

East Sussex Maternity Services Liaison Committee
User Group

Recommendations for Consultation on
East Sussex Maternity Services

March 2007

Richard Hallett
Ros Vinall

East Sussex MSLC Chairs
14th March 2007

East Sussex Maternity Services Liaison Committee User Group

The MSLC User Group

The Maternity Services Liaison Committee for East Sussex covers maternity units at Crowborough, Eastbourne & Hastings. It is a multi-disciplinary forum bringing together health professionals, managers and user representatives. As a body it monitors the quality of maternity services, provides feedback on service development to provider trusts and acts as an advisory body to the local primary care trust that commissions maternity services.

This committee was formally involved in the Clinical Services Review of Maternity & Gynaecology in 2004, and revived its interest in issues of re-configuration in November 2005 as described in Appendix 2 of this document.

Over the years the health professionals and managers on the committee have provided valuable input that has enabled the committee to work in an effective and co-operative way. Users have benefited from their input in understanding how maternity services function, while user feedback has been an important resource to health professionals and managers.

On major issues such as re-configuration, however, it is difficult for health professionals and managers to formally comment on proposals made by their employing trust. This document, therefore, while acknowledging the valuable contribution that the whole committee have made over the years in understanding issues of reconfiguration, is produced on behalf of the user group on the Maternity Services Liaison Committee. It offers advice on the forthcoming consultation proposals.

In summary the position of the user group is that:

- 1) 'primaeface' removal of obstetric services from either Eastbourne or Hastings is a major and undesirable reduction in local choice for women.
- 2) before a single site option is proposed it is essential that every other option to retain two-town obstetrics services is properly explored
- 3) if a single site for obstetrics is the only viable option, then that option should be thoroughly prepared, fully funded, and implemented in a manageable time-frame.

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Executive Summary

Women want as much care as possible to be delivered locally. The two main centres of population for East Sussex are Eastbourne and Hastings/St. Leonard's. Women living in or near to one of these population centres do not regard the other as local, and would regard the loss of an all-risk unit with obstetric support as a major and undesirable reduction in local choice. The National Service Framework for Maternity expects that "Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies."

The NSF also highlights the importance of designing a service that is easily accessible to women from disadvantaged groups. This includes women who suffer from deprivation, disability or come from ethnic minority groups. Hastings and Eastbourne both have women from disadvantaged groups, though for differing reasons. It is essential to recognize that any single site obstetrics proposal will have an adverse ease-of-access impact on women in various disadvantaged groups in whichever location the single site is proposed.

For these reasons the primary aim of commissioners and providers should be to establish and maintain a local women-centered service including obstetrics in the two main population centres in East Sussex. Changes in doctor training (Modern Medical Careers), European Working Time Directives and other constraints need incorporation into the design of a service, but abandonment of local obstetrics should only be an 'option of last resort'.

All the evidence of the last 16 months indicates that East Sussex Hospitals Trust have put substantial effort into promoting consolidation of obstetrics on a single site in East Sussex. Little or no effort has been put into identifying ways in which local obstetrics can be effectively maintained in both population centres. Draft guidance in 2005 from the joint colleges that a 4500 birth population was the minimum desirable was seized on as necessitating consolidation without due consideration of local circumstances. In the event, this guidance has now been reduced to 2500 births with recognition that the cut-off points are arbitrary, and recognition of the need for smaller units in certain situations.

Models for effective small obstetrics units do exist within the UK, and a chair of the MSLC has visited North Devon District Hospital to understand such a model at first hand. The report of that visit is included within this document, and highlights their local view that, not only is the obstetric unit viable, but that small units have much to offer local women in terms of the quality of individualised care that they can provide. A regional analysis of hospital maternity services within the south west does show that by May 2006 the smaller units had made most progress toward implementation of the National Service Framework on Maternity.

Economic evidence from the NHS Confederation shows that there are few financial savings from closing or consolidating maternity services. Moreover, a larger, consolidated unit may require a team of dedicated obstetric anaesthetists at an additional cost of £550,000. At the same time women from the town that loses its obstetric unit may well choose to access maternity services from other providers at Brighton, Ashford or Pembury. Under Payment by Results funding, if only 10% of existing women chose other providers, the loss of income would be £554,240. There is a concern that a single site obstetric will develop a significant funding gap of over £1 million within East Sussex Hospitals Trust. Under such financial pressure there is a real risk that the cost-reduction measures required to retain financial balance will impact on both the quality and safety of the maternity service provided.

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Section 1 A Woman-Centred Maternity Service

1.1 Women Expect Local Obstetric Care

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

(Clinical Services Review of Maternity & Gynaecology - August 2004)⁽¹⁾

This finding of stakeholder involvement into the 2004 Clinical Services Review cannot be lightly brushed aside. Whatever the strategic view of providers might be, any woman-centred configuration of maternity services must recognise this central position of women’s expectations.

Reconfiguration proposals should only depart from this woman-centred position due to some overriding constraint that makes it impossible for maternity services to provide women in each of the main population centres with obstetric care that they consider to be local.

1.2 ‘Stress Test’ Constraints

Despite this starting position outlined above, there may be constraints that prevent the provision of local obstetrics. These possible constraints might include cost, doctor recruitment, consultant on-calls, European working time directive, medical training (MMC), midwife recruitment & retention, anesthetic cover, and possibly others. However it is essential to “stress test” each of these constraints in turn. Only then it is possible to be certain that there is not an alternative solution to the constraint that is considered to be *‘the problem’*.

We do not believe that these possible constraints have been systematically tested by the hospitals trust or the primary care trust. Indeed since November 2005 the single-site option has appeared to be the ‘option of first resort’ and the only working groups created have been focused solely on the single-site option. In our view it is not a meaningful consultation if only a single site option is offered in various variations. Single site and twin site options should be laid out, with the advantages and disadvantages of both explained for comparison and feedback.

