PUBLIC HEALTH LEWISHAM

Analysis of the Potential Impact of the Trust Service Administrator's Proposals for Health Services in SE London

Impact on the Health and Wellbeing of Lewisham Children and of Lewisham Women Requiring Maternity Services

Introduction

This paper is part of the response of Public Health Lewisham to the draft report of the South London Healthcare Trust Service Administrator (the TSA) on health services in SE London[1]. It focuses in particular on the potential impact of the recommendations of the TSA's report on the health and wellbeing of children and expectant mothers living in Lewisham. These impacts are considered together as many, though not all, of the issues of concern are common to both women and children.

The TSA in his draft report proposes significant changes to health services in South London, but the draft report contains no analysis at all of the impact of these proposals on children's services and on the health of children. This is a major flaw in the report, particularly in the context of the UK having the worst levels of mortality in children in comparison with other major European countries[2]. It also matters that these levels of higher mortality in UK children are convincingly ascribed to problems in the delivery of health services for children[2]. The recommendations of the draft report should not be accepted without careful consideration of the impact of its recommendations on the health of children. As they stand, **the recommendations of the report would have a negative impact on the health of children in Lewisham**.

Maternity services are considered in the TSA report, and two possible options are put forward for maternity services in Lewisham:

- In the first, all deliveries would be centralised at King's College Hospital (KCH), St Thomas's Hospital (GSTT), Queen Elizabeth Hospital (QE) and Princess Royal University Hospital (PRU). In this model, there would be no deliveries at Lewisham Hospital (UHL), the recently opened midwife-led birth centre would be closed as would the obstetric-led service at the hospital. Antenatal and postnatal services would continue to be delivered by a community midwifery service based at the hospital. This option is referred to in the present paper as Option 1.
- In the alternative model, there would be a 'stand-alone' obstetric-led delivery unit at Lewisham Hospital and all other maternity care would continue to be provided in a range of locations across south east London. This option is referred to as Option 2 in the present paper.

The present paper is, in part, based on a review of the potential impact of each of the two options for the future of maternity services in Lewisham conducted on behalf of Public Health Lewisham by Debbie Graham, Health Strategist and registered midwife. This review is available separately if required; it focussed on four aspects of the proposals in particular:

> A. The capacity for implementation of Option 1, the so-called dispersal model, in SE London, taking into consideration the current and future numbers of births within the sector as a whole, as well as in Lewisham, the current capacity of maternity services within the sector and in immediately adjacent trusts, as well as looking at the potential for increasing capacity in other units in SE London

B. The likely changes in patient flows that will occur if Option 1 is implemented, and how these will influence capacity in neighbouring Trusts.

C. The possible effects on the safety of services and on the quality of women's experiences in the larger units that will inevitably result if Option 1 is implemented.

D. The likely viability and safety of Option 2 and the measures that would be necessary to address problems with viability and safety that might exist.

The review conducted by Ms Graham has informed the present paper, which concludes that **Option 1 would have a significantly damaging effect on the health and well-being of Lewisham children and their mothers. Option 2 as it stands at present is unlikely to be viable, safe, or inspiring of confidence in women, general practitioners or consultant obstetricians. Managers and clinicians at Lewisham Hospital have, however, drawn up a proposal as to how Option 2 can be modified. This modified Option 2 is accepted as the best way forward for Maternity Services in Lewisham, given the other recommendations of the draft TSA report.**

Area of Concern 1: The Loss of a Children's A&E Department

For some years, Lewisham children have enjoyed lower rates of admission to hospital for some illnesses. It is argued that this is because of the excellence of the children's outpatient services and especially because of the Children's A&E at the hospital.

The children's service at Lewisham Hospital has been rated as providing 'excellent care' by the Health Care Commission. Lewisham was one of just two district general hospitals to receive this rating and the only one in London, and has therefore been a benchmark for many other hospitals for the provision of high quality care of children. The Hospital is also one of the few hospitals in London with a Children's A&E service led by consultant paediatricians with appropriate training. The location of this service in Lewisham may well mean that Lewisham children are much less likely to be admitted to hospital. Lewisham's admission rates for children generally, and local admission rates for most problems of childhood (with one or two exceptions) are much lower than expected in a population of this diversity and experiencing such levels of deprivation (Figs 1 and 2).

Fig 1 Emergency admissions of children aged <5 for gastroenteritis
2010/11 Indirectly Standardised Rates with confidence Intervals
source: NHS IC Indicators Portal

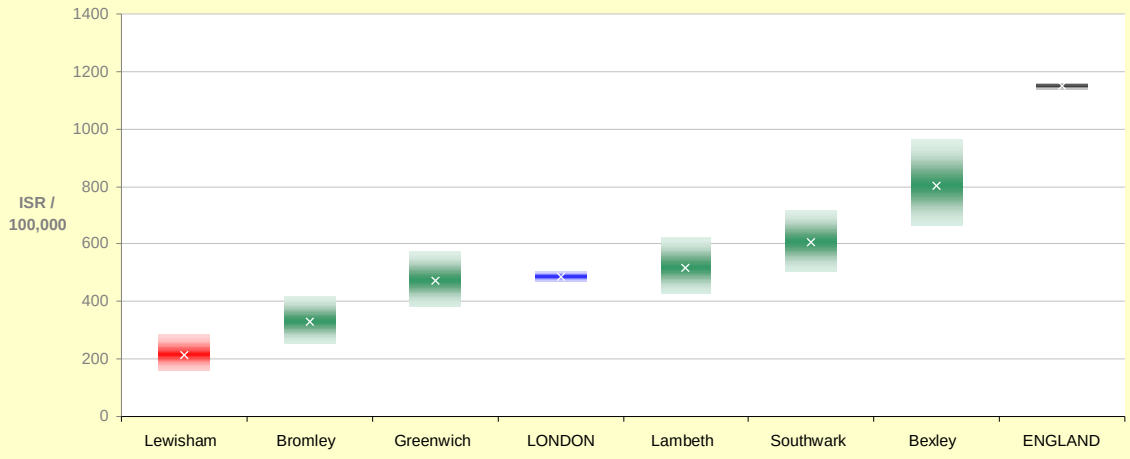
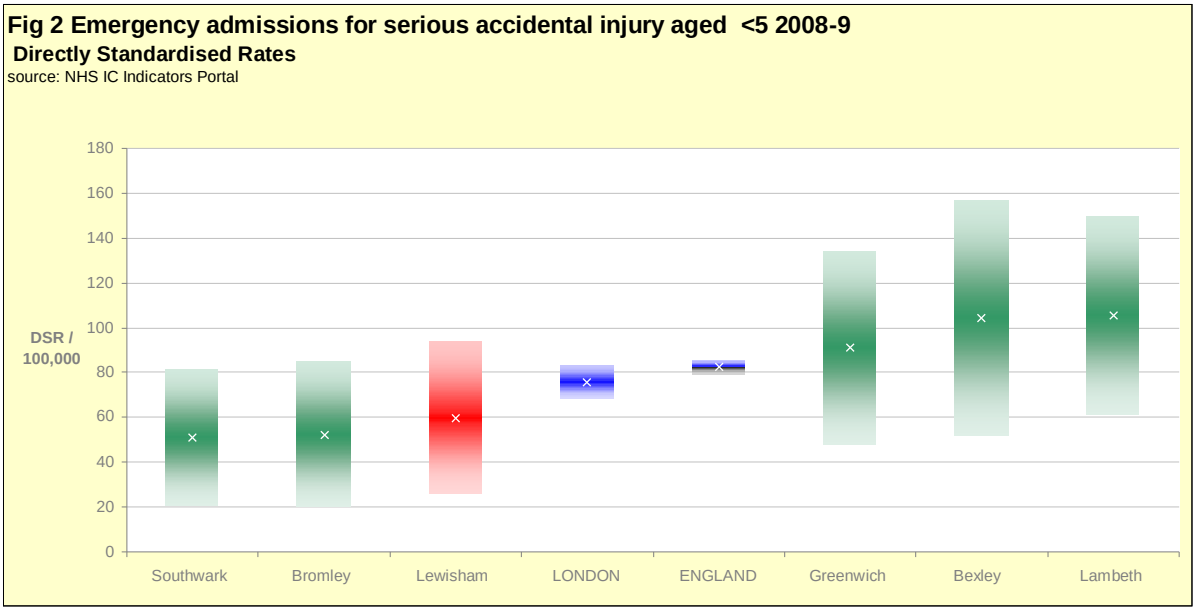


