NHS Kent and Medway

East Kent Hospitals University NHS
NHS Foundation Trust

MATERNITY SERVICES REVIEW

1. Executive Summary

- The primary driver for this review is safety for every woman and baby, whatever her risk or place of birth. This means having the right skills at the right place at the right time.

- The East Kent Hospitals University Foundation Trust (EKHUFT) has been working closely with the commissioners to agree common priorities and a clinical evidence base. It is our joint ambition to provide 1:1 midwifery care in active labour corresponding to a midwife to birth ratio of 1:28 at all birth units in line with "Safer Childbirth" recommendations.

- Accessibility, Choice, Sustainability and Equity/Fairness have also been factored in.

- The current position demonstrated EKHUFT provides excellent choice of place of delivery; home birth, birth centres, co-located Midwifery Led Unit and Acute Obstetric Unit, however the midwife to birth ratio varies from 1:9 at the stand alone birth units to 1:40 at the consultant led service at the William Harvey Hospital (WHH) which caters for the most complex deliveries providing inequity of service.

- Current live births per site are WHH - 4208, Queen Elizabeth Queen Mother (QEQM) - 2729, Dover Family Birth Centre (DFBC) - 217, Canterbury Birth Centre (CBC) - 300. The year on year 1.6% increase in births is expected to continue reaching 8000 deliveries of babies in 2015.

- The review group have identified four options for future service delivery to address current issues.

- Views of users have been sought and the Health and Overview Scrutiny Committee (HOSC) have been kept updated of progress in view of the continuing suspension of the birthing services at the Canterbury unit. The General Practitioner leaders of the future Clinical Commissioning Groups (CCG) have also had opportunity to review this paper. Further meetings with EKHUFT midwives in all four units will be held in the coming months to keep them abreast of the review.

- The review is committed to ensuring a robust engagement and consultation process, early engagement with staff, GPs, parents and local communities and the evidence that has been provided has influenced the options that have been arrived at. We have been fortunate to receive the assistance of the Maternity Services Liaison Committee in our preparations to date.

- It is expected that a decision will be made to go out to public consultation on the four scenarios that are being considered.

- The earliest opportunity for consultation will be October – December 2011. It has been decided in the interim that Canterbury Birth Centre continues to provide all antenatal care and postnatal day care but will not accommodate births or step down postnatal care.

- The view of the Maternity Services Review Group (MSRG) is that the most sustainable option would be to maintain all services except births and step down postnatal care at both Dover and Canterbury. This will enable a midwife to birth ratio at QEQM and WHH of 1:28 and will enable the QEQM co-located Midwifery Led Unit (MLU) to be opened.

- The indicative cost to provide additional midwives and enable a ratio of 1:28 is £700,468. This is in contrast to £2,126,667 which would be required to maintain birth facilities at the birth centres.

2. Introduction

The purpose of this paper is to provide the background to the current position of maternity provision within East Kent and suggests a number of options for future service provision. East Kent Hospitals University NHS Foundation Trust, Kent and Medway PCT cluster and local East Kent Clinical Commissioning Groups are working together to reach a solution to ensure safe, high quality maternity care for all mothers and families. This paper has been written with support from those who sit on the Maternity Services Review Group, terms of Reference and Group Membership is attached at appendix 1. The MSRG has carried out an initial options appraisal and formed a provisional opinion taking into account evidence collected from a wide spectrum of opinion.

The primary driver for this review is for maintaining a safe service configuration for Maternity Services provided by East Kent Hospitals University Foundation Trust (EKHUFT). This paper also highlights the need for a more permanent solution for future services based on:

Safety every women, whatever her risk and wherever her place of birth, should have one to one care in active labour.

Accessibility services as close to home as possible and where appropriate; which meet the needs of hard to reach groups and positively impact on local inequalities.

Choice information to enable women to make a clinically appropriate and informed choice about the type of birth environment.

Sustainability services that will be sustainable for the future in terms of funding, staff mix and experience and birth rates.

Equity/fairness ensuring the best ratio of staff for mother and baby wherever that service is provided.

In addition, this review of services will fully meet the four tests set out by the Department of Health (DH) in relation to service reconfiguration. Shortly after the new coalition government was elected in May the Secretary of State for Health introduced four tests against which current and future NHS service reconfigurations have to be assessed. According to NHS guidance the tests are designed to build confidence within the service and with patients and communities. The tests were set out in the revised NHS Operating Framework for 2010-11 and require existing and future reconfiguration proposals to demonstrate:

1. Support from GP commissioners.

2. Strengthened public and patient engagement.

3. Clarity on the clinical evidence base; and

4. Consistency with current and prospective patient choice

It is recognised that a long term strategic direction and review will be needed in the future; however this is seen to be far more complex due to its whole system requirements and obvious links to a wider Kent and Medway focus.

3. Background

There is significant evidence based in reports and national guidance that inform how maternity services should be provided. These include:

High Quality Women's Health Care: A Proposal for Change (RCOG 2011) The Government White Paper, The Health and Social Care Bill is reflected in the results of the Royal College of

Obstetricians and Gynaecologists (RCOG) expert review to produce a vision of patient centred high quality women's health care. Amongst the principles and values are:

- Care must be the right care, at the right time, in the right place and provided by the right person.

- Care should be provided closer to home (accepting this principle may require women to travel to access very specialist care).

- Care should be personalised, ensuring risk assessment, continuity of care and choice (this may be influenced by safety and availability of services).

Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (RCOG 2007). In "*Safer Childbirth"* the recommended ratio of midwives to assure a safe level of service is **one whole-time equivalent (WTE) midwife per 28 births for hospital births.** In the same document, it is stated that "there should be 1:1 care for women in established labour".

There are three main categories of care provided by a midwife:

- Community based midwives providing antenatal and postnatal care and supporting births at home or within stand alone birth centres.

- Hospital based midwives providing antenatal and postnatal care.

- Hospital based midwives providing care during labour and birth.

It is very important to maintain the number of midwives to support effective antenatal care as this supports women during pregnancy and allows for appropriate risk assessments to be made at the appropriate stage of pregnancy and therefore ensures women are able to make an informed choice when deciding on the place of birth for their baby.

Maternity Matters (Choice, Access and Continuity of Care in a Safe Service – DH 2007) sets out the following national choice guarantee that should be available to all women:

- Choice of how to access maternity care.

- Choice of type of antenatal care.

- Choice of place of birth.

Depending on their circumstances, women and their partners will be able to choose between three different options. These are:

- Home birth.

