2013 Maternity and Paediatric Services at Eastbourne District General Hospital

21st December 2013

Health Overview and Scrutiny Committee
East Sussex County Council
St Annes House
Lewes East Sussex

Dear Sirs

Maternity and Paediatric Services at Eastbourne District General Hospital

I feel I have to contact you about the Maternity unit at the hospital and the creating of temporary measures for Maternity and Paediatrics. I have lived and grown up in this area since 1960 and have seen the population of Eastbourne and surroundings increase in that time and know of the wide spread real concern of the people here. I want to see all services at our local hospital so it serves all of the local area.

Sometimes a straightforward birth can have a last minute emergency or the mother needs an emergency caesarean that has to be done sooner rather than later. It is not a good idea to send a woman in labour in an ambulance to the Conquest Hospital on the crowded road system between Eastbourne and Hastings. Also she may have had to wait sometime before one became available. What about all the extra stress being placed on expectant mothers wondering if they can get to the Conquest in time and thinking they might end up having their baby in the back of a car, which has happened or a death may occur.

What is wrong with having a small Consultant led Maternity Department at Eastbourne, it should be catering for the local women in this area. I'm sure Senior Staff would still get relevant experience working here. The Board should not be running the place down as is currently happening. We are not in London, this is East Sussex and should be able to have a well run hospital with all departments in Eastbourne for all the people who live here and surrounding area. It is not creating a good look for the recruitment of Obstetric and Gynaecological staff if potential medical staff read that the Eastbourne hospital department is unsafe – good positive messages should be given, and then the hospital would recruit staff.

A lot has been said in the press and on social media sites about parents having difficult times with their children because of being told to go to the Conquest at night because of no overnight provision for the children at the Eastbourne Friston Ward. I hope that many of these families have contacted you about their difficulties. No doubt you are aware that the East Sussex Council are going to arrange for extra primary school places in Eastbourne, Ringmer and Hastings, where 400+ places for Eastbourne are planned and about 80 for Hastings.

I understand that the Chairman of your Committee attended a recent meeting at the Eastbourne Hospital and heard what staff members said what was really happening in relation to the temporary measures for maternity and paediatrics and hope he made notes of what was said by the staff involved.

Yours faithfully

A Very Concerned Person

05/01/2014 Maternity & paediatric services at Eastbourne DGH

From: Luke & Karen Askew [REDACTED]
Sent: 05 January 2014 23:08
To: Health Scrutiny
Subject: Maternity & paediatric services at Eastbourne DGH

Hello

I am writing to express my grave concerns about full maternity & paediatric services being removed temporarily and possibly fully from Eastbourne DGH. I have lived in Eastbourne all my life and was myself born at EDGH. My 2 children were also born at EDGH in 2008 & 2009. I find it shocking that mothers to be have to travel an additional 45minutes to 1hour during peak times to the Conquest hospital in Hastings to have their babies. The choice has been completely taken away from them. I understand that they can choose to have their babies at the crowborough birthing centre or the EDGH midwife unit but both of these centres have been frequently closed since the downgrade at EDGH.

Babies and mothers lives have been put at risk by this stupid cost cutting exercise.

EDGH covers a HUGE area including hailsham, Polegate, Pevensey, hellingy, herstmonceux, seaford to name but a few. They are constantly building new homes in these areas which will put more of a demand on our local hospital especially the maternity & paediatrics units as many of them are starter homes.

A local town the size of Eastbourne including the surrounding areas needs a fully functioning hospital.

Paediatrics at EDGH is only open from 9am-6pm inevitably once again families have been having to travel by ambulance with their sick children to be treated over at the Conquest. And once again Kipling ward at the Conquest has been frequently closed due to not enough beds so children are being transferred even further away to Brighton and tunbridge wells since the downgrade at EDGH.

Hastings can't cope with Hastings growing population how on earth can you expect it to cope with Eastbourne's too?

My worry is that it is going to take a tragedy before something is done, and I pray selfishly it doesn't involve my children.

Please reconsider the changes that have been made, the maternity and paediatric services we have on offer locally are for yesterday not today and especially not for tomorrow.

Kind regards

Karen Askew

07/01/2014 FW: Your daughters Case

From: garry cairns [REDACTED]
Sent: 07 January 2014 20:01
To: Health Scrutiny
Subject: FW: Your daughters Case
Attachments: Case Study - 130913.docx

To whom it may concern

This is our daughters case study that was done by CCG, it shows that we went through a lot in a short period of time, which if Eastbourne paediatrics does not go back to a 24 hour service will only get worse for us.

We feel that the downgrade is unfair on our children. the ordeal of having to be in hospital is scary enough for children of any age, but this situation is making it worse for the children and families.

we also feel the downgrade has not made the maternity or paediatrics safer, as we have experienced first hand how people are forced to make decisions on their own children's health and also the suffering caused by transfers.

We hope you will read our daughters story and take on board what we as a family, like many others are having to experience for what is suppose to be safer. we feel very let down by our local hospital.

The Cairns Family

07/01/2014 FW: Your daughters Case (Attachment)

Interview with service user – 13/9/13

May 22nd 2013

My 4 year old daughter was ill in the morning. She couldn't move. I phone the GP at 830am and couldn't get through at first. When I did get through they said to go to A&E in Eastbourne. They organised patient transport. The ambulance arrived at 11am.

When we got to A&E in Eastbourne there were no cubicles available. We were left in the middle of the A&E department by the computers and it was very busy. We waited here for about 1 hour and 30 minutes for the orthopaedic consultant; someone had been transferred out so we eventually got the cubicle. When we got into the cubicle my daughters clothes had to be cut off due to the stiffness of her body.

Two other doctors then checked her; one of these was a locum. I overheard them talking and they were talking about why she hadn't been taken to Kipling, and why she was left in A&E. After this they gave up trying to examine her so sent her for x-rays on her hip. She then needed to see the paediatrician.

At approximately 2pm the porter took us upstairs to the Friston Ward. The nurses that saw my daughter dealt with my daughter quickly and observantly. What seems to be lacking though is the communication between the orthopaedic consultants and the paediatricians; we had to wait 1 hour for the paediatrician to come due to this poor communication. The paediatrician was happy for my daughter to be sent home. I refused for her to be sent home due to her condition, as she was still in agony and nothing had been diagnosed. The paediatrician insisted they couldn't find anything was wrong so said calpol and pain relief would help, and there is no point in staying. My husband got the nurse to come in and said we can't take our daughter home. We couldn't deal with her at home and she couldn't use the toilet or move her body.