Fig 2 Emergency admissions for serious accidental injury aged <5 2008-9
Directly Standardised Rates
source: NHS IC Indicators Portal



Inspired by this locally observed phenomenon, a major analysis of national data on admissions of children to hospital has been undertaken and has confirmed the hypothesis that, in general, children living in the immediate vicinity of consultant-led paediatric A&E departments are much less likely to be admitted to hospital[3]. This means that if the Children's A&E department at Lewisham closes, children in the area will be at increased risk.

Area of Concern 2: Loss of integration of services and the impact this will have on continuity of care for children and mothers, and on co-ordinated safeguarding of children in Lewisham.

The impact of the loss of integration between children's hospital services and community health and social services without an acute paediatric service at Lewisham Hospital is of major concern. The community services include health visiting and school nursing, but also (critically) the community paediatric nursing service, which is essentially a hospital at home service for children. There is also the importance of the links between hospital, paediatrics, maternity services and children's social care; these links were identified as important in a recent OFSTED inspection of arrangements for the safeguarding of children in Lewisham - an inspection which resulted in Lewisham's arrangements, and the contribution of the health service to those services being identified as outstanding[4].

Similar potential problems exist if Option1 for maternity services is accepted and implemented. The vulnerability of many Lewisham women in pregnancy because of mental health problems, drug or alcohol use, domestic violence, or because of their youth or low capacity for parenting led to the Lewisham Safeguarding Children Board identifying the management of such vulnerable pregnancies as a major focus for improvement. Since then, a safeguarding midwife lead has been appointed, a team to support women with mental health problems established and a vulnerable pregnancies pathway has been developed so as to ensure the better integration and co-ordination of care. These arrangements too have been identified as outstanding by OFSTED[4]. Because of the breakdown of these arrangements that would be an inevitable consequence of Option 1 for maternity services; women who would otherwise be delivered locally in future will be delivered at one of at least

four other hospitals and this must carry a significantly increased risk of problems in vulnerable pregnancies.

Option 1 for maternity services would also carry a risk of loss of integration of clinical care throughout pregnancy, with all Lewisham women receiving antenatal and postnatal care delivered at or through Lewisham Hospital, but their care in labour being delivered in any of at least four other units. The potential for breakdown in communication and for confusion is enormous and the risks of resulting harm to women and their unborn children is significantly high. The risks are summarised in Table 1

Table 1. The Potential Impact of Option 1 on Continuity of Maternity Care.

Issue	Impact	Risk
Midwives providing community based antenatal and postnatal care will be deployed from QE. However women will be booked for care with at least 3 other providers within the sector too.	➢ Integrated care pathway lost ➢ Loss of continuity of care ➢ The Community midwifery service disconnected from the providers of intrapartum care. ➢ Clinical protocols would need to be standardised across the sector ➢ Lower standard of information will be available to women, as midwives may not have in-depth knowledge of the alternative provider trust where the woman has booked	It is well documented that the greater the number of 'hand-offs' (i.e. the transfer of information, authority and responsibility) which take place in a patient's care, the greater the risk that one will be ineffective which can contribute to serious risks in healthcare delivery[5] Safeguarding issues may be missed. Clinical protocols not standardised and variations is protocol missed by community midwife e.g. readmission for neonatal jaundice.
G.P's will provide shared-care with at least 4 providers of maternity services	As above	As above
Under the new PbR tariff a commissioner will make one payment per pregnancy for all antenatal care included in the scope to the provider where the woman books.	Where a woman chooses to use a different provider for part of her care, it is the responsibility of the pathway provider to pay the other organisation.	QE will be required to capture each contact with every woman to enable accurate payment to occur. There could be substantial delay in provision to payment times. The advantages of PbR tariff (e.g. sensitivity to changes in clinical activity) are lost to an easier administrated block contract tariff

The final, but not the least important issue under this heading is screening. Both antenatal and neonatal screening often mean extremely complex pathways that can easily fail, as demonstrated by the relatively large number of Serious Untoward Incidents reported in London recently. The 'hand-offs' described in the table above are already considerable when one provider is responsible for screening and therefore two or more providers would greatly increase the risks to women and babies across all antenatal and newborn screening programmes. Any move that threatens the integrity of screening pathways, as implementation of Option 1 clearly does, and that can be avoided, must be rejected.

