Agenda Item 4

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**17 February 2014**
By:	**Assistant Chief Executive**
Title of report:	***Better Beginnings* – maternity and paediatric services in East Sussex**
Purpose of report:	**To agree plans for HOSC to undertake a review of proposed changes to the provision of maternity and paediatric health services in East Sussex.**

RECOMMENDATION

HOSC is recommended to agree the overall timetable and key lines of enquiry for the review of maternity and paediatric services as outlined in this report.

1. Background

1.1 Since April 2013, the three East Sussex Clinical Commissioning Groups (CCGs) have been responsible for commissioning maternity and paediatric services to meet the needs of East Sussex residents. In July 2013, the CCGs launched a period of engagement about the future of maternity and paediatric services and the standards of care they should commission against. The CCGs' review and engagement programme is known as 'Better Beginnings': http://www.betterbeginnings-nhs.net/.

1.2 At its meeting of 20 January 2014, HOSC decided that the service change proposals set out by the CCGs constituted a 'substantial variation' to health service provision requiring statutory consultation with HOSC under health scrutiny legislation. HOSC agreed to undertake a detailed review of the proposals from February to June 2014 and to prepare a report and recommendations to put to the CCGs on 19 June 2014.

1.3 HOSC has published details of its review together with a call for comments and evidence from all interested parties. The HOSC website includes guidance for those wishing to submit comments and the deadlines for each part of its evidence gathering. The HOSC website can be found here: www.eastsussexhealth.org.

2 HOSC Review

2.1 Appendix 1 to this report contains the key lines of enquiry for the review agreed by HOSC on 20 January together with the list of witnesses from whom HOSC is asking for written and oral evidence. Witnesses include NHS representatives, clinicians and patient and public representatives.

2.2 Appendix 2 contains a report compiled by the CCGs which provides an initial response to HOSC's lines of enquiry.

2.3 The evidence pack at agenda item 5 contains all the written evidence received to date. The information is grouped under the following headings:

1) Evidence from national bodies and other published evidence
2) Evidence from the East Sussex Clinical Commissioning Groups (CCGs) including the *Better Beginnings* consultation document that sets out the options and the reasoning behind them.
3) Relevant media reports

4) Written evidence from campaign groups and other stakeholder groups and organisations
5) Comments from individual members of the public.

2.4 A further evidence pack will be available on 14 March for consideration at the HOSC meeting on 20 March.

3. HOSC timetable

Action	**Date**
HOSC: Taking written and oral evidence from witnesses	17 February 2014
Final deadline for receipt of any written evidence to be considered by HOSC	**12 March 2014**
HOSC: Taking written and oral evidence from witnesses	20 March 2014*
Evidence is considered and report drafted	March – June 2014
HOSC: Agrees its report and recommendations to submit to the CCGs	19 June 2014
HOSC receives the decision of the CCGs and decides whether it is in the best interests of the health services for the people of East Sussex	10 July 2014

* HOSC may wish to consider extending this meeting to include an afternoon session depending on the anticipated workload

4. Recommendation

4.1 HOSC is recommended to agree the overall timetable and key lines of enquiry for the review of maternity and paediatric services as outlined in this report.

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APPENDIX 1: HOSC lines of enquiry

Why the two-site (consultant-led maternity service) option is not included

1. The earlier IRP report (31 July 2008) recommended that "Consultant-led maternity, special care baby, inpatient gynaecology and related services must be retained on both sites". What action was undertaken to implement the IRP decision? What changed subsequently? Why can't there be two obstetric units?

2. What has been the impact of the £3.1m that was spent in addition to regular income in supporting the two-site configuration before the temporary changes were introduced in May 2013

3. What supporting evidence is there from national policy, Royal Colleges and the National Clinical Advisory Team (NCAT)?

4. Staffing, recruitment and training issues for small consultant-led maternity units:

    - Why do staffing models in West Sussex (or in other relevant areas) operate successfully and why could a model would not work in East Sussex?
    - Could the different staffing models could be considered as discussed in the 2008 IRP report?

5. What is the outcome of like-for-like comparisons with other Trusts that have small consultant-led units?

6. How is patient choice balanced against safety and resources?

7. What impact do the options being presented have on other services such as changes to surgical services?

Evidence from the temporary changes introduced by ESHT in May 2013

1. What is the evidence from before and after the temporary changes (locating consultant-led maternity services at Conquest) in May 2013 ensuring like-for-like data comparisons? In particular, what does the serious incident data (where the incident has resulted in death or permanent/serious harm) and analysis tell us?

2. What information can be gleaned from complaints and legal claims: trends and indications for maternity related clinical liability claims and general complaints data?

3. What does Born-Before-Arrival (BBA) data tell us?

    - Using relevant cases where the temporary reconfiguration was a relevant factor, and not cases that would have happened regardless of the clinical model.
    - Comparisons with other areas of the country.
    - Number of births that have taken place outside of a hospital due to transfers being required (where not already included in BBA figures).

