healthscrutiny east sussex

Better Beginnings

HOSC evidence pack 3 (Late items)

HOSC: 20 March 2014

Contents

HOSC witnesses: 20 March 2014

Clinical Commissioning Groups

Eastbourne Hailsham and Seaford / Hastings and Rother CCGs
Amanda Philpott, Joint Chief Operating Officer
Jessica Britton, Associate Director of Quality and Assurance
Martin Writer, Chair, Eastbourne, Hailsham and Seaford CCG and GP
Roger Elias, Chair, Hastings & Rother Clinical Commissioning Group

High Weald Lewes & Havens CCG
Frank Sims, Chief Officer
Elizabeth Gill, Chair
Ashley Scarff, Head of Commissioning and Strategy
David Roach, GP

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Martina Pickin, Public Health Consultant, ESCC

Independent consultant
Mike Rymer, Consultant Gynaecologist at Western Sussex Hospitals NHS Trust

East Sussex Healthcare NHS Trust (ESHT)

Darren Grayson, Chief Executive
Amanda Harrison, Director of Strategy
Andy Slater, Clinical Director (Strategy) and Clinical Unit Lead, Paediatrics
Stuart Welling, Chair
Dexter Pascall, Clinical Lead Obstetrics
Lindsey Stevens, Assistant Director (Nursing)
Paula Smith, Associate Director of Nursing for Women and Children's Services

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Julie Fitzgerald, East Sussex Community Voice (Healthwatch provider)

South East Coast Ambulance Service (SECAMB)

Jane Pateman, Medical Director
James Pavey, Senior Operations Manager

HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC)

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 17 February 2014

PRESENT:

East Sussex County Members
Councillors Michael Ensor (Chair), Frank Carstairs, Ruth O'Keeffe (Vice Chair), Peter Pragnell, Alan Shuttleworth and Bob Standley.

District and Borough Members
Councillors John Ungar (Eastbourne Borough Council); Angharad Davies (Rother District Council); Diane Phillips (Wealden District Council)

Voluntary Sector Representatives
Jennifer Twist (SpeakUp)

WITNESSES:

High Weald Lewes Havens CCG

Frank Sims, Chief Officer

Hastings and Rother CCG/Eastbourne, Hailsham and Seaford CCG
Catherine Ashton, Associate Director of Strategy and Whole Systems Working

East Sussex Healthcare NHS Trust
Dr Amanda Harrison, Director of Strategic Commissioning and Assurance
Lindsey Stevens, Head of Midwifery and Assistant Director of Nursing

Save the DGH
Liz Walke, Chair of 'Save the DGH'
Dr Tim Gietzen
Mr Brian Valentine, MB, FRCS, FRCOG

Friends of Crowborough Hospital
Richard Hallett

East Sussex County Councillors
Councillor Richard Stogdon (Crowborough Division)

Other speakers
Stephen Lloyd MP, Eastbourne and Willingdon

SCRUTINY OFFICER:

Paul Dean, Scrutiny Manager

34. APOLOGIES

34.1 Apologies for absence were received from Councillor Dawn Poole (Hastings Borough Council); Councillor Elayne Merry (Lewes District Council) and Councillor Michael Wincott (East Sussex County Council).

35. DISCLOSURE OF INTERESTS

35.1 There were none.

36. REPORTS

36.1 Copies of the reports dealt with in the minutes below are included in the minute book.

37. BETTER BEGINNINGS – MATERNITY AND PAEDIATRIC SERVICES IN EAST SUSSEX

37.1. The Committee considered a report by the Assistant Chief Executive to agree plans for HOSC to undertake a review of proposed changes to the provision of maternity and paediatric health services in East Sussex.

Evidence from the East Sussex campaign groups

37.2. **Liz Walke:** 'Save the DGH' has looked at what is best for health services for East Sussex, not just in Eastbourne. The campaign considers, along with 'Hands off the Conquest', that there should be midwife-led units and consultant-led units at both Eastbourne District General Hospital (EDGH) and at the Conquest, Hastings (Conquest). This configuration would serve East Sussex better than a single consultant-led site.

37.3. We said in 2007 that we could not support an option that "takes an essential service away from a large proportion of the population". The current consultation has no two-site option for full maternity services at both hospitals. We therefore cannot contribute to the Clinical Commissioning Groups (CCGs) public consultation because it pitches Hastings against Eastbourne.

37.4. There are 5,500 births per year in East Sussex, which the CCGs claim is too few to justify two consultant-led sites. However, throughout the country there are maternity units that have fewer than 2,000 births that are not closing. We believe that the CCGs have not looked hard enough at the viability of commissioning two consultant-led sites and East Sussex Health Care Trust (ESHT) does not have the will to continue to provide two sites.

37.5. We would like the Independent Reconfiguration Panel (IRP) to look again at how a two site service could work; the IRP does not have vested interests and has previously said that two sites should be maintained.

37.6. Many of the reports that are included in the evidence pack (for this meeting) were compiled by people who have "vested interests" so may not be independent. For example, the GPs who sit on CCG boards are in favour of the single site option.

37.7. In our view, the increase in the number of safety issues at the Eastbourne maternity unit since 2007 is due to management failure at ESHT. The board assurance framework report from the January 2014 ESHT Board meeting is evidence of this, with most assurance measures marked as amber or red. [The report to be included in the next evidence pack for 20 March 2014 HOSC].

37.8. We have received evidence from one mother who gave birth since ESHT made temporary changes to maternity services. She believes that having to transfer from the midwife led unit at Eastbourne to the Obstetric unit in Hastings affected her child's health and her own emotional wellbeing.

37.9. The travel time from Eastbourne to either the Conquest or the Royal Sussex County Hospital (RSCH) in Brighton is more than 30 minutes. It takes 43 minutes to travel 21.3 miles between EDGH and the Conquest and 42 minutes to travel the 23.2 miles from EDGH to the RSCH.

37.10. The travel time for patients who need to transfer from the Crowborough Birthing Centre (CBC) is only 10 minutes to Tunbridge Wells Hospital in Pembury. They would not travel to EDGH in an emergency because it is too far.

37.11. **Dr Tim Gietzen:** The consultation does not reflect the cost and inconvenience of travel, not only for patients, but also for medical and nursing staff.

37.12. In response to a Freedom of Information (FOI) request, ESHT did not make it clear whether medical and nursing staff travel to Hastings in their own time or during their

contracted hours which would represent a loss to the Trust of 'clinical time' – a hidden cost. ESHT had responded that the cost of all staff travel over the last six months was around £200,000 per month but did not provide any further breakdown.

37.13. The views of GPs in the consultation documents are not necessarily representative of the views of GPs in Eastbourne and, presumably, Hastings. A confidential survey containing questions that are clear and not open to interpretation or bias is necessary to collect fully representative data.

37.14. **Brian Valentine, Save the DGH:** Based on the available data, ESHT had no choice but to temporarily single site the service in May 2013. However, the changes have become permanent and many people feel a loss of trust. The recommendations of the IRP report in 2008 are still pertinent. East Sussex is best served with the two district hospitals; they were built to a specification that allows for an expansion in population which is currently happening.

37.15. Figures show that first-time mothers have a 35% chance of needing consultant care. This means that a significant number of mothers will need to be transferred to Hastings. Combined with the poor road network, this increases the chance of mothers giving birth en route.

37.16. ESHT has to make sure it provides enough ongoing experience to doctors in all of the attributes of the discipline in order to continue with the specialist registration. ESHT should consider going back to having a consultant and career grade posts to ensure that full consultant cover can be provided on the obstetrics units, rather than on the telephone, in line with best practice from the Royal Colleges.

Staffing models and a 'two-site' option

37.17. **Cllr Alan Shuttleworth:** What could be done by ESHT to address the issues raised in the NCAT report (p 241/242 of the evidence pack refers) and the lack of insufficient middle grade doctors to justify a two-site option? What do other, smaller trusts do differently?

37.18. **Liz Walke:** ESHT needs to develop different ways of working and show initiative. The Trust did not adjust to accommodate the European Working Time Directive or the ongoing lack of middle grade doctors. ESHT cannot staff a maternity unit as if it were a London or city hospital; it must recognise that not only does it have two main sites in two separate towns, but also that access is very difficult between those towns due to the poor road network.

37.19. Other Trusts have adjusted, and some have successful units despite having fewer than 2,000 births. Yeovil District Hospital NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust have: succeeded by promoting services outside their catchment area; developed innovative ways to provide sufficient staffing levels and restructured staff grades. These trusts have a clear vision of what it is that they want to achieve. The provision of services at the hospitals should be seen from the perspective of safety for women and babies.

Staffing

37.20. **Cllr Angharad Davies:** The 2012 NCAT report raises serious concerns about safety and staffing. How can Save the DGH argue for a two-site option in the light of this report?

37.21. **Liz Walke:** We believe that ESHT's management caused the safety issues and that the service should not be run as it was before. ESHT should have staffed the EDGH consultant-led site properly. However, we recognise that the reputation of the Trust has led to difficulties in recruitment; many midwives are leaving and there is a national shortage. Things have got worse and that is why we need change but it doesn't mean to say that there cannot be two consultant units: not necessarily

consultant led, maybe consultant delivered. There may be different ways of staffing them, but there should be two units.

37.22. **Brian Valentine:** The NCAT report is damaging which is why the temporary reconfiguration was justifiable. During that time, ESHT said they were going to stabilise the situation, enhance recruitment and come back with another, safer model of care.

37.23. **Cllr Angharad Davies:** How could the Royal College of Gynaecologists' (RCOGs) recommendations for fully staffed services be achieved when ESHT cannot attract training grade, staff grade and associate specialist doctors to the sort of unit envisaged in a 'two-site option'?

37.24. **Liz Walke:** Clinicians consider the local area when deciding where to work; the south coast is an attractive place to live. Therefore, if ESHT can develop thriving, innovative hospitals, then doctors will want to work in the Trust. However, ESHT has historically failed to do this and, as a result, doctors have not come here. Enhanced recruitment is only possible in viable units that are attractive.

37.25. **Brian Valentine:** It is possible to provide a good service with small catchment areas. However, it almost certainly would have to be staffed by doctors who did not want to go onto consultant grades. This is possible as not all doctors want to be consultants; some are content with continuity of income and without the pressures of being a consultant.

37.26. **Cllr Michael Ensor:** The CCGs and ESHT say they have attempted to recruit and money is not a 'limiting factor'. However, they do not consider that they can recruit the staffing needed as you indicate. What would be needed to resolve this?

37.27. **Brian Valentine:** ESHT has to make potential doctors aware that it has viable and stable maternity units that will not be moved, broken up and have their staff displaced. For example, staff at CBC were moved temporarily to the Conquest on one occasion. ESHT should re-plan the service and let its staff know that there is continuity. If the Trust has doctors who are in stable career grades, it would not have the problem of trainees coming through who do not have sufficient experience.

37.28. **Cllr Frank Carstairs:** You mentioned 'associate specialists': can you explain why they do not exist anymore? Can they be brought back in and would that help?

37.29. **Brian Valentine:** The 'associate specialist' was abolished in 2008 at which point 'career grade' staff came in who required several years' experience. Some of the career grade staff did not require a RCOG qualification and most would not have had their certificate of completion of training. This would have prevented them from progressing to consultant level. However, they would have had at least four years' training within the specialist field. This means they would have been similar to the associate specialist.

37.30. **Cllr John Ungar:** What are your views of the current temporary arrangements in terms of clinical outcomes and the use of temporary staff?

37.31. **Liz Walke:** Some staff who work for ESHT have contacted Save the DGH. They are very unhappy with the Trust. None of these staff say that they want to continue working for the Trust and a lot of them have left. The future supply of non training grade staff is uncertain and solutions need to be investigated.

37.32. We can speak with more authority about women who have had babies and the often horrendous experiences that they have had. These experiences do not figure in any report because they do not count as a 'serious incident'. However, the psychological damage and trauma caused has been immeasurable and, whilst there may be no long term physical problems, the emotional scars will live with them forever.

37.33. There have been physical injuries to women as well, with delays in treatment being one of the major causes of damage to a baby and mother. That is why we say that transfers to the obstetrics unit should not be more than 30 minutes. An onsite obstetrics unit at EDGH is what we believe is the safest option and believe all women should start with a midwife.

Journeys

37.34. **Cllr Ruth O'Keeffe:** The public are concerned about transport for mothers and families. Is the boundary between serious incidents and 'middling incidents', like Born Before Arrival numbers (BBAs), something that HOSC will need to consider?

37.35. **Liz Walke:** People have spoken out about issues that would not qualify as a serious incident such as having a baby in car. If you have to transfer, and the outcome medically is not a serious incident, then that does not get recorded.

37.36. **Cllr Peter Pragnell:** Is there an ambulance almost permanently on standby at CBC?

37.37. **Dr Amanda Harrison:** There are no ambulances permanently on standby at CBC. South East Coast Ambulance NHS Foundation Trust (SECAmb) has a very sophisticated modelling system that allows them to identify where their next call is likely to come from and they station their ambulances accordingly. If an ambulance happens to be parked nearby, it would not be specifically there to support CBC.

37.38. **Cllr Michael Ensor:** HOSC will ask SECAmb whether its modelling system changed because of the temporary reconfiguration. We will also ask how frequently there are transfers between Eastbourne and Hastings.

Consultation with GPs

37.39. **Cllr Alan Shuttleworth:** Should there be a confidential questionnaire for GPs about the options as part of the CCGs' consultation?

37.40. **Dr Gietzen:** A confidential questionnaire could indicate that not all GPs support the proposals for a single site. Due to all sorts of factors, the single site question is not easy for all GPs to answer honestly. So we would want to see a properly worked up questionnaire that was statistically valid.

37.41. **Catherine Ashton:** The CCGs considers that there is no need for a GPs' questionnaire to be done in secret. The CCGs are providing opportunities for all GPs to have their voice heard. We are attending all of the cluster meetings and the locality meetings and we are talking to individual practices and GPs about their concerns. The CCGs want the process to be transparent.

37.42. **Brian Valentine:** The important thing about a poll is that every person's views should be considered individually. As long as the people who are making the decisions read it, they will query the veracity of the decisions and statements they are making, fairly or unfairly. An independently led poll would not be a bad idea.

37.43. **Cllr Michael Ensor:** If there is a GP out there who has concerns and wants to raise those confidentially, they can make their comments known to HOSC.

<u>Evidence from Stephen Lloyd, MP</u>

37.44. **Stephen Lloyd MP:** A senior clinician at ESHT (to remain anonymous) made the following comments about the state of maternity and paediatrics:

- Concerns about the supply of middle grade paediatric doctors who keep the service 'alive'. They are not in as short supply as obstetric middle grade doctors. But it is not easy to keep the service going and there are always gaps in the rota.

- There are a number of older paediatric consultants who do not go out on call at night and who are blocking posts for younger consultants who could help middle grade doctors.
- It is questionable whether consolidating paediatrics services onto a single site will improve quality. Those giving this advice are senior consultants who are likely to have vested interests.
- Concentrating obstetrics on one site rather than hiring obstetric consultants on both sites would limit consultant numbers and dilute the competition for lucrative private consultant practice.
- The reduction of obstetrics units to a single site would force people living in towns that border two catchment areas, such as Seaford and Uckfield, to go to obstetrics units in Brighton and Pembury, where demand is already too high.
- For the last 18 months, the vast majority of babies at CBC who needed resuscitating went to Pembury, not ESHT hospitals; these figures are not included in the consultation.
- It is likely that activity and income will not return to EDGH and a lot of experienced staff will leave both sites.
- The outcome has already been decided by the CCGs and they will choose Option 6, the same as the current temporary reconfiguration.

37.45. **Councillor Michael Ensor:** The Better Beginnings consultation includes a questionnaire that is structured in such a way that members of the public and clinicians can leave comments for the CCGs to consider during their decision making process. This should provide a sufficient source of anonymous comments from clinicians who have concerns about the consultation as it has been widely publicised amongst medical practitioners in East Sussex.

Crowborough Birthing Centre (CBC)

37.46. **Cllr Bob Standley:** If consultant-led units were to be maintained in Eastbourne and in Hastings, would CBC be needed?

37.47. **Liz Walke:** Women throughout East Sussex should have the opportunity to give birth in an environment that does not remind them of a hospital. We commend the CBC. It has been under threat for a long time, and still is. Yet it has remained open. Due to continued uncertainty, they want to be aligned with Maidstone and Tunbridge Wells NHS Trust. We support this idea and understand that women at CBC might not want to travel to Eastbourne or Hastings in an emergency.

37.48. **Cllr Angharad Davies**: Save the DGH appears to be in favour of having midwife-led units alongside, or within very easy access to, obstetrics units. What does Save the DGH feel about the future of CBC?

37.49. **Liz Walke**: The safest option for a midwife-led unit would be to have it alongside an obstetrics unit. However, CBC is less than 30 minutes from the obstetrics unit in Pembury, so it is sufficiently safe. An obstetrics unit at CBC would not be viable because there are only about 300 births.

37.50. As the age of women giving birth increases, more consultant-led births will be needed. However, it would be preferable for everybody to start with a midwife and then get referred to a consultant if necessary.

37.51. **Brian Valentine**: Midwives should be commissioned to continue to provide a home delivery style service at the CBC, rather than having to do it in a house where something might go wrong and they have no first line communication or evacuation. This would be preferable solution for residents in the north of the county as the CBC has demonstrated.

Evidence from Friends of Crowborough Hospital (Richard Hallett and Cllr Richard Stogdon):

37.52. **Cllr Richard Stogdon:** The people being served by Crowborough Hospital extend well beyond the boundaries of Crowborough and the High Weald. The evidence on pages 442 and 443 of the evidence pack ring exactly true with the discussions we have had with women living in the High Weald.

37.53. **Richard Hallett:** The CBC is a marginal issue compared to the issue of the location of an obstetric unit at either EDGH or Conquest Hospital. However, in the High Weald, concerns over the future of the CBC are very much at the forefront of women's minds.

37.54. Births are a small part of the workload for the midwife team and they spend about 70% of their time on antenatal care for the 800 pregnant women who use the service annually. This means that the midwife team is an integrated team, with the same midwives caring for women during their pregnancy and then helping to deliver their baby (if they choose to give birth there).

37.55. CBC does not operate in isolation and women who use it will need to use other maternity services during their pregnancy. These include 12-week and 20-week scans and a 28-week blood test that needs to go to a pathology lab to be analysed. Some women may also need to see a consultant, either for referral to higher risk consultant-led care, or to confirm that they can be placed on a low risk pathway.

37.56. Over the past few years, these support services provided by ESHT have gradually moved further away from High Weald, in part due to a series of crises at the Trust. This began in 2010, when ESHT stopped the scanning facility at CBC. Since the temporary changes in May 2013, the nearest consultant referral that ESHT provides is in Hastings. Due to the risks associated with being referred to consultant-led care at Hastings, most High Weald women are now opting out of the ESHT provided Crowborough maternity pathway and referring themselves to an alternative provider that has local facilities for maternity scanning.

37.57. Midwives at CBC find it frustrating that they cannot provide the full range of maternity care that the women using the facility expect.

37.58. The maps used to show patient flows are out of date as they do not take into account the changes that took place in May 2013. The maps that we have produced using midwives caseload data from July – December 2013 show that women in the High Weald are rarely using ESHT maternity services for their place of birth. ESHT is no longer in the position to provide joined up maternity care in the High Weald and fewer than 4% of women in the High Weald are using the obstetric services at Hastings. [NB the map was updated to fall in line with the postcode data presented by the CCGs – see revised submission for HOSC 20 March 2014 evidence pack 2, page 517].

37.59. Women in High Weald have described the disconnect that they experience with the maternity services in Hastings, yet this has not been fed into the consultation. None of the consultation options actually address these women's concerns.

37.60. Clinically robust alternative arrangements could re-join maternity services and be delivered more cost effectively without a subsidy of £400,000 each year.

37.61. In my view, the CCGs are not considering these options because ESHT has a monopoly on community-led midwifery and women cannot choose who provides this service. Until ESHT are prepared to relinquish their monopoly then the local CCG will find it very difficult to change the service to better suit women's needs.

37.62. High Weald Lewes Havens CCG should try to replicate the maternity pathway in the south of its catchment area. A woman living in Lewes will not have to travel further than Brighton to receive the full range of maternity services.

37.63. ESHT receives a £400,000 subsidy from the High Weald Lewes Havens CCG to run CBC. If Tunbridge Wells Health Care NHS Trust became the provider of the CBC, they would run maternity in High Weald so the CCG would no longer need to provide the subsidy.

Safety of standalone MLUs

37.64. **Cllr Michael Ensor:** Is it appropriate to have CBC such a long distance from consultant-led care?