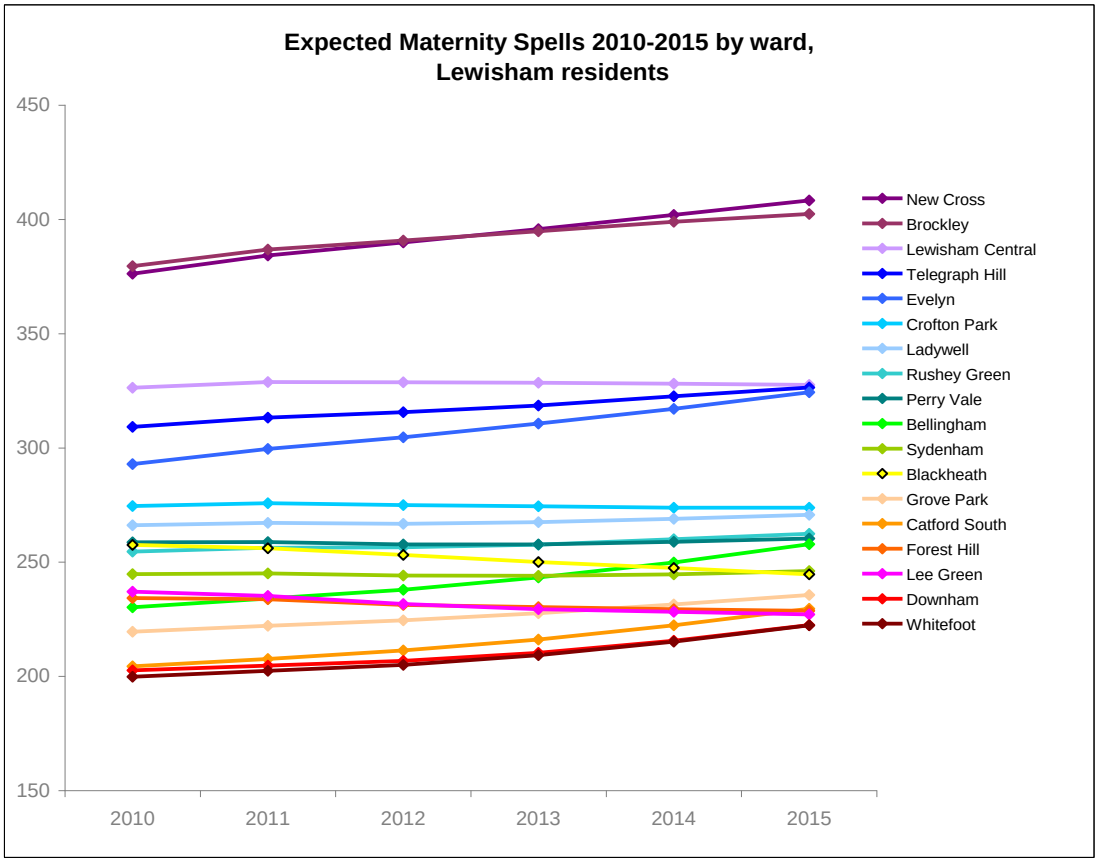
Area of Concern 3: The impact on capacity of Option 1 for Maternity services

Option 1 for maternity services would require major development of new capacity at other providers in a part of the Capital where maternity services are already stretched beyond capacity and dependent on a small number of external providers.

Using a methodology explained in a separately available paper[6], the numbers of expected births to Lewisham women by ward were estimated using two models:

1. By applying a borough-wide factor for each age group, which effectively applied overall population change fairly evenly across the borough (Fig 3)
2. By applying a factor separately for each ward and age group, which takes into account differential population changes at ward level as expected by the GLA and based on what is known about planned housing developments (Fig 4).

Fig 3. Expected Births using Model 1

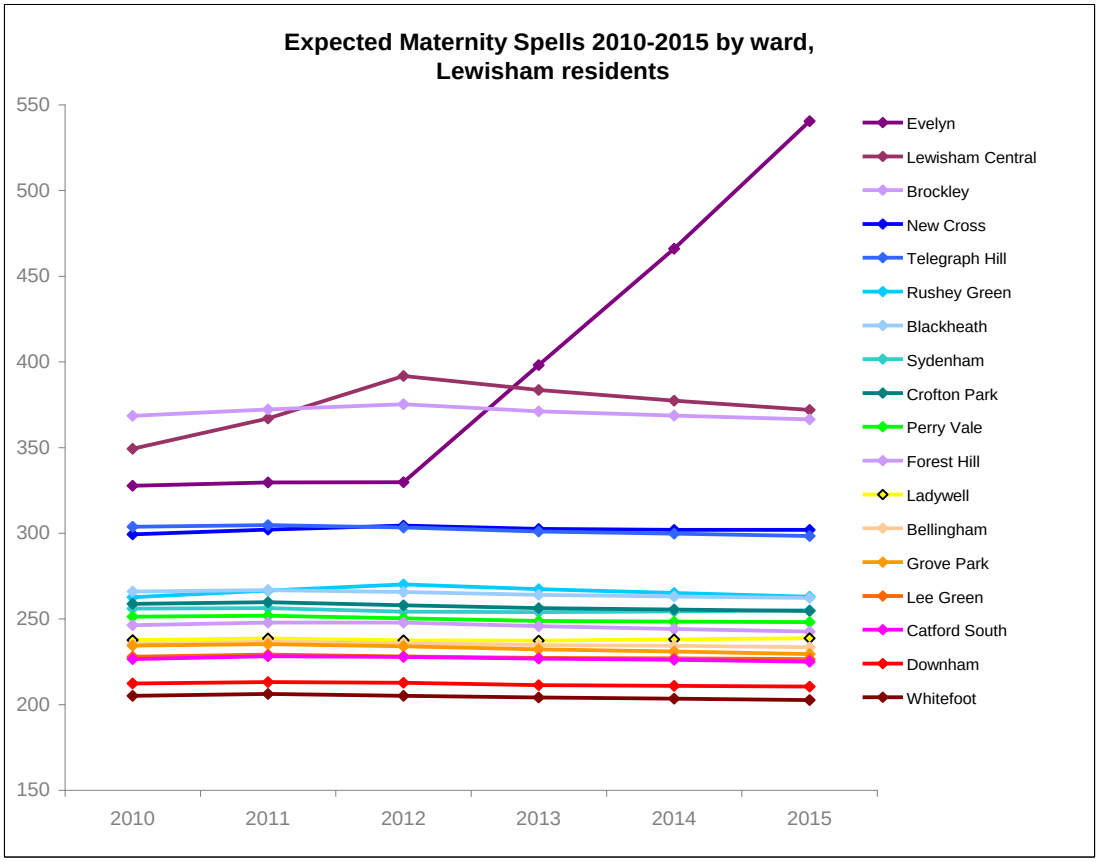


In Model 1, the greatest numbers of births are in New Cross and Brockley (Fig 3). The populations of these wards, along with the populations of Evelyn and Telegraph Hill, the other two wards categorised as North Lewisham, increase steadily through the period. Whitefoot, Downham, and Bellingham wards, in the South of the borough, start from lower rates but increase noticeably, particularly from 2013.