The nurses then spoke to the orthopaedic doctor and they organised for bloods to be done. This orthopaedic doctor said she can't go home and needs to be transferred to Kipling in Hastings. This was at 330pm. They said they wanted to get bloods and x-rays back before she was transferred. The bed at Kipling was booked at this point but they didn't transfer straight away. They also gave my daughter codeine at 5pm. After this she was settled and was giggling.

The transfer team came around 7pm. At this point my daughter started getting hysterical. She didn't know the nurses at Kipling, and knew the movement there would cause her pain.

Whilst this was going on, my son was left at home. I had a good family network so they were able to look after him. But I think about what if I didn't have that network. My husband was at home as well and he was calling me a lot to check how his daughter was.

The transfer was helped by that fact the my daughter was so tired from the day but the journey was not smooth and my daughter did call out in pain due to the road surface. The journey from Eastbourne to Hastings took approximately 45 minutes. The transfer team made a conscious decision not to come at 5pm, due to the traffic congestion at this time.

We arrived at Conquest at approximately 8pm, which was around staffing change over time. Getting her out of the ambulance was distressing for her as it was a new environment. When they got her out she was distressed. We went straight into the hospital and we didn't know where to go. A nurse who was from Eastbourne, who knew my daughter, came over

and helped to transfer her. The plan was to get her settled whilst they were doing the change over and get her comfortable. This movement made her so much worse, and then she wouldn't settle in her bed. As a result of this she needed morphine. At this point she still hadn't seen a doctor. She didn't see anyone other than nurses for the night.

I had a bed next to my daughters. We were on ward and it was very cramped. Both of us didn't sleep well. I had to ask for her drugs throughout the night, they didn't proactively give these to her.

On the morning of **23rd May**, we were told the round was between 9-11. A couple of student doctors came along and did some observations, and said the consultant would be along later. At this point there was no contact with any paediatricians. When I asked the nurse about the paediatricians they said that my daughter was under orthopaedics despite being in for a suspected viral infection.

The orthopaedic consultant came round about 1245pm. He spoke about his junior doctors' findings and said my daughter had an irritated hip and viral infection. He examined her himself and could tell it was the hip. He wanted to get some x-rays of the hip done. When we said to him that we hadn't seen the paediatrician, the orthopaedic doctor was clearly angry, he excused himself and stormed off. When he came back he asked for bloods to be taken.

The paediatrician came about 4pm. There was no apology. He wanted to know what went on and pointed out there was a slight temperature. He said he would wait for the bloods to come back.

Just before my daughter was taken down to x-ray, she was put on paracetamol through a drip. She was still on oramorph and possibly codeine as well. The movement of her being taken to x-ray was horrific. My sister arrived about this time, with her journey to the hospital being difficult due to the traffic. We were then left without any contact from doctors until the middle of the night.

My daughter was settled in sleep from 10pm. At 1230am a junior doctor came around and said they needed to examine her. I didn't understand why, so I questioned this. The doctor said they needed to know about the pain. The doctor lifted my daughter's legs and bent it. This woke my daughter and made her scream. The doctor then left and said she will come back tomorrow. I asked the nurse why this had happened and she didn't know. It took 2 hours to settle my daughter after this as she was physically shaking. Throughout this whole thing she still couldn't move, so was wetting the bed. When she was finally settled she slept through till 6 when she woke in agony.

When she woke at 8am she was a completely different child. She was sitting up, playing and being herself. The orthopaedic consultant came back around this time, and said would get the paediatrician to come round. We were included in the morning paediatrician ward round. They examined her and said once morphine was out of her system they would send her home with codeine and calpol.

The orthopaedic consultant came back about 1115am, examined her and said they were happy to discharge. They wanted to see my daughter in a week's time. The nurse came at 1pm to check my daughter was fine and agreed she could go home. It took until 530pm to leave, as we were waiting for the drugs to be delivered and to be discharged. My sister was looking after my little boy at home, so my husband was able to come to Conquest to pick us up. My daughter was lively and feeling OK; you could tell she had drugs in her system still. This was the **24th May**.

My daughter was fine for the 1st 24 hours at home.

The pain then started again. This time it was in her wrist. I gave her codeine and put her to bed. She slept until 1am and woke up screaming and couldn't move her wrist. I phoned the Kipling Ward and I was told I could risk going to A&E but we were not guaranteed a bed, or I could go to A&E in Eastbourne and take her myself. My husband was working nights, so I had my young boy and a sick daughter, and I don't drive. I phoned my husband and we decided I'll keep her comfortable until Friston was open in the morning.

I phoned Kipling on **Sunday 26th May**, and they said Friston opens at 9am. My husband left work early to get back to take my son to my mum's house to be looked after. I phoned Kipling at 9am and they then said that Friston didn't open until 10am. When I phoned Friston at this time they said they would see her straight away. When we got there, all of her notes were in Hastings. A nurse from Eastbourne phoned Hastings and asked them to fax the notes over, but the nurse in Hastings said they were too busy to do that. I know this as they nurse then had to ask me for the information and my husband then questioned why this couldn't be faxed and they told me. The paediatrician had to call to get the information. All of this took about 2 hours.

After this, they asked to do bloods again. We questioned this. They explained that the second lot of bloods taken before showed signs of infection. We had previously been told that 1 marker was high but the significance of this wasn't explained. They then took some more blood. My daughter was then given codeine, and this freed up her movement. We were then sent home.

After putting my daughter to sleep in the evening at our home, she woke up screaming at 1130pm. Her left hip was the cause of the pain and she couldn't move her whole body. I didn't bother phoning Kipling as I knew what the outcome would be, so I rang my husband. We made the decision to keep my daughter comfortable at home and monitor her. She wet the bed twice that night and was upset at the thought of hospital.

We knew that Friston was open at 9am on Mondays (**27th May**), so my husband came home early from work to take us there. We had to call another friend to lift my daughter to the car, as she couldn't move.

When we got to Friston, my daughter's levels had increased and they now thought it could be arthritis. They then tried ibuprofen. The paediatrician was shocked that this hadn't been tried before. When contacted, Hastings said that they didn't know why this hadn't been tried. Within 1 hour of getting this she was a bit more back to her normal self. This was at about 12noon.

