Agenda Item 6

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**19 June 2014**
By:	**Assistant Chief Executive**
Title of report:	***Better Beginnings* – maternity and paediatric services in East Sussex**
Purpose of report:	**To present HOSC's final report on its findings and recommendations.**

RECOMMENDATION

HOSC is recommended to agree and present its findings and recommendations on 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'.

1.2 At its meeting of 20 January 2014, HOSC decided that the service change proposals set out by the CCGs were a 'substantial variation' to health service provision that required statutory consultation with HOSC under health scrutiny legislation. HOSC has undertaken a detailed review of the proposals over the period February to June 2014.

1.3 The appendix to this report comprises HOSC's report detailing its outline draft findings and recommendations. This report is presented alongside the report and decision at item 5 on the agenda which relates to the Better Beginnings consultation.

2. Next steps

2.1 On 10 July 2014 HOSC will meet to consider the detailed decisions of the CCGs. If the CCGs disagree with any of HOSC's recommendations, then the CCGs and HOSC must take such steps as are reasonably practicable to try to reach agreement.

2.2 If, after following this process, HOSC considers that the CCGs' decisions would not be in the interests of the health service in its area, it can refer to the Secretary of State who may make a final decision on the proposals.

3. Recommendation

3.1 HOSC is recommended to agree and present its findings and recommendations on maternity and paediatric services using the appended draft report as a starting point for deliberations.

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East Sussex Health Overview and Scrutiny Committee (HOSC)

Better Beginnings – the future of maternity, in-patient children's services and emergency gynaecology in East Sussex

Draft report for discussion at HOSC

19 June 2014

Contents

Recommendations

Recommendation about the configuration of services

1) a) The future configuration of maternity services in East Sussex should provide for the best geographical spread of locations across the County whilst ensuring safe and sustainable services. Options 1, 2, 3 and 4 limit the choices of locations available therefore none of these four options should be selected.

   b) The choice of service configuration should take account of a range of factors including: financial viability; population size and growth; the needs of specific population sub-groups; deprivation and associated risk factors.

   c) Changes to the configuration of maternity services should include upgrading and modernising facilities, with due consideration given to the number of beds required across all type and location of unit. HOSC wishes to see excellent, modern obstetric and gynaecological services for women in East Sussex.

Recommendations about maternity services in the High Weald

2) The maternity care pathway for women in Crowborough and the North Weald needs to be addressed as a matter of urgency to include provision for reconnecting community midwifery with the birth choices now being made in practice by High Weald women:

   - Women should have the opportunity to give birth at CBC midwife-led unit with the option to go to Pembury seamlessly should an obstetric service be required or desired
   - The administrative pathway barriers, such as formats of patient notes and booking arrangements operating differently in different trusts, must be resolved
   - Activity levels at CBC should be improved pending longer term management decisions such as reinstating obstetric scanning services at CBC
   - The 'emergency transfer link' from the High Weald and Crowborough Birthing Centre (CBC) to Tunbridge Wells Hospital at Pembury must be strengthened as reflected in existing practice for women in distressed labour at CBC.

Recommendations about paediatric services

3) Both Eastbourne DGH and the Conquest need a Short Stay Paediatric Assessment Unit (SSPAU) that provides a level of service that is better aligned with peak periods of need than the current service. This will require a review of: a) SSPAU opening hours, b) consideration of how services can be provided outside normal opening hours and c) a robust protocol on transfers to ensure that, for example, the intended destination is clearly communicated and agreed amongst all parties in a timely manner.

4) a) Co-locating inpatient paediatric services with a consultant-led obstetric unit is appropriate based on the evidence available.

   b) The operation of the Special Care Baby Unit (SCBU) should be reviewed with the strategic clinical network to see whether Level 2 services would be more appropriate in future.

Recommendations relating to implementation

5) a) The evidence and arguments supporting the CCGs' options have failed to convince the campaigning organisations and many individuals of the need to change the configuration of services. This points to the requirement, whichever option is selected, for an effective and innovative communications strategy to be in place in advance of full implementation.

   b) The strategy needs to be targeted particularly at future users of the service to provide clearer information and advice about: risks, safety, choices of birth location, travel and transfers; and emphasise how and why longer travel times do not necessarily equate with increased risk.

6) a) Significant importance should be attached to understanding and communicating the lessons resulting from serious incidents; such learning and resulting actions should be included in future monitoring reports to HOSC.

   b) A 'clinical safety champion' should be appointed for obstetrics and gynaecology who would liaise with the Royal Colleges and other bodies to collate clinical, safety and outcomes data and ensure that safety lessons are effectively put into practice.

7) Being able to retain and develop the skills of midwives is critical to providing a sustainable and safe maternity service in East Sussex. HOSC will require evidence that the significant role undertaken by midwives is given widespread recognition and especially that:

   - Protocols are established to ensure that midwives can make consistently accurate assessments of place for delivery and provide safe and effective antenatal risk assessments.
   - A strategy is put in place to ensure the effective support and retention of midwives in East Sussex.

Introduction

Context

1 Throughout 2012 the NHS 'Sussex Together' programme engaged commissioners and providers across East Sussex, West Sussex and Brighton and Hove in a collaborative exercise to improve care. As part of this exercise they reviewed maternity and paediatric services across Sussex.

2 In July 2013 a clinical consensus emerged which was agreed by senior GP commissioners, consultants, midwives and other health professionals across Sussex. The 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 receive high quality, safe and sustainable levels of care. The need arose due to particular pressures experienced by ESHT concerning middle grade doctors, medical trainee numbers and a high number of serious incidents.

3 In April 2013 newly created NHS bodies called clinical commissioning groups (CCGs) took responsibility for commissioning maternity and paediatric services. In July 2013 the three East Sussex CCGs (Hastings and Rother; Eastbourne Hailsham & Seaford; High Weald Lewes & Havens) collectively embarked on a review of maternity and paediatric services in East Sussex called 'Better Beginnings'.

4 Meanwhile, in March 2013 ESHT took a decision to reconfigure its maternity and paediatric services temporarily based on safety considerations for mothers and babies using these services. Most significantly, a National Clinical Advisory Team (NCAT) report concluded that the obstetric and paediatric services being provided by ESHT were not safe or sustainable. The reconfiguration took effect in May 2013 and the details were considered at East Sussex Health Overview and Scrutiny Committee (HOSC) on 21 March 2013.

5 The reconfiguration involved 'single siting' consultant-led obstetric and inpatient paediatric services at the Conquest Hospital in Hastings. Until then these services were provided at both Eastbourne District General Hospital (EDGH) and the Conquest following the recommendations of an Independent Reconfiguration Panel (IRP) review in 2008. The IRP review followed a HOSC referral of the issue to the Secretary of State for Health in 2007/08.

6 A midwife-led unit (MLU) for low risk births and a paediatric assessment service were retained at EDGH. Other services including the Crowborough Birthing Centre (CBC) (a standalone MLU), elective (planned) gynaecology, outpatient and community services were unaffected. These arrangements continued pending the agreement of plans for the long-term future of the service.

7 Whilst the temporary arrangements focused the issue, the pan Sussex review and resulting clinical case for change reflected wider perceived local and national challenges in finding solutions for maternity and paediatric services that offer patients safety, choice and sustainability.

8 On 11 December 2013 the East Sussex CCGs unanimously agreed six potential service delivery options which they consider would enable the safe and sustainable delivery of maternity, inpatient paediatric and emergency gynaecology services in East Sussex. These are the only options that, in their view, meet the agreed quality standards against which they wish to commission services.

9 None of the options contain a two-site configuration for consultant-led obstetric and inpatient paediatric services. The CCGs consider that the previous two-site option could not be safely sustained. They see the single-site option as a better way to balance the risks involved whilst acknowledging that no system can ever eliminate all risks entirely.

10 The ESHT consultant body and senior midwives also consider that moving to one site is the safer option. Since the temporary changes in May 2013, ESHT has reported that the situation has stabilised and improved, and that the key performance indicators have allayed many of the concerns about moving to one site.

Role of the East Sussex Health Overview and Scrutiny Committee (HOSC)

11 The East Sussex Health Overview and Scrutiny Committee (HOSC) comprises: seven elected councillors from East Sussex County Council; one councillor from each of the five district and borough councils in the county; and two co-opted members representing local voluntary and community sector organisations. Its membership during the course of this review is shown in Appendix 1 on page 27. HOSC is independent of the NHS but works with local NHS organisations to improve health services.

12 HOSC's role is to review and make recommendations about local health issues and health services which are of concern or importance to East Sussex residents. Local NHS organisations are required by national legislation to consult with HOSC about any proposed major changes to health services, and must supply information and attend HOSC meetings to help the Committee to undertake this most important role.

