

**EAST SUSSEX DOWNS & WEALD PRIMARY CARE TRUST
AND
HASTINGS & ROTHER PRIMARY CARE TRUST
JOINT COMMITTEE MEETING**

Date: 20th December 2007

ITEM NO: 11

Title of report:

Chief Executives report on the outcome of the 'Creating an NHS Fit for the Future' consultation on obstetric, specialist baby care and inpatient gynaecology services.

Recommendation:

The Joint Committee are asked to discuss the report, and approve the following recommendations:

1. That the PCTs support a single site option for consultant led maternity services (plus a Special Care Baby Unit and inpatient gynaecology on the same site) subject to the following conditions:

- The strengthening of ante and post natal care specifically the development of further community outreach services including health visiting and community midwifery. This to build on existing services already delivered through children's centres.
- The adoption of the 'top ten' recommendations set out in the Confidential Enquiry into Maternal Death report (December 2007)
- Training of ambulance crews in advanced obstetric life support.
- Strengthening of risk assessment protocols for midwifery led care including adoption of the national obstetric early warning chart and the implementation of the safe practice from Crowborough for the transfer of women in early labour where any complications are identified.
- Achieving 60 hours of consultant presence on labour ward over a full seven day week.
- The minimisation of unplanned closures which are unacceptable.
- Agreement to establish emergency protocols for managing women in the community to ensure that in all cases women are in receipt of appropriate care.
- Movement towards 'Birthrate Plus' staffing levels to ensure there will be 1:1 care for women during labour.
- Implementation of the NICE guidance to affirm that women should be offered choice and to guide mothers in their decision on place of birth.
- Endorsement of the establishment of clinical indicators as the tool to monitor delivery of maternity services.

<ul style="list-style-type: none"> ▪ Acceptance of HOSC recommendations. ▪ Adoption of best practice in managing the implementation plans taking account of the learning from experiences elsewhere in the UK (including Northwick Park) to ensure a safe transition. ▪ Development and implementation of a maternity strategy to support the strengthening of community services for maternity. ▪ The development and implementation of a robust communications plan. ▪ The development and implementation of a robust transport plan. ▪ Commitment to implementing the above through the Strategic Commissioning Plan. The PCT will be full partners in delivering the agreed changes with East Sussex Hospitals Trust.
<p>2. That the single site be Hastings with a midwife-led birthing centre at Eastbourne, alongside the existing birthing centre at Crowborough.</p>
<p>Summary : The East Sussex PCT's 'Creating an Fit for the Future' formal public consultation on obstetric, specialist baby care and inpatient gynaecology services commenced on 26 March 2007, and closed on 27 July 2008. The proposals set out in this paper focus on key recommendations that the Joint Committee are asked to consider. The context for these changes is a clear commitment from both PCTs, working with the providers of maternity services, to develop and enhance all aspects of maternity care – from conception and ante natal care through a choice of place of birth, safe high quality care during delivery and effective post natal care.</p>
<p>Health Impact The Fit for the Future programme will enable the PCT's to deliver effective and seamless care for patients to further its ambition for better health and healthcare for people who live in East Sussex. Options for consultation have been assessed against both clinical effectiveness and health gain for the population.</p>
<p>Financial Implications A financial option appraisal of all the options was conducted as part of the post consultation analysis.</p>
<p>Legal Implications n/a</p>
<p>Link to report on Assurance Framework – yes, AF Reference 1 and 14</p>
<p>Equality Impact Assessment Completed: (ONLY REQUIRED FOR POLICIES or SERVICE SPECIFICATIONS, THIS MUST BE COMPLETE FOR THESE DOCUMENTS TO BE RATIFIED BY THE BOARDS) YES; presented to both the Boards in September 2007</p>
<p>Patient and Public Engagement Patients and members of the public have been involved throughout the consultation process, and the paper describes ongoing communication and engagement plans.</p>
<p>Further information from Name: Nick Yeo, Chief Executive Tel: 01424 735617</p>

DATE OF REPORT: December 2007

AUTHOR: Nick Yeo
Chief Executive

Chief Executives report on the outcome of the 'Creating an NHS Fit for the Future' consultation on obstetric, specialist baby care and inpatient gynaecology services.

SECTION ONE: Introduction

The public consultation in East Sussex which was launched on 26 March 2007 and ended on 27 July 2007 was part of the Surrey and Sussex-wide programme called 'Creating an NHS Fit for the Future'. This was based on discussion that had started in the summer of 2006 following recognition by NHS organisations that health services in the south east of England must change and adapt.

Health needs are changing; people's expectations about what the NHS should deliver are, rightly, rising. In East Sussex patients are benefiting from advances in medical technology, new drugs, and new care standards. The PCT has recognised that we need to maximise the use of our resources to make sure that we continue to make progress, delivering shorter waiting times and better outcomes, while giving staff better training and acceptable working hours.

The PCT involved as many people as possible in developing proposals for consultation, which were assessed against the pre-criteria of quality and safety, access and value for money. The overall vision for GP and community services, emergency care, planned care and special care and gynaecology services and children's services were set out in the consultation document. The aim of the consultation was to review the current pattern of services against the future health needs of the population, developments in clinical practice and the resources available in order to determine whether and where change was required.

The public consultation outlined the proposed high level direction of travel for health services and made some specific proposals to reconfigure maternity, inpatient gynaecology and special care baby services. The PCTs led the consultation process because we assess needs and plan the pattern of services required for the local population, before commissioning these services from NHS trusts and other providers. In undertaking this process both PCTs expressed their absolute commitment to maintaining two viable Hospitals in East Sussex and to retaining Accident and Emergency Services on both sites. This is supported by the Academy of Royal Colleges Working Party Report (2007) which supports the retention of emergency services on sites which do not provide all medical and surgical services.

SECTION TWO: The case for change

The PCTs considered both the current situation within maternity services and future trends in determining whether there was a case for change. The Clinical Director for Women's Health has described the current position as being 'at the margins of safety'. There are a number of reasons for this including:

- Consultant staff are being stretched across two sites and are unable to offer significant labour ward presence. More labour ward cover has been identified nationally as a key measure that is required to improve safety.
- There is less availability of experienced middle grade staff. Middle grades are able to take clinical decisions and seek advice appropriately. This is essential for the safe operation of the service. More experienced middle grade staff would be attracted to working in a centre with a more varied case mix and a more robust consultant presence.
- There are unplanned closures of both units caused by staffing difficulties and other operational pressures.

The combination of these factors means that the maternity service is unsustainable in its current form. These pressures for change will only grow in the immediate future. Maternity services will have:

- Difficulty maintaining CNST level 3 status. ***Maternity Matters*** indicates that *'there is a strong possibility the CNST will increase the standard to 60 hours'* (of consultant presence) – this is well in excess of what is being achieved now and difficult to achieve across two sites under any circumstances.
- Difficulty in attracting the best staff within the current environment with limited opportunity for skills enhancement and sub specialisation.
- Difficulty introducing the EU Working Time Directive in 2009 which will require shorter hours of working and further reduce the availability of medical staff.
- A physical environment that does not meet modern standards for maternity care and will need upgrading.

These factors together mean that the PCTs came to the view that maternity services needed to be changed and improved to enable the current and future challenges to be met in order to deliver a safe, high quality service for women.

SECTION THREE: Pre consultation engagement

In May 2006, the Surrey and Sussex Strategic Health Authority (now called South East Coast) published a discussion document entitled *Creating an NHS Fit for the Future*. This followed a detailed review of local healthcare and included a number of recommendations about the principles that should underpin local service re-design.

The document was distributed amongst stakeholders to stimulate discussion and three large stakeholder events were held during June 2006 in Eastbourne, Bexhill and Uckfield. In addition, key PCT staff attended over 60 pre-consultation meetings to present the document and invite feedback. These meetings covered a wide range of stakeholders including staff, independent contractors, the East Sussex Health Overview and Scrutiny Committee (HOSC), Patient and Public Involvement Forums, Local Strategic Partnerships, MPs and voluntary and community organisations. All feedback from this process informed the further development of local proposals for change.