Safety and sustainability of Midwife led units (MLUs)

1. What is the comparative safety record of stand-alone MLUs v. consultant-led units?
2. What are the pros and cons of co-located MLU and consultant-led services? / How safe is it having obstetric services on one site?
3. What are the factors that determine where consultant-led maternity services should best be located if they are to be limited to *either* Hastings or Eastbourne?
4. What factors affect the desirability of co-location with other services and other geographical factors?

5. What assurances would there be about the long-term sustainability of MLUs and the avoidance of sudden closures as recently seen at Crowborough?
6. Why the limit to two MLUs in East Sussex?

Safety and travel

1. To what extent do longer journey times (to different types of unit) and travel distances impact on health outcomes? What is done to mitigate the potential negative impact of a longer journey time?

2. Transfers from MLUs to consultant-led obstetric units (or to Special Care Baby Units SCBUs)

    - What is the rate of transfers of women after birth?
    - What is the average *waiting time* for transfer (and maximums and minimums)?
    - What are the relevant Royal College Standards?
    - How safe is it to transfer during labour?

3. Can the Ambulance Service meet the operational requirements of all the options? How long do transfers take? What performance standards are there in this area and are they being met?

4. Are there sufficient ambulances are equipped to transport newborn babies etc.?

5. Why can't medical staff travel between sites rather than making women and babies travel?

Demographic projections and assumptions

1. What assumptions are being made about anticipated future numbers of births in East Sussex and numbers of births by East Sussex residents? What historical data is available?

2. How are projected reductions in numbers of births in East Sussex reconciled with anticipated increases in school places needed in Eastbourne for example?

3. To what extent are the reduced projected numbers of births in East Sussex based on assumptions that women will choose Brighton, Haywards Heath or Pembury?

4. How accurate were the 2007 projections for birth numbers?

Crowborough Birthing Unit

1. What factors influence the decisions on the future of Crowborough Birthing Unit?

2. Sustainability of Crowborough birthing unit: how many times has Eastbourne/Crowborough MLUs been closed temporarily and why?

Financial viability

1. What is the relative financial viability of the different options?

2. Why money is not considered to be a motivating factor behind the proposed reconfiguration?

Witnesses/consultees/sources of written and oral evidence:

HOSC: 17 February 2014, 10:00 – 13:00

- Evidence Pack 1 – written evidence compiled to date (see agenda item 5)
- Save the DGH
- Hands off the Conquest –
- Richard Hallett: Co-chair of the East Sussex Maternity Services Liaison Committee (MSLC) also representing the Crowborough and North Wealden Focus Group
- Women's User Group at Crowborough Birthing Centre
- MPs and Councillors (if any wish to provide evidence)

Also in attendance

- ESHT
- CCGs

HOSC: 20 March 2014, 10:00 – written and oral evidence (to be agreed)

- CCGs
- ESHT
- NCAT
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Royal College of Midwives (RCM)
- Royal College of Paediatric and Child Health
- Trade unions
- Independent clinicians including: neonatal consultants / midwives
- Ambulance service
- ESCC Highways / economic development (road / travel issues)
- Healthwatch – evidence from the public 'question-time' events
- Public Health – clarification of demographic projections/impacts

APPENDIX 2

Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
High Weald Lewes Havens CCG

Report: *Better Beginnings:* The purpose of this report is to formally respond to the issues raised by the Health Overview and Scrutiny Committee at the meeting held on 10 January 2014 where the CCGs presented delivery options for maternity, inpatient paediatric and emergency gynaecology services.

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Date: 10 February 2014

SECTION 1: INTRODUCTION

1 Purpose of this report

1.1 On 11 December 2013, the three Clinical Commissioning Groups (CCGs) in East Sussex unanimously agreed six potential delivery options that they believe will enable the safe and sustainable delivery of maternity, inpatient paediatric and emergency gynaecology services.

1.2 The six options were presented to the East Sussex Health Overview and Scrutiny Committee (HOSC) on 10 January 2014. The HOSC decided that the six options constituted a substantial variation and it therefore agreed with the CCGs' plans for a period of formal public consultation. The *Better Beginnings* consultation was subsequently launched on 14 January and will run for 12 weeks until 08 April 2014.

1.3 During the HOSC meeting in public on 10 January, HOSC members asked for further clarification and information regarding some of the evidence supporting the six options. The purpose of this report is to formally respond to the issues raised.

2 Background

2.1 Throughout 2012, the NHS Sussex Together programme, where the commissioners and providers across East Sussex, West Sussex and Brighton and Hove worked together to improve care, reviewed maternity and paediatric services across Sussex as part of their programme of work. The resulting Clinical Consensus on the Evidence Base and the Case for Change[1] for

[1] NHS Sussex Collaborative, ' *Sussex Clinical Commissioning Groups' Report: The Clinical Case for Change for Intrapartum care and unscheduled care, emergency care and in-patient paediatric services in Sussex', (2013),* http://94.136.40.103/~betterbeginnings-nhs.net/wp-content/uploads/2014/01/Sussex_Clinical_Case_for_Change-FULL.pdf

Maternity and Paediatric services was developed and agreed by senior GP commissioners, consultants, midwives and other health professionals from across Sussex in July 2013.

2.2 The clinical consensus concluded that there was a pressing need to change maternity services at East Sussex Healthcare NHS Trust (ESHT) to ensure that patients using these services received high quality, safe and sustainable levels of care.

