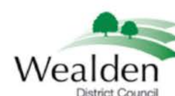
healthscrutiny east sussex

Better Beginnings

HOSC evidence pack 2

20th March 2014



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1. Evidence from campaign groups and stakeholder groups

A Submission

to

East Sussex County Council

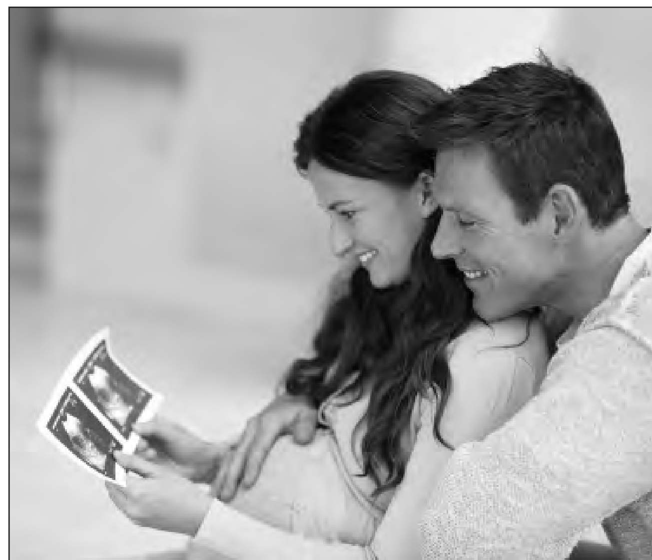
Health Overview & Scrutiny Committee

on

Maternity Services
in the
High Weald Locality

Not where...

...but how & by whom?



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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?

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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.

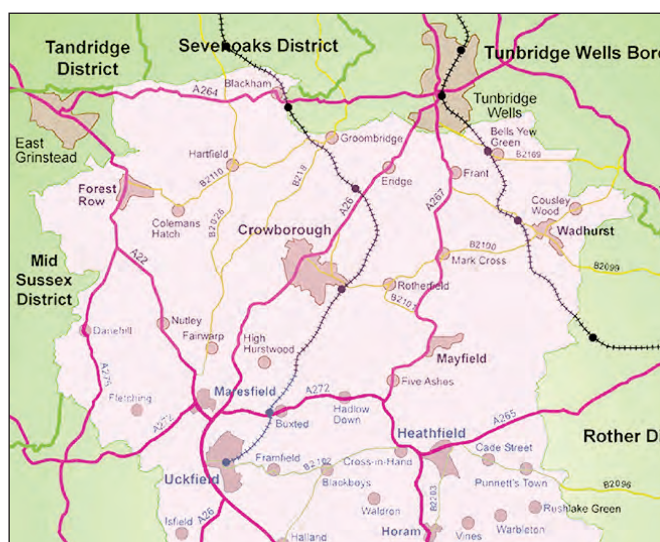
There were temporary closures of the Crowborough Birth Centre in November and December 2013 due to staff shortages at the obstetric unit at Conquest Hospital in Hastings. These closures attracted local media attention and appear to have significantly undermined local women's confidence in booking at 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.

The midwife team based at Crowborough Birth Centre care for around 800 pregnant women every year

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 are in reality the smaller part of the midwife workload

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.

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

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.

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.

The AA route planner recommended quickest route from Crowborough Birth Centre to Conquest Hospital directs the traveller via Pembury

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].

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2 High Weald Maternity

The current public consultation, when applied to High Weald, totally misses the real maternity issues and the main concern of local women

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.

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.

Only 6% of women in High Weald now use the obstetric unit at Hastings for the birth of their baby

In the six months from July to December 2013 only 6% of women in High Weald used the obstetric unit at Hastings for the birth of their baby. Women are voting with their feet away from booking at the Crowborough Birth Centre to avoid being sent to the South Coast for their maternity scans, and to avoid the risk of being referred within ESHT to consultant care at Hastings.

By default, Pembury has become a major provider of maternity care for High Weald women

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.

In the event of complications during labour at Crowborough, an urgent transfer will almost always be to Pembury

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.

High Weald women receive disjointed maternity care

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.

This is not a seamless, flexible care pathway, especially as regards continuity of midwife care

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.*

I'd like my partner to be with me, but Eastbourne is too far and takes too long for that.

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*

So if I still really want to birth at Crowborough and have a local scan I'll have to pretend?

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

The motivating factor for women choosing to book at Pembury is access to scans

"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,

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

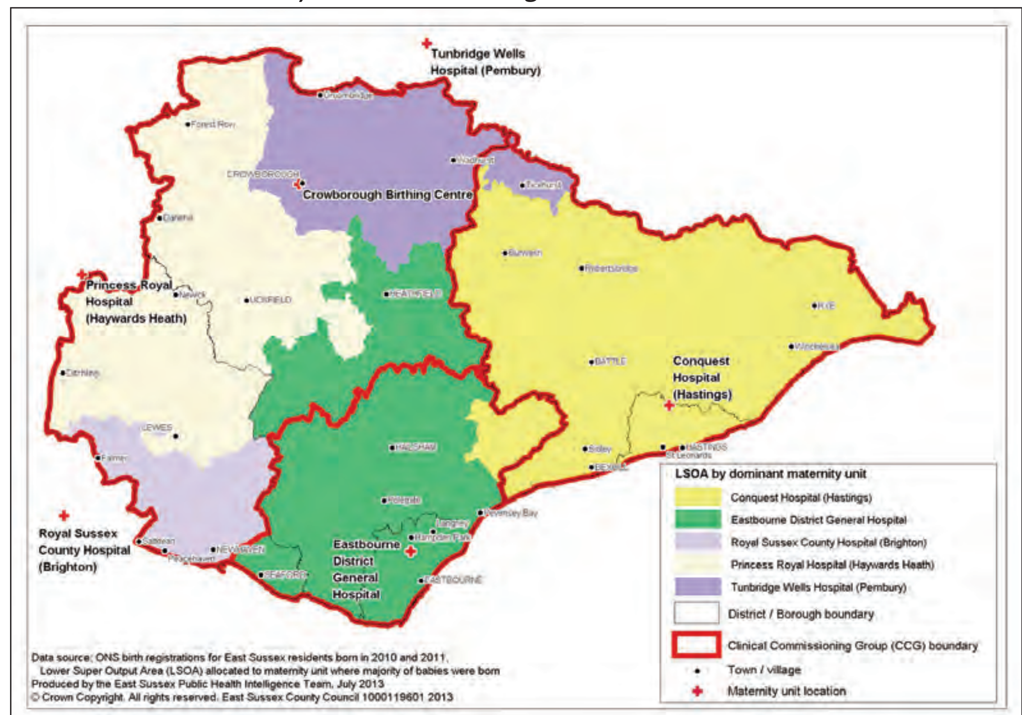
Section 2.3 revised by Richard Hallett, March 2014.

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.

