APPENDIX 7 & 8

Clinical Commissioning Group

| Documents | Appendix 7 - Greater Manchester, Lancashire and South Cumbria Clinical Senate Update Report  
| Date Completed | Appendix 7 - 27 February 2017  
| | Appendix 8 - Letter from the Northern England Clinical Network - Maternity  
| Date Completed | Appendix 8 - 16 December 2016  

Summary of the Documents

Appendix 7 - Greater Manchester, Lancashire and South Cumbria Clinical Senate Update Report

This independent clinical assurance report was produced by the Greater Manchester, Lancashire and South Cumbria Clinical Senate. It follows on from the first Clinical Assurance report produced to inform the development of the Pre-Consultation Business Case and gives an independent view on the Maternity Services and Children’s Services options put forward for public consultation. Clinical Senates are non-statutory advisory bodies and any recommendations made are non-binding.

Appendix 8 - Letter from the Northern England Clinical Network - Maternity

This letter is a response from the Northern England Clinical Maternity Network following a request from Professor Stephen Singleton, Medical Advisor to the Success Regime, in regards to an assessment of the evidence in relation to an increased incidence of adverse outcomes amongst women who live far away from consultant-led obstetric care.
Follow-up to the Independent Review of Proposed Clinical Models for the North, West & East Cumbria Success Regime: Maternity and Paediatrics

RESPONSE PAPER

27th February 2017
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chair’s Foreword</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Background</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Maternity</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>Paediatrics</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>Summary and Recommendations</td>
<td>13</td>
</tr>
</tbody>
</table>

Appendices:

<table>
<thead>
<tr>
<th>1</th>
<th>Clinical Senate Recommendations Regarding Maternity (May 2016)</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Clinical Senate Recommendations Regarding Paediatrics (May 2016)</td>
<td>16</td>
</tr>
<tr>
<td>3</td>
<td>Contributors to the Review</td>
<td>18</td>
</tr>
<tr>
<td>4</td>
<td>Descriptions of Maternity Services Options 1 to 3</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>Descriptions of Paediatric Services Options 1 to 3</td>
<td>22</td>
</tr>
</tbody>
</table>
Chair’s Foreword

In March 2016, the Greater Manchester, Lancashire & South Cumbria (GMLSC) Clinical Senate received a commission from Cumbria Clinical Commissioning Group (CCG) on behalf of the West, North and East (WNE) Cumbria Success Regime to review the proposed models of care for Integrated Care (including Community services), Mental Health, Elective Care, Proactive and Emergency Care, Children and Maternity.

The Senate produced its report in May 2016, which contained a number of recommendations. Since the publication of the Senate report in May 2016, the WNE Cumbria Success Regime have undertaken a public consultation and approached GMLSC Clinical Senate to undertake the additional work described in this paper.

The Senate would like to acknowledge the considerable amount of work undertaken by the Cumbria Success Regime towards progressing transformational service change in WNE Cumbria, particularly towards meeting many of the Senate’s original recommendations.

This paper is solely based on the work, supplementary reports and data submitted by the Success Regime at the time of the review, and the clinical workshops held on 7th and 14th February 2017. The Senate would like to stress that the process that has been undertaken does not amount to a full clinical review for the purposes of assurance.

I would like to thank the clinicians and managers who have contributed to this review. The contributors to this process provide their commitment, time and advice freely. I am grateful to the review team and members of the Clinical Senate for their ongoing support and commitment to the provision of robust clinical advice. I would like to thank Stephen Singleton and the Success Regime Team for providing the additional information requested in a timely fashion.

The clinical advice within this report is given in good faith and with the intention of supporting commissioners in further development of the models for maternity and paediatrics services in WNE Cumbria. This report sets out the methodology and findings of the review, and is presented with the offer of continued assistance should it be needed.

Professor Donal O’Donoghue
Senate Chair
Greater Manchester, Lancashire & South Cumbria Senate
1.0 Introduction

1.1 This response paper is written in response to the WNE Cumbria Success Regime’s approach to the GMLSC Clinical Senate to undertake the work described in this response paper, regarding maternity and paediatrics services.

1.2 This follows the Senate’s original report in May 2016 regarding the proposed models of care for Integrated Care (including Community services), Mental Health, Elective Care, Proactive and Emergency Care, Children and Maternity. This report contained a number of recommendations (the recommendations for maternity and paediatrics can be seen in Appendices 1 and 2 respectively).

1.3 The Senate have been made aware that mental health service transformation is taking place in a separate programme to this piece of work. From the evidence seen so far, the Senate recommends that the CCG should not underestimate the work required to meet these needs, particularly with regards to severe and enduring mental health.

1.4 Similarly the challenges facing the population of WNE Cumbria, as with many other areas, of a super-ageing population and rising dementia prevalence, cannot be underestimated.