2.3 Although all provider Trusts had identified some difficulties with workforce pressures and meeting some of the agreed standards, the 'pressing need to change maternity services in ESHT' was recommended due to their particular pressures on doctors in training (middle grade staffing), medical trainee numbers and experience and the high number of serious incidents.

2.4 Following the publication of the Sussex-wide Clinical Case for Change, the CCGs in East Sussex have led a review of maternity and paediatric services in the county. This included an extensive programme of clinical and public engagement that commenced in July 2013.

2.5 In March 2013 East Sussex Healthcare NHS Trust (ESHT) took a decision to temporarily reconfigure its maternity and paediatric services on the grounds on patient safety; this was implemented in May 2013.

2.6 The Sussex review and resulting Clinical Case for Change were not related to the decision by East Sussex Healthcare NHS Trust. However, both the Sussex-wide work and the decision to temporarily reconfigure services reflect wider national and local challenges in securing solutions for maternity and paediatric services that offer patients safety, choice and sustainability.

2.7 The decision on how these services will be offered in the longer term is the responsibility of each of the three Clinical Commissioning Groups (CCGs) in East Sussex: Eastbourne, Hailsham and Seaford CCG; Hastings and Rother CCG; High Weald Lewes Havens CCG. All three CCGs share an ambition to ensure that patients receive high quality, safe and sustainable care through these services.

SECTION 2: RESPONSE TO HOSC LINES OF ENQUIRY

3 ***Line of enquiry: Why is the two-site (consultant-led maternity service) option not included? The earlier IRP report (31 July 2008) recommended that "Consultant-led maternity, special care baby, inpatient gynaecology and related services must be retained on both sites". What has changed?***

The 2008 Independent Review Panel (IRP): Background

3.1 The 2008 IRP stated two main reasons for not supporting the PCTs' proposals and these were:

1) 'The panel (does) did not consider the proposal (have) made a clear case for safer and more sustainable services.'

2) 'The proposals reduce accessibility compared with current service provision'.

3.2 Following the recommendations of the IRP, the PCTs and ESHT continued to ensure obstetric services were provided on both hospital sites and worked hard to implement a safe sustainable service. A range of planning mechanisms was established including a clinicians' forum and multi-professional, multi-organisational maternity services development group were established. This resulted in a revised maternity strategy and implementation plan that was approved by the boards of the PCTs and East Sussex Hospitals Trust (ESHT) in March 2010 and provided a framework through which an agreed service model could be implemented.

What happened as a result of the IRP 2008?

3.3 A number of actions and service improvements were made by the Trust as part of the implementation of the commissioner's Maternity Services Strategy. The key improvements that have been achieved include:

- The employment of an additional consultant obstetrician by ESHT in 2009, thus meeting the requirements for 40 hours consultant cover to each unit on both sites
- The employment of an additional 10.26 whole time equivalent (WTE) midwives by ESHT which met the Birth-rate Plus16 standard
- Direct access to midwifery services
- Developing specialist and additional support roles for midwives
- Establishing services for early pregnancy
- Ensuring a choice between consultant led care, midwifery led care and home birth

- Increased staffing establishment
- Providing simulation training for trainees
- Establishing and implementing RCOG guidelines for good practice
- Establishing care pathways for the assessment and treatment of maternal mental health
- Development of a telephone triage service for antenatal patients
- Achievement of Baby Friendly Initiative (BFI) level 2

3.4 In 2010/11, an additional premium payment above tariff was agreed by the commissioning PCTs with a sum of £3.1m invested in 2010/11 with a reduced top up in 2011/12 and 2012/13 as services were by then expected to be delivered in a sustained way within the tariff.

3.5 The NHS locally therefore worked hard to implement the recommendations and to maintain obstetric-led services at both the Conquest Hospital, Hastings and at the Eastbourne District General Hospital. Difficulties in recruiting and retaining the right staff remained and the safety and sustainability of the service became increasingly difficult to maintain.

4 What has changed?

4.1 In addition to the local action described above, there have been significant national drivers that are detailed in the pre-consultation business case (section 4). For ease of reference, some of this is included here below.

National Challenges

4.2 In 2004 the National Service Framework (NSF) for Children, Young People and Maternity Services set national standards[2] for the first time for children's health and social care. This promotes high quality, women and child-centred services and personalised care that meets the needs of parents, children and their families.

4.3 Nationally, commissioners and providers are facing an increasing challenge in responding to the changes in their patient populations, whilst striving to ensure improved standards of quality and safety are delivered within a time of financial austerity. Public expectation of services has increased and CCGs are working to ensure that these are realised in improved clinical outcomes.

Maternity

4.4 Excellent maternity care must be comprehensive and flexible to respond to the clinical and social needs of women and their families. For the majority of women, pregnancy and childbirth is a totally normal and uncomplicated experience. The service must also be able to respond appropriately to those

[2] Department of Health: National Service Framework for Children, Young People & Maternity Services Core Standards (2004) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199952/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Core_Standards.pdf

who may require highly specialised care for existing medical problems, social circumstances and any complications that may develop[3].