13 On 10 January 2014, HOSC agreed that the possible delivery options, and the associated changes in service as described by the CCGs, constituted a 'substantial variation' in services. In order to meet its statutory duty to respond to the CCGs based on the evidence available, HOSC instigated its own review and received written and oral evidence at meetings on 17 February and 20 March 2014. The public was invited to submit comments to HOSC. All the evidence sources and public comments received by HOSC are listed in Appendix 2. The minutes of the HOSC evidence gathering meetings are available on the HOSC website www.eastsussexhealth.org.

14 HOSC will respond to the NHS, based on the evidence available to it, on two key points:

- Whether HOSC is satisfied with the content of the NHS consultation process and that sufficient time has been allowed.
- Whether HOSC is satisfied that the CCGs' preferred way forward is in the best interests of the health services in East Sussex.

15 The CCGs, as the consulting organisations, then have the opportunity to respond to HOSC's report and recommendations, decide a course of action and explain the reasons for their decisions. If the CCGs disagree with any of HOSC's recommendations, then the CCGs and HOSC *must take such steps as are reasonably practicable to try to reach agreement in relation to the subject of the recommendations*.

16 After following this process, if HOSC remains dissatisfied with the *consultation* in relation to content or time allowed it can refer to the Secretary of State who *may make a decision in relation to the matter*. If HOSC considers that the *proposals* would not be *in the interests of the health service in its area*, it can refer to the Secretary of State who may make *a final decision on the proposals*.

17 This report summarises the arguments heard by HOSC and the judgements made by Committee members about those arguments, together with recommendations for taking the proposals forward.

Findings and conclusions

The options

18 The CCGs put forward six options for the future of NHS maternity, in-patient children's services (paediatrics) and emergency gynaecology in East Sussex. The sites affected by the options are: Eastbourne District General Hospital (EDGH); The Conquest Hospital, Hastings ('The Conquest'); and Crowborough Birthing Centre (CBC).

19 These are the options put forward by the CCGs (adapted extract from the *Better Beginnings* consultation document):

Option	Eastbourne District General Hospital (EDGH)	Conquest Hospital, Hastings	Crowborough Birthing Centre (CBC)
1	'Alongside' midwife-led unit Obstetrics Emergency gynaecology In-patient paediatrics SCBU (Level 1) SSPAU	SSPAU	'Standalone' midwife-led unit
2	SSPAU	'Alongside' midwife-led unit Obstetrics Emergency gynaecology In-patient paediatrics SCBU (Level 1) SSPAU	'Standalone' midwife-led unit
3	'Alongside' midwife-led unit Obstetrics Emergency gynaecology In-patient paediatrics SCBU (Level 1) SSPAU	'Standalone' midwife-led unit SSPAU	No maternity service
4	'Standalone' midwife-led unit SSPAU	'Alongside' midwife-led unit Obstetrics Emergency gynaecology In-patient paediatrics SCBU (Level 1) SSPAU	No maternity service
5	Obstetrics Emergency gynaecology In-patient paediatrics SCBU (Level 1) SSPAU	'Standalone' midwife-led unit SSPAU	'Standalone' midwife-led unit
6	'Standalone' midwife-led unit SSPAU	Obstetrics Emergency gynaecology In-patient paediatrics SCBU (Level 1) SSPAU	'Standalone' midwife-led unit

Terms used

SCBU (Level1) – Special Care Baby Unit

British Association of Perinatal Medicine definitions:
Level 1 units *provide special care but do not aim to provide any continuing high dependency or intensive care'.*
(Level 2 units *provide high dependency care and some short-term intensive care as agreed within the network.)*

SSPAU – Short stay paediatric assessment unit

Obstetrics – Consultant-led maternity service

20 All the options include:

- An in-patient paediatric unit and a Level 1 Special Care Baby Unit located at the same, single site as a consultant-led maternity service (obstetrics)
- Two midwife-led units (MLUs)
- Two Short Stay Paediatric Assessment Units (SSPAU) (located at Eastbourne and Hastings); opening hours to be reviewed

21 The CCGs stated that they have tested these options with the wider clinical network and are assured that each of the options will deliver safe and sustainable care.

Safety and sustainability

Introduction

22 ESHT states that, since 2012, it has taken steps to improve the quality and safety of services within the available resources. Its business model and clinical strategy is based on the tenet of 'one hospital on two sites' at EDGH and the Conquest.

23 ESHT outlined the range of service improvements that it delivered as part of the Maternity Strategy since 2008. ESHT took the temporary decision to reconfigure maternity and paediatric services in May 2013 which, it argues, has led to improved experiences and safety outcomes for those mothers and babies who use that service. ESHT considers that returning to the previous configuration would reduce safety and quality of service. The factors, cited by ESHT and endorsed by the CCGs, that led to this conclusion are as follows:

- Staffing issues including: an increasing need to use temporary staff who were unfamiliar with policies and procedures; lack of suitable applicants for established posts; staff with required competencies not being available 24/7; and an increasingly high proportion of staff requiring greater supervision
- Low levels of maternity activity with the risk of de-skilling staff through a lack of opportunities to develop necessary skills
- Managing increasing complexity and acuity of maternity cases is a national issue and requires specialist units for maximum safety: East Sussex has witnessed a 58% increase in complex, high risk pregnancies between 2006/7 and 2011/12; an increased prevalence of medical issues such as: diabetes, hypertension and kidney disease; an increased percentage of women classed as obese; and, an increased number of women over the age of 40.
- The European Working Time Directive reducing the number of hours that clinicians may work to a maximum of 48 per week.
- Changes to immigration laws reducing the number of doctors entering the service from abroad; foreign doctors previously formed an essential part of the service.

Single siting consultant-led maternity services

24 The CCGs presented the evidence to HOSC that has led clinicians in East Sussex to conclude that they cannot maintain safe consultant-led maternity services on two sites *in the longer term*. The CCGs argue that a single site delivers a higher quality of care with a better experience for women once they arrive at the hospital. The evidence on which they base this view derives from:

- Performance indicators which purport to show improvements in services, a drop in the number of serious incidents, and improved maternal and neonatal morbidity
- 'Soft' intelligence from speaking to mothers
- The lack of any reported incident of any serious deleterious experience *as a result of having to travel further*.

25 The CCGs acknowledge that it is sometimes uncomfortable and inconvenient for the group of women, and their families, who now have to travel further than they did before. The experience of labour and birth are often perceived as traumatic events which can affect a woman's later interpretation of the event itself. Despite this, ESHT reported that some women who have given birth since the temporary reconfiguration and who also previously gave birth at the EDGH obstetrics unit, have said that they noticed the improved staffing levels. These women, according to EHST, have had more contact with their midwife and generally had a very good experience once they arrived at the Conquest Hospital.

26 The CCGs stressed that no maternity system is risk free. However, reconfiguring the service to a single site has created a much reduced risk environment than before. The CCGs consider that all the six options now being considered have significantly lower risk compared to any conceivable 'two-site model' for East Sussex.

27 A number of external bodies have endorsed this view and have commented as follows:

- January 2013: National Clinical Advisory Group (NCAT) recommended that "maternity and paediatric inpatient care be located onto one site as a matter of urgency."
- June 2013: The Care Quality Commission (CQC) in its review of the Conquest Site made the following observations:
    - "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."
    - "Midwifery staff said that obstetricians were now 'present' on the labour ward rather than 'available', which allowed them the time to support junior medical staff."
- June 2013: The CQC in its review of Eastbourne MLU noted that staff felt they were able to provide a personalised service for women. Although the service was new, staff felt they provided a safe service.

- August 2013: The Royal College of Obstetricians and Gynaecologists (RCOG) considered that: “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. As a result, staff appear to be happier, more confident and feel better supported. The hospital is seen as a more attractive place to work and will hopefully create enormous potential for reducing the numbers of staff in middle grade posts and expanding consultant numbers to increase labour ward presence, supervision and training.”
- November 2013: Royal College of Paediatrics and Child Health (RCPCH) commented that the arrangements that have been put in place are similar to reconfigurations that are being planned or implemented around the country. The review team considered that restoration of a dual site inpatient unit was “not appropriate or sustainable”.
- November 2013: Sussex Collaborative Children and Young People Clinical Reference Group and Maternity Clinical Reference Group supported the East Sussex Steering Group’s recommendation that any in-patient paediatric services should be co-located with the Obstetric Unit, as it would be difficult otherwise to sustain the workforce and skills needed.
- December 2013: South East Coast Strategic Clinical Network – Maternity, Children and Young People (MCYP SCN) considered that the siting of two obstetric led units in East Sussex could not be justified given the level of birth activity identified in 2011-13. Both units would be likely to have less than 2,000 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.

