Agenda Item 6

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**20 March 2014**
By:	**Assistant Chief Executive**
Title of report:	***Better Beginnings* – maternity and paediatric services in East Sussex**
Purpose of report:	**To take evidence for the review of proposed changes to the provision of maternity and paediatric health services in East Sussex.**

RECOMMENDATION

HOSC is recommended to consider the evidence as listed below as part of its review of maternity and paediatric services.

1. Background

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

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

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

1.4 At its meeting on 17 February 2014, HOSC considered the views of the campaign groups and Friends of Crowborough Hospital.

2. HOSC's continuing review

2.1 A number of appendices are attached to this report:

- **Appendix 1**: the key lines of enquiry for the review agreed by HOSC on 20 January and refined subsequently. (Page 23)
- **Appendix 2**: a report compiled by the CCGs which responds to the issues raised at HOSC on 17 February 2014 in relation to proposed delivery options for maternity, inpatient paediatric and emergency gynaecology services. (Page 27)
- **Appendix 3**: Demographic projections and assumptions. (page 65)
- **Appendix 4**: outcomes from the public 'Question Time' events hosted by East Sussex Community Voice as part of its Healthwatch East Sussex function (to follow because the last event takes place on 12 March).

2.3 Evidence pack 2 (agenda item 5) is a supplement to Evidence Pack 1 (published for the 17 February HOSC). The evidence is grouped under the following headings:

1) Evidence from national bodies and other published evidence
2) Evidence from the East Sussex Clinical Commissioning Groups (CCGs) including the *Better Beginnings* consultation document that sets out the options and the reasoning behind them.
3) Relevant media reports
4) Written evidence from campaign groups and other stakeholder groups and organisations
5) Comments from individual members of the public.

3. HOSC timetable

Action	**Date**
HOSC: Taking written and oral evidence from witnesses	17 February 2014
HOSC: Taking written and oral evidence from witnesses	20 March 2014
HOSC Task Group to review the evidence gathered	April/May date TBA
Evidence is considered and report drafted	March – June 2014
HOSC: Agrees its report and recommendations to submit to the CCGs	19 June 2014
HOSC receives the decision of the CCGs and decides whether it is in the best interests of the health services for the people of East Sussex	10 July 2014

4. Recommendation

4.1 HOSC is recommended to take evidence for the review of proposed changes to the provision of maternity and paediatric health services in East Sussex and to agree to the establishment of a HOSC Task Group (date to be fixed in April/May) to review the evidence gathered.

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Appendix 1

HOSC key lines of enquiry

(amended in response to issues raised at the 17 February 2014 HOSC meeting)

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

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

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

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

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

- What is the outcome of like-for-like comparisons with other Trusts that have small consultant-led units?
- Could alternative staffing models work as discussed in the 2008 IRP report and suggested by witnesses at the 17 February HOSC?

1.5. How will the CCGs balance patient choice against safety and viability considerations?

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

2. Evidence from the temporary changes introduced by ESHT in May 2013

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

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

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

- Using relevant cases where the temporary reconfiguration was a relevant factor, and not cases that would have happened regardless of the clinical model.
- Comparisons with other areas of the country.

- Number of births that have taken place outside of a hospital due to transfers being required (where not already included in BBA figures).

2.4. What has been the impact on BSUH/MTW of the changes / impact of the proposed options?

2.5. Paediatrics: issues around short stay units (SSPAUs) and in-patient paediatric services.

3. Safety and sustainability of Midwife led units (MLUs)

3.1. What is the comparative safety record of stand-alone MLUs v. consultant-led units?

3.2. What are the pros and cons of co-located MLU and consultant-led services? / How safe is it having obstetric services on only one site?

3.3. What are the factors that determine where consultant-led maternity services should best be located if they are to be limited to *either* Hastings or Eastbourne?

3.4. What factors affect the desirability of co-location with other services and other geographical factors?

3.5. What assurances would there be about the long-term sustainability of MLUs and the avoidance of sudden closures?

3.6. Why the limit to two MLUs in East Sussex?

4. Safety and travel

4.1. Travel times for callouts and transfers (especially between Eastbourne DGH and the Conquest, and transfers from Crowborough Birthing Unit to Pembury or PRH). Is the service meeting relevant performance indicators/confident about the future response under all the options? Meeting relevant Royal College standards?

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

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

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

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

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

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

5. Demographic projections and assumptions

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

5.2. How are projected reductions in numbers of births in East Sussex reconciled with anticipated increases in school places needed in Eastbourne for example?
5.3. To what extent are the reduced projected numbers of births in East Sussex based on assumptions that women will choose Brighton, Haywards Heath or Pembury?
5.4. How accurate were the 2007 projections for birth numbers?

6. Crowborough Birthing Centre

6.1. What factors influence the decisions on the future of Crowborough Birthing Centre?
6.2. Sustainability of Crowborough birthing Centre: how many times has Eastbourne/Crowborough MLUs been closed temporarily and why?

7. Financial viability

7.1. What is the relative financial viability of the different options?
7.2. Why money is not considered to be a motivating factor behind the proposed reconfiguration?

8. Consultation issues

8.1. Establishing GPs' views.

APPENDIX 2

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

Report: *Better Beginnings:* The purpose of this report is to formally respond to the issues raised by the Health Overview and Scrutiny Committee at the meeting held on 17 February 2014 in relation to proposed delivery options for maternity, inpatient paediatric and emergency gynaecology services.

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Date: 10 March 2014

SECTION 1: INTRODUCTION

1 Purpose of this report

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

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

During the HOSC meeting in public on 10 January and at the evidence gathering session on the 17 February, HOSC members asked for further clarification and information regarding some of the evidence supporting the six options. The purpose of this report is to formally respond to the issues raised.

2 Background

Throughout 2012, the NHS Sussex Together programme, where the commissioners and providers across East Sussex, West Sussex and Brighton and Hove worked together to improve care, reviewed maternity and paediatric services across Sussex as part of their programme of work. The resulting

Clinical Consensus on the Evidence Base and the Case for Change[1] for Maternity and Paediatric services was developed and agreed by senior GP commissioners, consultants, midwives and other health professionals from across Sussex in July 2013.

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

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

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

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

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

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

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

SECTION 2: RESPONSE TO HOSC LINES OF ENQUIRY

1. Further information on smaller units in England

When considering the sustainability of smaller units in East Sussex, it is important to note that the Sussex Collaborative Clinical Reference Group has identified that the optimum number of births for an obstetric unit in East Sussex is between 3,000 and 4,000.

This clinical consensus included senior clinicians from the Sussex Trusts (Western Sussex Hospitals NHS Foundation Trust (WSHFT), Brighton and Sussex University Hospitals NHS Trust (BSUH), Surrey and Sussex NHS Trust (SASH) and East Sussex Healthcare NHS Trust (ESHT), Sussex Community Trust (SCT), Sussex Partnership Foundation Trust (SPFT) and the 7 Sussex CCGs (Horsham and Mid Sussex CCG, Crawley CCG, Coastal West Sussex CCG, Brighton and Hove CCG, High Weald Lewes Havens CCG, Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG). The work of the Sussex Collaborative and the Clinical Consensus is detailed in section 9 of the pre-consultation business case.

The CCG leads spoke to or visited eight of the smaller maternity units in England (as outlined in the previous Response to HOSC Lines of Enquiry, February 2014).

In addition to speaking with smaller units, the GP leads and commissioners in East Sussex referred to the RCOG Census Report 2012 (Published August 2013). The figures quoted within this section are extracted from that report.

Nationally, there is clear drive to provide obstetric care in fewer units. This is evidenced in Table 1.0 (Comparison of number of obstetric units 2010 and 2012) which shows that the number of obstetric units in England reduced from 180 (2010) to 160 (2012), a reduction of 20 units over 2 years.

There is a national shortage of obstetric and paediatric consultants and middle grade doctors as a result of recent immigration laws and the introduction of the European Working Time Directive (which limits the number of hours that a doctor can work in any week).

In East Sussex, bringing doctors from multiple sites onto a single site has meant that there are fewer hours on the labour ward when a consultant is not present. There is consistent clinical evidence, including the evidence which we have seen locally since the temporary change, that increasing the number of hours that a consultant is present on the labour ward:

- increases safety and quality of services
- improves outcomes for women and babies
- increases supervision and training of middle grade doctors, which
- improves performance of middle grade doctors

Bringing obstetric deliveries from multiple sites onto a single site means that each obstetrician and training grade doctor will personally deliver more babies, which

- enables doctors to maintain their skills
- allows training doctors to experience enough deliveries to become qualified
- makes that hospital more attractive to middle grade doctors than hospitals with fewer births.

TABLE 1.0: COMPARISON OF NUMBER OF OBSTETRIC UNITS 2010 AND 2012

Please Note: The units listed below are as listed in the RCOG Workforce Census Reports, therefore some hospitals have been captured under both columns (No Longer Listed and Newly Listed) (e.g. Pembury Hospital no longer listed, Tunbridge Wells Hospital newly listed). It is important to note that this does not affect the final outcome of the table, for example, should Tunbridge Wells Hospital and Pembury Hospital be excluded from the table, the outcome will still read a reduction of 3 hospitals delivering obstetric care in Kent Surrey Sussex.

Deanery	+/-	Newly Listed 2012	Listed 2010, No longer listed 2012
East Midlands	-	-	-
East of England	-1	Broomfield Hospital (4900)	Queen Elizabeth II Hospital (<3000)
			St John's Hospital (<5000)
Kent Surrey Sussex	-3	Tunbridge Wells Hospital (5000)	Pembury Hospital (<3000)
			Benenden Hospital (<2500)
			Royal Surrey County Hospital (<3500)
			Maidstone Hospital (<2500)
London	-2		St Bartholomew's Hospital (<2500)
			Queen Mary's Hospital, Sidcup (<3500)
Mersey	-1		Noble's Hospital (<2500): **
North Western	-3	Lancashire Women and Newborn Centre (6850)	Fairfield General Hospital (<2500)
		Noble's Hospital (Isle of Man) (990)**	Rochdale Infirmary (<2500)
		UHSM (University Hospital South Manchester) (4400)	Burnley General Hospital (<3000)
			North Manchester General Hospital (<3000)
			Wythenshawe Hospital (<3500)
			Royal Blackburn Hospital (<4500)
Northern	-1		University Hospital of North Durham (<3500)
Oxford	0		
Severn	-2		Cheltenham General Hospital (<3000)
			Royal United Hospital (<5000)
South West Peninsula	0		
Wessex	-1	Poole/Royal Bournemouth Hospitals (4781)	Poole General Hospital (<5500)
			Royal Bournemouth Hospital (<2500)
West Midlands	-1		City Hospital, Birmingham (<4000)
Yorkshire & Humber	0		
	-15	**5 Newly Listed delivering +5000 births (Average)**	**20 no longer delivering obstetric care**
		+1 moved to new deanery**	**+1 moved from old deanery****

In 2008, there were 188 obstetric units
- 53 units reported fewer than 2,500 deliveries
- 33 of 53 units reported fewer than 2,000 deliveries

In 2010, there were 180 obstetric units
- 39 units reported fewer than 2,500 deliveries
- (number of deliveries under 2,000, unknown)

In 2012, there were 160 obstetric units
- 28 units reported fewer than 2,500 deliveries
- 12 of 28 units reported fewer than 2,000 deliveries.

2. Further information regarding travelling time whilst in labour

The following information is taken from a secondary analysis of the Birthplace National Prospective Cohort Study, published in December 2013[2] and relates to the duration and urgency of transfer in births planned at home and in freestanding midwife led units in England.

"In England, there is a policy of offering healthy women with straightforward pregnancies a choice of birth setting. Options may include home or a freestanding midwifery unit (FMU). Transfer rates from these settings are around 20%, and higher for nulliparous women (women who have never given birth to a viable or live infant).

"Transfers from home or FMU commonly take up to 60 minutes from decision to transfer, to first assessment in an OU, even for transfers for potentially urgent reasons. Most transfers are not urgent and emergencies and adverse outcomes are uncommon, but urgent transfer is more likely for nulliparous women.

"Most FMUs were located within 40 km (24.9m) of the nearest OU and more distant FMUs accounted for a very small proportion of planned FMU births. Distance had some impact on transfer times.

"The median overall transfer time in transfers for potentially urgent reasons from FMUs located within 20 km (12.4m) of the nearest OU was 8 minutes shorter, at 47 minutes, than for FMUs located between 20 and 40 km away (12.4 and 24.9m) (55 minutes), increasing to 61 minutes in the small number of FMUs located over 40 km (24.9m) away.

Table: Median Overall Transfer Times for Potentially Urgent Reasons

Distance from FMU to Obstetric Unit	Median Overall Transfer Time
Within 20km / *(Within 12.4 miles)*	47 minutes
20km – 40km / *(12.4 – 24.9miles)*	55 minutes
Over 40km / *(Over 24.9 miles)*	61 minutes

[2] Rowe, R. et al., "Duration and urgency of transfer in births planned at home and in freestanding midwifery units in England: secondary analysis of the Birthplace national prospective cohort study", (December 2013), http://www.biomedcentral.com/1471-2393/13/224

East Sussex Transfers

It is important to note that there is no definitive national target for transfer time. ESHT has developed a local robust and safe protocol for women requiring transfer from the EMU and from Crowborough to an Obstetric Unit. This has been agreed by clinicians and SECAmb. It reflects the transfer time used in East Kent of 80 minutes. Any transfers that breach this time are reviewed and reported on.

Table: Distance between birthing units, East Sussex and surrounding areas

	Royal Sussex	Princess Royal	EDGH	Conquest	William Harvey	Crowborough	Pembury
Royal Sussex		20	23	39	86	26	37
Princess Royal	20		29	39	78	17	27
EDGH	23	29		21	51	25	35
Conquest	39	39	21		32	35	25
William Harvey	86	78	51	32		51	43
Crowborough	26	17	25	35	51		11
Pembury	37	27	35	25	43	11	

Source: AA Route Planner, 2014. www.theaa.com/route-planner

The CCGs continue to monitor travel times and outcomes for women transferred from the midwife led units to the temporary obstetric unit site. To date, no serious incidents have been attributed to these transfers. The number of transfers in East Sussex is in line with the national average.

ESHT recently carried out a review of women arriving at the Conquest Hospital by ambulance transfer from the EMU. The review has shown that, on average, women give birth 3.15 hours after arrival. The shortest time for a woman arriving from the EMU, to giving birth, was approximately 35 minutes after arrival at Conquest Hospital. The longest time after arrival was 17 hours. This review was based on 7 months of data following the temporary configuration.

3. Further information regarding GP engagement and support

Pre Consultation: Developing the models of care and options

There has been continuous engagement with GPs throughout the development of the models of care and options. An open report[3] detailing the engagement that took place and the findings from GP feedback has been published on the Better Beginnings website and has been provided to the HOSC as part of their evidence pack.

[3] Coffey D, "*Evidence of GP engagement prior to the launch of Better Beginnings: A consultation on the future of NHS maternity, inpatient children's services and emergency gynaecology in East Sussex*", (February 2014), http://www.betterbeginnings-nhs.net/wp-content/uploads/2014/01/Report-on-GP-Engagement-v-4.pdf

Mid Consultation: Ensuring that GPs are informed of progress and have been provided with the means to respond to the consultation

The consultation document and a link to the online survey were emailed to every GP and Practice Manager in East Sussex on 14 January 2014. A copy of this email can be found in Annexe 1. 20 hard copies of the consultation were also posted to each practice during the week following the launch of the consultation.