4.5 The Intercollegiate Report (2007)[4], which outlined minimum staffing and training requirements for midwives and doctors identified the:

- central role of midwives as autonomous practitioners of normal labour and birth, together with their role as partners with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated labours

- importance of team working, as well the respective roles of midwives, obstetricians, anaesthetists, paediatricians, support staff and managers, as part of the local maternity care team

- increased involvement of consultant obstetricians on the labour ward in the care of women with complex or complicated pregnancies and in the supervision and education of medical staff.

4.6 The Future Workforce in Obstetrics and Gynaecology report (2009)[5] recommended levels of senior doctor (consultant) presence on a maternity unit related to the number of births taking place.

4.7 It was recognised by the Royal College of Obstetricians and Gynaecologists (RCOG) *High Quality Women's Health care* (July 2011)[6] that:

- the demand for women's health services is increasing, coupled with increasing case complexity caused by changing demographic factors such as the increasing age of first-time mothers, obesity, multiple pregnancies and an increase in the number of women with existing comorbidities

- in addition, there are three further major challenges that will impact upon planning and provision of women's services: the Health and Social Care Bill 2011 (England), the Working Time Regulations (WTR) and related legislation and financial constraints

- **with the implications of the WTR and the likely reduction in trainee numbers within obstetrics, gynaecology and neonatology, careful consideration will need to be given to the need for the current number and configuration of delivery units, the majority of which remain within a hospital setting. It is likely that there will be an increase in the number of midwife-led units, which women will be able to use after validated risk assessment, ensuring patient choice where appropriate**

- whilst patient choice is supported in principle, there is a need to be mindful that choice has to be delivered in a realistic manner, balancing

[3] Royal College of Obstetricians & Gynaecologists: Standards for Maternity Care: Report of a Working Party (2008) *(http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRMaternityStandards2008.pdf)*
[4] Royal College of Obstetricians & Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, Royal College of Paediatrics and Child Health: Safer Childbirth: Minimum Standards for the Organisation & Delivery of Care in Labour (2007) *(http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf)*
[5] Royal College of Obstetricians and Gynaecologists: The Future Workforce in Obstetrics and Gynaecology (2009) *http://www.rcog.org.uk/files/rcog-corp/uploaded-files/Future_Workforce_web.pdf*
[6] Royal College of Obstetricians and Gynaecologists: Expert Advisory Group Report (July 2001): High Quality Women's Health Care: A proposal for change *http://www.rcog.org.uk/files/rcog-corp/HighQualityWomensHealthcareProposalforChange.pdf*

wants and needs with what is clinically safe and affordable and what resources can be made available without destabilising other services

- the way in which women's services are configured should support choice as a principle. Choice includes: choice over whether, where and when to seek care, choice of care or treatment offered, choice of appointment (date and time) and choice of hospital and/or doctor. This builds in the National Service Framework (2004) recommendations including the opportunity for women to have a normal birth wherever possible

- there is a need to think laterally about how services can be provided and by whom, as well as the input and role of the wider multi-professional team

- commissioners must build into contracts the requirement to deliver services and manage performance against national standards

4.8 In May 2012, the Government pledged[7] to improve maternity care by making sure:

- women will have one named midwife who will oversee their care during pregnancy and after they have had their baby

- every woman has one-to-one midwife care during labour and birth

- parents-to-be will get the best choice about where and how they give birth

4.9 In November 2013 the National Audit Office published a report from the Auditor General[8], 'Maternity Services in England'. The report identified a number of key findings which include:

- the level of consultant presence on labour wards has improved substantially but some Trusts are failing to meet recommended levels

- the number of midwives has increased but the NHS is not meeting a widely recognised benchmark of midwife staffing levels

- the Government has commissioned more training places but it is unclear whether these will be sufficient to meet future demand for maternity care

- the Department of Health did not fully consider the implications of delivering the ambitions set out in its strategy for maternity services. There are potential tensions between different elements of the strategy, such as between choice and quality-and safety considerations. Reconciling these different elements is challenging for NHS bodies.

- there is substantial variation between Trusts in the costs of delivering maternity care. Some instances where providing funding to support services that would not otherwise be financially viable were identified. It is hard to see that supporting unviable services in this way will be

[7] Department of Health (May 2012): Government pledges support for women with postnatal depression and improvements to maternity care *https://www.gov.uk/government/news/government-pledges-support-for-women-with-postnatal-depression-and-improvements-to-maternity-care*

[8] Maternity Services in England: Auditor General, National Audit Office .November 2013

sustainable as the NHS seeks to make efficiency savings during a period of greater financial constraint.

- efficiency, in terms of length of say, has improved in recent years but local bed occupancy levels vary significantly, and some smaller maternity units are unlikely to be viable in the long term unless occupancy is better managed.

4.10 Recommendations from the Auditor General include:

- **CCGs and Trusts should agree long term sustainable plans for the distribution and capacity of maternity services in their locality**

Paediatrics

4.11 The 2004 National Service Framework for Children, young people and maternity services recognised that overall children are healthier than ever before. This is primarily attributed to better access to healthcare, early intervention and surveillance along with significant developments in medication, treatments and technology. The outcome of this is that a dramatic reduction in paediatric admissions has been seen and a reduced length of stay for those who are admitted. Those children who are admitted are likely to be acutely unwell and they will require a greater level of medical and nursing intervention. It is therefore imperative that CCGs create a healthcare system that ensures that staff with the right skills and expertise are available to treat patients and that commissioned services are safe and sustainable.

