IRP

Independent Reconfiguration Panel

ADVICE ON PROPOSALS FOR CHANGES TO MATERNITY, SPECIAL CARE BABY SERVICES AND INPATIENT GYNAECOLOGY SERVICES IN EAST SUSSEX

Submitted to the Secretary of State for Health

31 JULY 2008

IRP

Independent Reconfiguration Panel

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CONTENTS

RECOMMENDATIONS

1. **The IRP does not support the PCTs' proposals to reconfigure consultant-led maternity, special care baby services and inpatient gynaecology services from Eastbourne District General Hospital to the Conquest Hospital at Hastings. The Panel does not consider that the proposals have made a clear case for safer and more sustainable services for the people of East Sussex. The proposals reduce accessibility compared with current service provision.**

2. **The Panel strongly supports the PCTs' decision to improve antenatal and postnatal care and associated outreach services. These improvements should be carried forward without delay.**

3. **Consultant-led maternity, special care baby, inpatient gynaecology and related services must be retained on both sites. The PCTs must continue to work with stakeholders to develop a local model offering choice to service users, which will improve and ensure the safety, sustainability and quality of services.**

4. **The PCTs with their stakeholders must develop as a matter of urgency a comprehensive local strategy for maternity and related services in East Sussex that supports the delivery of the above recommendations. The South East Coast SHA must ensure that the PCTs collaborate to produce a sound strategic framework for maternity and related services in the SHA area.**

5. **The PCTs working with all stakeholders, both health providers and community representatives, must develop a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the Panel's recommendations.**

6. **Within one month of the publication of this report, the PCTs must publish a plan, including a timescale, for taking forward the work proposed in the Panel's recommendations.**

OUR REMIT

What was asked of us

1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included at Appendix One.

1.2 On 31 March 2008, Councillor Sylvia Tidy, Chairman of East Sussex Health Overview and Scrutiny Committee (HOSC), wrote to the Secretary of State for Health, The Rt Hon Alan Johnson MP, exercising powers of referral under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. The referral concerned proposals developed by the two primary care trusts (PCTs) in East Sussex, namely East Sussex Downs & Weald PCT, and Hastings & Rother PCT, for reconfiguring maternity and special care baby services and inpatient gynaecology services provided by the East Sussex Hospitals NHS Trust (ESHT) from Eastbourne District General Hospital (Eastbourne DGH), and the Conquest Hospital, Hastings. The Birthing Centre at Crowborough was not part of this reconfiguration of services.

1.3 The Secretary of State asked the IRP to undertake a review of the proposals. Agreed terms of reference were set out in an Annex to the Secretary of State's letter dated 13 May 2008 to the IRP Chair, Dr Peter Barrett.

1.4 Copies of correspondence are included at Appendix Two.

1.5 The IRP was asked to advise the Secretary of State by 31 July 2008:

a) *whether it is of the opinion that the proposals for the reconfiguration of maternity and specialist baby care and inpatient gynaecology services provided by ESHT will ensure the provision of safe, sustainable and accessible services for local people and, if not, why not;*
b) *on any other observations the Panel may wish to make in relation to the proposals; and*

c) *on how to proceed in the interests of local people, in the light of (a) and (b) above and taking into account the HOSC's referral letter of 31 March 2008.*

It is understood that in formulating its advice the Panel will pay due regard to the principles set out in the IRP's general terms of reference

1.6 The advice offered in this report relates only to the provision of maternity, special care baby and inpatient gynaecology services provided by ESHT.

OUR PROCESS

How we approached the task

2.1 The South East Coast Strategic Health Authority (SHA) was asked to provide the Panel with relevant documentation for the review. In conjunction with the PCTs and ESHT, the SHA completed the Panel's standard information template, which can be accessed through the IRP website at www.irpanel.org.uk The HOSC was also invited to submit documentation.

2.2 The HOSC, SHA and PCTs were asked to suggest Panel visits and stakeholders to be involved in meetings and interviews. The Panel identified additional sites to visit and stakeholders to interview. The SHA was also asked to nominate a lead person to arrange site visits, meetings and interviews with the identified parties.

2.3 The Panel Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 13 May 2008 informing them of the IRP's involvement (see Appendix Three). The letter invited local people who felt they had new evidence that was not submitted during the consultation process or believed that their views had not been heard to contact the Panel. Press releases were issued on 14 May and 11 June 2008, providing information on the progress of the review. These can be accessed through the IRP website at www.irpanel.org.uk.

2.4 A sub-group of the full IRP carried out the review. It consisted of four Panel members, Nicky Hayes who chaired the sub-group, Cath Broderick, John Parkes and Paul Watson. Other Panel members attended on a number of days during the review. The sub-group was supported and accompanied on all visits by the IRP Secretariat.

2.5 Panel members visited East Sussex for nine days in total. Site visits were made to Eastbourne DGH, the Conquest Hospital and Crowborough Birthing Centre. The Panel met members of the HOSC, Public and Patient Involvement Forums (now replaced by a Local Involvement Network (LINk)), local authority representatives, local Maternity Services Liaison Committee, user representatives, representatives of 'Save the DGH' campaign group (Eastbourne) and 'Hands off the Conquest' campaign group (Hastings),

local NHS staff and trade unions representatives. The Panel also took oral evidence from various professionals and management groups from East Sussex Hospitals NHS Trust, East Sussex Downs & Weald PCT and Hastings & Rother PCT, South East Coast SHA and South East Coast Ambulance Services NHS Trust (SECamb). A list of all visits, details of the people seen and Panel members attending on these visits are included at Appendix Four.

2.6 Two oral evidence sessions, specifically to hear from local people who had responded to Dr Barrett's letter to editors, were held on the evening of 5 June and on 9 July 2008.

2.7 Meetings were held in July with four local MPs and a telephone conversation took place with a fifth (see Appendix Four).

2.8 A list of all written evidence received from the SHA, PCTs, ESHT, HOSC, MPs and all other interested parties is contained at Appendix Five. The Panel considers that the documentation received, together with the information obtained during oral evidence gathering sessions, provides a fair representation of the views from all perspectives.

2.9 Throughout the Panel's consideration of the proposals, the aim has been to consider the needs of patients, public and staff, taking into account the issues of safe, sustainable and accessible services for local people as set out in the IRP's general terms of reference.

2.10 The Panel wishes to record its thanks to all those who contributed to this process, to those who made time available to present evidence to the Panel, and to everyone who contacted the Panel offering their views.

2.11 The advice contained in this report represents the unanimous views of the Chair and members of the IRP.

THE CONTEXT

A brief overview

Historical context

3.1 Discussions about the future direction of maternity, special care baby and inpatient gynaecology services in East Sussex date back to a Clinical Services Review conducted by the PCTs in 2004. The review was prompted by the need to improve care and to ensure sustainability in the face of expected difficulties both in recruiting staff and in reduced junior doctors' hours as a result of the 2004 European Working Time Directive (EWTD). The review recommended that ESHT should strive to retain two all risk units but recognised that circumstances could arise where two all risk units could no longer be sustained. It also recognised that a transition to a single unit might need to be managed.

3.2 In spring 2005, the then Surrey and Sussex SHA commissioned a review from McKinsey[1] of healthcare across Surrey and Sussex to *"understand what is causing the NHS to overspend in some areas"* and *"to make recommendations about how the healthcare system could change to meet modern clinical standards within the available budget"*. This review reported to the SHA in July 2005 and shared with partners in February 2006 the discussion document *Creating an NHS Fit for the Future, First Steps for Improving Services in Surrey and Sussex*. The document concluded that:

- Surrey and Sussex SHA was financially and clinically unstable.
- Lack of sustainability had more than one root cause.
- Surrey and Sussex should implement an integrated transformational change programme to achieve sustainability which would result in a significant change in the number and location of healthcare providers across Surrey and Sussex, and a shift in activity from the acute setting to the community setting.