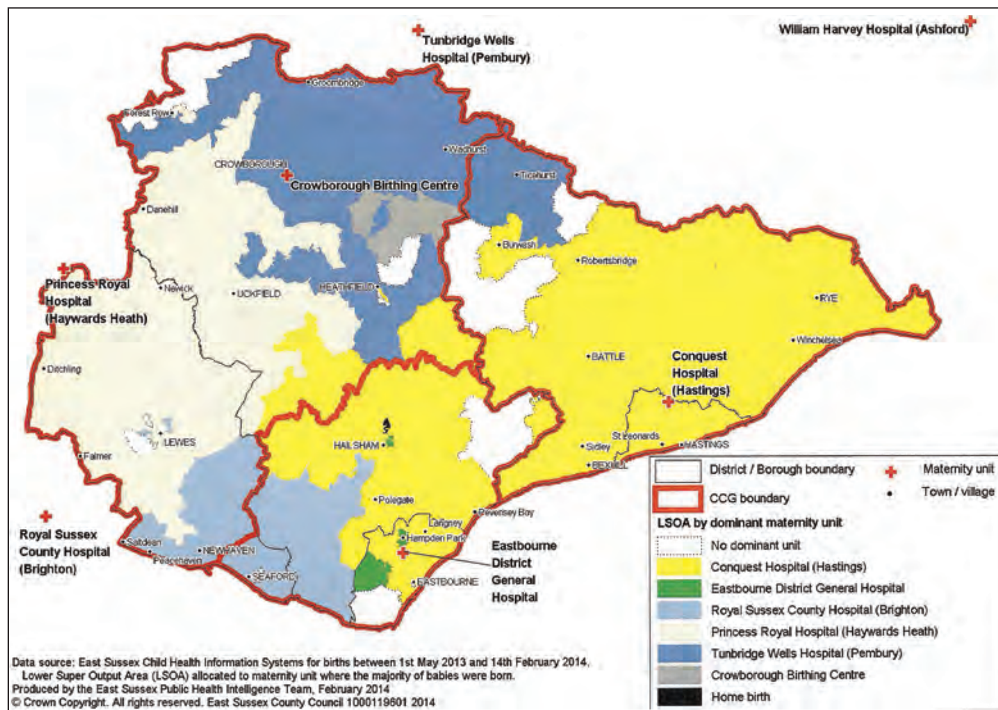
This map fails to take into account changes in 2013 which have had a significant impact on maternity in High Weald

Figure 25: East Sussex Lower Super Output Areas by dominant maternity unit for births registered in 2010 and 2011



Using more recent data available from July – December 2013, this mapping has been updated to show the maternity provider dominance with the single site obstetric unit located at Hastings (ie: as currently exists under the temporary emergency arrangements & would exist under Consultation Option 6 conditions) as follows:

East Sussex Lower Super Output Areas by dominant maternity unit for birth registered July - December 2013



There is negligible use of the Hastings obstetric unit by women in High Weald. Only 6% of women in High Weald use it for the birth of their baby

This revised map shows that with a single obstetric site at Hastings there is negligible use of the Hastings obstetric unit facilities by women in High Weald. The provision of an alongside midwife-led unit in Hastings will have no impact in High Weald. There is therefore no rationale to shape proposals for High Weald maternity on the basis of the local configuration of maternity care at Hastings (i.e. with an alongside midwife-led unit or not).

There is no rationale to shape proposals for High Weald maternity on the basis of the local configuration of maternity care at Hastings

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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]*

There is a prejudicial exclusion of a clearly viable alternative maternity arrangement that could bring significant benefit within High Weald

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.

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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

The current arrangement for Maternity in High Weald fails on all these three criteria.

However, the current arrangement for Maternity in High Weald fails on all 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.

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

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.

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

Author Richard Hallett MBE

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East Sussex Healthcare NHS Trust

Date of Meeting:	29th January 2014
Meeting:	Trust Board
Agenda item:	6
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Company Secretary

Action: This paper is for **(please tick)**					
Assurance	√	Approval		Decision	

Purpose:

Attached is the updated Board Assurance Framework (BAF) which brings together the strategic priorities and objectives of the organisation, with an assessment of their risks, the controls in place and details of the internal and external assurance along with associated actions.

Introduction:

Risks to achieving the Trust's strategic objectives were reviewed and agreed by the Board at a Risk Seminar as follows:

- We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies

- We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.

- There is a lack of leadership capability and capacity to lead ongoing performance improvement and build a high performing organisation.

- We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.

- We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.

- We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.

- We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.

- We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.

- We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.

- We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.

- We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change

The Assurance Framework has been reviewed and updated since the last meeting of the Trust Board. There are clear actions against identified gaps in control and assurance and these are individually RAG rated and any changes are marked. Updates are provided in red italics.

All items on the Trust Board agenda are reviewed to ensure they are aligned to the Trust's strategic objectives and risks outlined on the Assurance Framework.

Analysis of Key Issues and Discussion Points Raised by the Report:

The Trust Board is asked to consider whether the main inherent/residual risks have been identified and that controls are appropriate to manage and mitigate the risks. Updates and revisions are shown in red.

Benefits:

Identifying the principle strategic risks to the organisation provides assurance to the Trust Board that these risks are effectively controlled and mitigated which supports the Trust in achieving its strategic aims and objectives.

Risks and Implications

Failure to identify and monitor the strategic risks to the organisation will lead to an inability to demonstrate effective systems of internal control and an increase in the likelihood of adverse outcomes for the Trust.

Assurance Provided:

The BAF identifies the principle strategic risks to achieving the Trust's aims and objectives and the gaps in controls and assurance and subsequent actions being taken to mitigate these.

Review by other Committees/Groups (please state name and date):

Audit Committee – 8th January 2014
Quality and Standards – 7th January 2014

Proposals and/or Recommendations

The Trust Board is asked to review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified with any gaps in assurance or control and that actions are appropriate to manage the risks.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)

What risk to Equality & Human Rights (if any) has been identified from the impact assessment?

None identified.

For further information or for any enquiries relating to this report please contact:

Name:	Contact details:
Lynette Wells, Company Secretary	Lynette.wells@esht.nhs.uk

BOARD ASSURANCE FRAMEWORK

Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	RAG
What control/systems we have in place to assist in securing delivery of our objective	*Where we can gain evidence that our controls/systems, on which we are placing reliance are effective*	*We have evidence that shows we are reaonably managing our risks and objectives are being delivered*	*Where we are failing to put controls or systems in place or where we are failing to make them effective*	*Where we are failing to gain evidence that our controls/systems on which which we place reliance are effective.*	*Assurance level:*
Examples: • Strategies, policies, procedures, guidance • Robust systems, programmes in place • Budgets, control, monitoring • Working groups/committees • Specific or team accountability • Planning exercises • Training (or other) needs assessments • Training completed • Objectives set and monitored • Accountability agreed and known • Frameworks in place to provide delivery • Contracts/agreements in place • Performance/quality monitoring • Action plans agreed at appropriate level and monitored • Complaint/incident monitoring • Risk assessments • National returns • Routine reporting of key targets with any necessary contingency plans	Examples: • External audit • Internal audit • Care Quality Commission • Clinical audits/reports • Performance indicators • External reviews/reports • Internal reviews/reports • Benchmarking undertaken • Patient/staff surveys • Local/national audits • Internal/local committees/groups • Management/ performance reports from contractors/ partners • Minutes of meetings	Examples: • Actual performance figures • Achieved ratings/targets • Proven progress against action plans • Clinical audits/reports • Received external audit reports • Controls that are deemed to be satisfactory and can be shown to be operating effectively in relation to the risk	Examples: • No regular reviews/performance monitoring or no review mechanisms • Poor/unknown data quality • No monitoring of reviews or done at an inappropriate level • Insufficient training for staff to be competent to support process • Gaps in taking action required/linking findings to action • Lack of ownership • Control does not cover all the objective or risk indicators/reports not sufficiently developed to cover all that is required • Incorrect assumptions being made	Examples: • No or inadequate assurance that performance figures provided are correct • No real assurance that reports/planning/action plans/frameworks are correct/effective/have been done • No assurance that strategies, policies, training are known and effective	Effective controls definitely in place and Board satisfied that appropriate assurances are available. Effective controls thought to be in place but assurance are uncertain and/or possibly insufficient. Effective controls may not be in place and/or appropriate assurances are not available to the Board