4.12 In the last ten years there have been a number of reports that have highlighted concerns about the sustainability of the paediatric workforce across the country. They have highlighted the impact of child heath, the decrease in demand for in-patient admission and the changes in training requirements of the paediatric medical workforce. The Royal College of Paediatrics and Child Health (RCPCH) recognised in 2011[9] that the current UK paediatric workforce (both consultants and trainees) is facing huge pressures. The harsh reality is that it is impossible to do all of the following:

- staff in a safe and sustainable way all of the inpatient paediatric rotas that currently exist

- comply with the WTR

- continue with the present numbers of consultants and trainees

4.13 The report proposed that:

- to staff all of the UK's inpatient paediatric units with appropriate numbers of doctors at each tier of service, in a safe and sustainable way, comply with the WTR and relate trainee numbers to consultant opportunities, significant change will be required in a structured manner

- all acute general paediatric services meet ten minimum standards of care

[9] Royal College of Paediatrics & Child Health: Facing the Future: A Review of Paediatric Services (2011) www.rcpch.ac.uk/facingthefuture

- in order to deliver safe and sustainable services for children and young people, the NHS needs to:

  - **reduce the number of inpatient sites**
  - **increase the number of consultants**
  - **increase the number of registered children's nurses**
  - **expand the number of GPs trained in paediatrics**
  - **decrease the number of paediatric trainees**

4.14 The RCPCH (2012) Standards for Children and Young People in Emergency Care Settings[10] acknowledged the challenges of ever increasing attendances at emergency and urgent care settings. The standards also acknowledged the impact of the European Working Time Directive (EWTD) on availability of staff and increased public expectation of immediate access to care, which all require service planners to take a renewed approach to emergency healthcare. The 2012 standards provide clear standards of care applicable to all urgent and emergency care settings across the UK designed to improve the experience and outcomes of children and young people in their journey through the urgent and emergency care system. The aim of providing expert help as early as possible in a child's illness, in order to improve clinical outcomes, has to be balanced by the importance of accessible services as close as possible to home. This requires service planners, commissioners and providers to work together to assess need, clarify the roles of different access points, define patients who should be referred to larger, more specialist centres, and identify staff able to take these decisions.

4.15 The Department of Health set out its ambitions[11] in 2013 to give children the best start in life. As a result the NHS Outcomes Framework sets out standards for the time from first NHS presentation to diagnosis or start of treatment, integrated care and transition.

4.16 A review (March 2013)[12] for NHS South of England on Urgent and Emergency Care services identified the challenges faced by the growing demand for urgent care for children as well as adults, with an increased admission rate of 28% for children and a rise in common infections. The report recommends that in order to address the pressures on children's urgent care services the following should be conducted:

- an evaluation of GP access
- a review of GP skill mix and ensuring paediatric primary care is available at a high standard
- a review of the appropriateness and availability of paediatric cover in hospital

4.17 The Royal College of Nursing (RCN) reported (2013)[13] that there have been numerous public inquiries that have highlighted key issues related to the

[10] Royal College of Paediatrics & Child Health: Standards for Children & Young People in Emergency Care Settings (2012) *http://www.rcpch.ac.uk/emergencycare*
[11] Department of Health: Improving Children & Young People's Health Outcomes: a system wide response (Feb 2013) *https://www.gov.uk/government/news/new-national-pledge-to-improve-children-s-health-and-reduce-child-deaths*
[12] The King's Fund (2013): Urgent and Emergency Care: A review for NHS South of England *http://www.hsj.co.uk/Journals/2013/05/02/z/d/s/Kings-Fund-report-urgent-and-emergency-care.pdf*
[13] Royal College of Nursing: Defining Staffing Levels for Children & Young People's Services (2013) *http://www.rcn.org.uk/__data/assets/pdf_file/0004/78592/002172.pdf*

impact of inadequate nurse staffing levels or an inappropriate mix of skills. Most recently the Francis Inquiry highlighted the need for staffing levels to be appropriate and for all staff to be properly educated, trained and regulated to meet the needs of patients. The guidance and standards apply to all areas in which infants, children and young people receive care, as well as across all types of services and provision commissioned by the NHS including the acute and community, as well as third sector and independent sector providers. The standards are the minimum essential requirements for all providers of services for babies, children and young people.

4.18 This reflects national trends that have become increasing apparent over the last few years due to a number of factors. The Royal College of Paediatric and Child Health (RCPCH) (2012) Standards for Children and Young People in Emergency Care Settings[14] acknowledged the challenges of ever increasing attendances at emergency and urgent care settings. The standards also acknowledged the impact of the European Working Time Directive (EWTD) on availability of staff and increased public expectation of immediate access to care, which all require service planners to take a renewed approach to emergency healthcare. Women's health cases are also increasingly complex caused by changing demographic factors such as the increasing age of first-time mothers, obesity, multiple pregnancies and an increase in the number of women with existing co-morbidities

The Staffing, recruitment and training issues for small consultant-led maternity units and comparison with other hospitals

4.19 Senior CCG members including lead GPs have spoken with heads of midwifery and clinical directors at other smaller obstetric units of similar birthing numbers, approximately 2000 and under, in England (quoted births figures are 'Total Deliveries 2012' as taken from the RCOG census report 2012[15]).