[1] McKinsey & Company is a management consulting firm

3.3 This was followed in May 2006 by a consultation document titled *'Creating an NHS Fit for the Future: Discussion Document'* as part of a Section 11[2] public consultation process. This document:

- covered the need for change
- described new ways of delivering care
- described ideas for service development in each area and asked questions of the public
- set out what was happening, in terms of consultation, in the Surrey and Sussex localities

3.4 Wide professional and public engagement took place over the summer of 2006 and then, more locally, the East Sussex health community began detailed work on what sustainable health services could look like for its residents. This coincided with a 'handover' process from SHA to PCTs and the formation on 1 July 2006 of the South East Coast SHA. From summer 2006, the PCTs were responsible for taking the programme forward. At this stage, no specific services had been identified for reconfiguration. As part of this process, ESHT developed a clinical strategy which described the reasons why change was needed and noted that this was not driven by the need to achieve financial balance. Over the autumn and winter of 2006, these plans were the subject of SHA, PCTs and ESHT discussions which led to the East Sussex PCTs' formal public consultation, launched on 26 March 2007. The consultation period ended on 27 July 2007.

The proposals

3.5 *Creating an NHS Fit for the Future* set out four options, all proposing one consultant-led obstetric unit in East Sussex rather than two, supported by midwife-led care on both sites. It was proposed that antenatal and postnatal care should continue to be delivered locally. Additionally, it was proposed that the Special Care Baby Unit (SCBU) and inpatient gynaecology services should be provided on the same site as the consultant-led obstetric unit.

[2] The Health and Social Care 2001 Act places specific duties on NHS bodies in relation to consultation with overview and scrutiny committees and with the public. (now superseded by S.242 of the NHS Act 2006).

3.6 Before formal consultation began, a joint public meeting of the two PCT Boards expressed a preference for Options 3 and 4 which provided for a single site for consultant-led obstetric care open 24 hours a day, seven days a week at either Eastbourne DGH or the Conquest Hospital, with a SCBU and inpatient gynaecology care also at that hospital. The hospital without the consultant-led obstetric unit would have a midwife-led birthing centre. All options retained Crowborough as a midwife-led birthing centre.

3.7 The Joint Committee made up of the two Boards also indicated their willingness to consider other options generated during the consultation process, which would be assessed against the same criteria used to develop the proposed options. One of the specific objectives of the consultation process was:

"*To see if there are any realistic, cost-effective and preferred alternatives to those outlined in this document.' (Creating an NHS Fit for the Future Public Consultation 2007)"*

The invitation to generate alternative options was set out in both the summary and full consultation document.

3.8 To review emerging alternative options and to establish whether there was any common ground between clinicians, health service managers and the proposers or sponsors of alternative options, a New Options Assessment Panel was set up under an independent Chair, Professor Stephen Field[3]. A total of nine options were generated. The New Options Assessment Panel's recommendation was that all except two options should be taken forward to the next stage.

3.9 In accordance with the Health and Social Care Act 2001, the East Sussex HOSC was formally consulted on the proposals. In response, it commented on the process employed by the PCTs and made 24 recommendations.

3.10 Following the end of the consultation process, the PCTs also produced or commissioned various pieces of work in advance of the Joint Board meeting on 20 December 2007. These included:

- Alternative Models Project

- Maternity Services Health Impact Assessment
- East Sussex Maternity Services Review of Costings

From the end of July to 20 December 2007, the two PCT Boards received further evidence. In November 2007, the Boards received short presentations from the proposers of each alternative option and conducted a formal (non-financial) appraisal of all the options remaining after the conclusion of Professor Field's work. Two Board to Board sessions took place between the SHA and the Joint PCT Boards on 18 December 2007.

3.11 Subsequently, the final decision reached at a meeting of the two PCT Boards on 20 December 2007 relevant to this review was to select Option 4 as the preferred option, namely:

- Provide a single site for consultant-led obstetric care open 24 hours a day, seven days a week at the Conquest Hospital, Hastings, with a SCBU and gynaecology care also at the Conquest Hospital.
- Provide a midwife-led birthing centre at Crowborough.
- Provide maternity outpatients service, antenatal care and community midwifery at both Eastbourne DGH and the Conquest Hospital.
- Provide gynaecological outpatients service, day surgery, investigative service and emergency pregnancy service at both Eastbourne DGH and the Conquest Hospital.

The minutes of the joint meeting recorded that several Board members voted against the recommendations.

3.12 The HOSC met on 28 January 2008 to consider the PCTs' decision on the outcome of the *Creating an NHS Fit for the Future* public consultation. Whilst it supported the PCTs' intention to improve antenatal and postnatal care and associated outreach services, it believed that the decision to establish a single obstetric unit on the Conquest Hospital site and a midwife-led unit on Eastbourne DGH site was not in the best interests of health services for East Sussex residents. It therefore gave notice that it would refer the PCTs' decision to the Secretary of State for Health, subject to the PCTs being given the opportunity to respond to the HOSC's agreed position.

[3] Professor Stephen Field is Chairman of the Royal College of General Practitioners

3.13 The main reasons for the potential referral were as follows:

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

b. Evidence that longer travel times to the obstetric unit could endanger the safety of women and babies.

c. Evidence that the distance of the midwife-led unit from the consultant-led unit could create undue risk to the safety of women and babies and questions over whether this is the best configuration for midwife-led care.

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

e. Evidence that there may be a reduction in women's choice owing to the coastal location of both sites, the population distribution in East Sussex and the proposed configuration of services; all of which may be compounded in areas where there is significant deprivation.

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

3.14 The PCTs responded on 20 February 2008 to the issues raised by the HOSC. The response stated that the PCTs had reviewed the reasons for reaching the original conclusion in December 2007 and that they were not aware of any previously unconsidered issues or fresh evidence that might lead them to question that decision. Therefore, there was agreement to proceed with the decisions made by the Joint Committee of the two PCT Boards *'in order to ensure long term safety and a better service for local women and their babies'*.

3.15 On 31 March 2008, the Chairman of the HOSC wrote to the Secretary of State for Health to refer the proposals. It highlighted the six reasons listed at 3.13 as not being in the best interests of the health service for East Sussex residents. However, the HOSC also stated its support for the PCTs' decision to improve antenatal and postnatal care and associated outreach services and that it had urged the PCTs to make rapid progress on these aspects of the consultation.

3.16 In May 2008, the Secretary of State for Health asked the IRP to undertake a review of the proposals for maternity, special care baby and inpatient gynaecology services provided by the East Sussex Hospitals NHS Trust.

INFORMATION

What we found

4.1 The evidence submitted to the Panel is summarised below and divided into the following sections:

- General background information
- An outline of the proposals
- Concerns raised
- Evidence gathered

The Panel received a substantial volume of written and oral evidence, which has been invaluable in enabling it to conduct an analysis and reach its conclusions and subsequent recommendations. It was clear from the evidence sessions that took place that everyone had put considerable thought into their presentations and this was very much appreciated by the Panel.

General Background Information

4.2 **Services provided and activity**[4]

4.2.1 ESHT provides DGH services for approximately 400,000 people in East Sussex from two general hospitals, the Conquest Hospital in Hastings and Eastbourne DGH, both with Accident and Emergency departments. The majority of healthcare is provided at these two hospitals, but services are also provided at Bexhill, Crowborough, Hailsham, Hawhurst, Rye, Seaford and Uckfield.

4.2.2 Eastbourne DGH and the Conquest Hospital each have four consultants who work jointly to provide obstetric and gynaecology services. Five acute consultant paediatricians provide acute paediatric and neonatal services at both sites. ESHT also provides community paediatric services.

[4] This information is largely drawn from the standard IRP information template, ESHT and PCTs websites and background information supplied by SHA, PCTs, NHS Trust and local authorities

Women and Children's Services - Obstetric services

4.2.3 In 2007/08, 4,060 women delivered at ESHT a total of 4,121 babies. There are two consultant-led units, one based at Eastbourne DGH and the second at the Conquest Hospital. These units provide consultant-led obstetric and midwife-led care. Both sites also have consultant-led clinics, a day assessment unit and antenatal screening. In addition, there is a stand-alone midwife-led unit in Crowborough with six beds and a birthing pool that provided care for 317 women during childbirth in 2007/08.

4.2.4 ESHT provides a community midwifery service which incorporates antenatal, postnatal and parent education services. In 2007/08, 4.7 per cent of babies were delivered at home. There is a network of Children's Centres across East Sussex providing integrated services to children under five and their families.

4.2.5 At Eastbourne DGH, there are 28 antenatal/postnatal beds of which four are single rooms, with a further four bedded bay that can be used if all the beds are occupied. There are six delivery rooms and a separate birthing pool. There are also two admission rooms and a two bedded recovery/high dependency room. At the Conquest Hospital there are 20 antenatal/postnatal beds of which two are single rooms and eight delivery suites (all ensuite), one of which includes the birthing pool. There is also a recovery area.