1.3 Consultation Designed for Clear Feedback on Reconfiguration

In our view it is not acceptable to invite public feedback on general questions about ‘improvement to services’ or ‘the need for change’ and use this as a basis of support for a single site option. Maternity services are primarily used by ‘well-women’ and should be kept separate from questions relating to health services for sick people.

In East Sussex, re-configuration of obstetric services onto a single site is such a substantial change to maternity services that the consultation needs to be focused and explicit. It is important that questions for consultation are specific. Based on information laid out within the consultation document, questions should include *“Do you agree that obstetric maternity services need to change from being delivered at both Eastbourne & Hastings?”*

1.4 Specific Car Travel Assessments Required

We are concerned that the consultation paper will attempt to minimize the extent to which *“women living in or near to one of these population centres do not regard the other as local, and would regard the loss of an all-risk unit with obstetric support as a major and undesirable reduction in local choice.”*

A typical method of distorting the real impact on women is to calculate the impact on travel time as an ‘average’ across the whole catchment area. This is less than honest when considering the removal of local obstetrics from one town and locating on a single site, as inevitably impacts are polarised. The travel impact on women in the single-site town is nil, whereas the travel impact on women in the town losing the local obstetric service is double the ‘average’ impact.

The MSLC has been told that currently all East Sussex women live within 30 minutes of an obstetric unit and a single site option reduces this to only about two-thirds of women living within 30 minutes of the obstetric unit. This is a significant adverse reduction in accessibility.

Furthermore, it is common for travel times to use ‘off-peak travel times’ by car as part of the travel impact calculations. Women who need to attend the hospital ante-natally or in labour are not often able to choose the time at which they travel. In addition to this standard ‘off-peak travel times’ will include Saturdays & Sundays, whereas in East Sussex local coast road conditions on summer weekends make these days some of the most difficult and lengthy journeys. Consultation on single site obstetrics should make clear the impact on women in each town separately, and identify the travel impact at different times of the day and week.

1.5 Women Without Access to a Car

Not all women have access to a car, and reconfiguration proposals that fail to take this into account are likely to reduce easy access to maternity services for women from disadvantaged groups. These are the women that the National Service Framework on Maternity ⁽²⁾ identifies as needing a higher priority and focus in developing maternity services.

In the Hastings catchment area 50% of single parent families have no access to a car (~1500 households), while in the Eastbourne area 39% of single parent households have no access to a car (~1000 households). Not only are these significant numbers in both locations, but they also represent groups of women who tend to achieve less good outcomes of pregnancy and need additional support from maternity services.

Consideration must also be given to women in single car households. Often these women do not have access to that car during the working day when it is in use by her partner. A fully considered consultation should gather information locally on this in order to evaluate travel times based on public transport for such women. An assessment of the cost of travel should also be made as this can impact on the ability of lower income women to access good quality maternity care.

1.6 Indications of Disadvantage

The NSF on Maternity requires commissioners to give priority to needs of women from disadvantaged groups. Proposals should take into account indicators of disadvantage.

Hastings has long been recognized as having areas of deprivation and 10 out of the 14 most deprived small areas, by IDAC Index, ⁽³⁾ in the East Sussex area are located there. However, there are also areas of deprivation in the localities of Devonshire, Langney & Hailsham. The proportion of very low weight babies (under 1500 g) was slightly higher at Eastbourne District General Hospital than at Conquest during the three years 2003-2005. Similarly the proportion of births by ethnic minority was also higher at EDGH than Conquest, and the particular needs of these women have been highlighted by the national confidential enquiry ⁽⁴⁾ into maternal deaths.

It is, therefore, essential to recognize that any single site proposal will have an adverse impact on women in various disadvantaged groups in whichever location the single site is proposed.

1.7 Single Site Obstetrics ‘Last Resort’ not ‘First Resort’

For reasons of maintaining a women-centred service, travel considerations and indicators of disadvantage, a single site obstetric option that removes obstetric services from either Eastbourne or Hastings towns should only be considered as an ‘option of last resort’ if all other solutions prove to be impossible or too costly. The details of the hurdle (*‘the problem’*) that is considered insuperable, or the constraint that is considered pivotal, should be explicitly laid out in a transparent way so it can be understood by all stakeholders, not just health professionals or managers. Where cost is the pivotal issue, the appropriate costing and assumptions should be attached to the relevant options and made transparent in any proposals.

1.8 Special Care Baby Unit (SCBU)

During the discussions on Clinical Services Strategy in 2006, the consolidation of obstetrics onto a single site was claimed to benefit women by suggestion that the Trust would be in a position to apply for level 2 status for the SCBU. This was presented as likely to be approved and as a strong inducement for local women to support a single site proposal.

The users in those discussions were sceptical about the weight of this argument. It was understood that at SHA level, not only is there no money for any further development of a level 2 unit, but that the strategy is quite clear to focus neo-natal facilities in Brighton, Ashford and Medway.

At the Strategic Health Authority ‘Mapping Maternity’ Conference in July 2006 enquiries were made of the Neo-natal Services Co-ordinator about this possibility. It was made clear that, were funding for a level 2 SCBU unit to become available, then the preferred location would be centrally within the strategic health authority region at either Redhill or Frimley.

It would be quite unacceptable for any single-site proposal to offer a level 2 SCBU as a benefit of consolidation to East Sussex women if in practice this is not a real and genuine probability.

As recently as last month this was still being cited by a senior clinical director of East Sussex Hospitals Trust as a potential benefit and a reason to prefer a single site for obstetrics. ⁽⁵⁾ Unless there has been a change of view at Strategic Health Authority level this claim of potential SCBU benefit is disingenuous and lacks integrity.