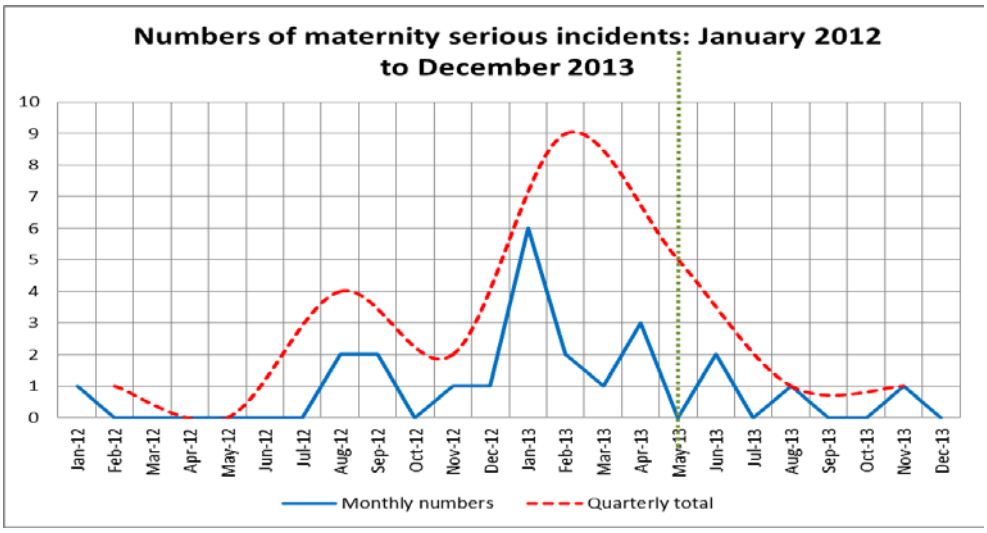
28 HOSC received a contrary view from campaign groups, in particular ‘Save the DGH’, and ‘Hands off the Conquest’, and from many individuals who emailed and wrote to HOSC directly as a result of the campaigns’ publicity. The campaign groups consider that the CCGs have not looked seriously enough at the viability of commissioning two ‘consultant-delivered’ sites in East Sussex (at EDGH and the Conquest) and that ESHT does not have the will or the innovation to provide two sites. Specifically, they assert that:

- The findings and recommendations of the IRP report from 2008 remain pertinent and should be complied with.
- The increasing number of safety issues since 2008 is due to a failure of management at ESHT and a lack of will to continue to provide for the two-site option.
- The temporary reconfiguration was justifiable (because of the findings of the NCAT review); however the situation has become permanent which has led to a loss of trust in ESHT.
- Other trusts provide consultant-led services at units with less than 2,000 births by promoting services outside their catchment area and developing innovative staffing and grade configurations (amongst other things).
- Travel times from Eastbourne to either the Conquest or Royal Sussex County Hospital (RSCH) in Brighton are greater than 30 minutes and that long travel times have detrimentally affected the health and wellbeing of mothers and children in some instances.
- The single-site configuration increases the travel to work time for many staff thus further reducing the time they spend working.
- The reduction of obstetrics units to a single site forces people living in towns that border two catchment areas, such as Seaford and Uckfield, to attend obstetric units in Brighton and Tunbridge Wells, where demand is already high.

- CBC, and the home delivery services that operate from it, is to be wholly commended and is considered sufficiently safe because it is less than 30 minutes from the nearest obstetric unit at Tunbridge Wells Hospital.

Serious incidents

29 The CCGs provided the following data which shows the monthly and quarterly numbers of serious maternity incidents between January 2012 and December 2013. Implementation of the temporary reconfiguration is indicated at May 2013.



30 ESHT anticipated that the number of serious incidents would reduce following the temporary reconfiguration in May 2013. This appears to be the case when compared to the position immediately before the reconfiguration. However, HOSC observes that there are periods of low numbers of serious incidents early in 2012 which appear to contradict that argument. The randomness of the spread of numbers of serious incidents is acknowledged in the January 2013 NCAT report: *statistically it would sometimes happen that incidents occur in a cluster with no related factors whatsoever*.

31 The CCGs reported that they contacted a number of smaller maternity units elsewhere in the country and none highlighted any relevant trends in serious incidents. That is not to say that such trends are not present. However, HOSC has no data that correlates the *number* of serious incidents to the *size* of a maternity unit.

32 HOSC concurs with the clinicians that it is critically important that lessons learnt from serious incidents are used to improve services and to reduce future risks. Understanding the causes of individual serious incidents is key to achieving this. The NCAT report (January 2013) highlighted a number of underlying themes arising from its analysis of 10 serious incidents at ESHT between August 2012 and January 2013. These included:

- a lack of escalation by midwifery, neonatal nursing or theatre staff to the consultant
- issues around obstetric staffing especially at middle grade level and the challenges of providing a safe service when locums are required at this grade.

33 HOSC would therefore expect to see such 'systemic' causes of serious incidents disappear following the May 2013 reconfiguration and would wish to be kept informed about the learning and resulting actions from serious incident analysis in future monitoring reports. (See recommendation 6).

34 The born-before-arrival (BBA) numbers have not changed significantly since May 2013. ESHT reported that babies born before arrival usually have excellent outcomes and CCGs consider that the focus should be on reducing serious incidents. 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.

Small obstetric units, staffing and training

35 The campaign groups asserted that there are smaller maternity units in other parts of the country, with under 2,500 births per year, that successfully provide a consultant-led obstetric service safely and economically by:

- Adopting an appropriate ethos deriving from approachable, strong leadership and clinical led management at a 'practical level'.
- Subsidising core services with 'profit making' activities or marketing clinical specialisms to other hospitals.
- Promoting services outside their catchment area.
- Joint bidding for services with private companies.
- Developing innovative staffing and grade configurations that retain staff effectively and promote a 'can do' approach.
- Sharing expensive services, such as pathology labs, with other trusts.
- Using a private healthcare partnership to provide management franchises across several trusts.

36 The clinical consensus states that there is a threshold of 2,500 births per year, below which the sustainability of the [obstetric] service should be scrutinised more closely due to the additional challenges of maintaining safety and quality. The most efficient unit size is in the region of 4,000 to 5,000 births per year. The CCGs cited the following evidence and experience underlying this:

- There is a national drive to provide obstetric units in fewer units is evidenced by the reduction in the number of units with less than 2,000 deliveries between 2008 and 2012. In 2012 there were 160 obstetric units of which 28 reported fewer than 2,500 deliveries and 12 with fewer than 2,100.
- 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.
- There are a range of staffing, recruitment and training issues for small consultant-led maternity units. In particular many small units have had to base their contingency plans on recruiting non-training grade staff, the future availability of which is very uncertain.
- In East Sussex, bringing doctors from multiple sites onto a single site has:
    - improved outcomes for women and babies
    - reduced the number of hours on the labour ward when a consultant is not present
    - enabled each obstetrician and training grade doctor to deliver more babies and so increase safety and quality of services
    - increased levels of supervision, training and performance of middle grade doctors
    - made the hospital more attractive to middle grade doctors than hospitals with fewer births.

- Smaller units elsewhere provide an average of 40 hours consultant presence per week on the labour ward; the agreed model of care for East Sussex aspires to a minimum of 60 hours in order to improve outcomes for women and babies and enable adequate training.
- Some smaller units found it difficult to deliver services in a financially sustainable way and some reported difficulties in recruitment and capacity issues that have led to temporary service suspensions and diverts.
- Many units are undertaking reviews and are facing similar problems to ESHT.

37 The campaign groups consider that ESHT's poor reputation has exacerbated the difficulties in recruitment. They see the south coast as an inherently attractive place to live and therefore, in their view, ESHT ought to have been able to develop thriving and innovative hospitals that are attractive to doctors. They consider that providing a good service within a relatively small catchment area requires non-training doctors on stable career grades who do not want to go onto consultant grades. By splitting obstetric activity between two locations, the same volume and variety of work exists and so the campaign groups argued that it is factors such as inflexible rotas that have prevented clinicians from reaching their training and career development potential.

38 ESHT explained that the key medical staff in obstetric units are ***middle grade doctors*** (registrars, staff grade doctors and associate specialists) who are competent to perform obstetric procedures such as caesarean sections and instrumental deliveries independently with indirect consultant support. Staff or associate staff or associate specialist middle grade doctors should be 'non-training' meaning that they are competent doctors who, by definition, have completed their training but do not wish to advance to become a consultant.

39 There are also ***trainee middle grade doctors*** who are deemed to have sufficient competence but require continual experience which is difficult for them to gain with low activity levels. If a trust employs additional doctors but does not have a sufficient level of activity within the unit that allows these doctors to maintain their competence, it will have created an additional risk.

