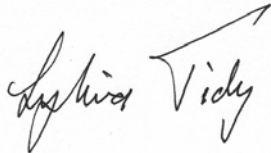




would expect to see interim action being taken to mitigate these issues prior to any substantive change, whether or not HOSC's referral was proceeding. I trust that any such temporary measures which would have been put in place during the planned implementation period will also be suitable to ensure the maintenance of the service during the Secretary of State's review.

I will of course send you a copy of HOSC's letter to the Secretary of State and the supporting information once it has been prepared and submitted.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Sylvia Tidy', with a long, sweeping flourish extending upwards and to the right.

Councillor Sylvia Tidy  
Chairman  
Health Overview and Scrutiny Committee

cc:

Cllr John Barnes, Chairman, East Sussex Downs and Weald PCT

Charles Everett, Chairman, Hastings and Rother PCT

Lisa Compton, Director of Patient and Public Engagement and Corporate Affairs, East Sussex PCTs



20 February 2008

Cllr Sylvia Tidy  
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Dear Councillor Tidy

**Fit for the Future: HOSC decision and referral to the Secretary of State**

Thank you for your letter of 30<sup>th</sup> January 2008 confirming the outcome of the HOSC meeting of 28<sup>th</sup> January 2008. In your letter you request a response from the Primary Care Trusts to the views expressed by the HOSC.

Your letter states that the HOSC will refer the PCTs' decision to the Secretary of State subject to three conditions and sets out the reasons for your decision to make a referral.

The PCTs have given careful consideration to the points that you have raised following our decisions at the public meeting of the Joint Committee of the PCT Boards held on 20<sup>th</sup> December 2007.

Both Boards welcome the HOSC's support for the decision to improve ante natal and post natal care and associated outreach services. The PCTs have already started work on the implementation planning for these changes.

In addition the Boards are most grateful to the HOSC for the views and evidence that were presented through the consultation period which helped to shape our decisions. In coming to their decisions the PCT Boards accepted in full the recommendations made in the HOSC's response to the consultation of 10<sup>th</sup> October 2007. Our decisions also recognised the importance of outreach care to the most vulnerable, the need to strengthen ante natal care, implement NICE advice, achieve 1:1 midwife care during labour, build on existing practice by putting in place risk protocols for best care based on CEMACH recommendations and to move forward the local maternity strategy to start implementing improvements in care.

The PCTs considered a wealth of evidence in reaching their decisions. We have reviewed the reasons for reaching the conclusion that we did on 20<sup>th</sup> December and are not aware of

any previously unconsidered issues or fresh evidence that might lead us to question that decision.

The Healthcare Commission's Review of Maternity Services released in January 2007 offers no evidence that would lead us to reconsider our decision and some that appears to confirm our concerns. The PCT Boards will work with East Sussex Hospitals Trust and other providers of maternity services for our population to address the issues raised in the Healthcare Commission's Review, principally through our work to develop a maternity services strategy as part of our Strategic Commissioning Plan.

In your letter you have set out a number of areas of concern that have led you to propose referral to the Secretary of State. The PCTs consider that these issues were taken into account by the Joint Committee in reaching its decisions.

Can we in turn express some concern about the way in which you expressed the third point, since as it stands it appears to convey some misunderstanding of our position?

Although we believe that single siting and an increased consultant presence in conjunction with the other measures we have recommended will lead to a significant improvement in services and outcomes, our more immediate concern was to ensure that a situation which is likely to deteriorate is made more safe for mothers and babies. Our obstetricians and gynaecologists have told us that maternity services are currently operating at the margins of safety. As the changes in medical training work their way through and are affected by the restrictions on working hours placed on both junior doctors and those supervising them, the situation will become ever more challenging. The evidence that only fifteen hours of consultant presence was being achieved in each of the labour wards – less than one in ten of all hours - indicates just how challenging this will be, and, as you were advised, 40 hours will be regarded as the necessary minimum even in a small unit. Additional staff would help, but in the end there has to be a sufficient flow of work to ensure that clinicians see enough of the right kind of case to keep both their judgements and operational skills well honed. We must add that the current rate of unplanned closures adds to our concern.

The Joint Committee therefore believed that fundamental changes to the way in which the service is delivered are not just necessary, they are required urgently. We understand that the letter you have recently received from Mr Zaidi (Clinical Director for Women's Health at East Sussex Hospitals) and his colleagues confirms this view.