- North Devon Healthcare NHS Trust
  - North Devon District Hospital (1684 total deliveries, 2012)

- York Teaching Hospital NHS Foundation Trust
  - Scarborough Hospital (1660 total deliveries, 2012)
  - The York Hospital (3300 total deliveries, 2012)

- East Cheshire Hospitals NHS Foundation Trust
  - Macclesfield District General Hospital (2000 total deliveries, 2012)

- Wye Valley NHS Trust
  - The County Hospital (1995 total deliveries, 2012)

- Yeovil District Hospital NHS Foundation Trust
  - Yeovil District Hospital (1600 total deliveries, 2012)

- North Cumbria University Hospitals NHS Trust
  - Cumberland Infirmary (1900 total deliveries, 2012)

[14] Royal College of Paediatrics & Child Health: Standards for Children & Young People in Emergency Care Settings (2012) *http://www.rcpch.ac.uk/emergencycare*
[15] Royal College of Obstetricians and Gynaecologists, *Workforce Census Report 2012,* (August 2013), http://www.rcog.org.uk/files/rcog-corp/Census%20Report%202012%20-%20Final%20(2).pdf

- West Cumberland Hospital (1470 total deliveries, 2012)

4.20 The CCGs wished to understand the ways in which other smaller units are currently delivering maternity services and to understand any issues or challenges that they are facing. The CCGs also wished to explore whether there were any innovative practices within these smaller units that might be incorporated into delivery of services in East Sussex, thereby enabling two smaller obstetric units to be safe and sustainable.

4.21 The CCGs also visited the Hinchingbrooke Hospital (2,573 total deliveries, 2012), maternity unit in Cambridgeshire. Hinchingbrooke is currently exploring the possibility of increasing activity in order to maintain financial sustainability within the new PBR tariff, ideally moving towards 3,100- 4,000 births per annum.

4.22 The discussions with other smaller units also illustrated the difficulties that were faced nationally, in particular in relation to the recruitment and retention of middle grade staff.

4.23 Smaller units were providing an average of 40 hours of consultant presence per week on the labour ward. The agreed model of care for East Sussex aspires to a minimum of 60 hours of consultant presence which is an important standard that would improve outcomes for women and babies and training for staff.

4.24 Whilst the smaller units contacted by the CCGs were not reporting the same increase in serious incidents as East Sussex, some reported difficulties in recruitment of medical staff and capacity issues brought about by workforce pressures, which for some units across the country lead to the temporary suspension of community services or diverts of women to another hospital.

4.25 In addition to workforce pressures, some other smaller units also noted that it was difficult to deliver a service in a financially sustainable way.

4.26 The CCGs also reviewed the outcome of a similar piece of work recently carried out by Hambleton, Richmondshire and Whitby CCG (HRWCCG) and found that the outcomes of both reviews were aligned with findings reported nationally.

4.27 The following is a direct quote from the HRWCCG's pre-consultation business case: The findings of their review illustrate that "many (small maternity units) are having to consider their future contingency plans – with an emphasis of recruitment of non-training grade staff, the future supply of which is very uncertain; that the future operation of many of these units is problematic. For example, Doncaster and Bassetlaw (4,000 and 1,600 total deliveries, 2012, respectively) has undergone reviews of its paediatric and obstetric services and there is still discussion going on about future service models for Bassetlaw. Furness General Hospital (1,300 total deliveries, 2012) has had a difficult time in respect of its services and is undergoing review as to the future delivery of both paediatric and obstetric services; Western Isles (total deliveries, unknown) is considering changes to a midwifery led unit and Withybush (1,365 total deliveries, 2012) is engaging on changes to its services". These findings were in line with the findings of the East Sussex review of smaller units in England.

Further evidence from external sources that supported the single siting of maternity and paediatric services

4.28 Detailed below are key external sources, fuller details can be found in the pre-consultation business case.

4.29 **Royal College of Paediatric and Child Health, 2013**: "New models of service and ways of working are urgently required to be implemented and the College must work with colleagues across the child health spectrum including general practice staff, surgeons and anaesthetists, nurses, allied health professionals and in Child and Adolescent Mental Health Services (CAMHS). This is in order to ensure the right staff with appropriate competencies are in the right place to deliver sustainable and safe services, and that reconfiguration continues to concentrate general and specialist inpatient services on fewer sites in clinical network arrangements, whilst ensuring that local services meet the majority of the needs of the child health population."[16]

4.30 **National Clinical Advisory Team, 2013**: In their January 2013 report regarding ESHT, NCAT recommended "That maternity and paediatric in-patient care be located onto one site as a matter of urgency"[17].