Using the second Model, a rather different picture emerges(Fig 4), At ward level, the GLA expect population growth to be restricted to Thames Gateway Zones of Change, in Lewisham Central to 2012, and in Evelyn Ward from 2013 onward, assumed to be anticipating the Convoy's Wharf development. In this scenario the population of the other wards is essentially stable. As the age-profile does not vary hugely from year to year, the changes are concentrated where there is major change in housing provision.

It seems most likely that the real future lies somewhere between the two estimates, with Model 1 being close to what is likely to happen in the early part of the period, and the changes represented by Case II coming into play when the planned developments come on stream. It is probably best therefore to plan for an increase in the number of births, mainly in North Lewisham, especially towards the end of that period.

Fig 4 Expected Births Using Model 2



Against this background of possibly uneven growth in births in Lewisham, the impact of Option 1 was considered just in terms of managing current demand. The term 'physical capacity' has been used to mean the capacity of a service to provide physical space/beds for the provision of in-patient antenatal, intrapartum and initial postnatal care. The total number of maternity beds available across the sector is 326 (Table 2). The total number of births to bed ranges from 61 to 97. It is difficult to interpret these data as maternity beds are utilised in different ways in each unit.

Table 2. Current Physical Capacity of Maternity Services in SE London

Trust	Births 10/11	Total no of beds	No. births: bed
GSTT	6849	91	75.26
KCH	5835	64	91.17
PRU	4291	44	97.5
QE	4266	69	61.8
UHL*	3973	58	68.5
Total beds in sector		**326**	

Source 2010/11 HES *UHL trust 2011/12 data

What is perhaps more important is how often maternity services have to be suspended, ie the number of occasions on which women in labour cannot be admitted to a unit. Between 1st April 2011 and 22nd November 2012, providers of maternity services across the sector have suspended services on 37 occasions (Table 3). On 26 of these 37 occasions suspension was necessary because of a lack of beds. In addition to these 37 times on which women had to be turned away, KCH attempted to suspend services a further six times, when they were unable to do so as no other unit had the capacity to accept KCH women.

Table3 Suspension of admissions to Maternity Units in SE London

	1st April 2011 to 22nd November 2012				
	Reason for service suspension				Unsuccessful attempts to suspend service
Trust	No. of times service suspended	lack of beds	Shortage of medical/midwifery staff	Other (not specified)	
GSTT	12	11	0	1	0
KCH	8	8	0	0	6
SLH	9	3	3	3	0
UHL	8	4	2	2	0
Total suspensions in sector	**37**	**26**	**4**	**3**	

Source: data supplied by each trust

The stress on units is such that many are now placing a cap on the number of bookings that they will accept (Table 4). Thus choices for Lewisham women are already reducing.

Table 4 Maternity Capping Criteria for Hospitals in SE London

	1st April 2011 – 31st October 2012
Trust	**Capping policy in place (if yes please give details)**
GSTT	Yes. Currently accept referrals from local PCTs (Lambeth, Southwark, parts of Lewisham and Wandsworth) + Tertiary referrals from outside of these areas.
KCH	Yes: Initial CAP in place when birth rate >5900 only take women from SW2 SW4 SE24 SW9 SE27 SW16 SE1 SE5 SE15 SE19 SE21 SE22 SE17 SE23 SE26 SE4 SE14 2011 Birth rate dropped to 5300 then CAP 'relaxed' partially and in addition to postcodes above also take from CR7, SW8,SE11,SE16, SE25
PRU	Not capping
QE	Not capping
UHL	Not capping

Source: Data from individual trusts

It is also important to note that SE London as a whole is very much dependent on Darent Valley Hospital in order to manage demand for maternity services within the sector. Darent Valley saw a 28% rise in births in 2011[6]. Darent Valley are expected to merge with Medway Hospitals in 2012 and are now considering introducing a capping policy[7].

If option 1 were the option of choice significant capital investment would be required to increase the existing physical capacity to meet future demands. It should be noted however, that greater revenue costs will also be incurred when providing larger maternity units. This

would include running a double obstetric rota, as well as increases in workforce support from services such as anaesthetic, neonatology and theatre departments. Midwifery workforce requirements should also reflect the standard of 1 midwife for every 30 women. The closure of maternity beds at UHL should not occur before the full establishment of the required increased capacity in the four maternity in-patient sites. Otherwise, there will be a real risk of increased numbers of babies born before arrival at a unit and\or real problems because of reduced quality of services resulting from increased pressures at other sites.

Area of Concern 4: The impact on patient flows and patient choices of Option 1 for Maternity Services.

Based on what is known about current and past patient flows, the development necessary to increase capacity would probably be uneven, with much development required at King's College Hospital where the potential for such development is limited. Any development would also push at least two of the units into becoming very large units so as to increase the total revenue required to deliver maternity services in the sector if a safe service is to be delivered at all four sites.

Historically, Lewisham women have chosen to access care at UHL, GSTT and KCH (Figs 5 and 6). Only a small minority of women (mainly a small proportion of women resident in Blackheath) have chosen to access maternity care at QE. A significant proportion of women do not choose their nearest alternative provider to UHL. For example, the nearest alternative provider for women residing in Catford South is QE. However, only a small minority of women in Catford chose to give birth at QE with GSTT and KCH being the alternative providers of choice.