4.2.6 The following table shows the 2008/09 midwifery budgeted establishment:

Table 1: 2008/09 midwifery budgeted establishment - whole time equivalents (wte)

	Area	Conquest	Crowborough	EDGH	Specialist
Qualified	Specialist				5.77
	Manager				1.00
	Delivery Unit	39.76	10.83	39.67	
	Day Unit	2.44		4.54	
	Community	18.30	3.80	16.90	
Unqualified	Delivery Unit	12.37	2.50	11.79	
	Day Unit	0.80		0.82	

Source: Hospital Information System

At the time of the review, all three sites had vacancies that were being actively recruited to and there were no long-term vacancies.

4.2.7 Maternity activity across ESHT in 2007/08 is shown in the following table:

Table 2: 2007/08 Maternity activity across ESHT

Site	Bookings	Number of mothers	Number of babies
Eastbourne DGH	2092	1975	2004
The Conquest Hospital	2029	1768	1800
Crowborough MLU	883	317	317
TOTAL FOR ESHT	5004	4060	4121

Source: Hospital Information System

4.2.8 If the MLU at Crowborough requires referral to a consultant-led obstetric unit, women are normally transferred to Eastbourne DGH, Princess Royal Hospital in Haywards Heath or Pembury Hospital near Tunbridge Wells.

4.2.9 2007/08 maternity diverts for ESHT are set out in the following table:

Table 3: 2007/08 Maternity diverts

	East Sussex Hospitals NHS Trust		
	The Conquest Hospital	**Eastbourne DGH**	**Crowborough MLU**
Number of diverts	**49** reason I 6 reason II 14 reason III 6 reason IV 21 reason V 2	**25** reason I 4 reason II 6 reason III 3 reason IV 12 reason V 0	**1** (reason: midwifery staffing)
Time bands of diverts	0-8 hours **15** 8-16 hours **26** 16-24 hours **6** over 24 hours **1** one duration not recorded	0-8 hours **8** 8-16 hours **16** 16-24 hours **0** over 24 hours **0** one duration not recorded	8-16 hours **1**

Source: Hospital Information System

Key: reason I Midwifery staffing/dependency
reason II Capacity
reason III Midwifery staffing/capacity
reason IV Midwifery staffing
reason V Medical staff

On two occasions during the year, the Conquest Hospital and Eastbourne DGH were on divert at the same time.

Women and Children's Services - Neonatal services

4.2.10 The Directorate has 13 level 1[5] neonatal cots. There are seven at Eastbourne DGH and six at the Conquest Hospital (although at the latter there is room for expansion in the current location with minimal movement of other services). Critical Care provision - designated paediatric and neonatal intensive and high dependency care – is either provided by Brighton and Sussex University Hospitals NHS Trust or by one of the Kent or London hospitals.

4.2.11 The budgeted SCBU establishment for 2008/09 is as follows:

- Eastbourne DGH has 14.73wte qualified SCBU staff
- The Conquest Hospital has 12.51wte qualified SCBU staff

4.2.12 Neonatal activity is set out in the following table:

Table 4: ESHT SCBU activity - calendar year 2006 and 2007

	SCBU level 1	
	2006 Activity SCBU admissions	**2007 Activity SCBU admissions**
Eastbourne DGH	271 (74 transfers, 196 discharged and 1 death)	257 (69 transfers, 188 discharged)
The Conquest Hospital	157 (27 transfers, 130 discharged)	145 (27 transfers, 118 discharged)
TOTAL FOR ESHT	428	403

Source: Hospital Information System

Women and Children's Services - Gynaecology services

4.2.13 ESHT provides both general and specialist gynaecology services for part of East Sussex. Gynaecological oncology is provided as part of the Cancer Network's hub and spoke model of care. The service has a full range of outpatient clinics and both sites have facilities for day surgery and inpatient gynaecology ward.

[5] Units providing care for new-born babies fall into three categories from level 1 providing routine and special care to level 3 providing the most specialist intensive neonatal care. Report of the Neonatal Intensive Care Services Review Group, Department of Health April 2003.

4.2.14 Gynaecology activity across ESHT in 2007/08 is set out in the following table:

Table 5: ESHT gynaecology activity 2007/08

Site	Daycase	Elective	Non elective emergency	Outpatients
Eastbourne DGH	401	533	579	6108
The Conquest Hospital	527	612	753	6332
TOTAL FOR ESHT	928	1145	1332	12440

Source: Hospital Information System

4.3 Population and deprivation indices[6]

Population

4.3.1 In 2006, approximately 500,000 people were resident in East Sussex. This is expected to increase to around 545,000 by 2016 - the principal demographic change expected over the next 20 years is a large increase in the elderly population.

Deprivation

4.3.2 Indices of deprivation for 2007 show that problems of multiple deprivation appear to have increased in all parts of East Sussex since 2004, which was the last time the indices were published. Key findings are:

- Hastings remains the most deprived local authority area in the region
- Hastings SOA[7]s that are in the most deprived 10 per cent nationally are mainly concentrated in Central St. Leonards, Castle and Gensing, but also affect five other wards in the borough. The most deprived SOA in the county is in Baird Ward (Hastings)
- Eastbourne has one SOA in the most deprived 10 per cent nationally

4.4 Transport

[6] All population statistics are sourced from ONS data on the East Sussex County Council and deprivation indices are national figures from the East Sussex County Council website.
[7] Super output areas (SOAs) are sub ward level areas of deprivation published by the Office for National Statistics (ONS).

4.4.1 East Sussex has no motorways, few stretches of dual carriageways and main roads are relatively narrow. Eastbourne and Hastings are connected principally by the A259 coast road (see maps over page), but this is often congested. Eastbourne and Hastings are approximately 20 miles apart and the journey normally adopted by the South East Coast Ambulance Services NHS Trust (SECamb) uses a combination of 'A' and 'B' roads. Data provided by SECamb[8] shows the average journey time by ambulance between Eastbourne DGH and the Conquest Hospital is 40 minutes (range 23 - 52 minutes), compared with an average journey time between the Conquest Hospital and Eastbourne DGH of 35 minutes (range 23 - 50 minutes).

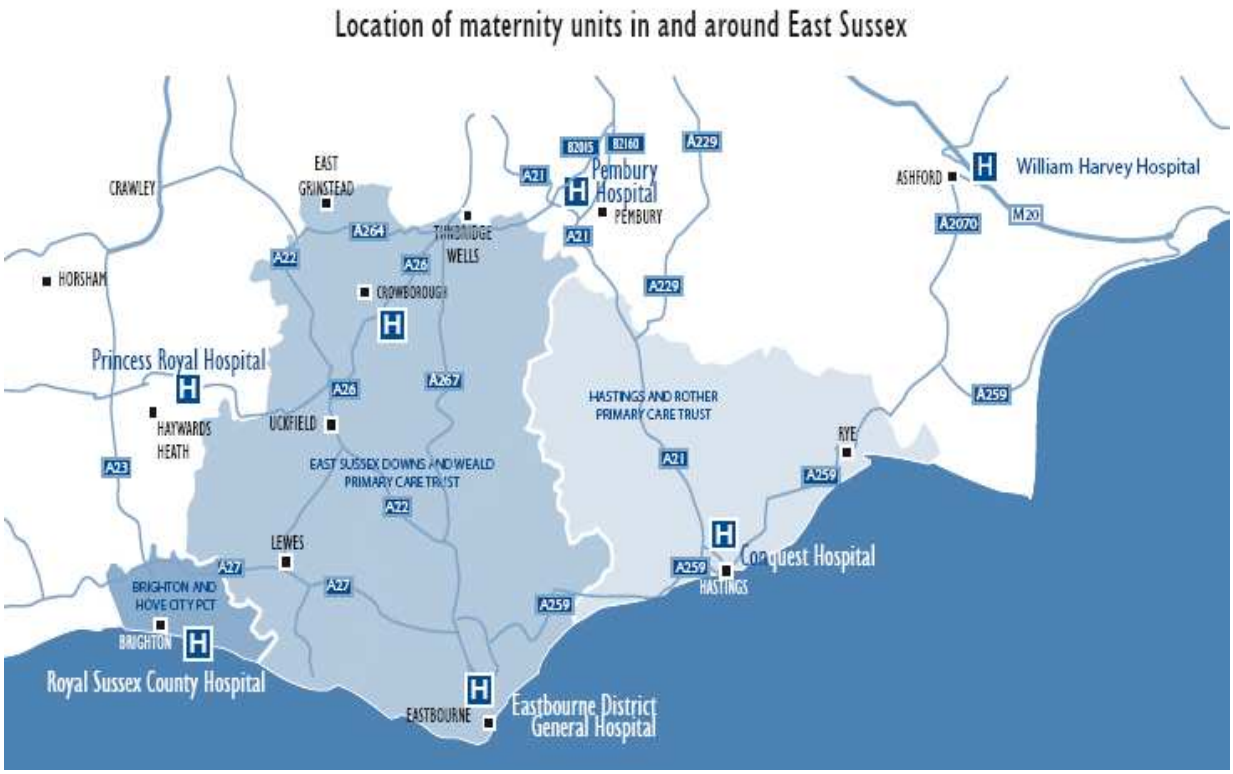
4.4.2 There is no direct commercial bus service between Eastbourne District DGH and the Conquest Hospital. At least one change is required and the journey time often approaches two hours.