Regular cluster or locality meetings take place on a monthly or bi-monthly basis and include GP representation from each practice in that cluster/locality.

Better Beginnings has remained a standing agenda item at all cluster meetings since 2013, when GPs were first asked to engage in the development of the options and the models of care.

Better Beginnings continues to be discussed at every cluster/locality meeting, where GPs are informed about the progress of the consultation, encouraged to provide feedback via the survey or email and openly discuss questions or concerns that they may have.

A monthly GP Newsletter has been established. The newsletter covers many different areas of interest for GPs; it continues to inform and update GPs on Better Beginnings consultation progress and promotes the methods through which GPs can influence decisions. The following is an excerpt from one of the GP Newsletters (February 2014):

> ***"Better Beginnings***
>
> *"The Better Beginnings public consultation is well under way. All practices should have received the consultation document and link to the website by email as well as hard copies to display in waiting rooms. We know some practices have already run out so if you would like to re-order please contact Dee Coffey. The Better Beginnings consultation will be discussed at upcoming cluster meetings. In the meantime if you or a member of your practice team would like to have an individual conversation or if you would like one of the Governing Body GPs to visit your practice to answer any questions or concerns you may have, please contact Dee Coffey.*

Post Consultation: Ensuring that GP Governing Body members' decisions are informed by the wider GP clinical network

Following the close of consultation, the feedback received from GPs via emails, surveys and meetings will be collated and analysed. The findings will be published in a second report on GP engagement and support, which will be made available to Governing Body members as one of the pieces of information that will be used to inform the CCGs' decisions.

4. Further information on how HWLH women's views were reflected in the engagement reports

The opportunity to influence the development of the models of care and the options and to fully engage with the Better Beginnings consultation has been made available to members of the public across the whole of East Sussex. These opportunities have been made available through online and social media, targeted focus groups, one-to-one interviews, media campaigns and market place events. In addition to the engagement work across East Sussex, targeted focus groups have also been established to ensure that the views of specific groups who were identified through the Equality Analysis, who may be impacted differently by the options, are also considered. The full Equality Analysis has been published as an appendix to the pre-consultation document.

Prior to the launch of consultation, the CCGs in East Sussex led this programme of engagement with local people across the county which was carried out in two phases.

The findings from this programme of engagement directly influenced the options.

Summary of how HWLH influenced the options

HWLH people in particular strongly voiced a desire to maintain services at Crowborough Birthing Centre, therefore four of the six options include these services.

Women from HWLH have also stated that they are unclear on the pathways for women choosing to give birth at Crowborough and that they have felt the need to 'bypass the system' in order to access the pathway of their choice. Whilst these issues are not part of the Better Beginnings consultation, as a direct result of this feedback, work has begun to simplify and clarify these pathways between providers, so that women are more aware of the options available to them.

Women from HWLH, in particular from the Crowborough area, felt very strongly that the choice of a normalised birth should be available for all expectant mums, where appropriate. The options include an increase in the number of midwife led units from one to two. Home births are available across the county, under every option.

Phase 1

During the initial discussion phase (15 July 2013 – 15 September 2013) of the "Better Beginnings" review, this activity was particularly focused on collecting views from recent or current service users. The analysis of learning from this period was captured in a report[4] and published as an appendix to the pre-consultation business case.

The aim of this activity was to raise awareness of the Sussex Clinical Case for Change for maternity and paediatric services, seek insight into recent experiences and capture people's aspirations for future service delivery options. It should be acknowledged that, whilst engagement has been focused on the future delivery of these services, views about the temporary changes to East Sussex Healthcare NHS Trust (ESHT) services featured prominently in these early discussions.

[4] *"Report on the findings from the initial discussions phase of Better Beginnings: Review of maternity and paediatric services in East Sussex",* (September 2013), http://94.136.40.103/~betterbeginnings-nhs.net/wp-content/uploads/2014/01/PCBC-Appendix-3-Pre-consultation-Stakeholder-Engagement-I.pdf

The engagement team used an online survey, one to one interviews and targeted focus groups to gather the views of East Sussex residents.

These opportunities were available to everyone who wished to engage with the pre-consultation and were advertised widely through our stakeholders and their networks, including Care for the Carers, Healthwatch East Sussex, Support Empower Advocate Promote (SEAP) and many more.

Respondents to the online survey were spread across East Sussex with proportionately more responses from Eastbourne. Respondents were asked to identify which council area they lived in and the breakdown is as follows:

- Eastbourne 42.5%
- Wealden 15.1%
- Lewes 5.9%
- Rother 25.3%
- Hastings 9.1%
- None of the above 2.2%

There were 27 one-to-one interviews about maternity services with recent maternity service users from different parts of the county (all female); Seaford (8), Hailsham (6), Battle (4), Willingdon (3), Eastbourne (2), Heathfield (2) Sidley (1), Lewes (1). Interviews were undertaken at family fun days, playgroups, children's centres and over the telephone.

There were 8 one-to-one interviews about paediatric services with parents that have recent experience of those services from different parts of the county; Seaford (2), Battle (2), Eastbourne (1), Sidley (1), Lewes (1), Heathfield (1).

6 focus groups were held in Hastings and Eastbourne. Most of the people attending (predominantly women) were very recent or current users of the services.

Phase 2

The "Phase 2" engagement programme[5] was undertaken as a short but intensive exercise between October and November 2013 and the analysis of learning was published as Appendix 4 to the pre-consultation business case. The timeframe of this engagement phase was defined in order that the insight was collated at a point when it could inform and influence the options appraisal process to identify which delivery options would be taken forward for further consideration.

As part of the briefing provided to participants, it was recognised that each of the different ways that the services could be delivered would bring opportunities but could also introduce challenges. The insight was capture via structured telephone interviews and focus groups and considered either maternity services or paediatric services. In all cases the same questions were asked:

- What are the opportunities presented by the different ways the service could be delivered?
- What are the challenges introduced by the different ways the service could be delivered?
- What could be put in place to address or lessen the impact of the challenges identified?
- What needs to be taken into account when considering where these services should be located?

[5] *"Report on the findings from the Phase 2 discussions of Better Beginnings: Review of maternity and paediatric services in East Sussex",* (November 2013), http://94.136.40.103/~betterbeginnings-nhs.net/wp-content/uploads/2014/01/PCBC-Appendix-4-Pre-consultation-Stakeholder-Engagement-II.pdf

Alongside public and service user groups, the engagement team also ran a number of focus groups and interviews with maternity and paediatric staff from East Sussex Healthcare NHS Trust (ESHT). The same process and questions was utilised with both staff and public.

This phase of engagement was promoted directly to people who had been involved in the initial discussion engagement, advertised in the local press and through community networks and newsletters and sent information sent to the CCGs' stakeholder distribution list.

In promoting the opportunities to engage specific consideration was given to target groups that may be directly or differently impacted by a change to these service areas. This included foster parents, parent carers of children with complex needs, young parents via the Family Nurse Partnership and children's centre users.

Structured telephone interviews were conducted with 21 people, 17 for maternity and 4 for paediatrics. This captured a mixture of public and staff views.

Six service user and public focus groups were held with a total of 32 participants:

- 2 in the Eastbourne area
- 2 in the Hastings area
- 2 in Crowborough

During Consultation
Engagement with the public will continue to take place during consultation. The consultation document and online survey has been widely circulated. As of 10 March 2014, there have been over 300 responses (a mix of online and written returns).

Responses have been submitted from all three CCG areas:

- 41% Eastbourne Hailsham Seaford CCG area
- 26% Hastings and Rother CCG area
- 16% High Weald Lewes Havens CCG area
- 10% Does not know (the CCG area)
- 6% None of the above

GP leads and commissioners are attending widely advertised market place events across the county. A map showing the spread of events across the county can be found in Annexe 2.

Healthwatch East Sussex will host a total of three public meetings at Eastbourne, Hastings and Uckfield. The events have been widely advertised in local media and take the form of a BBC Question Time event. The panellists include CCG Clinicians, senior commissioners, independent clinicians, MPs and campaign group leads.

HWLH CCG continues to liaise with MTW to improve and clarify the pathways for women wishing to give birth at Pembury Hospital.

5. Further information on whether the surrounding Trusts could cope with the impact of each of the six options

The CCGs in East Sussex have continued to engage with neighbouring trusts throughout the development of the options and during the consultation. The decisions, and the options themselves, were shared with neighbouring Trusts via the clinical reference groups.

Brighton and Sussex University Hospitals NHS Trust have confirmed verbally that they are able to support the changes and are doing so demonstrably under the current temporary configuration which is consistent with the most significant impact for BSUH under any of the 6 options. BSUH will be confirming this as part of a formal provider response to the consultation.

Maidstone and Tunbridge Wells NHS Trust have similarly verbally confirmed that it can and will support the changes proposed. MTW is also expected to confirm this as part of a formal provider response to the consultation.

The impact of the temporary changes on surrounding Trusts can also be found in section 7 of Annexe 4: Maternity and Paediatric Services Review: 7 Months Following Interim Changes, which reports the following.

The modelling work completed before the interim changes, which was submitted to the ESHT Board, made an assumption that approximately 260 women would elect to go to BSUH and 160 women to MTW.

- On average BSUH has seen an increase of 12 ESHT births per month against the same period last year. There is a lot of variance from month to month and the full impact of the effect the interim changes has on births will not be fully seen until December 2013 onwards when women who booked after the interim changes start to deliver.

- This increase is predominantly in line with forecasts of women from the Seaford and Uckfield areas choosing to go to Brighton.

- The Head of Midwifery at MTW has not reported any impact from ESHT births at Pembury.

- Only two women from the Polegate area delivered in Brighton in the period 1 April 2013 to 31 October 2013 (the original estimate was potentially 100 women in a 12 month period)

6. Summary of external advice, findings and recommendations

January 2013: National Clinical Advisory Group:
(Recommend that) “Maternity and paediatric inpatient care be located onto one site as a matter of urgency.”

June 2013: Care Quality Commission (Review of Conquest Site):
“The staff stated that the location of all obstetric intrapartum care on the Conquest hospital site had made the care for women in labour safer. The senior staff in particular said that they were now able to 'sleep at night' as they were not concerned regarding the level of care available to women in labour.

“The staff stated that the labour ward environment at the Conquest hospital was now a nicer environment for the women and for staff to work in. They said that staffing was maintained by the use of familiar bank and agency staff covering gaps in shifts. One staff member told us "I have hardly left the delivery room with my lady; it's really nice to be able to do that."

“Midwifery staff told us that obstetricians were now 'present' on the labour ward rather than available, which allowed them the time to support junior medical staff. The amalgamation of the obstetric intrapartum services on the Conquest hospital site had removed the need for the use of locum obstetric staff at night. Since the changes in configuration there had been a reduction in the number of serious incidents.”

June 2013: Care Quality Commission (Review of Eastbourne Site):
“When we spoke with an operational manager from South East Coast Ambulance (SECAMB) they told us that their staff and Trust staff had clear guidelines as to what category of patient could be conveyed with what type of skilled ambulance staff. Where a patient did not meet the criteria specialist support from the Trust would be expected to accompany the patient. The operational policy for Children's and Neonatal Services also made clear the arrangements for patients unfit for immediate transfer or requiring specialist support. The SECAMB representative told us that they had noted no specific trends or issues arising from transfers since the reconfiguration.

“Staff on MLU, the day unit and triage told us they were able to provide a personalised service for women. Although the service was new staff felt they provided a safe service.

August 2013: Royal College of Obstetricians and Gynaecologists
“Working on one site since 7 May 2013 has resulted in increased opportunities for senior staff, improving the workforce, increasing the resilience of middle grade staff and increasing the workload and as a result staff appear to be happier, more confident and feel better supported.

“As a result the hospital is seen as a more attractive place to work and hopefully this will improve recruitment of both junior and senior staff.

“There is an incidental benefit of an enormous potential for reducing the numbers of staff in middle grade posts and potentially expanding consultant numbers to increase labour ward presence, supervision and training.

November 2013: Royal College of Paediatrics and Child Health:
“The arrangements that have been put in place are similar to reconfigurations that are being planned or implemented around the country.

“Each setting is different in its approach but most changes are triggered by difficulty in recruitment of middle grade doctors and compliance with the standards set out in ‘Facing the Future’. Some equivalent models are further advanced than East Sussex, particularly the ‘making it better’ redesign project in Manchester where Salford operates with a single SSPAU supporting ED without inpatients.

“The Review Team is aware that the current arrangement is temporary in terms of paediatric services, and, building on the June 2012 review, considers that restoration of an (dual site) inpatient unit is not appropriate or sustainable.”

November 2013: Sussex Collaborative Children and Young People Clinical Reference Group and Maternity Clinical Reference Group: Supports the East Sussex Steering Group’s recommendation that the dual-sited option for East Sussex Maternity services should be excluded as an option (and)

Supports the East Sussex Steering Group’s recommendation that any in-patient paediatric services should be co-located with the Obstetric Unit, as although it is possible in theory for them not to be co-located, it would be difficult to sustain the workforce and skills needed.

December 2013: South East Coast Strategic Clinical Network – Maternity, Children and Young People: The MCYP SCN “agrees that the siting of two obstetric led units in East Sussex would not be justified given the level of birth activity identified in 2011-13. Both units would be likely to have less than 2000 births per annum which would not justify the required level of consultant presence, middle grade doctors and trainees to support a safe and sustainable quality service.

“The MCYP SCN would anticipate that neonatal services are co- located with the Obstetric Unit.

“The evidence provided indicates that the working group has sought innovative resolution models from other smaller units in order to understand possible approaches to mitigate safety and quality issues that had arisen prior to the establishment of the temporary changes.

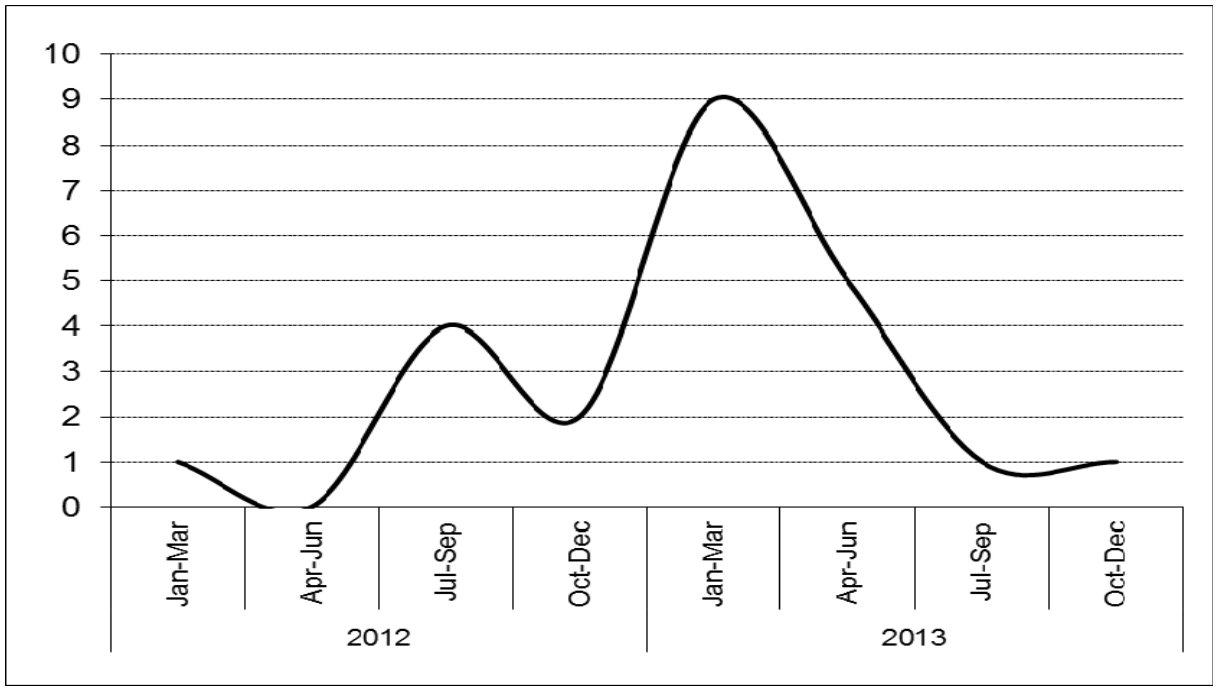
“Clinical inter-dependencies between obstetrics, paediatrics and the special care baby unit (SCBU) would not enable delivery of a separate safe and sustainable inpatient paediatric unit.