40 ESHT reported that prior to 2008, all middle grade doctors gained their competencies relatively quickly due to the number of hours they worked and because many came from abroad already with the required basic skills and knowledge. Since 2008 an increasing proportion of non-training middle grade doctors (30% in 2008 increasing to 80% in 2012) still required some degree of training due to their limited experience, changes in working practices and the increasing complexity of patients. Consequently, ESHT argued, there has been an increasing requirement for consultants to provide more direct supervision. The RCOG acknowledges this position in its report. The KSS Deanery visits and reports identify a significant improvement in training provision by ESHT since the reconfiguration.

41 Between 2008 and 2013, ***midwives*** at ESHT gradually began to take on roles that were traditionally within the remit of junior doctors, such as supporting surgeons in theatre. This took midwives away from their 'bed side' tasks. A high number of midwives were also on sick or maternity leave at that time. ESHT responded by employing agency staff who, whilst mostly technically competent, were unknown to the Trust and did not consider themselves a part of the midwifery team in a function where team working is critically important. Since the move to the single site in May 2013, ESHT has significantly reduced the number of agency staff.

42 Retaining midwives has proved difficult for ESHT historically with many who qualify in East Sussex then moving to London or Brighton. ESHT reported a recent successful recruitment drive resulting in the appointment of six full-time equivalent midwives and five band-5 nurses. The band-5 nurses will work on the postnatal ward, releasing midwives to the labour ward where they are most needed. (See recommendation 7). The number of ***consultants*** has increased from 8 in 2007/8 to 11 by 2011/12 which is a higher rate of expansion that the average national figure over this period.

43 ESHT considers that any move towards creating as second obstetric unit would also require the duplication of a wider support team typically comprising: a consultant obstetrician; a haematologist; senior midwives; and a theatre team of one or two anaesthetists and theatre nursing staff.

44 As a result of the interim changes in May 2013, ESHT now considers it has the optimum number of doctors concentrated on one site supporting the obstetric unit. It reports an improved ability to manage staff absences due to sickness, better management of unpredictability in obstetric birth numbers; and improved support for doctors without excessive recourse to locum staff.

Choice of birth setting and safety

45 Women have a choice of four location options where they can plan to give birth: 1) at home, 2) in a 'standalone' midwife led unit (MLU), 3) in an 'alongside' midwife led unit and 4) in an obstetric unit. The terms 'standalone' and 'alongside' refer to the proximity of an MLU to an obstetric unit.

46 All six service delivery options under consultation include one obstetric unit and two MLUs; this combination is considered appropriate by the clinicians for the current and projected number of births in East Sussex. (See section below on population and demographics). Options 5 and 6 include two standalone MLUs; options 1, 2, 3 and 4 each include a standalone and an alongside MLU.

47 The clinicians emphasised that obstetrics is not risk free and that it is therefore sometimes safest to give birth in a consultant-led unit that provides the infrastructure to deal with rare, catastrophic events. However, they consider that the likelihood of a sudden and unexpected complication is now exceedingly small. If they occur, complications can happen at any time and not just when a woman is in hospital or an MLU.

48 The Birth Place Study (2011) of 65,000 women shows that not only are MLUs very safe, there are greater benefits for low-risk women giving birth in an MLU compared to a consultant-led obstetric unit. The study demonstrates that:

- there are more interventions and higher transfer rates in alongside MLUs compared to standalone MLUs
- there are more natural births even in an alongside MLU compared to an obstetric unit.

49 The model of care provided in an MLU is the same regardless of whether the unit is 'standalone' or 'alongside'. However, the tendency to move patients from one unit to the other is increased if the transfer process is easier.

50 Judging the best location to give birth clearly requires an early and accurate assessment of risk by clinicians and mothers. The CCGs provided evidence from Eastbourne Maternity Unit (EMU) data to show that it is now possible to predict very accurately in advance whether women are likely to have an increased risk based upon levels of obesity, age, and various socio-economic factors such as smoking prevalence. All the evidence suggests that the correct approach to 'scoring' risk is now in place.

51 Midwives and obstetricians are trained to detect risks and inform women about the options when discussing, say, where she would like to give birth. During labour itself in an MLU the midwife closely monitors mother and baby throughout and makes an early decision to transfer to an obstetric unit if necessary, in discussion with the mother and their partner. Sometimes the woman requests a transfer to an obstetric unit for example, for pain relief, signs of increasing distress or when experiencing a long labour.

52 Generally, women who are considered high risk plan to have their babies in an obstetrics unit. However, sometimes, high-risk women choose to have their babies in an MLU or at home. Under these circumstances, the clinicians support the woman's decision and explain the risks fully.

53 Many low-risk women choose to accept the inherent risks of a MLU or home birth because they believe, and the evidence demonstrates, that the risk of an intervention for them is much lower. Some low-risk women choose to give birth at an obstetrics unit whilst requesting the lowest possible intervention and no involvement of obstetricians.

54 ESHT reported that there have been no incidents since the reconfiguration where a patient has had to be 'rushed' from the Eastbourne Midwifery Unit (EMU) to the Conquest for a caesarean section. All transfers have been made in adequate time. The percentages of women transferred to the Conquest, based on a risk assessment during labour, who end up having instrumental deliveries (5.2%) or caesarean deliveries (2.4%) are below the national average. Overall transfer rates from the MLU at Eastbourne to the consultant-led unit are in line with national average.

55 ESHT state that there have been no reported babies born during transfer, and all of the outcomes have been good. The average time from handover at the Conquest to delivery of the baby is 3 hours 15 minutes demonstrating that decisions are generally made in a timely way. (See section below on travel times and transfers).

56 The EMU has seen steady growth in the numbers of women choosing to give birth there; in the first year, 337 babies were born in the unit and the midwives dealt with over 2,800 visits by women for antenatal and postnatal care including those that have laboured and delivered on the unit.

HOSC findings about safety and sustainability for maternity services

57 In terms of safety and sustainability, HOSC's findings are that:

- Local clinicians are advocating a strong clinical case for change that they consider will achieve safe, sustainable and high quality maternity and paediatric services in East Sussex.
- Unsuccessful attempts have been made to implement the recommendations of the Independent Reconfiguration Panel (2008) recommendation to provide obstetric services at both Eastbourne and Hastings sites.
- The overwhelming clinical opinion locally is that the single-site consultant-led obstetric unit option has improved safety and outcomes for those women who receive the service compared to the previous two-site configuration.
- Pressures on maternity services have arisen from several sources: increasing numbers of more complex births, staffing, European Working Time Directive, junior doctors' training and Royal College and Clinical Negligence Scheme for Trusts (CNST) standards. Single siting obstetrics is a reasonable response to these pressures which has increased the resilience and efficiency of the service.
- There are only a small number of maternity units with fewer than 2,500 births per year; these units face comparable sustainability problems to those faced in East Sussex.

- Travel times and distances are widely perceived by the public to be critical safety factors for maternity.
- Being able to retain and develop the skills of midwives is critical in order to provide a sustainable, safe and reliable maternity service in East Sussex; there are indications that this is a problem with stretched midwife resources across East Sussex and South Kent. (See recommendation 7).

58 HOSC's findings on choice and safety issues are as follows:

- Women have the right to choose where to give birth within a framework of risk assessment and good information about the risks and benefits when making those choices.
- Most potential risks can be identified in antenatal care or early in labour and transfers organised before an emergency develops.
- Appropriate protocols must be in place to remove any barriers to swift and efficient transfer if required. (See recommendation 5).
- The optimum configuration of maternity services in East Sussex needs to provide for the best geographical spread of locations across the County whilst ensuring safe and sustainable services.
- Service configuration options 1, 2, 3 and 4 limit the choices of locations available (see recommendation 1).

Travel times and transfers

59 Fears and concerns about the greater travel times and distances many people would experience with a single-site option, wherever it is located, comprise the single greatest concern factor both amongst the campaign groups and the individuals who submitted their comments to HOSC. The campaign groups reported examples of individuals who described experiences of emotional damage and trauma; physical injury and delays in treatment. The campaign groups concluded that transfers to an obstetric unit should take no longer than 30 minutes and therefore the two-site proposal they have developed is safest.

60 The CCGs assert that there is no definitive national target for transfer time. ESHT has developed a local protocol for women requiring transfer from the EMU and CBC to an obstetric unit. It reflects the transfer time used in East Kent of 80 minutes. Any transfers that breach this time are reviewed and reported on. To date, no serious incidents have been attributed to these transfers. The 30 minutes RCOG guideline refers to the time from a clinical decision to intervention and does not include the travel or transfer time. The decision for a clinical intervention is made by a consultant, whereas the decision to transfer a patient to a consultant-led site is made by a midwife.