37.65. **Richard Hallett:** The 2011 Birth Place Study of 65,000 women showed that not only are midwife-led units very safe for women to use, there are benefits for low risk women being in a midwife-led unit compared to those same women being in a consultant-led obstetric unit. Midwife-led units also offer better value for money for low-risk women than obstetric units.

37.66. CBC works well because it has a very clearly defined and thorough pathway that allows women to be transferred to consultant-led care if needed. On average during 2013, there was less than one transfer per week and most transfers were for failure to progress in labour. The safety record of CBC, dating back to 1997, is very good.

37.67. In 2010, the number of births at CBC was 322 and rising. After the scanning facility closed, the number of births began to fall. This shows that the way the CCGs structure maternity pathways makes a significant difference to whether women choose a midwife unit.

37.68. A 2011 review of CBC shows that 35% of the women registered at the GP surgeries in Saxonbury, Beacon, Groombridge, Mayfield, Ashdown, and Forest Row were having their birth at CBC. In Eastbourne, it was closer to 20% of women using midwife-led units. If the maternity pathways were improved so that the majority of women could be encouraged to use midwife-led units, it would make the obstetric units less crowded. That is good for the women who did not need to be there and good for the women who need that service.

Transfers

37.69. **Cllr Michael Ensor:** It sounds as though CBC has worked out the significance of high risk to low risk patients and is able to minimise the need for transfers. Is that scenario equally applicable to birthing units elsewhere, for example, at the midwife-led unit at EDGH?

37.70. **Richard Hallett:** All maternity pathways must consider a critical non-medical factor: whether women and midwives perceive that there is a quick and efficient pathway to obstetric help for situations where complications develop during labour. If they perceive that they are too far from help, even if medically they are not, it will affect their confidence and the woman may not choose the midwife-led unit. Many of the women who have submitted comments to HOSC say that they are concerned about the closures due to staff shortages and the lack of certainty that this generates.

37.71. Currently, if a woman in the High Weald area chooses ESHT's maternity pathway and chooses to give birth at CBC, she will be offered a scan at EDGH or the Conquest. If she needs a referral to a consultant, she will be referred to the Conquest. Many women see this as inconvenient, so a significant number of women in the High Weald now opt for Pembury to have a consultant-led birth simply because they can receive all of their scans and blood tests at a single hospital near to where they live.

37.72. We need local, midwife-led care for the 800 women in the High Weald. Women can have a local community midwife as their named midwife; they can have a local scan at Pembury or Princess Royal, Haywards Heath; they can see a consultant locally and it would encourage many more women in High Weald to use non-obstetric facilities for birth. Although it sounds paradoxical, with the High Weald being linked to the local obstetric providers, it would actually give more women greater confidence to choose to try for a low risk midwife-led birth. Women in High Weald should be able to choose a midwife-led unit that can provide a local scan and have access to local consultant-led care.

37.73. Women must now choose to go to a maternity unit with scanning facilities (as they are not available at CBC) for a considerable amount of their pregnancy. After the final scan, they then have to be encouraged to opt-in to continue their maternity pathway at CBC (rather than remain at the other unit or go to an obstetrics unit). If CBC had scanning facilities, then local women could receive all of their care at the Centre from the beginning and only opt-out if they needed consultant-led care.

37.74. CBC requires very little upgrading or updating to accommodate this new model. Fundamentally, the only real problem is that the 16 midwives and 13 full time equivalent midwives are employed by the 'wrong trust'. Inevitably, when trusts have access to different information systems there is a built in disconnect: a scan at Pembury will be put onto their system, but the midwives in Crowborough work for ESHT and are on a different system. The tensions this creates in maternity pathways for local women is recognised but is not addressed in the consultation options. The problem is that the consultation is about maternity services provided by ESHT rather than maternity provided to the inhabitants of East Sussex.

37.75. The maternity landscape in the High Weald has changed. A maternity service for women on the south coast and a separate service for the women in the High Weald ought to be considered. However, the predominant issues that ESHT has to contend with are on the south coast. What goes on in land in the High Weald is a 'distraction' to the main issue.

37.76. **Cllr Ruth O'Keeffe:** The biggest problem appears to be an organisational one: because people cannot be booked at CBC for scans and then automatically transferred to Pembury in the event of a problem, or the identification of increased risk, people do not book at CBC in the first place. This leads to a drop in births at CBC, which then leads to a case being made that there are insufficient births there for it to be a viable unit.

37.77. The figures for 2012 in the evidence pack show that 77% of the women attending CBC who did transfer to an obstetric unit went to Pembury. We need to look at the how to make this a more formalised route. Women who receive scans at ESHT's Lewes Community Hospital are booked to give birth in the RSCH. This demonstrates that maternity pathways that cross trust borders are possible.

37.78. **Richard Hallett:** CCGs need to ensure that women have a choice of the type of birth they want, and that women who do not need to be at an obstetric unit have an easily accessible place at a midwife-led unit.

37.79. ESHT could provide a Midwife-Led Unit at Eastbourne and Hastings and let a different provider run CBC because the High Weald sits in the natural catchment area of other obstetrics units. These types of arrangements will help to stop staff shortages that have occurred periodically at CBC, as staff will not need to be transferred from CBC to make up shortages at the Conquest.

37.80. **Councillor Alan Shuttleworth:** The RCOG good practice report (December 2013) states that "40% of first time mothers who are identified as low risk need to be transferred to obstetrics units when in labour. These transfers need to be seamless".

Is CBC close enough to other obstetrics units (in Pembury and Haywards Heath) for this not to be a concern?

37.81. **Richard Hallett:** In an emergency Pembury is the unit that women are sent to because it is closer. The problem is that, at no notice, Pembury has to take on a woman whose medical records have only been entered on ESHT's databases. Transfers are done well and there have been no incidents, but this is because the midwives work well together rather than because the pathway is working well.

37.82. Contractual issues are making it difficult for the CCGs to act and change the provider, even though ESHT is not in a position to service the High Weald. Contract for maternity should be constructed around patient flows and the needs and choices of women. This might not be in the remit of this consultation, but it should not be let slip and the problem should be resolved for the long term.

37.83. **Councillor Michael Ensor:** It is not part of this consultation process but we will have a comment in our final report about the future provision of maternity in the High Weald. We will also look at this issue in the future if it is not resolved satisfactorily.

37.84. **Lindsey Stevens:** The reason we have made decisions to close CBC in the past is because we have the obstetrics unit at Conquest Hospital that has the vast majority high risk births, so at those times when we have difficulties with staffing, we have to prioritise Conquest Hospital. It is not ideal, or an easy decision, but safety has to be paramount.

37.85. **Frank Sims:** The prime reasons for the consultation are patient safety and choice, not the needs of providers. One of the big issues that has been raised is how the patient experience links with choice and patient flows. We will pick up some of the issues raised around women's transfers from the CBC with the providers immediately to ensure that operational elements of the service flow properly. We would do this even if there was not a consultation.

37.86. **Lindsey Stevens:** CBC is closer to Pembury than EDGH is to Conquest Hospital. This has led to the assumption that the closer a midwife-led unit is to an obstetrics unit, the safer it is. Maidstone Trust also has another midwife-led unit that is equal distance from Pembury that has had an increasing birth rate year on year. National evidence suggests that 'alongside' midwife-led units do not have the good outcomes that 'standalone' units do.

37.87. **Amanda Harrison:** ESHT is not inhibiting change. Our clinical staff and management have looked at, and continue to look at, any option that would benefit women in the local area and we would not stand in the way of that. It will not be income that drives us, it will be safety, quality and the experience that our patients receive that will drive us.

37.88. ESHT cannot make the consultation about something that we cannot legally make it about, the consultation cannot be contingent on an outcome of a procurement process that has not taken place.

The meeting concluded at 12.57pm.

East Sussex Community Voice

Better Beginnings Consultation

Independent Public Question Time Events

********ABSTRACT********

This document is an executive summary from East Sussex Community Voice (ESCV), of the key discussion points raised during three independent Question Time events, arranged by ESCV to support the Better Beginnings consultation.

March 2014

East Sussex Community Voice - Registered CIC: 08270069

1. Executive Summary

1.1. This document is an executive summary from East Sussex Community Voice (ESCV), of the key discussion points raised during three independent Question Time events arranged by ESCV to support the Better Beginnings consultation.

1.2. The main purpose of this summary is to give the HOSC an overview of the types of questions posed by attendees at the Question Time events, and in particular to highlight the areas where answers from the Clinical Commissioning Group officers were not accepted by the audience or where more detail would inform the process.

1.3. More information is available on the consultation at the Better Beginnings website www.betterbeginnings-nhs.net/get-involved/events/, by calling 01273 403563 or emailing hrccg.betterbeginnings@nhs.net

2. BACKGROUND

2.1. A core East Sussex Community Voice (ESCV) service is to deliver the Healthwatch East Sussex function (HWES).

2.2. The key Healthwatch East Sussex objectives are:

- Gathering views and understanding the experiences of patients and the public
- Making peoples' views known
- Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinized
- Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)
- Providing advice and information about services and support for making informed choices
- Making the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion
- Provide NHS Complaints Advocacy via a partner agency under contract

2.3. Better Beginnings Consultation: This consultation programme being delivered by the three Clinical Commissioning Groups (CCGs) relates to the future provision of maternity and in-patient paediatric services in East Sussex and

emergency gynaecology. There are 6 options under consideration and these are detailed in the consultation documentation.

2.4. Maternity and Paediatrics Programme Board: East Sussex Community Voice, under its Healthwatch East Sussex function, was invited to join the Programme Board by the CCGs as a non-quorate member.

2.5. ESCV has attended each Board, with lead representation from Julie Fitzgerald (ESCV Director), and deputised by Richard Eyre (Stakeholder Relationships Manager).

2.6. Maternity and Paediatrics Communications and Engagement Working Group: ESCV was also invited to participate in this working group. Our main purpose has been and continues to be to provide advice and support for the overall process including communications tools, engagement, the consultation design and use of accessible language.

2.7. ESCV has also supported the CCGs in organising additional focus groups via our partner framework. These have targeted key groups identified in the Equality Impact Assessment (EIA) that may require additional publicity and promotion of the consultation, and support in understanding how the options may affect them. The groups identified and the organisation delivering the work are indicated in the table below:

Vandu Language Services	Ethnic minorities particularly migrants
East Sussex Disability Association	Recent or potential maternity and / or paediatric service users with a disability or long term health condition
Care for the Carers / East Sussex Parent and Carers Council	Parents / carers of children with complex needs or long term conditions
Friends, Families and Travellers	Gypsies and Travellers
SPARK	Young parents

3. Why hold Question Time events?

3.1. ESCV suggested to the Programme Board that additional value might be brought to the consultation process through an independent forum at which the public could ask questions directly of decision makers, make their views known, and that promoted involvement of people in the commissioning and provision of local care services.

3.2. The solution was for ESCV, through delivery of its Healthwatch East Sussex function, to hold three independently Chaired Question Time events, one for each CCG area.

4. Meeting structure and panel

4.1. The event structure was designed similar to that of a BBC Question Time. With a panel (see below) made up of representation from the local CCG, elected representatives, independent clinicians (when available) and local campaign / interest groups.

Event timeline	
Welcome and introduction	5mins
Better Beginnings update	10mins
Comments / questions from the non-CCG panel members	10mins
Questions from the public	60mins
Final thoughts from the panel	5mins
Summary from the Chair	-

Panel structure
Role
Independent Chair person
CCG area based Campaign group
CCG area MP(s)
CCG Maternity and Paediatric Programme Lead
CCG Maternity and Paediatric Clinical Lead
CCG Senior Manager
CCG Patient Public Involvement Lead
Independent Maternity Clinician (Uckfield only)
Independent Paediatric Clinician (Uckfield only)

4.2. The objective for the Question Time events was to support the consultation process by providing people an additional independent environment to question and raise concerns with the key decision makers. It was hoped attendees would

be supported to gain sufficient knowledge and information from which they could confidently go away and complete a consultation document.

4.3. It was also felt important that this could be an environment for other individuals / groups with a significant interest in the consultation to provide answers to public questions.

4.4. The further consideration, which due to timing has only been available for the Uckfield event, was for representation from independent maternity and paediatric clinicians who have supported the development of the consultation options. ESCV did however suggest at both the Hastings and Eastbourne events, that if people had questions for these panellists, we would raise them with the clinicians and provide feedback to the individual, HOSC and the CCGs.

4.5. Event timings: This consultation is of county-wide relevance and ESCV intended for people to feel welcome to attend any event, not just the one in their local area.

4.6. Our original thinking was to hold one day time (Eastbourne) and two evening (Hastings and Uckfield) events. This was to ensure that people with commitments which made it impossible for them to attend evening events had an opportunity to still come and have their voices heard in an independent environment.

4.7. ESCV received formal representation from the Leader of Eastbourne Council, Cllr David Tutt, and the Eastbourne panellists' Liz Walke (Save the DGH) and Stephen Lloyd MP, which raised concerns that a daytime event might prejudice the Eastbourne public view, as the timing was not accessible.

4.8. As take up for the daytime event was at that stage minimal, ESCV re-scheduled the event to an evening time slot. At the Eastbourne event, a member of the public did query why a daytime version of the Question Time had not been made available, especially for parents who could not get out to an evening event. ESCV has noted this, and will duly consider it in future planning of similar events.

4.9. Publicity and communications: ESCV used a variety of methods to publicise the three events. Via the Healthwatch East Sussex and Better Beginnings websites, through our e-bulletin and contacts lists, through partner update lists and also to local media. Air time includes on the BBC Sussex Drive Time show (10 March), and written media included coverage in the Sussex Express, Eastbourne Herald and Hastings Observer.

4.10. A final point to note is that the Question Time events formed a part of the wider consultation engagement activity provided by the Clinical Commissioning Groups (CCGs), thus they were one of a number of events which provided

opportunities for people to go and find out information and to raise their concerns.

5. Hastings Question Time - key information for HOSC

5.1. Appendix A lists an abridged version of questions raised by attendees.

5.2. The panel for this event is detailed in the table below:

Role	Name
Independent Chair person	Julie Fitzgerald
CCG area based Campaign group	In the audience, not on panel.
CCG area MP(s)	Apologies received.
CCG Maternity and Paediatric Programme Lead	Amanda Philpott
CCG Maternity and Paediatric Clinical Lead	Greg Wilcox
CCG Senior Manager	Jessica Britton
CCG Patient Public Involvement Lead	Barbara Beaton

5.3. Although attendance at Hastings was low (10), a worthwhile discussion took place. Amongst the key concerns / comments were the following:

- that travel times affect patient safety
- that the road infrastructure is not sufficient across the county to support patient transfers
- request for information on how statistics used to inform the consultation document
- information on which factors will inform the decision on which site to locate services
- what guidance was used to inform staffing levels for maternity services
- training to be a midwife currently feels like training to be an obstetric nurse
- current mentor levels are low due to staff distribution
- equipment provision is not supporting equality of choice for women
- would two midwife led units be feasible in the long term
- does the decision of the 3 CCGs need to be unanimous, or is a two to one vote feasible
- will petitions affect the decisions made by the CCGs
- credit was given to the CCG for attending the event and working with Healthwatch East Sussex

5.4. Summary: The main reflections from the audience were almost entirely related to the options for maternity provision, with no specific concerns raised on the paediatric options.

5.5. The CCGs provided relevant and evidence led answers to questions.

5.6. One area, on which there was uncertainty, was on the effect a split CCG decision (two to one) would have on the final decision. This is an area which HOSC may wish to consider further.

6. Eastbourne Question Time – key information for HOSC

6.1. Appendix B lists an abridged version of questions raised by attendees.

6.2. The panel for this event is detailed in the table below:

Role	Name
Independent Chair person	Julie Fitzgerald
CCG area based Campaign group	Liz Walke - Save the DGH
CCG area MP(s)	Stephen Lloyd MP
CCG Maternity and Paediatric Programme Lead	Amanda Philpott
CCG Maternity and Paediatric Clinical Lead	Mark Barnes
CCG Senior Manager	Catherine Ashton
CCG Patient Public Involvement Lead	Frances Hasler

6.3. Attendance at Eastbourne was 37. Amongst the key concerns / comments were the following:

- there is confusion about current paediatric service delivery
- safety issues around transferring children with complex medical needs over distance, some parents had moved nearer to the hospital due to the severity of the child's need to avoid long travel times
- that road infrastructure affects safety and travel times
- how will peoples' views be weighted and reflected in final decision
- a situation similar to Mid Staffs happening in East Sussex if 2 site options are not delivered
- what consideration has been given to low risk births that become high risk and require intervention
- what process and evidence informed the decision to implement the temporary changes

- what external factors are affecting recruitment and therefore achievable staffing levels in units, i.e. visa restrictions
- why were services allowed to reach crisis point
- what will be done to change the perception Eastbourne DGH is being run down
- despite quality and safety guidelines, how will the CCGs justify their decision if the general community consensus is for services to be provided at both Hastings and Eastbourne sites
- how do the local CCG representatives justify making a decision that could be to the detriment of Eastbourne, Hailsham and Seaford residents

6.4. Summary: The main reflections from the audience were on both maternity and paediatrics services, with a slight higher reference to paediatrics.

6.5. The CCGs provided relevant and evidence led answers to questions.

6.6. One area which HOSC may wish to consider further is if the general community consensus is for services to be provided at both Hastings and Eastbourne sites, how will the CCGS incorporate this feedback into their decision making process?

7. Uckfield Question Time – key information for HOSC

7.1. Appendix C lists an abridged version of questions raised by attendees.

7.2. Attendance at Uckfield was 27. Amongst the key concerns / comments were the following:

- that the consultation focuses too much on location of services and not patients pathways
- improving access to patient records for women who go to Pembury, but who originally registered with ESHT?
- there is a desire for Crowborough Birthing Centre to be managed by Maidstone and Tunbridge Wells NHS Trust
- there was a request for the East Sussex CCGs to influence Kent CCGs to take on board needs of East Sussex residents
- there is a concern future population growth in Wealden has not been considered in the consultation
- there was confusion over why women are transferred to Conquest Hospital when Pembury is closer
- attendees questioned whether the Hastings / Eastbourne options are equally viable

- attendees felt the consultation should be about the residents needs not boundaries of the NHS Trusts
- clarity was asked for, on how the final decision will be reached if the other CCGs want different options
- attendees were concerned about the effect on patient choice for women in High Weald if Crowborough rural areas require different pathways to urban ones, different solutions are needed

7.3. Summary: The main reflections from the audience were on maternity provision at Crowborough Birthing Centre and the perceived lack of good quality pathways which meet the needs of the local population; whether the CCGs have an equal vote, if some are more influential than others, and on the potential for Crowborough Birthing Centre to be managed by a different provider with the aim of ensuring a service which better meets the needs of local women.

7.4. The CCGs provided relevant and evidence led answers to questions. They were unable to provide feedback on the number of serious incidents recorded by ESHT at Crowborough Birthing Centre, but promised to release this information.

7.5. Once the model of care is decided by the CCGs, an area the HOSC may wish to consider for further discussion is the request for local services which better reflect the needs of local people and the quality of the pathways available to them.

8. Conclusion

8.1. The Question Time events have met the objective of providing an independent forum for members of the public to ask questions, and have their voices heard.

8.2. Although numbers attending have not been significantly high, the quality of the discussion has been wide ranging, and informal feedback has suggested the events were a useful tool.

8.3. From the Healthwatch East Sussex perspective, ESCV also welcomes the CCG commitment to embracing the input of the public when key commissioning options are under consideration.

Hastings Question Time (3rd March) Appendix A

The information below is an abridged version of the questions asked by audience participants at the Hastings Better Beginnings Public Question Time event.

1. Where does it say in the consultation document about travel times to get to appropriate care? What does the CCG say about this?
2. Due to road infrastructure the travel times to services causes issues. What is the CCG going to commission with regards to obstetrics in order to address these issues and access to services in an emergency?
3. The new system has been in place for 9 months now and infrastructure has been put in place and now there is further discussion around these services being located at EDGH. Are stroke services going to be looked at again as these are now based at EDGH?
4. How are statistics around the improvement or changes in the service fed into the consultation?
5. What factors are being considered for site of consultant services?
6. Transport for Hastings residents is an issue. There is complacency in Hastings as the services are sited there at the moment.
7. How were staffing levels decided on at the Conquest to enable them to accept high risk women giving birth?
8. Staffing levels have affected training. Training to be a midwife now feels like training to be an obstetric nurse. Staffing levels not increased greatly and mentor levels are low due to staff distribution.
9. The equipment is not supporting this change for equality for women and care, and needs to be sorted. There are two midwife led units at the moment, is this feasible long term?
10. When the CCG makes the decision in July will the board consist of all three CCG's or just one of them?
11. Are the figures misleading as the Eastbourne figures are based on Eastbourne and the surrounding area and Hastings and Rother figures are split into 2 areas. Will this be taken into consideration?
12. Would you be willing to undertake a media event around what has led you to make this decision? Would you be willing to share the information around travel times and risks as there is anxiety around this?
13. I came today and I have been informed. This information has not been widely publicised. People are under the impression that the Conquest is ok now and not understanding that it is about quality of care not location of services. Will petitions affect the decisions made by the CCG's? If these are not considered in decision making then what is the point of doing them?