“It is recommended that inpatient paediatric services are co-located with the obstetric service.”

January 2014: Better Beginnings Consultation Document
“There is a wide range of clinical evidence that has led clinicians in East Sussex to conclude that we cannot maintain safe consultant-led maternity services on two small sites. We cannot move forward with options that we do not believe are safe”

The following chart shows the increase in serious incidents which led to the urgent decision in March 2013 by ESHT to temporarily site services, and the reduction in serious incidents since that time.

Trend of Serious Incidents leading up to, and following, the temporary changes in May 2013



7. Further information on the Royal Colleges views on non-training roles / consultant delivered services and evidence of national difficulties in recruiting obstetric staff

The following is an extract from the RCOG report "High Quality Women's Health Care"[6], which provides further insight into the national pressures relating to the Obstetrician and Gynaecologist workforce.

The document highlights a need to increase consultant hours on the labour ward, but also highlights the increasing shortfall in the number of consultants available to support this model.

"Across women's health care, workforce pressures are being felt which may require different ways of working. First, it is anticipated that there will be a significant bulge in the number of retirements among senior and experienced consultant obstetricians and gynaecologists because of changes in established practice, the potential for residence on call and alterations to the NHS pension scheme. Second, a key issue for the current workforce in women's health care is the impact of the WTR, notably the introduction of the 48-hour week, which formally came into effect in August 2009.

"As outlined in the Temple report, the impact of the WTR is summarised below:

- there has been an impact on rotas and the ability to staff services safely 24 hours a day, 365 days a year
- many units still rely on doctors in training to provide the majority of out-of-hours care
- the reduced working week has had an impact on the quality and comprehensiveness of medical training

[6] Royal College of Obstetricians and Gynaecologists, *"High Quality Women's Health Care",* (July 2011), http://www.rcog.org.uk/high-quality-womens-health-care

- there has been an impact on recruitment and retention of clinical staff

“Against this context of resource pressure, a high quality women’s service is one that should be compliant with professional standards. As outlined in *The Future Role of the Consultant*, there should be 24-hour consultant cover on labour wards to meet the needs caused by the growing complexity of the case mix, the increase in operative birth rates and the reduction in trainee numbers, hours and experience.

“Safer Childbirth and *The Future Workforce in Obstetrics and Gynaecology* set out the standards for delivery suite presence, signalling the consultant cover required at all levels and the additional direct clinical care activity which must be included. In addition, the age profile of the consultant workforce must be considered. It is unrealistic to expect a senior consultant aged, say, over 55 years to function out of hours, potentially with resident duties, after 8 p.m. at the same level and regularity as a junior, newly appointed colleague.

There will need to be expansion to achieve these standards for delivery suite presence. The Healthcare Commission review *Towards Better Births* concluded that maternity units in England have below average staffing levels and that consultant obstetricians are not spending the recommended time on labour wards. Trusts will face significant challenges to achieve the required increase in consultant numbers in terms of both the economic implications and the availability of specialists. However, RCOG census data show that in the UK between 2007 and 2009, there was a 7.7% increase in consultant numbers (from 2029 to 2186). This clearly demonstrates the trusts’ recognition of the need to increase consultant numbers to support implementation of a consultant-delivered service. However, despite the expansion in numbers, consultant presence on the labour ward still falls woefully short of the recommendations made in multi-professional standards.

Given that the majority of obstetrics and gynaecology is carried out by consultants who practise both specialties and the pressures on workforce demands for obstetric services, it was recommended in *The Future Workforce in Obstetrics and Gynaecology* that the majority of consultants, including subspecialists where relevant, should be expected to undertake some obstetric duties for the foreseeable future. This was purely a pragmatic solution. However, the restrictions of the WTR and delivery suite out-of-hours care mean that a gynaecology subspecialist providing obstetric services would require such a level of compensatory rest that their primary clinical focus would be diminished.

Changing practice in gynaecology is impacting on the gynaecological workforce. Therapeutic options for many conditions no longer require surgery and therefore there has been a decrease in the number of inpatient episodes and length of stay. While the number of major surgical procedures is decreasing, those that remain are often complex. With the devolution of some aspects of gynaecology to primary and community care settings, and with the recognition of sexual reproductive health as a specialty, there may also be a decline in referrals to secondary care.

Therefore, the number of consultants and trainees needs to be kept under review.

The King’s Fund in its report *Staffing in Maternity Units* states that the reforms to the postgraduate medical training programme have led to some concern that newly qualified specialists today are less experienced than under the previous system, having worked for fewer hours. A mentoring system for new consultants is to be supported.

Any workforce plan needs to take into account the increasing feminisation of the medical workforce. Although there is some concern about an increase in less than full-time working patterns, there is emerging evidence that a full-time contract of 10 programmed activities (PAs) involving resident consultant on call may not be unattractive because of the compensatory rest.

Paternity/maternity leave is another factor that needs to be considered within workforce calculations.

8. Further information on "Middling Incidents": Transfers and BBAs

At the recent HOSC meeting in February 2014, a discussion was held regarding events that caused emotional difficulties for women but were not classed as serious incidents. The term used at the meeting was "Middling Incidents".

The CCGs understand that the specific reference was regarding the emotional and psychological impact on women who experience a transfer from a midwife led unit or a baby born before arrival/assistance (BBA).

With regards to perinatal mental health, it is important to note that one of the service improvements that ESHT put in place to improve maternity services, prior to the temporary configuration, was the establishment of care pathways for the assessment and treatment of maternal mental health.

There are a range of services for women with mental health concerns from low level support, i.e. for women with anxiety issues through the 'Health in Mind' services to high level rapid response through 'CRISIS' and longer term support though the Perinatal Mental Health team.

The named community midwife or the additional support midwife is able to refer directly to any of these services, all of which are managed and run by trained psychiatric nurses and doctors.

An increase in midwifery led care within birth centres has increased normality in childbirth reducing intervention and associated morbidities; increasing maternal choice and satisfaction. The caesarean section rate has also decreased since the ability to offer more midwife led care.

This is something that women nationally and in East Sussex have demonstrably stated that they wish as a birthing option.

It is usual and expected that some women giving birth in a midwife-led unit may transfer during labour, due to complications or by choice. This is discussed with women throughout their pregnancy and labour and
arrangements are in place to quickly and safely transfer women and babies to a consultant-led unit where necessary.

Whilst a transfer or a BBA is not recorded as a serious incident, the frequency of and reasons for these are reported and reviewed weekly. The rate of BBAs has not increased since the temporary configuration and is in line with the number of BBAs from previous years.

The evidence regarding BBAs, as seen in Annexe 3 has been extracted from information provided by ESHT.

Further details on BBAs and transfers can be found in

- ESHT's submission to the HOSC Lines of Enquiry and
- Maternity and Paediatric Services Review: 7 Months Following Interim Changes (see Annexe 4).

9. Further information regarding close access to surgical backup.

The CCGs have been asked to clarify whether the six options proposed will meet RCOG good practice guideline regarding obstetric co-surgical support.

The following is an excerpt from the Royal College of Obstetricians and Gynaecologists report, "Reconfiguration of women's services in the UK" (December 2012) which details the specific guideline.

"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 CCGs have tested the options with the wider clinical network and are assured that each option will deliver safe and sustainable care.

With specific reference to the RCOG good practice guideline regarding obstetric co-surgical support, the CCGs have sought assurance from the clinical network and have received the following response:

"Occurrence of damage to the bowel or bladder is rare and not an emergency in the same way as a bleed that requires emergency gynaecology surgical support. At PRH we would call the surgeons on call, who are based at Brighton, and they would travel to PRH. This is a safe service and meets the requirements in RCOG as 'close access'"

Dr Heather Brown
Consultant Obstetrician and Gynaecologist and
Honorary Senior Clinical Lecturer BSMS
Chief of Women and Children's Division
Brighton and Sussex University Hospitals Trust

ANNEXE 1: EMAIL TO ALL GPS REGARDING LAUNCH OF CONSULTATION, SENT TUESDAY 14 JANUARY 2014.

Dear GP colleagues;

You will be aware from recent communications that in December 2013, the three East Sussex CCG governing bodies approved six potential options for the future of maternity and paediatric services. These proposals were developed by local GPs, hospital clinicians and other experts since the launch of the Better Beginnings review last summer.

East Sussex County Council's Health Overview and Scrutiny Committee met on Friday (January 10) and agreed that the six options represent a substantial change to local services. We are now launching a 12-week formal public consultation on the six options, which starts today (Tuesday January 14) and closes on April 8.

There is no preferred option at this stage. The consultation will enable us to continue to hear the views of patients, public and stakeholders, including local clinicians and this will inform our decision, which is likely to be made in July 2014.

To promote access to the Better Beginnings consultation we have developed a bespoke website www.betterbeginnings-nhs.net. The website hosts the full consultation document, an online survey and details of some of the 30+ public engagement events planned over the coming weeks. We will continue to develop content on the website and promote the consultation as widely as possible, including via the local media. Copies of the consultation document will be distributed to practices in the next few days and we would be very grateful if they can be placed in public areas.

As always, your continued engagement as local GPs is important in helping us work towards the right solutions for East Sussex. As consultation progresses, we will continue to ensure you receive regular updates, including specific opportunities for discussing these proposals further.

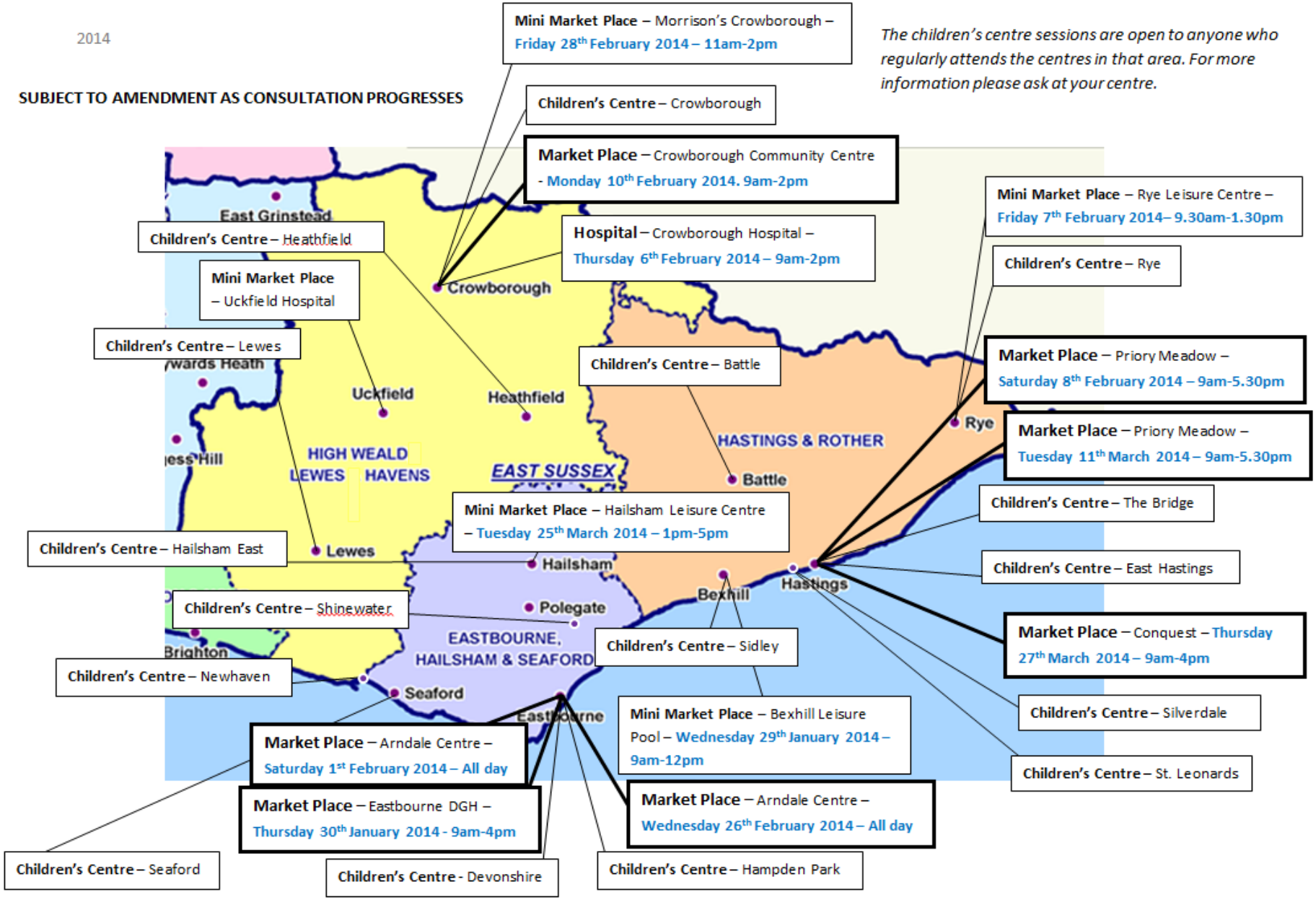
Thanks for your involvement in the process to date and we hope you will continue to engage during the consultation process.

Kind regards

Rob Hustwayte
Senior Communications Manager

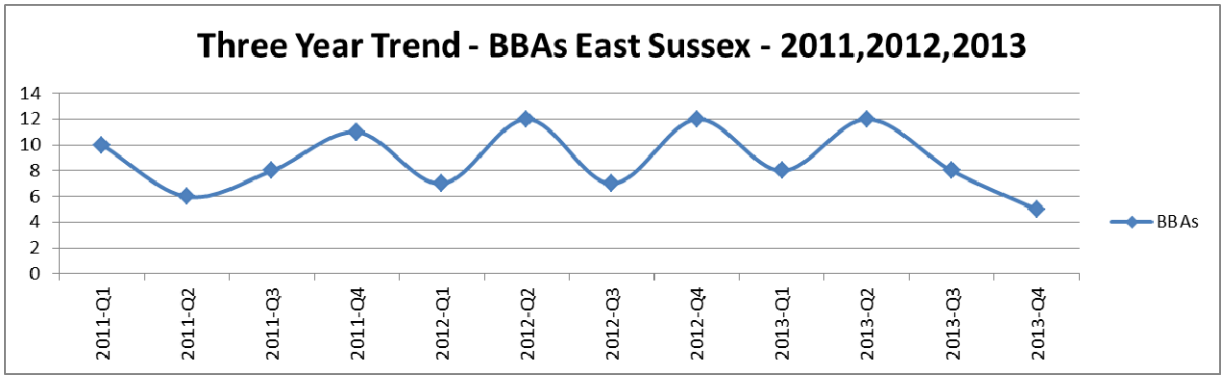
Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
High Weald Lewes Havens CCG

ANNEXE 2: MAP SHOWING SPREAD OF PUBLIC ENGAGEMENT EVENTS ACROSS EAST SUSSEX



ANNEXE 3: SUMMARY AND TRENDS OF BBAs (2013) BY CCG AREA.