This early discussion phase was consolidated with two further activities to enhance the process of engagement: a co-design event (in August 2006) and a deliberative event (in September 2006). The co-design event provided a basis for the subsequent development of an iterative engagement plan, and the deliberative event further tested out thinking around the priorities of local people.

Follow up stakeholder events were held in Eastbourne, Hastings and Uckfield during October 2006 to share thinking and emergent scenarios arising from the process to that point. Clinical workshops were also held throughout November 2006.

Three further pre-consultation events were held in January 2007 where there was an opportunity to present more information on the drivers for service modernisation and the potential options to be included for formal consultation. Participants also undertook group work to consider possible criteria for decision-making and to suggest ways to ensure the formal consultation would be inclusive and wide ranging. Alongside this, key interested parties such as the media, MPs and local councillors and NHS staff were briefed during the pre-consultation phase.

A public reference group was established in early February 2007 in order to ensure that patient and public perspectives were considered throughout the development of the Fit for the Future Programme in East Sussex and to oversee and assess the consultation process from a patient and public perspective. HOSC agreed the proposed process for consultation and engagement at a meeting on 23 March 2007 and formal consultation began on 26 March 2007.

SECTION FOUR: Consultation responses

The analysis of responses to this public consultation was recognised as being critical to the decision making process. The South East coast Strategic Health Authority identified, on behalf of East Sussex PCTs, an independent analyst to collate and report trends in the consultation feedback.

The independent analyst reviewed notes from meetings, correspondence, feedback forms, emails and all other responses logged by the PCTs. The analyst transcribed quotes and key comments and assigned “trend codes” to statements to allow key trends to be quantified. The codes from every response were then entered into a database for analysis.

Between 26 March 2007 and 27 July 2007, the two East Sussex PCTs formally consulted about the proposed changes. PCT representatives took part in 87 meetings and invited people to submit written feedback using letters, feedback forms, email, and online response forms. Responses representing almost 17,000 people were received. These comprised 250 response forms, 133 letters and emails, feedback notes from 57 meetings and notes from two focus groups. In addition, a number of ‘bulk completion’ responses were received including eight petitions and a postcard petition with 1521 individual submissions.

The majority of responses were from individuals, but key groups also submitted feedback including councils, hospital trusts, neighbouring PCTs, the Maternity Services Liaison Committee, campaign groups, political parties, businesses and patient and public involvement groups and forums.

Public consultation is a process that aims to inform stakeholders about proposed changes and foster discussion, debate, and thoughtful input prior to a final decision by the PCT boards. Consultation feedback is one of many factors that the PCT boards will consider when planning next steps. A public consultation is not a referendum where people are asked to ‘vote’ for a preferred course of action, and perceived levels of support for specific alternatives are not the only factor that boards are required to bear in mind. The perceived strengths and weaknesses of different alternatives must be measured against a range of other criteria in order to determine whether they are an appropriate way forward.

In total, 92% of responses were from individuals and 8% were from organisations or groups. As the table below indicates most responses were from members of the public but a significant proportion came from NHS staff.

Type of respondent	Proportion of responses
Member of the public	82%
NHS clinical staff	8%
Non clinical NHS staff	2%
Council / Parish Council	2%
Voluntary group	2%
Patient and public involvement member or group	1%
Health organisation	1%
Campaign group	1%
MP / councillor	1%
Social services staff	<1%
Business	<1%
Total	100

The PCTs asked respondents to consider the advantages and limitations of locating a consultant-led birth service in Eastbourne or Hastings and the benefits of developing a midwife-led centre in whichever hospital did not have a consultant-led unit. Additional options were suggested during the consultation period, including the potential to locate a midwife-led unit equidistant between Hastings and Eastbourne, locating midwife-led birth centres offsite from hospital, and locating a consultant-led unit at both hospitals.

Given that the consultation is not a vote, the support for different options should be considered as one – but only one – relevant factor. Levels of support are reported here for completeness. Of the 393 letters, emails and response forms received:

- 4% supported option 1
- 2% supported option 2
- 20% supported option 3
- 21% supported option 4
- 37% supported locating a consultant-led unit at both Eastbourne and Hastings (the so-called option 5)
- In addition, the PCTs received 9263 signatures on petitions and 1521 postcards stating that two hospitals should have consultant-led birth services

As might be expected, those living nearest to Eastbourne favoured locating a consultant-led unit in Eastbourne and vice versa for those living nearest to Hastings. Organisational stakeholders such as councils, hospital trusts and neighbouring PCTs were more likely than individuals to support the PCTs' overall vision for the future and proposed changes.

According to the independent analyst the perceived advantages of each option tended to be similar. For instance, someone supporting option 1 might say that 'ease of access' was a key advantage, whereas someone else might

list 'ease of access' as a key advantage of option 2. The main things that people thought were advantageous about different options included:

- locating services in areas where there is a growing population
- staff and infrastructure savings,
- locating services where more people are within travelling distance,
- locating services to promote the highest safety, locating services to encourage greater choice,
- better geographical placement (e.g. for travel to other centres),
- supporting deprived communities,
- having a local place of birth.

These advantages applied predominantly to options 1-4. The main perceived advantage to option 5 was continuing consultant-led services on two sites, with wide access.

The main things that people thought limited different options were very similar, regardless of the particular option being discussed. For example, people might suggest that long journey times were a potential disadvantage with option 1. They might also suggest that long journey times were a potential disadvantage with options 2, 3 and 4. The most commonly mentioned disadvantages were:

- safety concerns,
- long journey times,
- lack of services in one area,
- not catering for deprived populations,
- lack of choice,
- unacceptable to the public,
- lack of capacity / too many births for one centre to too cope with,
- increased travel may have negative environmental impacts,
- increased cost of travel,
- poor public transport and resulting pressure on ambulance service,
- negative impact if staff have to move location or travel to work,
- poor facilities available at specific sites.

People commenting on option 5 did not tend to describe disadvantages, but those that were mentioned included potential increased cost, practicality concerns, and difficulty recruiting and retaining staff.

Many of the concerns expressed above are reflected in the HOSC recommendations attached to this paper as Annex 1. Reference to transport and travel concerns are particularly made in recommendations 7,12,13,14 17,and 20.The issue regarding acceptability to the public is referred to in recommendations 3 and 8.The capacity issues are referred to in recommendations 9 and10.The impact on staff is referred to in recommendations 8,18 and.23 All the HOSC recommendations have been

accepted by the PCTs. Irrespective of which particular option people supported, there were some common messages in the feedback received.

- Some health professionals and voluntary groups felt that a greater focus on midwifery-led care could help to promote straightforward birth and facilitate choice. Councils also suggested that there was an opportunity to examine how health and social care services could work together to improve care around the time of birth, and that the PCTs should take a holistic approach to planning and implementation.

The PCTs agree with the need for a greater focus on midwifery-led care. Ensuring that home birth is a real choice for all East Sussex women where appropriate will be part of the work of developing our maternity strategy, and the implementation of Maternity Matters. We will also seek to exploit more fully the opportunities presented by the development of children's centres in the most deprived communities.

- However, people wanted to ensure that midwife-led units were an added choice for local women rather than a substitute for consultant led care. There was a concern that having one consultant-led maternity unit instead of two could increase journey times for women in labour which in turn could have a negative impact on both safety and convenience. People were worried that without a readily accessible consultant-led unit, the lives of mothers and babies might be at risk.

A range of alternative locations for a midwife-led unit (beyond those specified in Options 3 and 4) and potential alternative ways to offer midwife-led care within Obstetrics Units have been explored in consideration of the alternative options that have been put forward (Options 6, 7, 10, 11 and 12). We will also expect that on the site of the main obstetric centre there remains the opportunity for women to be given midwife led care.