1.5 This response paper is solely based on the work, supplementary reports and data submitted by the Success Regime at the time of the review, and the clinical workshops held on 7th and 14th February 2017.

1.6 The Senate would like to acknowledge the considerable amount of work undertaken by the Cumbria Success Regime towards progressing transformational service change in WNE Cumbria, and particularly towards meeting many of the Senate’s recommendations. This includes an audit of expected patient transfers under each of the options as well as consideration of the interdependencies between each of the models for maternity and paediatrics, and the wider system, including emergency departments, anaesthetics and surgery. Indeed, aspects of this additional work have been valuable in allowing the Senate’s panels to produce this response paper.

1.7 For this response, the Senate has focussed on the identification of the most clinically robust and sustainable solutions, as well as highlighting any clinical concerns or issues that need further examination or that should be considered by the CCG in making their decision regarding the future service delivery models for maternity and paediatrics in WNE Cumbria.

1.8 For further information please contact Caroline Baines, Clinical Senate Manager (NW) on carolinebaines@nhs.net
2.0 **Background**

2.1 Following the GMLSC Clinical Senate’s commission in March 2016 from Cumbria CCG (on behalf of the Cumbria Success Regime) to review the proposed models of care for Integrated Care (including Community services), Mental Health, Elective Care, Proactive and Emergency Care, Children and Maternity, the Clinical Senate:

- Agreed the Terms of Reference,
- Convened two independent review panels made up of clinical experts and citizen representatives (membership of which can be seen in Appendix 3),
- Reviewed the information provided,
- Provided a report in May 2016¹.

2.2 Due to the stage of development of the proposed clinical models at the time of the review, the process undertaken did not amount to a full clinical review for the purposes of assurance. Based on the work submitted by the Success Regime at the start of the review, the Senate focussed on the identification of the most clinically robust and sustainable solutions, as well as highlighting any clinical concerns or issues that need further examination or that should be considered by the CCG and other partners to inform the next steps in the development of the Success Regime programme.

2.3 Since the publication of this report, the WNE Cumbria Success Regime has undertaken a public consultation which, at the time of writing has drawn to a close and moved into a period of reflection and analysis. The Success Regime will report to the CCG Governing Body on 8th March 2017 regarding the consultation exercise, subsequent workshops and their recommendations.

2.4 It is clear from the consultation process that neither the public nor some clinicians supported any of the presented options for paediatrics and maternity. Therefore the WNE Cumbria Success Regime approached GMLSC Clinical Senate to undertake some additional work. The commission was that for both maternity and paediatrics, the senate:

1) Revisits the options and advises what they believe to be the best options and identifies any additional issues for consideration in the light of the consultation.

2) Revisit the preparatory work, including risk assessments, and provides a view regarding the quality of that work (i.e. a judgment about the relative safety and appropriateness of any of the options compared to doing nothing).

2.5 Supplementary information was provided to the original review teams to support part 1 of the commission:

---

¹ GMLSC. (9th May 2016). *Independent Review of the Proposed Clinical Models for the North, West & East Cumbria Success Regime.*
“Revisits the options and advises what they believe to be the best options and identifies any additional issues for consideration in the light of the consultation.”

2.6 Panel responses to this supplementary information were fed into two clinically-led workshops on Tuesday 7th February and Tuesday 14th February 2017, which were attended by Clinical Leads nominated by Chief Executives, together with Strategic/Director Leads from each provider organisation. The workshops were also supported by Independent Clinical Experts from the North of England Clinical Senate and the Greater Manchester, South Cumbria and Lancashire Clinical Senate. Other attendees included NHS Cumbria CCG Governing Body Lay Members and GP Locality Leads. There was no patient representation at the workshops.

2.7 At the latter workshop, the outcome was to recommend that Cumbria CCG chooses between the following:

2.7.1 Option 1 Paediatrics and Option 1 Maternity

This was with a caveat that an agreed review period is put in place (between 1-2 years) and if this option is deemed unachievable and/or unsustainable then the system moves to Option 2 paediatrics and Option 3 maternity.

This approach was deemed preferable because it demonstrates that the decision makers have listened to the consultation feedback. It involves the least change from the current situation and allows a period for co-production of the future model with the community. It also allows current initiatives regarding recruitment and wider system change to play forward to identify whether they reap rewards.

However, there was some feeling that this is too similar to the status quo, the recruitment challenges are insurmountable and that there needs to be a bold decision to go straight to:

2.7.2 Option 2 Paediatrics and Option 3 Maternity

The general (though not unanimous) consensus was that this is the right clinical choice of options and is more achievable and sustainable.

However there is likely to be significant opposition to this choice from the clinicians in West Cumbria including most of the GPs, most of the consultants in all specialities and most of the midwives. In addition opposition is likely to come from the public and politicians.