The next dose of ibuprofen was given at 6pm. They said they had 2 hours before they closed, so they felt my daughter should be transferred. We felt we didn't want to put her through that, after how she reacted before. If she could have stayed at Friston then we would have stayed. We all agreed that transferring would be too traumatic.

We took my daughter home about 8pm. This was on Monday. She was booked in for another appointment on the coming Friday in Eastbourne, for her bloods to be checked.

On the Tuesday (**28th May**) we had to call an ambulance for our son, as he had breathing difficulties. When the ambulance turned up we were told that the only available bed was in Pembury. My husband and I made the decision not to take him to Pembury. We had already been transferred with my daughter and this journey would have been further. It was also about the logistics of what parent stays with which child. If Eastbourne was open then

this would not have been an issue. We monitored him all night and took him to the doctor the next day, and he was OK.

At our Friday (**31st May**) appointment with my daughter more bloods were taken. At this stage my daughter was back to being herself. They came to the conclusion that it was a viral infection.

When we called the hospital on Saturday (**1st June**) for the blood test, they explained the results show my daughter does have juvenile arthritis and booked us an appointment with the rheumatologist.

On the Monday (**3rd June**) we had another appointment in Hastings for what we thought was with orthopaedics. We left home for this about 2pm. When we arrived they said the appointment was actually with the fracture clinic, and we are still not sure why this was. The fracture clinic did not have my daughter's notes, as the notes were in Eastbourne. We had to wait another 50 minutes for this to be sorted, then another 45 minutes to actually see the fracture doctor. By this time it was about 445pm. The fracture doctor did not know why we had been sent there, as he thought the issue was about arthritis. We asked to be discharged. We got home about 630pm. This was a complete waste of a journey.

Three and a half weeks later we had to go back to the hospital for the rheumatology appointment. My daughter was given a new drug at this point. All of the follow up appointments have been at Eastbourne.

As a result of all of this my daughter has a real fear of doctors and hospitals. She won't let doctors touch her or let bloods be taken. She kicked out at doctor when he examined her. She was too scared to tell me what was hurting her and said she was too scared. Before all of this happened she was fine with doctors and hospitals. It has caused arguments between us. It has knocked my daughter's confidence.

I now get anxious about taking her to appointments, as I know how she'll be. I have a constant anxiety of the kids becoming unwell, where my husband works nights and we don't know what hospital to go to. There have been no reassurances about the services. I also find it hard that people are saying that all the staff can speak out about the changes, when I have friends in the ambulance service who are told that they are not allowed to speak out freely. I know that these changes have put more pressure on them which in turn worries me as when my husband is working nights as I know that the level of care my children may need is not in Eastbourne.

09/01/2014 D.G.H

From: [REDACTED]
Sent: 09 January 2014 22:10
To: Scrutiny
Subject: D.G.H

I hear there is a meeting tomorrow. I am an assistant care worker and mobile hairdresser. There is a lot of people out here in the community really worried about the down hill slope the hospital is taking. I have heard some real horror stories and am ashamed to be hearing such awful things. I also hear some good comments too thank goodness. I know it's not easy with things as they are at the moment { over crowding and not enough staff and money I guess } . People should not have to go to Hastings when there is a perfectly good building here. Something has gone dreadfully wrong somewhere. And those people responsible should be fired { with no bonus or pay off } and new members appointed, people who know what they are doing and know how to run a business. These people in your community, most have paid their taxes and have earned the right to have a fully equipped hospital with all departments available. There must be some one brave enough higher up that can stand up for our D. G. H . I hope it's you Good Luck if it is.

09/01/2014 Bringing Services back to Eastbourne

Ray and Anne Martin

Residents from Eastbourne

Dear Mr Dean

We write this letter to express our concerns and wish to make an official complaint regarding the current state of healthcare being delivered at the moment to the people of Eastbourne and the very large surrounding areas of East Sussex. We would like to see Maternity and Paediatrics return to Eastbourne and have both departments on both sites as it should be.

This is utter madness and we have heard from people that have had the unfortunate to witness both departments and say the Conquest cannot cope with the volume of patients and are turning people away, that's without babies being born on roadsides.

Our little Granddaughter was recently admitted to EDGH at 4pm one afternoon after 2 of the out of hours doctors failing to diagnose pneumonia. The first doctor not prescribing antibiotics on the Saturday so missed nearly 48hrs of not being on medicine. Also on the Saturday the out of hours doctor system my daughter waited over 5 hours before a doctor called her for our little 5 year old granddaughter. Once admitted to EDGH by our GP on Monday afternoon my daughter could not fault the lovely staff or treatment they received, until at 10.30pm at night they were deciding whether to admit my granddaughter or not which would have meant calling an ambulance to transfer her to Conquest my daughter and son-in-law were very stressed at this happening as well as my little granddaughter crying as she didn't want to be moved after settling in on the ward in DGH.

East Sussex and especial Eastbourne is rapidly growing with extensive building of homes for people mainly families as well as the usual large elderly population who are always in need of healthcare services. The people of Eastbourne and Hastings need all their healthcare services to remain at both hospital sites.

The transport over to the conquest is very inadequate, there is no main railway station nearby, not everyone can afford taxi fares and not everyone has a car, whilst talking about the cost, how costly is it to run the ambulance service that is in operation at the moment ferrying patients to and from Eastbourne to Hastings.

Please please let us have our much needed services back in Eastbourne

Kind Regards

Anne & Ray Martin

10/01/2014 Concerned Resident of Eastbourne

From: f [REDACTED]
Sent: 10 January 2014 08:19
To: Health Scrutiny
Subject: Concerned Resident of Eastbourne

I would like to plead with the persons who decide the next step in Maternity care. Recently there have been two babies born on the Marsh road one in a car one in an ambulance. A friends daughter delivered a 10lb baby in Eastbourne then had to be transferred by ambulance to Hastings she insisted the baby came too, a midwife held the baby in the back of the ambulance, (I would have thought illegal,) There was then no transport for the midwife to return to Eastbourne. The baby subsequently had problems and fortunately was able to see a paediatrician which would have been delayed in Eastbourne. My first grandchild was born in Hastings. My Son was told to leave Hastings hospital at 1.30am after his baby had been born in the most appalling weather conditions, (it is a miracle he didn't have an accident.) My Daughter in Law felt isolated as her family don't drive and were unable to visit. The category of disasters goes on.... Mothers and babies are the most vulnerable in our society and should be well cared for in this day and age. We have just had the opening of St Wilfrid's Hospice for end of life patients which has marvellous facilities... do we think so little of our new generation ? Public opinion is strong in favour of maternity care consultant lead at both Hastings and Eastbourne will the powers that be only realise when lives are lost ? It is only a matter of time before this happens. The population of Eastbourne and Hastings is growing all the time Please some common sense and reinstate maternity services to Eastbourne as soon as possible.