Key:
Chair - Chairman
CD - Commercial Director
COO -Chief Operating Officer
DN - Director of Nursing
DF - Director of Finance

DSDA - Director of Strategic Development and Assurance
DT - Director of Transformation
HRD - Director of Human Resources
MD - Medical Director

↔ Status of risk unchanged

↓ Risk reduced

↑ Risk increased

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.1: We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies									
1.1	Robust CQC action plan in place, monitored at Board level. NHSLA project plan developed and monitored through Committee structure. Feedback and implementation of action following "quality walks" and assurance visits. Provider Compliance Assessments (PCA) training. Reinforcement of required standards of patient documentation	Outcome of CQC unannounced inspections NHSLA assessment Internal reviews inc/board level 'Quality Walks' CQC risk profile Board and Committee minutes Patient and Staff Surveys Health and Safety Executive IG Toolkit HR processes External accreditation/peer reviews	CQC reports. Provider Compliance Assessments being completed at ward level and gaps reviewed. Internal audit report on CQC compliance Weekly audits and reviews eg observations of practice Monthly reviews of data with each clinical unit Achievement of NHSLA level one and CNST (maternity) level two 'Quality walks' programme in place and forms part of Board objectives	Documented audit trail not always available eg declaration of serious incidents, discussions re DNAR.		Ward/department visits to continue involving assurance team and peer reviews. Focus on specific outcomes eg consent paperwork, medical devices checks. Incomplete DNARs being logged as incidents and escalated for action. Jan-13 Weekly DNAR spot checks by Resus team escalated to senior management. Trust wide audit took place Feb, compliance improving but agreed that Resus policy and audit methodology to be reviewed. Aug-13 Resuscitation policy tabled at Clinical Management Executive and will be updated with group's comments. Oct-13 Compliance with policies reviewed at Policy Group and paper drafted for CME (Nov-13)	April 2012 ongoing audit throughout 2013/14 Oct-13	↔	MD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued - Risk 1.1: We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies									
1.1	Accountability agreed and known eg ADN, ward matrons, clinical leads. Implementation of quality governance framework Health and Safety Risk Assessments External visits register Ongoing work to embed learning and review sources of assurance		External visits register maintained; reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors	PCAs not fully developed at ward/department level		Local PCAs have been developed and training provided. Audit of PCA self assessments undertaken. Jan-13 PCA compliance report presented to CME, focus on addressing gaps and concerns and testing evidence. May-13 Continued focus on addressing gaps, action plans to CME/Quality and Standards Committee Oct-13 Trust is reviewing changes in CQC compliance regime when published, including new surveillance model *Dec-13 Reviewing CQC inspections reports published for other Trusts recently inspected under new model*	Audit complete end Jan-13 ongoing developmen t in place complete by Dec-13	↔	DSDA

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Datixweb incidents are not 'finally approved' and a backlog has built up. This could impact export to NRLS and benchmarking reports against other similar organisations may not be a true reflection of the Trust incident profile.		01/09/2013 Proposal for sustainable management of incidents and achievement of timely incident agreed with divisions and working to clear backlog. *Dec-13 Quality checks and significant reduction in backlog achieved in time for export to NRLS end of Nov. Continued focus on incident management across Clinical Units.*	end Jan-14	↔	DSDA

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.									
1.2	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with divisions Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) monitoring Regular audit of cleaning standards	Performance indicators Benchmarking and Dr Foster data Accreditation visits/Peer Reviews National Cleaning Standards Audit Group established HOSC Healthwatch External Audit Internal Audit Clinical Audit Clinical Commissioning Groups Regulatory bodies eg CQC, HSE	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review National benchmarking by WM Quality Observatory Dr Foster HSMR/SHMI data Low HCAI and SSA breaches Performance delivery plan in place	Demand and patient choice impacts ability to deliver cancer metrics.		Sep-12 Cancer network discussions re urology capacity/expectations. Mar 13 - Review of pathways/clock pause criteria. Co-ordinators working outside normal hours to facilitate patient contact. GP referral issues highlighted to CCGs. May-13 Developed patient info leaflet. Diagnostic urologist joins June; training chichester and brighton consultants to undertake complexes cases. Sep-13 Somerset info system implemented. Reviewing DH benchmarks/engaging with regional screening centres. *Dec-13 General surgery move expected to improve colorectal screening response, meeting screening service Jan to review pathway or transfer treatment option to BSUH*	end Apr-13 Sept-13	↔	COO

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Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**									
1.2	Business Continuity and Major Incident Plans Training to develop service level BC plans Reviewing and responding to national reports such as Francis, Keogh and Berwick.	Information Governance Toolkit	Cancer - all tumour groups implementing actions following peer review of IOG compliance. Major incident testing debrief indicated plan is effective. Trust Board reviewed analysis of Keogh, Berwick et al and actions will be agreed and monitored through Quality and Standards Committee.	Inability to meet national screening standards for diabetic retinopathy due to increasing demand and limited capacity.		Recovery Plan and prioritisation in place Nov-12: Additional funding to support delivery of the Quality Standards not available - Exploratory meetings with Brighton DRSS to discuss possible Sussex wide service. Escalated to specialist commissioners who advised no additional funding, service provision being reviewed. Oct-13 Follow up waits currently at 17 months - discussion ongoing with Brighton re joint working.	01/06/2013 end Nov-13	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Jan-13 Demand on emergency services, impacting patient assessment and treatment time and subsequent discharge to other specialist/bed areas		Action plan in place to enhance patient flow. Currently meet with SECAMB monthly to review issues and high level operational meeting planned. May-13 Identified number of options to improve ambulance flows - being explored Sep-13 Ambulance flows improved. Focussed work to be undertaken on further improvement to minimise risk of handover fines. Oct-13 Discharge/admission lounges on both sites and escalation plan in place for winter pressures	end Nov-13	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**									
1.2				June-13 Inability to achieve reduced Cdiff trajectory. Risk register identifies concerns with weekly multi-disciplinary reviews and failure to meet national cleaning standards		June-13 Gastroenterology Consultants have an agreed job plan that ensures senior representation at the weekly ward round. Monthly audits of National Cleaning Standards (NCS) are undertaken and any failures identified and actioned. Oct-13 26 Cdiff cases ytd, RCA of all cases to identify actions and share learning. TDA supporting and action plan developed. *Dec-13 Review and monitoring ongoing as outlined above*	Ongoing review and audit throughout 2013/14	↔	DN/MD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Clinical laboratory diagnostics analytical equipment requires replacement. Heavily used equipment becomes prone to breakdown and possible loss of service.		Agreed that replacement should be undertaken via a managed services contract. Further input required from procurement and estates. TDA funding approval will be required. Sep-13 Business case being developed; equipment risks continue to be monitored and mitigating actions agreed. Oct-13 Temporary bio chemistry equipment to be installed in next month. Managed Service Contract being progressed. *Dec-13 Managed Service Contract ITT planned for Jan anticipated contract award will be Jun'14*	end Nov-13	↔	COO