4.4.3 Trains run between Eastbourne station and Hastings station approximately every 20-30 minutes during the week (often more frequently). Trains run between Hastings station and Eastbourne station every 20 - 30 minutes during the day and every 45 minutes after 21.30. The last train returning from Hastings is at 23.13. The journey time is approximately 30 minutes. A bus link from Hastings station to the Conquest Hospital operates Monday to Saturday with a journey time of approximately 25 minutes.

4.4.4 ESHT provides the following support to patients accessing the hospital sites:

- Some free parking for disabled users at both Eastbourne DGH and the Conquest Hospital site
- Free or reduced rate parking for patients / carers / family in particular circumstances
- Patients who are on Income Support or some other benefits can claim back costs of parking or travel expenses (the Government Hospital Travel Costs Scheme)
- Free non-emergency ambulance transport (ambulance / voluntary cars and taxis) for patients with a medical need

[8] Data provided by SECamb from a small sample survey August – November 2007.



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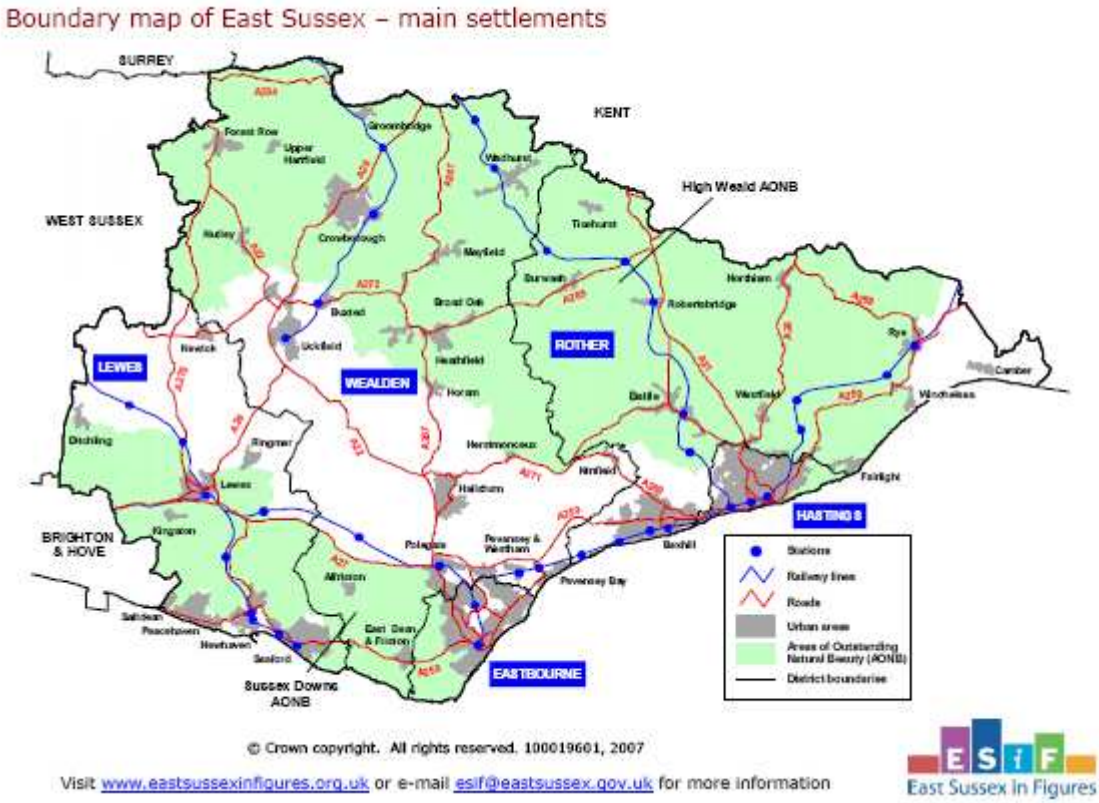

4.5 Estate

4.5.1 *Eastbourne DGH*

Eastbourne DGH consists of a 15.56 hectare estate located approximately two miles north of Eastbourne town centre. It comprises multi-storey buildings and includes accommodation for 522 inpatient beds. PEAT[9] 2008 assessment ratings are excellent for environment, food, and privacy & dignity. The site provides 1,023 staff, 294 visitor, and 32 disabled parking spaces.

4.5.2 *The Conquest Hospital*

The Conquest Hospital site is a 14.02 hectare estate located four miles from Hastings town centre on the B2093. It comprises multi-storey buildings and includes accommodation for 486 inpatient beds. PEAT 2008 assessment ratings are good for environment and excellent for food, and privacy & dignity. The site provides 743 staff, 270 visitor, and 27 disabled parking spaces.

4.6 Healthcare Commission annual assessment and Clinical Negligence Scheme for Trusts (CNST)[10] status

4.6.1 In January 2008, ESHT received the following assessments from the Healthcare Commission in its Maternity Review 2007, each score being out of 5, a score of 3 represents the acceptable level of performance where standards exist and an average performance otherwise:

- Overall assessment based on the question: "*Does the Trust provide a high quality value for money maternity service?"* was 3.199 which equated to "Better performing"
- Clinical focus : 2.625
- Women centred care : 3.75
- Efficiency and capability : 3.222

ESHT is working with the PCTs to address any area of concern identified by the Healthcare Commission.

[9] Patient Environmental Action Teams carry out a self-assessment of every healthcare facility in England with more than 10 beds each year and give a rating from unacceptable to excellent.

[10] The Clinical Negligence Scheme for Trusts is a scheme of risk pooling. It provides indemnity cover for NHS bodies in England which are members of the scheme against clinical negligence claims made by or in relation to NHS patients treated by or on behalf of those NHS bodies.

4.6.2 ESHT is accredited at CNST Level 3 for maternity services, the highest level available. The new pilot maternity standards for 2009 onwards have recently been published on the CNST website and reflect the higher standards in recently published guidance.

4.7 **The proposals for maternity services**

4.7.1 Currently there are consultant–led maternity units at both Eastbourne DGH and the Conquest Hospital, plus a midwife-led service at Crowborough Birthing Centre. Both hospitals also run a full paediatric service including a level 1 Special Care Baby Unit (SCBU).

4.7.2 The PCTs' preferred option, Option 4 as described in *Creating an NHS fit for the future Public Consultation*, is detailed at 3.11.

4.8 **Concerns raised**

4.8.1 *Issues raised by the East Sussex HOSC*

In referring the matter to the Secretary of State for Health, the HOSC stated that it had submitted a report to the PCTs in October 2007 which made a series of recommendations about issues the PCTs should consider when coming to a decision. The HOSC's key recommendation was that several new options had arisen through the consultation process, including some which retained services on two sites, and that the PCTs should fully assess them before coming to a final decision. In December 2007, the PCTs took their decision to proceed with one of their original options, Option 4. However, the HOSC remained unconvinced that its key recommendation for the PCTs to assess the potential alternative options had been fulfilled. In addition, the HOSC considered that the PCTs' decision was not in the best interests of the health service for East Sussex residents as stated earlier at 3.13. These issues are discussed in detail in the HOSC's *Response to East Sussex Primary Care Trusts on Creating an NHS fit for the future Public Consultation* dated October 2007.