14. Credit given to the CCG as this public event has had a very different feel to it and along with the inclusion of Healthwatch East Sussex has been very positive. What are the plans for community midwifery and home births?

Eastbourne Question Time (10th March) Appendix B

The information below is an abridged version of the questions asked by audience participants at the Eastbourne Better Beginnings Public Question Time event.

1. There is strong confusion about where paediatric services are delivered. In particular within the ambulance service and where children will be treated. Some of this depends on time of day and if the short stay unit is open at the DGH or not. What is happening about this?
2. Why are paediatric services affected by maternity services moving?
3. How can it be safe to transfer to Hastings a child who has complex medical needs when the EDGH is 3 minutes away from home? How is travel safer for children with complex medical issues?
4. [Personal story], patient taken by ambulance from [West Sussex location] to Hastings via DGH during adverse weather and took a very long time. Road infrastructure is not good. How is this being addressed?
5. There is a subtle difference between consultation and negotiation. In consultations the decision has already been made. When are we going to see a 'Mid Staffs' occurring in Eastbourne? When is the DGH going to close?
6. The proposals only seem to cater for low risk or high risk births. What about low risk births that turn high risk and need intervention?
7. Letter home from school saying that if child needs to go to hospital by ambulance they would automatically go to Hastings unless the parent could get there first and take the child to Eastbourne. How can this happen without parents' permission especially when parents don't drive and won't be able to get to the child easily? Who will be held to account when something goes wrong?
8. Are the public able to see the processes the trust took to make the changes? Is this process transparent?
9. I understand the safety issue, however it has been safe in the past and other areas in the country have made it safe. How can we address the issue of few middle grade doctors available?
10. How did it reach crisis point without people knowing and then the sudden move? Who is accountable for allowing it to get into that state without people knowing? The perception across the town is that the EDGH is being run down. Morale amongst staff is very low. Many hospital staff believe that the hospital is going to close. What is being done to change perception?
11. What was before was not good but now it is horrendous. There isn't always a paediatric doctor available to treat as has already been stated.
12. The decision was taken in 2007 to keep maternity services across two sites. Why

then did it take until 2013 to move services? What was going wrong to make these changes happen? What were the problems and what caused them? Was it use of bank staff?

13. Does the community want this to happen? Most people in the community want the Save the DGH option for services across two sites. What will you do if the wider community do not want these options, but want a two sited option?
14. There are more births and paediatric admissions in Eastbourne than Hastings. Why then did the services go to Hastings and not stay in Eastbourne? What happened all of a sudden to cause the units to close?
15. Question to the local CCG and those commissioning services in the Eastbourne area…would you only support the decision to have services Eastbourne? Those involved in the decision making, how many of them have made journeys while in labour, travelled with sick children, made the decision on which hospital to go to? How many of the decision makers have made the journey emotionally?

Uckfield Question Time (12th March) Appendix C

The information below is an abridged version of the questions asked by audience participants at the Uckfield Better Beginnings Public Question Time event.

1. Can the panel explain the rationale of a consultation that focusses on location of services and not patients pathways? Local women book PRH in Haywards Heath or Pembury in Kent, not coastal areas. Why has this been overlooked?
2. A personal experience from a Heathfield resident, 7 years ago. Booked into Crowborough, ended up at Pembury so needed also to go there for follow up. Conquest is too far and difficult to get to from Heathfield, Eastbourne at least has bus links. Point is that it is not just for birth but also for follow up, and for visitors who need to travel.
3. Can the CCG confirm here, today, that they will not countenance the closure of the Crowborough birthing unit?
4. A Woman 30 weeks pregnant, had very short labour last time (30 mins) where can she book to attend? If no Crowborough then she would need a home birth. No way could she get to Conquest. Surely it will cost more for CCG to have home birth as need more midwives?
5. Another woman was sent home from Crowborough as told not in labour, had baby at home. What would have happened in this situation if no Crowborough?
6. Consultation is not relevant to needs of the High Weald so why are we included in it? ESHT have women's notes so it causes difficulties if ending up at Pembury. Only verbal hand overs are possible.
7. This only just one aspect of cross border issues – what about consultants coming to see patients from PRH as well as Pembury? This is a long standing issue for High Weald. Earlier consultations have included this by including other trusts in the consultation.
8. A Number of births out of 800 in 2010 in High Weald went to Pembury; 250 in 2012 and now 400 as have to go there for scans as well. Is this by default Pembury taking over by default? Or is it a threat to Crowborough? Do some Pembury consultants come out?
9. What happens to a midwife if the person is transferred out of area/ They can't stay with the woman.
10. Can CCG persuade the Kent CCGs to take on board needs of East Sussex residents? How influential can it be? Will they listen or be concerned?
11. Housing need in the High Weald is only likely to create higher numbers of birth. Have these been factored in? Good transport link to London. Women need to find birthing choice and don't know what to do now?
12. A man whose daughter had to go to Pembury was disappointed that couldn't register birth as Sussex- born, wanted Crowborough.

13. Options 3&4 don't include Crowborough, what will happen if these are the preferred ones chosen? Why are they included as options? Would prefer a home birth in that instance, will these continue?
14. Attendee knew of two instances where people sent to Conquest, which means driving past Pembury, does this make sense? What of extra costs?
15. What is the logic of the Conquest/ Eastbourne DGH options – are they really equally viable? Or is there an inherent bias towards Conquest? Who will eventually make the decision?
16. Attendee accepted the need for one consultant unit in ESHT not two but consultation should be about the residents needs not boundaries of Trusts. The original website for the consultation asked people to enter a preference before being able to make comments. This is changed but will the earlier contributions be counted equally?
17. Are there any serious incidents recorded for the birthing unit as opposed to Eastbourne DGH?
18. No-one from Uckfield area ever considers going to Hastings for anything, so why need to now for births? Are we going to have to go there for other things e.g. where we may have used PRH, RSCH or Pembury? Some things we used to go to Eastbourne for, will this change? Eastbourne is now taken out of the mix of choices for us.
19. How will the final agreement be reached if the other CCGs want different options?
20. If Crowborough closes what patient choice is there for women in High Weald? There is no real choice for those who don't want hospital led births. Rural areas are different cultures from urban ones, need different solutions.
21. Even midwives not aware of choices, one was told that only PRH was an option until they asked about birthing unit then midwife went "oh yes". Is it really a choice at the moment?
22. The myths and facts pages say no closure of consultant led unit has occurred what about closures of Crowborough last year to pull midwives into conquest? When staff arrived they weren't expected apparently. It caused all sorts of problems of women not knowing where to attend and fears that it will close again.

East Sussex Healthcare NHS
NHS Trust

17 March 2014

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Private & Confidential
Paul Dean
Scrutiny Manager
East Sussex County Council
County Hall,
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Lewes,
East Sussex BN7 1UE

Dear Paul,

As the current Staff Side Chair for East Sussex Healthcare Trust I am responsible for ensuring concerns from Staff Side are shared with Management and vice versa.

We have an active Joint Consultative Committee (JSC). We meet with management bi-monthly the agenda's for the Management meetings are produced by myself and the Director of Human Resources. As Staff Side Chair I sit at Trust Board meetings and report to the JSC Forum.

East Sussex Healthcare Trust has Whistle Blowing Policies and Staff Side Representatives from all recognised Unions are always willing to assist any member who may wish to raise concerns individually or collectively.

At times when serious issues have to be discussed I have been called to meetings with the Chief Executive who has alerted us to serious events the last being that of Maternity Services.

We were informed of the number of serious incidents and the then current service was unsustainable.

Staff Side were made aware and in deed at the time it became apparent Midwives were leaving. Also at the time there were a number on ill health leave and Maternity Leave. High numbers of Agency staff both Midwifery and Medical were being engaged, which was not assisting in delivering best care at the point of delivery. Concerns of patient safety were raised with us too.

We were informed officially by Management at the JSC held in March 2013 and this is fully recorded in the minutes, which all staff have access to via the extranet.

Since the decision to single site Obstetric, Paediatric and SCBU services after initial adjustments, Staff report to us that they are much happier and feel they are now able to deliver better care for this group of patients.

On the occasions I personally, as Staff Side Chair, have visited the area Staff appear much happier.

The organisation has over the past few months undertaken a recruitment drive and has been successful in recruiting new Staff.

Staff Side and the Unions it represents are committed to safe quality care for patients. We continue on our negotiation with the Trust to ensure this is and remains the best option for patients and staff.

Individual Unions relevant to this area have been involved independently in sharing their views on the future of these services.

Yours sincerely

Jan Humber
Staff Side Chair Joint Staff Committee

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

Review carried out by: East Sussex CCGs
Document Reviewed: Reshaping Maternity Services in High Weald
Document Author: Mr Richard Hallet

On 17 February 2014, Mr Richard Hallet submitted the above paper to the Health Overview and Scrutiny Committee for consideration.

The following day, Frank Sims (Chief Officer for High Weald Lewes Havens CCG) received an email from Councillor Richard Stogdon, cc Mr Hallet and Charles Hendry MP, requesting clarity on the legal grounds that consideration of alternative service providers cannot be consulted on.

Frank Sims responded on 25 February as follows:

> Without prejudice
>
> Richard
>
> Many thanks for your email and thank you both for your well-presented feedback to HOSC.
>
> Let me try to be clear on the limits of the consultation and also to pick up your points regarding the contract as I think we have not explained this well enough.
>
> The current consultation – better beginnings:
> The consultation is principally the statutory duty of the 3 CCGs in East Sussex to identify a permanent commissioning solution resulting from the decision by East Sussex Healthcare NHS Trust (ESHT) to take urgent, but temporary changes to maternity and paediatrics on the grounds of clinical safety. This is because whilst the temporary change focused the issue, the Better Beginnings review is based on the outcome of the clinical consensus and Sussex wide work, which highlighted the need for an East Sussex solution and this is an important distinction as part of the clinical case for change.
>
> The legal issue alluded to is that we are consulting on a limited range (maternity, paediatrics and gynaecology) of services provided in East Sussex. We are looking to consult on service models of care and are not consulting on the provider of those models. And indeed we are not consulting on the wider range of patient flows outside East Sussex.
>
> I think Richard made a point relating to whether HWLH CCG should, separately review provision in the High Weald area and whether this should also be subject to consultation.

I then believe Amanda Harrison (she was the ESHT director) stated the basis for the Better Beginnings consultation – the legal issue – i.e. that we are unable to consider who provides services as the consultation is legally limited to the services and not the provider.

So, I believe two related points became intermixed.

The fundamental issue is that as part of the current Better Beginnings consultation we are not able to consider providers outside of those currently providing the service. That is because we then move from a consultation issue over commissioning arrangements to a procurement issue, which raises different legal obligations.

However, you did raise important points about the nature of the clinical pathways (access to ultrasound and transfer to Conquest rather than Pembury) and these we are able to follow up as part of ‘’normal’’ commissioning. To this end, I can confirm that I spoke immediately with Amanda Harrison and have arranged an initial meeting with her team (and I hope to include MTW) so that we can take forward the immediate issue of operational pathways.

The second point – patient flows – was picked up well by Richard and is something that we have to consider carefully about how best to understand the implications. Indeed, this maybe something that other providers, outside East Sussex, may wish to comment on as part of their own response to the consultation.

<u>The contract with ESHT</u>
The contract is 2013/14 NHS Standard contract. There are a range of parties; ESHT as the provider, Eastbourne, Hailsham and Seaford as the coordinating commissioner and 10 other commissioners (generally known as associate commissioners). The specific contract with ESHT is commercially confidential between the parties, as with any other contract but the standard contract can be found at:

http://www.england.nhs.uk/nhs-standard-contract/

I should emphasise again that the focus of the consultation and the scrutiny and evidence the HOSC are gathering relates to service models and not providers. This is about the long term safety and quality of clinical services. I am unable to be drawn into discussion about contracts with providers as that could be:

In breach of the remit of the consultation and potentially opens up the consultation process to review (judicial review)
Prejudicial to procurement law
Deemed as anti-competitive and subject to anti-competition legislation

I am however following up the issues of pathways as part of routine CCG business.

I hope that is helpful.

Frank Sims
Chief Officer
High Weald Lewes Havens Clinical Commissioning Group

The CCGs and Public Health met with Mr Hallett on 26 February to further discuss the proposals contained in his report and to understand the data and methodology used within the document.

Conclusion

"Reshaping Maternity Services in High Weald":

- has been updated and resubmitted to the Health Overview and Scrutiny Committee in advance of the March 2014 evidence gathering meeting [Evidence Pack 2 page 517]
- has been received by the East Sussex CCGs
- is included amongst the formal consultation responses
- has been circulated to the HWLH CCG senior management team and Governing Body

This will ensure:

- that the points raised are picked up properly within the consultation
- where "normal business" issues have been raised (eg the pathway aspects), along with any new information or data these are taken forward as part of our day-to-day business
- that the model of care and patient pathways are consistent with safe and effective care, that allows choice and of course which are deliverable.

Dear Members of the HOSC,

It is with great distress that I feel the need to register my opposition to the proposed changes. The six options that are being presented, as compiled by the CCG, do not even present an option that I believe meets the needs of our local population. I believe that Eastbourne DGH must maintain a consultant-led maternity unit and full paediatric services and it is most concerning that there is not an option where both Eastbourne and Hastings maintain full maternity and paediatric services. Proposed changes to these services must be prevented; closure of these facilities will mean that many people's lives will be put in unnecessary danger by having to travel to the next nearest hospital which could be anything from a 45 minute to a one hour journey away. This journey is also something that may be quite traumatic for pregnant women in labour or post delivery, especially for those who have a caesarean section given the further discomfort and pain the journey can cause. This may also be a traumatic journey for any child having to make the journey both physically or emotionally for medical care. We are lead to believe that the temporary changes have made things safer and that full services are not possible on both sites, however, just listening to the public many people still present cases of traumatic or unacceptable experiences caused by the loss of services at Eastbourne during the temporary changes. Further, the impact on the local population has been great, for some the impact has been huge, I have met people who would have chosen to deliver in Eastbourne but due to their need for consultation-led care they could not and have subsequently have had complex consequences such as Birth Before Arrival. For others the consequences have been less traumatic but have resulted in a variety of impacts such as complex decision-making regarding birth choices, financial impact, families being left with very difficult situations whilst one child is in hospital and 45 minute minimum journey away whilst others are still at home and school to give just a few examples. This is quite simply unacceptable.

As I am sure clinicians will advise, childbirth can be a complex act even for those mothers considered low-risk at the start of their labour. Nature does not let you know the outcome in advance, and a woman whose labour is progressing normally could suddenly need an emergency procedure. No longer are consultants on-site at Eastbourne, but instead, a long ambulance journey away. For those considered high-risk, giving birth at Eastbourne is no longer an option and risk is created again if any of these high-risk mothers-to-be were to go into labour unexpectedly. With 36% of new mothers and 20% of mothers who have already given birth having to be transferred to a consultant-led unit, and that is only from those who are considered low risk, it is clear that not only does a midwife-led unit lead to a high proportion of ambulance transfers it places the lives of these mothers and their unborn children at risk. In addition, this places a further requirement for sufficient services in terms of patient-transport. Therefore, not only does this create an immediate concern for the people who would use the services of Eastbourne DGH, but it will also put a strain on the provision of services at the surrounding hospitals in Brighton, Hastings and Pembury especially as our population grows. Furthermore, the health of women considered high risk is also placed in danger as if they go into labour there is no guarantee that these women will be able to reach a consultant-led unit before intervention is required. High-risk women may also require patient transport. It is upsetting to learn that having had these services temporarily taken from us as a population that we now made loose them permanently.

As both the services in danger involve children, it brings into question the impact that these changes have on family life. If people have to attend hospitals that are further afield it will add a minimum journey time of 90-minutes for a round trip – and that's people with their own transport. In terms of new babies being born it is important that families are able to spend as much time during visiting hours together and that siblings are able to visit. Adding extended commuting time to hospitals, because of the downgrade of Eastbourne, makes this complicated for parents in the period when their child is being welcomed into the world. In terms of inpatient paediatric services, for parents trying to look after their family further strains are created by the extended commute too, especially for extended stays. Again, if a child is extremely poorly the increased journey time could have a detrimental effect on the child's chances of survival.

Finally, encouraging commuting to hospitals further away, places further strains on the already stretched local infrastructure and also has a negative impact on the environment.

The proposed changes are unacceptable, are not in the interest of the local populations serviced by Eastbourne DGH or the other surrounding hospitals that will be impacted. I strongly believe that services must be returned after the temporary downgrade, in fact, they should be returned as soon as possible; the population has a right to a consultant-led maternity unit and full paediatric services especially given our forecasted population growth. Any issues in terms of quality of care and staffing issues must be resolved by improving current services not simply removing services. There are always ways to resolve issues that are faced and a team must be in place where those leading are able to find workable solutions to complex issues. HOSC must demand reassurance that there is absolute commitment from the Chief Executive and the Board of ESHT and the CCG to ensure provision of excellent care for all; without such commitment success will not ensue.

Given the IRP rulings and that nothing has in fact changed in terms of the distance to the nearest hospital and road conditions, it is difficult to see why anything other than a return to full services on both sites should not be called for.

I am sure the members of the HOSC will consider carefully their role and their duty to the public. As someone who has participated in the CCGs consultations to date, it would appear that the public have not been listened to, despite this being promised, as the options presented do not cater for the opinions selected by those in the focus groups that were run. I strongly believe that it is possible to return to full services on both sites and whilst this may not be simple I believe that there are solutions that would result in safe, efficient and financially viable care and importantly a solution that would meet the needs of the local population. I hope that the HOSC do everything in their power to ensure the needs of the local population are fully catered for with high quality local care that is fit for purpose.

Yours sincerely,

Selene Edwards

HIGHWAYS AGENCY

Our ref: FOI 144-10

Martin Wright

Floor 4C
Federated House
London Road
Dorking RH4 1SZ

Direct Line: 01306 874146
12 March 2014

Ms Emma Cox

evc2706@hotmail.com

Dear Ms Cox

REQUEST FOR DATA on the A259

Thank you for your email dated 24 January 2014 about the traffic delays and congestion on the A259. I am writing to confirm that we have now completed our search for information.

The information we are giving you relates to the section of the A259 between Pevensey roundabout (east of Polegate) and Glyne Gap roundabout (west of Hastings).

1. Journey reliability data for the A259 (between Pevensey and Hastings) from September 2012 until December 2013.

Journey time reliability data is provided on the attached sheet 'A' but to help you I should explain that when the traffic is flowing normally this section takes around 13 minutes to travel, assuming driving in accordance to speed limits and obeying traffic signals etc. Also it takes the same time, 13 minutes, whilst traveling east or west bound (when normal traffic flow circumstances are operating).

Sheet 'A' shows that the route in both directions has been reliable, against its expected journey time, for 60-77% of the time.

The important factor regarding journey time reliability is that "blue light" (emergency) vehicles are not restricted in the same way as normal traffic and all traffic gives way to emergency vehicles enabling them to reach their destination more quickly.

2. Road closure data for the A259 (between Pevensey and Hastings) from September 2012 until December 2013.

Our second sheet 'B' shows the 'emergency' road closures and 'planned' road closures that have occurred over the same period. In the case of planned closures such as road works, we exempt emergency vehicles i.e. they are not held up by the planned closures.

In the case of emergency closures such as road traffic collisions and emergency incidents, the emergency vehicles are either attending the incident or if attending a separate incident they would be allowed past the collision or incident.

In keeping with the spirit and effect of the legislation, all information is assumed to be releasable to the public unless exempt. We may therefore be publishing the information you requested, together with any related information that will provide a key to its wider context, via our website: http://www.highways.gov.uk/

If you are unhappy with the way we have handled your request you may ask for an internal review. Our internal review process is available at: http://www.highways.gov.uk/foicomplaints

If you require a print copy, please phone the Highways Agency Information Line on 0300 123 5000; or e-mail ha_info@highways.gsi.gov.uk . You should contact me if you wish to complain.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

If you have any queries about this letter, please contact me. Please remember to quote the reference number above in any future communications.