- Birth in a local facility, including a hospital, under the care of a midwife.

- Birth in a hospital supported by local maternity care team including midwives, anaesthetists and consultant obstetricians; for some women, this will be the safest option.

The Care Quality Commission has stated: "There will be a need to be mindful that choice needs to be realistic, balancing wants (and sometimes needs) with what is affordable and what resources can be made available".

Bliss (national charity dedicated to improving both the survival and long-term quality of life for babies born too soon) also stated "it's not just about extending choice; it's about ensuring that services are in place to deliver the best possible outcomes for women with high risk-pregnancies and babies admitted to neonatal care".

4. Current Position

Maternity services are delivered across a variety of locations by EKHUFT, as detailed below:

Ante Natal Care – *including:* • *Midwife led* • *Consultant Led* • *Fetal Medicine* • *Maternity Day care*	William Harvey Hospital Queen Elizabeth Queen Mother hospital Canterbury Birth Centre (Kent and Canterbury Hospital) Dover Birth Centre (Buckland Hospital) Royal Victoria Hospital Variety of community settings i.e. GP surgeries and Children Centres Woman's own home
Intra Partum Care (Delivery)	William Harvey Hospital – Obstetric Unit (Labour ward) William Harvey Hospital – Singleton Midwifery-led Unit Queen Elizabeth Queen Mother Hospital – Obstetric Unit (Labour Ward) Kent & Canterbury Hospital – Canterbury Birth Centre Buckland Hospital – Dover Birth Centre Home Birth
Post Natal Care	Immediate postnatal care in all birth settings including birth centres. Step down postnatal care in stand alone birth centres Client's own home GP surgeries and children's centres

EKHUFT built and fully equipped two new Midwifery Led Units (MLUs) on the William Harvey (WHH) and Queen Elizabeth Queen Mother Hospital (QEQM) sites. The WHH MLU opened in July 2009. The QEQM MLU has not yet opened, due to insufficient midwife numbers to staff the unit. Unlike the current birth centres in Dover and Canterbury, the new units are co-located with obstetric units (labour wards).

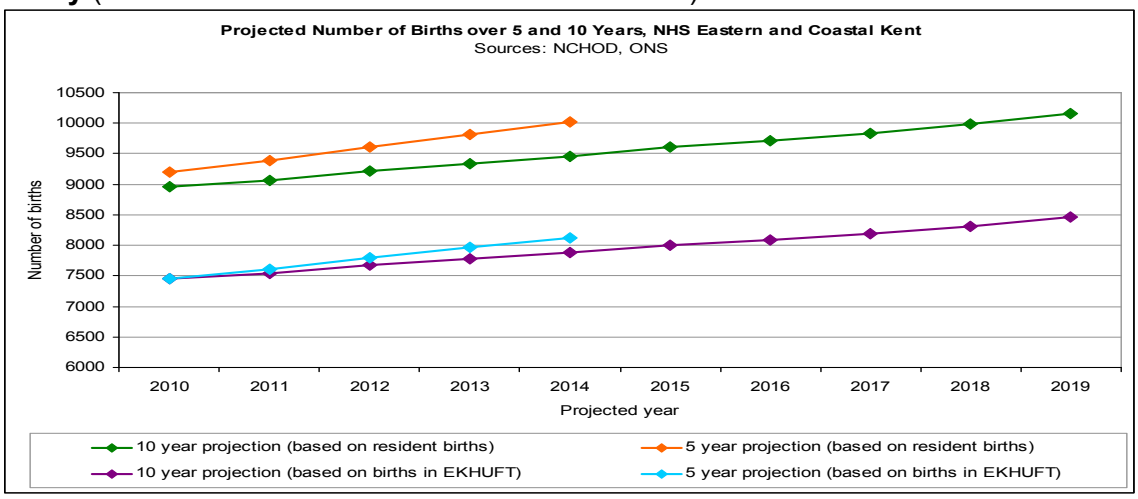
4.1 Rise in Birth Rates

Births across EKHUFT had increased year on year up to 2008/09, and showed a 1.6% increase from 2009/10 to 2010/11. This year on year increase is expected to continue, with the number of babies born in east Kent reaching 8000 by 2015. As demonstrated within the following tables.

Year on Year Increase in Births

	2003 - 04	2004 - 05	2005 - 06	2006 - 07	2007 - 08	2008 - 09	2009 - 10	2010 - 11
Total live births delivered by EKHUFT	6462	6477	6671	7080	7100	7373	7336	7454

Birth Activity (NB. 'based on resident births' includes Swale)



Births by Site

Total live births delivered by EKHUFT	WHH	QEQM	DFBC	KCH	TOTAL
2010-11 (Number of home births included above)	4208 (66)	2729 (57)	217 (59)	300 (65)	7454 (247)
2009 -10	3976 (97)	2746 (50)	249 (53)	365 (51)	7336 (251)
2008 – 09	3762 (114)	2898 (59)	345 (80)	368 (54)	7373 (307)
2007 – 08	3558 (114)	2779 (53)	366 (91)	398 (67)	7101 (325)
2006 - 07	3500 (121)	2697 (55)	433 (45)	450 (70)	7080 (291)

As can be seen from the table above births at the WHH have increased while all other sites have decreased. More than 50% of the births within EKHUFT are now at the WHH site. One reason for this increase on the WHH is the opening of the Singleton Midwifery Led unit. However, the decline in births at the birth centres was an established trend and by 2009-10 a total of 510 births took place in the birth centres. This decline has continued further since the opening of the MLU

Of the births in 2010 at the WHH, 662 were births that took place on the Singleton Midwifery Led unit. However, some women who may have chosen the midwifery led unit for birth will not have delivered there as they have required transfer to the acute unit for obstetric, medical or personal reasons.

This continued increase in activity on the WHH site requires appropriate midwifery staff numbers and expertise in order to support women in active labour.

4.2 Midwifery Staffing

Following a recent benchmarking exercise through the Foundation Trust Network (FTN), the maternity services provided by EKHUFT were compared with seventeen other foundation trusts (FT) that provide maternity services. Only two other trusts within this cohort equalled the number of multiple sites within EKHUFT. Both these had only one acute site offering a 'hub and spoke' service. EKHUFT was the only trust that had two acute sites and three midwifery led units.

This six month review provided a substantial database and adds to local evidence which will be considered within the review. This data highlights a number of important facts, these include the following:

- There are currently some 7,500 births within east Kent and this is likely to rise to 8,000 by 2015 (1.6% per year).