Fig 5

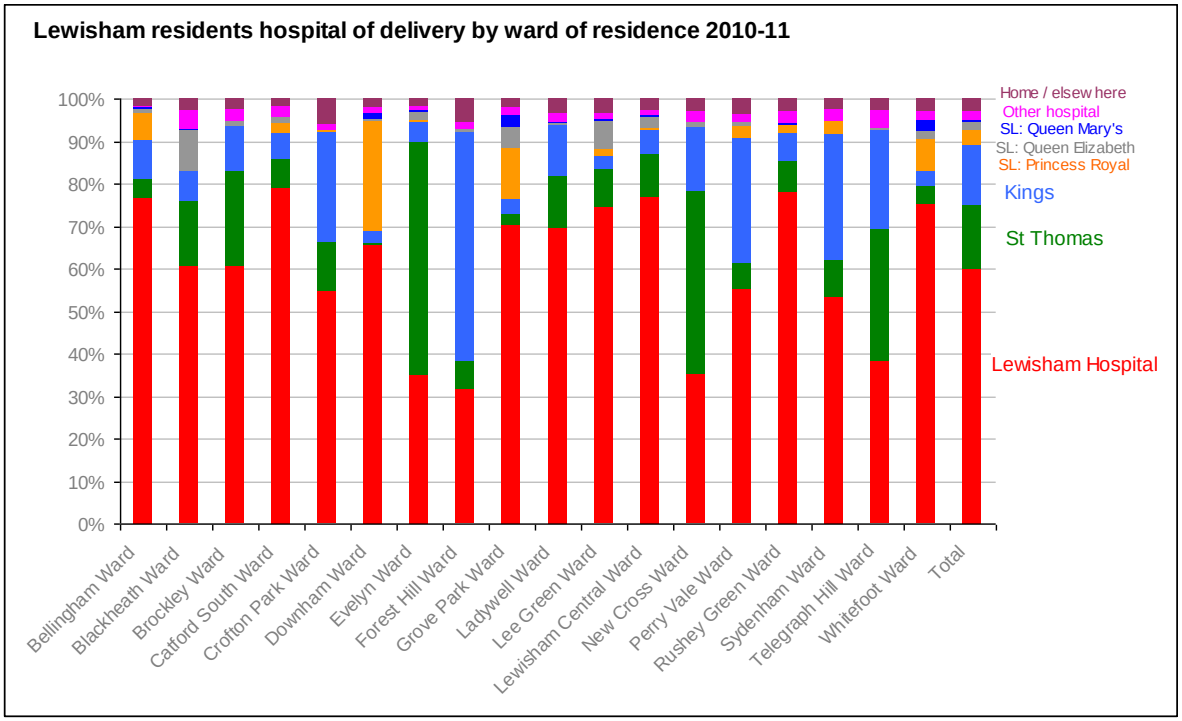
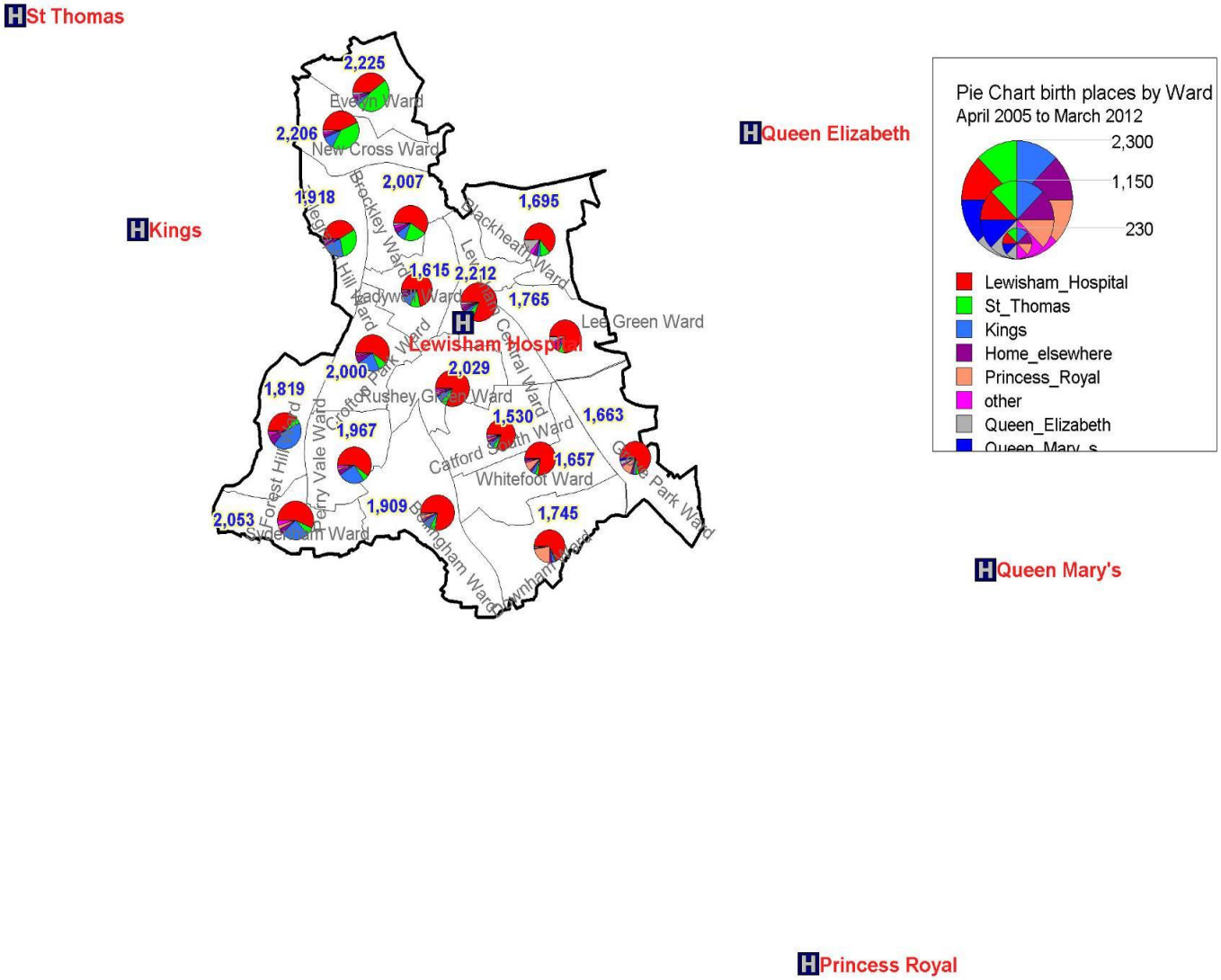


Fig 6 Place of Birth for Babies born in each Lewisham ward between 2005 and 2012



However, even if we assume that women will choose to have their babies delivered at the hospital nearest to them, we know that a large number of births in 2010/2011 would have occurred at QE, GSTT or KCH (Table 5)

Table 5. Lewisham Births 2010/2011 by ward and by nearest provider

Total births nearest provider GSTT	
Name of Ward	**Births 10/11**
Evelyn Ward	**345**
Total births	**345**

Total births nearest provider PRU	
Name of Ward	**Births 10/11**
Downham Ward	**279**
Total births	**279**

Total births nearest provider KCH	
Name of Ward	**Births 10/11**
Bellingham Ward	**291**
Brockley Ward	**361**
Crofton Park Ward	**329**
Forest Hill Ward	**283**
New Cross Ward	**361**
Perry Vale Ward	**326**
Rushey Green Ward	**311**
Sydenham Ward	**313**
Telegraph Hill Ward	**302**
Total births	**2877**

Total births nearest provider QE	
Name of Ward	**Births 10/11**
Blackheath Ward	**256**
Catford South Ward	**230**
Grove Park Ward	**261**
Ladywell Ward	**278**
Lee Green Ward	**276**
Lewisham Central Ward	**389**
Whitefoot Ward	**256**
Total births	**1946**

If we therefore assume that Lewisham maternity service users will access care at their nearest provider site, and allowing for a 4% increase in birth rate per annum, in line with the 4% rise seen in London in recent years, when each trust's own local projected increases in birth rate are taken into consideration, three of the maternity providers in SE London would have a birth rate 7000 or very close to those rates. These would be considered large obstetric units, requiring double obstetric rotas and increased levels of anaesthetic and other types of care.