Yours sincerely

Martin Wright
NDD South East Asset Development
Email: martin.wright@highways.gsi.gov.uk

On Time Reliability Measure data for the A259

SHEET A

Monthly - Journeys 'On Time' **2012 Sep - Dec**

Link	Direction	Sep-12	Oct-12	Nov-12	Dec-12
A259 between A27 (A259) and A2036	Both	70.0%	70.8%	68.5%	67.0%

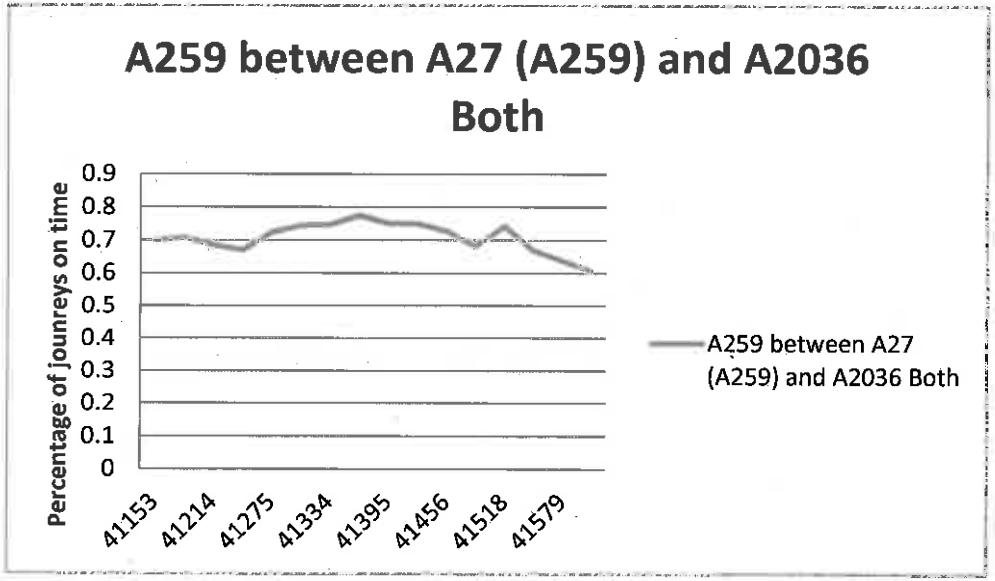
2013 Jan - Jun

Link	Direction	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
A259 between A27 (A259) and A2036	Both	72.4%	74.4%	74.8%	77.6%	75.2%	75.1%

2013 Jul - Dec

Link	Direction	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
A259 between A27 (A259) and A2036	Both	72.9%	68.1%	74.3%	66.8%	63.7%	60.6%

Table showing Journeys 'On Time' A259 between A27 (A259) and A2036



These figures are calculated by using the average journey time and working out how many journeys were made on time.

(Sheet sheet A.1 for average journey times)

Average Journey time for the A259

SHEET A.1

Average Monthly Journey Times (minutes) **2012 Sep - Dec**

Link	Direction	Sep-12	Oct-12	Nov-12	Dec-12
A259 between A27 (A259) and A2036	Either	14.4	14.2	14.1	13.7

2013 Jan - Jun

Link	Direction	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
A259 between A27 (A259) and A2036	Either	13.0	13.0	13.1	13.1	13.2	13.2

2013 Jul- Dec

Link	Direction	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
A259 between A27 (A259) and A2036	Either	13.3	13.4	13.1	13.2	13.4	13.4

Road Closure data for A59

SHEET B

Emergency Closures

Date	Start	End	Duration (Mins)	Location	Type	Delay (Mins)	Closure
09/04/2013	09:29	10:25	56	Little Common Road junction with Eastwood Road	RTC	15	East Bound is closed
17/05/2013	07:29	08:19	50	Bexhill-on-Sea, East Sussex Between B2182 and A269	RTC	10	Blocked in both directions
08/08/2013	11:42	22:35	653	De La Warr Road, Bexhill (opposite junction with Glyne Ascent) Westbound	Vegetation	10	Temp traffic signals
28/08/2013	13:00	13:30	30	Bexhill, junction with Harley Shute Road	RTC	20	West Bound is closed
17/09/2013	16:29	17:30	61	Between B2095 (Hooe) and B2182 (Little Common Roundabout)	RTC	10	Full closure in both directions
01/10/2013	16:45	18:45	120	Barn horn road junction with marsh road Both directions	RTC	20	Full closure in both directions

Planned Closures

Start Date	End Date	End time	Duration (Days)	Location	Traffic Management	Delay (Mins)	Description of works
21/03/2013	26/03/2013	23:29	5	Middle Bridge and Green Lane, Hooe (Nightworks)	Convoy	10	Junction improvements
05/04/2013	07/04/2013	00:31	1	Middle Bridge and Green Lane, Hooe (Nightworks)	Convoy	10	Junction improvements
13/06/2013	15/06/2013	04:42	1	Between Pevensey & B2095 (Nightworks)	Convoy	10	Carriage way repairs
02/10/2013	03/10/2013	03:55	0	Between Belle Hill & Pevensey RA (Nightworks)	Closure	30	Carriage way repairs

Dear HOSC members

We have been working hard on our option to provide consultant maternity and paediatric services at both Eastbourne DGH and the Conquest in Hastings. We had hoped to produce Option 7 earlier but it has not been possible however I have attached the final draft which I hope you will consider as a realistic Option as against all of those that have been proposed and more in line with what the Secretary of State for Health and the IRP recommended in 2008.

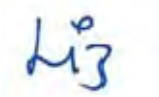
I would like to make the following important points:-

1. The RCOG Good Practice publication dated December 2013 states "There is no published evidence on the ideal size for a maternity unit."
2. Eastbourne is the 67th largest town in the UK. All bigger towns have essential core services including consultant obstetrics (except a few large towns which are part of the same conurbation e.g. Poole – Bournemouth).
3. Withdrawal of core services would make Eastbourne the most disadvantaged town in the UK (possibly Europe) with the worst population access factor (size of population x distance to core services).
4. Large towns require essential core services – Consultant Obstetrics and Gynaecology, Consultant Acute Paediatrics, Emergency Medicine (Accident and Emergency), Acute Medicine, Acute Surgery and Acute Psychiatry with the ability to undertake required necessary interventions.
5. ESHT has not implemented the recommendations of the 2008 IRP Report. Little effort has been put into how two sites can work. It can be done. Yeovil is an example of an outstanding financially stable Foundation Trust which is fully committed to maintaining the essential core services as its fundamental goal.
6. Nearly 20% of all the consultant units in England have under 2500 deliveries - 28 out of 160.
7. There is no evidence that larger units are safer for the great majority of standard emergencies.
8. The Total Transfer Time from Eastbourne to Hastings is about 94 minutes. This is the 'down time'. This far exceeds the acceptable safety limits for many interventions e.g. emergency Caesarean section.
9. Freestanding Midwifery Units are failing across the UK. East Kent Trust has closed Canterbury and Dover FMUs as pregnant women have serious concerns about access to emergency procedures and because of concerns about safety. The costs are around twice the NHS tariff. The RCOG recommends that first time mothers should not use such FMU units as they are safer in a co-located CU/AMU.
10. The Ambulance Service (SECAMB) are not trained in pre-hospital Obstetric emergencies.
11. The people of the Eastbourne area are fully committed to the maintenance of essential core service in both Eastbourne and Hastings. Eastbourne Borough Council, the Eastbourne Business Community, the Churches and Services Organisations all support the need for modernised networked essential core services.
12. Essential core service should not be withdrawn just because of staffing problems, training problems or to suit consultant working hours.

Eastbourne, compared with many places, is a very attractive option for anyone contemplating a consultancy. A teaching hospital is close, it is wealthy and there should be no lack of private gynaecology work. The only drawback is the hospital and the on-going problems in Obstetrics and Gynaecology and the removal of other core services. A clear, well defined vision for the future of the DGH as a whole (with its core services) would be a massive attraction.

Please give Option 7 your consideration.

I hope to be in attendance at the HOSC meeting tomorrow.
Many thanks and best wishes



Liz Walke
Chair - Save the DGH Campaign

www.savethedgh.org.uk

Maternity and Paediatric Service Proposals

Consultation Document

OPTION 7
THE CAMPAIGN OPTION

A Safe and Accessible Service for East Sussex

Pride of the Community

Adapt, Develop, Evolve, Specialise

This consultation document sets out the need for safe, accessible and affordable essential core services in East Sussex.

The clearly supported local need is for both Eastbourne District General Hospital and The Conquest Hospital (Hastings) to have the same essential core services:

Consultant Delivered Obstetrics 24/7
Paediatric – Consultant Ambulatory Service with In-patient beds 24/7
Acute Medical Admissions 24/7
Acute Essential Surgical Admissions 24/7
Accident and Emergency – Trauma Golden Hour 24/7
Acute Psychiatric Service 24/7

This is to be provided with sensible relocation of subspecialist services to the Regional Teaching Hospital at the Royal Sussex County Hospital, Brighton (and Pembury) together with an increase in Community Care and the General Practice Referral Management System.

OPTION 7
THE CAMPAIGN OPTION

Eastbourne – Medium Risk Obstetric Unit
Level 1/2 SCBU (Special Care Baby Unit)

Hastings – Medium Risk Obstetric Unit
Level 1/2 SCBU (Special Care Baby Unit)

Crowborough – Midwife Led Unit

Brighton and Pembury – Very High Risk Obstetrics and Neonatal Intensive Care Unit, Subspecialist Gynaecology, Level 3/4 SCBU (Special Care Baby Unit)

Eastbourne and Hastings – Community Care Obstetrics and Gynaecology

Foreward

As a Campaign Group we feel passionate about keeping essential core services at our local hospital, Eastbourne DGH. It is essential that core services, those services you need in an emergency, are literally on the doorstep or at least can be reached within 30 minutes.

The local NHS have launched their public consultation on 'Better Beginnings' with proposals for the future reconfiguration of Maternity and Paediatric services in East Sussex. Their consultation document presents six options NONE of which include a TWO SITE option for Consultant delivered services, despite a successful campaign in 2008 which resulted in the then Secretary of State for Health, Alan Johnson, stopping an attempt by the local NHS to do exactly what the local NHS are now proposing.

The local NHS Case for Change is flawed

- Myth – The need for 2500 births per unit.
  Fact – this is not a national standard but one created by a local team. There were about 5,500 births in East Sussex in 2012 and this is expected to rise.
- Too many serious incidents
  This is the result of management failure to staff the units safely. This same management which removed consultant-led Maternity and Paediatrics from Eastbourne DGH in May 2013 is still in charge!
- Too many transfers
  Transfers should only happen if more specialised care is needed. Again management failure to staff units appropriately has resulted in this.
- High number of diverts
  Again this is management failure to manage units correctly. What was an unsatisfactory arrangement before the changes is now much worse. Using this as a reason suggesting this makes things better for women in labour is the opposite. Now the place where some women were previously diverted to (before the changes) is now where the majority of women are forced to go.

Once again we have had to explore other areas and units to see what is possible. There are many other smaller Maternity units with under 2500 births, which are very safe, so we know it's possible. Option 7 – The Campaign Option provides the answer. It provides the safest option which we believe is what the majority of the population want.

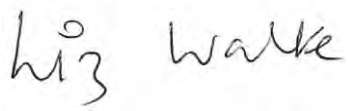
The Trust implicitly argues that training/career development issue is satisfied by a mixed consultant/midwife unit with around 4,000 births per annum. By splitting this activity between two locations the same volume and variety exists and it is simply the inflexibility of the rotas that prevent individual clinicians from the same training/career development potential. What resources are required to adequately staff two such units? Surely this would then be implicitly safer than just one unit.

Eastbourne, compared with many places, is a very attractive option for anyone contemplating a consultancy. A teaching hospital is close, it is wealthy and there should be no lack of private gynaecology work. The only drawback is the hospital and the on-going problems in Obstetrics and Gynaecology. A clear, well defined vision for the future of the DGH as a whole would be a massive attraction.

No-one in training spends their whole time in one place - they would move to general units, like Eastbourne, for hands on experience and specialist units for greater experience in the narrow field they hope to specialize in. What is lacking is the will to make it work on two sites.

Option 7 – The Campaign Option provides a two-site solution for consultant-led maternity and paediatrics which is what the local population want. This is the safest and most accessible option which does not reduce choice. The CCGs must consider this!

Please feel free to contribute with your comments and feedback via our Campaign website www.savethedgh.org.uk. If you are completing the Better Beginnings survey, please do not tick any option (Option 1-6) but write in Option 7 in the comments box.



Chair – Save the DGH Campaign

The Save the DGH Campaign Group members are:-

Monica Corrina-Kavakli – Parent Campaigner and public representative
Richard Booth – Treasurer and Chartered Accountant (LMDB Accountants, Eastbourne)
Barry Davis - Legal Advisor and Solicitor (Mayo Wynne Baxter, Eastbourne)
Martyn Relf - Chair of Churches Together for Eastbourne.
Stephen Lloyd MP for Eastbourne and Willingdon (Liberal Democrat)
Vincent Argent – Consultant Obstetrician/ Gynaecologist and Medical Advisor
John Clarke - Community Dermatologist and Medical Advisor
Sandy Medway - Churches Together and previous East Sussex Hospitals NHS Trust non-executive Director
Tim Cobb - Public Relations Advisor (Cobb PR, Eastbourne)
Ian Lucas - Representative of Local Business and Director of Eastbourne & District Chamber of Commerce
Councillor David Tutt -Leader of Eastbourne Borough Council (Liberal Democrat)
Councillor Caroline Ansell – Conservative Prospective Parliamentary Candidate for Eastbourne and Willingdon
Councillor Colin Murdoch - Conservative
Lee Comfort - Labour Party Representative
Selene Edwards - Facebook and Social Media
Alan Thornton – UKIP Party Representative
Tim Geitzen - Retired GP and Medical Advisor
Brian Valentine – Retired Consultant Obstetrician/ Gynaecologist and Medical Advisor
Liz Walke - Chair

East Sussex Residents Deserve The Best

Communities put maternity and paediatric care at the forefront of their healthcare programmes. They expect the best for their future citizens. They are prepared to invest in high quality services.

The residents and business community regard obstetric and paediatric services as the flagship of their community and essential for the retention and relocation of businesses.

There is no doubt that they require high quality consultant delivered obstetric services on both Eastbourne and Hastings.

The two campaign groups SaveTheDGH and HandsOffTheConquest have campaigned since 2006 and have received huge support from residents who have clearly expressed that essential core services must be kept in both towns.

Clinical Commissioning Groups – Buying the Service that People Need
Clinical Commissioning Groups which are GP-led decide and purchase the services needed by their patients and the local community. This should allow them to obtain the best high quality care based on clinical need rather than any reconfigurations which centralise services.

Maternity Units in Eastbourne, Hastings and Crowborough
In 2007, the Consultant Led Units in Eastbourne and Hastings, and the Midwife Led Unit in Crowborough were very popular. They were run by dedicated staff who provided a high standard of care to the local people.

The constant threat and rumours of single siting Maternity services in Hastings over the years has resulted in threatening the stability of a previously very safe unit. Threats and rumours which were realised by the centralisation of obstetrics in Hastings and a Midwifery- led unit in Eastbourne as a temporary measure in May 2013.

The ‘Worthing Report ‘ showed that both Eastbourne and Hastings had a very good safety record and that their perinatal statistics were equivalent to regional and national figures.

The high quality of these units was recognised at that time by the award of Level 3 Clinical Negligence Scheme for Trusts (CNST) Accreditation. Such high standards had only been achieved by 20% of maternity units in the South East.

Yet despite this, in 2007, there was an attempt by the local NHS to single-site Maternity services at the Conquest hospital in Hastings, removing the consultant-led Maternity service from Eastbourne DGH. The Save the DGH Campaign fought the proposals and received overwhelming public support, but despite this the local NHS pressed ahead. This was only stopped by the Secretary of State for Health at the time when the East Sussex Health Overview Scrutiny Committee referred the matter to him. The local NHS were told that consultant-led Maternity services MUST remain at BOTH Eastbourne DGH and The Conquest.

However, these services have been constantly under threat despite the Secretary of State for Health's directive that the IRP decision be implemented. The management of Obstetrics has been under constant threat of single-siting and consequently job satisfaction and staff retention have been a problem with attraction to the unit for new applicants. Added to this instability and offer of short term contract has added to staff recruitment problems.

INDEPENDENT REVIEW BY THE INDEPENDENT RECONFIGURATION PANEL

The Independent Reconfiguration Panel (IRP) published its report on proposed changes to maternity, gynaecology and special baby care services in East Sussex on September 4th 2008. This report made clear recommendations for ensuring the delivery of safe, sustainable services in East Sussex. These were as follows:

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

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

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

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

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

Alan Johnson, the Secretary of State for Health in September 2008, accepted the IRP's recommendations in full.

Safety
Recommendation 1 clearly states:
The Panel does not consider that the proposals have made a clear case for safer and more sustainable services for the people of East Sussex.

Must keep two Maternity Units
Recommendation 3 states:-
Consultant-led maternity, special care baby, inpatient gynaecology and related services **must be retained on both sites**.

Improving access for women
Recommendation 1 states:-
The proposals reduce accessibility

IRP Conclusion stated

The IRP concluded that the proposals were principally driven by the Primary Care Trusts' (PCTs) attempts to address future medical staffing issues, as perceived at the time of consultation. The strong focus on staffing concerns meant that less consideration was given to the issue of accessibility and choice of services for local people.

Arguments that a single site solution would have compensating improvements in safety and sustainability were also considered by the IRP. The IRP does agree that some changes to the staffing of the units is required to continue to deliver safe, sustainable services, however ***it does not accept that the single site solution is the only or best option*** *to achieve this.*

The PCTs should consider alternative staffing models which have not been explored so far, such as using advanced midwifery practitioners to support junior and middle grade staff. It is incumbent on the local NHS to explore the potential of these roles to develop midwifery careers and support doctors' roles locally.

During the review the IRP considered the local geography and transport infrastructure, deciding that the journey from Eastbourne to the Conquest Hospital in Hastings posed a risk of incidents for women, especially during unexpected transfers.

The IRP also recognised the potential time consuming and costly journeys to Hastings for both staff and women's families.

The PCTs must continue to work with stakeholders to develop a model of maternity care that provides choice for women and further enhances the safety, sustainability and quality of services. The IRP was impressed by the PCTs' commitment to support home births, which is likely to be further enhanced by the retention of consultant-led maternity units at both sites

The IRP decision and recommendations in response to the local NHS plans are as relevant today as in 2008.

Women want choice in maternity care, and ideally they wish to have the opportunity to opt for a birthing centre/home birth style of care, with the knowledge that the full range of hospital support would be available rapidly and seamlessly on the same site.

Women want as much care as possible to be delivered locally. The two main centres of population for East Sussex are Eastbourne and Hastings/St. Leonard's. Women living in or near to one of these population centres do not regard the other as local, and would regard the loss of an all-risk unit with obstetric support as a major and undesirable reduction in local choice.

Keeping the NHS Local - A New Direction of Travel
The Department of Health published a document: Keeping the NHS local – A New Direction of Travel.

The document sets a clear direction of travel for the NHS, especially when considering expansion and redesign. It will help the local NHS to work in a new stronger partnership with the public and staff to find high quality, sustainable solutions for local services, and deliver the agenda for reform.

The Report outlines an approach to local service design and consultation that reflects both the new requirements for partnership, the 'closer to home' model of care supported by the National Beds Inquiry and the new opportunities generated by service and workforce modernisation.

Most importantly, the Report states 'The mindset that "biggest is best" that has underpinned many of the changes in the NHS in the last few decades, needs to change. **The continued concentration of acute hospital services without sustaining local access to acute care runs the danger of making services increasingly remote from many local communities.** There is evidence that "small can work" and new models of care need to be developed. **It is time to challenge the biggest is best philosophy.**

SAFETY

Serious Untoward Incidents
This is what the local NHS said prompted the centralisation of Consultant-led Maternity at the Conquest. There were an increasing number of serious incidents – indeed a huge increase! What prompted this is unclear as the serious incidents have not been made public. Could it have been one member of staff or a particular staffing model, or something else which showed a risk which resulted in this massive increase? Had management decided to single-site services before these serious incidents occurred? If the local NHS Trust say there are significant safety issues, they can just remove services in the name of safety with absolutely no public consultation at all, which is exactly what happened at the beginning of 2013. Of course this was the same NHS Trust

who made an attempt to single site Maternity in 2007 and spectacularly failed when the Secretary of State for Health intervened, but there has always been a view held that the threat to single-site Maternity services at the Conquest never went away and the decision in 2007 had never been fully accepted.