- The average number of deliveries per midwife in east Kent is within the average range for other FTs. However, critically, when this analysis is broken down by birth unit the WHH unit which supports those mothers with the highest health risk has the highest number of births per midwife. The average birth:midwife ratio on the four main sites is as follows:

  1. WHH 1:40

  2. QEQM 1:35

  3. Dover Birth Unit (BHD) 1:9

  4. Canterbury Birth Unit (KCH) 1:10

- Antenatal and postnatal midwifery episodes in line with NICE guidance.
  http://www.nice.org.uk/nicemedia/live/11947/40115/40115.pdf
  http://www.nice.org.uk/nicemedia/live/10988/30144/30144.pdf

- The FTN paper suggests that maternity services operate at a loss nationally. When compared to other FTs in the benchmarking exercise EKHUFT had a 5% greater loss than the cohort considered in the FTN data. However, two trusts within this cohort omitted to provide information about Clinical Negligence Scheme for Trusts (CNST) costs and indirect costs. Had these been added EKHUFT would have been closer to the mean. Additional funding provided to EKHUFT by commissioners this financial year has closed the gap but provides insufficient income to support the service as a whole.

- The majority of maternity services are paid for by the PCT at national tariff which is set by the DH.

- Total pay costs per delivery at the two stand alone birth centres are almost twice as high as the obstetric units within EKHUFT and more than twice the current tariff for a normal delivery (£1292).

Despite investment into midwifery staffing over the previous two years this has only been sufficient to support the increase in births therefore maintaining the status quo in terms of birth to midwife ratio.

As demonstrated through the FTN benchmarking exercise, there is significant discrepancy between the birth to midwife ratio. To further complicate this problem the women who come to the WHH are often high risk and not able to use the services of a birth centre. EKHUFT therefore has a situation where women who are entirely low risk and without complication receive one to one care from a midwife in labour whilst high risk women with complex pregnancies were unlikely to receive this. It has been identified that delivering safe maternity services across EKHUFT is strongly dependent on midwifery staffing numbers.

The table below indicates the future requirements for midwifery staffing alongside the annual increase of births.

Midwifery Staffing Profile

Year	Birth/projected births	Current Establishment	Establishment required for 1:28	Deficit from baseline (2010/11)
2010/11	7454	236	266	30
2011/12	7570	236	270	34
2012/13	7691	236	275	39
2013/14	7814	236	279	43
2014/15	7939	236	284	48
2015/16	8056	236	288	52

4.3 Capacity

Unfortunately, there are times when services have to be suspended to ensure safe levels of care in acute labour wards (as is discussed below). The requirement to move staff to acute areas to support high risk care has an obvious impact on the ability to maintain the choice of birth in a low risk setting. In the majority of cases this is only for a small number of hours. Further details and financial break down can be found at appendix 2.

As has been described throughout this paper, safety is the main priority when considering the provision of maternity care. As such there are times when midwifery managers have to make the decision to divert a unit. This is applicable to all sites; the acute and the birth centres.

There are two main reasons for the need to divert:

Lack of capacity – this problem arises at times of high activity and can be two fold; high numbers of women labouring at the same time filling all available labour beds or high numbers of women who have recently given birth and filling postnatal beds. This is the most common scenario, once the postnatal beds are full it is not possible to move women from the labour ward to the postnatal ward and women have to remain on the labour ward until fit for discharge home or until a bed becomes available on the postnatal ward. When a site is full it is not possible to continue to admit women when there is no bed space. The availability of an additional four co-located beds at QEQM and full utilisation of MLU at WHH will mitigate against this.

It is fortunate that EKHUFT have the benefit of two acute sites and hence women are always able to access maternity care within the trust when one site is diverted although this may necessitate travelling further than they had anticipated (see appendix 4) To date, it has not been necessary to suspend services on both sites simultaneously.

Lack of midwifery or obstetric staffing – this is a problem that results from a deficit of staff through sickness/absence. If staff cannot be found to cover the shifts then services have to be suspended to maintain safety both for those women already on the unit and those who need to access services. Sometimes there is the need to suspend service because of the complexity of cases on the labour ward. In this scenario there may be the required/usual number of staff but the complexity of the women on the labour ward require such intensive care that it is not safe to admit any further women.

The current maternity capacity across the Trust and more in depth information about unit diversions is detailed in appendix 3.

5. Delivering Safe Maternity Services across East Kent

In September 2010, EKHUFT identified an increase in neonatal admissions to the WHH neonatal intensive care unit had occurred between April and August 2010. A decision was made to investigate this increase and, as a precautionary measure, to enhance staffing levels on the obstetric unit (Labour ward) at WHH while the investigation was being carried out.

To achieve the enhanced staffing levels, births within the Dover Birth Centre at Buckland Hospital were temporarily suspended and midwives were redeployed to WHH. All other services provided at the DFBC continued such as antenatal and day care.

The rise in admissions to the neonatal intensive care unit has been further investigated without definitive conclusions but both EKHUFT and the Primary Care Trust (PCT) agree that midwifery staffing levels were a key factor. In January 2011, it was agreed it was necessary to maintain the temporary suspension of a birth centre. It was decided that this should be the Canterbury Birth Centre, this has remained temporarily suspended and the MLU within QEQM remains unopened.

EKHUFT have moved midwives to follow the flow of activity. It is clear the rise in births at the WHH required more experienced midwives to support this. The suspension of the services at one of the

Birth Centres has been agreed by EKHUFT, Kent and Medway PCT cluster and local East Kent Clinical Commissioning Groups as the paramount priority is to ensure safe care on all sites.

Since the suspension of one or other of the birth centres there has not been any adverse effects on safety in any of the other sites. The births that would have taken place at a birth centre have been accommodated within the other units and there has not been a significant increase in home births.

5.1. Choice For Women

The Maternity Matters Framework sets out the national choice guarantee that should be available to all women, comprising choice of how to access maternity care, choice of type of antenatal care and choice of place of birth. East Kent delivers comprehensively on the choice guarantee. Women using services in East Kent are offered choice of antenatal and postnatal care in a range of settings, and choice of place of birth - home birth, birth in a local setting under midwifery led care and birth in an acute hospital supported by a maternity care team. The choice guarantee will continue to be fully met by each of the options set out in this paper.

As well as a tangible shift in women in EKHUFT choosing to have their baby within co-located midwife led units, there is evidence from the interviews conducted as part of the current maternity review. In the spring of 2011 a snap shot survey of 95 recent service users was undertaken. Participants were asked what type of delivery service they would prefer the majority of respondents favoured the midwife led units co-located with obstetric support (near to the Labour ward).