- People were eager for levels of deprivation to be considered in future planning, as well as the impact that changes may have on local families, staff, and the environment. Those living closest to Hastings suggested that their area had great deprivation, and some living near Eastbourne suggested that deprivation was also an issue locally.

The PCTs have taken deprivation into full account as part of the decision making criteria. Tackling deprivation and ensuring that women at highest risk receive targeted care is also a key recommendation leading to, for instance, the proposals to build upon outreach services for these women.

- Some believed that a shortage of midwives and consultants would make some of the options impractical. Others were worried about the impacts of any change on staff and potential redundancies. Many individuals and organisations questioned whether the implications of the proposals had been fully thought through.

The PCTs with ESHT have developed workforce and training plans which will ensure that staff with the right skills are available to deliver new service models. The ability to recruit and retain staff has been a key factor in our decision making.

- There was a strong feeling that the PCTs should not make their decisions in isolation. People felt that consultations currently underway about potential service changes in West Sussex and Kent may have important implications for the people of East Sussex. In particular, there were concerns about potential closures in Haywards Heath and the capacity of the Royal Sussex County Hospital in Brighton.

The PCTs have worked closely with colleagues in neighbouring health systems to ensure that the impact of any proposals for change is fully considered across organisations. Specifically views of neighbouring PCTs were sought (although the numbers of women from outside East Sussex using our maternity services is very small) and to the extent that women from East Sussex use services in hospitals outside the area the impact for those hospitals has been identified and assessed.

- People expressed concern that finances were driving change rather than safety or improved quality. There were concerns that any changes in birth services may be followed by reconfiguration of other unrelated services. The changes were seen to be the start of further closures.

The PCTs have made it clear that financial savings are not being sought through these changes and that the continuation of two viable hospitals is a key criterion in decision-making.

- There were concerns about the consultation process itself, specifically regarding its scope, the presentation of content, the accuracy of information, and the extent to which the boards will use the feedback.

The PCT commissioned an external independent review of the consultation process, and this is described in detail in section five. The review found that overall the PCTs conducted this consultation in a generally fair, adequate and appropriate manner. By comparison with other NHS public consultations there was a reasonable level of activity and a reasonable balance of responses, and a large number of alternative options for change were generated. However, there were also important lessons to be learnt for future engagement with the public. The PCTs are committed to working with partners and the public in the future to ensure these recommendations are implemented.

The consultation document asked people to describe which factors should be most important to the boards when making decisions. About 220 people reported their priorities. Among these responses, the most important factors for the boards to consider were making sure services are provided in the

safest way possible, making sure it is viable to keep two hospitals, and being able to recruit enough high quality staff.

Other factors that people wanted the boards to consider when making decisions were:

- impact on ambulance services / adequate blue light transfers available
- public demand
- reducing staff travel
- staff morale
- age of buildings and facilities available
- increasing the number of staff available
- better efficiency of services
- reducing overall travel
- access for visitors
- long-term impacts on other services and businesses
- reducing costs for less advantaged families
- offering more services in other areas (e.g. Bexhill)

To summarise, the PCTs received over 2000 responses representing more than 16,500 people. Irrespective of which option people supported, the key concerns were safety and travel time. People were also eager for levels of deprivation to be considered, as well as the impact that changes may have on local families, staff, and the environment. The PCT Boards recognise these concerns and they have formed an integral part of Board debates and discussions during the decision making process.

SECTION FIVE: The consultation process

The PCTs' formal consultation process was launched on 26 March 2007 and ran until 27 July 2007. The level of consultation activity and the balance of responses (see tables below) were reasonable by comparison with other NHS public consultations. Indeed, we do not know of any other NHS public consultation that has generated as many as nine new options for change during the course of the consultation.

Activity	Numeric
Copies of the full consultation document distributed	1555 - distributed to individuals, libraries, post offices, supermarkets, pharmacies, GP surgeries and hospitals.
Copies of the consultation document summary distributed.	18,525
PCT roadshows	2 - in Eastbourne and Hastings
Feedback formats	6 - mail, email, questionnaire, electronic feedback form, public meeting, focus group)
Consultation meetings	87 - with 1370 people attending
Focus groups	2

Response	Numeric
Response forms from individuals (hard copy and online)	250
More detailed responses delivered by mail or email (from individuals or organisations)	133
New options for change (other than the four options proposed by the PCTs) generated by the consultation.	9 - Some came from organisations and some from individuals.
Types of individuals/organisations responding	9 - Local authorities, hospital trusts, neighbouring PCTs, patient representative groups, campaign

	groups, political parties, businesses, PPI groups and forums
Petitions received (mail and email)	9 - including one postcard petition. In total 9263 people signed mail or email petitions and 2280 people appended their names to the postcard petition.

An analysis of the consultation process noted:

- The total number of response consultation forms returned by individuals was rather low
- The questionnaire in the consultation document could have been designed a little better
- The PCTs might have distributed a larger number of the full consultation documents.

However it also noted:

- The PCTs organised and/or attended a large number of meetings (87)
- And encouraged the generation of a significant number of new options (9)
- The PCTs distributed a large number of summary documents (almost 20,000)
- The formal questionnaire response rate may also have been low because a significant number of people decided to support one of the local petitions instead
- The PCTs generated a wide range of responses in different formats including hard copy questionnaires, online questionnaires, letters, emails and verbal responses (at public meetings).

The East Sussex Health Overview and Scrutiny Committee (HOSC) took a substantial interest in the public consultation. The East Sussex HOSC held a series of evidence gathering meetings to hear a range of views on the PCTs' proposals. The PCTs were fully engaged in this process and felt they were given every opportunity to fully present the case for change.

The HOSC presented a report to the PCT setting out its findings and making a significant number of recommendations to the PCTs. The recommendations have all been accepted by both PCTs (see annex 1).

Regarding the consultation process itself the HOSC concluded that the mechanisms used to engage people were adequate in principle although it noted areas for improvement in the future. HOSC felt the time allowed for responses was appropriate. HOSC's view was that content of the consultation document was not sufficiently detailed, but that additional information was made available to supplement this during the consultation.

SECTION SIX: Post consultation analysis

New Options Assessment Panel

In the consultation document *Creating an NHS Fit for the Future* the boards of East Sussex Downs and Weald Primary Care Trust and Hastings and Rother Primary Care Trust stated as a specific objective that they wanted... “to see if there are any realistic, cost-effective and preferred alternatives to those outlined in this document.”

In order to help us assess the various new options that were tabled during this consultation programme we established a New Options Assessment Panel – chaired by Professor Stephen Field (the former Dean of the NHS West Midlands Workforce Deanery) – to review emerging alternative proposals (to those presented by the Primary Care Trusts in their consultation document) and to establish whether there was any common ground between clinicians, health service managers and the proposers or sponsors of any emerging options.

Professor Field’s role was to chair formal meetings of the panel, facilitate discussion around any new options, seek to find consensus on any new proposals, raise questions with proposers/sponsors of new options to test out their proposals and seek any other expert opinion as may be necessary.

As a result of the work of the New Options Assessment Panel ten new options were considered (in addition to the four options placed on the table by the PCTs). The panel considered that eight of these options should go forward for further consideration and two should not. (Option 5 was considered as two options Option 5a and Option 5b with variations in the medical staffing model.)

The PCTs have also received the views of East Sussex Hospitals Trust on all of the options that were recommended by the New Options Assessment Panel.

Non – financial option appraisal

Following the work of the New Options Assessment Panel – and using its report as their starting point - board members from East Sussex Downs & Weald PCT and Hastings & Rother PCT conducted a formal (non-financial) appraisal of all the options remaining in the public domain after publication of the report of the New Options Assessment Panel. This included the four options proposed by the PCTs themselves and a total of eight other options proposed by other parties. This option appraisal took place in Lewes on Tuesday 13 November. It was chaired by an external facilitator and voting technology was supplied by an external contractor.