After the temporary change was made a review was undertaken by the RCOG namely "Review of the Obstetric and Neonatal Services of East Sussex Healthcare NHS Trust at Conquest Hospital Undertaken by: Mr Paul L Wood MD FRCOG (Lead Assessor), Mr Andrea Galimberti FRCOG (Co-Assessor) and Professor Stewart Forsyth OBE MD FRCPCH (Co-Assessor) on 8 and 9 August 2013"

This review identified the main risk factors before the changes being:-

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

The themes identified from the serious incidents before the temporary changes were:

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

The concerns raised by NCAT included:

- Delays in escalation.
- Lack of supervision of locum and middle grade staff.
- Validity of the interpretation of Serious Incident Reports.
- A very worrying culture of complacency in relation to risk within maternity and paediatrics.
- Poor record keeping.

- Poor communication.
- Lack of plan of care.
- Lack of documentation.
- Lack of appropriate level for opinion/planning.
- Inappropriate grades/level of staff undertaking or providing care.
- Where a serious incident involved a poor outcome for the baby there appeared to be a minimal review of obstetric care prior to the birth.

The report also said that NCAT stated that they felt that the RCA (Root Cause Analysis) Enquiry Team did not appear to have asked the appropriate questions and therefore they felt the conclusions were likely to be incorrect.

All the areas highlighted reflect the dependence on a management who appear to have failed to fully explore alternative staffing models which was demanded by the IRP. The determination by the local NHS to succeed in single-siting consultant-led Maternity has been rewarded by management allowing a previously very safe service delivered on two sites to become unsafe.

It is this same organisation (ESHT), where these serious incidents happened, which allowed Maternity services to become unsafe to give them reason to single-site these services, who are to be trusted with the future reconfiguration of our services. This should be challenged and Option 7 does just that.

WHAT IS SAFEST?

You CANNOT predict obstetric emergencies

It is clear that many obstetric emergencies are not predictable. It is perhaps the only part of medical practice where a fit young woman undergoing a normal life event suddenly becomes seriously ill with an emergency that threatens the life of her baby and even her own life.

Skilled obstetricians and midwives can prepare and predict some problems and can plan ahead for high risk cases. Despite this action, many emergencies occur during the 3rd stage of labour with no warning and require **immediate** action.

Sudden severe fetal distress
Placental abruption
Placenta and vasa praevia

Ruptured uterus
Collapse from epidural complications, tocolytic drugs
Shoulder dystocia
Prolapsed cord
Malpresentation of second twin
Undiagnosed breech
Post-partum haemorrhage
Post-natal collapse
Unstable lie/ presentation

Litigation

Litigation for medical accidents is at an all time high despite the dedicated work of health care professionals who do their best to avoid adverse outcomes. Over 50% of all claims in medical practice concern obstetrics and gynaecology. These claims account for about 85% of the overall costs in compensation because of the high value of brain damaged baby claims. Obstetrics is unpredictable and brain damage is not always avoidable even in the best circumstances.

We believe that closure of local services and the increased travel times will lead to a large increase in legal claims, even if some litigation is based simply on the perception that the delay in transfer caused the problem. This will be difficult to defend and the costs to the NHS will far exceed any savings made.

Medico-legal experts will use the 30 minute standard described below to support claimants.

Timing – The 30 Minute Standard

Time is crucial in the management of obstetric emergencies.

A decision to delivery interval (DDI) of less than 30 minutes is the accepted audit standard for response to emergencies within maternity services.

The 30 minute standard is laid down in the National Institute of Clinical Excellence (NICE) Guidelines on Caesarean Section. This time period was accepted by the Joint Committee of the Royal College of Obstetricians and

Gynaecologists (RCOG) and the Royal College of Anaesthetists (RCA) Joint Committee in their response to the Yentis criteria for the urgency of Caesarean Section.

It is generally accepted that a Grade 1 Emergency caesarean section should be performed within 30 minutes. A Grade 1 emergency section means that there is risk to the life of the mother or baby.

A DDI of less than 30 minutes is not in itself necessarily considered to be critical in influencing fetal outcome and up to 75 minutes may be reasonably be accepted for a Grade 2 Urgent Caesarean but it is not considered ideal and could not be defended should there prove to be fetal cerebral damage acutely or at a later date.

Conversely, it is generally agreed that 'Crash' Caesarean sections for unexpected emergencies such as a potentially terminal fetal heart trace, ruptured uterus, severe ante-partum haemorrhage and a trapped second twin must be done as soon as possible with target DDIs of less than 15 minutes.

In the rare cases of maternal collapse e.g status eclampticus, APH with catastrophic hypovolaemic shock, RTAs, then Caesareans may have to be done within 5 minutes according to the Managing Obstetric Emergencies Trauma (MOET) protocols.

Consultant Presence

It is no longer considered acceptable for difficult Caesarean sections to be performed by medical staff in training and a consultant presence is considered optimal risk management at any caesarean section..

The Caesarean Decision

Decision making is very important. There is concern about increasing Caesarean section rates which has been ascribed to a lack of senior presence on the labour suite during the decision making process. Some emergency caesareans might be avoided if a Consultant is actually physically present to assess the situation, examine the woman and make a decision.

The Caesarean Operation

The RCOG Caesarean Section Sentinel Report and other guidelines require a Consultant to be present for the following whether they occur day or night:

Caesarean at Full Dilatation
Placenta Praevia
Previous multiple caesareans
Sever APH and surgical bleeding
Tearing of the uterine angle
Concern about the ureter
Malpresentations

Consultants and Core Skills

All fully trained consultants in obstetrics and gynaecology are able to carry out the core skills of Caesarean section and interventions for vaginal delivery. They are also trained to deal with emergency gynaecology especially the management of ectopic pregnancy. These are not subspecialist skills.

All essential core procedures in obstetrics and gynaecology can be performed by any trained consultant at any time of the day or night.

Traditionally consultant obstetricians and gynaecologists rarely attend night time Casearean sections which are left to middle grade staff although the previous paragraph described the RCOG's stated wish and requirement for far greater consultant input.

Nearly all subspecialist procedures, which are only performed by those with appropriate subspecialist training, are elective gynaecological procedures carried out during normal working hours e.g. laparoscopic hysterectomy, radical gynaecological cancer operations, chorionic villous sampling and in-vitro fertilisation egg collection.

This situation is very different from other fields of practice e.g. vascular surgery and neurosurgery. Highly complex major operations may need to be performed only by subspecialist consultants as emergencies during the day or night e.g. aortic aneurysm repair, craniotomy for head injury. In the case of aortic aneurysm, this would only be performed by a specialist consultant vascular surgeon and not by a generally trained surgeon. Likewise, best results are obtained by a dedicated consultant vascular anaesthetist. These

procedures are usually only done in teaching hospitals or acceptably recognised specialised units.

Travel

It is well established that transfer of obstetric patients should be avoided wherever possible, being potentially unsafe, particularly so with haemorrhage and hypovolaemic shock.

Resuscitation and controlled fluid replacement prior to transfer is a cornerstone of immediate care in obstetrics as well as in major trauma as seen in RTAs (Road Traffic Accidents), major incidents and on the battlefield. Such cases are best supervised by an anaesthetist with Advanced Trauma Life Support (ATLS) certification.

Bleeding is a major threat to the survival of both mothers and babies. Advanced Trauma Life Support (ATLS) is also used to gauge obstetric shock as Classes 1-4 shock can develop both rapidly and unexpectedly in obstetric practice. Such emergencies require senior anaesthetic input as events can change rapidly and fatally if not recognised and immediately acted upon.

The need for close essential life saving services is discussed in the leading text book: The Principles and Practice of Immediate Care by Greaves and Porter.

This was the basis of the obstetric flying squads. These were generally replaced in the late 1970s and early 1980s when there was a planned expansion in the number of local consultant maternity units on the basis of enhanced safety. Subsequently it was assumed that Ambulance Paramedics would play an increasing role in transfers to and between hospitals but lack of resources has restricted the development of a comprehensive training programme for Paramedics in Emergency Obstetric Care, which is recognised for its stabilisation difficulties.

The need for Emergency Domiciliary Obstetric Services and a prompt competent response was recognised by the RCOG in their 1990 publication entitled: The Future of Emergency Domiciliary Obstetric Services (‘Flying Squads’).

Any single site arrangement requires an obstetrician, anaesthetist and midwife as in the old flying squads. Even then it would not be as safe as a core competent static unit in both towns.

Time between Eastbourne and Hastings
This is a crucial issue.

Emergency transfer times should include ambulance call up time, pick up time, actual road transfer time and then the download time and diagnostic assessment time. That will always be in excess of RCOG and NICE 30 minute rule and this clearly breaches the national benchmark standard of 30 minutes for the management of obstetric emergencies.

AA road distance and times are as follows:
Eastbourne DGH – Conquest Hospital 20.5 miles – 37 minutes

However, it is well known that the actual travel time taken is often far longer up to an hour or more because of the poor roads which are very busy at peak times and during the holiday season. Ambulances do have problems with emergency transfers because cars cannot always 'pull over' on the poor narrow roads. Total gridlock is not an unusual occurrence. The journey west to the Royal Sussex County Hospital in Brighton is often quicker as in parts there is a dual carriageway.

The actual bed to bed patient transfer time is often double the travel time so that total transfer time would be well over 1 hour.

The Royal College of Obstetricians and Gynaecologists (RCOG) Reconfiguration of women's services in the UK – Good Practice No. 15 Dated December 2013

Capacity and size of Obstetric units
This newly published report recognises that there is no optimum number of births to make a unit safer. It says that in smaller units (between 2500 and 4000 births per year), 24-hour presence may not be cost-effective and *Safer Childbirth* suggested a 60-hour-per-week presence as a minimum standard. It states "**There is no published evidence on the ideal size for a maternity unit**."

Geographical access to units

It also states "Women who choose to give birth out of hospital must have access to ambulance services for quick transfer to hospitals in the event of emergencies. The Birthplace study conducted by the National Perinatal Epidemiology Unit (NPEU) has revealed that the transfer rates vary between 9% and 45%, depending on the mother's parity." For clarity a Birthing unit such as currently temporarily reconfigured at Eastbourne DGH and Crowborough would be considered as out of hospital.

The document also states that other circumstances such as geography and location of units must be carefully considered.

Workforce Planning – Obstetric staffing

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

Co-Dependent Emergency General Surgery

The report mentions Co-Surgical support. The Save the DGH Campaign has consistently said about the need to have all core services at Eastbourne DGH. It says "Every obstetric service must have close access to surgical backup for infrequent complications occurring during childbirth, which include damage to bladder, bowel or major blood vessels. In addition, major bleeding complications in obstetrics and gynaecology may need access to interventional radiology and close proximity to laboratory services providing blood transfusion".

The local NHS should listen

This report also adds under the heading "NHS reform and change" the recent RCOG report Tomorrow's Specialist found a difference between what doctors perceive women need from healthcare services and what women actually want. There is therefore the need to ensure close working with women so that patient-centred care can be delivered.

Making It Better: For Mother and Baby – the Shribman Report
In 2007, Sheila Shribman, National Clinical Director ('Tsar') for Children, Young People and Maternity Services in her paper making It Better: For Mother and Baby states:

The Report recognises that there is no optimum number of births to make a unit sustainable.
She says that 'Proposals for change must be developed in consultation with local people' and 'What will be right for Whitechapel will not necessarily work in Whitehaven'. She notes the need for a balance between accessibility and the need for specialist care.

The Report states 'reconfiguration that provides an opportunity to improve access to the full range of care and specialist services through networks is to be encouraged 'adding' change is vital if we are to ensure the safety and well-being of all mothers and babies and that pregnancy and birth are as normal an experience as possible for the majority of women, whilst those with risks and complications also receive the best possible care wherever they live'.

The Shribman Report focuses on the sensible move of consultant maternity services from Calderdale Royal Hospitals to Huddersfield Royal Infirmary Hospital while maintaining midwife-led services and ante-natal clinics in Halifax. The hospitals are only 5 miles apart and both in the Halifax-Huddersfield conurbation. They are connected by a very good A road with a consequent travelling time of 10 minutes. The very large maternity units in Leeds, Bradford and even Manchester are also within 30 minutes travelling time. This is a very different situation form the relatively isolated towns of Eastbourne and Hastings in East Sussex.

Whitechapel is in the heart of urban London close to the City and there are a large number of big consultant maternity units within a 5 mile radius.

Eastbourne and Hastings are like Whitehaven, being rural seaside towns well over 30 minutes from their nearest hospital.

With the trend for Care in the Community, there may be many more home births and Shribman adds ' Any woman giving birth at home should have the assurance that if something goes wrong she can be transported to a consultant led unit safely and quickly. Every woman needs a midwife which means that

there must be enough midwives for one-to-one care.' Remember there are supposed to be 2 midwives at a homebirth or 1 midwife with a doctor, but in these litigation conscious days, most GP's do not undertake home deliveries.

The following official AA times and mileages are also of interest in the context of this report:

Calderdale Hospital – Huddersfield Hospital (the merger mentioned in the Shribman Report) 5.3 miles – 10 minutes

Which is less than:
Eastbourne DGH – Hailsham 6.5 miles – 14 minutes

and the same time travelling as:
Eastbourne DGH – Stone Cross 4.4 miles – 10 minutes

Halifax is also quite close to other major hospitals in Leeds and Bradford and using multi carriageway motorways:

Halifax – Leeds 16.3 miles – 27 minutes

Halifax – Bradford 9 miles – 18 minutes

These are all within 30 minutes and are less than;

Eastbourne DGH – Conquest 20.5 miles – 37 minutes

Stand Alone Midwifery Units

Women should be allowed the choice of Midwifery Led Units (MLUs). MLUs are either attached to consultant units (e.g. Addenbrooke's, Cambridge) or are 'stand alone' at a nearby location or in a more distant town.

Crowborough is a stand alone MLU. It has proved both popular and successful. It is actually far closer to Pembury and Haywards Health rather than Eastbourne and is a long way from the Conquest. Serious emergencies are usually transferred to Pembury while less urgent emergencies, e.g. delay in the second stage, were often transferred to Eastbourne but Hastings is too far and therefore Pembury is used.

There has been some concern about the relative safety of stand alone MLUs. In November 2005, the National Insitute of Clinical Excellence published a warning that evidence suggested that MLUs were slightly less safe.

Consultant numbers

In 2002, there were 10 substantive consultant obstetrician and gynaecologists in Eastbourne and Hastings with an imminent advertisement for an 11th and plans for a 12th.

By 2007 the PCT and ESHT stated that there were only 7 substantive consultants. There was no attempt to explain why the consultant workforce had been reduced by 30% in complete contravention of the RCOG requirements for consultant expansion and a consultant delivered service. The Trust appeared to make no attempt to advertise for new substantive consultants yet consistently stated that there was a national shortage of eligible consultants. There was not a shortage and, as was stated at that time, there was, in fact, a large number of fully trained doctors who had been unable to secure consultant posts because of the downturn in much-needed consultant expansion and the all too common practice of not replacing retiring and relocating colleagues.

Prior to the changes in May 2013 there were 5 consultants on each site providing obstetrics and gynaecology. The consultants provide 40 hour presence on each site (ie 20 PA's) but this is not prospective. ESHT said that emergency measures had been required in September 2012 due to a middle grade vacancy of 37.5% and the retirement of 1 consultant and emergency leave for another at Eastbourne DGH. There were16 "middle grade" staff, 8 on each site. Of these 4 were Specialist Trainees and 12 were non training grade doctors.

There has been increasing difficulty recruiting and retaining adequate middle tier doctors. This has been compounded by legislation surrounding employment of overseas doctors, the availability of training grade doctors partly out of choice but also the national reduction in specialty trainee numbers and ST3 recruitment. This is further challenged by the reputation of ESHT with a history of the prospect of reconfiguring Maternity and other core services over the last 10 years or more.

Midwifery staffing
ESHT has stated a ratio of 1:31 (range 1:30 - 1:34) over the last 7 months against their target of 1: 28. In only 2 months during this period was the target reached. NCAT said this should be RAG (Traffic Light - Red Amber Green) rated as Orange and at times Red.

Staffing is particularly challenging as many midwives are leaving due to work pressures and increased travel time to work. And considerable unrest has been caused with staff being transferred at short notice to the Conquest even from Crowborough.

Prior to the changes in May 2013, use of bank staff had been particularly heavy at the Conquest to cover the acute care (150 hours/month) and surprisingly at Crowborough which averaged 85 hours/month.

Maintaining skills
A lot has been made of the need for staff to maintain 'hands on experience' even when fully trained as Consultants. Attainment of which has always been difficult. Especially in big training units when there are several levels of staff looking for that experience/training numbers as in Teaching Hospitals. Even with small Consultant lead units, with only Senior House Officers [SHO] on their first basic introductory experiences, the Consultant may only accrue his numerical requirements if the training events with the juniors are double accounted. Otherwise the junior member of staff might not be able to get his experience and training.

So to contend that increasing the delivery numbers on one site, whilst at the same time increasing the numbers of Consultant and Junior staff at Registrar and SHO level, does not mean there will be greater personal hands on procedural experience in all the interventive obstetric procedures. As this requirement is stated to be so important one has to consider whether the present method of delivering the service might be less than ideal to fulfil all the criteria for Continuing Professional Development for the staff that require numerical confirmation of continuing experience.

Whatever the size of a unit the dilutional effect of overstaffing on personal involvement is a problem and the anxiety has always been that Consultants seldom perform assisted deliveries once appointed, unless they work privately where there is a personal contract. But in most NHS units who have a middle

grade Registrar staff layer and an SHO layer the Registrar is generally tasked to teach the SHO whilst increasing his/her own experience in both teaching and experience.

It is for this reason the Royal College of Obstetricians & Gynaecologists [RCOG] have for at least 15yrs been attempting to ensure and increase Consultant guaranteed presence on the labour suite with the absolute ideal being 24 hr presence 7 days a week. [168 hrs]. Most units achieve 40 hrs/ wk availability, but not necessarily presence, and some 60 hrs but with the European Working Time Directive [EWTD] that is only achieved by increasing the numbers of Consultants. Which again reduces their chance of experiencing the unusual even in the largest of units.

So no system is perfect but in a small unit it would seem sensible to consider a staffing module that only consists of Consultants or Senior Specialist staff who are fully qualified and competent. There may be junior staff who require initiation or onward experience training in the presence of a trained Consultant or Specialist but if events were double accounted for both participants then the reduced numbers should not be a problem with the RCOG.

As the CCG's and ESHT have stated that finance is not a consideration the staffing of 2 units in this manner would be feasible and safer for all the patients in the catchment area. It would also comply with the original inception of having a hospital in both towns so that services were both composite and as easily accessible to patients as was possible, especially from the fringe areas. The paediatric and anaesthetic services would have to be similarly available.

All units should be Midwifery led in that midwives have historically met and triaged patients as they arrived. They have, in most places, worked harmoniously as a team with the medical staff doing joint rounds every 4 hours so that everybody is appraised of the workload and the possible cases that might give a problem later when the midwife would decide that medical assistance or consultation is sensible in the patient's interest even if that simply involved being a spare pair of hands when necessary due to the workload at the time, and that can occur in both very big and small units.

The Trust implicitly argues that training/career development issue is satisfied by a mixed consultant/midwife unit with around 4,000 births per annum. By splitting this activity between two locations the same volume and variety exists

and it is simply the inflexibility of the rotas that prevent individual clinicians from the same training/career development potential.

NICE Guidelines – Intrapartum Care

The National Institute of Clinical Excellence (NICE) has published the Final Draft for Consultation of the guidelines – Intrapartum care: care of healthy women and their babies during childbirth.

NICE recommends that women should be offered the choice of planning birth at home, in a midwifery-led unit or a consultant unit. Before making their choice, women should be informed of the potential risks and benefits of each birth setting.

NICE states:
Birth outside a consultant led unit is consistently associated with an increase in normal vaginal birth, an increase in women with an intact perineum and an increase in maternal satisfaction. The quality of evidence is not as good as it ought to be for such an important health care issue, and most studies have inherent bias. **The evidence for stand-alone MLUs and home births is of a particularly poor quality**.

The only other feature of the studies comparing planned births outside consultant units is a small difference in perinatal mortality that is very difficult to accurately quantify, but is potentially a clinically important trend. Our best broad estimate of the risk is an excess of between 1 death in a 1000 and 1 death in 5000 births. We would not have expected to see this, given that in some of the studies the planned hospital groups were a higher risk population. Several factors may play a role in this observation, including study design, effect size, statistical precision and rareness of these events. Geography may be important, as may organisation of services and communication between all involved.