4.9 *Issues raised by others*

4.9.1 In reviewing the PCTs' proposals, many views and items of information were either presented or sent to the Panel by a wide range of contributors. These are summarised in key points below according to whether contributors were opposed to, or in support of, the proposals. The subsequent paragraphs describe issues relating to relevant service areas and key groups.

4.9.2 Those opposed to the proposals:

- Strongly believe that the two PCTs should have included a two site consultant-led obstetric service , SCBU and inpatient gynaecology service proposal
- Believe that the proposed service change is financially driven
- Believe that the PCTs had already decided on a single site option prior to the consultation process
- Are concerned about the potential implications of travelling from Eastbourne to Hastings, a distance of approximately 20 miles on roads which are subject congestion in terms of:
  - Emergency transfers of women in labour
  - Women, birthing partners and families being subjected to long travelling times
- Consider that the Government's declared aim of choice for women is being eroded
- Believe that a single site solution will contravene best practice guidance by the National Institute for Health and Clinical Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG)
- Do not believe that SECamb will be able to provide an effective rapid transfer service from Eastbourne to Hastings
- Are concerned that the loss of the consultant-led obstetric service from Eastbourne DGH will result in a 'domino' effect with other services being transferred from the site to other hospitals
- Consider that alternative options were not properly taken into account during the consultation process

4.9.3 Those in support of the proposals:

- Are concerned that, although the consultant-led obstetric service delivered by ESHT is currently safe, it is often stretched to the limit

- Are concerned about sustainability across two sites in view of the implications for consultant obstetricians in continuing to operate small units, for example, appropriate casemix, the effects of Modernising Medical Careers (MMC) and the European Working Time Directive (EWTD)
- Believe that operating a larger obstetric unit will result in a safer, more sustainable maternity service which will be more attractive professionally to medical and clinical staff
- Believe that locating the consultant-led obstetric unit at the Conquest Hospital will have a stabilising effect in terms of services, particularly in not jeopardising the long term emergency care at the Conquest Hospital
- Believe that the proposals would present an opportunity for a level 2 neonatal unit

4.10 *Maternity services*

4.10.1 In the proposals set out by the PCTs, the key issue is clinical sustainability of services and how best to develop high quality maternity services for the whole of East Sussex. The principal factor is that both Eastbourne DGH and the Conquest Hospital are classed as small units (that is, less than 2,500 births per year each). The supporters of the proposals, which include the SHA, PCTs (excepting the East Sussex Downs & Weald Professional Executive Committee), ESHT and East Sussex Downs and Weald Patient and Public Involvement Forum (Eastbourne area) believe that retention of the status quo is unsustainable for reasons of safety, recruitment, consultant presence, training status and meeting EWTD 2009. They consider that the adoption of a single site proposal with appropriate additional resource would give increased resilience and flexibility.

4.10.2 *Safer ChildBirth* (Royal College of Obstetricians and Gynaecologists' *et al 2007*) gives guidance for units with less than 2,500 births:

"*…this document strongly recommends 40 hours of consultant obstetric presence and this should be mandatory if the unit accepts high risk pregnancies (2007).*"

There is no requirement to increase beyond 40 hours but the document states that units should continually review their staffing to ensure adequate based on local needs.

For units with 2,500-4,000 births, the document states a requirement for 60 hours consultant presence by 2009. The SHA has set local guidance to increase to 60 hours presence by 2010 (*Healthier People, Excellent Care 2008).*

4.10.3 Currently, 15 hours per week per hospital is being provided by eight consultants, four on each site. The Women and Children's Service has estimated that 6.5 wte consultants would be required on each site to achieve 40 hours consultant presence on the labour ward. ESHT indicated that a further increase to 60 hours presence could be achieved in theory by increasing to ten consultants at each site. However, to retain their skills and be competent to be on call for gynaecology emergencies, the job plan would need to include both gynaecology operating lists and outpatient sessions. It was also the Service's view that the resulting job plan would not be attractive unless it made some provision for the postholder's special interest and that a job plan that consisted mostly of labour ward cover would be unlikely to receive RCOG approval. On a single site, the Service believes that the 60-hour standard could be achieved with 10 consultants.

4.10.4 The Panel heard concerns from consultants that small units are unlikely to have complex cases in sufficient numbers to maintain consultant skills, provide job satisfaction or to attract new applicants to Eastbourne DGH and the Conquest Hospital.

4.10.5 The Panel was also told of concerns over the provision of middle grade doctors for two reasons. First, the effect of MMC means that, in future, middle grade doctors will not have the breadth and depth of experience which presently exist. Secondly, the implementation of the EWTD means a further reduction in hours currently worked by doctors and, therefore, a need to increase the number employed to provide the same level of medical cover. The obstetricians consider that recruiting middle grade doctors for small units will be difficult. The Panel heard that there have already been problems with a shortage of doctors and frequent use of locums. Additionally, there is a lack of required skills amongst middle grade doctors for non-training posts. There is also a concern that, due to the small size of the units, ESHT would have difficulty in gaining training accreditation for middle grade doctor posts in the future.

4.10.6 Supporters of the proposals suggest that all the disadvantages stated above could be either overcome or largely ameliorated by centralising services on a single site and that these would outweigh the problems of distance and transfer times. Clinical protocols would be set up with SECamb and also within the MLU at Eastbourne DGH to strengthen the safety aspects of the proposals.

4.10.7 Opponents of the proposals argue strongly that a two hospital site option as well as single site options should have been included. There is substantial opposition in and around Eastbourne to the potential loss of the consultant-led obstetric unit at Eastbourne DGH as evidenced by a protest march in 2006, together with declared opposition by Eastbourne and Hailsham GPs, the Eastbourne MSLC, East Sussex Downs and Weald PCT PEC and East Sussex LMC, and local MPs. Opponents are particularly worried about the travel and transfer times to the Conquest Hospital, with perceived consequences for the safety of women and babies. They are unhappy at the prospect of a MLU at Eastbourne DGH that would only cater for low risk births, and of an obstetric unit being some 20 miles away in Hastings or Brighton. However, no concerns were expressed about the MLU model. For example, Crowborough Birthing Centre is well known and popular with women and their partners.

4.10.8 In giving evidence to the Panel, a group of midwives emphasised women-centred care and choice, believing that a reduction to one consultant-led obstetric unit at the Conquest Hospital would reduce choice, going against the direction of government policy as described in *Maternity Matters.* They too expressed concerns about the travel and transfer times to Hastings, which would result in additional stress for women. They also referred to the growing number of women of childbearing age from Eastern Europe, a matter which was elaborated upon in evidence to the Panel by representatives from a local organisation *'English in the Community'*. The Panel heard that local recruitment of midwives was satisfactory and that additional posts could be filled, if funded.

4.10.9 Concerns about the potential effect of moving the consultant-led obstetric unit from Eastbourne to Hastings were expressed by a group of GPs from Eastbourne and the surrounding areas. They believe that moving the unit will move the problem into the community. The GPs stated that safety was the key issue and that, in their view, many

women would opt to give birth in Brighton rather than Hastings. They were also already concerned over closures at Eastbourne and Hastings. A similar view was expressed by one of the two local PECs, which was also concerned about the proposed changes to maternity services in West Sussex. The PEC was further concerned about the effect of patients having to travel to Hastings in an emergency. Conversely, the other PEC supported a single site, principally because it had concluded that the status quo relating to two sites was only sustainable in the short term.

4.10.10 Trade union representatives expressed concerns about longer travel times and the effect on staff after long shifts, together with the extra cost involved.

4.11 *Special Care Baby Unit (SCBU)*

4.11.1 The proposals involve the transfer of the SCBU from Eastbourne DGH to the Conquest Hospital. A group of SCBU nurses acknowledged the challenges of maintaining two units and spoke of gaps being filled through goodwill. They saw the advantage of moving to a single site as providing an opportunity to develop a level 2 unit. A level 2 unit would reduce the need to transfer babies out of East Sussex who needed this level of care and would also enable them to be brought back from level 3 units earlier. The main concern of the staff on moving to one site was the potential impact of increased journey times on families living in the west of East Sussex.