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.3: There is a lack of leadership capability and capacity to lead ongoing performance improvement and build a high performing organisation.									
1.3	Divisional structure and governance process support clinical ownership Clinicians engaged with clinical strategy Job planning aligned to Trust aims and objectives Joint Medical Director appointed to lead on Clinical Strategy Implementation of Organisational Development Strategy and Workforce Strategy Stakeholder Primary Access Points (PAP) groups in place Board Development Programme Leading for Success Programme	Clinical Quality and Patient Safety Reports Dr Foster metrics Appraisal and revalidation process Pre Consultation Business Case (PCBC), National Clinical Advisory Team (NCAT) review and gateway review Stakeholder review process eg HOSC Shaping our Future Project Board	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy and PCBC PAPs identifying workforce implications. Clinical engagement events taking place Training and support for those clinicians taking part in consultation and reconfiguration. On-going monitoring of safety and performance of the temporary reconfiguration of obstetric and paediatric services and permanent reconfiguration of stroke services.	Requires demonstrable clinical leadership to take forward reconfiguration following consultation process.		Continue to operate PAP stakeholder groups throughout consultation period. Nov-2012 Consultation period finished - PAP groups to continue to develop implementation plans. Mar 13- PAP implementation group established and corporate support group in place. 30 PAP sub groups established to support delivery. *Dec-13 Structure to provide ownership and accountability to clinical units. Clinical Forum being developed.*	Jul - Sept 12 ongoing review throughout 2013/14	↔	MD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 2 – Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences.									
Risk 2.1: We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.									
2.1	Develop effective relationships with CCGs Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners including ESCC and MPs	Evidence of participation in Clinical Leaders Group External reviews and reports	Membership of newly formed local Health Economy Boards – UCN, Elective, Integrated. Commissioners, GPs, Adult Social Care invited to be members of Strategy Board. Collaboration with neighbouring Trusts through networks	Transition in commissioning arrangements mean clinical networks and leaders groups under review. Relationship with HOSC now focused on implementation. Communications strategy and approach needs refocusing following consultation.		Jan-13: ESHT participant in emergency clinical senate. Reinstatement of HOSC working Group. HOSC member on Shaping our Future Implementation Board. Communications strand part of implementation work. Build relationships with CCG teams and leads and emerging LAT leads. Ongoing Contract Management meetings and Single Performance Conversations. Oct-13 Ensuring sound plans for the delivery of Service transformation are developed and aligned to the Clinical Strategy. Meetings taking place with CCGs on development of primary care strategy. Programme for strategic change 2020 vision instituted by EHS and HR CCG	Mar-13	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: Risk 2.1: We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations									
2.1	Clinical Strategy engagement Communications Strategy and map of stakeholders Regular meetings with League of Friends		Trust participates in Sussex wide networks eg stroke, cardio, pathology. Monthly performance meetings with CC and TDA. Working with clinical commissioning exec via Sussex Together to identify priorities/strategic aims. Board to Board meetings with CCGs, SECAMB and other bodies.	Marketing strategy not yet developed, therefore assurance cannot be provided that the Trust is actively and effectively participating in the local market or developing and responding to market opportunities.	Risk that during the period of dissolution of the SHA/PCT to Local Area Teams and CCGs there is a loss of organisational memory and focus on the key issues affecting the Trust.	Mar 13: Stakeholder engagement strategy to be reviewed and further developed Aug 13 - Trust participating in CCG led 'large scale change' programme. Trust engaged in CCG process for public engagement, development of the case for change, model of care and options for delivering agreed service standards for Maternity, Paediatric and Gynaecology services Oct 13 - Trust fully engaged with CCGs on developing PCBC for Maternity and Paediatrics	Commenced and ongoing through 2013/14 end Sep 13	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 2 – Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences.									
Risk 2.2: We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.									
2.2	Develop and embed key strategies that underpin the Integrated Business Plan (IBP): Clinical Strategy Workforce Strategy IT Strategy Estates Strategy Membership Strategy Clinical strategy and development of full business case	Stakeholder engagement in developing service plans Trust Board approves IBP and strategies Department of Health and Monitor	HOSC engagement in clinical strategy and plans for delivery at service level	Need to develop FBC to support Integrated Business Plan.		Jan 13: Developing FBC following consultation based on implementation plans for reconfiguration, redesign and efficiency/productivity across all 8 PAPs. *Dec-13 FBC approved at Nov Board and will be submitted to TDA for ratification*	end Mar-13	↓	COO
				Underpinning strategies eg Estates, Membership and IT not yet fully developed.		Develop Membership Strategy Aug 13 - early draft developed, on hold pending agreement of FT trajectory with TDA	end Jun- 13	↔	DSDA
						Develop Estates Strategy (see 3.4)	end Nov - 13	↔	CD
						Aug-13 Develop IT Strategy to support IBP	end Jan-14	↔	DF

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3	Develop and embed Patient and Public Involvement Strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and new quality dashboard. Risk assessments Complaint and incident monitoring	CQC patient and staff surveys and inspection reports SHA benchmarking PROMs Clinical quality & safety reports reviewed through Trust Committee structure Dr Foster metrics	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives.	Insufficient triangulation of clinical governance information and impact on patient outcomes.		Quality governance framework approved and quality dashboard implemented but to be fully embedded . May-13 Information Management Review finalised and structure changes being implemented. Sep-13 - BI restructure implemented. Redefining organisation's information requirements in collaboration with the TDA. *Dec-13 Ongoing work to triangulate information and identify areas of focus*	end Jun- 13 end Dec-13 end Mar-14	↔	DN/ COO