The evidence in relation to perinatal mortality is not strong enough to support past or currently planned policies of increasing or decreasing current provision outside consultant units.

Size of Units
It has been mentioned previously in the section under the newly published RCOG report headed "Reconfiguration of women's services in the UK – Good Practice No. 15" that it states "**There is no published evidence on the ideal size for a maternity unit**."

Another article: Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women was published in 2006 in the British Journal of Obstetrics and Gynaecology. The study was carried out in Australia but the conclusions are valid in the UK. It was found that lower hospital volume is not associated with adverse outcomes for low risk women. It questions the view that there is a volume threshold below which quality of care may be both inferior and economically unsustainable and notes that local obstetric services are a vital component of the community.

The article : The true cost of the centralisation of maternity services published in 2006 in the Midwifery Digest MIDIRS actually demands that we stop and question the strategy of centralisation as there is no evidence for the assumption that large hospitals are cost-effective and lead to better patient outcomes.

The Report from the Reform Group has emphasised the need for '**An end to the drive towards larger, more centralised delivery units across the UK'.** The Report stresses the need for integrated networks between high, medium and low risk providers and the necessity for the actual presence of consultants on labour ward in line with the situation in the rest of Europe and the USA and Canada.

There have been some high profile disasters in large merged obstetric units in Northwick Park and St Peter's/Ashford and in other large units which have had major problems e.g Wolverhampton. The Healthcare Commission held enquiries into these three large hospitals. They found major problems of poor communication, poor change management, poor levels of midwife and consultant staffing combined with widespread client dissatisfaction. In Northwick Park, these problems led to an unacceptably high level of avoidable maternal death.

ACCESSIBILITY

Choice

The policy of the Government is to allow choice as paramount to the provision of accessible services. OPTION 7 - THE CAMPAIGN OPTION clearly provides the greatest choice between consultant delivered services in both Eastbourne and Hastings as well as care in the community, midwife-led care in the AMUs (Alongside Midwifery Units) at Eastbourne or Hastings and a MLU (Midwife-led Unit) at Crowborough, supported home birth and care of very high risk problems in the Brighton Teaching Hospital.

Removing consultant-led Maternity reduces choice for the majority of women who previously used Eastbourne DGH. Prior to the temporary changes in May 2013, there were on average 38 births a week in Eastbourne. Since May 2013, on average, there has been less than one birth a day.

Deprivation

Eastbourne and Hastings are both areas of relatively high social deprivation and disadvantage compared with most areas in the affluent Home Counties. The Income Deprivation Affecting Children Index map shows that Hastings has many of the poorest areas in the County. The map also shows that the largest area of deprivation is in Hailsham near Eastbourne. The social housing estates of the Diplocks and the Town Farm Estate in Hailsham are very deprived and have one of the highest birth rates in the area. Additional problem areas in the Eastbourne catchment are in Seaside, Shinewater, Kingsmere, Hampden Park, Willingdon Trees and parts of central Eastbourne.

The Boles Report has shown that both Eastbourne and Hastings have similar areas of deprivation with very little difference between them.

Currently, birth rates are far higher among this group of clients. They have high rates of teenage pregnancy, smoking, poor ante-natal clnic attendance, psychiatric problems, pre-term labour and maternity complications.

Hastings mothers had a higher rate of low birth weight babies but Eastbourne historically had more induced births for clinical reasons, Caesareans and admissions to the Special care Baby Unit.

The Confidential Enquiry into Maternal and Child Health (CEMACH) has shown that the maternal death rate is as much as twenty times as high among the most disadvantaged groups. CEMACH recommends that services target these groups and improve access to local care both in the Community and with local Consultant services.

Many of these clients do not have cars or cannot afford transport costs and research has shown that they are far less likely to attend appointments in distant hospitals.

Increasing Population

Birth rates in East Sussex are projected to rise over the next ten years. According to the latest statistical data provided by East Sussex County Council:

"In 2012, there were about 5,500 live births in East Sussex, the highest number since 1994. The number of births last fell in 2002 and has increased by 20% since then. Over the last five years the number of births has risen by almost 6% in the county, higher than nationally (3%) and regionally (4%).

The largest increase was seen in Eastbourne (9%) followed by Lewes (8.5%) and Rother (7.6%). At the same time the number of births in Wealden has increased by only 1% in the last five years and in Hastings by almost 5%."

Eastbourne is an area of increasing population growth and housing development. There are also several areas around Eastbourne and the Weald where there is further proposed housing development with the prospect of several thousand MORE homes being built.

Many couples who moved to the area in the last ten years will now be entering their 30s and will be in a more stable financial position to start a family. The most popular age to have a baby has now passed 30.

Private Care

Unlike most areas of secondary and tertiary care, women do not have the option of private care. This is one of the few areas where choice is restricted to the NHS. The majority of pregnant women would not be able to afford the high costs of private obstetric care which is not usually offered by private

health insurance companies. The clients are young and include a large number who are socially deprived or who are just managing to pay their rent, mortgage and living expenses with little to spare.

Obstetricians and gynaecologists rarely undertake private obstetric care because of the very high costs of medical indemnity and they tend to restrict their private practice to elective gynaecological services.

There is no provision for private obstetric care in Eastbourne or Hastings. Brighton might do private deliveries, though women may go to London.

Independent midwives are expensive and few in number. In reality, the nearest areas for private obstetrics are in Guildford and London.

Diverts and Temporary Closures of Maternity Units

Eastbourne and Hastings Maternity Units occasionally shut for temporary periods for various reasons eg. when there is a high workload and shortages of staff. This problem also happens in Haywards Health and other medium size units around the country. Temporary closures are also common in large units such as Brighton for the same reasons. There is no evidence that numerically large units would be better off when the unit itself has not been enlarged exponentially (in terms of more beds, facilities and space).

The Midwife Crisis

Historically midwife staffing in Britain has been in crisis with huge shortages. However locally, the over-riding fact which is affecting the local maternity service is the reputation of East Sussex Healthcare Trust (their employer) with their expectations. Midwives who previously worked at Eastbourne DGH now have nearly 2 hours added to their working day for travelling time to the Conquest. There have also been sudden closures of the Crowborough Birthing Centre due to staffing shortages at the Conquest many miles away with midwives having not only to travel but working in a completely different environment. Midwives who previously had enjoyed their vocation are leaving as a result of the current situation.

ESHT and the (European Working Time Directive) and Modernising Medical Careers

The EWTD has been a great challenge to all NHS management however the implications locally are even more severe since the temporary changes were instituted. Staff travel from Eastbourne DGH to the Conquest (or Brighton) in their contracted hours, and with women being transferred in labour accompanied by midwives, this will erode clinical time and deplete unit staffing even further.

The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives have produced ample evidence that future maternity care must be delivered by fully trained consultants and midwives around the clock. At all times, trainee doctors and trainee midwives must be closely supervised. This approach has been ratified by many reports from the NHS Litigation Authority (NHSLA), the National Patient Safety Agency (NPSA) and the Care Quality Commission (CQC).

In particular, junior medical staff must not be expected to make difficult decisions and undertake difficult procedures especially at night without consultant presence. The RCOG suggests this is bad practice and is dangerous and it must be stopped.

In 2007, the new system for training doctors 'Modernising Medical Careers' came into being and meant that there would be less experienced doctors who would therefore require greater supervision. Is this where ESHT failed to provide adequate supervision which led to the serious incidents which resulted in the temporary removal of the consultant-led obstetric service at Eastbourne DGH?

The then Chief Medical Officer, Liam Donaldson, stated in 2007 that MMC will enable more service to be restricted to fully qualified doctors. Implications locally are even more severe since the temporary changes were instituted. From 2009, the European Working Time Directive (EWTD) will restrict doctors to a 48 hour week and this reduced the availability of junior doctors to cover maternity services. The combined effect of MMC and the EWTD was acknowledged but the clear response from the RCOG was that more consultants must be appointed and that they should provide a consultant supervised service on the labour suite. The junior doctors in training would no longer be required to provide unsupervised service but would work alongside

their consultants. **All decisions and procedures should be closely supervised by fully trained consultants.**

In 2004, the RCOG published: The European Working Time Directive and Maternity Services – Advice from the Royal College of Obstetricians and Gynaecologists. The Report stated '**The need for an experienced obstetrician to be resident in the Maternity Unit throughout the 24-hour period was universally recognised**. '

The Report makes no recommendation about the size or location of consultant units. The Report describes the Rotherham Initiative stating 'The Rotherham Initiative provides a solution to the difficult problems of middle grade cover at night, an issue that remains unresolved in units around the country'.

The major change at Rotherham is on how the consultant works. 'We have expanded consultant numbers and embarked on night-time duties normally assigned to doctors in training. Although the changes are radical they have been manageable and at times enjoyable'. Consultants essentially do direct work at the coal face without the constant need for a middle grade doctor.

Midwives

The role of midwives is very important and there should be an increased use of fully trained Advanced Midwifery Practitioners (AMPs) and Advanced Neonatal Nurse Practitioners (ANNPs). These colleagues will work alongside consultants and will practice extended skills such as clinical decision making and practical procedures such as Ventouse delivery. AMPs must only be developed when attention has been given to the present need for an increase in midwifery staff to deliver the essential skills of midwifery practice in ante-natal care, normal deliveries and post-natal care. AMPs and Midwife Consultants will reduce the need for junior doctors to provide service and will allow them to spend more time being trained by their consultant supervisors.

Subspecialist Care in Brighton and Pembury - Networks

Tertiary subspecialist care should be relocated in regional teaching hospitals and special units to allow secondary DGHs to concentrate on core services.

This is not a new idea and, in fact, very difficult cases have always been referred to London Hospitals e.g Guy's for anticipated neonatal cardiac surgery and Great Ormond Street for rare children's problems.

The Royal Sussex County Hospital, Brighton, is now the regional teaching hospital for Sussex and home to the Brighton and Sussex Medical School.

NHS England and the NHS Trust Development Authority should network health care in the South East. The Scottish Network provides an excellent model for networking whereby essential core service are kept at local level with innovative staffing patterns where needed. Larger hospitals provide a broader range of services while subspecialist tertiary services are centred in the major urban teaching hospitals. The Scottish Network has maintained the provision of consultant obstetric services even in very small units in isolated areas such as Caithness, the Hebrides and the Borders.

Networks in Obstetrics and Gynaecology

Major gynaecological cancer operations are already centralised in Brighton with an excellent Sussex Cancer Network. Other procedures that can benefit from subspecialist centres can include assisted conception, complex laparoscopic surgery for hysterectomy and endometriosis, complex urogynaecological procedures and fetal medicine.

High Risk Obstetrics

A small number of women would benefit by transfer of their obstetric care to the regional teaching hospital e.g. extreme prematurity, intra-uterine growth retardation and congenital anomalies where Neonatal Intensive Care is likely to be needed. This often happens already but more robust arrangements could be required if there are areas without excellent basic core services as proposed by ESHT and the 3 CCG's. Family travel then becomes a problem both financially and with family disruption etc.

But at present with Eastbourne being an MLU only the statistics suggest a move away from Eastbourne DGH to Brighton from Seaford and Haywards Heath from the High Weald area. These changes could only be altered by a return to 2 Consultant-led units (CLU) as promised by ESHT when they temporarily closed the Eastbourne (CLU) in May 2013.

TRANSFERS TO BRIGHTON
Neonatal Intensive Care – NICU – Level 3

The tertiary level Trevor Mann Neonatal Intensive Care Unit in Brighton is the designated NICU for Eastbourne and also takes transfers from Hastings. Some Hastings cases are transferred to Pembury which provides a full Level 3 NICU (Neonatal Intensive Care Unit).

The redesign of obstetric services must improve prompt access to high risk care within the region.

Historically, Brighton has had major problems in accepting in-utero and neonatal transfers from Eastbourne. This situation should not happen.

In 2008, in about 50% of requests, there was no room and the unit was shut to admissions. Staff in Eastbourne wasted many hours when trying to find a suitable available unit and neonatal cot. Consequently, mothers and babies were transferred to many other hospitals across the South East and London and even as far afield as Southampton and Cambridge.

If this is still a problem this must be addressed. The obstetric and neonatal services in Brighton must be properly resourced and staffed so that the unit can always accept admissions from neighbouring areas. The situation is dangerous and likely to lead to heavy litigation costs in the future due to cerebrally damaged babies at birth or antenatally.

Care in the Community
There has been an increase in care delivered in the community. Community Ante-Natal, Post-Natal Clinics and clubs are held regularly in centres throughout the area and these must continue and expand if demand is not met.

Much benign elective gynaecological care could be managed in the community by General Practitioners with a Special Interest in Gynaecology (GPSIs) and Community Gynaecologists (Consultants in Sexual and Reproductive Health).

General Practice Referrals with triage of patients should allow up to 50% of GP referrals for benign gynaecological problems to be managed in the community. This allows implementation of NICE Guidelines on the management of heavy menstrual bleeding and infertility in primary and secondary care with significant savings in the cost of health care. The savings can be re-invested in the provision of essential core services at local level and subspecialist services at secondary and tertiary levels.

Consultant Maternity Services in other areas

Many Communities have bent over backwards to design local high quality consultant delivered maternity services which suit their health care needs. In many areas, the consultant body have supported the need to change their working practices, appoint more colleagues and redesign their work patterns to meet these needs.

These range from slightly bigger units such as Hinchingbrooke and Yeovil to slightly smaller units such as Withybush, Pembrokeshire to very small units in Caithness, Elgin, Gibraltar and the Isle of Man.

In these areas, local women have expressed a very high degree of satisfaction with a consultant delivered local service and these units have a high level of safety. They are all sensibly networked with major tertiary hospitals in their regions.

WHAT ABOUT PAEDIATRICS?

It has been made clear by the local NHS that the only reason the Paediatric service and Littlington Ward (at Eastbourne DGH) was downgraded was a direct result of the inter-dependency with Maternity services. It is absolutely essential that consultant-led Paediatric services are brought back to Eastbourne DGH.

Currently, under the temporary arrangements a very sick child who cannot be discharged home as they are so ill cannot stay at Eastbourne DGH, they are transferred to the Conquest. It is these children who have to undertake an ambulance journey whatever the weather and road conditions outside the comfort of the hospital when they are too sick to go home!

This is a terrible testament to the local NHS who have inflicted this on the most vulnerable members of our society – our children! This must NOT continue.

OPTION 7 – THE CAMPAIGN OPTION is clearly the most popular option and should be worked on to produce an excellent service which meets the needs of the local population.

Appendix 1 shows a proposal in full made to ESHT by the Paediatricians who worked at Eastbourne DGH and their recommendation. Although not ideal, we would support their recommendation.

AFFORDABILITY

The Clinical Commissioning Group insist that safety is the factor and not cost. Interestingly previous studies in 2007/08 have shown that the retention of essential core services on both sites may be the most cost-effective option with the correct staffing models. It is important to note that travel costs to staff, hotel accommodation for Eastbourne consultants (in all specialities) on call plus additional ambulance journeys must be accounted for in the single-site options.

East Sussex Clinical Commissioning Groups (CCG) forecast expenditure is shown below and split into each CCG. EHS (Eastbourne, Hailsham and Seaford), H&R (Hastings and Rother) and HWLH (High Weald, Lewes and The Havens).

Option 7	**2013/14 Forecast Expenditure**			
Service Description	**EHS £m**	**H&R £m**	**HWLH £m**	**TOTAL £m**
<u>Obstetrics and Midwifery</u>				
In-patient obstetrics and midwifery	3.0	3.2	0.4	6.6
Other Obstetrics and Midwifery	3.2	3.3	0.6	7.1
Total	6.2	6.5	1.0	13.7
<u>Gynaecology</u>				
Emergency In-patients	0.4	0.4	0.0	0.8
Total	0.4	0.4	0	0.8

Paediatrics				
Emergency & Elective In-patients	2.5	2.6	0.3	5.4
Total	2.5	2.6	0.3	5.4
All Services	**9.1**	**9.5**	**1.3**	**19.9**

The two big points on finance are:

(1) The Trust argues everything on "safety" grounds and say it's not about finance.

(2) Any modest savings from centralisation are small in comparison to the Trust's overall deficit.

GOING FURTHER...

East Sussex Healthcare Trust who provide Maternity and Paediatric services have failed the local population not only by removing consultant-led Maternity and Paediatrics, but by removing emergency General Surgery, Trauma and emergency Orthopaedics from Eastbourne DGH which has, in our opinion, threatened the future of our local hospital. Removing any core service undermines the others and the domino effect happens.

TIME TO CHANGE

Relying on a local NHS Trust who have removed core services from our local hospital and have consistently not met quality standards or financial budgets does not make for a bright future.

ESHT have had to delay becoming a Foundation Trust hospital several times because they have not met the requirements set down by the Department of Health. Currently they are being overseen by the NHS TDA (Trust Development Authority) with constant financial problems not being solved despite employing Turnaround directors and teams over the years at great expense.

ESHT admitted its failure by downgrading Maternity and Paediatric services at Eastbourne DGH for reasons of safety, in May 2013 and against IRP recommendations. This Trust had failed to ensure a safe service was provided.

The Save the DGH are leading in the call to the NHS, nationally and locally, to explore the following :-

1. **The possibility of a de-merger of East Sussex Healthcare NHS Trust into:**
   - Eastbourne & District Foundation Trust with community hospitals/services
   - Hastings & Rother Foundation Trust with community hospitals/services
2. **The possibility of dividing East Sussex Healthcare Trust into:**
   - EDGH with Brighton & Sussex University Hospitals Trust, with separated Community Services if necessary.
   - CHH with Pembury or Ashford, with separated Community Services if necessary
3. **Creating a 'new structure' similar to Hinchingbrooke Hospital in Huntingdon**
4. **Other models for services similar to Yeovil District Hospital which has embraced alternative financing solutions to keep emergency core services**

Our one requirement under any new proposal is that ALL CORE SERVICES ARE PROVIDED AT EASTBOURNE DGH.

The core services for clarity are:
24 hour A & E full service (including Trauma & Orthopaedics), 24 hour in-patient Paediatric beds, 24 hour Consultant - led Obstetric service, 24 hour acute Medical and Coronary care beds, 24 hour acute Surgical, Intensive Therapy Unit & High Dependency Unit beds and 24 hour Acute Psychiatric Service.

CONCLUSION

OPTION 7 – THE CAMPAIGN OPTION provides the best high quality health care for pregnant women, babies and children by maintaining consultant delivered services in both Eastbourne and Hastings. It is the option that is clearly favoured by the people of both towns and will provide for the future with resident populations being expanded with increased industrialisation and working facilities for the reproductive age groups.

If the local NHS had shown the same degree of enthusiasm in getting it right as has been shown in getting it wrong, Eastbourne and Hastings could be the Gold

Standard units against which others were judged. Option 7 will hopefully start the process.

Public confidence is at an all time low and one expectant Mum called for the hospital board to resign because ESHT has been unwilling to listen to local concerns over 6000 members of the public signed up in 2 weeks!

On May 7th 2013, ESHT downgraded Consultant-led Maternity services at Eastbourne District General Hospital (EDGH) to a Midwife-led unit. Local women who are not low risk, as well as those who chose the safety of a Consultant-Led Unit, now travel over 20 miles to give birth. As a Campaign Group we vehemently opposed this as we believe it will seriously compromise women and babies lives. A few days later, our fears confirmed, on May 10th a baby was born in the back of his parents car on the way to the Conquest Hospital (Hastings). This did not even register as a serious incident and was 'unfortunate'!

Option 7 – The Campaign Option is safe and accessible and addresses the needs of our local population and will provide the best outcome for our future.

Have your say

If you want to have a say on the future of Maternity and paediatric services, please respond to Better Beginnings before 8th April 2014. What is important to you? Is there anything else you think they should have considered? Have you got any experiences they should know about?

For more information visit our website www.savethedgh.org.uk. You can also go straight to www.betterbeginnings-nhs.net and complete their online questionnaire. Please remember not to tick any box for Option 1-6 but enter Option 7 in the Other information/comments box.