Although we have gone into some detail on that key issue, this is not the place for a detailed rehearsal of all the evidence we considered, or a full discussion of its significance, but we offer a brief resume of the PCTs' views on the issues you raise:

1. Evidence relating to the impact of longer travel times to the obstetric unit on the safety of women and babies.

The PCTs reviewed published evidence and found no research that suggested that longer travel times from home to the obstetric unit would reduce safety for women and babies.

The PCTs modelled travel times from every electoral ward in the county to the nearest consultant led unit if obstetrics was single sited at Eastbourne or Hastings, showing that 97-98% of women would be within 40 minutes of a consultant led obstetric unit, with an average journey time of 19-20 minutes (off peak travel by private car).

No evidence has been seen that women who already live at a greater distance from their chosen place of birth (either in East Sussex or elsewhere) are more likely to have babies born before arrival. Women in rural parts of the South West peninsula have similar and longer journey times to those envisaged in East Sussex: this is not reported to cause problems.

The PCTs also considered experience in East Kent where no increase in the number of babies born before arrival was seen when the service was reconfigured

Some women using Crowborough Birthing Centre come from well outside the immediate catchment area, and again this has not been seen to cause problems.

## 2. Evidence of safety concerns relating to the distance of the midwife-led unit from the consultant-led unit and questions over whether this is the best configuration for midwife-led care.

The PCTs reviewed published evidence and found no research that addresses specifically the issue of transfers of mothers in labour and no guidance or evidence to indicate that travel times become unsafe beyond a particular time or distance. This includes the recently published NICE Guideline on Intrapartum Care and the joint Royal College document Safer Childbirth.

The PCTs therefore considered best practice nationally and discovered that stand alone midwife led units (MLUs) commonly operate at some distance from their consultant led unit (CLU). In a review of stand alone MLUs, all units identified as delivering more than 300 babies each year were situated between 9 and 24 miles from their nearest obstetric unit, though a few smaller units were at much greater distance from the CLU. We have taken detailed advice from Crowborough Birthing Centre and the birthing centres in Dover and Canterbury. The outcomes data from Crowborough, Canterbury and Dover were reassuring. The PCTs noted for example that women living in the centre of the county (e.g. Heathfield) choosing home birth and those delivering at the Crowborough Birthing Centre potentially already have transfer times of over 20 minutes, in some cases up to 28 minutes (using data derived from the model of off peak travel by private car). Concern has not been expressed about these journey times, and there is no evidence that they are unsafe. We have also discussed home deliveries with senior midwives working with highly dispersed rural populations. We are reassured therefore that our proposals are in the mainstream of clinical practice nationally.

The Confidential Enquiry into Maternal and Child Health (CEMACH) report Saving Mother's Lives, published in December 2007 analysed all maternal in the UK between 2003 and 2005 and reported that one woman died in a midwife led unit, and three following home delivery. It is significant that transfers are not reported as being a contributory factor to any death.

In the 'Chief Executive's report on the outcome of the 'Creating an NHS Fit for the Future' consultation on obstetric, specialist baby care and inpatient gynaecology services' public concerns about longer journey times and the potential risk to women involved in travelling to an obstetric centre are recognised. The PCTs therefore described a range of approaches so that, to the extent that such a risk exists, it would be mitigated successfully. These are described more fully elsewhere, but include:

**Early assessment:** 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.

**Informed choice:** Women choosing homebirth or a birthing centre must be making an informed choice, and will be provided with information and support in making that choice, following NICE recommendations.

**Best practice transfer arrangements:** The approach in midwife led care is focused on normality. As soon as there is any sign that a delivery is deviating from normal, for whatever reason, the midwife will make arrangements for the woman to be transferred to the consultant led unit. The PCTs will work closely with East Sussex Hospitals Trust and South East Coast Ambulance Trust to ensure that appropriate agreed protocols and practice are in place that remove any barriers to rapid transfer when required. A midwife will travel with women requiring transfer. They will take account of the latest guidance and follow the recommendations of The 5<sup>th</sup> Report of the Confidential Enquiry into Stillbirths and Deaths in Infancy, on transfer arrangements.

**Enhanced paramedic skills:** Although no new risks are introduced by the proposed reconfiguration, in order to ensure a consistently high level of ambulance response, the PCTs are requiring the ambulance trust to ensure all crews undertake additional training in obstetric life support

As the Chief Executive's report notes, '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'.