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3	Robust complaints process in place that supports early local resolution Clinical audit plan Communications and marketing strategies developed and implemented Equality strategy and equality impact assessments Framework for delivery of mandatory training in place Appraisal policy and process in place	Internal patient experience surveys Complaints data and trends CQUINs Internal and external auditors Clinical audit FFT for Patient Experience Compliance rates for mandatory training and appraisal	Trust benchmarking by WM Quality Observatory Dr Foster HSMR data Trust data and possible benchmarking for FFT	Change in process/contract for patient transport services having a detrimental impact on patient care and experience.		Review of Trust's SLA and KPIs with SECAMB and escalation of risks to commissioners. Incidents logged and reported monthly to SECAMB for investigation. Sep-13 SECAMB reviewed management arrangements. Ongoing review - issues escalated to commissioners.	end Nov-13	↔	COO
				Inconsistent delivery of trust guidelines, policies and best practice is not addressed leading to variations in patient care and clinical outcomes. Poor quality of medical case note folders increases risk of inappropriate treatments, duplication of tests and interferes with patient care. Electronic records sitting outside of the nursing audit programme currently.		Action plans in place if deficiencies identified eg completion of nursing records, compliance with DNAR policy. Quality walks/assurance visits target specific areas. Nov-12 Establishing sub committee of health records steering group. Service, review by south coast audit and monitoring at patient safety committee. Sep 13- Quarterly audit of health records in place for 13/14. Review of how electronic records are monitored. Keogh review being evaluated and necessary actions implemented.	Mar-14	↔	DN/ MD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
				Mandatory training rates and completion of appraisal levels below expected levels.		Embed revised policy and compliance monitoring systems. Jun-13 - Discussing e-learning issue with local Trusts. IT currently sourcing solutions. Aug 13 - The e-learning content issue has been resolved by agreeing with Kent & Medway to utilise their server. All modules are now loaded and working on the K&M server. Oct 13 - Work is continuing on developing a mandatory training staff passport across the region which will focus on 10 key areas of mandatory training. All other training will be role related. For some areas of mandatory training, we are also looking to develop a competency assessment process which will reduce the need for staff to attend training.	Improved performance by Aug-12 ongoing throughout 2013 Work is ongoing but aim to complete passport and competency work by April 2014	↔	HRD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic objective 3 – Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.									
Risk 3.1: We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.									
3.1	Clinical strategy development informed by commissioning intentions, with involvement of PCT and consortia QIPP delivery managed through Urgent, Planned and Integrated Care divisional governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work.	Activity plan Workforce planning Clinical Strategy Divisional governance structure and performance meetings Joint audacious goal meeting with commissioners Monthly KPIs monitored PMO office in place	Trust participates in Sussex wide networks eg stroke, cardio, pathology. Written reports to CME on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored.		Require robust controls to ensure achievement of 2013/14 financial plan and prevent crystalisation of identified risks eg fines, penalties, slippage on CIP programme, achievement of CQUINs, capacity and operational cost pressures	May-13 Impact of fines and penalties being assessed on monthly basis and actions taken to mitigate income loss. Monitoring of QIPP schemes and CQUIN delivery. Activity being monitored against plan Aug-13 In-year Financial Recovery Plan being developed to ensure delivery of planned deficit budget. *Oct/Dec-13 FRP in place and Turnaround Director appointed and focussing on cost base reduction. Progress on FRP delivery reported to F&I committee and Board.*	Commenced and ongoing review and monitoring to end Mar-14	↔	DF/DT

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
		Monthly review by Finance and Investment Committee	Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)	Increased pressure on Trust cash holding will impact ability to generate required surplus of cash to make payments.		Aug-13 Daily monitoring of cash balances and weekly meeting re managing cashflow and assessing risks. £15m cash funding loan received from TDA,. Oct-13 Application for PDC Finance submitted to TDA 11th October 2013 *- to be considered at Jan ITFF meeting*	Controls implemented ongoing review throughout financial year	↔	DF

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.1 continued: We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2013/14 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.									
				OPD referrals have reduced but not in line with original demand management expectations and there are some capacity constraints, especially in Trauma and Orthopaedics (T&O) and gastroenterology		OPD review undertaken of planned activity against capacity. Whole system recovery plans being discussed with commissioners	end Mar 2014	↔	COO
						T&O to model impact of loss of MSK contract. June 2012 - paper circulated to CLT for consideration. Sept-12: Service is being monitored to analyse impact ongoing May-13 Concerns with service to be escalated through Service Quality Review meeting Sep-13 Ongoing monitoring with commissioners. Oct -13 T&O referrals increased back to previous levels - being monitored. *Dec-13 Focus on reducing RTT times in line with Trust Policy, discussed by Board Nov 2013*	end Jun-12 with ongoing monitoring to end of Mar 2014	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.2: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.2	Development of workforce strategy: - to align workforce plans with strategic direction and other delivery plans; - to ensure a link between workforce planning and quality measures	NHS Sussex workforce assurance process Staff utilisation reports. Integrated performance	Training and resources for staff development CQC maternity report DGH Jul-13	Final workforce strategy will be developed once plans for clinical strategy and financial recovery/market testing further defined.		Further develop workforce strategy aligned to clinical strategy	Mar-14	↔	HRD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
	measures Workforce assurance group disbanded and will be re-formed in line with CCG requirements which are still to be advised. Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data. Rolling recruitment programme	performance report. CQC staff survey		Inability to recruit to some specialties and significant vacancies in some areas . Some areas have identified that there could be shortages in the future due to ageing workforce and changes in education provision. Also national shortages in some areas eg cardiac physiologists, ODPs and anaesthetic staff Currently significant nursing and therapy vacancies - Oct 2013		Vacancies/difficult to recruit to posts reviewed. Jun-13: Rota and establishment review - escalation for hospital at night team and cardiology on call rotas. Aug -13 Action plan to support reduction in staff absence. Oct-13 Recruitment campaign in local and national press. *Dec13 appointed 40 Nurses - 28 already started. Disclosure and barring check times reduced from average of 4 weeks to 48 hours supports expedited recruitment. 40 newly qualified nurses interviewed expected to start Feb'14* *Ongoing therapy recruitment.*	Ongoing throughout financial year - end of Mar-14	↔	HRD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.2 continued: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.2				Maternity and paediatric inpatient services cannot provide a consistent quality of service so for some patients some of the time we do not meet the expected and required standards.	Dependency on mitigating actions is such that the risk of service failure is increased to an unacceptable level The delivery of a safe service becomes rapidly unsustainable in the short to medium term leaving us little time to implement mitigating actions	Daily monitoring and senior review. External NCAT review of services. Mar-13: NCAT report received. 8 Mar - Board considered safety of services; resolved that temporarily consultant led obstetric service, neonatal service (inc SCBU) in-patient paediatric service and emergency gynaecology service be based at the Conquest Hospital only and a stand alone midwifery led maternity unit be established alongside enhanced ambulatory paediatric care at DGH. May-13 Temp. reconfiguration implemented and being monitored. Sep-13 CCG seeking views to shape options for future consultation. *Dec-13 CCG Board reviewed and agreed options for future consultation. Consultation commencing Jan'14*	end Mar-13	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.3: We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.									
3.3	Leading for Success Programme Listening in Action Programme Feedback and implementation of action following “quality walks”. PAPs clinically led with staff engagement Developing organisation values	CQC Staff Survey results Quality walks and assurance visits	Positive relationship with JSC Weekly CEO message to staff well received Effective clinical leadership of clinical units		CQC staff survey improved but in some areas the Trust is still in the bottom 20%	Implementing LiA programme and developing values. Big conversations held and key themes developed. Taking forward quick wins, enabling projects and clinically led team projects to deliver improvements against themes. Aug-13 Participation in year two of LIA programme confirmed. Further themed conversations held and planned. Oct-13 Plans in place to work with Optimise in applying the framework to multi-faceted challenges. Over 20 wards/teams working on improvement projects for first half of phase 2.	01/01/2013 Phase 2 to commence Jul-13	↔	CEO
				Need to develop clinical engagement		Working with Hay to develop Clinical Leadership Forum Oct-13 Clinical Leadership Forum development conversations taken place. TORs and membership in development.	end Sep-13	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.4: We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.									
3.4	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey to obtain core estate information, to include community hospitals; £300k secured invitation & award of service contract; survey with written report.	External company, T&T, produced six facet estate survey	Draft assessment of current estate alignment to PAPs produced	Lack of an appropriate estates strategy and backlog maintenance plan		Develop estates strategy content framework. Align estate survey with clinical delivery options. Estates Strategy Board presentation and approval. *Dec-13 A number of backlog maintenance issues on the high level risk register being reviewed, monitored and prioritised.*	end Nov-2013	↔	CD