Responses to be received by Better Beginnings before 8th April 2014

You can send your comments to us as well at info@savethedgh.org.uk even if it's just "We want Option 7 – The Campaign Option"

Bibliography

The IRP's (Independent Reconfiguration Panel) report on proposals for changes to maternity, special care baby services and inpatient gynaecology services in East Sussex was submitted to the Secretary of State for Health on 31 July 2008 and is available below.
IRP: Advice on proposals for changes to maternity, special, care baby services and inpatient gynaecology services in East Sussex (294kb)
IRP: Report Appendices (410kb)
IRP: Press Release
IRP: Report Recommendations

The Royal College of Obstetricians and Gynaecologists (RCOG) Reconfiguration of women's services in the UK – Good Practice No. 15. December 2013

The RCOG Review of the Obstetric and Neonatal Services of East Sussex Healthcare NHS Trust at Conquest Hospital Undertaken by: Mr Paul L Wood MD FRCOG (Lead Assessor), Mr Andrea Galimberti FRCOG (Co-Assessor) and Professor Stewart Forsyth OBE MD FRCPCH (Co-Assessor) on 8 and 9 August 2013

NCAT review of East Sussex NHS Healthcare Trust Maternity & Paediatric Services dated: 11 February 2013

A summary of the investigation into maternity services provided by the Royal Wolverhampton Hospitals NHS Trust at New Cross Hospital. 2004. Healthcare Commission.

Bones E. The true cost of the centralisation of maternity services. 2005. MIDIRS **15**:4 559-564

Childbirth. Greaves L and Porter K. The Principles and Practice of Immediate Care. Pre-Hospital Medicine. 1999. Arnold. London.

Clinical Standards – Advice on Planning the Service in Obstetrics and Gynaecology. 2006. RCOG.

Focus on: Caesarean Section. 2006. NHS Institute for Innovation and Improvement.

Future Role of the Consultant. 2005. RCOG.

Intrapartum Care Guidelines – Draft – National Institute of Clinical Excellence. 2007. London.

Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005.

Keeping the NHS Local – A New Direction of Travel. 2003. Department of Health.

Managing Obstetric Emergencies and Trauma (MOET) Manual . Advanced Life Support Group. Manchester.

Maternity and Gynaecology Services Review. Final report. 2004. East Sussex Clinical Services Review.

Maternity services – Ashford & St Peter's Hospitals NHS Trust. 2003. Commission for Health Improvement

Maternity Services in the NHS. Bosanquet et al. Reform 2005.

National Sentinel Caesarean Section Audit Report. 2001. RCOG Clinical Effectiveness Support Unit.

Neonatal Services in East Sussex NHS Trust. A paper to inform decision-makers as reconfiguration of maternity and neonatal services is being contemplated. Dr I Boles, Paediatric Consultant.

Reconfiguration of Maternity Services. Department of Health Working Paper. 2006. London

Safe Maternity Services. Royal College of Obstetricians and Gynaecologists. 2006. London

Safer Childbirth: Minimum Standards for Service Provision and care in Labour – Draft – Joint Royal Colleges. 2006.

Seeking Sustainable Health Services for the People of Huntingdonshire. Summary Consultation Document. 2007. Cambridgeshire PCT.

Survey of Models of Maternity Care. Towards sustainable WTD compliant staffing and clinical network solutions. 2004. NHS Modernisation Agency.

The European Working Time Directive and Maternity Services. Advice from the Royal College of Obstetricians and Gynaecologists. RCOG 2004 London.

The Future of Obstetrics and Gynaecology in Scotland. Scottish Committee of the RCOG. 2005

Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women. *BJOG* 2006 86-96.

What is a Neonatal Network? NHS Neonatal Networks. Levels of care as defined by the British Association of Perinatal Medicine. www.neonatal.org.uk

Why Mother Die 2000-2002. Report of the Confidential Enquiries into Maternal Deaths in the UK. 2004. CEMACH. London.

Women's deaths soar in NHS midwives crisis. Independent on Sunday – 5 March 2007

EAST SUSSEX HEALTHCARE NHS TRUST

EASTBOURNE DGH - ACUTE PAEDIATRIC SERVICE OPTIONS

INTRODUCTION

The paediatric staff at Eastbourne District General Hospital (EDGH) have proposed changes to the recently reconfigured paediatric service on the grounds of patient safety and access. The service has recently been reviewed by the Care Quality Commission (CQC) and the Royal College of Paediatrics and Child Health (RCPCH). The CQC were content that the service was safe. The RCPCH has expressed concerns about children presenting to the Emergency Medicine Department (EMD). The final RCPCH report is awaited.

The paediatricians are concerned that winter pressures will impact on service delivery and an urgent decision with regard to any service change is therefore required. However it is acknowledged that the current configuration is temporary and any permanent changes are subject to public consultation during the coming year. Any future changes will need to take account of work that is being undertaken in the rest of Sussex.

It is known that the majority of paediatric inpatient admissions last less than 24 hours and that the majority of admissions take place between 17:00 and 21:00. Services are changing to become more patient focused and need to reflect the requirement for local access.

Closer working with Brighton and Sussex University Hospitals NHS Trust (BSUH) and the Royal Alexandra Children's Hospital (RACH) is felt to be desirable and the transfer of more Eastbourne children to the RACH rather than the Conquest Hospital is an option worthy of consideration. This would provide additional choice and access for Eastbourne families and would enhance working relationships with the Children's Emergency Department at BSUH; This could subsequently reduce the flow of patient referrals from the Eastbourne and Seaford areas to Brighton.

No change to the current service at Hastings including the Special Care Baby Unit (SCBU) is proposed.

This paper summarises the results of the discussions that have taken place to date.

AIMS:

- To improve patient safety and access.
- To reduce the number of unnecessary transfers of children.
- To enhance local confidence in paediatric services whilst ensuring the safety and stability of future services.
- To improve working relationships with BSUH (RACH).
- To improve choice and accessibility for patients.

- To utilise the skills and experience of the existing health professionals and extend their roles and training.
- To enhance the current Children's Emergency Medicine service
- To encourage GPs with an interest in paediatrics, and EMD staff to help develop and deliver the service.

OPTIONS FOR EASTBOURNE

Although several other alternatives were considered the options thought worthy of further consideration are as follows:

Options:

1. A return to the original paediatric service prior to reconfiguration.

2. Continuing with the current reconfigured service (with revised opening times of Eastbourne SSPAU to reflect the demand on the service).

3. Co-locating the Eastbourne SSPAU with the EMD with a 24-hour 7-day a week service staffed by both paediatrics and emergency medicine.

SERVICE DESCRIPTION

Option 1: In-patient service with three tiers of doctors and full nursing provision. 15 beds. No neonatal/SCBU services.

Choice & Access: Considered better for Eastbourne patients. Gives choice of Eastbourne or RACH for patient transfers. Hastings patients - no change.

Quality & safety: Considered safest option for Eastbourne paediatric patients, no change for Hastings.

Clinical sustainability: Challenges with recruitment & retention of middle-grade doctors remain. Staff would need to rotate to Hastings for SCBU experience. A consultant 1 in 5 rota will be increasingly difficult to comply with WTD.

Deliverability: Probably not possible long-term.

Risks & interdependencies: Provides support for EMD, overnight surgical patients, safeguarding, unexpected deaths etc

Option 2: Current reconfigured service with SSPAU open on weekdays and at weekends Eastbourne, inpatients transferred to Hastings or RACH. Seriously ill children should not taken by ambulance to EMD. Children are transferred to Hastings for overnight admission if not suitable for home discharge when SSAPU closes. Day surgery would continue but children may need to be transferred to Hastings if not fully recovered.

EMD is currently staffed by locum paediatric middle-grade responsible to EMD. Middle-grades spend two weeks out of 12 in Eastbourne. Two middle-grades are present during the day, one for OPD clinics and one for SSPAU/EMD. Staff are underemployed.

Access & choice: The reduced access and choice for Eastbourne patients is unpopular. There is a risk of reducing activity due to increased referrals from Eastbourne to Brighton (RACH).

Quality & safety: The increased numbers of inpatients in one unit is good for training, experience, maintenance of skills and teaching of nurses and doctors.

Clinical sustainability: Some middle-grades and experienced nursing staff are leaving. Significant senior nurse experience is being lost; replacements are being recruited but may be much less experienced. There is a need to continue with the EMD paediatric locum middle-grade which is a cost pressure. Training objectives for EMD are not being achieved due to dependence on locums. There are concerns about a possible reduction in activity with implications for income and long term referral patterns.

Deliverability: An increase in nursing acuity has been noted in Hastings. An increase in nurse staffing in Hastings might impact on the service available to EDGH.

Nursing acuity is a technical way of documenting the clinical intensity of patients admitted in terms of nursing input. It appears that nursing acuity has increased a factor of 4 since the reconfiguration. Much of the nursing work is at the time children are admitted or discharged. Arranging transfers for sick children or trying to get them well enough to go home before a SSPAU shuts has dramatically increased the intensity of work.

This has serious implications for required numbers of nurses, and is affecting morale and retention of experienced staff.

Risks & interdependencies: the main concern is the safety of children attending EMD. The continuing dependence of EMD on locum staff and the cost pressure is also a major concern. There is sometimes a delay in SECAMB transfers in the evening after the SSPAU closes and this impacts on staff working patterns.

Option 3: A 10-bed 24-hour SSPAU co-located with EMD. This would be staffed and supervised by paediatricians until late evening and then by EMD staff overnight with support from paediatric nurses and medical staff.

Elective admissions and the assessment of children referred by GPs or attending the EMD would continue and be seen by the paediatric middle-grade and/or consultant during the day. Training could be offered to GPs undertaking 'Out of Hours' duties to enhance their ability to deal with sick children and contribute to the future running of the service. Experienced nurses could also be given training to enable them to function as advanced nurse practitioners who could replace medical staff.

Access & choice: Provides better and safer access for Eastbourne patients. No change for Hastings patients.

Quality & safety: Should lead to fewer transfers of potentially unstable patients who may deteriorate en-route.

Clinical sustainability: Will depend on the ability to involve other specialties and the need for nursing/medical staff to also run the inpatient service in Hastings. Should enhance working relationships with BSUH by using shared protocols, increase referrals and attract high quality staff through the link with BSUH.

Deliverability: Should be possible within current budget (medical & nursing). Paediatric consultant rotas would continue at 1 in 10, with consultants working at times of peak activity on both sites.

Risks & interdependencies: Close working with EMD and anaesthetic staff would be required. Engagement with GPs as participants and commissioners would be needed. Should help to reduce the number of SECAMB transfers. Is likely to be popular with the local community and enhance the safety and future of local services.

RECOMMENDATION

The CYPCU recommends Option 3 as the preferred Option and that a Business Case is developed to progress this option as soon as possible.

Dated: September 2013

Maternity and paediatric services at East Sussex Healthcare NHS Trust 2007 to 2013

Presentation to the East Sussex Health Overview and Scrutiny Committee 20th March 2014

Mr D Pascall, Consultant Obstetrician and Gynaecologist
Paula Smith, Associate Director
Lindsey Stevens, Head of Midwifery

Background

East Sussex Healthcare NHS
NHS Trust

- **2007** - Public consultation on reconfiguration of maternity services.
- **December 2007** - Decision to provide consultant led obstetrics and Neonatal services on a single site at Conquest Hospital, Hastings.
- **January 2008** - The IRP rejected the proposal to centralise these services and made a series of recommendations to the PCTs.
- **2008** - PCTs established the Maternity Services Clinicians Forum and Maternity Services Development Panel to oversee the development of a new Maternity Service Strategy.
- **November 2009** - Maternity Service Strategy 2009-2012 outlining a three year strategic direction for improvement this was endorsed by the HOSC. The implementation and progress has been monitored by them since.
- **2011** - Maternity and paediatrics included in the Trusts' Strategic Direction to deliver clinically and financially sustainable services in the future.
- **March 2012** - The strategy was approved by the Trust.

Choice of:

- How to access maternity care.
- Type of antenatal care.
- Place of birth - depending on individual circumstances, women and their partners will be able to choose between three different options; at home; a local midwifery facility or in hospital supported by a maternity team including midwives, obstetricians, paediatricians and anaesthetists. For some women, this type of care will be the safest option.
- Choice of postnatal care - either at home or in a community setting.

Service improvements delivered as part of the maternity strategy

East Sussex Healthcare NHS Trust

- Offering direct access to midwifery services.
- Developing specialist and additional support roles for midwives.
- Establishing services for early pregnancy.
- Ensuring choice of consultant led care, midwifery led care and home birth is available.
- Increasing the consultant establishment by three posts since 2007.
- Providing simulation training for trainees.
- Establishing and implementing RCOG guidelines for good practice.
- Maternity services achieved CNST level 2.
- Establishing care pathways for the assessment and treatment of maternal mental health.
- Development of a telephone triage service for antenatal patients.
- Achievement of Baby Friendly Initiative level 2.

Factors influencing the quality and safety of service provision

East Sussex Healthcare NHS Trust

- Increasing requirement to use temporary staff who were unfamiliar with the environment, policy and procedures of the units
- lack of suitable applicants to fill established posts
- Low levels of activity meant that staff were at risk of becoming de-skilled or having insufficient opportunities to fully develop the required skills
- Staff with the required competencies were not available twenty four hours a day seven days a week.
- Availability of clinical leadership in a service that is delivered on multiple sites
- consultant labour ward presence could not be consistently provided at levels above 40 hours per week
- Changes in the acuity and complexity of maternity cases

Change in number of pregnancies with high risk factors

East Sussex Healthcare NHS
NHS Trust

Risk factors	2006/7	2008/9	2011/12	% change 2006/7 to 2011/12
Twins	17	15	24	41%
Assisted reproduction	98	71	156	59%
Maternal medical factors	609	754	948	53.2%
Maternal obesity	606	815	1076	51.6%
Maternal age over 40	164	167	191	12.6%
Total high risk	1494	1822	2395	
Women booked	4396	4496	4448	
Percentage of women booked Who are high risk	34%	40.5%	53.8%	58.24%

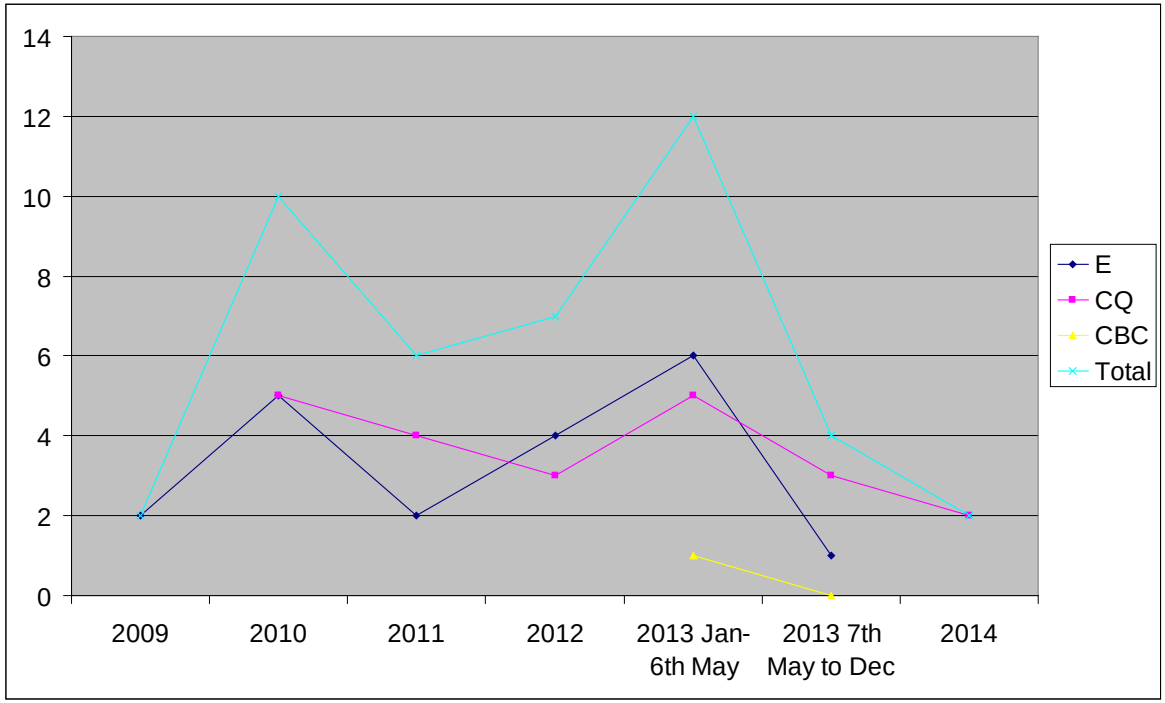
Challenges faced by service

East Sussex Healthcare NHS Trust

- Increase in serious incidents
- Concerns raised about junior doctors training

Serious incidents

East Sussex Healthcare NHS Trust



12 in the period January to 6th May 2013 (period of 4 months)
6 following the interim changes on 7th May (period of 10 months)

Deanery reports 2008

East Sussex Healthcare NHS Trust

- Inability of Eastbourne or Hastings to deliver appropriate curriculum for O&G training from ST2 and above highlighted
- In light of this from October 2009 training only to be offered at year one level

Deanery reports 2011 – Anaesthetics / Obstetrics (O&G)

East Sussex Healthcare NHS Trust

- **Anaesthetics** - ST3 and higher ST5 trainees must not be rostered to undertake training modules in obstetric anaesthesia at Conquest Hospital.
- **O&G** - inadequate experience for delivery of the curriculum at all levels.
- **O&G** - the 40hour consultant presence on labour ward must be used more effectively to deliver practical training to maximise all training opportunities.

Further challenges

East Sussex Healthcare NHS
NHS Trust

- Dr Foster data demonstrated that in the period 2010/11 and 2011/12 women were 5 times more likely to experience trauma at Caesarean Section in ESHT than elsewhere
- European working time directive and immigration changes - decreased quantity of middle grade doctor pool
- Retention of staff – one junior doctor appointed since 2008 has remained with trust
- Persistent decrease in junior doctor experience resulting in increased requirement for direct supervision by consultants
- Mitigations put into place to ensure adequate consultant support on the labour ward had a negative effect on antenatal and gynaecological work. The latter often had to be cancelled on the day
- Previous extension of MSW/midwives role to support medical staff in theatre now not recommended by National Preoperative Care group

Mitigations initiated at various levels

East Sussex Healthcare NHS
NHS Trust

- Staffing
- Divisional
- SHA
- Further external advice

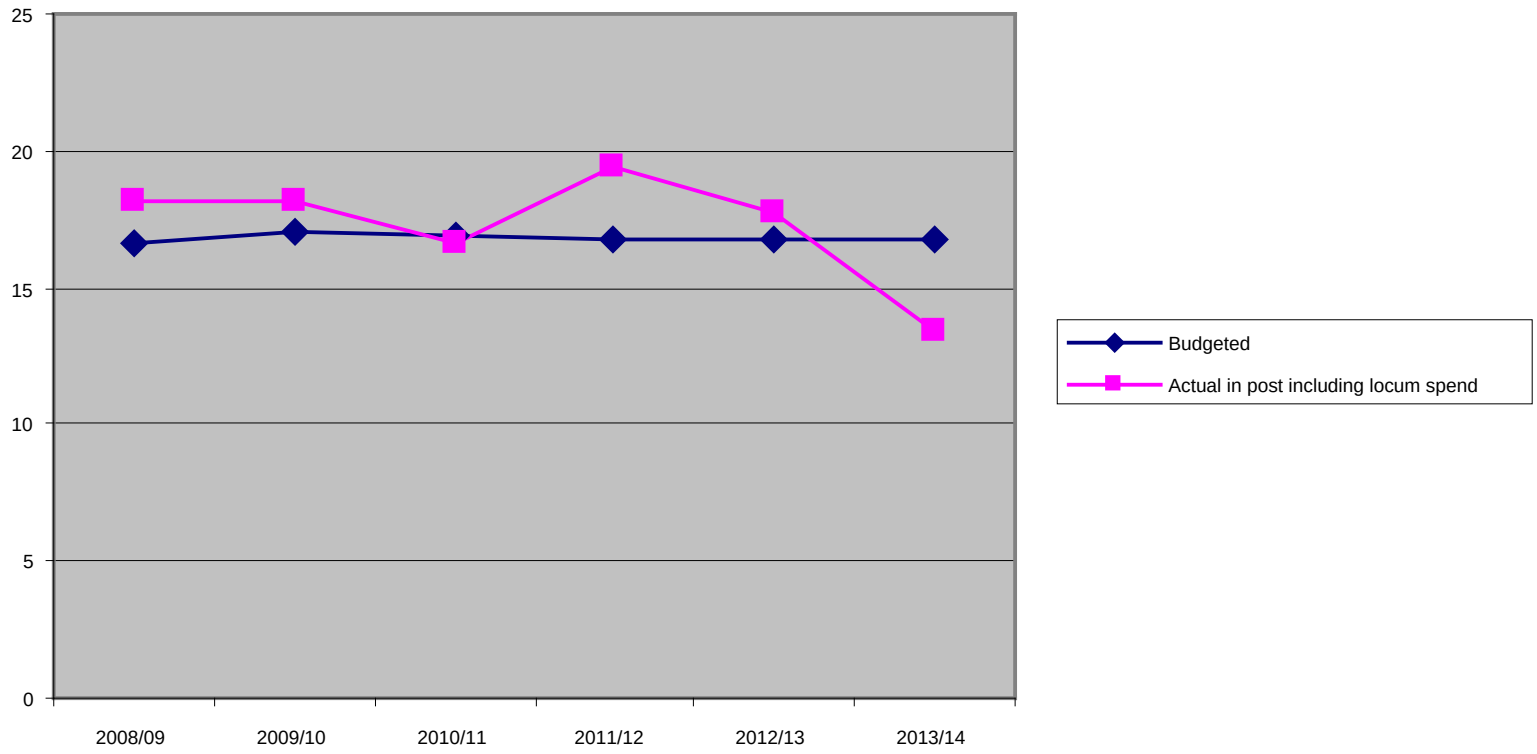
Staffing Mitigations

East Sussex Healthcare NHS
NHS Trust

- Active management of all rotas to identify gaps
- Full CV checks of all locums and agency
- Intensive induction for all agency/locums into trust and unit systems and processes
- Where individual concerns have been identified actions were taken to support the individual including restricting working hours to ensure direct supervision
- Ongoing recruitment campaign
- Escalation protocol
- Differential locum rate (Paediatric registrar)

Middle grade doctors

East Sussex Healthcare NHS Trust



Middle grade - is a doctor competent to perform obstetric procedures independently with indirect consultant support.