The options considered by the option appraisal process were as follows:

Option 1	Consultant led unit at Eastbourne District General hospital (EDGH). Midwife led unit (MLU) at Crowborough. No other MLUs in the area.
Option 2	Consultant led unit at the Conquest Hospital. Midwife led unit (MLU) at Crowborough. No other MLUs in the area.
Option 3	Consultant led unit at EDGH. MLU at Crowborough and at the Conquest Hospital.
Option 4	Consultant led unit at the Conquest Hospital. MLU at Crowborough and at EDGH.
Option 5a	2 Consultants led units, at EDGH and the Conquest Hospital. MLU at Crowborough. All consultant medical staffing model.
Option 5b	2 Consultants led units, at EDGH and the Conquest Hospital. MLU at Crowborough. Six consultants at each site, middle grade tier, no junior doctor tier.
Option 6	Consultant led unit at EDGH. MLU at Crowborough and at a point in-between Hastings and Eastbourne, serving the population of Hastings.
Option 7	Consultant led unit at the Conquest Hospital. MLU at Crowborough and at a point in between Hastings and Eastbourne serving the population of Eastbourne.
Option 10	Consultant led unit at EDGH. MLUs at Crowborough, Eastbourne and Hastings.
Option 11	Consultant led unit at the Conquest Hospital. MLUs at Crowborough, Eastbourne and Hastings.
Option 12	Consultant led units at EDGH and at the Conquest Hospital. Form of MLU at Crowborough and co-located with consultant led units. 5.5 consultants at each site, 7 middle grade staff and a full tier of first on calls.
Option 13	Consultant led unit at EDGH and at the Conquest Hospital. Integrated MLU at each site. Keep Crowborough but assess long term viability in the future. 5 consultants at each site, 8 middle grades as each site, 2 trainees at each site.

Options 8 and 9 were dealt with by the New Options Assessment Panel and were not considered at the option appraisal stage.

In phase one of the non-financial option appraisal board members were asked to score each of the twelve options against four criteria previously agreed by board members. The four criteria are detailed in the full option appraisal report but essentially they involved consideration of 1) clinical effectiveness and quality 2) health gain and demographics 3) sustaining two viable hospitals and 4) questions of access and choice.

Board members were asked to give each option a score of one to ten for each criterion with a high mark being awarded if the option was felt to largely satisfy

or deliver the relevant criterion and a low mark being awarded if the option was felt to barely satisfy or deliver the criterion.

Phase two of the non-financial option appraisal involved weighting the various scores in order to achieve a final score. Board members had previously agreed that the four criteria were not of equal importance and that the scores for each of the criteria should be weighted. Prior to the option appraisal all board members had been invited to “weight” each criterion in percentage terms so that the four criteria together added up to a 100% weighting. The 22 individual weightings were then averaged in order to achieve a final weighting figure for each criterion.

The mean average weightings for the four criteria were:

CRITERION 1 – (clinical effectiveness and quality)	33.5%
CRITERION 2 – (health gain and demographics)	26.4%
CRITERION 3 – (sustaining two viable hospitals)	19.6%
CRITERION 4 – (access and choice)	20.5%

The weighting criteria closely reflected the issues raised in the public consultation, indeed the single most important issue raised by consultation respondents was “safety” which linked very closely with criterion 1 of the weighting exercise. Board members had received a full report on views received during the consultation before they undertook the non-financial option appraisal.

Key points to emerge from the non-financial option appraisal included:

- In the weighted scoring, the top ranked option - option 4 - was over 60 points ahead of the second ranked option – option 3 - (693 points out of 1000 compared with 632 points out of 1000).
- All six of the top ranking positions were held by options proposing consultant led maternity services on a single site.
- Three of the top four ranking positions favoured Hastings as the most appropriate site for consultant led maternity services.

Financial option appraisal

In addition to conducting a non-financial option appraisal the PCTs also conducted a financial option appraisal. We are clear that financial issues are not a driver in this particular case but our duty to use our resources wisely is of course an ongoing responsibility.

The attached table shows the relative costs of the different options that were considered within the overall option appraisal.

Financial Band	Option No	Option	Net Cost £000s	Income Loss £000s	Total £000s	Capital £000s
up to £500k						
Between £501k and £1,000k	2	Cons led service I/P @ Conquest. No I/P service @ EDGH.	236	639	875	1,329
Between £1,001k and £1,500k	1	Cons led service I/P @ EDGH. No I/P service @ Conquest.	802	297	1,098	2,642
	4	Cons led service I/P @ Conquest. MLU in Eastbourne.	785	415	1,200	2,621
	7	Cons led service I/P @ Conquest. MLU at brownfield site between E'bourne & Hastings	865	415	1,280	3,970
	3	Cons led service I/P @ EDGH. MLU in Hastings.	1,114	193	1,307	2,742
	13	Cons led service I/P @ EDGH and @ Conquest and based on the Keith Brent Report	1,311	-	1,311	-
	6	Cons led service I/P @ EDGH. MLU in betwn Hastings & E'bourne at Bexhill Hospital	1,143	193	1,336	3,280
	11	Cons led service I/P @ Conquest. MLU in Eastbourne. Additional MLU at Hastings.	962	415	1,377	2,721
Between £1,501k and £2,000k	10	Cons led service I/P @ EDGH. MLU in Hastings. Additional MLU at Eastbourne	1,385	193	1,578	4,034
Over £2million	12	Use of both EDGH and Conquest to provide both a consultant-led and an improved midwife -led service.	2,055	-	2,055	-
	5b	Consultant-led maternity units at both Hastings and Eastbourne	2,119	-	2,119	-
	5a	Consultant delivered maternity units at both Hastings and Eastbourne	2,454	-	2,454	-

SECTION SEVEN: Chief executive's conclusions and recommendations

This paper has outlined the case for change, the pre-consultation engagement process, the consultation process, the responses we received to that consultation and our analysis of those responses.

Both boards, coming together as a joint committee, have met on several occasions to consider the evidence and outcome of the consultation process.

After careful consideration of the debate and discussion that has taken place both during and after the consultation period, I have now reached a position where I feel able to make recommendations to the joint committee and therefore to the boards of East Sussex Downs and Weald PCT and Hastings and Rother PCT.

My recommendations are:

RECOMMENDATION ONE

1. That the PCTs support a single site option for consultant led maternity services (plus a Special Care Baby Unit and inpatient gynaecology on the same site) subject to the following conditions:
 - The strengthening of ante and post natal care, specifically the development of further community outreach services including health visiting and community midwifery. This to build on existing services already delivered through children's centres.
 - The adoption of the 'top ten' recommendations set out in the Confidential Enquiry into Maternal Death report (December 2007)
 - Training of ambulance crews in advanced obstetric life support.
 - Strengthening of risk assessment protocols for midwifery led care including adoption of the national obstetric early warning chart and the implementation of the safe practice from Crowborough for the transfer of women in early labour where any complications are identified.
 - Achieving 60 hours of consultant presence on labour ward over a full seven day week.
 - The minimisation of unplanned closures which are unacceptable.
 - Agreement to establish emergency protocols for managing women in the community to ensure that in all cases women are in receipt of appropriate care.

- Movement towards 'Birthrate Plus' staffing levels to ensure there will be 1:1 care for women during labour.
- Implementation of the NICE guidance to affirm that women should be offered choice and to guide mothers in their decision on place of birth.
- Endorsement of the establishment of clinical indicators as the tool to monitor delivery of maternity services.
- Acceptance of HOSC recommendations.
- Adoption of best practice in managing the implementation plans taking account of the learning from experiences elsewhere in the UK (including Northwick Park) to ensure a safe transition.
- Development and implementation of a maternity strategy to support the strengthening of community services for maternity.
- The development and implementation of a robust communications plan.
- The development and implementation of a robust transport plan.
- Commitment to implementing the above through the Strategic Commissioning Plan. The PCT will be full partners in delivering the agreed changes with East Sussex Hospitals Trust.