4.11.2 Consultant paediatricians expressed mixed views about the proposals. Those in support thought that the potential increase in availability of middle grade doctors was a pressing reason to move to a single site. Concern was expressed that, with a MLU only site, there would be no neonatal cover and therefore any baby requiring SCBU care would need to be transferred to the SCBU at the Conquest Hospital. Those opposed to the proposals argued that it is possible to sustain the service on two sites and that development of level 2 neonatal services on a single site was dependent on a number of factors. These include birthing numbers and staffing, none of which are factored into the current proposals (which are for a level 1 unit on the single site) and which in reality may not be achievable.

4.11.3 The PCTs and ESHT confirmed that paediatrics would be maintained on both sites for three years. However, it was the view of some staff that, if consultant-led obstetrics were located on one site, then paediatrics would follow at some date in the future.

4.12 *Inpatient Gynaecology*

4.12.1 As with obstetrics and the SCBU, inpatient gynaecology is planned to move to the Conquest Hospital under the PCTs' proposals, with day surgery, outpatients and diagnostic testing remaining at Eastbourne DGH. ESHT stated that only a small number of patients would be affected by this change. However, the planned activity levels show that over 50 per cent of gynaecology surgery is inpatient care rather than daycase. Representatives of the gynaecology department also raised the issue that, without a gynaecology inpatient ward, the breadth of procedures undertaken in the day surgery unit may decrease. Under these circumstances, patients could only be operated on if they could be discharged within 12 hours of attending, as there would be no specialist ward to move patients to if they needed extended recovery. This issue could be resolved if the day surgery unit on the site without gynaecology inpatients was developed as a 23 hour day surgery unit.

4.13 *Anaesthetists*

4.13.1 In taking evidence from anaesthetists, the Panel was advised that a significant staffing change would be required to develop a dedicated obstetric tier of the anaesthetic rota if the obstetric unit exceeds 3,000 births per year, as would be the case with the adoption of any single site option. At present, anaesthetists cover both obstetrics and critical care but, should the 3,000 birth threshold be reached, then dedicated anaesthetic cover for obstetrics would be required. There is support for moving to a single unit in terms of safety and training, though some reservations were expressed about the ability to recruit suitably skilled staff.

4.14 *South East Coast Ambulance Services NHS Trust*

4.14.1 Various groups presenting evidence to the Panel expressed concern over the transfer time for an ambulance between Eastbourne DGH and the Conquest Hospital, with its safety implications for a woman and unborn baby. SECamb advised the Panel that its main priority was to ensure an effective service, and gave details of transfer times which varied

between 23 and 52 minutes. The decision regarding which hospital an ambulance would take a patient to would depend on the condition of the woman at the time and would be protocol driven. SECamb was commissioning a training programme to increase obstetric emergency skills by November 2008.

4.15 *Campaign Groups*

4.15.1 Two groups, namely the 'Save the DGH' and 'Hands off the Conquest', have campaigned jointly against the proposals and have done much to promote local support for their campaign, focussing on a specific two site solution. Two site solutions have the support of large numbers of the public. The campaign groups gave evidence to the Panel on five occasions, including two sessions devoted to 'new data', and one to the joint campaign groups' alternative option.

4.16 *National Childbirth Trust*

4.16.1 In written evidence, the NCT stated that the most important factors relating to where to give birth are choice, safety and access. The NCT was supportive of women having access to both antenatal and postnatal care closer to their homes, and welcomed the increase in MLUs under the PCTs' proposals. However, it saw the potential transfer of the obstetric unit at Eastbourne DGH as removing choice from some women. The NCT also expressed concerns over access and travel times.

4.17 *Local Authorities*

4.17.1 The Panel heard evidence from five local authorities which had produced much useful and carefully compiled information. Opinion was divided over the proposals, with the councils in and around Hastings being in favour, while those further to the west supported the retention of two consultant-led obstetric units. Comment was made about the potential impact on the East Sussex community of the maternity proposals in West Sussex.

4.18 *Alternative options*

4.18.1 The Panel heard evidence from the proposers of each of the alternative options which had emerged from the consultation process. The majority of presenters were dissatisfied with the process which the PCTs had employed to assess the options. Following the screening

of the alternative options by the New Options Assessment Panel, Professor Field in his report stated:

"*Inevitably there is a little more work to be done on some of the options before the PCTs can fairly test them against each other but I am confident that work can easily be concluded during the month of August 2007 and that the PCTs will then be able to conduct an effective and robust option appraisal process in September 2007."*

A number of the proposers, together with others who gave evidence to the Panel, assert that this did not take place and that the alternative options were not fully explored before being discounted. The dissatisfied proposers were also unhappy that no two site consultant-led obstetric unit options were included in the PCTs' consultation document.

4.19 *The Local NHS - Strategic Health Authority*

4.19.1 Early in the Fit for the Future process, the SHA modelled the impact of a wide range of potential scenarios across all of Sussex and Surrey. The mapping demonstrated that there was not a material and critical interdependency between East Sussex and Brighton, mid and West Sussex. The SHA recognised the benefits of all the Sussex proposals being consulted on at the same time but, early in 2007, it became clear that the West Sussex proposals required more time. Consequently, it was decided to allow the PCTs to proceed alone, a decision taken after confirmation by Brighton and Sussex University Hospitals NHS Trust that they could deal with an additional 1,000 births from the local area without major capital expenditure.

4.19.2 The SHA's final view was that it accepted the arguments in favour of a single consultant-led obstetric unit. However, it had no view regarding the location, accepting the PCTs' rationale for their preferred choice.

The local NHS - Primary Care Trusts

4.19.3 The PCTs, in describing the rationale for their decision to select Option 4, had identified a number of drivers for change:

- Urgent issues
    - Day to day realities, namely at the margins of safety; consultant staff being stretched across two sites; inadequate labour ward consultant cover; unplanned closures; difficulty recruiting middle grade doctors

- Physical environment does not meet modern standards
- Modernising Medical Careers
- Safe working hours (EWTD)
- High quality staff

- Future challenges
  - Drive to improve safety
  - Increased consultant labour ward cover
  - SCBU: Network standards
  - Maintaining CNST level 3
  - Tackle inequalities
  - Promote choice
  - Local where possible, central where necessary
  - Enhanced training

The local NHS - East Sussex Hospitals NHS Trust

4.19.4 In presenting evidence to the Panel, ESHT highlighted the clinical issues relating to both two site and single site options:

Clinical issues - two site options

- Do not provide sufficient patients to maximise training opportunities and enhancement and retention of skills
- Do not maximise the benefits of sub-specialisation
- Do not allow for upgrading of facilities
- Do not facilitate recruitment for consultants and trainees/non consultant career grades
- Do not allow potential upgrading to SCBU level 2

Clinical issues - single site option

- Provides 60 hours consultant presence and is affordable
- Gives maximum clinical experience and opportunity to retain skills in complex cases
- Allows maximum opportunity for sub-specialisation
- Permits upgrading of facilities

- Facilitates recruitment in consultants and trainees
- Allows for good training in obstetrics and anaesthetics
- Potential for upgrading to SCBU level 2

4.20 Other evidence

4.20.1 A number of documents and reports were taken into account by the Panel when reviewing the proposals, including:

- *Maternity Services: Future of Small Units RCOG (2008)*
- *Maternity Matters: Choice, access and continuity of care in a safe service (2007)*
- *Safer Childbirth: Minimum standards for the organisation and delivery of care in labour RCO, RCM, RCA, RCPCH (2007)*
- *The Safety of Maternity Services in England King's Fund Report (2008)*
- *Healthcare Commission review of Maternity Services (2007) & (2008)*
- *CEMACH: Saving Mothers' Lives – Reviewing maternal deaths to make motherhood safer 2003-2005 (2007)*
- *Safe Births: Everybody's Business – Report by the King's Fund (2008)*
- *High Quality Care For All: NHS Next Stage Review Final Report (2008)*

4.20.2 During the course of its review, the Panel spoke to a number of staff concerning the level of integration achieved between the two hospitals since ESHT was formed. Whilst formally integrated at the senior managerial and clinical level, with individuals undertaking cross site working, below this level the hospitals are generally viewed as separate entities although, as a single Trust, they both follow the same procedures and policies.

4.20.3 The Panel is aware from national policy and guidance that, together with recommendations regarding consultant cover for labour ward, maternity services are also to aim for one to one midwife to woman ratio during labour *(Safer Childbirth 2007).* Whilst the Panel did not receive any evidence of planning to meet this target, it noted that a reworking of Birthrate Plus was to be undertaken.