Section 2 Royal Colleges Guidance

2.1 Assumption of 4500 Births Minimum

The RCOG guidance relating to size of obstetric units was quoted as a key driver for change in the ESHT draft paper “Re-configuration Options for Women’s Health” May 2006 (Section 2.1)

“The final proposals of the Strategic Health Authority were published in February in the paper “[Creating an NHS fit for the Future](#)”. This outlined a reduction in the number of maternity units providing consultant-led care related to population size and supports the guidelines of the Royal College of Obstetrics and Gynaecology (RCOG), in suggesting that a birth population of approximately 4500 was necessary to provide adequate training for medical staff. The current birth number for East Sussex Hospitals NHS Trust (ESHT) are approximately 3900, with ~1600 at Conquest, ~1900 at Eastbourne and ~350 at Crowborough. It is projected that the birth rate will increase in the next 2 – 5 years given the additional housing developments in both the Eastbourne and Hastings catchment areas. Even a modest 15% rise in birth rate will achieve the 4500 births recommended by the SSSHA.”⁽⁶⁾

2.2 “Safer Childbirth” in Smaller Units

The joint royal colleges’ guidance was finally made available in draft consultation form as “Safer Childbirth” in November 2006.⁽⁷⁾ Significantly 4500 births is no longer regarded as the minimum size for an effective obstetric unit. This guidance recognises and proposes specific obstetric staffing targets (Section 5.2.6) for units from 2500 births per year upwards while also recognizing that cut-offs are arbitrary and really only provide a framework for local implementation.

For units with less than 2500 births (category A) the guidance, rather than propose a minimum number of consultant hours, proposes a continual review of staffing based on local needs. This is relevant to models of obstetric service within the UK (such as North Devon at 1600 births) where geography & local conditions require a small obstetric unit to operate effectively.

2.3 Only Single Site Option Being Considered

The user group on the MSLC believes that an internal proposal from May 2006, when supportive guidance was believed to indicate 4500 births as a minimum, has retained its own momentum even when the external circumstances have changed. This 16 month-old initiative should be abandoned now that the external guidance has fundamentally changed, and the process restarted with a ‘clean sheet’. There has been no user involvement offered by East Sussex Hospitals Trust at director level since the MSLC meeting of June 2006 though internal work has continued on a single site proposal as the only option.

2.4 Forward Planning and Birthrate Information

Year	2003	2004	2005
Births to East Sussex Residents	4799	4828	4803

Births to East Sussex residents have been steady over the last three years. Only 3900 births take place within East Sussex Hospitals Trust, which suggests that already some 900 births a year are 'lost' to other providers. This can be due to a number of factors including proximity to other providers, women's choices and periodic temporary obstetric unit closures.

In the East Sussex Hospitals Trust draft paper of May 2006, a 15% increase in birthrate over the next 2-5 years was considered 'modest'. It was claimed that "*even a modest 15% rise in birth rate will achieve the 4500 births recommended by the SSSHA*".⁽⁶⁾ In actual fact, projections for the birthrate in East Sussex are for steady state or possibly a slight fall. If a 15% increase in birthrate is seriously envisaged then EDGH and Crowborough together would soon provide the 2500 birth population identified by the Royal Colleges.

It is a serious concern to the MSLC chairs that important background information (such as birthrate) appears to be open to manipulation by a local hospital trust in order to meet a specific number (in this instance 4500) that supports their pre-determined aims. The MSLC chairs would hope that the basis for this '15% increase in birthrate' claim in May 2006 will be identified soon by ESHT to ensure that it was not entirely spurious. If new housing developments are expected to create such a rise then it is important for this to be recognised in reconfiguration proposals, particularly in regard to future maternity capacity.

The consultation document would be expected to identify the birth rate projections assumed for the medium term. This should take into account the significant new housing developments planned within the local catchments area of the maternity services, not just those currently approved. If, as is likely, the consultation document seeks to minimize any growth in birthrate (*increasing birthrate is inconvenient for a single site proposal*) then it is important that the circumstances behind the U-turn in birthrate projections between May 2006 and March 2007 are clearly understood.

3.1 East Sussex Temporary Closures Unacceptable

The league table of the worst ten units in England for closure to expectant mothers in 2006 contained both the EDGH & Conquest obstetric units.

Ranked 5th worst - EDGH closed for 145 hours

Ranked 9th worst - Conquest closed for 102 hours.

In the view of the MSLC it is simply unacceptable to turn away an expectant mother in labour from the maternity unit to which she is booked and ask her to find another unit.

Documented Comments regarding maternity units closure ⁽⁸⁾

a) I went into labour and called XXXXXX only to be told they couldn't take me as they were full. I then had to find another hospital to go to, which I had never been to before, drive there late at night and try to find the way in. It was horrific. (woman in her 20's)

b) My third child was delivered at home due to the lack of bed spaces (closed wards). I had no pain relief and no midwife available at home. My child was delivered by my partner whilst on the phone to the emergency services. She was delivered before the ambulance arrived. I would never want this to happen to any one else. (woman in her 30's)

3.2 Reasons for Closures

Almost all closures are due to a shortage of midwives or beds, and hardly ever due to issues of medical staffing. The MSLC user group would sharply criticise a consultation document that presents guaranteed opening (ie: reduced temporary closures) as a benefit of single site obstetrics.

The principal cause of closures is a shortage of midwives to deal with women requiring admission. During 2006, midwifery management at East Sussex Hospitals Trust requested an additional 4 (whole time equivalent) midwives to bring their establishment up to recognized 'birthrate plus' levels and so avoid maternity unit closures. This request was turned down by the ESHT.