61 The number of transfers in East Sussex is broadly in line with the national average as indicated in the following table.

	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-31 Oct 2013	15	11	26	34.9%	13.9%	**36%**	**9%**

EMU transfer to obstetric-led unit 7 May-31 Oct 2013	17	13	30	38.6%	10.4%		

62 ESHT provided evidence following a review of women arriving at the Conquest by ambulance transfer from the EMU. On average, women give birth 3 hours 15 minutes after arrival. The shortest time for a woman arriving from the EMU, to giving birth, was approximately 35 minutes after arrival at Conquest Hospital. This review was based on seven months of data following the temporary configuration.

63 South East Coast Ambulance NHS Foundation Trust (SECAmb) says it responds appropriately to the level of urgency required which is decided on clinical grounds by SECAmb and, typically, the accompanying midwife. ESHT and SECAmb are satisfied with this situation and cite the evidence from running this system for almost a year. All transfers that have taken place have resulted in no serious incidents.

64 The CCGs acknowledged that the travel times and transfer times issue is complex, counterintuitive and therefore requires careful explanation.

65 An independent consultant providing evidence warned against placing too much emphasis on the importance of travel times for maternity cases. His view was that there are virtually no circumstances where a woman arriving ten minutes earlier would have an improved the outcome. The evidence indicates that very few women require urgent intervention and, for those rare occasions where an unpredictable and potentially catastrophic event occurs, the transfer time makes very little difference. The primary aim is to get the patients to a unit with an expert, senior team who can best manage the situation. Almost all bad outcomes occur when there is an inexperienced, junior team that is unable to cope with the emergency.

SECAmb perspective

66 This stance is supported by the evidence from SECAmb. SECAmb takes patients to the closest *appropriate* receiving unit because the outcome is better. This approach applies to many conditions, such as stroke, trauma and cardiac conditions where previous reconfigurations of these services in East Sussex have resulted in improved outcomes. Taking a patient to a unit that then requires an onward transfer increases the risk of a worse outcome.

67 SECAmb's evidence:

- Travel times between EDGH and the Conquest vary between 30 - 35 minutes (blue light) to 45 – 55 minutes (non emergency).
- The decision whether to use blue light depends on the individual circumstances of the patient and would be a joint decision between the crew and an accompanying medical professional.
- Maternity accounts for about a third of the total of maternity and paediatrics ambulance transfers.
- The temporary reconfiguration (May 2013) generated an increase in demand on the ambulance service by approximately two additional patient journeys per day (equating to 4 or 5 hours of ambulance time per day); this covers all paediatric, obstetrics and gynaecological related cases.
- Capacity planning for SECAmb occurs continually; a significant challenge is that the lead-in time for a service expansion means that it is difficult to do this quickly. The temporary change happened quickly and wouldn't have given SECAmb time to plan as part of the normal commissioning process.

- SECAmb is learning from the temporary changes to help judge the impact of the permanent configuration.
- Ambulance staff/paramedics are 'generalists' in emergency medicine providing expert care in resuscitation for all people including children and babies.
- The quantity of gynaecological, obstetric and paediatric work is very small overall; ambulance staff rarely see complex or difficult deliveries. When such emergencies occur, SECAmb looks to the appropriate medical professional for support, a midwife for example.
- Ambulances carry a delivery pack in the ambulance. Most births that are delivered in the community go well and tend to happen quite rapidly.
- The Joint Royal College Ambulance Liaison guidelines set out the methodologies by which ambulance staff operate.
- Any configuration of services needs to be kept simple; SECAmb maintains a directory of services but considers that services should be such that identifying the nearest appropriate unit is always straightforward.
- Problems occur when there are multiple options for different times of the day or different days of the week, or multiple sites providing services at different times.

68 Evidence from the project team responsible for the Bexhill Hastings Link Road indicates a likely saving of 9 minutes on a rush hour journey between EDGH and the Conquest when the route opens in May 2015.

69 Prior to the temporary changes, it was not uncommon for either one of the consultant-led units to find that, because of capacity and workforce issues, they had to tell an expectant mother to go to the other unit. This created *unexpected* travel which was acknowledged bad for women and for the service. ESHT states that it has not stopped maternity admissions to the Conquest at any point since the temporary reconfiguration.

Travel to neighbouring trusts

70 In 2011/12 there were 5,500 births amongst East Sussex residents but fewer than 4,500 gave birth within East Sussex. So there is a substantial flow of patients to units outside the county. ESHT reported that:

- The number of additional women (as a result of the reconfiguration) who choose to go to the RSCH is approximately 12 per month, slightly less than originally predicted.
- Tunbridge Wells Hospital (Pembury) has not reported any significant increase.

71 Brighton and Sussex University Hospitals NHS Trust (BSUH) have confirmed that they are able to support the changes and are doing so demonstrably under the current temporary configuration which has the most significant impact for BSUH of any of the six options.

72 BSUH saw an increase of 12 'ESHT births' per month following the reconfiguration. This is predominantly in line with forecasts of women from the Seaford and Uckfield areas choosing to go to Brighton. Maidstone and Tunbridge Wells NHS Trust (MTW) has similarly confirmed that it will support the changes proposed. The Head of Midwifery at MTW has not reported any impact from ESHT births at Pembury.

HOSC findings on travel times and transfers

73 HOSC's findings on travel times and transfers are as follows:

- Because most potential risks can be identified in antenatal care or early in labour, transfers can normally be arranged before an emergency develops.

- The public response to the consultation has highlighted widespread concerns about the safety associated with travel times from MLU to an obstetric unit and from home to a maternity unit.
- During implementation, an effective information strategy will be needed to address a range of negative public perceptions associated with the proposals. (See recommendation 5).

Special issues relating to Crowborough Birthing Centre (CBC)

74 The Friends of Crowborough Hospital representative who gave evidence to HOSC provided evidence to show that, in the High Weald, concerns over the future of the CBC are very much at the forefront of women's minds. The evidence and arguments include:

- The Crowborough midwife team provides antenatal and postnatal care for approximately 800 women who use the service annually; 70% of the workload is antenatal care.
- The safety record at CBC is very good.
- Women using CBC also require other services such as scans, blood tests and referrals to a consultant. Since 2010, ESHT has gradually moved these support services further away from High Weald when ESHT stopped the scanning facility at CBC.
- Since the temporary changes in May 2013, only 6% of High Weald women now have their birth at the obstetric unit at the Conquest. Most High Weald women now refer themselves to an alternative, local provider.
- Half of North Weald women are birthing at Pembury. In an emergency women are sent to Pembury because it is closer. However, there have been problems in transferring medical record data; the midwives have worked well to mitigate these problems.
- CBC has been temporarily closed on a number of occasions in recent years in order to manage staffing difficulties and to prioritise services elsewhere; this has led to a reducing confidence locally in the sustainability of the service at Crowborough.

75 Women in the High Weald have voiced their strong concerns about a disjointed maternity care pathway, with different parts of their care being provided by different trusts and midwife teams. This situation does not, in their experience, make for a seamless, flexible care pathway and effective continuity of care. There has been significant adverse media attention over the last year and number of senior staff have left.

76 All of these factors are collectively undermining women's confidence in using the services at CBC. The Friends of Crowborough Hospital are now very concerned that there has been such a significant drop in birth numbers that the viability of the CBC has now been undermined. In 2010 the number of births at CBC was 322 and rising; however, since 2010 when the scanning facility closed, the number of births began to fall.

77 Clinically robust alternative arrangements are urgently needed to enable local providers to re-join maternity services in this area and deliver services more cost effectively. Overcoming the pathway and other issues will raise confidence and thus enable women, when trying for a low risk midwife-led birth, to be safe in the safe knowledge that they would have easy access to local consultant-led care.

HOSC findings on CBC

78 HOSC's findings on CBC are as follows:

- Consultation in Crowborough amongst the public and medical community has overwhelmingly supported CBC.

- Maternity services in Eastbourne or Hastings do not currently provide a natural pathway for women residing in the North Weald requiring obstetric services.
- The maternity care pathway, and especially the links between CBC and Pembury, need to be addressed as a matter of urgency.
- Women should have the opportunity to give birth at CBC with the option to go to, or transfer to, Pembury seamlessly should an obstetric service be required or requested.
- The administrative pathway issues current being experienced (such as formats of patient notes and booking arrangements operating differently in different trusts) should be resolved as a matter of urgency.
- Obstetric scanning should be reintroduced at CBC as one step towards improving services and confidence locally.
- With all these improvements and focus on long term service improvements, the number of births at CBC can be increased and the unit made sustainable. (See recommendation 2)

Population and demographics data and projections

79 In 2011/12 there were 5,500 births amongst East Sussex residents and there is already a substantial flow of patients to units outside the county as illustrated by this table:

East Sussex resident births 2012	
Eastbourne District General Hospital	1,919
Conquest Hospital	1,790
Royal Sussex County Hospital (Brighton)	584
Princess Royal Hospital (Haywards Heath)	425
Tunbridge Wells Hospital (Pembury)	356
Home	167
Crowborough Birthing Centre	178
Other	82
Total	**5,501**

80 The number of mothers delivered in ESHT services in 2011/12 was 4,091, and the number in 2012/13 was 4,047; a decrease of approximately 1%.