The Divisional Director and the Clinical Unit Lead for Women's Health issued a directive on 29 June 2012:

(This directive was over and above RCOG guidance No.8 "Responsibility of consultant on call")

- All elective caesarean sections must be directly supervised by a consultant or doctor holding the Certificate of Completion of Training (CCT)
- All caesarean sections undertaken in advanced labour or at full dilatation by middle grade doctors who are not CCT holders also require direct consultant supervision.

Mitigations identified through SHA review

East Sussex Healthcare NHS Trust

A review of the actions put in place by the Trust was undertaken by Mr Malcolm Stuart FRCOG Medical Advisor at the SHA in September 2012. A number of additional mitigations were suggested and implemented. These include:

- The appointment of a locum consultant at Eastbourne for a six month period. This commenced on the 8th October 2012 with an associate specialist who holds a CCT acting up into this role for a two week interim period prior to this start date.
- The consultant with split site on-call responsibilities was requested by the Medical Director to contribute exclusively to the Eastbourne rota for the short term. This commenced on 7th December 2012 for a three month period.
- A further joint directive from the Divisional Director and the Clinical Unit Lead for Women's Health required the mandatory attendance of consultants at trial of instrumental delivery in theatre in addition to consultant attendance as recommended by RCOG guidance. Only CCT holders are exempt from this level of supervision.

Mitigations taken following further serious incidents

East Sussex Healthcare NHS
NHS Trust

January 2013

- A **formal handover** on delivery suite at 0830 on weekdays led by the incoming on duty consultant and including the labour ward co-ordinator, registrar, SHO and other duty midwives as necessary.

- A **consultant led ward round on delivery suite and the antenatal ward daily** on week days at 0830 following the delivery suite handover and at 17.00. A ward round is also undertaken at any time there was a change of consultant during the day. On weekends, a telephone Consultant handover occurred.

- A consultant telephone ward round at 2200 hours daily with the discussion of specific cases formally documented by the middle grade doctor on duty.

External advice

East Sussex Healthcare NHS
NHS Trust

National clinical advisory team visited in January 2013 and advised:

- Maternity and paediatrics in-patient care should be located onto one site as a matter of urgency.
- Maternity; gynaecology and paediatrics in-patients should be on the same site; ideally alongside acute surgery and ITU.

March 2013

East Sussex Healthcare NHS
NHS Trust

The rationale for action was based on the current risks to patient safety which were:

- For some patients some of the time the safety and quality standards we would expect and require were not being met
- Our dependency on mitigating actions meant that the cumulative risk of service failure was at an unacceptable level
- The delivery of a safe service could have become rapidly unsustainable leaving little time to implement effective mitigating actions

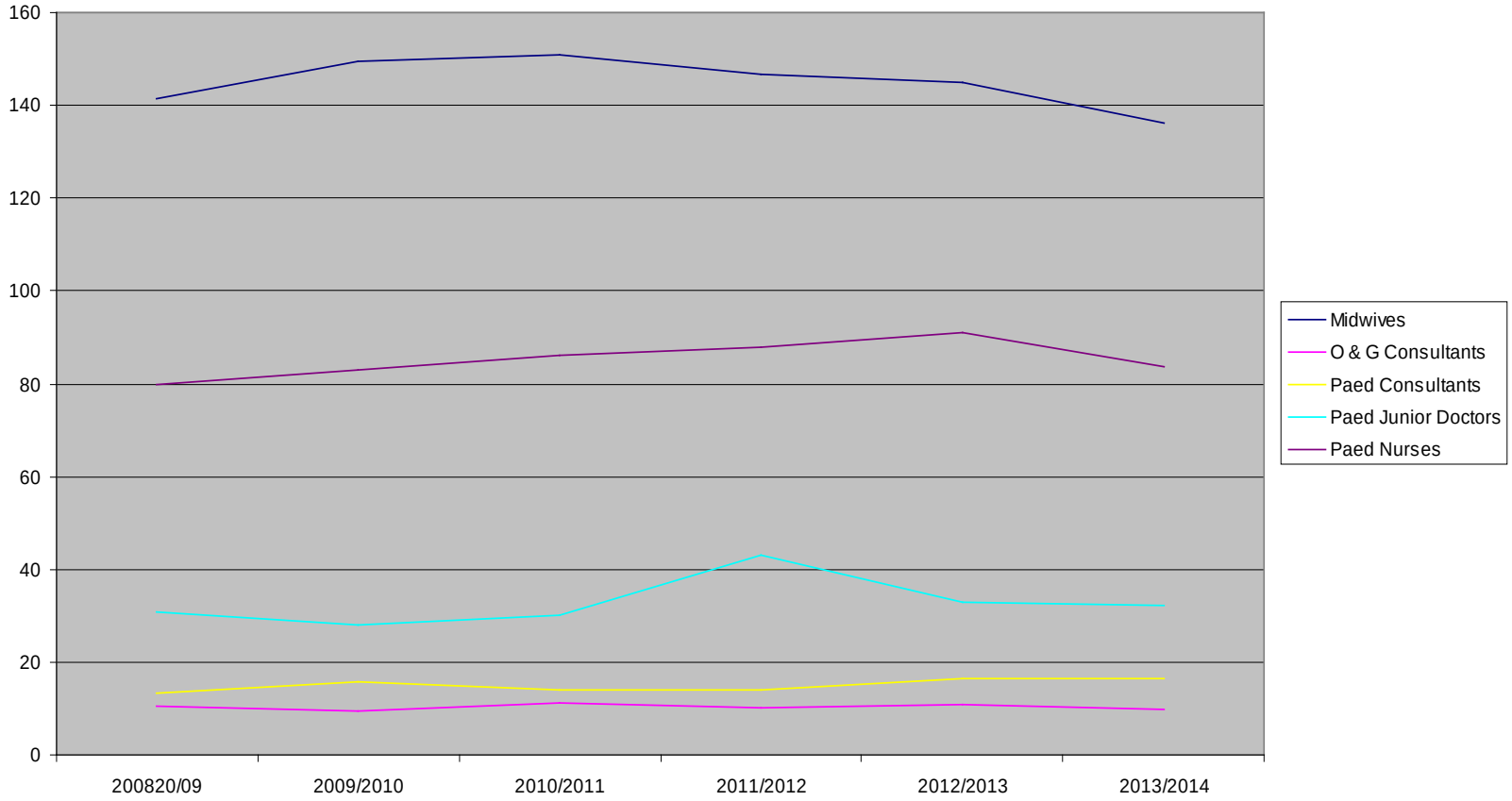
Overview of service since 7th May 2013

East Sussex Healthcare NHS Trust

- Staffing
- Birth outcome data
- Morbidity
- Midwife led care
- BBA's
- KSS Deanery report
- Paediatrics

Staffing – 2008 to 2014

East Sussex Healthcare NHS Trust



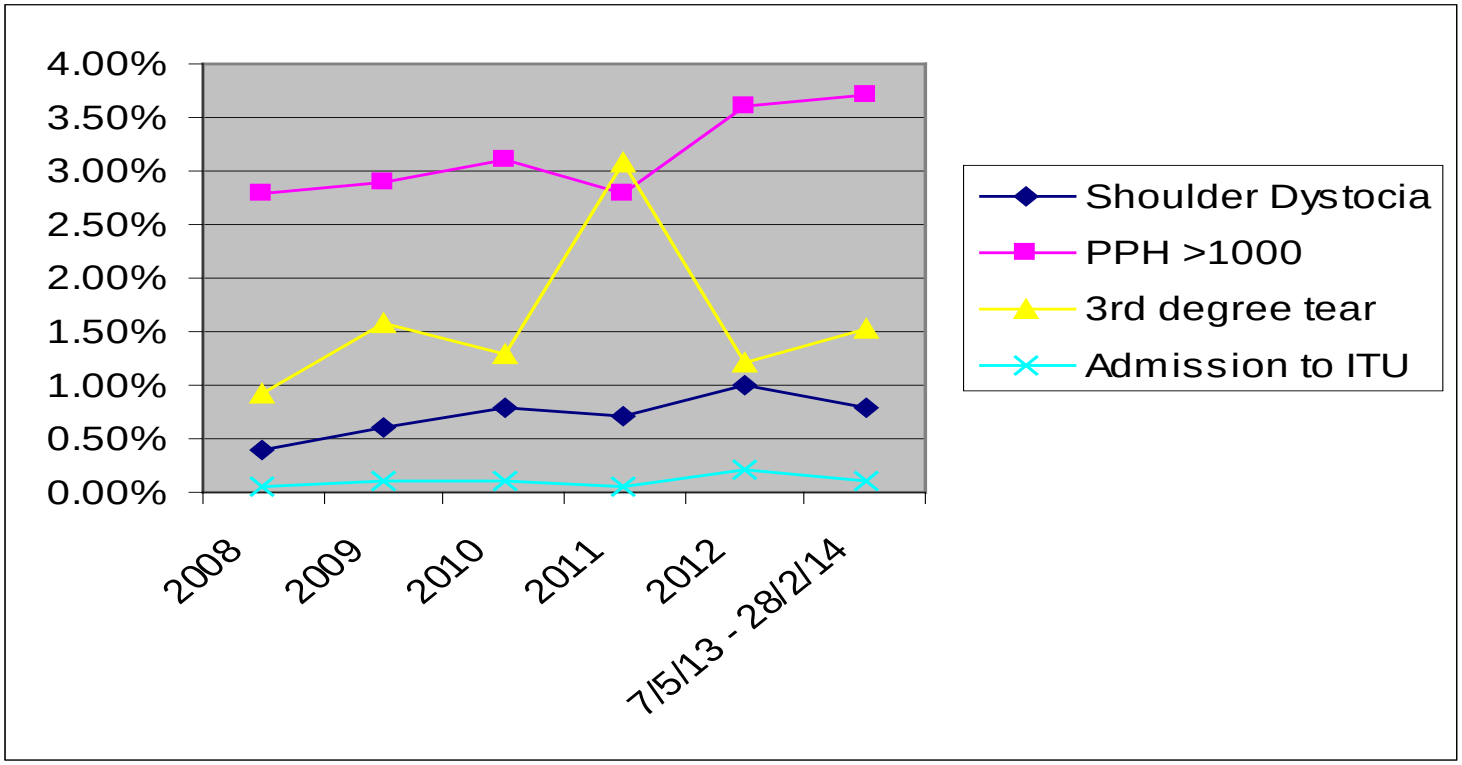
Caesarean Section and Instrumental deliveries

East Sussex Healthcare NHS
NHS Trust

Activity 2008 - 2014						
	2008	2009	2010	2011	2012	7/5/13 - 28
Elective	8.57%	8.23%	8.78%	9.36%	9.80%	10.40%
Emergency	12.56%	12.19%	12.51%	13.50%	13.57%	13.30%
Total LSCS	21.13%	20.42%	21.29%	22.86%	23.37%	23.70%
Instrumental	10.60%	10.60%	11.50%	11.90%	13.20%	12.80%

Maternal morbidity

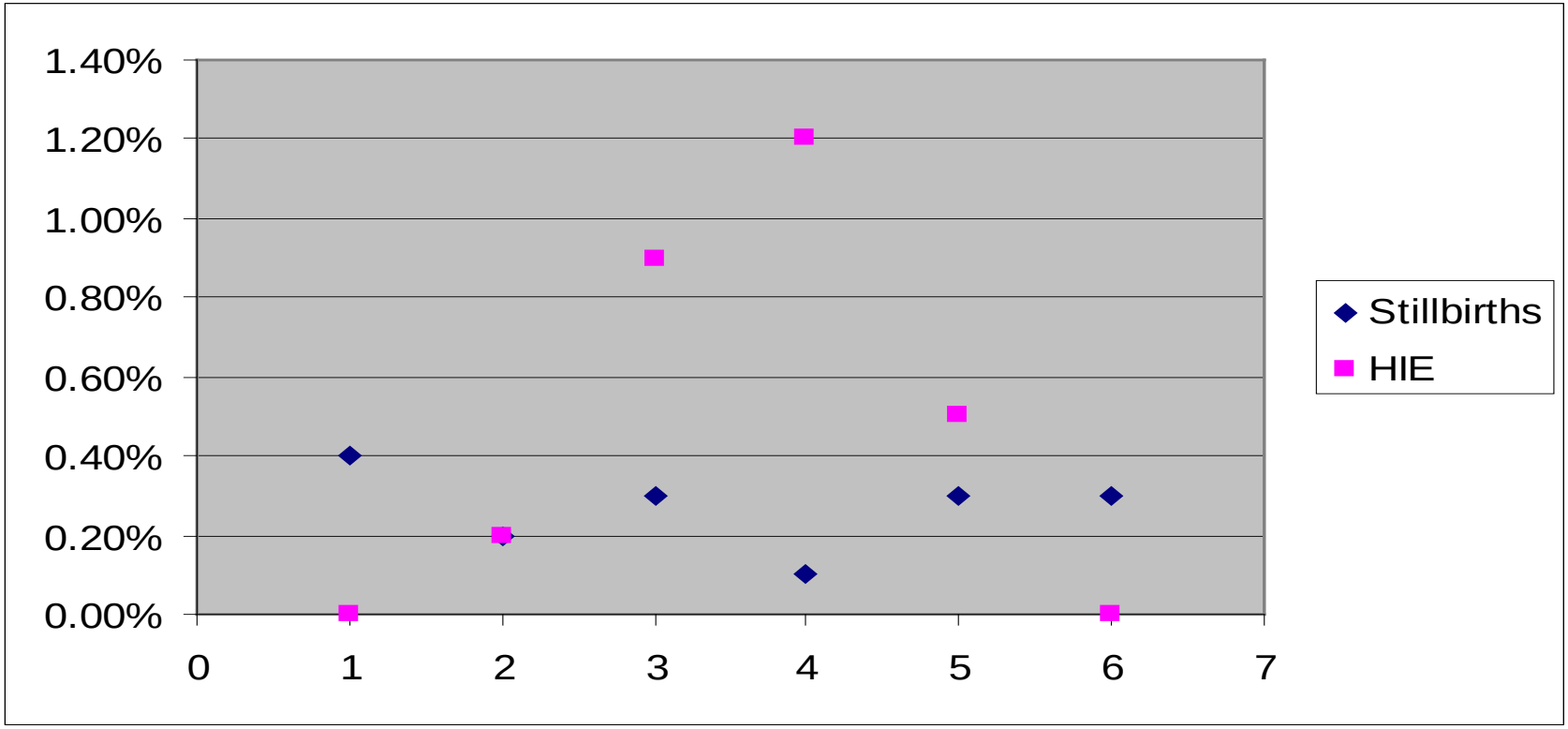
East Sussex Healthcare NHS Trust



Neonatal outcome

East Sussex Healthcare NHS
NHS Trust

No cases of HIE since temporary reconfiguration



Key
1 – **2008**; 2 - **2009**; 3 - **2010**; 4 - **2011**; 5 -**2012**; 6 – **7th may 2013 – 28 Feb 2014**

BBA (excl. CBC)

East Sussex Healthcare NHS
NHS Trust

	2011	2012	2013	7/5/13 - 28/2/14
Total	31	34	28	22
Conquest	18	16	20	14
EDGH	13	18	8	8
	Eastbourne			
Home	12	17	8	
transit	1	1	0	

BBA - post 7th May 2013

East Sussex Healthcare NHS
NHS Trust

- **22 women**
- **8 booked for EMU – all delivered at home**
- **14 booked for Consultant Unit, Hastings –**
- **Delivered at home - 5**
  - Eastbourne - **1 /** Hastings - **3 /** Bexhill - **1**
- **Delivered in transit - 9**
  - Eastbourne - **3** / Hailsham - **2**
  - Hastings - **2** / Bexhill - **1** /New Romney - **1**

Overview of EMU data

East Sussex Healthcare NHS Trust

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Labour	14	27	32	39	33	36	37	41	25	44		328
Births	10	20	28	33	28	31	31	36	20	35		272
Transfers	4	7	4	6	5	5	6	5	5	9		56

Outcomes	EMU	National average (Birthplace study)	
Primip transfers	36.7%	36%	
Multip transfers	4.6%	9%	
Transfer time (average)	78.9 mins		
Admission to delivery (average)	3.15 hours		
Instrumental	5.2%	5.7%	
Caesarean	2.44%	3.5%	

Deanery reports 2013

East Sussex Healthcare NHS Trust

- **Obstetrics**
- The timetable clearly tailors the training to individual trainees needs
- Marked improvement in the trainees' exposure to practical obstetric procedures.
- No locum cover needed since re-configuration which has contributed to the improved educational environment.
- Core trainees have been released to use the regional ultrasound simulation equipment
- The daily consultant led review of complicated cases is an excellent learning opportunity
- There has been a considerable improvement in the standard of training in obstetric anaesthesia since the previous visit in 2011.
- **Anaesthesia:**
- Strong educational leadership was evident
- Consultant involvement in CEPOD cases on the Conquest site greatly benefited both patient care and training.
- There has been close and constructive collaboration with the School of Anaesthetics regarding the service reconfiguration in the Trust .
- Feedback from ARCPs and the GMC survey has been thoroughly considered and has led to sensible organisational changes to improve training.
- Trainers have been appraised in their educational roles and receive appropriate time allocation for departmental educational activity.

Paediatrics

East Sussex Healthcare NHS
NHS Trust

- On average 152 children are seen in A&E at Eastbourne DGH of which on average 6 a week transferred to Kipling ward at Conquest Hospital for admission.
- On average 202 children seen each week in A&E at Conquest Hospital of which on average 12 a week have an Eastbourne area address.
- On average 81 children a week are seen in the Short Stay Assessment Unit (SSPAU) at Eastbourne DGH of which on average 5 a week are transferred for admission to Kipling ward at Conquest Hospital.
- On average 77 children a week are seen in the SSPAU at Conquest Hospital.

Temporary reconfiguration

East Sussex Healthcare NHS
NHS Trust

- Demonstration of continued safety of midwifery led units.
- MLU – lower transfer rate than national average.
- MLU – outcomes demonstrate improved outcome for low-risk women in-line with birthplace study 2011.
- No negative impact on neighbouring trusts.
- BSUH has had on average increase of 10 births per month.
- MTW reported very little difference in “ESHT” births at Pembury.
- Minimal impact on SECAMB.
- Minimal transfer of acute gynaecology emergencies.
- Registrar cover of gynaecology leading to improved decision making.

Temporary reconfiguration

East Sussex Healthcare NHS Trust

- Increased consultant presence
  - from 40 to 72 hours with 45% out of hours
  - more direct involvement in intrapartum care
  - Improved training opportunities for all levels of staff
- Concentration of clinical leadership and less duplication of effort enabling time released to be used efficiently.
- Improved risk process – identifying and responding to risks in a timely fashion.
- FFT demonstrating patient satisfaction.
- Positive trainee feedback.
- All staff feel better supported.
- Projected 15% loss of activity has only been 12% in reality.

Why is it safer now ?

East Sussex Healthcare NHS
NHS Trust

- Increased capacity and ability to manage acute decrease in staffing ie sudden sickness.
- Improved flexibility of staff within service to manage unpredictability in obstetric birth numbers.
- Improved ability to support doctors requiring increased supervision without excess recourse to locum staff.
- Stabilisation of indicators of maternity care.
- Improvement of maternal and neonatal morbidity.