4.31 **South East Coast Strategic Clinical Network, 2013:** When asked if the strategic clinical network (MCYP SCN) agrees that dual siting of obstetrics in East Sussex should be excluded as an option, they reported "The MCYP SCN supports this statement and agrees that the dual siting of two obstetric led units in East Sussex would not be justified given the level of birth activity identified in 2011-13[18].

4.32 **Royal College of Obstetricians, 2013:** "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"[19].

5 *Line of enquiry: Choice Issues*

5.1 The East Sussex agreed models of care for maternity state that "Women should be given a choice of where to give birth. This might include a consultant led unit, a co-located midwife led unit, a free-standing midwife led unit or a home birth". The six options proposed by the three East Sussex CCGs ensure that these choices are available to local women. Previously,

[16] Royal College of Paediatric and Child Health, *"RCPCH Medical Workforce Census 2011",* (June 2013), p.11, http://www.rcpch.ac.uk/system/files/protected/page/RCPCH%20census%20FINAL_0.pdf
[17] National Clinical Advisory Team (NCAT), *"Review of proposals to change the configuration of maternity, gynaecology and paediatric services of the East Sussex Healthcare Trust",* (4 January 2013), http://94.136.40.103/~betterbeginnings-nhs.net/wp-content/uploads/2014/01/PCBC-Appendix-2-National-Clinical-Advisory-Team-NCAT-Review-January-2013.pdf
[18] South East Coast Strategic Clinical Network, *"A request to the Maternity, Children and Young People Strategic Clinical Network for advice on proposed delivery options for maternity and paediatric services in East Sussex",* (December 2013), http://94.136.40.103/~betterbeginnings-nhs.net/wp-content/uploads/2014/01/PCBC-Appendix-6-Advice-from-the-Maternity-Children-and-Young-People-Strategic.pdf
[19] Royal College of Obstetricians and Gynaecologists, *"Review of the Obstetric and Neonatal Services of East Sussex Healthcare Trust at Conquest Hospital",* (August 2013), p.98, http://www.esht.nhs.uk/about-us/meetings/?assetdet7171406=504609

women wishing to use a maternity led unit needed to travel to Crowborough or out of county. Current proposals are to introduce a second midwifery led unit into the county and the CCGs are consulting with the public as to where they should be sited. Also included in the proposals are options including a co-located obstetric and midwifery unit. Many women have stated that this would their preferred place of birth, but this has so far been unavailable within East Sussex. The option for obstetric led birth and home birth will continue to be provided in all options.

5.2 It is acknowledged that for some women and families, the experience of travelling further to a single sited service than they may have been used to can present difficulties. As such, opportunities for lessening any impact have been fully explored through early engagement discussions. The CCGs wish to signal a clear intention to ensure services are commissioned that expand patients access to local services where possible, for example through careful consideration of opening hours of paediatric assessment units , through the offer of choice of birth settings and through informing our wider work looking at enhancing community maternity and paediatric provision as we move forward.

6 *Line of enquiry: Evidence from the temporary changes introduced by ESHT in May 2013*

- *Serious Incidents Data*

6.1 Since the temporary single siting of services, there has been a reduction in the number of serious incidents, which can be seen in section 7 (from paragraph 7.8) of the pre-consultation business case[20] and in the tables below. At the request of HOSC, the full year figures for 2012 and 2013 have been included. It is important to note that the figures for October to December 2013 have yet to be validated; the reporting, investigation and scrutiny process for incidents means that some incidents may be downgraded following completion of investigation.

January 2012 to December 2012

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
1	0	0	0	0	0	0	2	2	0	1	1

January 2013 to December 2013

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
6	2	1	3	0	2	0	1	0	0	1	0

**Source: STEIS National Database and ESHT Maternity Dashboard*

6.2 Further information regarding serious incidents and other quality indicators will be published in a CCG report in February 2014. The document will report on the quality and safety outcomes, following six months of reviewing the quality indicators since the temporary changes and will build on the report which was published by the CCGs after three months of review.

[20] *Better Beginnings* pre-consultation business case, (2013), http://www.betterbeginnings-nhs.net/wp-content/uploads/2014/01/PCBC_-_FINAL_AGREED.pdf

7 *Line of enquiry: Evidence from the temporary changes introduced by EHST in May 2013*

- ***Complaints and Legal Claims***

7.1 Data and trends regarding complaints will be submitted to the HOSC by ESHT under separate cover.

7.2 The number of legal claims will be submitted to the HOSC by ESHT under separate cover, however it should be noted that these will be unlikely to yield comparable figures due to the length of time required to process a legal claim, which can sometimes be over a year.

8 *Line of enquiry: Evidence from the temporary changes introduced by EHST in May 2013*

- ***Born Before Arrival (BBAs)***

8.1 In addition to the evidence contained within the pre-consultation business case and the consultation document, further information can also be found in the "Maternity and Paediatric Services Review: 3 months following the interim change"[8] report. An updated report will be published by the CCGs in February 2014.