81 The number of births in ESHT services from May to October 2013 was 1,827: an average of 305 births per month. Public Health projects a decline in births in East Sussex between 2012 and 2021 due to:

- A decline in the number of women of childbearing age (15-44) due to changes in net migration levels for this age group.
- A decline in the average number of children that women are having (the total period fertility rate).

82 The largest predicted decrease in East Sussex is around 24% in Eastbourne. The number of births for East Sussex as a whole is expected to decline by 9%.

83 The model used has some limitations and will need to be continually revised in future. As with any model, its predictions become less certain the further into the future you go. The model is based on migration from the five previous years and includes the housing information supplied by the district and borough councils contained in their strategic plans.

84 The CCGs' interpretation of the population modelling data is that the number of births in East Sussex would need to increase by some 50% to more than 6,000 per year before two East Sussex consultant-led units would become viable. This scenario is considered by the CCGs to be inconceivable in the foreseeable future based on available data.

HOSC findings on population, demographics and projections

85 HOSC's findings on population, demographics and projections are:

- The population and demographics data that support the proposals are the best available under current models.
- There would need to be a significant variation from projected number of births for there to be a material impact on the proposed service configuration options.
- HOSC expects the CCGs to address factors such as population projections deprivation factors, perceived risk factors there are issues in both the Eastbourne and Hastings areas that need careful consideration when planning maternity related services.

Paediatric services

In-patient paediatric services

86 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:

- a national shortage of children's doctors
- inadequate nurse staffing levels or an inappropriate mix of skills
- 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 highlighted by the Francis Inquiry.

87 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 consultant-led maternity services because of the clinical co-dependencies between obstetrics, gynaecology and neonatology. The Royal College report recommended that the level at which the SCBU is functioning should be reviewed.

88 Following the 2008 IRP report, ESHT considered that there was uncertainty about whether it could maintain the staffing levels of middle grade doctors and thus reconfigured paediatric services to a single site (at the Conquest) at the same time as the obstetrics reconfiguration. Paediatric services have been reviewed by the CCGs to determine the type of service and the staffing model that would best meet the needs of East Sussex. Since the May 2013 reconfiguration, activity in this service has not declined.

89 The reconfigured services have had an impact on BSUH which has reported an increase in emergency paediatric attendances and admissions from 188 (April to December 2012) to 341 (April to December 2013). No other impact has been reported by other surrounding Trusts regarding paediatric services.

Short stay paediatric assessment units (SSPAUs)

90 The standalone Short Stay Paediatric Assessment Unit (SSPAU), currently situated at EDGH, is open from 7am to 9.30pm (last admission at 7pm) on weekdays, and 10am to 6.30pm (last admission at 4pm) at weekends and bank holidays.

91 The alongside SSPAU, currently situated at Conquest Hospital, is open from 7am to 9.30pm (last admission at 7pm) on weekdays and is not open on weekends.

92 During the consultation, concerns emerged about transfer times, associated anxiety, especially at night time, and for those children with longer term conditions. SSPAU opening hours were not part of the Better Beginnings consultation. The CCGs are undertaking analysis of the case mix and number of children attending the SSPAUs to identify: peak times of usage, the optimum opening hours for a SSPAU, and potential ways to reduce the number of children requiring a transfer.

93 In the small number of cases where children require transfer, a robust protocol is needed to ensure that the intended destination is clearly communicated and agreed amongst all parties in a timely manner. SECAmb has indicated a preference for minimal variation in the times of service provision.

94 The CCGs state they will review all these factors as part of ongoing work to ensure that services are aligned with need.

HOSC findings on paediatric services

95 HOSC's findings on paediatric services are as follows:

- Co-locating inpatient paediatric services with the consultant-led obstetric unit makes sense based on the evidence available.
- Siting a Special Care Baby Unit (SCBU) alongside the obstetric unit should allow for redevelopment of neonatal services with improved staffing levels and standards of care.
- The current opening times for the SSPAU at Eastbourne currently does not align with peak periods of need.

Financial viability

96 The CCGs stated throughout the engagement and consultation that this reconfiguration is primarily about safety and sustainability. There is a national tariff for 'payment by results' which sets the amount commissioners (the CCGs) would expect to pay for services including maternity and paediatrics and most other specialties. The financial appraisal of the six options are as follows:

Capital and revenue differences for Better Beginnings Options compared to current arrangements						
Capital	Option 1 £m	Option 2 £m	Option 3 £m	Option 4 £m	Option 5 £m	Option 6 £m
Estimated Capital Investment	9.430	2.784	9.430	3.230	8.984	2.116
Revenue Differences	Option 1 £000	Option 2 £000	Option 3 £000	Option 4 £000	Option 5 £000	Option 6 £000
Revenue impact of Capital	802	237	802	275	764	180
Other expenditure differences	-52	-52	-83	-83	0	0
Total Revenue Differences	750	185	718	191	764	180

97 The CCGs explained that in the normal scheme of things, the costs associated with any capital investment would normally be met by the provider. ESHT undertakes approximately £10 million capital expenditure annually and anticipates that an application would be needed to the Department of Health for an additional loan to fund all or most of any investment required.

98 The changes in the CCGs' spending power that vary from year to year, which is determined by a range of factors such as inflation, demographics, or technological changes.

HOSC findings on financial viability

- The Conquest appears sufficiently well equipped to be a single consultant-led unit, albeit temporarily.
- EDGH has a decommissioned theatre and an apparent lack of space for any further expansion. If a consultant-led unit were to be at EDGH, additional capital would be needed for the equipment, infrastructure and space.
- All the options involve some additional capital investment.
- Facilities will need to be upgraded or modernised in the longer term (at all units) to provide an excellent, modern obstetric service with due consideration given to the number of beds required.

The consultation

The CCGs' engagement process

99 CCGs undertook the 'Better Beginnings' consultation with members of the public across the whole of East Sussex. Methods used included: online and social media, targeted focus groups, one-to-one interviews, media campaigns and market place events.

100 In addition, focus groups were established to capture the views of specific groups identified through an equality analysis. The groups were: gypsies and travellers, migrants, carers, young parents and service users with a disability.

101 Many members of the public sent comments to HOSC directly. Appendix 2 (page 33) summarises these comments.

Consultation with GPs

102 The CCGs consider that they have taken many opportunities to elicit the views of GPs at regular locality meetings with practice representatives, through email, questionnaires, telephone calls, newsletters and face-to-face discussions. They have attended cluster meetings and the locality meetings and have talked to individual practices and GPs about their concerns.

103 The Campaign groups alleged that much of the evidence compiled by the CCGs' for the consultation were compiled by people who were not independent. For example, the GPs who sit on CCG boards are in favour of the single site option.

Healthwatch

104 Healthwatch worked as an independent advisor with the CCGs on the community and engagement programme and assisted with the equality impact assessment to identify communities impacted by the proposals. The CCGs commissioned Healthwatch to run independently-chaired focus groups to inform and gather evidence from affected groups.

105 Public focus groups were held in Hastings, Eastbourne and Uckfield. Invitees included: campaign groups, local MPs, CCGs, clinical leads, patient and public involvement leads from CCG boards. Two independent maternity and paediatric specialists attended the Uckfield event. Three common key themes emerged:

- Concern about travel and transfer times: the perception that longer journeys increase risk and therefore impact on safety
- Concerns about the robustness of the evidence from before the temporary reconfiguration (May 2013) used to justify the CCGs' case for a single site option
- The process if there isn't unanimity about the chosen options amongst the three CCGs.

106 At Eastbourne the discussion focussed on:

- why a two-site option was not being considered
- paediatrics – with particular concerns about transfer times, associated anxiety, especially at night time and for those with longer term conditions
- confusion arising from information available to the public (about paediatric services)
- concerns about the long term future of the hospital because some felt that the decisions relating to maternity, paediatrics and gynaecology would impact on the long term future of EDGH

107 At Hastings the discussion focussed on:

- why a two-site option was not being considered
- the staffing issues at the Conquest
- how the views of local communities, who weren't fully engaged currently, could be captured as only ten members of the public attended the focus group (the smallest public turnout of the three)

108 At the Uckfield event the discussion focussed on:

- concerns about current choices available to women and how they are (not) working in practice
- concerns around patient flows at CBC, the handling of patient notes and the compatibility of patient record formats between units (Healthwatch requested that HOSC address these issues in its recommendations).