I recognise that a significant number of people expressed support for two consultant led sites, particularly the Option 5 proposals. We gave significant and substantial consideration to the issues raised by those supporting this configuration of services. However, I do not believe that the two site options proposed would deliver the necessary requirements in relation to safety, recruitment, consultant presence, anaesthetics or service reliability.

The reasons for my first recommendation are therefore as follows:

1. Safety Issues

It is my view that the main reason for choosing a single site option is that it will lead to a safer service for the women of East Sussex. The weight of evidence and research indicates that whilst for the majority of women childbirth can be a natural process, for the minority where significant complications arise, it is important that this care is delivered in an obstetric unit.

The position of the ROCG has been subject to some debate with respect to the East Sussex maternity consultation. However, in their HOSC paper of

July 2007 – which they have subsequently confirmed remains their position – they said ‘It would be very hard for a unit delivering under 2000 births a year to offer adequate training opportunities for junior doctors and enough complex cases for more senior staff to maintain their skills’.

If our smaller units cannot offer adequate training for junior doctors and we cannot provide enough cases for more senior staff to keep up their skills then we must look at ways to provide a safer service. A single site would provide safer care.

2. Recruitment

It is accepted that recruitment and retention of good staff is essential if the PCTs are to commission a viable and sustainable service into the future for the people of East Sussex. From experience locally and elsewhere there is good evidence to suggest that it will be easier to recruit and retain good staff to a larger, single site. It is accepted that high quality clinicians would wish to work in an environment where they see a varied case mix and where their skills can be stretched and tested. It is also easier to recruit to a single site because in total fewer consultants are required than if recruitment is to smaller units on two sites. A single site therefore makes it easier to recruit the numbers of doctors required (because fewer doctors in total are required) but crucially there would also be the opportunity to select the very best applicants (because more doctors would be likely to apply for posts at a larger, single site consultant service thus giving us choice from a larger pool of applicants). This in turn gives the potential to deliver the best quality of care that can be achieved.

3. Consultant Presence

By 2009 the service delivered to the residents of East Sussex should be able to provide 60 hours of consultant presence on the labour ward, well above the level currently achieved, and more than the 40 hours proposed in all the two site options considered (except for option 5a). This is a key national target to improve quality and safety through increased consultant input into decision making. Increasing the presence of consultant obstetricians on the labour ward has been shown to reduce both the caesarean rates and complications of delivery, a major contribution to improving safety for women and their babies.

This will mean that we will need more consultants, but any two site solution would need at least twice as many consultants to achieve the same level of consultant presence, and we could not be sure that we would be able to recruit consultants in those numbers, for what would be small, and therefore potentially less attractive units.

4. Training Status

If two units are maintained and staffing levels are increased at each unit, the consultants will not be able to deliver enough babies to maintain their skills and that could have implications for the training status of the units. Concern has also been expressed regarding the calibre of junior medical staff that would be available to provide adequate cover to two units at the middle grade level. A single site maximises clinical experience and the opportunity to retain and enhance skills. I believe this offers a potential benefit in terms of quality of care.

5. Anaesthetics

If a single site option for consultant-led maternity services is developed it would be supported by its own dedicated anaesthetic support. This would provide an improvement in the quality of service that would be delivered, but will require an increase in the number of anaesthetists. For two units a separate tier of anaesthetists would be hard to justify in terms of the numbers of cases, and this would also affect the maintenance of skills for those providing the service.

6. European Working Time Directive

The European Working Time Directive comes fully into force in 2009. This too, is an issue of safety. It will restrict the number of hours junior doctors are able to work, which is important in ensuring that care is provided by staff who are fresh and alert. The effect of this will be to increase the number of doctors needed to provide 24 hour cover, 365 days a year.

With a single consultant unit, 24 hour cover need only be provided for one site. Supporting two units would double the number of doctors required and it would be very challenging to recruit this much greater number. We would also have concerns about ensuring that all these doctors would be of the very best quality.

7. Reliability

A single site option for consultant-led maternity services would improve service reliability and enable us to offer a more robust service. Concern has been expressed throughout the consultation regarding the number of unplanned closures that have been taken place while East Sussex Hospitals Trust is sustaining two consultant-led units. There are a number of reasons for these closures, which we are determined to tackle. As part of a package of measures, a single consultant site, with greater critical mass would give increased resilience and flexibility in staffing, which would also support better care. Fewer unplanned closures mean better care for mothers and babies.

Public concerns

The greatest concerns that have been expressed through the consultation relate to the travel aspects of any proposals to move towards a single obstetric unit.

The measures we are proposing are aimed at providing both choice for women and also high quality of care for those choosing or requiring medical assistance during childbirth. Concern has been raised at the potential risk to women involved in travelling to an obstetric centre. The consultation document identifies that for some women the creation of a single consultant led unit will increase travel distances. Whilst there is no evidence over what constitutes a safe transfer time or distance, this is an understandable area of concern.

There are four things that make me conclude that, to the extent that such a risk exists, it can be mitigated successfully in a number of ways.

First, it is important that women are enabled to make an informed choice of birth location, and this will include an explanation of the risks associated with the different alternatives. NICE has recommended that women be given the following information upon which to make that choice:

‘ Women should be offered the choice of planning birth at home, in a midwife led unit or in an obstetric unit. Women should be informed:

That giving birth is generally very safe for both the woman and her baby.

That the available information on planning place of birth is not of good quality, but suggests that among women who plan to give birth at home or in a midwife led unit there is a higher likelihood of a normal birth, with less intervention. We do not have enough information about the possible risks to either the woman or her baby relating to planned place of birth.

That the obstetric unit provides direct access to obstetricians, anaesthetists, neonatologists and other specialist care including epidural analgesia.

Of locally available services, the likelihood of being transferred into the obstetric unit and the time this may take.

That if something does go unexpectedly seriously wrong during labour at home or in a midwife led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care.

That if she has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications during her next birth, she should be advised to give birth in an obstetric unit.'

Second, once a woman knows that she is pregnant it is very important that ante natal care is provided. This will help to give advice and support but also to identify through scans and other tests if there are potential complications expected. For these women it will be recommended that they give birth at the medically staffed obstetric unit.

Third, for those women where there are no expected complications who choose to give birth either at home or in a midwife led birthing centre it is important that they can draw upon the skills of midwives. For any women where complications start to develop, or there is a concern that complications may develop, it is important that early transfer to the main obstetric unit is initiated. In practice this is what happens currently at Crowborough and whilst the level of transfers is high (at around 18%) this is a reflection that women are transferred as a precaution in the vast majority of cases. Women will be assessed as soon as they arrive in the consultant led unit, but it is unusual for an urgent caesarean to result, and where a caesarean does take place, this is usually some hours later.

Fourth, we are requiring the ambulance trust to ensure all crews undertake additional training in obstetric life support over the next 12 months to ensure that we have a consistently high level of ambulance response, in addition to the skills of the midwife, in ensuing safe transfer when this is necessary.

It is never possible to guarantee that there will be no adverse outcomes for mothers and babies in any system, but the evidence we have both locally and from around the country is that what is proposed is safe.

Equally we are aware that consultants in ESHT are telling us that currently the obstetric service is 'stretched for safety' and, as set out above, the creation of a single obstetric unit will significantly address these safety concerns.

The above issues outlined could not be solved simply by putting endless financial or other resources into the current configuration of services. It is therefore my conclusion that we should support a single site option for consultant-led maternity services with a special care baby unit on the same site.