### **3. A lack of convincing evidence that patient outcomes will be improved with a single site configuration for consultant-led care.**

The principal sources of evidence supporting the view that a single consultant led unit will improve outcomes have been:

Safer Childbirth  
Maternity Matters  
Saving Mothers' Lives  
The advice of RCOG and our local obstetricians and midwives

However a very wide range of evidence has been examined much of it focussed on the issues of the quality and safety of maternity services, and therefore relevant to achieving good outcomes.

CESDI found most intrapartum deaths had sub-standard care and in over half alternative management would have made a difference. The PCTs agree with the view reached by the joint Royal Colleges in their report *Safer Childbirth* that the evidence that increasing presence of consultants, to supervise, train, support and intervene is key to improving safety and quality is compelling, and that more hours of consultant presence is better than fewer. A single consultant led unit will give 60 hours of consultant presence ensuring a consistent level of consultant involvement and supervision seven days a week. This is an important advance in comparison with the current situation where consultant presence on labour ward at each of our two hospitals is limited to 15 hours per week, and significantly better than the 40 hours proposed for most two site options.

### **4. Evidence that there may be a reduction in choice due to the geography and the proposed configuration of services, which may be compounded in areas where there is significant deprivation**

In our Consultation Document the PCTs were clear that 'We want to ensure that women can exercise choice – either midwife-led care when it is clinically appropriate or consultant-led care if they prefer or because it is necessary due to the risks they face.' Maternity Matters, the most recent national policy document on maternity care describes new national choice guarantees. These are:

1. Choice of how to access maternity care
2. Choice of type of antenatal care
3. Choice of place of birth – Depending on their circumstances, women and their partners will be able to choose between three different options. These are:
  - a home birth
  - birth in a local facility, including a hospital, under the care of a midwife
  - birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option
4. Choice of place of postnatal care

The decisions of the Joint Committee will ensure that we are able to meet these choice guarantees for all women in East Sussex. The importance of enhanced antenatal care that reaches out to hard to reach groups, including those in areas where there is significant deprivation should not be underestimated in ensuring real choice along the whole maternity pathway.

The PCTs' Maternity Services Impact Assessment found that improvements in preconception and antenatal care were the priority for the most deprived women in order to improve the management of antenatal risks and thus improve overall childbirth and infant health outcomes.

### **5. Evidence that possible alternatives which could maintain services on two sites may not have been fully explored and considered.**

The PCTs gave careful consideration to alternative options in their decision making. A new options assessment panel was established with an independent expert chair. Research into 17 other locations in the UK was undertaken to evaluate

different service delivery models. Four options that proposed a 'two site' model for consultant led services were assessed and taken into full consideration by the Joint Committee in its final decision making.

**6. The divergence of clinical opinion on what configuration of maternity and obstetric services will be best for the residents of East Sussex.**

A range of clinical views have been expressed about the proposals, and these were fully considered by the Boards. The proposals were supported by the majority of ESHT obstetricians including the clinical director and deputy clinical director, the ESHT Clinical Operations Board (the Clinical Directors management forum), the Hastings and Rother PEC and the PCTs' own medical director.

Where specific concerns have been raised the PCTs have responded and the PCTs intend to maintain dialogue with clinicians through the PECs, the Clinical Leaders Group, GP Forums and meetings at practice level.

In summary, whilst noting the reasons within your letter for the HOSC's intention to refer, the PCT Boards believe that the points raised were considered and given due weight in coming to our decisions.

For these reasons the PCTs wish to confirm to the HOSC our intention to proceed with the decisions made by the Joint Committee of the Boards on 20<sup>th</sup> December 2008, in order to ensure long term safety and a better service for local women and their babies.

We understand that the letter to HOSC we have referred to above from Mr Zaidi (Clinical Director for Women's Health at East Sussex Hospitals) and his colleagues expressed their concern at the implications of possible delays in implementing the PCTs' decisions if HOSC refers the matter to the Secretary of State.

In the interests of local women and their babies the PCTs will, of course, seek to minimise any such delay but we would urge the HOSC to bear in mind the risks associated with delay when making its final decision on whether or not to refer.

Yours sincerely



**Nick Yeo  
Chief Executive  
Hastings and Rother PCT  
East Sussex Downs and Weald PCT**