With regards to the future of the services in the longer term, EKHUFT, Kent and Medway PCT cluster and local East Kent Clinical Commissioning Groups need to agree on how maternity services within East Kent will be delivered. The priority remains safety but we are also conscious that services need to be accessible to the local population, that there is appropriate choice for women and that the services are sustainable given the continued rise in birth rates. Hence the review of services has begun which will conclude by December of this year at the earliest. Until this time EKHUFT has decided, in the interest of safety, to keep the Canterbury Birth Centre suspended for births. The immediate future of all the maternity services in east Kent will be decided through this review.

5.2 The engagement of communities and parents

The maternity review has always recognised the importance of working with staff, patients, GPs, stakeholders and the local population to enable a transparent and well informed debate about the issues faced by our maternity services, so that any decisions taken are informed by both local opinion and clinical/workforce evidence that meets section 242 and 244 requirements.

Hence the review leaders are working with the Maternity Services Liaison Committee as champions, and using contacts in children's centres and Sure Start centres or Young Active Parents' groups, to ensure conversations are held with parents where they are most comfortable.

The early engagement has focused strongly on recording patient and parents' experience is an important strand of evidence within the maternity review.

So far the citizen engagement has collected current patient's experience via 230 surveys – based on the national care quality commission's survey which was run in 2010. The commissioners and citizen engagement team has also interviewed 95 mums and dads with recent experience of services by visiting children's centres and sure start centres across east Kent, The engagement team has also held focus groups with some seldom heard communities including young parents and those with learning disabilities. This approach will be expanded upon in the consultation to ensure a wide range of communities are able to actively take part in the consultation process.

In addition the PCT is running an online survey for interested citizens to comment, and we have also held several community road shows for staff and community members. Also the citizen engagement team are visiting a number of family friendly events this summer to discover how local people about the criteria being used to define the options and which should have the highest priority. The importance of ante natal and postnatal care has come through in all of the work, so the steering group options clearly recognise that the community teams will remain in situe and the birthing centres will continue to offer both ante natal and post natal care along with the monitoring and clinical advice for worried mothers during their pregnancy.

Also throughout the engagement the midwifery staff and doctors whilst praised and supported overall, are frequently recognised as being very busy and unable always to devote the time to one to one level of care they might intend.

''I can highly recommend all the staff at William Harvey and my local support network. Everyone has made my labour (despite my an emergency c. section) a positive experience'

'They could do with more staff for better care. It was too long between seeing anyone.'

All of this work and the views collected have been fed into the maternity review and will be formally considered as part of the engagement and consultation process.

6. Options

The review group's view is that the most sustainable solution to the issues identified was to provide a midwife to birth ratio of 1:28 as per "*Safer Childbirth"* recommendations. It is agreed that the continuation of providing birth facilities at Dover Birth Unit, Canterbury Birth Centre and the 2 acute sites without additional investment is not a safe option and is therefore not included as one of the scenarios. A review of current staffing levels and skill mix has been undertaken and by reconsidering the roles of Band 2 staff and incorporating 24 hour ward clerk and administration into this role it has been agreed to convert 18.04 WTE of these posts into Band 3 Maternity Care Assistants. This will reduce the external investment required as including these posts in the midwifery workforce will allow flexibility in matching the appropriate tasks with the required skills and knowledge. The workforce has been modelled using a 90:10 (Midwife:MSW) split as recommended by Birthrate Plus (the only recognised midwifery workforce planning tool supported by the DH), 'Safer Childbirth' (RCOG 2007) and the Kings Fund. These changes will be phased in to allow training and skills development. Appendix 1 shows the workforce and financial modelling of each scenario which is summarised below. It should be noted that in considering the options for sustainable maternity services in East Kent, choices must be made about how resources are spent across the whole health economy. Substantial additional investment in maternity services would inevitably result in other services having to cease.

6.1. Scenario 1

- Maintain all facilities including births at Canterbury Birth Centre, and Dover Birth Unit
- Ensure midwife to birth ratio at QEQM and WHH is 1:28
- Open QEQM co-located Midwifery Led Unit

Indicative additional service costs: £2,126,667

6.2. Scenario 2a

- Maintain all facilities including births at Canterbury Birth Centre. Maintain antenatal and postnatal outpatient services at Dover Birth Unit and cease births on this site
- Ensure midwife to birth ratio at QEQM and WHH is 1:28
- Open QEQM co-located Midwifery Led Unit

Indicative additional service costs: £1,475,241

6.3. Scenario 2b

- Maintain birth facilities at Dover Birth Unit. Maintain antenatal and postnatal outpatient services at Canterbury Birth Centre and cease births on this site
- Ensure midwife to birth ratio at QEQM and WHH is 1:28

- Open QEQM co-located Midwifery Led Unit

Indicative additional service costs: £1,355,320

6.4. Scenario 3

- Maintain all facilities except births at both Dover Birth Unit and Canterbury Birth Centre
- Ensure midwife to birth ratio at QEQM and WHH is 1:28
- Open QEQM co-located Midwifery Led Unit

Indicative additional service costs: £700,468

Scenario 1

Maintain all existing services and open second MLU

Not deliverable with current resources hence current suspension of birth centre and QE MLU not opened

Advantages

- Local services maintained
- Open MLU QEQM
- Meets current normalising birth and choice agenda
- Reduces risk of rising C/S rate in the future
- Potentially aids capacity management by use of postnatal beds at birth centres
- No change of work place for staff

Disadvantages

- Poor estate will need upgrade / replacement
- Demand at the birth centres is reducing year on year
- Significant midwife recruitment required to allow birth to midwife ratio of 28:1
- Services are inefficient and midwifery staffing inflexible and unable effectively to follow patient flow
- Inequitable service as low risk women received the highest level of care
- Impossible to maintain safe services on all areas particularly WHH site
- Significant increase in unit diversions
- High pay costs per delivery on birth centre sites
- Continued risk of unit closures in order to accommodate staffing pressures

Scenario 2a

Maintain antenatal and postnatal services but cease births at Dover Birth Centre

Scenario 2b

Maintain antenatal and postnatal services but cease births at Canterbury Birth Centre

Scenario 3

Maintain antenatal and postnatal services but cease births at both Dover AND Canterbury Birth Centres

Reflects current model of care with one birth centre suspended

Sustainable option

Requires public consultation

Advantages

- Better utilisation of resources
- Access to standalone and co-located Midwifery Led Units maintains choice of birth experience
- Maintenance of local outpatient and day care services
- Potential for increase in home births
- Open MLU QEQM