RECOMMENDATION TWO

2. That the single site be Hastings with a midwife-led birthing centre at Eastbourne, alongside the existing birthing centre at Crowborough

Location of the single site unit

The PCTs need to consider the following issues when determining on which site the single obstetric-led maternity unit should be located.

Health Inequalities

East Sussex is considered to be part of the affluent South East. However, this is misleading. Pay levels are about two-thirds of those in the rest of the South East. There are pockets of deprivation across the county, notably Hailsham, Eastbourne, Sidley and Newhaven, but deprivation most significantly affects the residents of Hastings. 'East Sussex in Figures' reports that 13 small areas in East Sussex (technically referred to as 'Super Output Areas') were in the 10% most disadvantaged areas in England and 12 of these are in Hastings. Altogether just over one-third of all the Super Output Areas in Hastings are among the 20% most disadvantaged in England and the borough has the most disadvantaged Super Output Areas of any area in the south east. Almost four times as many deprived women of child bearing age are resident in the Conquest catchment area compared with the EDGH. Five times as many babies in the most deprived areas were born in Hastings and Rother (the Conquest catchment area) compared with Eastbourne and Wealden South (the EDGH catchment area).

These markers of deprivation are also reflected in indices considered to reflect social complexity, such as teenage mothers, smoking in pregnancy and late booking, all of which are more common amongst the population using the Conquest than amongst the population using the EDGH, and all of which would be expected to adversely affect outcomes for mother and baby.

National evidence shows a striking difference in outcomes for both mothers and babies from deprived communities. The direct maternal mortality rate is almost five times as high in the most deprived communities as the least, and the total mortality rate more than five times as high. Stillbirths and neonatal death rates are similarly known to be higher amongst deprived communities. The recent CEMACH report, *Saving Mothers' Lives* shows that the rate of maternal death amongst women whose partners were unemployed or whose occupations were unclassifiable was over seven times higher than that for all women with partners in employment. Amongst women who had no partner, the mortality rate was over four times that of women who had partners in employment. Local data cannot show these differences because the numbers are too small, but there is no reason to suppose that East Sussex would be immune from these effects.

In addition women from deprived communities are more likely to have a baby that is premature or low birth weight. Conversely such women are less able to undertake regular travel to be with their baby if the unit is distant from their home, for a range of reasons including the costs of travel and because the level of car ownership is lower. (In East Sussex access to a car or van is lower in Hastings than the other boroughs.)

The Maternity Services Health Impact Assessment prepared for the PCTs recommended that as the most deprived women are more likely to have greatest needs for high quality specialist obstetric and SCBU services, their access to these services needs to be facilitated to enable them to receive care closest to where they live to maintain family support networks.

Patient Flows

The PCTs have modelled the potential impact for patient flows. It is clear that for all single site options we would expect between 2500 and 4000 mothers. This will support ESHT in putting in place the right facilities and services to meet current and emerging future standards for care. There is a possibility that siting the obstetric unit in Hastings will see a smaller level of increase in births than if the unit were located in Eastbourne but in every scenario we would expect to exceed 2500 births.

Fit with agreed criteria

Options with Conquest as the single site scored highly within the options appraisal against the agreed criteria for judging the outcome of the consultation.

My conclusion is therefore that I recommend to the boards that the single consultant-led site be located at the Conquest Hospital in Hastings.

Configuration of midwife-led birthing centres

There has been much debate and discussion regarding this and this has been reflected in the number of options showing the various configurations of midwife-led units. We have confirmed throughout the consultation that the Crowborough midwife-led service be maintained. The outcome of debate and discussion is that the preferred option of the boards is that the midwife-led unit should be based in the town which does not have the obstetric-led unit.

New options that emerged during the consultation offered the PCTs the opportunity to weigh and consider a wider range of configurations of midwife led birthing centres than originally proposed and it was the clearly stated view of consultation respondents that their preferred option (should there be a decision to go for a single obstetric site) was that the a midwife led unit should be located in the other location to the one chosen as the single obstetric site.

I therefore recommend that the midwife-led unit be based in the Eastbourne area.

The maternity pathway

From the outset we have been clear that maternity care is about more than just the birth, and that we wanted to develop better midwife-led services.

During consultation most attention has focussed on the proposals for the configuration of consultant-led and midwife-led units, perhaps inevitably given the interest this has aroused.

Over and above this, however, it has been stressed throughout the discussions that it is important that we have a robust maternity strategy covering the whole pathway of care: preconceptual, antenatal and postnatal care as well as birth.

Maternity Matters, issued during the consultation period, provides the policy framework within which to develop this thinking, and gives national choice guarantees to be in place for all women by the end of 2009: choice of how to access maternity care; choice of type of antenatal care; choice of place of birth; choice of place of postnatal care. In addition *Maternity Matters* gives a commitment that every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth.

I therefore recommend that a Maternity Strategy Group commences work in January 2008 with a remit to make recommendations to the Boards in summer 2008 on a strategy for East Sussex across the whole maternity pathway, specifically to review community midwifery services, particularly the provision of ante and post-natal care in more deprived areas and the provision to support home births. This group will also lead *Maternity Matters* implementation for East Sussex.

HOSC has recommended that a plan for working towards 'Birthrate Plus' staffing standards should be agreed between the Hospital Trust and PCTs, and I recommend that this should be part of the remit of the Maternity Strategy Group. While it would be unusual for a PCT to specify a staffing model to a provider, the PCTs' commissioning specifications will require that providers ensure that there is 1:1 care during labour, and that enhanced community antenatal and postnatal care are provided.

We are putting place arrangements to monitor a number of clinical indicators for monitoring the impact of our proposals, and including a number that will focus on the wider pathways of care: reduction in late booking; development of outreach in deprived communities; reduction in smoking during pregnancy; breastfeeding rates; women's experience of care. In addition we will be monitoring the provision of 1:1 care during labour.

The PCTs are fully committed to improving services for mothers and babies and to taking forward the National Service Framework(NSF) for Children, young people and maternity services published in September 2004. The framework is a 10 year programme and forms an integral part of *Every Child Matters; Change for Children* which was set up in the wake of Lord Laming's inquiry into the murder of Victoria Climbié.

Maternity Matters, which builds on standard 11 of the NSF gives clear direction as to the choices that should be available to all women by the end of

2009. Lord Darzi's review further encourages trusts to consider the way services are provided.
All these requirements will be considered by the PCTs in developing a maternity strategy. This work will be taken forward from January 2008.

SECTION EIGHT: Next steps

It is the responsibility of the Hastings and Rother and East Sussex Downs and Weald PCTs to develop proposals for change, lead consultations on these proposals and make the final decision on any proposed changes. The Strategic Health Authority also has responsibilities. In respect of the PCTs' specific proposals the Strategic Health Authority will meet its responsibilities by:

- i) agreeing with PCTs what objectives any proposals must meet
- ii) quality assuring the process to develop proposals
- iii) ensuring that all stages of the consultation reflect best practice, designed in a fully inclusive way to engage all stakeholders
- iv) quality assuring the process the PCTs go through in coming to their final decision

The PCTs' final decision will therefore be subject to the formal endorsement of their decision making process as demonstrated through the Strategic Health Authority's quality assurance process.

With respect to the decision itself the PCTs and ESHT will be putting in place detailed implementation plans once a decision is made. However preliminary work alongside the option appraisal has taken place to ensure that for each option there is an outline implementation pathway that includes consideration of:

- Governance and agreed project management and project planning to ensure successful delivery of the agreed option.
- Benefits realisation planning to ensure that the project plans are implemented and deliver required outcomes.
- Financial planning to underpin project plans.
- Communications and engagement to ensure that there is active engagement of service users, staff and stakeholders in the development and delivery of new service models.
- Maternity strategy working group to oversee the transition towards new models of service and ensure that local services are able to deliver improvements in service delivery
- Workforce planning to ensure that sufficient skilled staff are available to meet future service requirements.
- Estates planning to ensure that any building works is carried out on time and meets service specifications.