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
	Capital funding programme and development control plan			Delay/failure of national IT programme means that the Trust cannot support the effective development of electronic records that support new models of clinical care.		Draft IT strategy presented to May Bd seminar; further stakeholder consultation being undertaken. Aug-13 Community and Child Health (CCH) system FBC approved by Board/TDA. Project initiated 2 July 2013. *Dec 13- Implementation of CCH project ongoing. Trust confirmed readiness to participate in procurement of Electronic Document Management System and Clinical Portal as part of the Sussex Collaboration. OBC approved by board Oct-2012.*	end Sep-2013	↔	DF

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.5: We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change									
3.5	Horizon scanning by Executive team and Board. Board seminars Board development programme. Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports	Minutes of Board seminars Attendance at FTN/NHS Confed events Developed and implemented effective marketing strategy	Policy documents and Board reporting reflect external policy. Strategic development plans reflect external policy. Board seminar programme in place	Trust has limited success in tender exercises. Specialist skills required to support Any Qualified Provider and tendering exercises by commissioners		Agreed method for handling tender opportunities and AQP which includes allocating an exec lead. Aug-13 Contract team strengthened to support AQP process. Ongoing monitoring of AQP and tenders. Oct-13 New MSK tender identified need to further increase leadership and skills of tendering team. *Dec-13 Reviewing best practice in tendering - meeting with Hempson Jan 2014*	end Nov 13	↔	COO

Board Assurance Framework - Dec13 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
						Commencing phase 2 to develop options for implementation of the clinical strategy. Need to develop positive working relationship with the new HOSC following local elections Aug-13 Steering Group and Programme management arrangements for Phase 2 in place. Assessment of services for inclusion underway in line with agreed methodology. Oct-13 Agreed to restrict activity during period of intense action on FRP. Work on frailty to be maintained as integral to successful achievement of FRP *Dec-13 Focus on developing 2014/15 business plan*	end Jul 2013	↔	DSDA

2. Evidence from members of the public and patient participation groups

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Comments received by email from members of the public

12/02/2014 Re: For Info: HOSC - 17 February 2014 - Agenda - For Witnesses

Sent: 12 February 2014 16:01

Subject: Re: For Info: HOSC - 17 February 2014 - Agenda - For Witnesses

Dear Colleagues

EASTBOURNE AND CONSULTANT OBSTETRICS - MOST DISADVANTAGED TOWN IN WESTERN WORLD

It is simple really.

All other discrete towns, with the population size of Eastbourne in the UK, the EEA, Canada, Australia and the USA, have a consultant obstetric maternity unit capable or undertaking emergency obstetric interventions.

Eastbourne will therefore be the most disadvantaged town.

The other towns do provide safe, accessible services. It can be done, if there is the will to do so.

Simple.

Vincent Argent FRCOG

Consultant Obstetrician and Gynaecologist

Clinical Adviser

16/02/2014 Eastbourne DGH

Sent: 16 February 2014 14:56

Subject: Eastbourne DGH

I would like to express concern as to how so many services seem to have been moved to the conquest and royal Sussex hospitals seemingly without the majority of people in Eastbourne being aware. My impression is that the justified furore over Maternity Services has to some extent provided the trust with a smokescreen behind which to surreptitiously move other services without the general public being aware.

I understand that if I have an accident and break bones in Eastbourne, I am more likely to be sent over to Brighton but don't know why – there is a very good orthopaedic ward at Eastbourne, I know because my mother was treated there. It would have been extremely difficult to cover visits over to the royal sussex or the Conquest. Honestly speaking, I would not know how to get to the Conquest hospital – all I know is that it is somewhere at the back of Hastings. Surely regular visits from friends and relatives are a critical part of a patient's well being and aid recovery yet the haul from Eastbourne to the Conquest deters visits and reduces the time available to actually spend with the patient.

There was a lengthy debate and controversy about the relatively new helicopter pad being built at the DGH, yet since it was built I see very few helicopters landing there – this suggests a horrible waste of money. Are there any figures available to show how many helicopter visits were made in the years before and the years after the pad was built – and is the cost available to the general public? Such decisions do not instil confidence in the governance there.

We are told that the DGH have problems recruiting staff yet surely it is common sense that with all this uncertainty no one is going to give up a secure job in order to take up a position at the DGH and is therefore self-fulfilling for as long as this uncertainty remains. On the other hand Eastbourne has both a large elderly population and sufficient birth rate to require local services.

My fear is that it is intended to downgrade Eastbourne to not much more than a cottage hospital – this would be a travesty and disservice to the population of Eastbourne if this is allowed to happen.

Kind regards,

Patricia Hughes

17/02/2014 Maternity and Paediatric Services

Sent: 17 February 2014 20:49

Subject: Maternity and Paediatric Services

Sirs,

I am glad to note that the above is to be recommended for formal consultation. It seems to me that in this day and age preposterous to send expectant mothers to Hastings by ambulance or other means, the road links between the two towns are at best inadequate, this will put lives at risk. Eastbourne, Seaford and Hailsham and all outlying areas deserve a local hospital that can cater for all the core services. we are not a third world country, the prime minister said recently we are a rich country, so let's spend our money on local services for local people and for the safety and well-being of future generations.

regards,

John Hill

21/02/2014 Copy of letter from Brian Valentine to Eastbourne, Hailsham and Seaford CCG

Mr Brian H Valentine.
MB, FRCS, FRCOG

Tel/Fax:- [redacted]
Mobile:- [redacted]
E mail:- [redacted]

Friday 14th February 2014

Eastbourne Hailsham & Seaford CCG,

36-38, Friars Walk,

Lewes,

East Sussex, BN7 2PB.

Dear Drs Writer, Elias and Gill,

Re:- Better Beginnings Maternity & Paediatrics Options Consultation-2014.

I hope you will forgive me for responding to your consultation in this manner. I appreciate it will most likely mean I am 'out of order' and may well be wasting both of our times in writing.

I would commend your organisations on the material you have put out and the manner in which you have tried to allow people to find a multiplicity of views on the subject of what is a difficult and vexed problem for all concerned. Especially for those less fortunate than us in terms of financial where with all, family situation or mobility options. I am barely computerate but have managed slowly to find my way around all the papers and I hope I have read enough not to be a complete dinosaur, being well retired.

I was a Consultant Obstetrician & Gynaecologist at Eastbourne DGH until I was retired on ill health grounds due to 'Burnout' in 2000. Subsequently I slowly returned to clinical work in various places including Caithness for my last 21/2 yrs. So, having obtained my Certificate of Completion of Training [CCT] whilst senior registrar to the Nottingham Hospitals Group I have been privileged to work in all sizes of unit on the old staffing/working patterns before Working Time Directives were enforced. Good for one's experience & personal 'hands on' maintenance of skills but with other obvious drawbacks.