Disadvantages

- Will be seen to disadvantage the area that ceases services for birth
- Inefficient use of available resource
- Possible rise in C/S
- Effect on midwifery staffing through potential increase in home birth
- High pay costs per delivery on birth centre sites
- Continued risk of unit closures in order to accommodate staffing pressures

Advantages

- Ability to open MLU at QEQM
- Better utilisation of physical and staffing resource
- Access to collocated MLU maintains choice of birth experience
- Maintenance of local outpatient and day care services
- Potential for increase in home births
- Improved care on acute sites for high risk women
- Most cost effective option
- Increase service stability, less anxiety for women regarding unit diversions

Disadvantages

- Reduced choice of local birth centre for low risk women in Dover and Canterbury
- Potential higher activity on acute centres as a result of increased transfer rate from co-located MLUs
- Reduction in overall capacity
- Possible rise in C/S rate
- Effect on midwifery staffing through potential increase in home birth

7. Risks to change

The temporary suspension of the one stand alone MLU has been accepted on safety grounds, given the rise in admissions to the neonatal unit. If there is to be a case for permanent closures, this would have to be taken through a formal consultation process. It is recognised that the current position cannot continue and reconfiguration is required to sustain safe services. If consultation was to be delayed, legal advice should be sought as to the legitimacy of the current temporary arrangements.

The evidence which is being gathered through the maternity review has established a strong case to support service change. It is necessary to follow a careful timetable of consultation to avoid legitimate legal challenge.

National policy is clearly based on improving access and choice, whilst ensuring safety and offering high quality of care, these imperatives cannot be ignored. The National Perinatal Epidemiology Unit national 'Birth Place' study is due to be released shortly, and the DH is concerned that all maternity services reconfigurations are coherent with current policy and practice.

The review group must be assured of equity of access and be able to articulate the average transfer time between all units and from all areas. Finally, adequate capacity must be provided within any service reconfiguration to avoid women having to travel outside east Kent to give birth.

7.1 Recommendations

In order to provide appropriate, safe and high quality 1:1 care in established labour, within two locations additional midwifery staff levels to the current establishment are required. The current provision of choice given to women in terms of additional co-located and stand alone midwifery units further increases the gap in staffing.

EKHUFT and the East Kent Maternity Services Review Group would recommend Scenario 3 as the most sustainable option. This facilitates the effective use of maternity staff to open the co-located unit at QEQM and support the acute units. This would require reallocating staff from both the birth centres and investment in more midwives in order to adequately support the co-located midwife led units, obstetric units (labour wards) to deliver a midwife to birth ratio of 1:28 on both sites. Data issued by NHS South East Coast indicates that 40% of east Kent births are normal deliveries. A normal delivery includes all spontaneous births without induction of labour, augmentation, artificial rupture of membrane, epidural or episiotomy.

The Dover and Canterbury Birth Centres would continue to offer all their current day and community services. This includes two consultant clinics at Canterbury weekly; one joint consultant clinic at Dover; various midwifery clinics; day care services on both site and parent education classes. Both areas undertake high volumes of work and this will continue as it is recognised that local services are important to women. Furthermore, there is not the capacity either in space or staff time to undertake this work on the acute sites.

It should be recognised that the criteria for delivery at these stand alone birth centres is the same for home births and this option continues to be available and would be expanded if that was the choice of women in the future.

Appendix 1

JOINT MATERNITY SERVICE REVIEW

Draft Terms of Reference
June 2011

1. Purpose

The purpose of the Joint Review is to continue to deliver and maintain a safe, sustainable model of care for maternity services through a joint approach with commissioners, clinicians and providers for East Kent residents.

In addition this review will further enhance and:-

- improve health and reduce health inequalities;
- improve access to safe services;
- ensure choice of provision and improve access to services ensuring equity across eastern and coastal Kent;
- pursue perfection in the safety and quality of clinical services;
- respond effectively to the diversity and changing demographics of our population;
- deliver value for money.

The work of the Joint Review will contribute to the delivery of the Integrated Strategic Operating Plan (ISOP) and the initiatives set out in the Maternity Commissioning Strategy, ensuring that investments are productive, effective and efficient.

2. Outcomes

- Agreed clinical outcomes.
- Agreed activity levels.
- Agreed level of choice in line with Maternity Matters.
- Agreed sustainable workforce model and plan.
- The Review will have an East Kent focus but will take into consideration the wider implications of capacity across Kent and Medway
- Agreed birth to midwife ratios.
- Agreed communication/public engagement management.
- Agreed/clear funding and costing.
- Agreed service provision through period of review – status quo for service delivery unless evidence of patient safety and quality issue.

3. Agreed Evidence

- Detailed sustainable workforce plan and calculations (including work undertaken by University of Kent).
- Activity by site including all sites (including home births), MLU and obstetric delivery areas including, cross boundary. Activity data to include postcodes.
- SUS data and coding.
- Patient experience of temporary closure.
- KPMG clinical review
- FTN benchmarking document.
- Kent and Medway Integrated Operational Plan (QIPP)
- Finance funding and costs.
- Commissioning strategy.
- Public Health data.
- Data around transfers of mothers during delivery
- Midwife to patient ratios re equity of services

4. Membership

The membership of the Joint Review will be made up as follows:-

PCT Role	Member
Interim GP Chair	Dr Sarah Montgomery
Interim GP Chair (nominated deputy)	TBC
Director Sponsor	Hazel Carpenter / Helen Buckingham
GPCC Maternity Commissioner	James Ransom
Citizen Engagement	Sara Warner
Finance/Information	Deborah Bateson / Stewart Town
Communications	Glynis Alexander or substitute
Clinical – Quality & Safety	Debbie Dunn
Public Health	Jonathan Sexton
Locality SCAO reference group	Dr Chee Mah Dr Jessica Crouch Dr Anne Weatherley

EKHUFT Role	Member
Medical Director	Dr Neil Martin
Director of Specialist Services (nominated deputy)	Jane Ely
Assistant Director of Strategic Development & Capital Planning	Anne Neal
Maternity & Obstetric Leads	Lindsey Stevens - Head of Midwifery and Gynae Nursing
Citizen Engagement	Kunie Thomas - Head of Patient Experience
Finance/Information	Dawn Allaway
Communications	Jim Murray - Director of Communications
General Manager Specialist Services Division	Ben Stevens
Consultant obstetrician clinical Lead	Dr Kate Neales

5. Chair

The GP Clinical Commissioner will act as Chair of the Joint Review and will be mandated by NHS Eastern & Coastal Kent's Commissioning Strategy Committee. If the Chair is absent from a meeting or absent temporarily on the grounds of a declared conflict of interest, the Medical Director from East Kent Hospitals University Foundation Trust (EKHUFT) will act as Chair for the duration of the meeting. The Chair will be responsible for ensuring that GPCC leads from each locality (including Maidstone and Medway) are consulted with as part of the Review.