- Transport working group to ensure that the impact of any service changes is planned for and that an action plan is developed and implemented to address the transport issues that arise.
- Clinical engagement assurance group to ensure that at all stages there is clinical involvement in planning for new service requirements and that there is ongoing communication with clinical staff.

SECTION NINE: Continuing consultation/engagement

In the period after the decision making board meeting we propose to undertake a major post-consultation communication programme to communicate with our local communities and stakeholders the thinking and rationale behind our decision.

We will do everything we can to ensure that everyone understands the decision including NHS staff and contractors including midwives, consultants and local GPs. But, of course, our key audiences are local stakeholders and the general public.

It will be important to explain that no change will be implemented for many months. For the immediately foreseeable future we expect services to be maintained as they are at present. But we want to engage the public fully in developing the plans to make maternity services safer and more robust in East Sussex.

Our key engagement activities will include:

- A letter to key stakeholders offering a post-consultation meeting
- The development of communication materials to explain how and why the PCTs made their decision and how it will be implemented
- A consultation feedback report
- A number of stakeholder groups to search out any continuing concerns and implementation issues

SECTION TEN: Summary

The proposals set out in this paper focus on key recommendations that the Joint Committee are asked to consider. The context for these changes is a clear commitment from both PCTs, working with the providers of maternity services, to develop and enhance all aspects of maternity care – from conception and ante natal care through a choice of place of birth, safe high quality care during delivery and effective post natal care.

I commend these recommendations to the Joint Committee.

Annex 1

Creating and NHS Fit for the future: PCTs response to the East Sussex Health Overview and Scrutiny Committee (HOSC) recommendations.

1. Introduction

The East Sussex HOSC published their response to the East Sussex PCTs Fit for the future consultation in October 2007. This annex outlines the East Sussex PCTs response to the HOSC recommendations.

2. Background

Health Overview and Scrutiny committees were established under the Health and Social Care Act 2001. They may review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority. In accordance with Section 7 of the Health and Social Care Act 2001, the East Sussex PCTs were required to consult the East Sussex HOSC prior to the launch of the Fit for the future consultation on changes to maternity, gynaecology and special care baby services. The HOSC has a statutory duty to give a response to the PCT on the following two key questions:

- Is the Committee satisfied with the content of the NHS consultation process and that sufficient time has been allowed?
- Is the NHS preferred way forward in the best interests of the health services for people in the area affected?

In order to answer these questions, the East Sussex HOSC held a series of evidence gathering meetings to collect views from the local NHS, representatives of local people and service users, and independent experts. Four main sessions were held during May, June and July, with additional sessions in September and October following the close of the formal consultation period. Following this, the HOSC produced their response to the East Sussex PCTs proposals, which are set out in the accompanying document, and includes 24 formal recommendations.

3. PCT response to the HOSC recommendations

R1 The PCT Boards should undertake a full assessment of the additional proposals put forward through the New Options Assessment Panel, and discuss these with hospital clinicians, before making any decision on the configuration of obstetric, special baby care and inpatient gynaecology services.

PCT response:

This recommendation is accepted. The PCT has been advised throughout its consultation by senior hospital clinicians including both the Clinical Director

and Deputy Clinical Director for Obstetrics and Gynaecology. This has naturally included their advice on all the options put forward during consultation. The PCTs took further evidence on all the additional options on 5 November, at a special evidence gathering session in public, to support full assessment. Each option was then assessed as part of an option appraisal process which took place on 13 November (see attached annex 1). Further discussion with the hospital clinicians regarding the additional options is ongoing, including discussions with the clinical leaders with the East Sussex Hospitals Trust Clinical Leaders' Group, most recently on November 27th 2007.

R2 Any option chosen by the PCT Boards should improve access to midwifery-led care. However, the Boards should consider alternative locations for a midwife-led unit (beyond those specified in options 3 and 4) and potential alternative ways to offer access to midwife-led care within obstetric units before taking a decision on preferred configuration of services.

PCT response:

This recommendation is accepted. The PCT Boards will seek to ensure improved access to midwifery-led care whatever option is chosen. A range of alternative locations for a midwife-led unit (beyond those specified in Options 3 and 4) and potential alternative ways to offer midwife-led care within Obstetrics Units have been explored in consideration of the alternative options that have been put forward (Options 6, 7, 10, 11 and 12). Ensuring that home birth is a real choice for all East Sussex women where appropriate will be part of the work of developing our maternity strategy, and the implementation of Maternity Matters.

R3 The PCT Boards should discuss with HOSC an appropriate level of further engagement with the public on any additional options which they consider to be viable.

PCT response:

This recommendation is accepted. Discussions have taken place with HOSC regarding the potential need for further consultation with the public in the light of the additional options that came forward in response to consultation. It has been agreed that there may need to be further public consultation should the PCT Boards recommend the adoption of one of the additional options, and that the nature of this further consultation would be agreed between the PCTs and HOSC should it prove necessary. In any event the PCT has confirmed that a six week period of post consultation engagement will be implemented. Planning for this is well advanced.

R4 Before any decision is taken to implement changes to services, the PCT Boards should ensure robust capital and revenue costings are in place and local health economy sources of funding clearly identified. Sources of funding should minimise the impact on other services as far as possible.

PCT response:

This recommendation is accepted. External consultants have assisted the PCTs and ESHT in ensuring that the capital and revenue costings for all options are robust. This financial assessment will be reflected in the Board papers for the decision making meeting. The impact of any changes on other services will be taken into account by the Boards in their decision making.

R5 The PCTs and Hospitals Trust should review other reconfigurations of maternity services nationally in order to build the lessons learnt into any East Sussex implementation plans.

PCT response:

This recommendation is accepted. The PCTs have reviewed other configurations of maternity services nationally and visits to other providers of maternity services have taken place (see attached annex 2). Advice from the Department of Health has been received both prior to the commencement of the consultation and at other stages to ensure that there is the most up to date understanding of national policy. Advice issued by the Independent Reconfiguration Panel to other organisations planning changes to the configuration of maternity services has been reviewed. The lessons learned from other reconfigurations (including Northwick Park) were discussed with HOSC, and will be incorporated in local implementation planning.

R6 The Director of Public Health should, in consultation with clinical staff and service users, agree a set of audit measures to assess outcomes and quality of care which will be regularly monitored before, during and after implementation. These should demonstrate at least stability and preferably, improvement in quality of care and patient experience.

PCT response:

This recommendation is accepted. A set of audit measures to assess outcomes and quality of care have been developed with the SHA and is being agreed with local clinicians through the clinical leaders group. Monitoring arrangements are also being put into place.

R7 The PCTs should work with the Hospitals Trust and local transport providers to specify what improvements to transport between the two sites can be made and to develop a travel action plan which includes consideration of car parking. Specifically, the feasibility of an inter-site bus for staff, visitors and patients should be examined.

PCT response:

This recommendation is accepted and is part of an ongoing work programme with the East Sussex Hospitals Trust and the County Council. In addition the PCT intends to engage an independent transport consultant to consider all aspects of transport arising from the agreed option, including exploration of an intersite bus service, development of a transport communications plan and production and implementation of a transport action plan.

R8 The PCTs and Hospital Trusts should establish mechanisms to effectively involve service users and staff in design and implementation of any reconfigured maternity, special baby care and gynaecology services to ensure that the concerns of service users and staff are identified and addressed as far as possible.

PCT response:

This recommendation is accepted. The PCTs and Hospital Trust will be in ongoing discussions with the Maternity Services Liaison Committee. A Maternity Services Strategy Group is also being launched in January to further take this work forward.

R9 The PCTs should work closely with PCTs and Trusts in neighbouring areas to ensure the effect of any changes in these areas on services for East Sussex residents is fully considered. In particular, the PCTs should work with Brighton and Sussex University Hospitals NHS Trust to ensure the Trust puts in place appropriate capacity to safely manage additional demand and ensure quality.