To allow this situation to continue and then present the solution as a move to a single site would demonstrate a serious lack of integrity by both providers and commissioners and be misleading to the general public. East Sussex Hospitals Trust are able to eliminate these temporary closures now by approving sufficient midwifery staffing without the need to move to a single site for obstetrics.

3.3 Sufficient Capacity is Critical

Any single site re-configuration proposals have to ensure that sufficient capacity (primarily midwives & beds) is available in the obstetric unit to ensure that there is never a need to close to expectant mothers. The midwifery perspective prepared in April 2006 ⁽⁹⁾ for the then 'quick strategy review' noted that increased distances of travel will mean that women access services sooner during labour. This means that women will be in the unit longer and will be less likely to travel home to await events, thus significantly increasing pressure on capacity.

3.4 Time-Frame to Build Midwife-led Capacity

Provisional single-site planning in 2006 assumed that 500 women would access a Midwife-led unit in the town without the consolidated obstetric unit.⁽⁶⁾ On this basis it might be considered that the single-site obstetric unit would require physical bed capacity for 3000 women.

However, the experience from the Crowborough Birth Centre development as a midwife-led unit demonstrates that it can take some two to three years for birth centre numbers to build up as local women develop confidence to use this new model of service.

Crowborough Births as a Midwife-led Unit	1997	1998	1999	2000	2001
	179	185	282	265	300

3.5 Physical Capacity for Sufficient Beds

It will therefore be essential that any single-site obstetric unit can physically accommodate sufficient beds for 3500 births in order to avoid the current situation of closures worsening. The MSLC would expect to see plans (with costs and timescales) in any consultation paper for the retention of the existing 48 obstetric beds in East Sussex within any single site option in order to maintain existing bed capacity.

3.6 Retention of Midwives for Sufficient Capacity

Anecdotal experience from other reconfigurations (eg: Crawley) suggests that not all midwives transfer with the relocation of obstetric units, and around 30% may be lost to the service or to other providers. This can have a major, adverse impact on the viability & sustainability of a single site obstetric plan. A full assessment of midwife home location, travel ease and employment intentions in the event of reconfiguration needs to be undertaken as part of the options preparation process.

In May 2006 the MSLC was concerned to note that the majority of savings theoretically obtained from Option 3.2 derived from a reduction in midwife and maternity care assistant staffing by a total of 15.7 whole time equivalents. This accounted for £325K of the total proposed saving of £400K. In the context of a proposal that consolidates medical obstetric care and creates a new large midwife-led unit in either Eastbourne or Hastings it is inconceivable that this can be effectively and safely obtained with a reduction in midwifery staffing.

3.7 Midwife Establishment to Birthrate Plus

One of the recommendations in the draft of “Safer Childbirth” is that midwifery establishment is maintained at **birthrate plus levels**. In April 2004 this evaluation showed that for East Sussex an additional 11 wte midwives were required. In a single-site proposal with an additional midwife-led unit, some additional midwifery resources will be required over a two or three year transition period in order to safely staff both the obstetric unit and the MLU while birth numbers build up in the MLU. These requirements should be built into the costing for the single-site proposal.

4.1 No Evidence that Closing Maternity Units Saves Money.

An economic study by the NHS Confederation in 1999 concluded that there was:

- 1) no evidence of returns to scale in maternity - may be some in medical staffing.
- 2) minimal reductions in staff costs
(it may cost more if the service being replaced is not up to strength)
- 3) almost no reduction in overhead costs (pathology, radiology, hotel services)
- 4) major increase in capital costs if a re-provision is required

(Nigel Edwards - July 1999. NHS Confederation)

It is noteworthy that East Sussex Hospitals Trust's own cost outline in May 2006 showed that a single site obstetric proposal would cost £328K more than the 2006 /2007 budget for the existing two site configuration, (and without taking any account of capital costs).

On the basis that, in childbirth, every woman requires a midwife, but not every woman requires a doctor, it would be expected that a single-site proposal would generate some savings in medical staffing within a consolidated obstetric unit. In fact no savings were indicated in the May 2006 proposals, and we would suggest that this is an item for further evaluation.

4.2 Dedicated Obstetric Anesthetists

Currently anesthetic cover for the two obstetrics departments is provided from within the anesthetics departments at each of the hospitals. A larger consolidated single-site obstetric unit is likely to require provision of dedicated obstetric anesthetists of 5.5 whole time equivalents. The cost of this provision was estimated in the previous 2004 Clinical Services Review to be some £550K per annum, and is now probably greater. This cost should be transparently factored into any single-site obstetrics proposals.

In relation to dedicated obstetric anesthetists the proposals should also:

- a) confirm that recruitment of sufficient obstetric anesthetists into East Sussex Hospitals Trust is achievable. This would involve considering the number of trained specialists becoming available nationally and the attractiveness of ESHT as a location for this specialization.
- b) consider the timescale for recruitment of a team of dedicated obstetric anesthetists, and ensure that the timetable for any consolidation proposals allows sufficient time for this recruitment.

4.3 Payment by Results (PbR)

Under the newly introduced 'Payment by Results' system of financing, the income to East Sussex Hospitals Trust for the maternity service it provides depends on the activity within that maternity service. This is not particularly an issue for a PCT (commissioners) as the funding they provide follows the woman and is unaffected by the choices women make. It is however a vital issue for a provider trust such as East Sussex Hospitals trust in ensuring that they maintain financial balance.

One of the important aspects of cost-effectiveness and financial balance, therefore, is retaining women (customers!) within ESHT area so that income is retained within the hospitals trust to balance the cost of the service provided. In a maternity service retaining this income depends on women's choices of where to access the service and where to have their baby, which in turn is also influenced by GP referral patterns.