Table 7 Projected increases in Maternity Units in SE London

Trust	Births 210/11	Projected births from Lewisham borough 2013/14 all owing 4% increase in birth rate per annum	Total (not inclusive of trusts own projected increase)
GSTT	**6849**	**386**	**7235**
KCH	**5835**	**3235**	**9070**

PRU	**4291**	**313**	**4604**
QE	**4266**	**2187**	**6453**

If option 2 were the option of choice there would be no initial change in capacity at UHL. However the following factors should be taken into consideration.

- In 2010/11 approximately 60% of women residing in Lewisham chose to give birth at UHL. However since the introduction of the Midwifery-led unit there has been a step increase in UHL births greater than the projected annual increase in births.

Table 8 Total births and percentage change in clinical activity at UHL from 2008 projected to 2013.

Year	Total births	% change
2008/09	3549	
2009/10	3473	-2.14
2010/11	3649	+5.1
2011/12	3973	+8.8
2012/13*	4200	+5.7

*UHL data for projected births

- There is an opportunity for UHL to become the maternity service provider of choice for the 40% of women residing in Lewisham who chose to birth at an alternative provider in 2010/11. This would have a positive effect on the capacity of alternative providers such as GSTT and KCH who are presently experiencing capacity problems.

- There is an opportunity for UHL maternity services to increase physical capacity by occupying vacated capacity at UHL following the reconfiguration of other services.

Area of Concern 5: The impact on Quality of services of Option 1 for Maternity Services

Unlike major trauma or stroke centres, there is little evidence that larger obstetric units are safer or better, indeed there is some considerable evidence that women's experience in these larger units is not as positive as it is in small to medium size units. Dr Suzanne Tyler, Associate Director of Maternity & Newborn, NHS South Central England summarised the position recently as follows:

The first claims for bigger is better in terms of safety in maternity care appearing in the UK, can be found in a House of Commons Social Services Committees Report on Perinatal and Infant Mortality, published in 1980, which concluded that stillbirth rates were higher in smaller units. However, Macfarlane points to the lack of any robust analysis to take account of selection criteria and characteristics of different units in terms of models of care, staffing levels or the acuity of women[9].Equally a 2002 review in Germany showed a threefold increase in neonatal mortality between the smallest and largest hospitals - however in that study only the five largest units delivered more than 1500 births a year[10]and they account for less than 16% of all the births in Germany. The available literature on neonatal mortality does indicate that looking at known high-risk babies, survival rates are better in hospitals

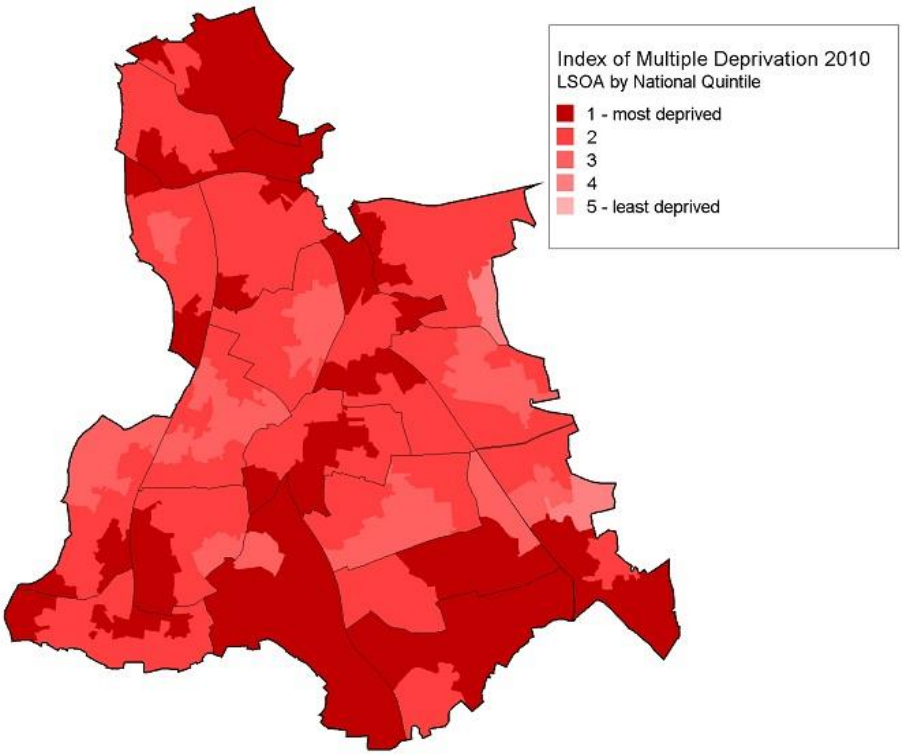
which care for high volumes of such births[11] And this was part of the logic for the centralisation of Level 3 neonatal units and for the establishment in the England of neonatal networks. By contrast a 2003 Euronatal Working Group on sub-optimal care leading to perinatal death seems to suggest that despite having larger units, England has the highest rates of perinatal death, where substandard care might have caused the death[12]

The closure of the midwife-led birth centre and the obstetric-led unit at Lewisham Hospital would mean that women's perceptions of the quality of service would fall, and the problems with capacity and greater journey times necessary at the time of delivery will also lead to an increase in the numbers of babies born before arrival, an outcome to be avoided if at all possible.

Area of Concern 6: Loss of momentum in improving the health of women and children in Lewisham.

Over the past five to six years, much improvement in the health of mothers and children in Lewisham has been achieved. Low birthweight rates have reduced over time, as have the proportion of mothers who smoke at delivery, whilst the percentage of women who book before the 12th week of pregnancy is now almost at target. All the progress made in this time would be severely affected if Option 1 were to be implemented.