The population of Eastbourne and Hastings is growing all the time and surrounding areas. We both need consultant lead maternity and midwife maternity on both sites. I understand this is a nationwide campaign to save money, with maternity services being withdrawn from various towns across the country, lives will be lost on a huge scale, and the down grade will never be put back to how it should be. I suggest more money should be spent on training mid wives and proper services be resumed as soon as possible. I think it is complete madness to have only midwife led maternity services in Eastbourne or Hastings, a doctor is needed with the care of mothers and babies. The unpredictability of pregnancy demands every eventuality to be covered. I understand a huge amount of money is spent on ambulances and taxis for staff to Hastings from Eastbourne... please some common sense ! We have a fantastic facility with St Wilfrid's Hospice for the end of life.... please consider the beginning of life as important ! Stop the madness before it is too late.

Fiona Backler Eastbourne Resident.

15/01/2014 EDGH downgrading

As a local resident and mum of two, I can say with no hesitation that I am deeply concerned by the changes that have been made at the hospital. I had my son (4) out of area, as we lived in London then, but my daughter (15months) was born at the DGH before the downgrade and I had a very positive experience. I was induced, as my water's broke but labour did not follow, and I understand that if this had happened after the DGH downgrade I wouldn't have been allowed to have my baby at the DGH, but I would have had to go to the Conquest in Hastings, where the consultant-led care is now based. While I am pleased that Hastings has this facility, every town with a hospital should have the same. Eastbourne is a town that is growing and young families and couples are flocking here, it is no longer a place where OAPs come to retire. At the moment the downgraded facilities at DGH are making me reconsider having another child - and this decision should be mine and my family's not a government bodies!

I worry also that my son, who will be attending school next year, hopefully locally, would be taken to the Conquest if he became ill or was in an accident at school and I couldn't drive to collect him from school and take him to the DGH. What utter nonsense when there is a perfectly good hospital just down the road!

These changes are not only preying on disadvantaged parents who don't have transport to get to the Conquest, but they are potentially dangerous and life-threatening. Ambulances have to allow for 1hr for the route to the Conquest from Eastbourne, most babies don't wait that long, nor children who have been involved in an accident away from their parents' care.

It is a shameful waste of NHS money using ambulances as taxis, when labouring mothers or sick children need to be moved from one hospital to another, and a mother could potential be left stranded in hospital on her own with a newborn or a small child away from its parents, if the family doesn't have transport.

Each town's hospital should have the same facilities. We as the people of Eastbourne are not being listened to and decisions are being made on the basis of money not residents' needs.

Imagine you were in labour, stuck in a traffic jam with only your husband or a taxi-driver for support. Imagine you were a little boy or girl lying in the back of an ambulance without your mother or father to hold your hand. Now imagine you are frightened and scared of the unknown as well. Do deaths have to occur before something gets done? We already have more babies being born in cars on-route to Hastings than we did before. As an Eastbourne resident I do not like the changes that have taken place.

I hope you reconsider the decisions that have been made.

17/01/2014 Consideration of CCG Options for Maternity and Paediatric Services in East Sussex by the ESCC HOSC

These comments and concerns are from both my wife and myself who have been residents of Eastbourne for more than 40 years and are now both retired.

We have followed this review process regarding Maternity and Paediatric Services in East Sussex over recent times and were, like many other local people, dismayed about the "temporary" cessation of the consultant led maternity services and in patient paediatric services at the Eastbourne DGH from May 2013.

The recent Joint East Sussex CCG press release of 5th December 2013 is most concerning as it does not include in the 6 options presented for further review provision of obstetrics and in patient paediatrics on both the Eastbourne and Hastings sites.

We find this quite amazing and distressing especially when the reason for not doing so is given as safety i.e. " We cannot move forward with options that we do not believe are safe".....quote from Mr Frank Sims in the above mentioned press release.

It is extremely difficult if not impossible to comprehend and understand how (and why) this can be given as the reason. How can the transfer by ambulance from one of these two sites to the other by road taking at least 45 minutes in normal weather and traffic conditions in an emergency situation be considered safe?

It is important to remember that this has all been through before when there was the previous attempt to remove obstetrics from one of the 2 sites in 2007/8. The result then was the decision by the incumbent Health Secretary in 2008 that both sites should retain full maternity services and crucially he cited the issue of safety regarding transfer between the sites as being fundamental in making his decision.

So what has changed now to render such transfers safe?

It is reasonable to assume (has anyone actually looked into this in detail ?) that road traffic volumes have increased over the last 5 years with increased potential for delays and without doubt weather conditions especially in the late autumn and winter months have deteriorated with increased risk of flooding and more severe snow and icy spells. We trust that these points have been looked into /will be considered by the HOSC.

In addition the additional journeys to and from Hastings/Eastbourne to make these transfers is placing significant stress on the already overstretched Ambulance Service which we understand has not had any increased funding to take account of the extra work. We can give a real example of the day to day problems experienced in this scenario which we heard about just today...the daughter and her 2 week old baby of a friend of ours had to wait 2 hours at the DGH earlier this week for an ambulance to come from Southampton (!!!!) to transfer them to the Conquest as no local ambulances were available.

In our view (and we know this is shared by many others) the situation with only one site having full maternity and in patient paediatrics and the transfer issue is a tragedy waiting to happen....there have been a number of "near misses" in this regard already. Will the death of a mother/baby/child have to happen before this proposed policy is overruled?

Surely maternity and paediatrics are two of the NHS services which must be protected and preserved especially as these involve the future generations for our country ?

It is also important to remember that in making the decision he did in 2008 the Health Secretary clearly told the Trust that it needed to take all steps necessary to ensure sufficient numbers of appropriately qualified and experienced staff in the various disciplines/ specialities involved were available at both sites to provide safe and high quality services. It would now appear that the Trust has been unsuccessful in achieving this consistently over time as it seems this is the cause of the quoted unsafe situation.