Source: ESHT Data regarding women booked into EDGH, CBC or Conquest.



- Total BBAs (2011) – 35
- Total BBAs (2012) – 38
- Total BBAs (2013) – 33

Further details of BBAs for 2013 (and 2012 as a comparator) can be found in Annexe 4: Maternity and Paediatric Services Review: 7 Months Following Interim Changes.

In 2013 (January to December), there were 32 BBAs to women with an East Sussex address. These women had planned to give birth in various places, as shown in the table below:

CCG Area	BBAs	Mother's Address (Town)
Eastbourne, Hailsham and Seaford	11	Eastbourne (6), Hailsham (3), Polegate (1), Seaford (1)
Hastings and Rother	15	Bexhill (4), Etchingham (1), Hastings (7), St Leonards (3)
High Weald Lewes Havens	1	Heathfield (1)
Data Not Available	5	Unknown (5)*
Non East Sussex Resident	1	Patient diverted from a hospital outside of East Sussex**
Grand Total	**33**	

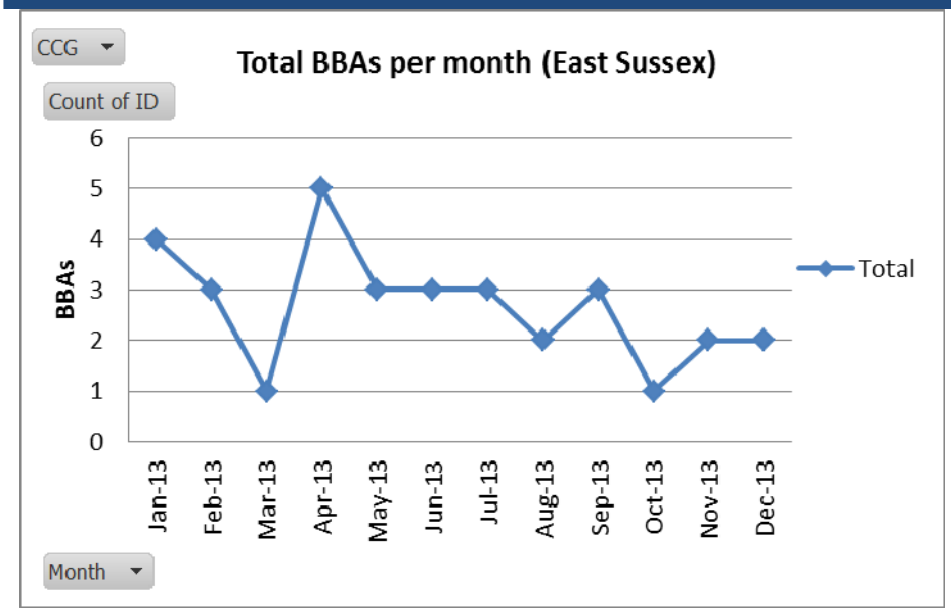
** There were 5 women whose home town is not reported. Their birth plans comprised: 1 planned homebirth, 3 planned births at Crowborough, 1 planned birth at PRH. An assumption is therefore made for the remainder of this document that these women fall under HWLH CCG area.*

*** The Better Beginnings consultation is relating to people from East Sussex, therefore the non East Sussex resident has been excluded from the remainder of the document so that East Sussex trends can be clearly seen.*

When the above assumptions and exceptions are applied, the 32 BBAs in 2013 can be seen in the following amended table.

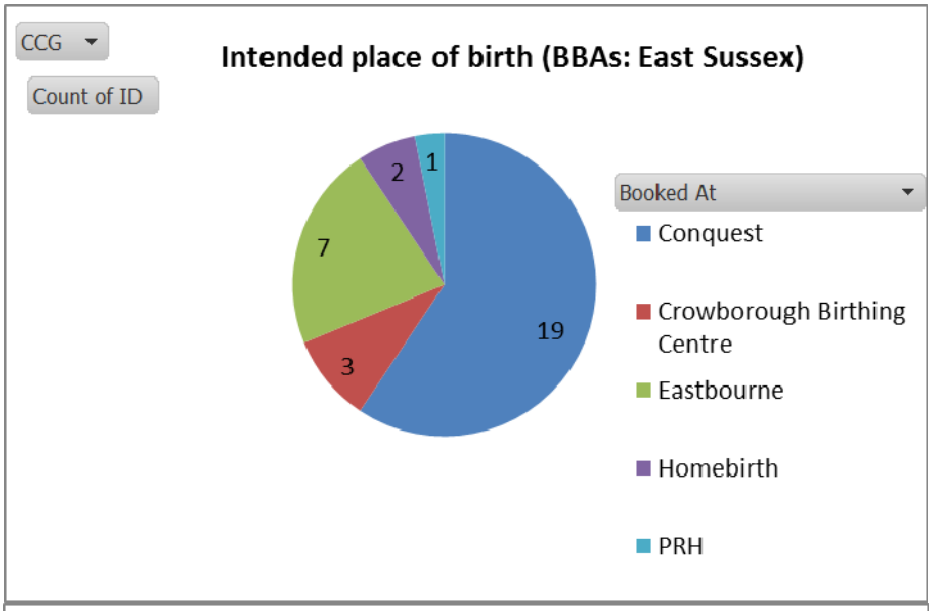
CCG Area	BBAs (2013)	Mother's Address (Town)
Eastbourne, Hailsham and Seaford	11	Eastbourne (6), Hailsham (3), Polegate (1), Seaford (1)
Hastings and Rother	15	Bexhill (4), Etchingham (1), Hastings (7), St Leonards (3)
High Weald Lewes Havens	6	Heathfield (1), Unknown (5)
Grand Total	**32**	

TREND OF BBAs (2013) EAST SUSSEX, BY CCG AREA

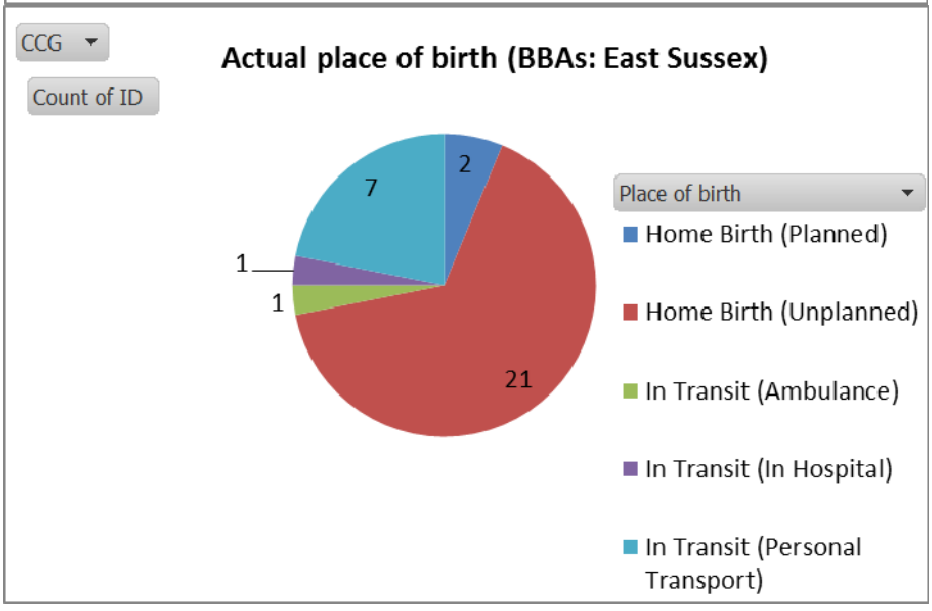


The number of BBAs in East Sussex has not increased since May 2013 and is in line with the number of BBAs from previous years.

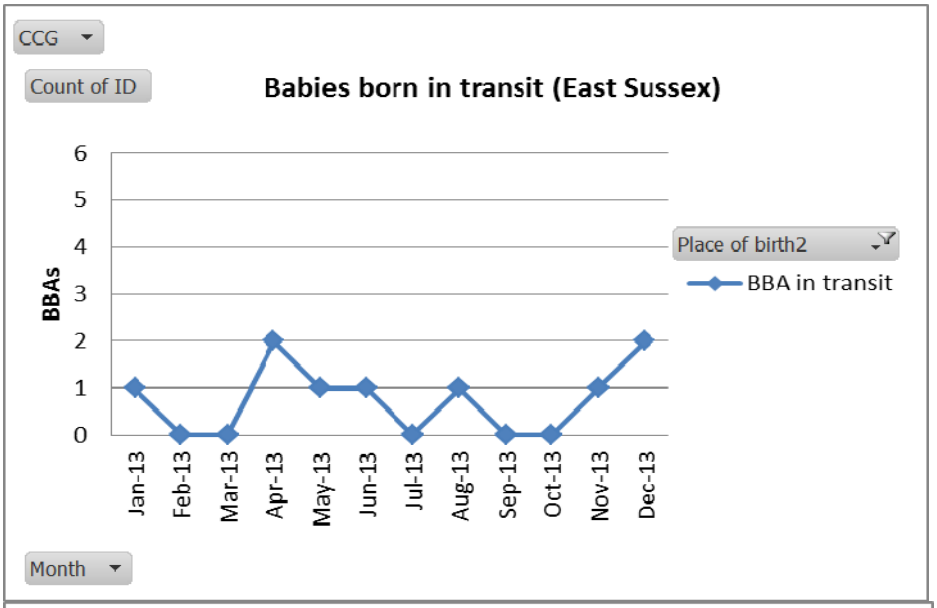
2011: 35 BBAs
2012: 38 BBAs
2013: 33 BBAs



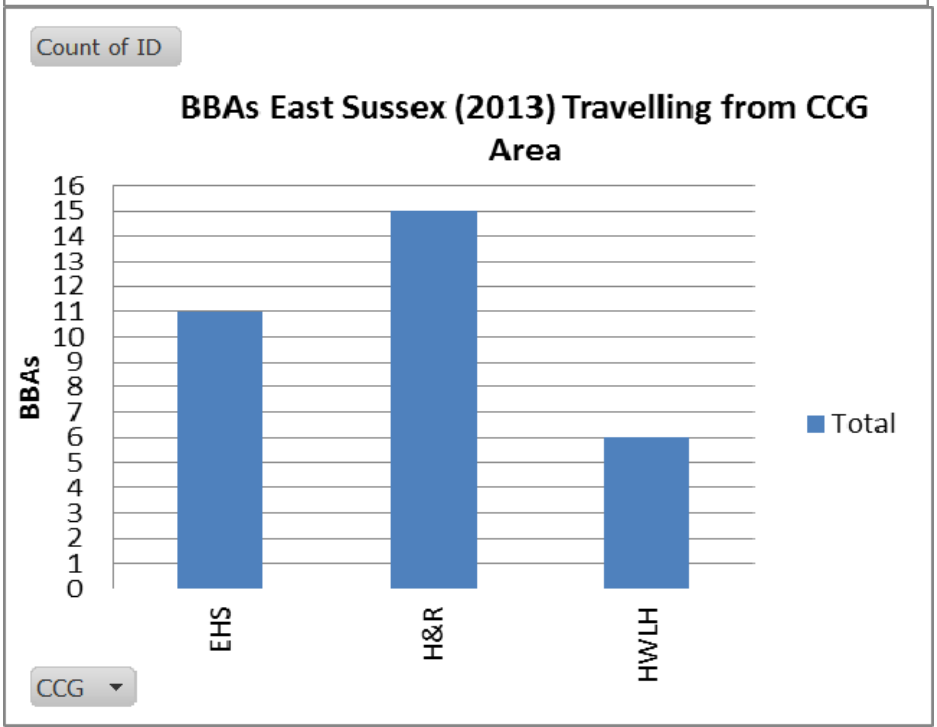
Predictably (with obstetrics temporarily single sited at Conquest since 07 May 2013), the majority of women (59%) who experienced a BBA were booked to give birth at the Conquest Hospital, Hastings.



The majority of BBAs (66%) resulted in an unplanned home-birth, suggesting that the distance of transfer was not a factor.



The number of babies being born en-route to hospital (in transit) has remained steady throughout 2013, with an average of one BBA in transit, per month (fluctuations between 0 and 2).

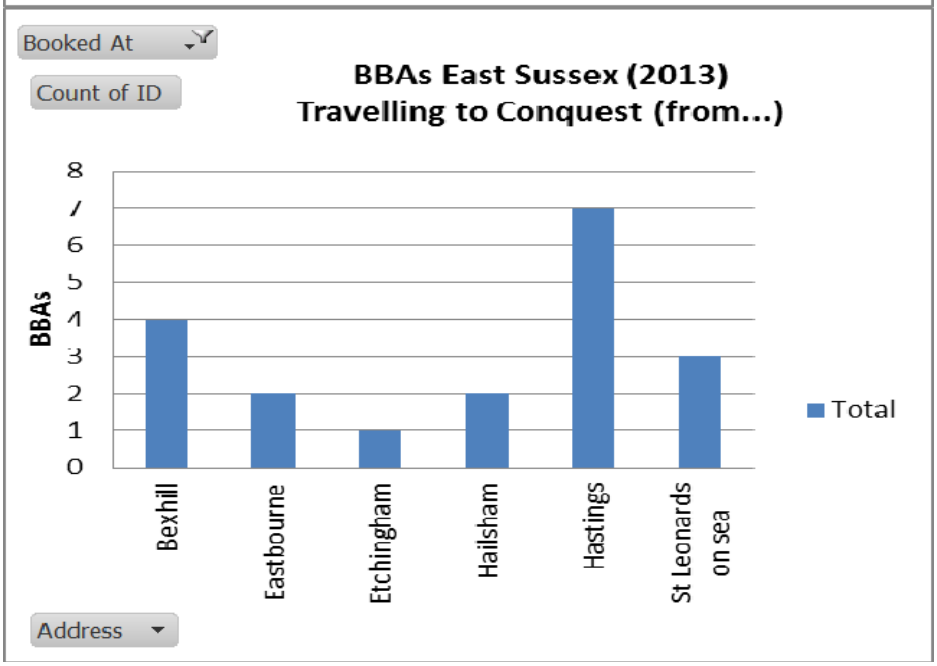


Overall, regardless of intended destination, the majority of women who experienced BBAs were from the Hastings and Rother CCG area.