I do not wish to be rude but from my reading of the CCG's charter they not only have to commission the clinical services but it is incumbent upon them to solicit their local populations **preferred choices** as to how they would **like** to see their services provided. Choices, however, are not Options which by definition are a refined list of possibilities that others have decided to offer you. This, unfortunately, is what you have decided to do by revisiting the stance of the Primary Care Trusts [PCT] in 2007 regardless of the Independent Reconfiguration Panels [IRP] contradictory advice in 2008. Endorsed in its entirety as an instruction, and hence a legal requirement in my understanding, upon East Sussex Healthcare Trust [ESHT] by the then Secretary of State for Health, Mr Alan Johnson MP.

I appreciate it is neater for the CCG's to offer options in this way but you would have accrued greater trust from the catchment population by offering a full set of **choices**, including the original configuration of services, even if you thought it unlikely you would be able to deliver the populations choice should it have been for the 'status quo.' Through no fault of the CCG's but caused by ESHT's refusal to implement the populations preference and Mr Johnson's directive. It is not only Mr Norman Baker MP who feels a vote for any of your options would unfortunately be considered an endorsement by all of you. When most people I've spoken with actually feel they are having the ESHT wishes forced upon them by the CCG's against their personal wishes. Hence this letter format as a submission of my opinion, which unfortunately also does not fit within your proffered options. I hope it will not simply be discarded as irrelevant because it is consistent with the views of many who feel it is a waste of time trying to get you to listen to them. Not just on Maternity & Paediatric siting I should add.

I can understand that having been informed there was no way that ESHT, having made its 'temporary' changes in May 2013 was ever going to revert to its original 2 hospital sites for **all core services** model; an all **choices** option list could have seemed ridiculous. Even though publically ESHT still stated the changes were only temporary. By seeming to side with ESHT you have also seemingly deserted your organisations original mandate and left a lot of people distrusting your organisations as much as they distrust the ESHT Board and management. Instead of being their champions, as Mr Andrew Lansley MP when Sec of State for Health originally intended, you appear to have aligned your organisations with what many consider to be a domineering but ineffectual, disingenuous & 'less than fit for purpose' organisation. I obviously feel that is a great shame, especially as your organisations were so hopefully viewed by many as new brooms untainted by the attitudes of past aloof & unaccountable managerially controlled administrations.

I would obviously prefer a 2 site Obstetric Lead facility [OLU] as I believe it is the only way to ensure any interventive delays are kept to a minimum, be that in transfers, travelling or in unit responses.[Even **within** a location you can easily get delays when arranging surgery between departments and disciplines.] You have mentioned travel times between hospitals but conveniently omitted, or forgotten, to mention the time taken to wait for an ambulance to arrive, getting the patient from her hospital bed and into the ambulance and the reverse at the other end on arrival and then making a clinical decision and actually actioning it, even as an emergency. In my experience one should at least double your estimates as I've not found such events to take less than 20 minutes per item and often a lot longer. Whilst I appreciate the UK/RCOG standard is 30 minutes decision to delivery time in urgent cases that is based on working within a unit. It is also ASAP and 10 minutes in crash situations like a massive APH etc as confirmed by your literature and that can occur with any

categorised risk of patient. That is the nature of the subject and I do speak from considerable experience of low risk cases producing haemorrhagic or hypoxic foetal emergencies occurring in the patients you least expect them to, even in low volume units like Caithness where we saw on average 6 [1%] such caesarean section requiring emergencies each year. This was why that unit was not closed regardless of its low delivery numbers. The decision eventually implemented on the specific instructions of the Minister of Health for Scotland.

I appreciate titles have become more important since I was trained when most units were integrated units controlled and triaged at admission by Midwives who might keep the medical staff informed of admissions in case of need or on the 4hrly ward rounds with midwifery cases. Midwifery care cases were just that and you simply said 'Hello' as you went round in case the patient ever had to see you again, and 35% did if they were primipara, as confirmed in your literature. With 20 labour suites and 8000 deliveries annually nobody needed to acquire direct responsibility for a patient's immediate ongoing care unnecessarily so there was no professional rivalry. At that time units would not dream of turning a patient away even if they had to deliver in unexpected places occasionally. Safe & adequate care of the mother & baby was all that mattered and that would be achieved regardless of setting. The delivery unit rightly being considered the place of ultimate safety by medical/midwifery staff as well as patients. Today it seems everything has to be legally titled to the point of designating a midwifery lead unit [MLU] even within a setting labelled as an obstetric lead unit [OLU] but in doing so your limit of 2 MLU's for East Sussex gets drawn into the argument of service dispersal, which is very unfortunate.

I have always felt the Growborough Birthing Centre was an anomaly since being attached to Eastbourne, rather than Pembury as was originally the case. It has certainly satisfied a lot of patients, as well as the GP.s and midwives who ran it both well and safely. Regardless of all the acute clinical problems thrown at them which have always been successfully & rapidly transferred, generally to Pembury being only 10 minutes away. With their ambulances locally sited they easily conform with the need for rapid transfer to a place of safety. Eastbourne is hopelessly too far away in real emergencies, and Hastings is ridiculous whichever way you travel. So I think Crowborough should be in the Pembury sphere which I understand to be the preferred **choice** of the population, Crowborough Staff & Friends, and most importantly the Pembury Consultants and Managers. The Birthing unit has an important place in the obstetric care plan being safer with onsite midwives and equipment than home deliveries, which it mimics well. It also provides ante and post natal care in the local vicinity. If Pembury do not want Crowborough then Eastbourne is the safest option for non-urgent transfer within ESHT, but The Princess Royal Hospital in Haywards Heath is another and possibly better option.

Having to make a choice on your options, as a second best choice, I would favour Option 5 as it protects Seaford and the northern zones but I would have profound anxieties for the easterly side towns and villages such as Rye. I would also have anxieties for the Hastings ladies who required transfer or even having to travel to reach Eastbourne. All those anxieties would be safely and sensibly redressed if there were 2 Obstetric Lead Units, as is the status quo, even if management did have to look at how they obtained safe continuity staffing. That is an ongoing conundrum even within the Royal College of Obstetricians & Gynaecologists [RCOG], especially with the Working Time Directives now in force but the bigger units have shown the lead by their approach to Consultant provided services. As Junior doctors are not enamoured by what they see in ESHT as an adequate training facility it would seem the appropriate time to consider providing a Consultant & career grade staffed & provided service. Fully qualified Career grades I should add, at senior middle

grade level but with the structured training arrangements I do not know how one could service the ‘SHO’ tier if the speciality tier is unwilling to consider ESHT as a worthwhile training environment. Perhaps the GP training scheme could become involved as used to be the case.

Such a service would not be without its problems and it is a shame the Associate Specialist post has been withdrawn since 2008 as it would have complimented the Consultant posts to provide continuity of experienced specialist care & employment acceptable to some doctors with their CCT either waiting for a Consultant vacancy or not wishing to tread that road. There is most likely something that equates to the position but I could not ‘pin point’ it looking at the differing grades, hence my using the old positions terminology, although I gather 6,000 such posts still exist in the UK. The RCOG suggested 55yr labour suite ‘on call’ watershed could also produce staffing problems in small peripheral units with many similarly aged staff but if there is a will there is usually a way as Scotland, Banbury, Yeovil and Hinchinbrook have shown as they **actively** sought the safest possible local solution for their mothers and babies. In ESHT that should remain 2 equal facility sites, even if only one site has a level 2 SCBU, so that transfers to Brighton or Pembury are unnecessary.