We are fully aware that the NHS is experiencing (and this will continue) severe financial pressures and our local trust is not immune from this having currently a very significant deficit. Clearly NHS costs have to be reduced to ensure frontline services (including maternity and paediatrics?) are not adversely affected.

We suggest for example that a start could be made on this by removing some layers of unnecessary bureaucratic management (but not then taking them back on as consultants/contractors!), stop paying out huge sums in compensation to trust chief executives and others who leave their posts and stop paying very large salaries to trust chief executives (many earn more than the Prime Minister).

In our view both Eastbourne and Hastings and their respective hinterlands as large and growing communities should both have full maternity and in patient paediatrics at their own local hospitals and surely the not insignificant challenge for the Trust is to find a way of achieving this to provide these services in a safe, efficient and high quality manner.

We remain wholly unconvinced that the options proposed by the CCG's represent the best way of ensuring safe and high quality services in the interests of women and children in East Sussex.

We trust that the HOSC will agree that the proposed options from the CCG's should be subject to further review and crucially full public consultation with the potential ultimately for referral of this crucial issue to the Secretary of State for Health.

David & Lesley Cockayne 14 South Lynn Drive Eastbourne BN21 2JF 17th January 2014

17/01/2014 Bringing Services back to Eastbourne

Mr & Mrs D Bland

Dear Mr Dean

I write this email to express our concerns about the current state of healthcare to the people of Eastbourne with no Maternity and overnight paediatrics ward, and most recently emergency operations being moved to Hastings.

This is utter madness and have heard the conquest can't cope already, without babies being born on roadsides. It completely puts young children and babies lives at risk as my 5 year old granddaughter was unfortunate enough to experience at the weekend. My Wife & I waited over 5 hours for a doctor to ring us on Saturday morning, finally getting an appointment at the out of hours doctor service at 7.30pm in the evening, only to be told by the doctor on duty that my Daughter had a viral infection and sent them home with calpol.

She had in fact got pneumonia but that was not discovered until Mon evening 6th Jan after being admitted to EDGH on Monday afternoon by their GP feeling very poorly and came very close to being admitted and doing the ambulance journey over to the Conquest at 22.30 pm, causing much distress for my little daughter & my wife.

East Sussex and especially Eastbourne is rapidly growing with extensive building of homes with younger people moving in with young families as well as the usual large elderly population who are always in need of healthcare Services. The people of Eastbourne and Hastings needs all their health care services to remain at both hospital sites.

The transport over to the conquest is very inadequate, there is no main railway station nearby, not everyone can afford taxi fares, and not everyone has a car, whilst talking about cost, how costly is it to run the ambulance service that is in operation at the moment ferry patients to and from Eastbourne to Hastings.

Please please let us have our much needed services back in Eastbourne.

Yours sincerely

Darren Bland

22/01/2014 Comments to HOSC re: maternity and paediatric services

Sent: 22 January 2014 17:10
To: Health Scrutiny
Subject: Comments to HOSC re: maternity and paediatric services

I live in Ringmer, in Lewes District, and when my family have needed obstetric/gynae or paediatric secondary care or other acute services (all of which we have needed) we have always been able to use those provided by BSUHT. I thank the Lord for this excellent provision, and feel sorry for other residents living further east in East Sussex who have to rely on services offered by the neighbouring acute trust serving that part of the county.

Although a Ringmer or Lewes resident is roughly equi-distant in travel time between the acute maternity services offered at Brighton, Haywards Heath & Eastbourne, the great majority of pregnant mothers here prefer to use Haywards Heath if all seems well, Brighton if there is a serious concern.

A significant minority of local women have in the past used the Crowborough birthing centre. This used to be excellent, for the mothers it accepted, but now it is under the care of the acute trust the writing is on the wall.

The problems in the East Sussex acute trust can, in my view, be ascribed to penny-pinching management and a medical directorship that has considered it acceptable for most consultants to work normal working hours Mon-Fri only, so that the two thirds of antisocial hours are covered by cheap "middle grades". As this trust has been unable to persuade specialist trainees to work there (for entirely understandable reasons, based on the Trust's policies, from the ST perspective), so these "middle grades" have to be recruited from the medical mercenaries cruising the international scene. The current value of the pound, and shortages elsewhere, do not help. You get what you pay for. The only acceptable solution in my view is consultant-led care 24/7.

Given the greater social needs in the Hastings area, I would support options in which services were concentrated at the Conquest site. Whether the services provided on a single site will be good enough remains to be seen. However, this would have the beneficial side-effect of more women, especially in the Seaford-Alfriston-Uckfield areas of East Sussex, being likely to select on geographic grounds what I consider to be the better quality care available from BSUHT.

I would however strongly recommend that HOSC force the development of a network approach to healthcare provision covering the two Sussex counties, in which BSUHT was formally recognised as the lead organisation, and the other Sussex acute hospitals as its dependents, so that modern medical practices and 24/7 consultant-led care would be spread across the two counties.

Dr John Kay

(former non-executive director ESDW PCT; former associate dean, Brighton & Sussex Medical School; current chair, Ringmer parish council; but responding as an individual)

06/02/2014 Liz Walke Personal Statement

Real Life Yesterday 5th February 2014

Woke up and read the words.....*"Again I saw all the people who were mistreated here on earth. I saw their tears and that they had no one to comfort them. Cruel people had all the power, and there was no one to comfort those they hurt. I decided that the dead are better off than the living. But those who have never been born are better off still; they have not seen the evil that is done here on earth."* Thinking never so more true as we fight to save essential services at the DGH.

Coincidentally I am waiting for the arrival of two babies who were due 3rd and 4th February. These two women don't know each other but one is my niece and the other a friend who I met about 14 months ago. Both these women desperately wanted to give birth at Eastbourne DGH and live locally near the Town Centre, and less than two miles and within 5 minutes (driving time) of the hospital.

Interestingly both gave birth yesterday 5th February 2014. This is real life and very current. This is what choices our women, the women who want to give birth at EDGH, are going through and the subsequent result of a decision which has changed the whole experience of women giving birth in this area.