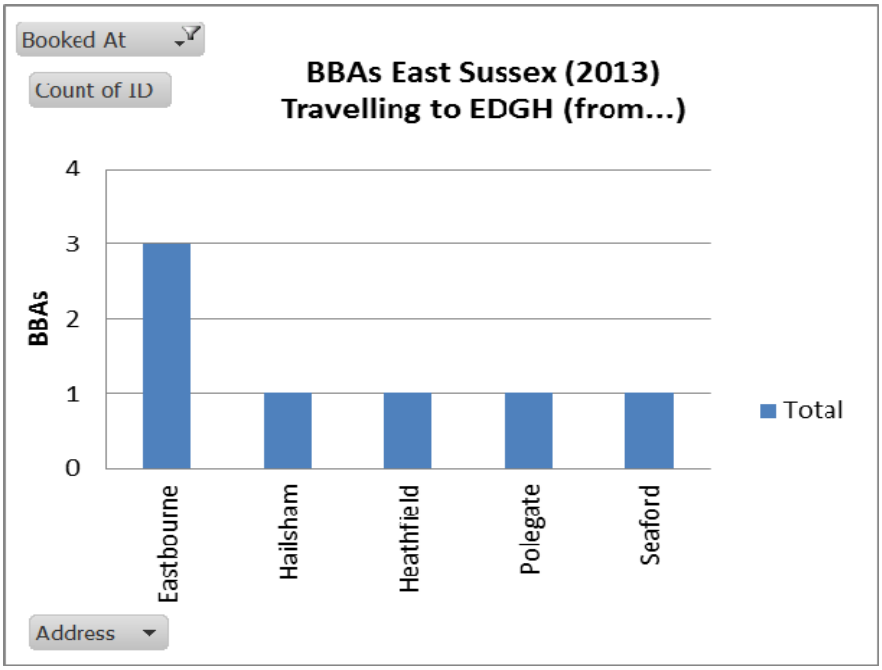
47% - Hastings and Rother

34% - Eastbourne Hailsham and Seaford

19% - High Weald Lewes Havens

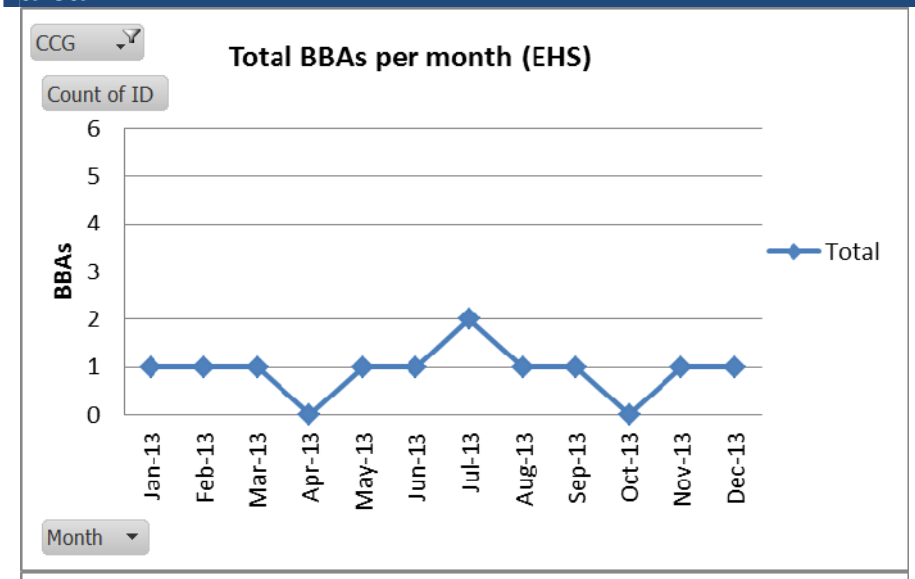


The majority of women (79%) who were booked at Conquest and experienced a BBA were from the Hastings and Rother CCG area.

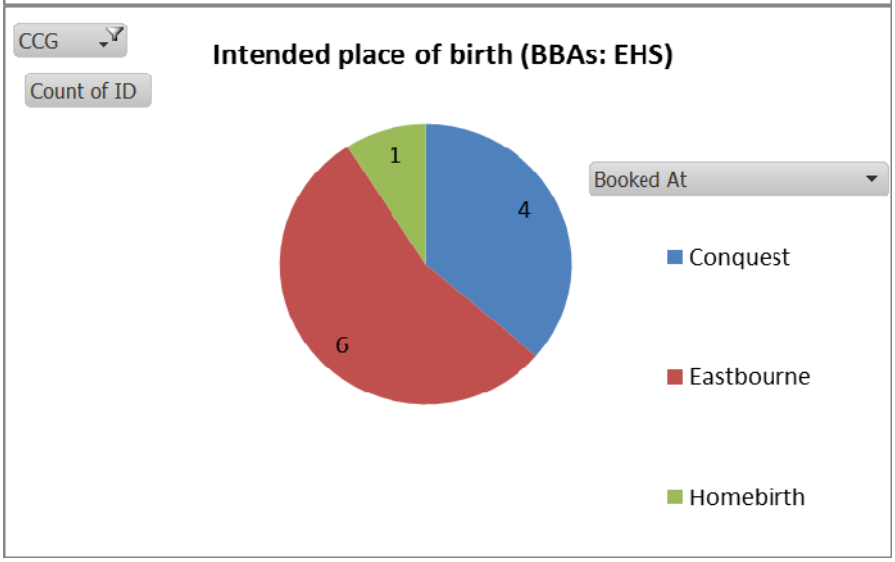


The majority of women (85%) who were booked at EDGH and experienced a BBA were from the Eastbourne, Hailsham and Seaford CCG area.

Summary of BBAs for women in the EASTBOURNE, HAILSHAM AND SEAFORD CCG area

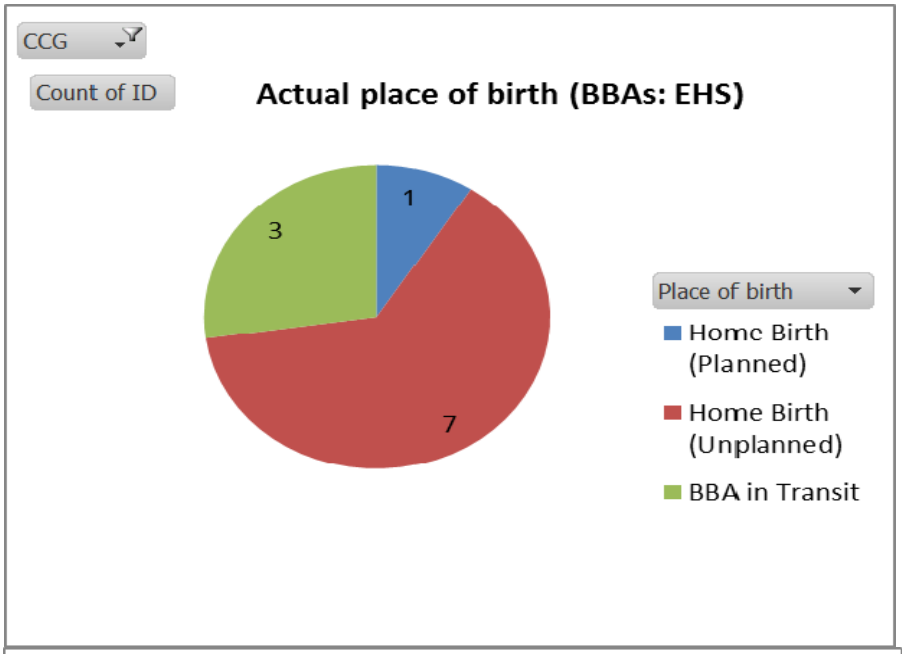


The number of BBAs to women in the EHS area has remained at an average of 1 per month, fluctuating between 0 and 2.

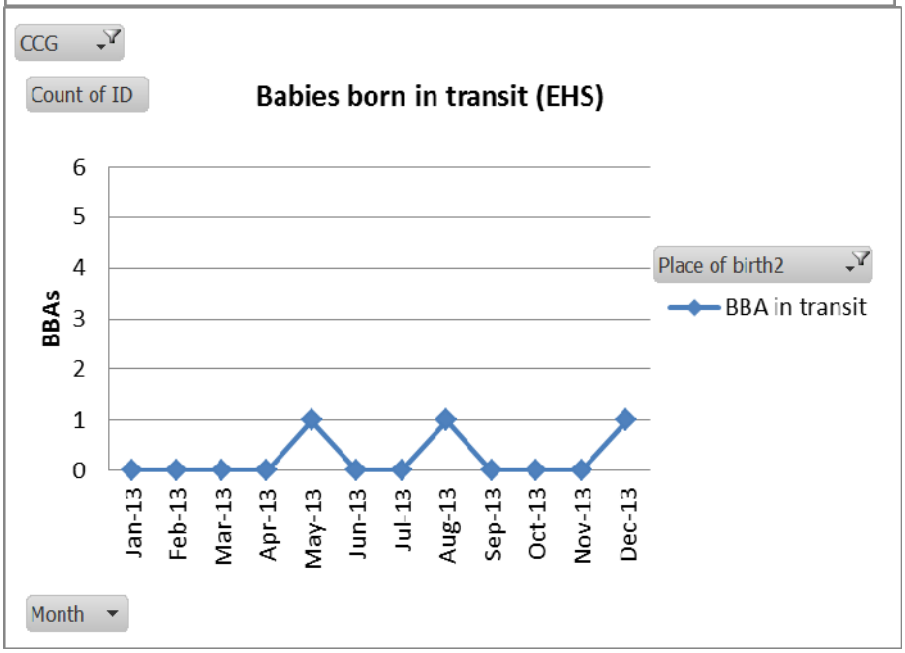


Despite obstetric services being temporarily sited at Conquest Hospital, Hastings since 07 May 2014, only 4 of the 11 BBAs were booked at the Conquest.

The majority of BBAs for women in the EHS area were to women who were booked at EDGH

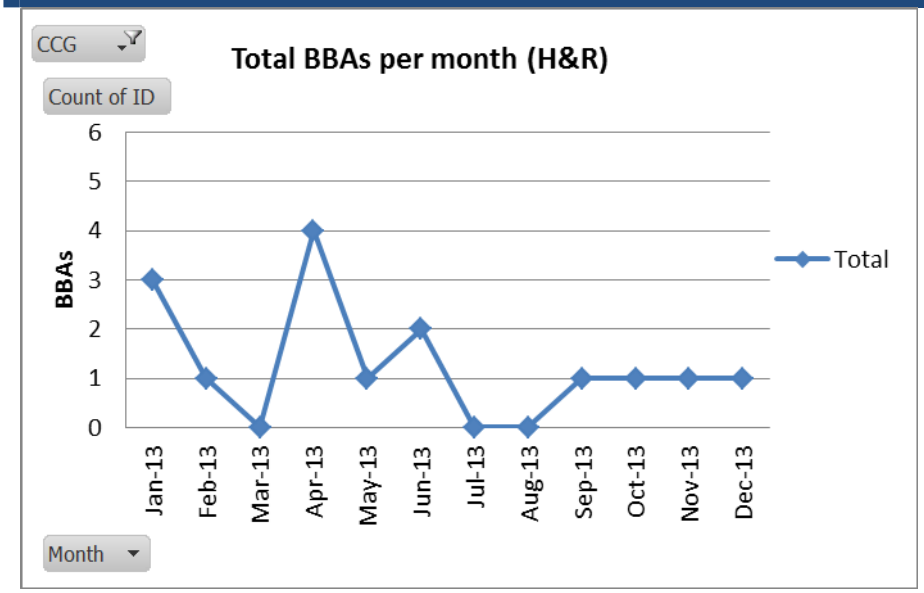


In line with the East Sussex trend, the majority of women in EHS who experienced a BBA in 2013 had an unplanned home birth, suggesting that distance of travel was not the root cause.

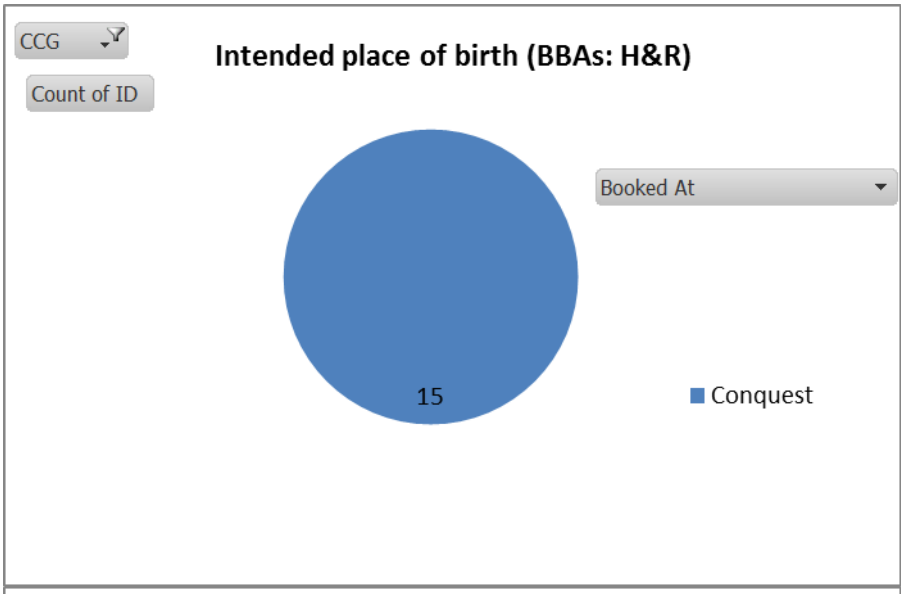


There were three BBAs in 2013 en route from EHS to Conquest since the temporary configuration. This is below East Sussex average.

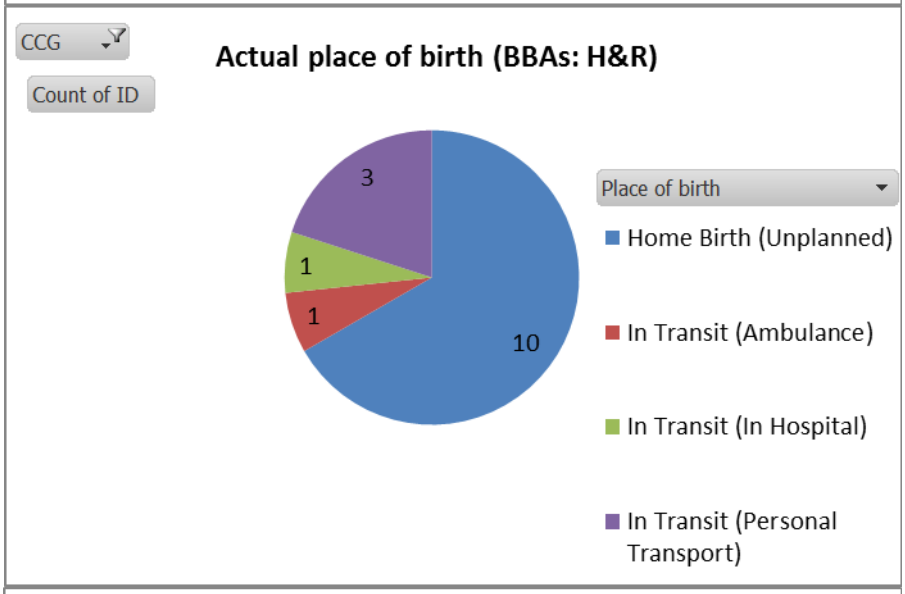
SUMMARY OF BBAS FOR WOMEN IN THE HASTINGS AND ROTHER AREA



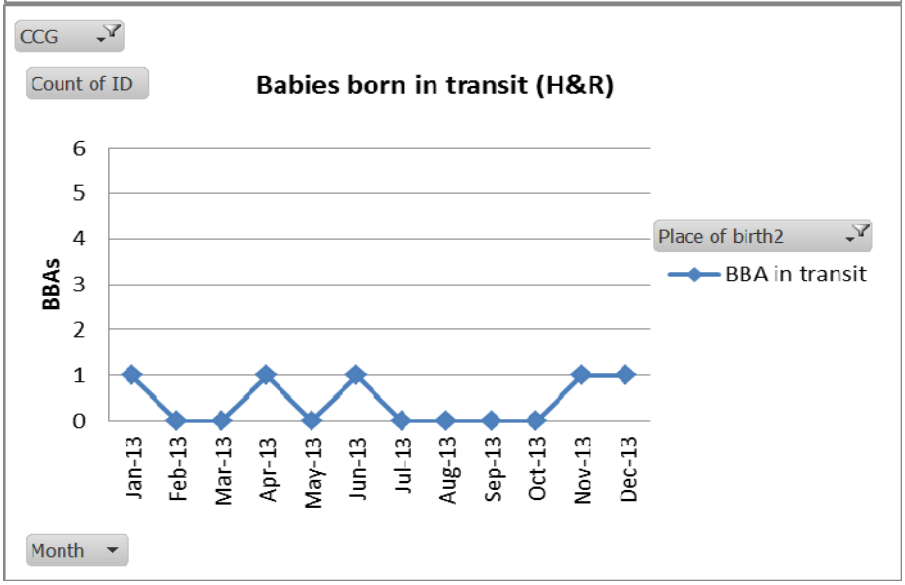
In line with the EHS area, the number of BBAs is averaging at 1 per month.