OUR ADVICE

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5.1 **Introduction**

5.1.1 Following the East Sussex HOSC's referral in 2008, the Secretary of State for Health asked the IRP to undertake a review of the East Sussex Downs & Weald and Hastings & Rother PCTs' *Creating an NHS Fit for the Future* proposals to reconfigure maternity and related services provided by ESHT.

5.1.2 In presenting evidence, the PCTs highlighted that the decision to opt for a single site solution was taken for reasons of safety, reliability and sustainability in terms of medical staff recruitment, consultant presence on labour ward, training status, developing the neonatal service to level 2 and meeting EWTD 2009.

5.1.3 The Panel considered the PCTs proposals under the headings of safety, sustainability and accessibility. It became clear during the taking of evidence that the safety of women and babies during transfer between sites was a predominant and recurring theme, and sustainability was clearly a major issue.

Safety

Safety of women and babies during transfer between sites

5.1.4 In both written and oral evidence to the Panel, safety of women in labour and babies during transfer between sites or in transport to hospital was clearly of paramount concern to a wide range of stakeholders, including MPs, members of the public, GPs and staff groups. The distance between Eastbourne and Hastings is approximately 20 miles, but there is currently no consensus on what constitutes 'safe' distances for transfer of women during labour. The Panel heard that the nature of the road network between the two locations frequently results in long journey times of an hour or more by private transport. Evidence was received from SECamb that the range of journey times is 23 - 52 minutes with consequent concerns regarding emergency transfer of women in labour. Many clinicians were concerned for the safety of a woman and unborn baby if an emergency transfer was required between Eastbourne DGH and the Conquest Hospital. The Panel heard from members of the public and clinicians of unforeseen emergency cases treated

at Eastbourne DGH. Had they needed to be transferred to Hastings, then there would have been fears for the woman and unborn baby or child. The PCTs have agreed to commission additional training places for SECamb to support clinical skills development of crews in managing obstetric emergencies. SECamb cites a very low level of emergencies encountered, although there is little national or local data available to boost the confidence of the public and many professional health workers. On balance, whilst recognising the efforts made by the PCTs and SECamb to reassure stakeholders that action would be taken to reduce risks, the Panel accepts the concerns raised by a number of stakeholders that there is an unquantifiable risk of incidents during transfer or transport of women during labour.

5.1.5 The Panel recognises that the condition of a woman and baby can change rapidly during the course of labour. When complications arise, urgent assessment by the attending clinician is required. Initial assessment is usually by the attending midwife with referral to an obstetrician as necessary. In a consultant-led unit or with integrated midwife-led maternity units, such referral can take place immediately. The Panel's attention was drawn to the '30-minute' rule, originally defined by the American Association of Anesthesiologists, as a possible yardstick for assessing maximum transfer times. However, the 30-minute rule is a specific clinical guideline for carrying out an emergency caesarean section once the decision has been made to operate and has not been published or endorsed as a guide to acceptable transfer to hospital times.

Staffing issues

5.1.6 The Panel noted that the PCTs had described the maternity services as being 'at the margins of safety' and this issue was raised with ESHT. These concerns were echoed by the consultant obstetricians from both sites who argued that, at current levels, they are overstretched and unable to deliver the current recommended level of cover for labour ward. ESHT stated that it believed the service to be safe, but that significant staffing problems will need to be addressed in order to meet the future standards and the EWTD. Currently, both hospitals are accredited at CNST level 3 and were assessed as 'better performing' at the last Healthcare Commission Maternity Review in 2007 as stated at 4.6.1. Ninety per cent of women during pregnancy, and eighty eight per cent of women during labour and birth, rated the care they received as 'excellent', 'very good' or 'good'.

5.1.7 The Panel heard that there have been a significant number of diverts and closures as detailed at 4.2.9. The majority of these are associated with midwifery staffing issues. The Panel was told by ESHT that it is currently addressing the matter.

5.1.8 The Panel recognises that concerns raised have some basis and that change needs to occur in order to sustain quality and ensure future safe medical staffing levels.

Sustainability

5.1.9 Currently, RCOG guidance advises 40 hours consultant presence on the labour ward for small units. The SHA's stated aim is for 60 hours consultant presence by 2010. ESHT considers that 10 consultants per site would be needed to achieve this, but the Panel heard evidence that this might be achieved with fewer. Since the end of the PCTs' consultation period, *Maternity Services: Future of Small Units* (RCOG) has been published which adopts a more flexible approach to staffing models. The Panel has considered this in detail in relation to the subject of required presence on labour ward. Furthermore, there are examples of innovative practices such as those implemented at other hospitals which demonstrate alternative approaches to maintaining small units which could be revisited in the light of guidance published since the consultation was carried out.

5.1.10 The Panel also noted that other hospitals are planning to provide greater consultant presence with a lesser enhancement of consultant numbers. For example, there are hospitals which are planning to provide 60 hours consultant presence per week with six to seven consultants on each site. These hospitals have higher delivery numbers than either the Conquest Hospital or Eastbourne DGH. However, the Panel also noted from *Safer Childbirth* (2007) that a minimum of 60 hours consultant presence is not stipulated for smaller units providing a service for less than 2,500 births.

5.1.11 The effect of the EWTD was discussed at length by the Panel, particularly in relation to clinical supervision. The result of MMC which will reduce the experience level and narrow the skill base of middle grade doctors in the future, together with the EWTD and its shorter weekly working hours, will mean that more doctors' hours are needed to deliver a comparable service. However, ESHT is concerned that recruitment of extra

doctors to compensate for the reduced working hours will be difficult to accomplish. The Panel heard that ESHT had calculated that a minimum of 10 middle grade staff was required on the proposed single site to provide appropriate cover. But, as with consultant staffing, the Panel noted that hospitals elsewhere in England have used different assumptions. For example, the hospitals referred to at 5.1.10 are planning to provide EWTD compliant cover with fewer than 10 middle grade staff for a site.

5.1.12 From the above analysis, the Panel questions ESHT's assumption for future medical staffing, considering it to be over-generous in the light of evidence received during the review. The Panel considers that alternative staffing models may be feasible which could still deliver a safe, sustainable service. However, the Panel acknowledges that the recruitment issues for middle grade staff are potentially the most challenging, regardless of the size of the unit, whereas recruitment of future consultants is less problematic

5.1.13 In terms of quality, *Safer Childbirth* recognises the central role of the midwife as lead autonomous practitioner in childbirth and also endorses the role of the consultant midwife. Yet the Panel considered that the medical staffing issues had, to an extent, eclipsed the concurrent issues relating to the future nursing and midwifery workforce. *Safer Childbirth* recommends that there should be a designated midwife per woman when in established labour for 100 per cent of the time. This issue was not raised during evidence sessions by the PCTs, but is clearly relevant to safety, sustainability and quality of services and must be actively addressed as part of the maternity strategy development. The Panel noted that the development of alternative models such as advanced midwifery practitioners to support junior and middle grade staff had not been considered either by the PCTs or ESHT. Exploration of the potential of these roles in both developing midwifery careers and supporting doctors' roles should be taken further locally.

Accessibility

5.1.14 In addition to safety concerns for women in labour who might require transfer to Hastings under the proposals, the Panel also heard that the journey to Hasting for those families who have to travel by public transport is very time consuming and costly. Furthermore, one of the principal reasons for choosing Hastings as the site for the single consultant-led obstetric unit was because of the higher levels of deprivation in and around Hastings and,

therefore, the Conquest Hospital would mean easier access for families from these areas. But the Panel heard evidence that Eastbourne also has a number of areas of deprivation whose residents would be particularly disadvantaged by the proposals because of their need to travel the extra distance to Hastings. The effect of travel time on staff should also not be underestimated, with many having to undertake much longer journeys to and from work.

5.1.15 Besides the physical reduction of consultant-led obstetric units from two to one, the Panel also heard evidence that transfer of the obstetric unit from Eastbourne DGH is likely to deter a number of women from having either a home birth or opt for the Eastbourne MLU, because of worries over accessibility of the consultant-led unit in Hastings. Paradoxically, this would conflict with the PCTs' aim to increase home births or encourage women to opt for intrapartum care in a midwife-led unit.

Drawing the discussion together

5.1.16 Taking all the evidence into consideration, the Panel made a judgement on the PCTs' proposals using the criteria of safety, sustainability and accessibility.