6. Secretary

James Ransom will act as Secretary to the Joint Review.

7. Quorum

The quorum necessary for the transaction of the business shall be the Medical Director from EKHUFT and GP Clinical Commissioner, or their nominated deputies.

A duly convened meeting of the Joint Review at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable, by the Group.

8. Frequency of meetings

The Review Group shall meet as and when required as part of the project plan process.

9. Notice of meetings

Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed and supporting papers, shall be forwarded to each member of the Joint Review and any other person required to attend no later than two weeks before the date of the meeting.

Meetings of the Joint Review other than those regularly scheduled as above, shall be summoned by the chair of the Joint Review.

10. Conduct of meetings

Except as outlined above, meetings of the Steering Group shall be conducted in accordance with the provisions of Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions approved by the Board of NHS Eastern and Coastal Kent and also that of East Kent Hospital University Foundation Trust.

11. Minutes of meetings

The Secretary shall minute the proceedings and resolutions of all meetings of the Joint Review, including recording the names of those present and in attendance.

The minutes of the Project Group's meetings will be reported to NHS Eastern & Coastal Kent's Commissioning Strategy Committee and made available to each GPCC. The minutes will also be made available to the Chief executive of East Kent Hospitals University Foundation Trust.

All decisions made by the Joint Maternity Service Review working group will be ratified by EKHUFT Board, Commissioning Steering Committee (CSC) and Kent and Medway PCT cluster.

12. Review of Terms of Reference

The terms of reference will be reviewed as appropriate by the Joint Review.

Appendix 2 Financial details

Scenario 1

Birth: Midwife Ratio based on 1:28 per Acute Site

Site	No of Births per paper	Staffing			Number of Births per Midwife	Average number of Births per Midwife
		Total Midwives and MSW's (per 2011/12) establishment WTE	Investment in Acute Sites to ensure ration is 1:28 WTE	Total Staff to Deliver Service WTE		
WHH	4208	105.50	44.79	150.29	**28**	
QMH	2729	78.20	19.19	97.39	**28**	
KCH	300	28.80	0.00	28.80	**10**	
BHD	217	23.03	0.00	23.03	**9**	
	7454	**235.53**	**63.98**	**299.51**		**25**

Will ensure that ratio of 1:28 is achieved at Acute Sites and as based on birth rates would allow for the opening of the MLU at QMH

Staffing split 90% : 10% Qualified to Unqualified

Current Staffing			Proposed Staffing			Changes		
Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE
99.50	6.00	105.50	135.26	15.03	150.29	35.76	9.03	44.79
72.22	5.98	78.20	87.65	9.74	97.39	15.43	3.76	19.19
28.48	0.32	28.80	25.92	2.88	28.80	-2.56	2.56	0.00
22.50	0.53	23.03	20.73	2.30	23.03	-1.77	1.77	0.00
222.70	**12.83**	**235.53**	**269.56**	**29.95**	**299.51**	**46.86**	**17.12**	**63.98**
			Indicative Investment in Service Required			**2,056,351**	**70,316**	**2,126,667**

Scenario 2a

Birth : Midwife Ratio based on Staffing Levels with Closure of Dover Birth Centre
Birth : Midwife Ratio based on 1:28 per Acute Site

Site	No of Births per paper	Transfer of Births from BHD	Total Births	Staffing					Number of Births per Midwife	Average number of Births per Midwife
				Total Midwives and MSW's (per 2011/12) establishment WTE	Transfer Staffing from BHD WTE	Total Staffing per proposal to invest WTE	Investment to 1 : 28 WTE	Total Staff to Deliver Service WTE		
WHH	4208	130	4,338	105.50	13.97	119.47	35.53	155.00	**28**	
QMH	2729	87	2,816	78.20	9.06	87.26	13.24	100.50	**28**	
KCH	300	0	300	28.80	0.00	28.80	0.00	28.80	**10**	
BHD	217	-217	0	23.03	-23.03	0.00	0.00	0.00	**0**	
	7454	**0**	**7,454**	**235.53**	**0.00**	**235.53**	**48.77**	**284.30**		**26**

Will ensure that ratio of 1:28 is achieved at Acute Sites and as based on birth rates would allow for the opening of the MLU at QMH
Assumes transfer of all staff at BHD on the assumption that a Day Care Centre will still provided at Dover Site (no different from offering service in Community by Community Midwives)

Staffing split 90% : 10% Qualified to Unqualified

Current Staffing			Proposed Staffing			Changes		
Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE
99.50	6.00	105.50	139.50	15.50	155.00	40.00	9.50	49.50
72.22	5.98	78.20	90.45	10.05	100.50	18.23	4.07	22.30
28.48	0.32	28.80	25.92	2.88	28.80	-2.56	2.56	0.00
22.50	0.53	23.03	0.00	0.00	0.00	-22.50	-0.53	-23.03
222.70	**12.83**	**235.53**	**255.87**	**28.43**	**284.30**	**33.17**	**15.60**	**48.77**
			Indicative Investment in Service Required			**1,411,172**	**64,069**	**1,475,241**

Scenario 2b

Birth : Midwife Ratio based on Staffing Levels with closure of Canterbury Birth Centre
Birth : Midwife Ratio based on 1:28 per Acute Site

Site	No of Births per paper	Transfer of Births	Total Births	Staffing					Number of Births per Midwife	Average number of Births per Midwife
				Total Midwives and MSW's (per 2011/12) establishment WTE	Transfer Staffing from KCH WTE	Total Staffing per proposal to invest WTE	Investment to 1 : 28 WTE	Total Staff to Deliver Service WTE		
WHH	4208	180	4,388	105.50	17.47	122.97	33.82	156.79	**28**	
QMH	2729	120	2,849	78.20	11.33	89.53	12.15	101.68	**28**	
KCH	300	-300	0	28.80	-28.80	0.00	0.00	0.00	**0**	
BHD	217	0	217	23.03	0.00	23.03	0.00	23.03	**9**	
	7454	**0**	**7,454**	**235.53**	**0.00**	**235.53**	**45.97**	**281.50**		**26**