All of the women from H&R who experienced a BBA were booked at the Conquest Hospital.

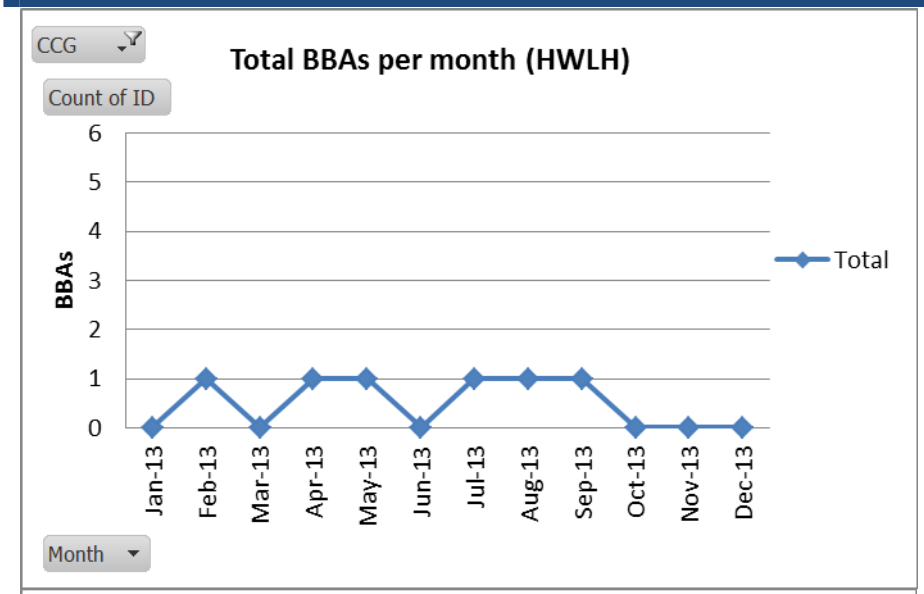


In line with women from the EHS area, the majority (66%) of H&R women who experienced a BBA had an unplanned home birth.

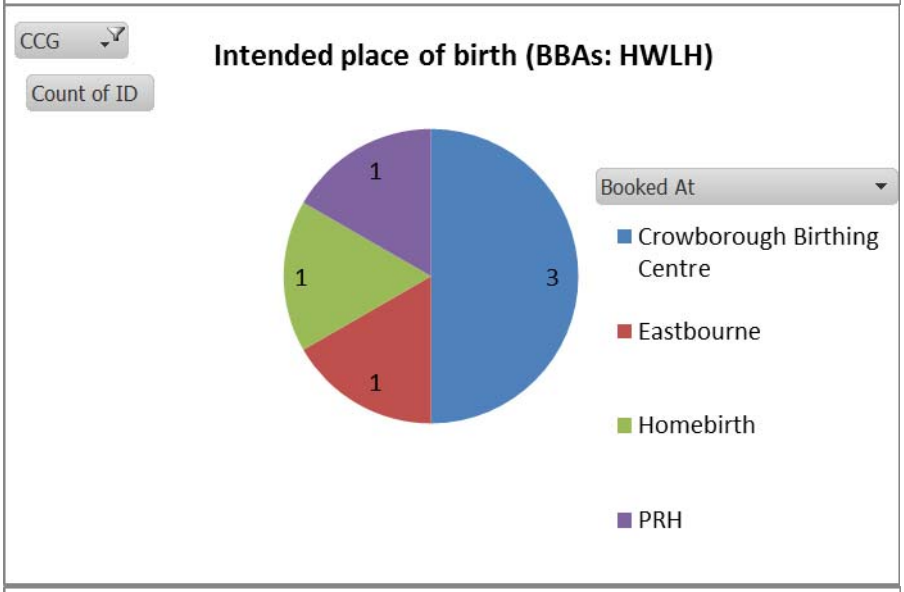


There were more babies born in transit to H&R women (5) than EHS women (3) or HWLH women (1).

SUMMARY OF BBAS FOR WOMEN IN THE HIGH WEALD LEWES HAVENS CCG AREA

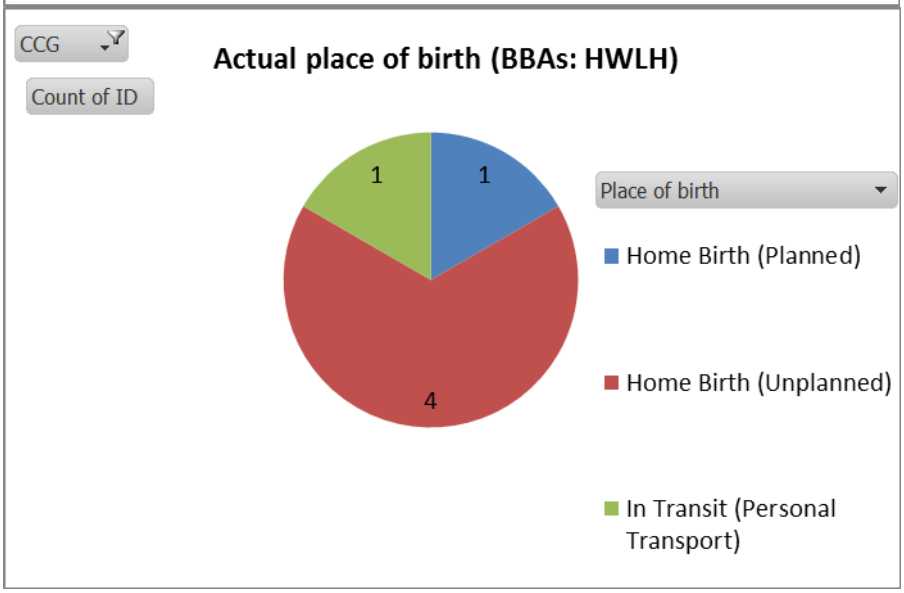


The number of BBAs for women in HWLH remains at an average of 0.5 per month.

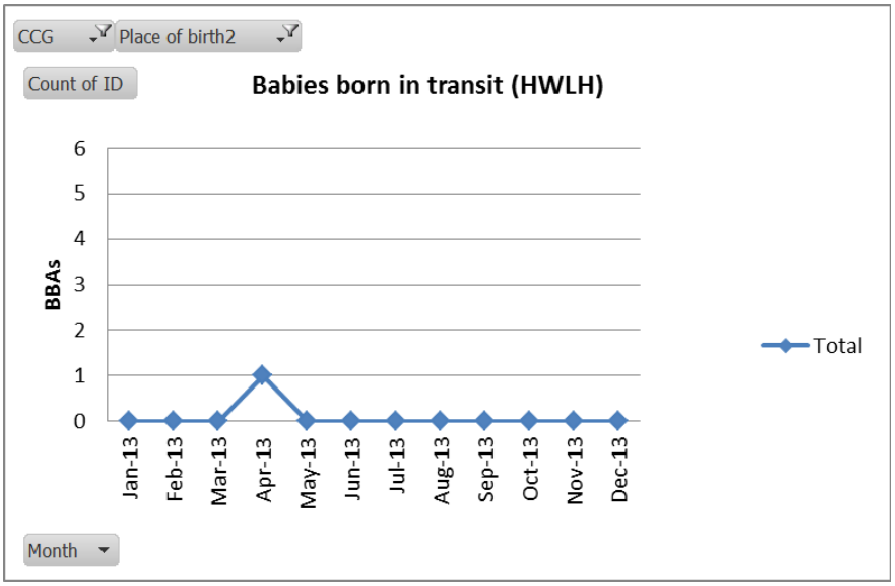


50% of the women in HWLH who had experienced a BBA had booked to give birth at Crowborough Birthing Centre.

None of the women in HWLH who had experienced a BBA had booked to give birth at Conquest.



In line with the other areas of East Sussex, the majority of HWLH women who experienced a BBA had an unplanned home birth.



In 2013, one mother gave birth in transit.

ANNEXE 4: MATERNITY AND PAEDIATRIC SERVICES REVIEW: 7 MONTHS FOLLOWING INTERIM CHANGES

1. Context

In May 2013 East Sussex Healthcare NHS Trust (ESHT) introduced temporary changes to local Maternity and Paediatric services on the grounds of safety. This resulted in a centralisation of obstetrics and in-patient paediatrics at the Conquest Hospital, Hastings and was supported, as a temporary change, by the East Sussex Clinical Commissioning Groups (CCGs) because the safety of services is paramount. This paper provides a 7 month review of key performance indicators following implementation of the reconfigured services. A previous paper 'Maternity and Paediatric Services Review: The first 3 months following interim changes' is published on the East Sussex CCG websites. It should be noted that where data is available for the full calendar year (2013) this has been included.

2. Monitoring the impact of the temporary change to service delivery

Because the driver for the temporary change was to ensure sustainably safe services, the CCGs have continued to monitor the quality and safety of the services that are currently being delivered, with an enhanced focus on key indicators that are most likely to be impacted by the temporary change and that patients and the public have indicated are of high importance to them. It should be noted that these form part of a wider set of indicators that continue to be monitored as part of the CCGs' clinical quality review meetings, and reported to the joint meeting of the Quality and Governance Committee.

3. Quality and safety

Serious Incidents (SIs)

Two years of SI data is tabled below. There have been four Maternity SIs since the interim changes on 7 May 2013; one of the SIs in June 2013 was not assigned to the Maternity department but involved a pregnant woman and has therefore been included within the SI numbers below.

Increased consultant presence on the labour ward has improved supervision of junior doctors and provided enhanced teaching and clinical leadership. The number of SIs has decreased and similar incidents are not recurring indicating learning has taken place.

Enhanced governance measures continue to be in place to closely monitor the safety of the service which consists of a weekly review of Maternity performance with the Head of Midwifery or her deputy, the CCG Head of Quality and the Joint Commissioner for Children and Maternity. *It is important to note that the figures for October to December 2013 have yet to be validated; the reporting, investigation and scrutiny process for incidents means that some incidents may be downgraded following completion of investigation.*

Maternity SIs

January 2012 to December 2012

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

January 2013 to December 2013

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

6	2	1	3	0	2	0	1	0	0	1	0

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

Caesarean section rate

The total caesarean section (C-Section) rate has decreased since the interim changes.

ESHT C-Section (scheduled and unscheduled) target = 23% or less. The December 2013 data is currently being validated.

January 2012 to December 2012

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
22	23	27	26.8	19	25.2	26	21.9	22	23	22.2	20.7

January 2013 to November 2013

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov
22	21.8	26.7	22.3	24.1	19.6	18.5	23.2	22.9	22.3	26

The emergency caesarean rate has decreased since the interim changes.

Emergency C-Section (unscheduled) target = 13%)

January 2012 to December 2012

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
13	14	14	14.4	10.1	13.1	17	12.7	13	12.5	15.2	10.4

January 2013 to November 2013

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov
14	13.5	15.5	10.8	12	14.5	11.1	12	12.9	10.7	14.9

Source: ESHT Maternity Dashboards 2012/13 and 2013/14/ Joint Commissioners data, January 2014.

Induction rates

The rate of induction of labour has not changed significantly and has not increased. This is therefore not analysed here but remains a focus for in-depth audit and analysis as part of continual service monitoring.

Staffing

Medical staff

The single siting has enabled increased substantive medical cover for the Obstetric service. There has been a good response to the advertised Middle Grade Doctor posts and we await the outcomes of interviews and start dates for these Doctors. We will continue to monitor the impact of the interim changes on recruitment.

Further changes since the 3 month report following the interim changes include:

- no external locum doctors used since reconfiguration
- increased consultant input into emergency management
- 100% planned consultant supervision of elective caesarean lists
- more protected teaching time for the junior staff and medical trainees
- a daily risk review of previous 24 hour incidents between 1-2pm
- consultant led and multidisciplinary input to handover and ward round
- flexibility to cover medical sickness with substantive staff

Midwifery

There have been some vacancies as a result of the interim changes and some due to normal turnover. During the last three months six midwives have been recruited and a further four posts are out to advert. We will continue to monitor the impact of the interim changes on recruitment. Staff continue to report positively on increased consultant presence on the labour ward at the obstetric-led unit and are feeling better supported.

4. Experience

The experience that women have will clearly be affected by a range of factors including the quality, safety and staffing issues summarised above. However, in addition to this, levels of complaints and numbers of babies born before arrival (BBA) at a unit or before assistance of a midwife are monitored and these are shown below.

Complaints

A comparison of complaints from the interim changes to the end of September 2013 with the same period last year showed the same level. The most mentioned theme in complaints (a complaint may have more than one theme, hence the themes are greater than the number of complaints) in the current year was jointly the attitude of staff and communication. For the previous year it was quality of care. *Please note this data provides a five month review. The data to six months is being confirmed.*

	07 May 2012-30 Sept 2012	07 May 2013-30 Sept 2013
Total complaints	**5**	**6**
Attitude	4	4
Communication	4	4
Pain control	2	0
Quality of care	6	3

Babies Born Before Arrival (BBAs)

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

Source: Euroking, 2013

A review of the place of residence for women with babies born before arrival at hospital since the interim changes shows an increase in Hastings and St Leonards BBAs. More detailed analysis is in progress and will be reported to the Governing Body. There have been no adverse clinical outcomes for mother or baby in any of these cases.

Patient feedback

ESHT continues to collect women's birthing stories and experiences to better understand these. ESHT has piloted the Friends and Family Test (FFT) in Maternity and this has been rolled out across the service since October 2013. This is part of the national project focussing on listening to what patients tell us about the services provided. In addition to this there is a Maternity dashboard which looks at a range of quality and experience issues which is reviewed by the CCGs, Joint Commissioners and ESHT on a monthly basis. The CCGs have been engaging with local people across East Sussex, particularly current and

recent users of Maternity and Paediatric services, to understand what they want, need and expect from these services. The two reports that capture what we have learned through focus groups, one-to-one interviews, individual patient case studies and an online survey can be found at www.betterbeginnings-nhs.net

5. Eastbourne Maternity Unit (EMU):

The EMU has seen steady growth in the numbers of women choosing to give birth there. The Trust anticipated 30 births per month by the end of March 2014 and this is currently being achieved.