8.2 Since May 2007, no babies have been born in an ambulance.

8.3 The table below shows the numbers of BBAs for the calendar years 2012 and 2013.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2012	3	4	3	1	6	4	3	2	2	5	3	5	**41**
2013	3	4	1	7	4	6	4	3	4	2	3	2	**43**

9 *Line of enquiry: Safety and sustainability of Midwife Led Units*

- ***The safety of standalone MLUs v consultant led units***
- ***The pros and cons of standalone MLUs v consultant led units***

9.1 All pregnancies are proactively risk managed for the duration of the pregnancy, to ensure the most appropriate level of care is planned for all expectant women. This is an essential and normal part of midwifery care that ensures women are able to safely choose a setting of care for their delivery.

9.2 Further details regarding the comparison of standalone MLUs and collocated MLUs can be found in the Birthplace Programme Overview, November 2011[21].

[21] HOSC evidence reference 1.2

10 *Line of enquiry: Arguments for consultant-led maternity services to be located at either Hastings or Eastbourne, factors affecting desirability of co-location with other services and other geographical factors*

10.1 The CCGs in East Sussex are currently leading a public consultation. Part of this will help governing body members to understand public views on location of services as well as what is important to local people in considering this. Following the close of consultation, the CCGs will meet in public to make their decisions and each CCG will separately record the decision they have made.

10.2 The decision will be informed by a range of information including:

- 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).
- The equality analysis

10.3 Many services will continue to be provided on both sites, including: Maternity Day Assessment Unit; Antenatal Clinic; Ultrasound; Early Pregnancy Unit; Paediatric Outpatients; Gynaecology Outpatients; Paediatric Day Surgery; Gynaecology Day Surgery. Community services are also outside of this review and will therefore also continue to be provided.

11 *Line of enquiry: Assurances of long-term sustainability and sudden closures of MLUs*

11.1 Each of the six options has been developed by commissioners, with input from providers, who agree that all options are both deliverable and sustainable. The CCGs believe that the proposed options will result in fewer unplanned closures of any midwife led unit and are working with ESHT to understand the staffing model that will support this.

12 *Line of enquiry: Safety and travel*

- ***The extent to which longer journey times (to different types of units) and travel distances impact on health outcomes. What is done to mitigate potential negative impact of a longer journey time?***

12.1 There have been no adverse outcomes as a result of temporarily single siting services, since May 2013.

12.2 Of the serious incidents that have occurred since May 2013, further travelling distance has not been identified in the Root Cause Analyses and has not been a contributing factor.

12.3 In addition to this, several public engagement events and activities were carried out prior to the consultation to understand what might be put in place to ease the difficulty of members of the public who may need to travel further.

12.4 Two reports were produced following these activities and can be found under appendices 3 and 4 of the pre-consultation business case[22].

13 *Line of enquiry: Safety and Travel*

- ***Transfers from MLUs to consultant led obstetric units (or SCBU)***

13.1 All women choosing to give birth at any MLU will discuss the possibility of a transfer during or after labour with their midwives and robust plans are in place to ensure that these transfers happen safely. Transfers from an MLU to a Consultant led unit are a routine and safe part of maternity care. Rates in East Sussex are in line with the national average.

13.2 All South East Coast Ambulance Service NHS Foundation Trust (SECAmb) ambulances are equipped to standard level. In the event that a baby requires transfer from a midwife led unit to an obstetric unit, 'baby pods' (a kind of mobile incubator) are provided to the ambulance crew by the midwife led unit. There are currently two baby-pods at Eastbourne and one at Crowborough. Should mother and baby both require transfer for clinical reasons, two ambulances are dispatched. (Only a stretcher or a baby-pod can fit in an ambulance). Should a mother require transfer for clinical reasons, but baby is stable, the mother will be transferred by ambulance with the baby travelling by car-seat, either in the ambulance or in a family member's car, as appropriate. This is a considerable improvement to safety of services, when women on stretchers were required to hold their baby on their stomach during transfer. Babies requiring transfer to a Neonatal Intensive Care Unit (NICU) are transferred using the dedicated neonatal service.

14 *Line of enquiry: Safety and Travel*

- ***Is the ambulance service satisfied that it can meet the operational requirements of the options?***

14.1 The six options have been shared with SECAmb who are continuing to engage with the CCGs and with ESHT. SECAmb will submit a formal response to commissioners as part of the consultation. It has been established that SECAmb can support the delivery options; they have a proven track record of delivery across their geographical catchment and across a range of different clinical specialties. Where there may be resourcing implications for SECAmb, dependent upon the final agreed delivery option, this will be addressed through NHS commissioning arrangements.

[22] HOSC Ref - New

15 *Line of enquiry: Demographic projections and assumptions*

15.1 Demographic projections and assumptions can be found in Appendix 12 of the pre-consultation business case[23].

16 *Line of enquiry: Crowborough Birthing Unit (Future Sustainability)*

16.1 The current number of births suggests that there is enough activity to sustain two midwife led units in East Sussex. All of the options, four of which include maternity services at Crowborough, are agreed as deliverable and sustainable.

17 *Line of enquiry: Financial Viability - Why is money not considered to be a motivating factor behind the proposed reconfiguration?*

17.1 The paramount reason for these changes is to ensure that services are safe and of high quality, following serious safety concerns prior to the temporary measures which are detailed in the pre-consultation business case and in the consultation document. Whilst it is recognised that there will be different costs for each option, this is not the driving factor for this consultation.

[23] HOSC reference – health needs analysis