Will ensure that ratio of 1:28 is achieved at Acute Sites and as based on birth rates would allow for the opening of the MLU at QMH
Assumes transfer of all staff at KCH on the assumption that a Day Care Centre will still provided at Dover Site (no different from offering service in Community by Community Midwives)

Staffing split 90% : 10% Qualified to Unqualified

Current Staffing			Proposed Staffing			Changes		
Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE
99.50	6.00	105.50	141.11	15.68	156.79	41.61	9.68	51.29
72.22	5.98	78.20	91.51	10.17	101.68	19.29	4.19	23.48
28.48	0.32	28.80	0.00	0.00	0.00	-28.48	-0.32	-28.80
22.50	0.53	23.03	20.73	2.30	23.03	-1.77	1.77	0.00
222.70	**12.83**	**235.53**	**253.35**	**28.15**	**281.50**	**30.65**	**15.32**	**45.97**
			Indicative Investment in Service Required			**1,292,401**	**62,919**	**1,355,320**

Scenario 3
Birth : Midwife Ratio based on Staffing Levels with the Closure of both Birth Centres plus opening of MLU and close 2 of birth centres
Birth : Midwife Ratio based on 1:28 per Acute Site

Site	No of Births per paper	Transfer of Births	Total Births	Staffing					Number of Births per Midwife	Average number of Births per Midwife
				Total Midwives and MSW's (per 2011/12) establishment WTE	Transfer Staffing from BHD/KCH WTE	Total Staffing per proposal to invest WTE	Transfer Staffing from KCH	Total Staff to Deliver Service WTE		
WHH	4208	310	4,518	105.50	31.44	136.94	24.56	161.50	**28**	
QMH	2729	207	2,936	78.20	20.39	98.59	6.12	104.71	**28**	
KCH	300	-300	0	28.80	-28.80	0.00	0.00	0.00	**0**	
BHD	217	-217	0	23.03	-23.03	0.00	0.00	0.00	**0**	
	7454	**0**	**7,454**	**235.53**	**0.00**	**235.53**	**30.68**	**266.21**		**28**

Will ensure that ratio of 1:28 is achieved at Acute Sites and as based on birth rates would allow for the opening of the MLU at QMH
Assumes transfer of all staff at KCH & BHD on the assumption that a Day Care Centre will still provided at Dover Site (no different from offering service in Community by Community Midwives)

Staffing split 90% : 10% Qualified to Unqualified

Current Staffing			Proposed Staffing			Changes		
Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE
99.50	6.00	105.50	145.35	16.15	161.50	45.85	10.15	56.00
72.22	5.98	78.20	94.24	10.47	104.71	22.02	4.49	26.51
28.48	0.32	28.80	0.00	0.00	0.00	-28.48	-0.32	-28.80
22.50	0.53	23.03	0.00	0.00	0.00	-22.50	-0.53	-23.03
222.70	**12.83**	**235.53**	**239.59**	**26.62**	**266.21**	**16.89**	**13.79**	**30.68**
			Indicative Investment in Service Required			**643,828**	**56,640**	**700,468**

Appendix 3

Diversion of units – further details

Current maternity bed capacity in EKHUFT

WHH

10 labour beds and 4 beds for induction of labour and triage
29 postnatal/antenatal beds

Singleton Midwifery led unit

6 labour /postnatal beds
2 pool rooms

QEQM

9 labour beds and 3 induction of labour beds
21 postnatal/antenatal beds

MLU (not used at present time)

4 labour/postnatal beds

CBC

2 labour beds
5 labour/postnatal beds

DFBC

3 labour beds
8 postnatal beds

Diversion of a unit is always undertaken in close liaison with all sites and only ever authorised by a midwifery manager. There is a comprehensive guideline that managers follow and includes notification of all sites, hospital managers and ambulance control. It is fortunate that EKHUFT have the benefit of two acute sites and hence women are always able to access maternity care within the trust when one site is diverted. To date it has not been necessary to close both sites simultaneously. Midwifery managers and the co-ordinating labour ward midwifery staff maintain close communication throughout the time a unit is on divert and the unit is opened as soon a possible so that women are not disrupted for any longer than is necessary.

All women are advised of the possibility of unit diversions both verbally by their community midwife and this is reinforced in the patient information leaflet 'Your birth, Your choice'

Although diversion of birth site is disruptive and can cause significant anxiety to women, there have been no adverse incidents arising as a result of a unit diversion. On review of maternity statistics it is clear that the number of babies born before arrival (BBA is recorded as such if the woman delivers on route to the hospital or prior to the arrival of a midwife to the home) have not increased. In the period 2009/10 there was 50 BBAs and in 2010/11 there were 42.

In 2010 there were 27 diversions as follows:

Unit	Reason	Diversions
CBC	Staffing	2
DFBC	Staffing	1
MLU	Staffing	2
QEQM	Capacity	18
WHH	Capacity	4
Total		**27**
Total number of women requiring transfer		**18**

To date in 2011 there have been 26 diversions as follows:

Unit	Reason	Diversions
CBC	Suspended	0
DFBC	Staffing	1
MLU	Staffing	15
QEQM	Capacity	9
WHH	Capacity	1
Total		**26**
Total number of women requiring transfer		**9**

As can be seen there has been an increase in the requirement to divert birth sites although the need to divert because of capacity appears to be fairly consistent. This is unlikely to continue to be the case for two reasons

1. The local birth rate continues to rise.

2. In September the acute labour ward at Maidstone will close and will be replaced with a midwifery led service similar to that provided in the birth centres in Canterbury and Dover. It is likely that women, both those who are high risk and those who prefer the option of a co-located birth centre, who live in the South of Maidstone will choose to come to the WHH for birth. In the past estimates have been made of approximately 500 women who will choose the WHH. This remains unclear at this time and there is the thought that many women will travel to Pembury for birth because the excellent facilities there (all single rooms and the ability for partners to stay).

The above alongside the possibility of changes in services and removal of one or both birth centres as a result of the maternity review need to be considered. What is clear from the bed occupancy data below any increase in numbers of births on either site will have a further impact on capacity.