4.4 Activity Flow Assumptions

With a single obstetric site, a number of women from either Eastbourne or Hastings are likely to decide to use Brighton or Ashford / Pembury respectively. Some estimates are as high as 50% for Eastbourne women and 25% for Hastings.

The attached budget outline uses the very cautious assumption that only 10% of existing user women are lost to providers outside of East Sussex Hospitals Trust. (ie: 20% of women from the smallest site) The impact of this on the financial stability of a single site maternity service is considerable, and can be seen in the following financial outlines.

Outline 1) Single Site Obstetrics + New Birth Centre in E or H + Crowborough Birth Centre. (As produced by ESHT May 2006) Costs are £327,734 more than existing, though this appears to include an estimated £187,000 of midwifery salary increase.

Outline 2) Outline 1 has been modified to show the impact of the cost of Dedicated Obstetric Anaesthetists and loss of PbR income to adjoining trusts of 10% of women choosing other providers. Increased cost and loss of income shows a funding gap of £1,431,974

The consultation proposals need to show that additional funding is available for any proposed single obstetric site configuration. Unless this funding is available then there will be a real concern that a funding gap of £1.4M will, in due course, create enormous cost-cutting pressures on the service. Under such conditions safety and quality may both be compromised.

This 'loss of activity' assumption is very conservative. Significantly higher loss of income may be experienced. If this were to be the case there is a very real (paradoxical) risk that the funding gap created by a single site may make that configuration financially unstable and create greater pressures on an obstetric service in East Sussex in the longer term.

Financial Outline 1

"Re-configuration of Women's Health"

Appendix 1

Ken Murphy (May 2006)

Cost Comparison: Proposed 06/07 Budget for Two Obstetric Sites vs Single Site + Crowborough BC + Additional BC

	Status Quo		Obs Option B - Single Site + CBC + Add'l BC (Gynae Sole Option)			
	Proposed 06/07 Budget	Proposed 06/07 Budget	Proposed Budget	Proposed Budget	Diff to 06/07 Proposed	Diff to 06/07 Proposed
<i>Pay Costs (By staff group)</i>	wte	£	wte	£	wte	£
Management	2.18	152,477	2.18	152,477	0.00	0
Medical - Senior	16.00	1,735,324	16.00	1,735,324	0.00	0
Medical - Junior	14.09	870,543	14.09	870,543	0.00	0
Medics	30.09	2,605,867	30.09	2,605,867	0.00	0
Community Midwifery - Qualified (Band 5+)	39.65	1,618,078	39.00	1,587,827	-0.65	-30,251
Hospital Midwifery - Qualified (Band 5+)	97.16	3,635,624	101.77	4,004,792	4.61	369,168
Hospital Midwifery - Unqualified (Band 1-4)	28.89	555,323	26.60	488,824	-2.29	-66,499
Total Midwifery	165.70	5,809,025	167.37	6,081,443	1.67	272,418
Gynae Nursing - Qualified Nursing (Band 5 +)	24.50	827,623	21.00	708,212	-3.50	-119,411
Gynae Nursing - Unqualified Nursing (Band 1-4)	9.20	165,764	15.00	281,391	5.80	115,627
Total Gynae Nursing	33.70	993,387	36.00	989,603	2.30	-3,784
Admin & Clerical	25.46	495,913	25.46	495,913	0.00	0
AfC Assimilated funding	0.00	0	0.00	0	0.00	0
Total Pay	257.13	10,056,669	261.10	10,325,304	3.97	268,634
<i>Non-Pay</i>	0.00	905,769	0.00	905,769	0.00	0
<i>Income</i>	0.00	-32,949	0.00	-32,949	0.00	0
<i>Agreed Cost Pressures</i>	0.00	0	0.00	0	0.00	0
<i>Trust Overheads (22% estimate only)</i>	0.00	2,404,488	0.00	2,463,587	0.00	59,100
Total of Directorate	257.13	13,333,977	261.10	13,661,711	3.97	327,734

ESHT own costings in May 2006 indicated that a single site option (with provision of a birth centre in the town without an obstetric unit) would be more costly than the existing twin obstetric site configuration.

Financial Outline 2

"Re-configuration of Women's Health" (Appendix 1) Ken Murphy (May 2006) with inclusions of PbR & Dedicated Obstetric Anaesthetists, MSLC March 2007

Cost Comparison: Proposed 06/07 Budget for Two Obstetric Sites vs Single Site + Crowborough BC + Additional BC