The first was expecting her third child and despite giving birth to her previous two children in the DGH was not able to 'choose' the DGH as she had previously had caesarean sections and was hoping for a VBAC (Vaginal Birth After Caesarean) delivery. Prior to the temporary change this had been possible. So despite a vain hope that consultant maternity services might have returned then being classed as a temporary change, she had to consider arrangements for her two other children, for an event which could happen anytime realistically in a four week period, being away from her small children much longer due to the distance to travel and additional related costs. If she had her baby by caesarean section or a vaginal delivery she would be away from her small children a significant length of time without contact – an unnecessary anxiety when previously a younger child could be brought in for a quick visit. In any case as I write this I don't know any of the details apart from, my friend had a daughter yesterday morning. I don't know how she coped with childcare or transport to and from Hastings or any of the practicalities but I do know the changes had caused her considerable anxiety and anger.

The second, my niece, was expecting her first child. Was she high or low risk? She was told low risk. However, getting increasingly anxious and concerned that should anything go wrong and then having to be transferred, she decided and planned to give birth in the Brighton hospital as she used to live there and didn't even know where the Conquest was. After talking with her midwife and others, she agreed to go to the EMU (Eastbourne Midwife-Led Unit) initially when she thought she was having contractions to confirm she was in labour. I do not know the full details but what I do know is that my niece was at the EMU yesterday at 2.30pm as she felt she was having strong contractions and unable to travel by car to Brighton as it was too painful to go that far. She decided to stay at EDGH to have her baby and was told that if there were any problems she would be transferred to the Conquest. I did not have direct contact with my niece but queried this with my brother-in-law as Brighton was only marginally further away and with 2 current incidents with road closures on the A259 between Bexhill and Hastings, it may even be quicker. Furthermore, she should have choice. In any case, the next we heard (7.30pm), she was transferred to Brighton as she was needing to have an epidural as although my niece was "pushing" the

baby wouldn't come out. We have had no further contact from my niece's husband as I write this (6.30am on 6th Feb) apart from when my brother-in-law phoned Brighton hospital at 10pm as my sister (and all) were increasingly anxious with no news. He was told baby had been born but rushed into Special Care with my sister and brother-in-law rushing out the door on one of the stormiest nights with gales and high winds driving over 25 miles to see their daughter and their grandchild! What if my sister had crashed on the way to the hospital? That would not be included in statistics about safety! My sister texted to say "baby in scbu" late last night, but nothing about my niece.

This is real life and would have been so much better if all had just been down the road. If they are willing, I would urge you to speak to these two women or for that matter any other women who would have given birth at EDGH since the changes or is due to give birth. They have had untold additional anxiety before the birth and during, not to mention risk.

With previously over 2000 babies being born at EDGH and only by optimistic standards aiming to have 500 births this year, a massive 1500 women are being put through the dilemma of additional travel and reduced choice not to mention risk of an accident on the way. How can this be safer? Closing the consultant-led unit at EDGH REDUCES CHOICE!

As an ordinary women and mother, and not some highly paid executive, I urge you not to forget real life. I have had 4 children, two of whom, I believe, would either have been severely damaged or dead had these changes been in force when I gave birth. Briefly my first almost died, as did I, due to insufficient staffing – I went into labour on News Years Day over 20 years ago and gave birth the following day. I am happy to give more detail separately. Then my fourth (due to my first birth) would not have been classed as low risk, so I would have had to travel to Hastings. I arrived at the delivery suite at EDGH at 6.50am and gave birth to my baby at 7.00am with the cord wrapped round his neck several times!

And then there's Paediatrics. Our children, very sick children, who cannot be discharged home as they are presumably too ill, are being transferred to Hastings when the unit closes. This EDGH childrens ward which had 15 beds is now just a day unit. I cannot mention how many women have contacted me with really traumatic experiences as a result, but again I will give you my own personal experience. My children appear to be extremely healthy and I have probably not visited our GP/ hospital in the 20 odd years more than 10 times each with any of them. However on one occasion one of my sons rushed into my bedroom in the middle of the night complaining that his brother was snoring loudly. When I went to investigate I found that he was not snoring and woke him. He was then sick and complained that he couldn't breathe. I could see that it seemed like there was a blockage but realised it was an emergency and woke my husband and all 6 of us rushed to the hospital less than 10 minutes away all the while seeing my sons lips turning blue and life ebbing away as he was trying to breathe. When we arrived at EDGH A&E during the night, there was no wait, my son and I were rushed through, me signing papers and answering questions, while my youngest son was being worked on, and my husband parking the car with the other three children. An hour later we were being asked if we wanted our son admitted or we could take him home now appearing perfectly fine and breathing normally! Of course we went home. It almost seemed like a bad dream, but here's my point, we did not have a minute to waste, not even to call 999 for an ambulance. If we had to have gone all the way to Hastings it is quite likely that the consequences would have been very different. Truly frightening but real life.

Again, I am sure you may have heard from some people who have experienced these 'temporary' changes. Please consider also that most people don't complain or say anything. There are many many more babies, children and families who have been affected by these changes. Please don't medicalise what is going on in real life. At the very least, please refer this decision to a truly independent panel via a referral from you to the Secretary of State for Health. We are seeing the consequences of a decision which should never have been made WITHOUT an independent review. Yes, there should have been immediate changes but not removal of services! Please don't make this change a permanent one without a referral.

07/02/2014 Re:- East Sussex Maternity & Paediatrics 2014

Mr Brian H Valentine.

MB, FRCS, FRCOG

Tel/Fax:- [REDACTED]

Mobile:- [REDACTED]

E mail:- [REDACTED]
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Wednesday 5 February 2014

East Sussex CC Health Overview & Scrutiny Committee. [HOSC]

East Sussex County Council,

County Hall,

St Anne's Crescent,

Lewes, BN7 1UE

Dear Sir,

Re:- East Sussex Maternity & Paediatrics 2014.

You have requested written comments on this subject for your meeting on 17th February 2014. Could I please make the following points.

1. This matter was scrutinised and decided upon by the Independent Reconfiguration Committee, [IRP] from whom the Secretary of State for Health, Mr Alan Johnson MP requested advice in 2008. The matter having been referred to him by your Committee after a public consultation on the matter.
2. The decision of Mr Johnson confirmed the IRP advice that single site obstetrics and paediatrics services were not considered safe because of the separation distance of Eastbourne DGH and Hastings Conquest Hospitals. The distance problem was also considered to be further adversely affected by the types of roads involved and their liability for further delays in travel times.
3. The report also suggested that there was not a list of 'choices' for the public to decide upon but more a list of 'options' which did not contain the choice of Obstetric Lead Maternity and Paediatric services being available on both sites. This meant that the consultation was not considered to be adequate as people at the extremes of the catchment area would be disadvantaged by a single site obstetric service according to which unit was chosen for that service. Locally provided services were also considered to be a basic tenant of the NHS mandate.