Area of Concern 7: The Health Equality Impact of the TSA proposals and how these will affect Lewisham children and their mothers in particular.



- Lewisham's population is one of the most deprived populations in England.

- Relative to the rest of the country Lewisham's deprivation is increasing
- The highest deprivation is found in Evelyn ward in the North and Downham in the South and along the A2 corridor. These wards are amongst those with the very highest projected numbers of births in the future.
- Lewisham's population is amongst the most diverse in England. This is particularly true of Lewisham's mothers, over 50% of whom were not born in the UK.

All of these factors mean that Lewisham's population is likely to be less resilient in relation to increased costs of journeys, and more complicated and lengthy journeys to more distant hospitals. Emergency care of children and care of women during labour are bound to be adversely affected by proposals which require such journeys in such a deprived population.

Although Option 1 will retain community antenatal and postnatal services at Lewisham Hospital, women will still be required to travel to their provider of choice during their antenatal episode to book for care and access ultrasound scans. Women with a significant obstetric or medical risk will access some antenatal contacts in the obstetric-unit, including in-patient antenatal admissions. All women not electing (or not suitable) to have a home birth, will be required to travel to their provider of choice for intrapartum care.

Table 9 Distance in miles from UHL to the centre of each ward and the percentage increase in mileage each woman will need to travel to access her nearest alternative provider.

Name of Ward	Distance to UHL miles	Nearest alternative provider	% increase in miles
Bellingham Ward	2.3	KCH	143
Blackheath Ward	1.8	QE	66
Brockley Ward	1.8	KCH	94
Catford South Ward	1.5	QE	253
Crofton Park Ward	1.7	KCH	129
Downham Ward	3.4	PRU	47
Evelyn Ward	3	GSTT	13
Forest Hill Ward	2.7	KCH	40
Grove Park Ward	2.7	QE	63
Ladywell Ward	0.7	QE	557
Lee Green Ward	1.6	QE	181

Lewisham Central Ward	0.3	QE	1400
New Cross Ward	2.7	KCH	44
Perry Vale Ward	2	KCH	125
Rushey Green Ward	0.6	KCH	800
Sydenham Ward	3.2	KCH	34
Telegraph Hill Ward	2	KCH	60
Whitefoot Ward	3.1	QE	74

Source: NHS SE London

Women resident in Sydenham ward will experience the lowest increase in travel distance (Table 9). Women resident in Lewisham Central ward will experience the greatest increase in travel distance to their nearest alternative provider. Lewisham Central ward is in the top two most deprived quintiles for deprivation in England

Table 10 Journey times from UHL to each provider site.

To	**Journey time (min)**	**Journey time (max)**	**Interchanges (min)**	**Interchanges (max)**
GSTT	49	78	1	2
KCH	52	68	1	2
PRU	67	83	2	3
QE	52	76	1	3

Source: Royal College of Midwives (2008)

Option 1 will significantly add to both travel time and costs for Lewisham's maternity service users, particularly if they rely on public transport (Tables 9 and 10). These factors will be compounded for women who need to travel outside the hours when public transport is running.

Similar problems will face the parents of children should the Children's A&E Department at UHL close.

Table 11 Issues and associated risks raised by the increase in travel distance for Lewisham maternity service users and Lewisham Parents

Issue	Factor	Risk
Access	The Confidential Enquiry[13] has reached clear conclusions about the extent of the risk to maternal health which 'late booking' involves. This means that outcomes for all women will be improved if the numbers booking late are reduced.	Research has highlighted some important differences in the way that women from BME backgrounds may access and utilise maternity services compared to their white counterparts. Such differential receipt of services is identified as a factor contributing to adverse maternal and neonatal outcomes.[14] Notwithstanding important diversity within and between minority ethnic groups, national surveys indicate that, as a whole, women from BME groups are more likely to 'book late' (i.e. receive their first antenatal check-up beyond the recommended twelve weeks' gestation), are less likely to receive antenatal care regularly and therefore also tend to receive fewer antenatal check-ups [15]
Capacity	Best practice recommends that women with a normal pregnancy should remain at home in the early stages of labour	Women will have a lower threshold before travelling to access intrapartum care. Women will be more reluctant to return home if they are in the latent stage of labour. Women who may have chosen a home birth will be more reluctant due to greater transfer distances. Bed occupancy will increase Increase in NZ07A and NZ07B tariffs[17]
Mode of transport	Not all parents will have access to private transport, nor the funds to use public transport. Public transport is not available 24/7	There will be a greater use of ambulance services as a 'taxi' service.

The above tables clearly show that option 1 will have a disproportionate and adverse impact on the most vulnerable and socially excluded women resident in Lewisham. There is also a high risk that women, having made a relatively difficult and long journey, will not be willing to be discharged home again, even in circumstances where best practice indicates that they should.

Safety and quality conclusions

- Research indicates that 'bigger is not better' in the provision of maternity services
- Option 1 poses potential serious risks in healthcare delivery due to the increased number of 'hand-offs' that will occur during each woman's continuum of pregnancy.
- There will be a significant increase in travel distance for all women accessing their nearest alternative provider. For many women this will include a more complex journey too.
- Option 1 will have an adverse impact on the most vulnerable and socially excluded women
- Option 1 may compound capacity issues for SE London sector maternity services by increasing non-essential admissions and NZ07 usage.
- Option 1 is non-compliant with national policy which recommends local provision of services

Area of Concern 8: The Safety and Viability of Option 2

Table 13 R.A.G rating of Options 1and 2 against the identified benefits in the TSA report

Benefits of implementing the aspirations and clinical standards across south east London		
Community Based Care	Option 1	Option 2
Significant health inequalities in part due to a lack of good preventative and primary care access.		
Variation in access to and quality of community based care		
Unnecessary admissions to hospital care		
Maternity Care	Option 1	Option 2
Inability to meet Royal College of Obstetricians and Gynaecologists' standards for consultant labour ward presence across all hospitals		
A skilled and competent workforce is essential to deliver a safe and high quality maternity service for all women and their babies yet there is variation in the level of consultant labour ward cover.		

The above table shows that Option 1 will have a significant negative impact on the issues identified in community based care due to:

- Increased travel times impacting on early access, especially for vulnerable and socially excluded women.
- The increased travel times and complexity of travel will directly affect NZ07A and NZ07B usage.
- Quality of community based care will be adversely affected due to the increased number of 'hand-offs'.