2013/14	May	June	July	Aug	Sept	Oct	Nov	Dec
Births	10	20	28	33	28	31	31	36

Source: Email from ESHT Maternity services to CCG Quality Team, 07 February 2014

Day care continues to offer a local service to Eastbourne women. There have been good outcomes for both mother and baby. Small numbers of women are choosing to return to the EMU for postnatal care and breast feeding support. There is an increase in midwife led care since the interim changes.

Transfers from the Maternity units to the Obstetric-led unit have been appropriate and continue to be in line with national averages (Birthplace 2011).

	First birth	Second (+) birth	Total	Local Transfer % First birth	Local Transfer % Second (+) birth	National transfer % First birth	National transfer % Second (+) birth
CBC transfer to obstetric-led unit 7 May-28 July2013	5	3	8	33.3	8.8	36	9
EMU transfer to obstetric-led unit 7 May-28 July 2013	7	6	13	38.9	12.2		
CBC transfer to obstetric-led unit 7 May-31Oct 2013	15	11	26	34.9	13.9		
EMU transfer to obstetric-led unit 7 May-31 Oct 2013	17	13	30	38.6	10.4		

A protocol is in place for women requiring transfer from the EMU to the Conquest Obstetric Unit. This means that women requiring transfer should complete this within 80 minutes. The majority of transfers have taken place within this standard and any that do not are reviewed by the Head of Midwifery and the ambulance service. The average delivery time following transfer is three hours.

6. Overall activity

The CCGs have been monitoring overall activity in order to note any wider changes that may impact on the stability of services across Sussex or the ability of ESHT to provide a safe service. The number of mothers delivered in ESHT in 2011/12 was 4,091, and the number in 2012/13 was 4,047; a decrease of approximately 1%.

If there were a similar 1% decrease in deliveries in 2013/14, then the estimated number of deliveries within ESHT would be 4007. The modelling work completed by ESHT prior to the interim changes also suggested 260 women would elect to go to Brighton and Sussex University Hospitals Trust (BSUH) and 160 to Maidstone and Tunbridge Wells NHS Trust (MTW). The estimated births for ESHT working on these assumptions for 2013/14 are 3587.

The number of births at ESHT from May to October 2013 is 1827. This is an average of 305 births per month. If this average stays the same over the next six months then the estimated number of births at ESHT for 2013/14 is 3657.

ESHT comparison of births May 2012 – Oct 2012 with same period 2013/14

May 2012	June 2012	July 2012	Aug 2012	Sept 2012	Oct 2012
378	306	334	329	361	343

ESHT 2013

May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013
299	275	297	332	279	345

Source: SHA Dashboard 2012 2013 ESHT Maternity Dashboard, 2013

7. Impact on Other Trusts

The modelling work completed before the interim changes, which was submitted to the ESHT Board, made an assumption that approximately 260 women would elect to go to BSUH and 160 women to MTW.

- On average BSUH has seen an increase of 12 ESHT births per month against the same period last year. There is a lot of variance from month to month and the full impact of the effect the interim changes has on births will not be fully seen until December 2013 onwards when women who booked after the interim changes start to deliver.
- This increase is predominantly in line with forecasts of women from the Seaford and Uckfield areas choosing to go to Brighton.
- The Head of Midwifery at MTW has not reported any impact from ESHT births at Pembury.
- Only two women from the Polegate area delivered in Brighton in the period 1 April 2013 to 31 October 2013 (the original estimate was potentially 100 women in a 12 month period)

The South East Coast Ambulance Service (SECAmb) continues to review the impact of the interim changes in terms of additional conveyances from Eastbourne to Hastings and on any other areas of service delivery. SECAmb, ESHT, Joint Commissioners and the CCG liaise across all issues raised and these are monitored to inform planning of future services.

8. Royal College of Obstetricians & Gynaecologist (RCOG) Review (August 2013)

In August 2013 the Trust invited the RCOG to review the obstetric and neonatal services at Conquest Hospital. The review focussed on 3 key areas:

- clinical decision making
- clinical risk assessment
- clinical risk management

Staff were interviewed by representatives of the RCOG, a review of case notes and review of policies and procedures. The RCOG also looked at the themes from the recent SIs, information available from the Maternity Dashboard, the National Clinical Advisory Team (NCAT) recommendations and the recent CQC Maternity and Paediatric inspection. The RCOG noted that the Royal College of Paediatrics and Child Health (RCPCH) were undertaking a visit to assess the operational delivery of service during this time.

The review panel made a series of recommendations relating to the three key areas. It concluded that the interim arrangements for the Obstetric and Neonatal services at Conquest Hospital have had positive outcomes for clinical governance and these should continue to be monitored and developed. The RCOG view was that single site Obstetric services had provided increased senior cover, more supervision of staff, improved the workforce especially for the middle grade doctors and increased morale, which all contributed to a safer service. This report is available on the ESHT website.

9. Paediatrics

Whilst the **Sussex Clinical Case for Change** found that local Paediatric services did not have the same degree of safety or quality concerns as Maternity, it did highlight a number of challenges to address.

There is a national shortage of children's doctors, as highlighted in the Facing the Future report published by the RCPCH in 2011. In order to cope with these shortages, the RCPCH report said the NHS needed to make radical changes to ensure safety, including reducing the number of hospitals with in-patient children's wards. Some of these pressures were beginning to be felt locally with two in-patient units prior to the temporary changes of May 2013. For instance, ESHT was reliant on temporary (locum) staff to maintain safe levels of staffing.

The Royal College of Nursing (RCN) reported via the report "Defining Staffing Levels for Children & Young Peoples Services" (2013),[7] that there had been numerous public inquiries that had highlighted key issues related to the impact of inadequate nurse staffing levels or an inappropriate mix of skills. Most recently the Francis Inquiry highlighted the need for staffing levels to be appropriate and for all staff to be properly educated, trained and regulated to meet the needs of patients. The guidance and standards apply to all areas in which infants, children and young people receive care, as well as across all types of services and provision commissioned by the NHS including the acute and community, as well as third sector and independent sector providers. The standards are the minimum essential requirements for all providers of services for babies, children and young people.

In January 2013 NCAT reviewed East Sussex Maternity and Paediatric services and recommended that in-patient Paediatrics should be situated at the same location as

[7] Royal College of Nursing: Defining Staffing Levels for Children & Young People's Services (2013) http://www.rcn.org.uk/__data/assets/pdf_file/0004/78592/002172.pdf

consultant-led Maternity services owing to clinical co-dependencies between Obstetrics, Gynaecology and Neonatology.

In the summer of 2013 ESHT invited the RCPCH to review the operational policy for Paediatrics, give consideration to raised safety concerns following the interim reconfiguration with specific reference to emergency attendance and the ambulatory care model and make recommendations to the Trust Medical Director.[8] This report is available on the ESHT website.

10. Paediatric quality and safety

Serious Incidents (SIs)

There have been no paediatric SIs in the six months before the interim changes or in the six months since.

Transfers of Children

There is an average of 20 children transferred from Eastbourne District General Hospital Short Stay Unit (EDGH SSPAU) to Conquest Hospital each month. There is an average of 27 children transferred from EDGH Emergency Department (ED) to Conquest Hospital each month. There are less than five Conquest ED transfers out of the Trust each month.

For children who are admitted as emergencies the average length of stay is less than 24 hours for about half of these children. Figures provided from the period 07 May 2013 to 25 October 2013 indicate that there were 343 admissions from patients with an Eastbourne postcode to Kipling Ward (other than direct admissions from Friston ward). Of this number of admissions 223 stayed for less than 24 hours, of these 115 stayed for less than 12 hours and of these 70 stayed for less than six hours.[9]

Staffing

The initial challenges for nursing staff were; working in new teams, rotating to different sites and refreshing old skills and learning new ones. The majority of the professional development associated with these changes is complete and the new teams continue to strive to provide the highest quality of service for patients. The additional paediatric Middle Grade Doctor covering the EDGH Emergency Department continues. The Trust is currently recruiting to the two vacant paediatric consultant posts. The RCPCH have ten standards which are primarily about the ability of consultants and Paediatric medical staff to respond directly to a child's need or to provide advice. Prior to the interim changes the Trust could not always ensure a consultant paediatrician was on duty at peak times due to the demands on the Paediatric rota to cover both inpatient sites.

11. Paediatric Feedback

The CCGs have actively been engaging with families, carers and local residents to seek their views on the interim changes. The key messages the CCGs have heard so far are:

- People want access to Paediatric care as close to home as possible.
- Parents would prefer their child to be discharged and to take them home rather than stay overnight, providing this is safe.
- Parents are concerned about how they might manage the challenges of additional travel with an in-patient unit on just one site.

[8] Royal College of Paediatrics and Child Health Service Review Report, (November, 2013)
[9] Information provided by the Joint Commissioners to CCG Quality Team via email, (06 February, 2013)

12. Impact on Other Trusts

The biggest impact has been on BSUH. BSUH report an increase in emergency attendances and admissions which are in line with the initial estimates made prior to the interim changes. There were 188 emergency children admissions to BSUH between April to December 2012 and 341emergency children admissions April to December 2013. Admissions related to Maternity, Gynaecological and Neonatal services from the East Sussex area remain similar when the same time period is compared in relation to emergency admissions.[10]

There is capacity in terms of beds and staffing to safely care for these children. No other impact has been reported by other surrounding Trusts regarding Paediatric services.

CCGs continue to monitor and seek assurances on the safety and quality of temporary Paediatric services at ESHT. Weekly scorecards provide Paediatric data which is reviewed in real time and triangulated with other available Paediatric information at the CCG Maternity and Paediatric meeting.

13. Conclusion

There are measurable improvements in safety within the Obstetric and Maternity services. The full impact of the interim changes will be seen from December 2013 onwards and the CCGs continue to monitor the situation closely. There is no change to the safety of the Paediatric services.

The enhanced governance measures will remain in place during the period of interim changes and quarterly reports regarding the quality and safety of these interim changes will be submitted to the CCG Governing Bodies.

Jo Thomas,
Head of Quality EHS and H&R CCGs

February 2014

[10] Information provided by BSUH Maternity Services to CCG Quality Team via email, (10 February, 2013)

APPENDIX 3

Demographic projections and assumptions

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

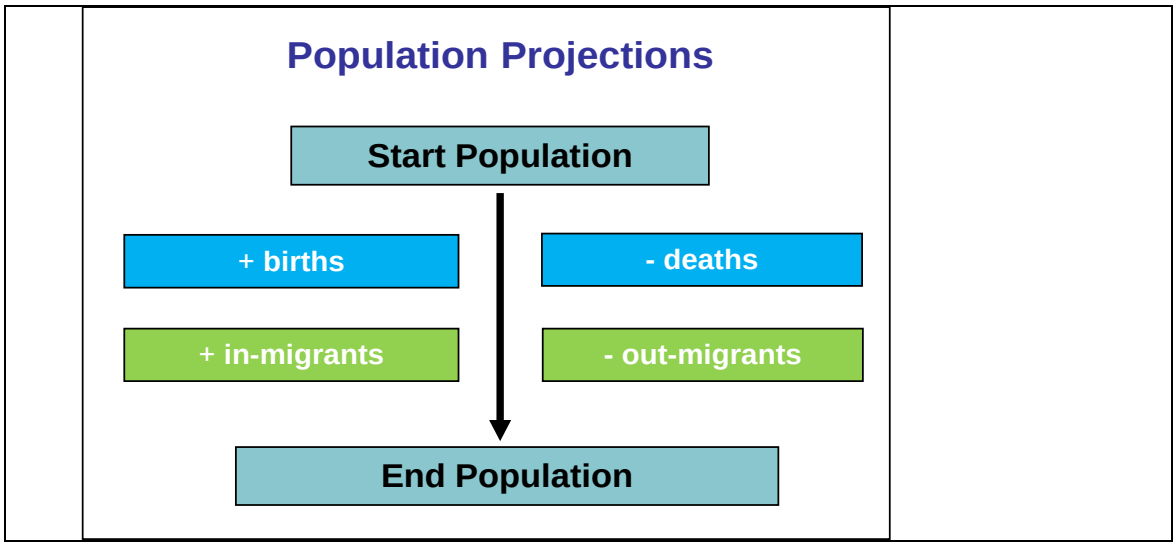
Estimated future numbers of births in East Sussex are available from the latest 2012 policy-based population projections produced by East Sussex County Council (ESCC). These projections were calculated by using a Model (POPGROUP Model – see note below) which takes into account the most up-to-date data as at July 2013:

1. The latest 2012 mid-year population estimates released by ONS in June 2013 and the rolled forward 2011 Census based mid-year estimates.
2. The revised 2002-2010 mid-year population estimates released by ONS in April 2013, based on the results of the 2011 Census.
3. Data on births and deaths released by ONS, 2001-2011.
4. The latest trends on fertility and mortality based on the 5-year average 2006-2011.
5. The latest migration rates based on the average of the preceding 5 years from 2007 to 2012.
6. Future housing provisions in each borough and district as set up in their Local Plans (or Core Strategy Documents) as at 1st July 2013.

All the data and assumptions used in the model follow the national guidelines and they were used to calculate projections for East Sussex and its district/boroughs.

Note: The latest ESCC Policy based 2012 Population Projections, released in July 2013, were produced by using the POPGROUP Model developed by the Local Government Association (LGA), which is widely used by Local Government, commercial and academic users in the UK.

The Model is based on a 'cohort component method' where the starting point is an existing estimate of the population which is projected forward taking account of the impact of births, deaths and migration (internal and international) as well as the number of extra dwellings being planned for the future. Assumptions about future fertility, mortality and migration trends are derived from recent historical evidence, whereas the latest housing provision figures are provided by districts and boroughs through their Local Plans (Core Strategies) as at 1st July 2013.



Changes in the number of births can result from a change in the average number of children women are having (Total Fertility Rate) and/or a change in the size of the population of women of child-bearing age. The latter is influenced both by migration and the number of women entering and leaving child-bearing age.