109 Healthwatch considered all three events a success. Further observations from the events were:

- Overall, all the public questions were answered comprehensively at all the events. However, not every member of the public necessarily accepted all the answers provided.
- The reason for the relatively low turnout in Hastings, suggested by one of the public participants at that meeting, was that there was already an obstetric unit at the Conquest and a widespread assumption that that would continue automatically.
- There was a mixed audience at the Uckfield event: a blend of people who had used CBC, with tremendous support for the unit from all age ranges. The consensus was that mothers from this area would not travel to EDGH or the Conquest as a natural pathway.
- More people in Eastbourne than in Hastings said they were unhappy with a one-site obstetric option.

HOSC findings from the consultation

110 HOSC's observations and findings from the consultation process were:

- The CCGs' consultation process was extensive, well organised and well publicised.
- The time allowed for consultation with the public was sufficient.
- The content of the full consultation document was sufficiently clear and detailed.
- The consultation amongst medical practitioners provided every opportunity for them to give their views.
- The engagement of Healthwatch to run focus groups proved helpful and innovative.
- The online questionnaire was amended after a week into the consultation following an alert from the HOSC Chair; the amendment made it possible for consultees to complete the questionnaire without having to specify a preferred option.
- The independent analysis of the consultation concluded, as its headline finding, that the two most preferred service delivery options from the survey were for Options 5 (24.6% of responses) and 6 (24.8% of responses) with the vast majority of respondents preferring the option which provided the most services closest to where they lived. (see recommendation 1).
- The main issues and concerns emerging from the consultation were: location of services; travel and transport difficulties; the need to consider population size, growth and the needs of specific population sub-groups (see recommendation 1); and a strong desire to retain the CBC (see recommendation 2).
- Towards the end of the consultation period, there was evidence of considerable support for two campaigns: Option 7/'Save the DGH' (full consultant-led services at both Eastbourne and Hastings) and the 'Oppose the Conquest maternity downgrade' campaign."

Appendix 1: HOSC membership and project support

Committee membership

East Sussex County Council Members (Voting)

Councillor Michael Ensor (Chair)
Councillor Frank Carstairs
Councillor Kim Forward (from April 2014)
Councillor Ruth O'Keeffe (Vice-Chair)
Councillor Peter Pragnell
Councillor Alan Shuttleworth
Councillor Bob Standley

District and Borough Council Members (Voting)

Eastbourne Borough Council
Councillor John Ungar

Hastings Borough Council
Councillor Dawn Poole – until 4 June 2014

Lewes District Council
Councillor Elayne Merry – until 19 May 2014
Councillor Jackie Harrison-Hicks – from 20 May 2014

Rother District Council
Councillor Angharad Davies – except 19 June 2014 HOSC
Councillor Bridget George – substitute at 19 June 2014 HOSC

Wealden District Council
Councillor Mrs Diane Phillips

Voluntary Sector Representatives (Non-voting)

Ms Julie Eason (SpeakUp)
Ms Jennifer Twist (SpeakUp)

Project support – East Sussex County Council

Project Manager: Paul Dean
Project Support: Harvey Winder

HOSC email: healthscrutiny@eastsussex.gov.uk
HOSC website: www.eastsussexhealth.org

Committee meeting dates

10 January 2014, 17 February 2014, 20 March 2014, 19 June 2014

Witnesses providing evidence to HOSC

The Task Group would like to thank all the witnesses who provided evidence:

10 January 2014

Eastbourne, Hailsham and Seaford CCG/Hastings and Rother CCG
Amanda Philpottt, Joint Chief Officer
Catherine Ashton, Associate Director of Strategy and Whole Systems Working
Jessica Britton, Associate Director of Quality and Assurance
Dr Martin Writer, Chair Eastbourne, Hailsham and Seaford CCG

High Weald Lewes Havens CCG
Dr David Roche, High Weald locality Chair
Frank Sims, Chief Officer
Ashley Scarff, Head of Commissioning and Strategy

East Sussex Healthcare NHS Trust
Dr Amanda Harrison, Director of Strategic Commissioning and Assurance

17 February 2014

High Weald Lewes Havens CCG
Frank Sims, Chief Officer

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

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

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

Friends of Crowborough Hospital
Richard Hallett

East Sussex County Councillors
Councillor Richard Stogdon (Crowborough Division)

MPs
Stephen Lloyd MP, Eastbourne and Willingdon

20 March 2014

High Weald Lewes Havens CCG
Ashley Scarff, Head of Commissioning and Strategy
Dr David Roach, GP
Michael Rymer, Secondary Care Doctor Member, Consultant Gynaecologist, Western Sussex Hospitals NHS Trust

Eastbourne, Hailsham and Seaford CCG / Hastings and Rother CCG
Jessica Britton, Associate Director of Quality and Assurance
Amanda Philpott, Joint Chief Officer
Dr Martin Writer, Chair Eastbourne, Hailsham and Seaford CCG

East Sussex Healthcare NHS Trust
Darren Grayson, Chief Executive
Dr Amanda Harrison, Director of Strategic Commissioning and Assurance
Dr Andy Slater, Clinical Director (Strategy) and Clinical Unit Lead, Paediatrics

Dexter Pascall, Clinical Lead Obstetrics
Paula Smith, Associate Director of Nursing for Women and Children's Services
Lindsey Stevens, Head of Midwifery and Assistant Director of Nursing
Stuart Welling, Chair

Healthwatch
Julie Fitzgerald, Director East Sussex Community Voice

South East Coast Ambulance NHS Foundation Trust (SECAMB)
James Pavey, Senior Operations Manager

Public Health, East Sussex County Council
Martina Pickin, Public Health Consultant

HOSC Member visits

Crowborough Birthing Centre, 3 March 2014

Conquest Hospital Labour Ward, 6 March 2014

Eastbourne Midwifery Unit, Eastbourne District General Hospital, 7 March 2014

Written evidence schedule

1.	**Evidence from national bodies and other published evidence**	
1.1	**State of Maternity Services Report 2013 (The Royal College of Midwives)** Details birth rates, increases in complex births, and the scale of the national shortage of midwives.	**Evidence Pack 1** P. 7
1.2	**Birthplace programme overview; November 2011 (Birthplace in England Collaborative Group)** A report on the costs and outcomes of giving birth in different settings in the NHS in England.	**Evidence Pack 1** P. 23
1.3	**Reconfiguration of Women's Services in the UK; December 2013 (Royal College of Obstetricians and Gynaecologists)** A guide to understanding the reconfiguration of women's health services.	**Evidence Pack 1** P. 67
1.4	**Royal College of Obstetricians and Gynaecologists (RCOG) Good Practice No. 10: Labour Ward Solutions; January 2010** A document highlighting the challenges and issues that arise from expanding the consultant presence on a maternity ward.	**Evidence Pack 1** P. 79
1.5	**Emergency surgery standards for unscheduled surgical care; February 2011 (The Royal College of Surgeons of England)** A report on the standards for the care of unscheduled adult and paediatric surgical patients.	**Evidence Pack 1** P. 103
1.6	**Independent Reconfiguration Panel (IRP) report; July 2008** The IRP report to the Secretary of State for Health on the proposals for changes to maternity, special care baby services and inpatient gynaecology services in East Sussex in 2008.	**Evidence Pack 1** P. 187
1.7	**National Clinical Advisory Team (NCAT) Review of ESHT Maternity and Paediatric Services; January 2013** A review of East Sussex Healthcare NHS Trust's (ESHT) proposals to	**Evidence Pack 1** P. 231

	temporarily change the configuration of maternity, gynaecology and paediatric services.	
1.8	**Royal College of Obstetricians and Gynaecologists (RCOG) review of the Obstetric and Neonatal Services of ESHT at Conquest Hospital; August 2013** An independent review of ESHT's temporary reconfiguration of maternity services at the Conquest Hospital.	**Evidence Pack 1** P. 247
1.9	**Royal College of Paediatrics and Child Health Service review of ESHT; November 2013.** An independent review of ESHT's temporary reconfiguration of paediatric services.	**Evidence Pack 1** P. 263
2	**Evidence from Clinical Commissioning Groups (CCGs)**	
2.1	**Better Beginnings consultation document; 2014 (Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG, & High Weald Lewes Havens CCG)** The primary consultation document explaining the proposals for the future of NHS maternity, in-patient children's services and emergency gynaecology in East Sussex.	**Evidence Pack 1** P. 309
2.2	**Maternity and Paediatric Needs Assessment: Appendix 12 of Pre consultation business case for maternity and paediatric services in East Sussex; December 2013 (Public Health)** A maternity and paediatric needs assessment of East Sussex's population from late 2013.	**Evidence Pack 1** P. 349
2.3	**CCGs' response to Mr Hallett's report on Crowborough Birthing Centre; 2014** See 3.3 below for original report.	**Evidence Pack 3** P. 31
2.4	**CCGs' summary of the proposed delivery options and intentions for public consultation; 10 January 2014**	**10 January Agenda** P. 3
2.5	**CCGs' response to the issues raised by HOSC at the meeting held on 10 January 2014; 17 February 2014**	**17 February Agenda** P. 7
2.6	**CCGs' response to the issues raised by HOSC at the meeting held on 17 February 2014; 20 March 2014**	**20 March Agenda** P. 27
2.7	**Independent Analysis of the Better Beginnings Public Consultation in East Sussex: 14th January – 8th April 2014, Final summary report; April 2014 (Dr Lester Coleman and Dr Nigel Sherriff)** An independent analysis of the results of the Better Beginnings consultation.	
2.8	**Better Beginnings Consultation Review; April 2014 (Verdant)** An independent report reviewing how the CCGs planned and carried out the Better Beginnings consultation.	