The London Health Programmes, Quality and Safety Programme have set Clinical Quality Standards and Key Services for maternity services.

When considering the viability of Option 2, consideration should be given to a networked model of provision between UHL and QE. This could include the appointment of an Obstetric Physician and the commissioning of interventional radiology services. The modifications to Option 2 proposed by managers and clinicians at Lewisham Hospital are also critical to the viability and safety of Option 2. The features of the Hospital's proposal that we view as critical are as follows:

- Level 2+ Neonatal Intensive Care Unit, as currently commissioned. This is essential for purposes of neonatal care capacity in SE London, and indeed in the Capital as a whole.
- Consultant obstetrician presence of 168 hours per week on the labour ward, supported out of hours by a three tier rota.
- 24/7 access to critical care beds – enhanced recovery model providing short term level 3 care, with transfer of patients requiring long term level 3 care to a general ICU. To be managed by consultant anaesthetists and a separate team of consultants in intensive care supported by a junior rota.
- 10 Consultant Anaesthetists a week, with 24.7 access to a supervising consultant obstetric anaesthetist and a separate consultant anaesthetist for elective section lists
- Surgical and physician support provided by arrangements for elective centre
- Emergency imaging, acute pathology, haematology and 24/7 blood bank.

Table 14 UHL planned compliance with London Health Programme Standards

Quality and Safety Programme: Maternity services Clinical quality standards		UHL compliance
1	Obstetric units to be staffed to provide 168 hours (24/7) of obstetric consultant presence on the labour ward.	Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour[18]recommends 98-hr consultant presence in units with 4000 – 5000 births. Remaining 70-hrs on-call consultant

		will be available, supported by SpR and team Current provision is 72 hours per week
2	Midwifery staffing ratios to achieve a minimum of one midwife to 30 births, across all birth settings.	Current establishment delivers a 1:28 ratio
3	Midwifery staffing levels should ensure that there is one consultant midwife for every 900 expected normal births.	UHL has 1 WTE Consultant Midwife for 4000 deliveries.
4	All women are to be provided with 1:1 care during established labour from a midwife, across all birth settings.	Achieved
5	There is to be one supervisor of midwives to every 15 WTE midwives.	Achieved
6	A midwife labour ward co-ordinator, to be present on duty on the labour ward 24 hours a day, 7 days a week and be supernumerary to midwives providing 1:1 care.	This standard has been assessed as unmet by NHS London. UHL has a Labour Ward co-ordinator present 24 hour a day and they are supernumerary to midwives providing 1:1 care in labour. The issue is the tangible evidence to demonstrate this. This is currently being addressed.
7	All postpartum women are to be monitored using the national modified early obstetric warning score (MEOWS) chart. Consultant involvement is required for those women who reach trigger criteria.	In development
8	Obstetric units to have 24 hour availability of a health professional fully trained in neonatal resuscitation and stabilisation who is able to provide immediate advice and attendance. All birth settings to have a midwife who is trained and competent in neo-natal life support (NLS) present on site 24 hours a day, 7 days a week. CNST Department of Health (2004) National Framework for Children, Young People and	Level 2+ NICU co-located

	Maternity Services British Association of Perinatal Medicine (2011) Neonatal support for stand-alone midwifery units	
9	Immediate postnatal care to be provided in accordance with NICE guidance, including: ➢ advice on next delivery during immediate post-natal care, before they leave hospital ➢ post-delivery health promotion ➢ care of the baby ➢ consistent advice, active support and encouragement on how to feed their baby ➢ skin to skin contact ➢ Follow-up care is to be provided in writing and shared with the mother's GP.	Achieved
KEY SERVICES		UHL compliance
10	Obstetric units to have a consultant obstetric anaesthetist present on the labour ward for a minimum of 40 hours (10 sessions) a week. Units that have over 5,000 deliveries a year, or an epidural rate greater that 35%, or a caesarean section rate greater than 25%, to provide extra consultant anaesthetist cover during periods of heavy workload.	Achieved
11	Obstetric units to have access 24 hours a day, 7 days a week to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions.	Achieved
12	Obstetric units should have a competency assessed duty anaesthetist immediately	Achieved

	available 24 hours a day, 7 days a week to provide labour analgesia and support complex deliveries. The duty anaesthetist should not be primarily responsible for elective work or cardiac arrests	
13	There should be a named consultant obstetrician and anaesthetist with sole responsibility for elective caesarean section lists.	Achieved
14	All labour wards to have onsite access to a monitored and nursed facility staffed with appropriately trained staff.	On site HDU and ITU and in reach service.
15	Obstetric units to have access to interventional radiology services 24 hours a day, 7 days a week and onsite access to a blood bank.	Access to on site to blood bank. No on site access to 24/7 interventional radiology. Where known e.g. placenta accreta women transferred to tertiary centre.
16	Obstetric units to have access to emergency general surgical support 24 hours a day, 7 days a week. Referrals to this service are to be made from a consultant to a consultant.	Full surgical on call rota in place.

Source: UHL

Conclusions

- The modification of Option 2 as proposed by clinicians and managers at UHL meets all the standards for community based care as outlined in the TSA report.
- The modified Option 2 meets almost all the Clinical Quality Standards and Key Services for maternity services set by The London Health Programmes, Quality and Safety Programme and outlined in appendix J of the TSA report. For those which are not met, a clear contingency plan is in place or in development.
- Clinical agreement would be required as to the conditions women may present with which would be considered too high a risk to be cared for at UHL, underpinned by the establishment of robust and auditable communication and referral pathways.

Recommendations

1. A detailed analysis of the impact of the recommendations of you report on the health and well-being of children in SE London should be conducted before any of the report's recommendations are considered further.

2. The possible impact of the loss of a Children's A&E Department in particular must be considered. The almost inevitable adverse impact might be mitigated by preserving as many of the features of the current service in the future development of the Urgent Care Centre that will continue on site, but this too would need to be considered in some detail. Consultant Paediatrician leadership is particularly important.

3. Option 1 for Maternity services should be rejected completely because of its impact on capacity, quality of care and integration of services, which will all lead to worse outcomes for women and their children. It should also be rejected because of the increased costs of double rotas at GSTT and KCH which will be required in the near future as most Lewisham women will go to these sites to have their babies. Finally, it should be rejected because of the increased admissions that will inevitably occur because women in early labour will not wish to go home due to long travelling distances, or in the case of disadvantaged women, simply not being able to get home by public transport.

4. Option 2 for Maternity services, if modified as proposed by Lewisham Hospital, should be accepted as the only possible option.

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DOS and PC