The projected decline in births in East Sussex between 2012 and 2021 is mainly due to:

- A decline in the average number of children that women are having
- A decline in the size of the female population of child-bearing age

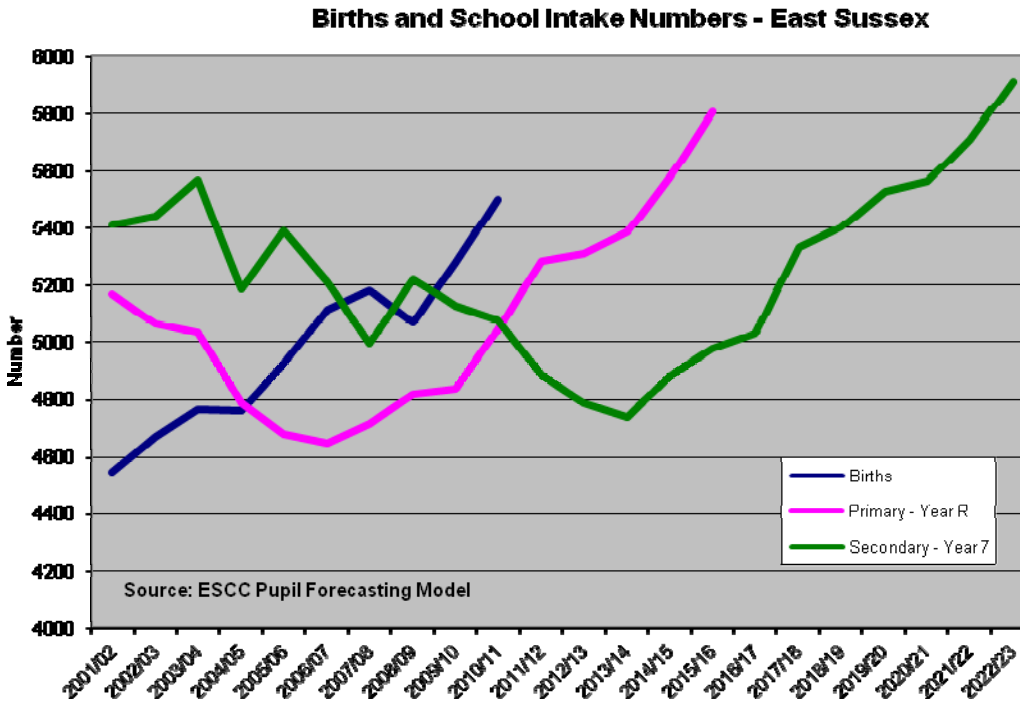
2. How are projected reductions in numbers of births in East Sussex reconciled with anticipated increases in school places needed in Eastbourne for example?

Figure 2 (which looks at births and school intake numbers) and Figure 3 (which looks at total number of pupils on the school roll) demonstrate that there is a time delay between children being born and the time they go to primary and secondary school.

Based on historic data of actual live births, GP registrations and Child Benefit take-up, East Sussex County Council can relatively confidently predict and plan for a bulge in demand for school places that will continue into the next decade.

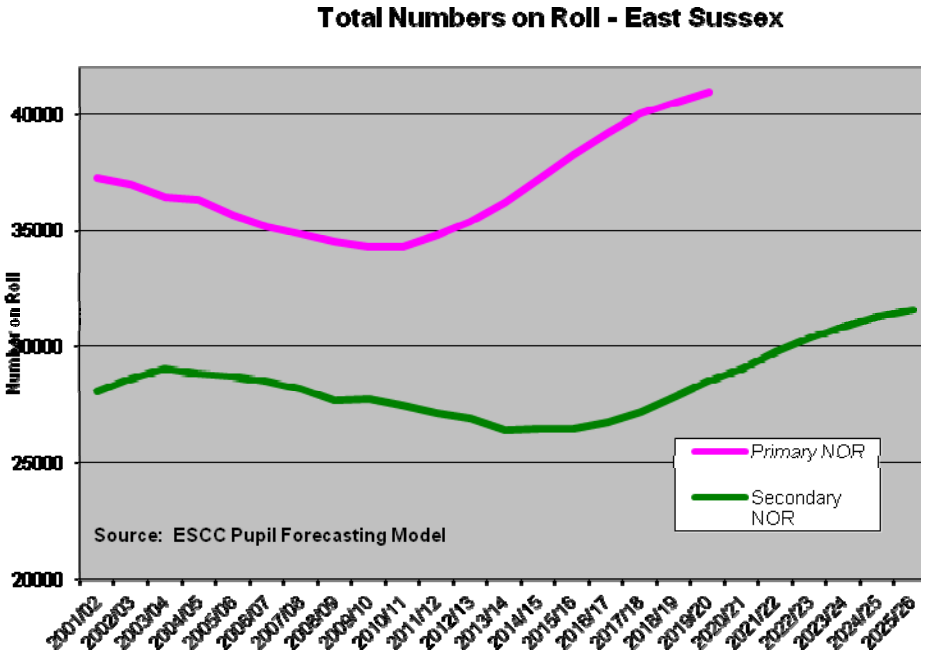
It is important to note that the years in these Figures relate to academic years (ie September to August). Hence the most recent year of births in Figure 2 is September 2010 – August 2011. Whilst it might appear that births continued to grow, there was actually a decline in births to 5,408 in academic year 2011/12.

Figure 2:



Source: School Organisation and Place Planning in East Sussex 2013/14 report

Figure 3:



Source: School Organisation and Place Planning in East Sussex 2013/14 report

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

   The projected numbers of births relate to East Sussex resident women and are based on ESCC Policy based 2012 Population Projections. They are not based on any assumptions about where East Sussex women might choose to deliver their babies.

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

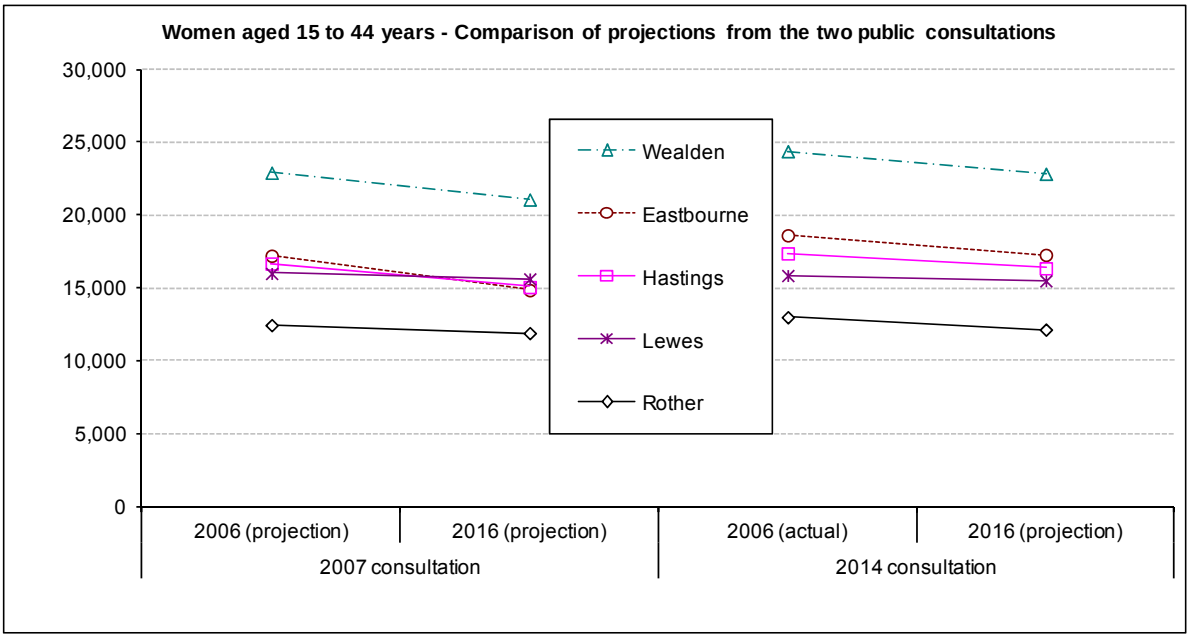
   The ESCC Demographic Projections used in the 2007 consultation are those produced by ESCC in October 2005 using the Chelmer Model, housing numbers from the former South East Plan, and migration and population estimates based on the 2001 Census results. These projections were based on the 2004 mid-year population estimates (also based on the 2001 Census) and the actual projection period was from 2005 to 2026.

   The projections used in the 2014 consultation document were based on the 2012 mid-year population estimates (based on the 2011 Census) and the actual projection period was 2013 to 2026. (Please see note for detailed comparison of the two.)

   The two projections for East Sussex women aged 15–44 years old have the same trends, although the 2012-based projections are higher than the 2004-based projections due to the differences between the two Censuses 2001 and 2011. Further detail comparing the 2004 and 2012 projections is provided below.

   Figure 4 illustrates the difference in projected number of women of childbearing age between 2006 and 2016 by East Sussex districts and boroughs in the 2007 and 2014 consultation documents. The number of women aged 15-44 years in 2006 was a projected estimate in the 2007 document, but an ONS mid-year estimate in the 2014 document. Therefore the numbers are not comparable. Whilst the number in 2006 and the projected number in 2016 are higher in the 2014 consultation document compared to the 2007 document, the projected decline seen in Eastbourne remains the largest of all the districts and boroughs.

Figure 4: Table 1: Projected number of East Sussex resident women of child bearing age (15-44 years) by districts and boroughs in 2007 and 2014 consultations

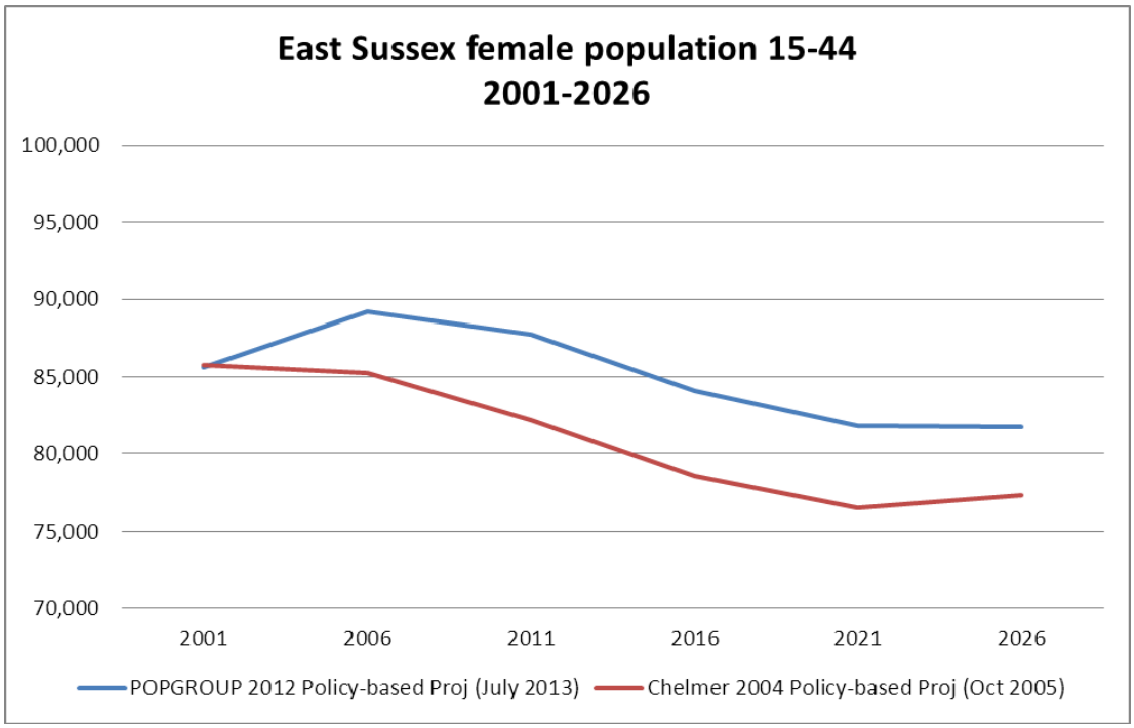


Data source: Maternity consultation documents 2007 and 2014

Comparison of 2004-based and 2012-based projections

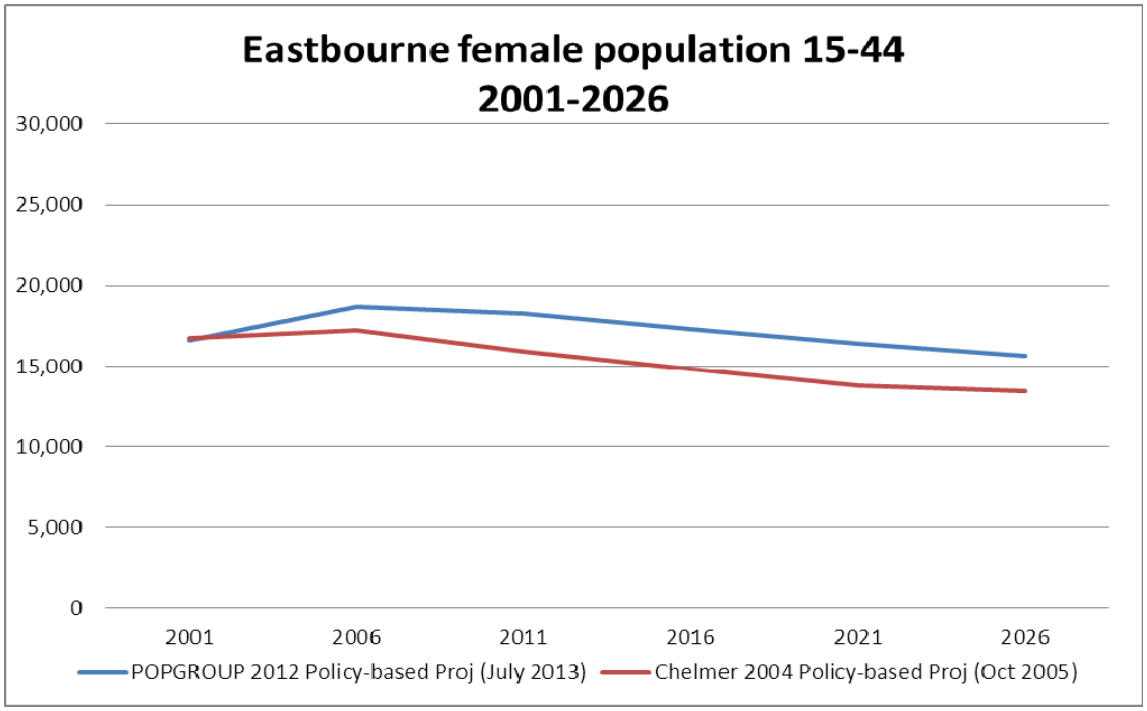
The graphs in Figures 5 and 6 show that the two projections for East Sussex women aged 15–44 years old have the same trends, although the 2012-based projections (using POPGROUP) are higher than the 2004-based projections (using Chelmer) due to the differences between the two Censuses 2001 and 2011. The 2001 Census under-counted the total population of East Sussex in particular people aged 16-44.

Figure 5: East Sussex resident 15-44 year old women, 2001-2026



Source: ESCC Research and Information Team, Communities, Economy and Transport

Figure 6: Eastbourne resident 15-44 year old women, 2001 - 2016



Source: ESCC Research and Information Team, Communities, Economy and Transport

Note:

Differences between the previous 2004 Policy-based Projections (October 2005) and the latest 2012 Policy-based Projections (July 2013):

2007 consultation: 2004 Policy-based Projections (produced in October 2005)	**2014 consultation: 2012 Policy-based Projections (produced in July 2013)**
Chelmer model: the population is projected forward every 5-year period (5-year average for births, deaths and migration). More sensitive to any changes in the input data.	POPGROUP: project the population forward year by year (single year information for births, deaths and migration). More reliable and robust.
Estimates and projection periods: the actual estimates are from 2001 to 2004 and the projected period is from 2005 to 2026.	Estimates and projection periods: the actual estimates are from 2001 to 2012 and the projection period is from 2013 to 2026.
2001 Census: the mid-year population estimates based on the 2001 Census (2001-based MYE) under-estimated the size of the population aged 16-44 in East Sussex as well as in all its districts.	2011 Census: population estimates and migration are based on the 2011 Census which shows higher population in East Sussex and its districts, except for Lewes.
Fertility, mortality and migration: assumptions: based on the previous 5-year period 1999-2004. This was before the EU expansion in 2004.	Fertility, mortality: based on the previous 5-year period 2006-2011 and migration on the 5-year period 2007-2012.