4. I assumed that decision, and the manner in which it was taken, would continue to be legally binding until such time as the Secretary of State deemed otherwise on behalf of Parliament or the decision was challenged in the Courts.

To the best of my knowledge neither of those actions has taken place so one can only assume that the original decision still remains legally in place.

I would submit that nothing has changed from 2008 and that the East Sussex Healthcare Trust failed to fulfil their duty, as stated in the report, that both units should be adequately staffed to provide equal safety for the mothers and children in the catchment area. Especially those situated at the margins of the area whose travelling to Hastings would be at least doubled from the West and North or vice versa from the East if Eastbourne had been chosen as the Obstetric Lead Unit [OLU] and paediatrics had also been centred there.

I would respectfully suggest that: -

1. The roads have not improved; indeed with congestion they are significantly worse.
2. The 6 options delivered by the CCG's are just that. They are not a full range of choices of all the possibilities upon which the public can make their wishes known for what they consider safer services. Generally the public have faith in the medical services they will receive when they reach a hospital, which they see as a haven of safety. Single siting of core and emergency services to one side or other of the catchment area therefore reduces the local accessibility and thus quick availability of medical care in those core services for marginal zones.
3. Even if we were not in a time of financial constraint, with considerable and increasing deprivation in both towns, nobody seems to have openly considered the problems of families, let alone emergency patients, travelling to a hospital in the other town. Taxi's are costly for short journeys, when 3 miles is charged at £10, and prohibitive for long journeys. Similarly buses run infrequently and when they do they take a couple of hours there being no non-stop services between the hospitals or towns. Again the costs are not insignificant for most families trying to visit sick children, spouses or relatives.

We are not living in a major city with fast roads & good reasonably priced and quick transport options. Neither are we living in a City where there are multiple hospitals but also fast link facilities, using emergency bus lanes etc between hospitals when some are curtailed in the services they supply and centralisation is a safe and feasible option. A rural location is just that and should not be considered the equal of a city location when trying to provide single site emergency services.

4. The ambulance services do not have an infinite capability and whilst they can give averaged times of transfer that does depend on availability of vehicles and staff able to work. Recently there have been numerous media reports of enforced delays through no inherent fault of the ambulance services or personnel. I would also add at least another 30 minutes to transfer times for uploading and unloading patients, and generally more in my experience before any form of treatment can begin.

Recently, as quoted in the Daily Mail on Feb 4th 2014, Prof Julian Savulescu and Prof Lachlan de Crespigny, an Oxford medical ethicist and Consultant Obstetrician and Gynaecologist warned about the risks of home births and the effect delays in transfer can have on the risks of death or a lifetime disability for the child. If you have a Midwifery Lead Unit [MLU] on one site then in effect you have provided a homebirth situation within a hospital confine there being no obstetric backup facilities. Transfers will occur, especially if

primiparous [first full term pregnancy] mothers are booked for confinement in an MLU. A thrice greater risk for first born babies has been suggested from a 2011 study.

5. The number of new homes due to be built on the Eastbourne side of the catchment area has been stated to be 1000. I expect a similar number are due to be built in Hastings. The 2 hospitals had previous problems coping with the number of admissions and closed their units on occasions. The old adage that you cannot pour a quart into a pint pot springs to mind and that will be even truer in the future when the catchment population expands around the 2 towns and mid Sussex. Each town was not given its own hospital without good reason and both functioned properly before their amalgamation.
6. I have read the Royal College of Obstetricians & Gynaecologists (RCOG) report with regret as these problems did not seem to occur when the unit had less qualified staff but a similar number of deliveries. I would suggest managerially induced changes to the staffing and working practices would seem a better option for the population than the pursuit of single siting of the OLU. I would contend that the Secretary of State and the IRP made the correct decision in 2008.

I write as a retired former Eastbourne Consultant Obstetrician & Gynaecologist. I trust I have not wasted your time in writing.

Yours sincerely,

Brian Valentine.

Comments about Crowborough Birthing Centre

05/01/2014 Closure of Crowborough Birthing Centre

From: Laura Clark [REDACTED]
Sent: 05 January 2014 22:00
To: Health Scrutiny
Subject: Closure of Crowborough Birthing Centre

Hi,

My second baby is due in just under three weeks and I have just found out that again Crowborough Birthing Centre has been closed without warning where I am due to give birth. Fortunately (I hope) the closure is only for one night this time around, but I find this whole situation incredibly stressful. Due to being a resident of Crowborough, I would need to make the trip to Eastbourne Midwifery Unit should Crowborough be closed. My labour was very quick last time and I am deeply concerned that I may not make it in time. The last three weeks of pregnancy are not a time for stress as I'm sure you can understand.

Ultimately, it is the unforeseen nature of this situation that is the most stressful - I do not know where I stand and I cannot properly plan for my labour in terms of getting to the right place and getting childcare for my first child when I do not know where it is I will be giving birth until I am actually in labour when I call Crowborough to find out if they are open or not.

Thank you for your time - I am sure I am not the only one with these sort of concerns!

Kind regards

Laura Clark

07/01/2014 Crowborough birthing unit

From: Hayley Watts [REDACTED]
Sent: 07 January 2014 14:19
To: Health Scrutiny
Subject: Crowborough birthing unit

I wanted to say how wonderful the birthing unit in crowborough is. I think its so important that it continues to be available to women.

I had my baby there in june 2013. I had to be transferred to hospital due to him being stuck. But I transferred back on his 2nd day. The care I got at cbu was outstanding. There were constantly highly experienced midwives around to help me learn about being a first time mum. The care was beyond anything that the hospital could provide.

I had trouble breastfeeding. The hospital team were too busy to spend much time with me. At cbu they watched me feed to check his latch and gave me advise on different positions for breast feeding. I would never have persevered if it wasnt for them. They helped me through day 3 blues and I would have been very depressed and overwhlemed if it wasnt for them.