PCT response:

This recommendation is accepted. This is part of an ongoing work programme. The East Sussex PCTs are assured that Brighton and Sussex University Hospitals Trust has in place plans to ensure that sufficient capacity will be available for the residents of East Sussex whatever decisions are taken in East or West Sussex.

R 10 A robust implementation plan should be developed, including assurance that sufficient capacity would in place at the single obstetric unit before closing the second unit to obstetric admissions.

PCT response:

This recommendation is accepted. The implementation plan is currently being developed by the East Sussex PCTs working closely with partners in East Sussex Hospitals and South East Coast Ambulance to address such issues. South East Coast SHA will provide quality assurance advice on this plan.

R11 The PCTs and Hospitals Trust should make a clear commitment to meet the Royal College standard of 60 hours of consultant presence per week by 2009 and to put policies and procedure in place that aim to maintain CNST level 3 status.

PCT response:

HOSC's recommendation will be taken into account by the PCT Boards in their decision making. The PCTs agree with HOSC that achieving a higher level of consultant presence on labour ward is crucial for ensuring safer high quality services for the women of East Sussex. Not all of the options before the Boards propose 60 hours of consultant presence. If the option finally selected is for a single obstetric unit in East Sussex, the PCT Boards and East Sussex Hospitals are committed to ensuring that the Royal College standard of 60 hours of consultant presence by 2009 will be met.

The fact that we currently have CNST level 3 accreditation should not encourage complacency or a feeling that the local health community does not need to plan for the future. The PCTs believe that part of the reason that these services have achieved accreditation is that they look ahead in striving to constantly improve patient outcomes. The need to assure the safest service for women and their babies is at the heart of this consultation, and achieving CNST standards both now and in the future form an important part of that. The recommendation that policies and procedures should be in place which aim to maintain CNST level 3 status is therefore accepted. Although no announcement has been made about what future changes to CNST standards will be, ***Maternity Matters*** indicates that *'there is a strong possibility the CNST will increase the standard to 60 hours'* (of consultant presence). Maintaining CNST level 3 accreditation may therefore require 60 hours of consultant presence.

R12 Appropriate facilities for the assessment and care of women early in labour must be included in the obstetric unit, recognising that women may

arrive earlier if travelling further. The Unit's advice to women arriving early in labour must also be amended to recognise the potential increased distance to their homes.

PCT response:

This recommendation is accepted. This will be incorporated into the Service Level Agreement with East Sussex Hospitals Trust, and the designs for the redeveloped obstetric unit.

R13 The PCTs must work with the Ambulance Trust to agree and fund the extra capacity required to support a reconfigured service, particularly bearing in mind potential pressures from changes in other areas. These calculations and Ambulance Trust protocols must recognise that more women will require ambulance transport to hospital in labour if they are travelling further. There must be a commitment to providing this service where women need it.

PCT response:

This recommendation is accepted. The Service Level Agreement with the Ambulance Trust is linked to the number of journeys taken by residents of the PCTs, and will ensure that any additional journeys are properly funded.

R14 Additional training must be made available to paramedics working in East Sussex on handling obstetric cases and the cost of this provided for.

PCT response:

This recommendation is accepted. The PCTs have agreed a programme of workforce development with South East Coast Ambulance to ensure that paramedics are appropriately trained. The PCTs will support this programme with pump priming money.

R15 Implementation plans must allow a period of up to five years for a new midwife-led unit to become established and reach its planned level of activity. The costs of this transitional period must be recognised and accounted for within the plans.

PCT response:

This recommendation is accepted, though it is anticipated that 5 years would be the maximum period that would need to be allowed for the midwifery-led unit to become established and reach its planned level of activity. The PCTs will agree appropriate transitional funding with East Sussex Hospitals in line with national guidance.

R16 The PCTs should review the information available to parents-to-be when choosing birth environment, and the way this is provided, in consultation with service users, to ensure the relative risks and benefits of midwife-led units, home births and consultant-led units and the care available in each is described as clearly as possible. The effectiveness of this information should be monitored through feedback from service users.

PCT response:

This recommendation is accepted. The PCTs will work closely with East Sussex Hospitals Trust and the Maternity Services Liaison Committee to ensure that clear appropriate information is made available. Feedback from service users will form part of the monitoring programme discussed above.

R17 Protocols must be agreed between the midwife-led unit and the ambulance service regarding transfers to a consultant-led unit. Protocols should seek to remove any barriers to rapid transfer when required. A midwife should be available to travel with women requiring transfer.

PCT response:

This recommendation is accepted. Protocols are already in place for Crowborough Birthing Centre. The PCTs will work closely with East Sussex Hospitals Trust and South East Coast Ambulance to ensure that appropriate agreed protocols and practice are in place, and that these take account of the latest guidance.

R18 Only suitably experienced and qualified midwives who wish to work in such an environment should be recruited to work in the midwife-led unit. Appropriate training and induction into the ethos and practice of midwife led units must be completed by these staff.

PCT response:

This recommendation is accepted. A workforce plan has been prepared, and as part of this a training needs assessment will be undertaken to take this forward so that appropriate training programmes can be developed. This will build on the experience of the very successful local Crowborough Birthing Centre, and the work of our existing community midwives.

R19 The PCTs should work with the hospitals trust and the regional neonatal care network to determine which higher level services could be safely provided within the unit in order to maximise the care available locally within East Sussex.

PCT response:

We are determined that as many women as possible living in East Sussex will be able to have choice of place of birth within East Sussex. This will include provision for hospital birth, midwifery led birthing centre and home birth. This will help to minimise the number of women who chose to give birth outside the county by providing a full range of choice locally. The choice to give birth in hospitals surrounding East Sussex will of course be maintained and any woman wishing to exercise this choice will of course be able to do so.

R20 The PCTs should work with the Hospitals Trust to determine whether facilities for visiting parents can be improved to mitigate the impact of some parents needing to travel longer distances.

PCT response:

If the option finally selected is for a single SCBU in East Sussex , the PCT Boards and East Sussex Hospitals will work to provide suitable family facilities.

R21 The PCTs should work with the Hospitals Trust to agree protocols for handling emergency pregnancy cases outside the 9-5 service, avoiding the need for transfer where safely possible.

PCT response:

This recommendation is accepted. Early Pregnancy Clinics will run on both sites for women who require same day consultation. The PCTs are working with the Hospitals Trust to ensure appropriate that the hours of working for this service are appropriate, and that arrangements outside these hours are clear to women and their healthcare professionals.

R22 The PCTs should work with local GPs and the Hospitals Trust to ensure gynaecology care is provided in community settings or as day case procedures as far as is safely possible.

PCT response:

This recommendation is accepted as a desirable direction of travel for the PCTs In line with our overall strategic direction. The feasibility of this is being explored through our Practice Based Commissioning Groups.

R23 A plan for working towards 'Birthrate Plus' staffing standards should be agreed between the Hospital Trust and PCTs.

PCT response:

This recommendation is accepted. Workforce plans will be developed following the decision. The PCTs commissioning specifications will require that providers ensure that there is 1:1 care during labour. Our wider maternity strategy and the implementation of Maternity Matters will seek to ensure that enhanced community antenatal and postnatal care are provided.

R24 The PCTs should urgently undertake a review of community midwifery services, particularly the provision of ante and post-natal care in more deprived areas and the provision to support home births. They should produce and publish a plan for developing these services to be implemented alongside any reconfiguration of childbirth services.

PCT response:

This recommendation is accepted. Work is being set in train as part of the development of the Maternity Strategy which commences in January.

4. Conclusion

As stated above, the PCT accept the recommendations of the East Sussex HOSC. It is recognised that implementation of some of the recommendations will be affected by the option chosen by the PCTs.