2.9	**CCGs' response to a consultation submission received from a campaign group; April 2014** A response by the CCGs to Save the DGH's submission to the consultation: "Option 7, The Campaign Option".	
3.	**Evidence from campaign groups and stakeholders**	
3.1	**Save the DGH Evidence:** • Save the DGH campaign statement • Notes of meeting with Yeovil NHS Trust • Notes of meeting with Hinchingbrooke NHS Trust • 'Homebirth and the Future Child'; 22 Jan 2014 (Lachlan de Crespigny, Julian Savulescu) • EDGH to Conquest by public transport	**Evidence Pack 1** P. 417
3.2	**Review of Obstetric Scanning at Crowborough; June 2012 (Crowborough Birth Centre Stakeholder Consultation Group)** A review of Obstetric Scanning at Crowborough Birth Centre.	**Evidence Pack 1** P. 453
3.3	**Maternity Services in the High Weald Locality: Not where…but how & by whom; Revised Edition, March 2014 (Richard Hallett)** An alternative viewpoint affecting maternity services for the people of Crowborough and the High Weald.	**Evidence Pack 2** P. 517
3.4	**ESHT's Board Assurance Framework; 29 January 2014** A standing item on ESHT's Trust Board containing the strategic priorities and objectives of ESHT, the associated risks and the controls in place.	**Evidence Pack 2** P. 535
3.5	**Outcomes of Healthwatch public Question Time events; 2014** A report on the outcomes of the public Question Time events held by Healthwatch on the Better Beginnings proposals.	**Evidence Pack 3** P. 13
3.6	**ESHT Staff Side Committee comments; 17 March 2014** A letter from ESHT's Joint Staff Committee providing a summary of how staff view the temporary reconfiguration.	**Evidence Pack 3** P. 29
3.7	**Option 7, The Campaign Option; 2014 (Save the DGH)** A submission from the campaign group, Save the DGH, on the future of maternity and paediatric services in East Sussex.	**Evidence Pack 3** P. 43
3.8	**Maternity and paediatric services at ESHT, 2008-2013; 2014** A PowerPoint presentation by ESHT to accompany the evidence the Trust gave at the 20th March HOSC meeting.	**Evidence Pack 3** P. 89
4.	**Evidence from members of the public**	
4.1	**Summary of comments from members of the public** A summary of the comments HOSC received from members of the public and three groups, including Eastbourne Borough Council.	**Appendix 2**
4.2	**Data on road closures and delays on A259; 12 March 2014 (Highway's Agency)** Data supplied, in response to a FOI by a member of the public, on journey reliability and road closures on the A259 between Pevensey Bay and Hastings	**Evidence Pack 2** P. 577

	from September 2012-December 2013.	

Links

Evidence Pack 1 || **Evidence Pack 2** || **Evidence Pack 3**

10 January 2014 Agenda || **17 February 2014 Agenda** || **20 March 2014 Agenda**

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Appendix 2: Comments received by HOSC

HOSC publicised a request for public *comments* over the same period as the formal consultation undertaken by the CCGs.

HOSC received 415 individual emails and letters in respect of the proposed changes to maternity and paediatric services. Towards the end of the consultation period, HOSC received many emails and letters in support of two campaigns: Option 7/'Save the DGH' (full consultant-led services at both Eastbourne and Hastings) and the 'Oppose the Conquest maternity downgrade' campaign." This mirrored the response to the consultation exercise undertaken by the CCGs.

HOSC received 415 comments in total.

51 comments were from people who have used the temporarily reconfigured services (since May 2013).

Three groups sent comments: Eastbourne Borough Council, Groombridge and Hartfield Medical Group (a patients participation group), and Friends of the Eastbourne Hospital.

1. Overall view

Opposed to all proposed single site options	In favour of a proposed single site option	Support the retention of Crowborough Birthing Centre (CBC)
385	**3**	**30**

*Two respondents were in favour of a single site option and of retaining the CBC. One respondent was opposed to any single site option and supported retention of the CBC

2. Location (by Clinical Commissioning Group area)

Unknown	Eastbourne, Hailsham and Seaford CCG (BN20-BN26)	High Weald Lewes Havens CCG (BN8, TN3, TN7, TN21)	Outside East Sussex	Hastings and Rother CCG
376	**35**	**4**	**2**	**0**

3. What people said

Here is a summary of the main issues raised by members of the public in their comments to HOSC, alongside the number of times each issue was raised. Some people raised more than one issue.

Comment	No. of occurrences
Option 7 - Expressed a preference for "Option 7", the consultation submission from the campaign group, Save the DGH.	321
Travel/transfer - Expressed concern over the risk to the safety of patients having to travel from the Eastbourne area to Conquest Hospital, or transfer from Eastbourne District General Hospital (EDGH) to Conquest Hospital. • **12** comments were from people who have been transferred to the Conquest Hospital	214

Comment	No. of occurrences
by ambulance.	
Population of Eastbourne – Felt that Eastbourne was a large town with a growing population and should have full consultant-led services at EDGH.	147
Access – Concerned that relatives of patients would have difficulty visiting the Conquest Hospital if they lived in Eastbourne or the surrounding area.	79
Temporary single site – Concerned about overcrowding and understaffing, and the quality of care at the temporary single site maternity and paediatric units at Conquest Hospital. • **26** comments based on personal experience of the units.	45
Support the Crowborough Birthing Centre (CBC) – Expressed support for the retention of the midwife-led unit at CBC. Gave various reasons, including: • the CBC should not be closed on a temporary basis due to staff shortages; • the south coast is too far for pregnant women in the High Weald area to travel; • services at CBC should be run by Maidstone and Tunbridge Wells NHS Trust; • the full range of services usually available at a midwife-led unit should be available at CBC, for example, scanning facilities.	30
Money saving – Claimed that the Better Beginnings consultation was being carried out for financial reasons rather than the stated clinical reasons.	14
"Not done enough" – Claimed that ESHT has not done enough to retain two consultant-led sites. Claimed that ESHT was: • not carrying out the Secretary of State's 2008 recommendations; • not offering the right incentives to recruit the right staff; • failing to maintain sustainable maternity units despite other trusts managing to do so with a similar number of births.	10
In favour of a proposed single site option – Felt that one of the six proposed options in the Better Beginnings consultation was acceptable.	3
Staff travel – Concerned that staff would have to travel further to get to work.	2

Appendix 3: Glossary of terms used in this report

BBA	Born-before-arrival
BSUH	Brighton and Sussex University Hospitals NHS Trust
CBC	Crowborough Birthing Centre
CCG	Clinical commissioning group
CQC	Care Quality Commission
EDGH	Eastbourne District General Hospital
EMU	Eastbourne Midwifery Unit
ESHT	East Sussex Healthcare NHS Trust
HOSC	(East Sussex) Health Overview and Scrutiny Committee
IRP	Independent Reconfiguration Panel
KSS Deanery	Kent, Surrey, Sussex Deanery
MCYP SCN	South East Coast Strategic Clinical Network – Maternity, Children and Young People
MLU	Midwife-led unit
MTW	Maidstone and Tunbridge Wells NHS Trust
NCAT	National Clinical Advisory Team
Pembury	Tunbridge Wells Hospital
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
RSCH	Royal Sussex County Hospital
SCBU	Level 1 special care baby unit
SECAmb	South East Coast Ambulance NHS Foundation Trust
SSPAU	Short stay paediatric assessment unit
The Conquest	The Conquest Hospital, Hastings