They were also brilliant with my husband. He was a first time parent too and they had more time than the hospital to talk him through things and help him in his role. They had really flexible maternity check up appointment times even at weekends. My earlier surgery and hospital appointments were always at the latest 5.00pm in the week so he rarely made them. Involving a dad like this from the start encourages two parent family stable set ups in the long term. It reduced stress on our marriage in the early days as we weren't stuck on our own with a crying baby and no experience or help with what we should do.

Also the flexible hours meant I could ring in at any time night or day for help once I was discharged. I rang several times about breast feeding issues at times when no other health visitor or breast feeding clinic was open. No other such service was available.

I believe that the cbu unit helped grow and stabilise us as a new family in a way the hospital never could. A stable home life and confident parents reduces all kinds of problems later on: post natal depression, gp visits by mothers who dont have confidence in their abilities, demands on all ready busy health visiting/child care providers, breast feeding fall out rates, marriage stress and emotional problems in children and parents which has varied social impacts.

In short I believe a lot of ways to deal with problems is to be proactive and stop them developing in the first place. This is what cbu did for us and can for others. So I suggest we should have more of this kind of service not less. Not just for women to have choices, but for reducing problems and costs in the long term.

08/01/2014 Crowborough birth centre

From: Kim Hardy [REDACTED]
Sent: 08 January 2014 10:06
To: Health Scrutiny
Subject: Crowborough birth centre

Hello,

As a woman due to give birth in March I wanted to give you my views on Crowborough Birth Centre ahead of your meeting on the 10th.

I had my son at CBC in 2008 and had a truly fantastic experience. I am not the sort of person who could go into a hospital and feel relaxed or comfortable – something I consider to be incredibly important in birth. My home in 2008 was not suitable for home birth either, so that option was not available to us. Crowborough offered us the perfect solution, a home birth experience with the care and attention of specialist staff. I felt confident in the midwives and the entire team there and I was able to deliver my son with little fuss and was then looked after properly afterwards.

I feel this option needs to be available to women who don't want a hospital birth, home is not always an option. My confidence in hospital care has sadly been knocked over the years due to my own bad experiences, but I also hear similar things from others.

If CBC is not an option for me in March my options will be Brighton where I really don't want to go, and if that was busy, Haywards Heath – somewhere I refuse to go to because of past ill treatment. It is so important to keep centres like Crowborough open to offer this option to women who don't want to be pressured to go into hospital. I realise that it may not be the most economical option, but surely that could change if more women were aware of it. With my son, I had to seek it out myself – it wasn't promoted by my midwife in Newhaven.

Please consider this point – that there are few options for women who don't want a hospital birth in Sussex and this is a precious and valuable service. It is the care and professionalism that make Crowborough what it is. To hinder that will be to make the experience more like that of a hospital, where underfunded staff are under a huge amount of pressure and as a result the standards of care fall.

Thank you for the opportunity to contribute,

Kim Hardy

15/01/2014 Crowborough Birthing Centre Closure

Dear Sir or Madam,

I am very concerned that Crowborough Birthing Centre was closed **again** on Sunday 5th Jan until the morning of 6th Jan.

I am 37 weeks pregnant and as I am sure you can appreciate the uncertainty of not knowing if CBC will be open when I go into labour is unfair and stressful.

Surely closing CBC randomly leaves Crowborough hospital open to the possibility that pregnant women may turn up and end giving birth in the hospital car park or hallway because they do not have time to transfer to Pembury or Eastbourne, especially as women in labour often want to stay at home for as long as possible to help them stay calm and relaxed.

CBC is a fantastic facility and the people of Crowborough and the surrounding area appreciate its value. I think it is a terrible lapse in judgement that it is being considered for closure at all!

Crowborough Birthing Centre should not close.

I think that it would be better to transfer Crowborough Birthing Centre to the Tunbridge Wells NHS Trust as it would provide a more seamless care pathway for the women of the Northern Area of East Sussex. It would mean all the care is offered locally and if the need for transfer from CBC became necessary at any point in the pregnancy or labour then it would be to the nearest Trust which is convenient not only for the women but also their families. It would also mean that the woman's named midwife would be able to provide continuity of care throughout their pregnancy, which is line with Government recommendations.

Yours Sincerity

Karina Lindfield

Index of comments from members of the public

A

Access

Partner · 7

Visiting · 11, 14, 18, 19, 30, 36, 40

C

Clinical Commissioning Groups (CCGs) · 20, 23, 32, 33, 40

Conquest Hospital · 4, 6, 7, 9, 11, 12, 13, 15, 18, 19, 21, 22, 24, 25, 29, 30, 31, 32, 34, 35, 36

Consultation

2008 · 11, 22, 32, 33, 39

Choice · 15, 22, 36, 37, 39

Downgrade · 4

Options · 9, 32, 33, 35, 39, 40

Secretary of State · 33, 39

Single Site · 35

Crowborough Birthing Centre · 6, 16, 17, 22, 35, 42, 43, 44, 45

Change of providers · 45

E

East Sussex Healthcare NHS Trust (ESHT) · 11, 15, 17, 33, 35, 40

Eastbourne District General Hospital (DGH) · 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 22, 29, 31, 32, 34, 36, 39

M

Maternity · 4, 5, 6, 10, 11, 15, 16, 17, 18, 20, 21, 22, 23, 29, 30, 32, 33, 34, 35, 39, 43

Consultant-led · 30, 35

Obstetrics · 6, 32

P

Paediatric · 5, 10, 16, 17, 18, 20, 21, 22, 23, 29, 32, 33, 34, 35, 37, 39

S

Safety · 4, 6, 10, 13, 17, 32

Born Before Arrival (BBA) · 14

Staff · 6, 10, 16, 17, 18, 19, 21, 27, 28, 29, 33

Midwives · 7, 12, 13, 14, 30, 43

Understaffed · 7

Sustainability

Birth Rate · 17, 20

Population · 6, 17, 21, 22, 29, 30, 34, 41

Young Families · 34

T

Temporary Reconfiguration · 6, 10, 11, 12, 15, 17, 19, 21, 22, 23, 29, 30, 31, 32, 34, 36

Travel · 6, 18, 22, 35, 36, 40

Ambulance · 6, 7, 9, 12, 13, 16, 18, 21, 22, 24, 26, 27, 29, 30, 31, 32, 34, 37, 40

Journey · 6, 7, 9, 13, 19, 24, 26, 27

Transfer · 7, 17, 18, 19, 20, 22, 24, 25, 26, 29, 32, 40, 43, 45

Transport · 9, 24, 29, 31, 34