I have formulated my views assuming the Eastbourne Consultants still provide outreach clinics in Uckfield, Heathfied, Hailsham and Seaford as was previously the case to ensure ladies in those areas did not have to travel unnecessarily, especially in late pregnancy. But also to ensure that the numbers of babies delivered in Eastbourne did not reduce from the peripheral areas as new facilities opened with its consequent effect on personal case involvement for re registration for doctors and midwives. [Now a days the financial loss would also have to be taken into account.] The midwives worked hard & successfully to make delivery as homely as possible within a friendly safe clinical unit. I presume all those conditions have been preserved because without them the likelihood of a birth numbers reduction, and therefore significant income reduction, would be considerable and even more so if Hastings was the only unit of ultimate safety. If that occurred and ESHT simply became a Costal maternity zone, with Uckfield going to Haywards Heath & Heathfield to Pembury, the safest provision of services would still be Obstetric, Paediatric and Anaesthetically competent units at both Eastbourne & Hastings hospitals, unless you wished to see Seaford becoming aligned to Brighton.

Finally I suggest we need to remind ourselves that we are ultimately trying to ensure the best cerebral outcome for the baby as its brain is the most vulnerable part in the process of birth. Damage it in any way, and that need only take a couple of minutes, and not only is the child condemned for the rest of its life but history unfortunately shows that whole families and any children they already have are affected adversely. The litigation costs are also horrendous.

I hope I have not offended you by responding by letter. Hopefully constructively whilst stating the various possibilities rather than simply choosing one of your Options. I appreciate the letter is protracted and the contents known to you but I did not feel ignoring your considerable effort for input was either constructive or polite.

Yours sincerely,

Brian Valentine

23/02/2014 Changes to Maternity at Eastbourne Hospital

Sent: 23 February 2014 09:48

Subject: Changes to Maternity at Eastbourne Hospital

Dear Sirs,

As part of these 'proposed' changes I believe Gynaecological clinics may be moved to Hastings. I just want to point out that it is not just women of child bearing age have gynae problems. Women of all ages can experience these problems and thought should be given to the provision of clinics and emergency help for those women at Eastbourne Hospital. I am sure older ladies will not want the expense and/or stress of having to go to the Conquest when there is a hospital in Eastbourne. I certainly do not want that extra stress and expense and worry and I live in Polegate.

With regards

Mrs J Ade

Patients Participation Group

c/o Groombridge and Hartfield Medical Group

Better Beginnings,
East Sussex CCGs,
Freepost SEA2474
BN8 2 ZZ

4th March 2014

Our response to the Consultation Document "Better Beginnings"

Our Preferred Option

Groombridge and Hartfield Medical Group PPG are of the considered opinion there is only one viable option for North Weald and that is Option 5.

Our main reasons for this are distance and travel time.
We think it is essential to retain Crowborough Birthing Unit and if we have to remain in ESHT it would at least give a direct route to Eastbourne DGH.

Scope of Consultation

Although this consultation document is about the options available throughout East Sussex it concentrates on the South coastal areas and overlooks the Natural Patient Pathway in North Weald.
Expectant mothers in the North Weald, annually around 800, are not being offered acceptable choices.

The Natural Pathway for North Weald

The natural pathway for women in this area is to have all maternity services offered at the Crowborough Birthing Centre (CBC). It has all the facilities needed including a state of the art scanner provided by the community via the League Of Friends of Crowborough Hospital. This particular service was terminated without discussion in 2010 and the scanner, donated by the community, has remained unused by ESHT therefore despite this generous donation no scans are available at Crowborough. The women of this area wish to have all their antenatal services delivered here, "a one stop shop" and unless there is a requirement for consultant intervention, we believe the vast majority would opt for delivery here too.

Present Situation in North Weald

Currently the North Weald expectant mother has to travel by the limited public transport available or by her own means to the South Coast or to Pembury DGH for her scans: whichever way she goes she is put under pressure to book for delivery at the hospital she attends. It is a very strong woman that can still say she wishes to be delivered at CBC as at the moment , if delivery becomes complicated ,i.e. requiring Consultant intervention, she would be sent to the Hastings Conquest by ambulance, passing close by Pembury DGH in order to reach the A21 i.e. the most direct route to Hastings.

Restriction of Choice -Suppression of Demand and Access to Advice

This process seriously undermines the true demand there is for the CBC. Mothers should be able to have all their scans, blood tests and antenatal care at Crowborough, building up a strong rapport with the midwives.
Currently all scans, 12 and 28 week blood tests, have to be completed at the Hospital that is booked for delivery.
CBC and its potential clients are being denied this option, thereby reducing patient choice even further. The removal of the midwives and the shutting of the CBC at a moments notice, as happened in 2013, has further eroded patient confidence. Up until this time, all patients having antenatal care at CBC had a telephone contact number for advice and information 24/7.

We repeat that "Better Beginnings" seems to concentrate on the coast and its hospitals whilst offering no choice of local services to North Weald women.

Consequences on Existing Service

So what is happening? The clients of the North Weald are voting to have their babies in Pembury DGH in fact since obstetrics have been removed from EDGH in 2013, over 400 of these women have chosen to have their babies at Pembury, a Consultant led short stay unit, which is becoming increasingly busy. So now we have the situation that these women are being offered a fragmented care path and by default Pembury is de facto becoming the major provider of maternity care for the North Weald women.

The Human Aspects

It has been shown in many studies, that a mother delivering her baby in known surroundings, in a relaxed atmosphere, with midwives with whom she is familiar, has a greater chance of a normal delivery. Bonding with her newborn is more successful and there is a far greater success for breast feeding in the long term. This is surely proactive and preventive care for mothers and their babies .

Travelling relatively long distances to the coastal hospitals is not something that will be enjoyed by most women, their partners and families, especially as it is likely to require lengthy time off work, thus Pembury scores again.

New Thinking

We therefore ask for some further lateral thinking.
Perhaps it is time to recognise that the CBC needs to be re-joined to the Maidstone and Tunbridge Wells Health Trust for Maternity Provision.
In emergencies Pembury is still the nearest and most easily accessed hospital for North weald residents.

Given an operational scanner and access to a blood laboratory, the CBC's midwives would be able to provide the antenatal care and book for delivery in respect of the majority of North Weald's expectant mothers. It is accepted there will always be a number of mothers who will need a Consultant led unit but with the CBC fully operational these mothers might be returned to Crowborough afterwards to familiar midwives for their post natal care.

It is now understood from the League of Friends of Crowborough, that the Maidstone and Tunbridge Wells Trust believe there is a potential demand for the CBC from mothers of West Kent. It is thought that this could lead to a further 100 births being managed at CBC annually.

Conclusion

We consider CBC should be retained as a competent local service for the benefit of North Weald residents and that this would best be achieved by extending the service to include West Kent mothers. Its location and convenience to PemburyTW suggests to us that the management and operation of CBC should be subsumed into that Trust.

Yours sincerely

On behalf of Groombridge and Hartfield PPG

David Butcher OBE
Chairman