2.8 The recommended choices for Cumbria CCG, described in section 2.8, were fed back to the review panel leads to seek their responses to the second part of the commission: “Revisit the preparatory work, including risk assessments, and provides a view regarding the quality of that work (i.e. a judgment about the relative safety and appropriateness of any of the options compared to doing nothing).”
2.9 This response paper summarises the GMLSC Clinical Senate response to this commission, for which a final view from GMLSC was required by Tuesday 28\textsuperscript{th} February 2017.
3.0 Maternity

3.1 The first aspect of this follow-up commission was for the senate review panel to revisit the options and advise what they believe to be the best options, identifying any additional issues for consideration in the light of the consultation.

3.2 The three maternity options are described in detail in Appendix 4. The preferred option going into consultation was Option 2: A consultant-led unit (CLU) and alongside midwife-led unit (MLU) for births in Carlisle and a 24-hour standalone MLU unit for low risk births at Whitehaven.

3.3 The review panel noted that all options had strengths and weaknesses, but that the most clinically robust and sustainable model was Option 2. This agreed with the preferred option highlighted in the consultation. The panel considered it a transformational model that needs testing, assuming the risks are robustly identified and properly mitigated against.

3.4 One of the key risks identified was that women would opt not to use MLU. Public expectation in the area is not in line with current best practice guidance and could lead to an unintended consequence of women requesting caesarean sections to avoid travelling to Carlisle. There is a need to consider how expectations can be managed and attitudes changed.

3.5 The panel felt that the team had clearly thought about the model and that it contained some good ideas, such as assessing women in the latent phase of labour at Whitehaven to prevent unnecessary travel to the obstetric unit in Carlisle.

3.6 They were also reassured and pleased to hear that the North West Ambulance Service (NWAS) had been fully involved in the discussions and planning regarding the use of the dedicated ambulance vehicle.

3.7 However, they identified a number of issues regarding the robustness of the plans, which would need addressing before this model was implemented. These are:

3.7.1 Would the elective consultant service at Whitehaven be an outpatient service or include elective caesarean section? If elective caesarean sections were to be delivered during consultant-hours this would need to be timed to ensure there is post-surgical doctor cover within the hospital.

3.7.2 Would the day unit be for planned activity only or could it accommodate non planned maternity assessment for common complications of pregnancy?
3.7.3 What would be the protocol at weekends when there was no medical cover? There would need to be robust management algorithms for during and outside consultant presence at Whitehaven.

3.7.4 Would the VBAC provision be a clinic alone or include deliveries?

3.7.5 How does the day assessment unit from 8.00am-6.00pm described in Section 3.1 of the Maternity Options Addendum paper differ to the antenatal assessment day unit from 8.00am-8.00pm described in the same section?

3.7.6 Why are anomaly scans not down to be performed at Whitehaven?

3.7.7 Would the Emergency Gynaecological Unit be provided during weekend days?

3.7.8 Is paediatric medical cover 7 days a week from 8.00am-11.00pm?

3.7.9 It is not usual for a retrieval team to attend MLU. Red 1 Paramedic ambulance is the norm. Would the maternity ambulance be equipped to transfer neonates with a midwife (and paediatrician during their hours)?

3.7.10 Who would provide cover for post-surgical complications overnight?

3.7.11 Could telemedicine provide some useful support?

3.8 Further issues identified concerned workforce issues in particular:

3.8.1 The ability to provide the required upskilling of midwives in a timely way and whether any work was underway with the local educational establishments regarding the provision of this.

3.8.2 Whether there had been a consideration using midwives in specialist roles such as diabetes management

3.9 The panel agreed with the case for change as the current service was felt to be unsustainable and fragile due to workforce issues, particularly regarding recruitment of consultants, the lack of advanced nurses and an ageing midwifery workforce.

3.10 Option 1 was felt to be too close to the status quo and therefore subject to the same issues previously identified in the case for change. It was not seen as transformational and reliant upon an expanded workforce, particularly consultant, which is unlikely to be deliverable.
3.11 Option 3 was not supported as this removes all provision for births at Whitehaven and there is good evidence to support standalone MLUs and the provision of high quality care for low-risk multiparous and nulliparous women\textsuperscript{2}.

3.12 In light of the recommendations being made to the CCG (described in Section 2.8), the review panel does not support a decision that would lead to there being no MLU in Whitehaven.

\textsuperscript{2} Nice. December 2014. Intrapartum care for healthy women and babies. www.nice.org.uk/guidance/cg190
4.0 Paediatrics

4.1 The first aspect of this follow-up commission was for the senate review panel to revisit the options and advise what they believe to be the best options, identifying any additional issues for consideration in the light of the consultation.