	Status Quo		Obs Option B - Single Site + CBC + Add'l BC (Gynae Sole Option)			
	Proposed 06/07 Budget	Proposed 06/07 Budget	Proposed Budget	Proposed Budget	Diff to 06/07 Proposed	Diff to 06/07 Proposed
<i>Pay Costs (By staff group)</i>	wte	£	wte	£	wte	£
Management	2.18	152,477	2.18	152,477	0.00	0
Medical - Senior	16.00	1,735,324	16.00	1,735,324	0.00	0
Medical - Junior	14.09	870,543	14.09	870,543	0.00	0
Medics	30.09	2,605,867	30.09	2,605,867	0.00	0
Community Midwifery - Qualified (Band 5+)	39.65	1,618,078	39.00	1,587,827	-0.65	-30,251
Hospital Midwifery - Qualified (Band 5+)	97.16	3,635,624	101.77	4,004,792	4.61	369,168
Hospital Midwifery - Unqualified (Band 1-4)	28.89	555,323	26.60	488,824	-2.29	-66,499
Total Midwifery	165.70	5,809,025	167.37	6,081,443	1.67	272,418
Gynae Nursing - Qualified Nursing (Band 5 +)	24.50	827,623	21.00	708,212	-3.50	-119,411
Gynae Nursing - Unqualified Nursing (Band 1-4)	9.20	165,764	15.00	281,391	5.80	115,627
Total Gynae Nursing	33.70	993,387	36.00	989,603	2.30	-3,784
Admin & Clerical	25.46	495,913	25.46	495,913	0.00	0
AfC Assimilated funding	0.00	0	0.00	0	0.00	0
Total Pay	257.13	10,056,669	261.10	10,325,304	3.97	268,634
<i>Non-Pay</i>	0.00	905,769	0.00	905,769	0.00	0
<i>Income</i>	0.00	-32,949	0.00	-32,949	0.00	0
<i>Agreed Cost Pressures</i>	0.00	0	0.00	0	0.00	0
<i>Trust Overheads (22% estimate only)</i>	0.00	2,404,488	0.00	2,463,587	0.00	59,100
Total of Directorate	257.13	13,333,977	261.10	13,661,711	3.97	327,734
PbR income loss of 80 birth per year (c/s) to others		0		155,040		155,040
PbR income loss of 240 birth per year (normal) to others		0		202,080		202,080
PbR income loss of 320 women antenatal care to others		0		197,120		197,120
Total of Directorate including PbR Costs		13,333,977		14,215,951		881,974
Dedicated Obstetric Anaesthetists Provision	0.00	0	5.50	550,000	5.50	550,000
Total of Directorate inc PbR + Anaesthetists			266.60	14,765,951	9.47	1,431,974

4.5 Avoidance of Future Costs

In a situation where the single site option will be more expensive than the existing service configuration, it is likely that the financial reasoning within the consultation will focus on the avoidance of future costs. Indeed it is common-place for consultation proposals to present these as financial savings! This usually makes a real financial analysis of consultation proposals obscure to the general public, being a comparison of two unknown and undisclosed estimates some distance into the future.

Re-configuration on to a single site whilst maintaining a safe and high quality service is a major undertaking that will require preparation and implementation over a considerable period of time. This is especially so if building alterations and refurbishments are required in both the obstetric and any midwife-led unit. Public support for any re-configuration must be on the basis that sufficient funding is available for effective implementation over several transitional years, including funds for one-off costs of transition, (see Section 6) and that cost-effectiveness is clear.

In our view the consultation proposals should lay out the three year ahead costs of both a single site and a two site configuration so that the financial position relating to each option is transparent. (ie: covering financial years 2007/8; 2008/9; 2009/10)

Section 5 Models for Effective Small Obstetric Units

5.1 North Devon as a Model

Maternity services in North Devon are provided by the Northern Devon Healthcare NHS Trust based in Barnstaple. This is an acute trust that manages both hospital and community maternity services in an integrated way. Approximately 1600 women use the service each year, from within a geographical area that stretches from the East Somerset border (Lynton & Lynmouth) to North Cornwall (Bude / Holsworthy). There are many similarities between North Devon and Hastings.

- a) coastal town
- b) around 1600 births per year
- c) rural hinterland
- d) geographically remote
- e) poor road network
- f) summer tourism

A summary report on the obstetric and maternity service provided by North Devon District Hospital is contained in **Appendix 1**. The extract below from that report indicates that, not only is there a model in North Devon for an effective small obstetric unit, but that there might be quality benefits for women in maintaining a unit of that size.

“There was no doubt from those spoken with that obstetric care at North Devon District Hospital was sustainable, and the consultant’s view was that in no way did the unit provide sub-standard clinical care. Indeed he took the opposite view, that in many ways as a smaller unit it was able to provide better quality woman-centred care than some other larger units. In his view medical and midwifery staff are less rushed and less stressed than in larger units and therefore have more time to provide individualised and one-to-one care for women in the unit”.

The problems of larger obstetric units have been well documented by the Healthcare Commission in recent years, and before a single site option is presented in the consultation document as the only option available, it would be wise to consider & evaluate the North Devon model in regard to East Sussex coastal towns.

5.2 Modern Medical Careers

Much of the drive for larger obstetric units is designed around changes in medical training and consultant sub-specialisation. While clearly important, the primary intention of obstetrics should be to provide a woman-centred service. Modern Medical Careers (MMC) is currently in transition and suffering considerable teething problems. The final shape of doctor training is still likely to change and it may be some time before career pathways and doctor training are settled into a clear and steady pattern.

In the meantime a potential model for two East Sussex obstetric units (that may offer quality benefits through being local and small), should be thoroughly explored before a single site is presented as the only option available.

6.1 CNST Re-assessment Required

The Directorate obtained CNST Level 3 status in 2006, bringing a saving on insurance premiums of over £400,000. This level 3 status is for the existing configuration of services and any significant re-configuration (such as that proposed) would need to be reassessed. In the meantime it is likely that

a) either insurance premiums would revert to their previous charge for level 1 status, adding significantly to the inevitable transitional costsor....

b) that the whole CNST assessment process would have to be repeated. This would create considerable resource demands exactly at the time when re-configuration would be stretching management resources. Resources planning and costs for both re-configuration and CNST re-assessment need to be built into any single-site proposals in a transparent way.

6.2 Other Transitional Costs

It is to be expected that transitional costs from the existing configuration to a single site configuration are likely to be large (capital charges, protected pay, travel allowances, re-training, possible redundancy & recruitment costs, refurbishments costs, etc) and these will not be borne by commissioners, but will have to be financed out of Trust funds. This will create additional cost pressures within a (currently under-establishment) maternity service while it is trying to cope with significant change.

6.3 Explicit Transitional Resources for Safe Service Development

We believe that a safely managed major re-configuration requires the transitional costs and the explicit additional resources to match, to be clearly identified as part of the consultation process. Only in this way can it be clear that any proposed option is capable of effective implementation in practice, and with sufficient resources to provide a safe service during a complicated transitional process with stretched management.