Detailed analysis of bed occupancy is collated via the information team which demonstrates the following:

Year Summary 2010/11 Bed Occupancy	
Unit	**Percentage**
CBC	19. 91% (suspended from January)
DFBC	22.15% (suspended from October 2010 to January 2011)
MLU	41.18%
QEQM	**91.28%**
WHH	**89.09%**

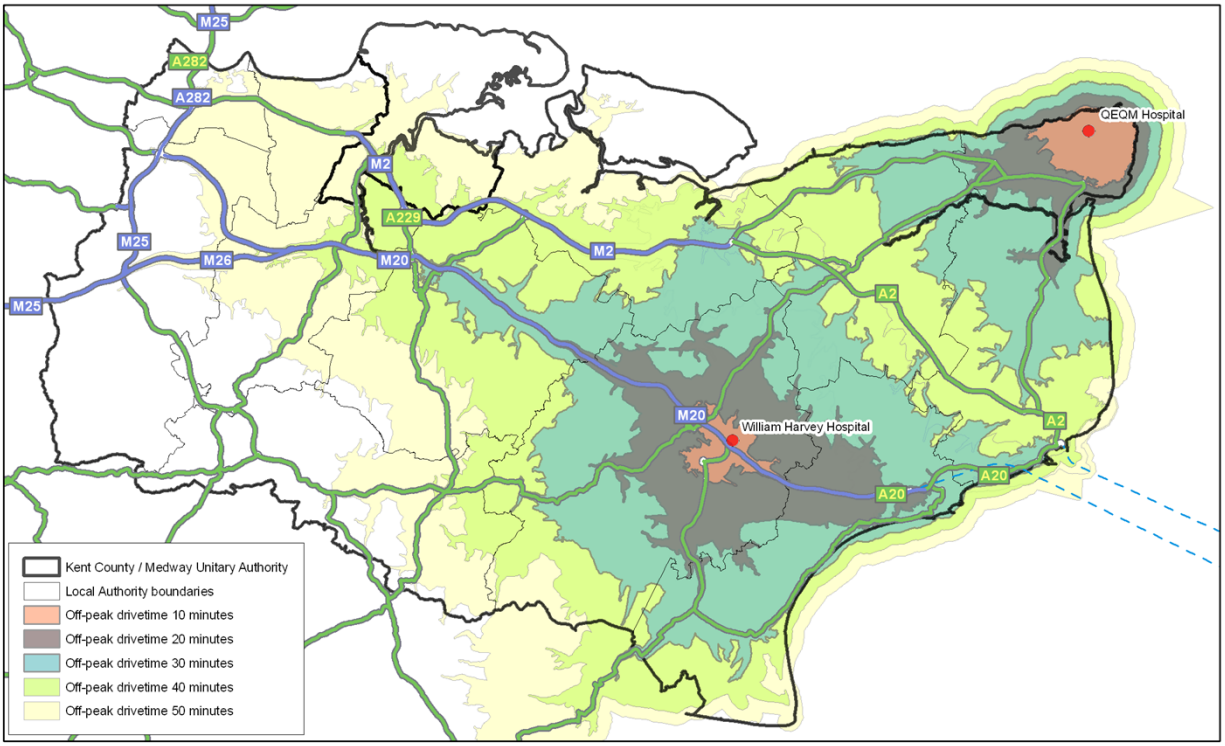
Search of relevant literature would suggest that bed utilisation of more than 80-85% is likely to cause service failure (Sylvester, K; NHS Institute). Both acute sites are frequently working beyond capacity.

Appendix 4

Travel times between the two main hospitals

Off Peak Drivetimes for William Harvey and QEQM Hospitals

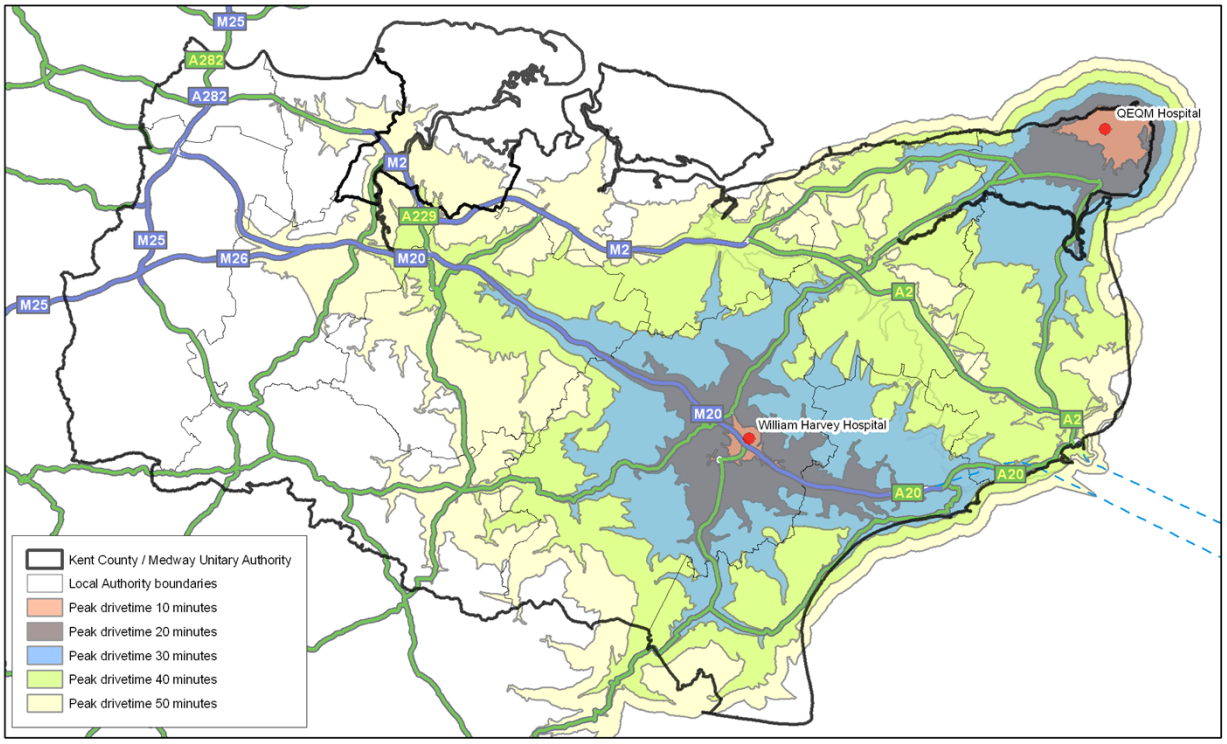
Kent & Medway Public Health Observatory



 Produced by Kent and Medway Public Health Observatory (KO) 13th Jluy 2011

Peak Time Drivetimes for William Harvey and QEQM Hospitals

Kent & Medway Public Health Observatory



 Produced by Kent and Medway Public Health Observatory (KO) 13th Jluy 2011