5.1.17 In terms of safety and sustainability, there was a divergence of opinion amongst clinicians as to whether implementation of the proposals would result in improved services. Consultant obstetricians and gynaecologists support the proposals overall, whereas some GPs and consultant paediatricians expressed reservations. These included that there would only be one, as opposed to two, SCBUs and therefore there would be no enhancement of care for neonates. Additionally, although paediatric cover would remain at Eastbourne DGH, this would not include cover for neonatal emergencies. In receiving evidence from the Anaesthetic Department, the Panel recognised the importance of appropriate anaesthetic cover for labour ward which, for a single site solution, would be provided by a dedicated obstetric rota. However, the Panel heard evidence that a two-site solution would be potentially sustainable from an anaesthetic perspective, provided the consultant-led obstetric units remained small.

5.1.18 The Panel concluded that the proposals were principally driven by the PCTs' attempt to address future medical staffing issues as perceived at the time of consultation. It also

concluded that, for the PCTs, the strength of this driver outweighed the issues of accessibility and choice. It formed a clear view that the PCTs had not given due weight to accessibility and that the reconfigured services would result in a real reduction in accessibility compared with current service provision for the people of East Sussex. Additionally, the IRP was not convinced by the arguments that there would be compensating improvements in safety and sustainability that could only be achieved through reconfiguration. Overall, whilst recognising that there does need to be some change in staffing the units in order to continue to deliver safe, sustainable services, the Panel does not accept that the single site solution is the only or best option to achieve this.

5.1.19 **Recommendation One**

The IRP does not support the PCTs' proposals to reconfigure consultant-led maternity, special care baby services and inpatient gynaecology services from Eastbourne District General Hospital to the Conquest Hospital at Hastings. The Panel does not consider that the proposals have made a clear case for safer and more sustainable services for the people of East Sussex. The proposals reduce accessibility compared with current service provision.

5.2 **Community maternity services**

5.2.1 The Panel commends the PCTs' proposals to improve antenatal and postnatal care and associated outreach services. The HOSC commented favourably on this proposal and requested that the PCTs implement the plans without delay. This is strongly supported by the IRP, as it will bring clear benefit to the East Sussex community. The Panel was impressed by the commitment to support home births, which is likely to be further enhanced by the retention of consultant-led maternity units at both sites.

5.2.2 **Recommendation Two**

The Panel strongly supports the PCTs' decision to improve antenatal and postnatal care and associated outreach services. These improvements should be carried forward without delay.

5.3 **Further work**

5.3.1 The Panel's view is that the PCTs must develop a local model that enables consultant-led maternity and related services to be retained at both hospital sites. As part of this process, they must examine emerging policy and practice examples and re-examine alternative models that emerged post consultation. This includes full consideration of options which promote choice for service users, including the feasibility of offering midwife-led units at both or either site.

5.3.2 While the IRP does not support the PCTs' proposals, it was nevertheless impressed by the thoroughness of aspects of the consultation and proposal development. It acknowledges that a great deal of hard work was put into both drawing up the consultation document and the subsequent follow-on work.

5.3.3 However, the Panel considers that the formal consultation was unsatisfactory in that the retention of a two-site arrangement was not included. A number of stakeholders put forward a variety of alternative options, some of which impressed the Panel by the detail included in their proposals. Whilst the initial screening process led by Professor Field provided support for further development of options, there is evidence that the formal post consultation option appraisal process was not able to give sufficient consideration and support for development of all alternative proposals.

5.3.4 Evidence from other reconfigurations demonstrates more open and transparent methodologies that may have been helpful in gaining support and trust for the process from the public, clinicians and others. For example, one approach involved two stages; the generation of a number of options at an early stage by a wide range of stakeholders, including clinicians, which were independently analysed to create a shortlist. A separate independent process generated criteria which were then used to assess the options. Only when this wider process had been undertaken did a joint committee of PCTs decide on which options to take forward to formal consultation.

5.3.5 The Panel disagrees with the PCTs' decision not to consult on a two site option. There is evidence that, in other parts of the country, reconfigurations of maternity services have taken place which retain small units such as those at Eastbourne and Hastings. The IRP nevertheless recognises that sustaining the two sites will require additional clinical staff,

but the staffing levels quoted of requiring ten consultants and ten middle grade staff per site for 60 hours cover is considerably higher than plans used in many other small units. The Panel recommends that the PCTs and ESHT revisit the Alternative Models Project work to benchmark their plans against other small maternity units.

5.3.6 **Recommendation Three**

Consultant-led maternity, special care baby, inpatient gynaecology and related services must be retained on both sites. The PCTs must continue to work with stakeholders to develop a local model offering choice to service users, which will improve and ensure the safety, sustainability and quality of services.

5.4 Maternity services strategy

5.4.1 Both Eastbourne DGH and the Conquest Hospital currently have a paediatric assessment unit which provides rapid assessment, observation and treatment under the care of experienced paediatricians. The PCTs have undertaken to maintain paediatrics on both sites for a period of three years. The general view expressed by ESHT's consultant paediatricians was that, logically, if obstetric and gynaecology services moved to one unit, then paediatrics should follow. Additionally, there were mixed views expressed by the consultants and other clinicians as to whether safety would be better or worse in a combined single site unit.

5.4.2 The Panel learned that no children's or maternity strategy presently exists within the PCTs and, therefore, was unable to judge the proposals against such a strategy. It heard that a maternity strategy group has now been convened to drive implementation of the reconfiguration proposal. The Panel considered that local proposals for change were not clear in the context of reconfiguration proposals in neighbouring West Sussex. It is the Panel's view that the implications of adjacent reconfiguration should be clear to all, particularly in relation to patient flows and the accessibility of midwife-led and consultant-led services for residents to the west of the catchment area/Downs and Weald PCT boundary. Additionally, it is considered that, in accordance with the *Department of Health's Operating Framework for 2008/09*, the PCTs will need to take particular action for maternity to improve access, as part of the wider *Maternity Matters Strategy* to deliver safe, high quality care for all women, their partners and their babies.

5.4.3 It was clear to the Panel that many stakeholders were concerned at an apparent lack of a 'joined-up' approach to service planning, particularly that affecting the population to the west of the area. Whilst the SHA had carried out impact assessments and projections of patient flows, and has more recently carried out some strategic review as part of the wider NHS review (*Healthier People, Excellent Care 2008*), the lack of an overall strategy in relation to maternity services across the area was of concern to the Panel.

5.4.4 **Recommendation Four**

The PCTs with their stakeholders must develop as a matter of urgency a comprehensive local strategy for maternity and related services in East Sussex that supports the delivery of the above recommendations. The South East Coast SHA must ensure that the PCTs collaborate to produce a sound strategic framework for maternity and related services in the SHA area.

5.5 **Future communication and engagement**

5.5.1 The Panel acknowledges that the consultation exercise has been a difficult time for many people, but recognises that the PCTs undertook a substantial programme of engagement with the public. Evidence from the campaign groups suggests that aspects of this were not universally perceived as successful. The Panel was disappointed by an unnecessarily adversarial attitude adopted throughout the review period by some members of the campaign groups. During their visits to East Sussex, the Panel became aware that relationships between the PCTs and some stakeholders had all but broken down. However, the Panel considers it essential in the long-term interests of the whole community that all stakeholders support the PCTs in the further work which they will be undertaking.

5.5.2 To ensure that services are informed by the needs and preferences of patients, the public and other key stakeholders, the PCTs should establish appropriate, rigorous and timely involvement and engagement. This must be used to inform commissioning decisions in respect of maternity, special care baby and gynaecology services. The Panel would wish to see the PCTs develop a strategy to ensure open and effective communication with the people of East Sussex in taking forward these recommendations.

5.5.3 **Recommendation Five**

The PCTs working with all stakeholders, both health providers and community representatives, must develop a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the Panel's recommendations.

5.6 **Next Steps**

5.6.1 The PCTs, SHA and ESHT should work together, linking with the East Sussex HOSC, to agree a plan for taking forward the recommendations in this report as a matter of high priority. The Panel noted that local workstreams have addressed Lord Darzi's Next Stage Review and expects that the ongoing local planning process should also take account of the final report by Lord Darzi.

5.6.2 **Recommendation Six**

Within one month of the publication of this report, the PCTs must publish a plan, including a timescale, for taking forward the work proposed in the Panel's recommendations.