Appendix 1

North Devon District Hospital Obstetrics & Maternity

Overview

Maternity services in North Devon are provided by the Northern Devon Healthcare NHS Trust based in Barnstaple. This is an acute trust that manages both hospital and community maternity services in an integrated way. Approximately 1600 women use the service each year, from within a geographical area that stretches from the East Somerset border (Lynton & Lynmouth) to North Cornwall (Bude / Holsworthy). This is an area of around 930 square miles within which the number of births has been rising.

The Caesarean Section rate is 22%, with home births in the area over 5%. There are two pools for water births, and more than 50% of births use water for labour and / or birth. The unit achieved CNST Level 2 in November 2006.

Midwifery

Midwife-led care is offered in conjunction with consultant-led care within the unit at Barnstaple. Sliders on the doors show whether a woman is under midwife or consultant care, and this allows doctors to know which women they need to focus on while working in the unit.

The community midwifery service is organised in 6 teams of 6.2 whole time equivalent (wte) midwives. Case loading is by team, not by individual midwife, which reduces individual midwife stress and burn-out. The case-loading ratio is approximately 35 women to 1 midwife (though not on an individual basis.) Each woman will meet the team responsible for her care. For every woman, (“low-risk” or “high-risk”) the midwife is the pivotal point of contact, and when going into labour all women will contact a midwife who will come into the unit with that woman. This includes women coming in for elective caesarean sections.

The Delivery Suite is manned by a Delivery Suite Co-ordinator (Grade 7 Senior Midwife) and a Maternity Care Assistant (MCA) 24 hours a day, 7 days a week on a shift basis. The Delivery Suite Co-ordinator is responsible for managing all intra-partum within the unit and the community, and remains available for contact and advice to any midwife caring for a woman in labour.

The Antenatal & Postnatal ward is a combined ward and is covered by 2 Midwives and 1 MCA per shift, though there will be 2 MCA’s on shifts designated for elective caesarean sections.

Medical Staffing

Consultant medical staffing for Obstetrics and Gynaecology is provided by 4 Consultants and 1 Consultant on annualised hours (at 30 hours per week). This consultant covers annual leave, sickness and other absence thus avoiding the need for locum cover. All the consultants are recognised as ‘substantive consultants’ and are on the specialist register. Within these consultant numbers there is a Clinical Lead Consultant for the directorate (Obstetrics & Gynaecology) and a consultant who acts as clinical lead for “Delivery Suite & Audit”. Each of the consultants exercise sub-specialty interests (eg: fertility, oncology, gynaecology, terminations).

The consultant team have long appreciated that for senior medical staffing, holiday cover is often the issue and therefore ‘self-manage’ annual leave effectively and tightly. Each consultant will clear the timing of his own annual leave with the consultant on annualised hours who co-ordinates the rota to ensure he is only covering for one consultant at any one time. In this way only 1 consultant out of 5 will be on leave at any one time. The significance of this for senior staffing levels should not be underestimated. Appendix 7 of “Safer Childbirth”⁽⁷⁾ notes that:

“This report urges units to ensure that labour wards are covered for a minimum of 40 hours, allowing for peak periods when up to half of the consultant obstetricians may be on annual leave during the summer time.” (our italics)

In addition to the consultants there are 4 fully trained staff grade doctors (registrars) who have full membership of the RCOG. These doctors cover each other and work ‘1 in 4’, which keeps their working hours close to ETWD compliance. All are comfortable with their existing balance of work and remuneration. There are also 6 junior doctors; some at FT2 level and some employed as trust doctors.

This medical team provide medical staffing for gynaecology and 24/7 obstetrics medical cover for 1600 women. The Obstetrics and Gynaecology Departments are in the same building which assists with covering both departments. There is just enough gynaecological work for 4 consultants, and as result there are no waiting lists.

Their view is that they work within the framework of “Safer Childbirth” Section 5.2.5

“In units where there are relatively few births (less than 2500 per year), a consultant continually present on the labour ward may be a wasteful use of resource. It is crucial therefore, that to ensure the best use of resources, both financially and in terms of manpower, individual units with less than 2500 births a year or a low risk population perform a risk assessment exercise, and plan labour ward cover compatible with the needs of the unit.”

Neo-Natal Services

Northern Devon NHS Healthcare Trust run a Level 2 Special Care Baby Unit (eg: can provide short-term ventilation) and works within a managed network for paediatrics. This on-site unit provides the capability to treat sick babies and then transfer them to the tertiary neo-natal unit at Derriford, Plymouth.. Any known cases of gestation under 30 weeks (singleton) or 32 weeks (twins) are referred direct to Plymouth.

Sustainability & Quality

There was no doubt from those spoken with, that obstetric care at North Devon District Hospital was sustainable, and the consultant's view was that in no way did the unit provide sub-standard clinical care. Indeed he took the opposite view, that in many ways as a smaller unit it was able to provide better quality woman-centred care than some other larger units. In his view medical and midwifery staff are less rushed and less stressed than in larger units and therefore have more time to provide individualised and one-to-one care for women in the unit.

The Head of Midwifery was equally adamant that the unit provided a high quality of medical and midwifery care. She provided a south-west regional comparison of the extent to which the five obstetric units in Devon & Cornwall had progressed towards implementation of the National Service Framework on Maternity. This comparative study identified 117 issues for implementation and categorised them as

- a) green fully implemented
- b) amber action plan identified for implementation
- c) red no identified action plan

A quantitative analysis of this study demonstrates that most progress towards implementation had been made by the two smaller units in the region at North Devon District Hospital (Barnstaple – 1600 births) & South Devon Health Care Trust (Torbay – 2000 births).

Report based on a tour of the Ladywell Unit (maternity unit) on 6th March 2007 and interviews with:

Clinical Lead Consultant (Delivery Suite & Audit)	Stephen Bennett
Head of Midwifery:	Julia Drury
Delivery Suite Manager	Sally Scott

Clinical Services Review 2004

A detailed Clinical Services Review of Maternity in East Sussex was carried out in 2004. The summary recommendation of this review (Section 7.4) was that:

“The review found no compelling reasons that suggested clear advantages under any of the following key parameters to support a change to the configuration of existing maternity services:

*Improving choice and access for women
Offering a significantly higher quality of care
Making a significant saving
Only making that change would be sustainable in staffing*

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

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

November 2005

On 4th November 2005 an internal meeting of senior Obstetrics & Gynaecology Management was held within East Sussex Hospitals Trust. The leaked notes of this meeting indicated that a decision had been taken at a senior level within the trust to progress towards a single site for Obstetrics & Gynaecology within the East Sussex area, and that clinical staff were required to provide the supportive reasoning for this decision.

There was considerable local press coverage of this meeting, and at the next meeting of the Tri-Forum MSLC it was agreed that the chair should write to the Trust to confirm that the MSLC would be involved in any re-opening of the Clinical Services Review. As a result a number of MSLC user representatives were invited to join the ‘Women’s & Children’s Working Group Meeting’ on 14th March 2006.

“Reconfiguration Options for Women’s Health”. May 2006

Following the March 2006 meeting a draft paper was prepared by Ken Murphy (Women & Children’s Services Directorate Business Manager) entitled “Reconfiguration Options for Women’s Health”. This paper outlined the ESHT-favoured option:

“Option 3.2, a single consultant-led obstetric unit supported by a midwifery-led birthing facility is the only option that is viable and sustainable and represents a financial saving.”

The MSLC considered this paper at its meeting of 5th May 2006 and prepared a considered critique of shortcomings of that document. This was forwarded to the trust CEO, and as a result the Trust's Director of Operations (Graham Griffiths) attended the next MSLC meeting in June 2006. He confirmed that a locum doctor had been made available to cover a consultant resignation, that the intended timetable had now been delayed and that it was now accepted that there were no financial savings to the Trust from a single site option.

'Management Decision looking for a Clinical Reason?'

A 'quick review', lack of detailed analysis and an ill-prepared reconfiguration are a recipe for disaster, especially when the conclusion is very different from a detailed and through Clinical Services Review that reported in August 2004 only 15 months before the internal management meeting that determined the single-site intent.

The MSLC was concerned that the whole episode of 'quick review' fitted into an impossibly tight timescale appeared to be a "management decision looking for a clinical reason". In the meeting of March 2006 it became quite clear to the chairs of the MSLC that the managers driving the 'quick review' process were not familiar with the work of the 2004 Clinical Services Review, and did not at the time even have access to a copy of the report and the working papers.

The process of re-configuration to a single site would be a major change for maternity services. It would create upheaval for many local women, it would require significant changes in working patterns for many staff, and would stretch management and financial resources within the Trust that are already under severe pressure. It is not a process to be undertaken lightly or without thorough preparation.

The MSLC, in their role as monitors and advisors on maternity services to the PCT, are determined to ensure that every option developed for consultation should be properly women-centred in its focus and implementation, thoroughly researched and genuinely viable. Local women deserve nothing less.

It is an 'easy assumption' that in a single obstetric site proposal the unit that was not the obstetric site would be converted into a midwife-led unit. This would be an unwarranted assumption.

A local study during 2004 into women's preference covered this issue in some detail. ("Birth Services in Mid Sussex" August 2004) The results have important implications for any decision about location of a new midwife-led unit.

In regard to giving birth at a local hospital without specialist facilities (obstetrics) "only one in five said this was one of their top two choices (21%). In contrast, double this amount wanted a small midwife-led birth centre away from hospital (43%). In fact, a local hospital without specialist facilities was women's least favoured option overall.

"In our discussion groups women told us why they perceived few benefits from a hospital unit without specialist facilities. Most commonly, this was because if specialist facilities were not available in hospital, women would prefer to give birth away from hospital."⁽⁸⁾

"A hospital unit without specialist facilities for women at high risk would cater for the same group as women eligible to use birth centres. Birth centres are more homely, holistic, and you get more individual care. So why would you want to go to hospital if it doesn't have any of the medical services you might need?"

There may also be issues of safety related to a birth centre within a functioning hospital building in that many local women may still perceive it a maternity service where there are doctors around if needed. For separate birth centres, such as Crowborough, it is quite clear to women that there no emergency or anesthetic medical cover, and that is factored in to their choice of where to give birth. The experience of other consultant units turned birth centres has not been wholly satisfactory (eg: Wyre Forest, Weston-super-Mare)

The consultation proposals should identify alternative locations (& costs) of a separately located midwife-led unit in the town without an obstetric unit. An assumption that to create a midwife-led unit the service can simply "withdraw doctors from that part of the hospital building" is inadequate and is not a sufficiently detailed proposal to be sure of effective implementation.

References

- 1) Review of Maternity & Gynaecology Services August 2004
East Sussex Hospitals NHS Trust
- 2) National Service Framework on Maternity September 2004
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- 3) Income Deprivation Affecting Children Index (IDACI)
*(The percentage of an areas children under 16 who were living
in families in receipt of benefits with the lowest income.)*
- 4) Why Mothers Die 2000-2002
6th Report of Confidential Enquiries into Maternal Deaths in the UK
- 5) “EASTBOURNE today” 18th February 2007.
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- 6) Reconfiguration Options for Women’s Health Ken Murphy, May 2006
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