4.2 The three paediatric options are described in detail in Appendix 5. The preferred option going into consultation was Option 1: Full service at Carlisle and short stay paediatric assessment unit (SSPAU) and low acuity beds at Whitehaven plus Dedicated Ambulance Vehicle and consultant on-call overnight.

4.3 The review panel felt the best option was Option 2: Full service at Carlisle and 14 hour SSPAU at West Cumberland Hospital plus Dedicated Ambulance Vehicle.

4.4 The primary reason for this preference is that it is a transformational model that has a good clinical case. This is demonstrated through provision of SSPAU on both sites, having consultants working across both sites in a network model to provide resilience and maintenance of skills, as well as integration of community and secondary care.

4.5 Option 2 was also considered to offer higher deliverability and sustainability by being more attractive to prospective consultants (offering an improved on call rota ratio) and by requiring fewer overall WTE consultants than in Option 1 – the preferred option.

4.6 Option 2 presents a minimal number of additional transfers required between Whitehaven and Carlisle than Option 1 (estimated as 58 additional journeys/year with 279 in Option 1 and 337 in Option 2).

4.7 The panel felt that the following issues required consideration before the implementation of Option 2 to strengthen the case:

4.7.1 A strong narrative to support the vision (e.g. better access to consultants who will be present until 22:00).

4.7.2 The development of APNP role including:

4.7.2.1 More work needs to be undertaken to enable recruitment and retention of these highly skilled practitioners.

4.7.2.2 Consideration of the reasons for the previous loss of advanced nurse practitioners to primary care.

4.7.2.3 Consider as to where this workforce will come from (e.g. experienced paediatric nurses).

4.7.2.4 Time needed to train this cohort and resilience of rotas during that period.

---

3 Data based on “Acute Hospitals Travel Impact Assessment version 0.8”, 17th October 2016.)
4.7.3 Reliance on GPs within development of the whole system approach and the need to develop required skills through education, training and recruitment.

4.7.4 The lack of overnight paediatric cover at WCH requires:

4.7.4.1 By-pass policies and procedures for Whitehaven.

4.7.4.2 Public education around facilities at Whitehaven to minimise seriously ill children presenting there.

4.7.4.3 Consideration of ED/Anaesthetic staff and their management of critically ill children. These clinicians are likely to feel deskillled with fewer critically ill children passing through the ED and would feel vulnerable without presence of Paediatricians. This could be mitigated through provision of targeted training (e.g. by Nectar / Paediatric Critical Care ODN).

4.8 If the decision is made to move to Option 2, this could be phased in over 1 year by initially keeping overnight beds at Whitehaven. This has been done elsewhere but carries risks to the service (e.g. resilience).

4.9 Reflection on the current service is that it is fragile, and as such the case for change is supported. In particular, at Whitehaven, where there is a high reliance on locum consultants. Indeed, CQC West Cumberland Hospital Quality report (08/09/2015) states “Review the consultant paediatric cover provided out of hours. This was a concern as the service still offered a 24 hour emergency service for children and young people”. To date, Whitehaven has not been able to recruit substantive consultants. The panel noted that the outcome of the consultation was that either the current service, or the least possible service reconfiguration (Option 1), was the preferred choices. However staffing and service resilience makes these options difficult to support.

4.10 Option 1 also includes overnight beds at WCH. This would support overnight deliveries in maternity and again it was noted that the outcome of the consultation was that the current service or the least possible service reconfiguration (Option 1) were the preferred choices. However the panel felt that due to this option delivering minimal change from the current service, then there is significant uncertainty as to whether this is either deliverable or sustainable. Some of the key issues highlighted include:

4.10.1 The requirement for two rotas or a dual rota across Whitehaven and Carlisle.

4.10.2 The number of consultants required to support these rotas and associated daytime work.⁴

---

⁴ RCPCH “Facing the Future” document suggests 7.8 wte consultants for a small unit such as Whitehaven (<2,500 admissions/year) and 8.6 wte for a medium sized unit such as Carlisle (2,500-5,000) based upon 2SPAs/consultant and 10PA job plans.
4.10.3 No indication that it is possible to recruit the number of substantive consultants required to cover these rotas thereby placing an undue reliance on locums (often long term).

4.10.4 Any maternity option based upon this paediatric option would also be at risk if Option 1 becomes unsustainable.

4.11 Option 3 had no convincing clinical case and there would be a significant number of transfers required (1,713/year). It also had minimal support at consultation and is therefore not supported by the panel.

4.12 In light of the recommendations being made to the CCG (described in Section 2.8), the review panel:

4.12.1 Reiterates to the CCG that clinically Option 2 is the panel’s preferred option but that if Option 1 is chosen then the panel would suggest that the CCG seeks reassurance that there are clear timetables for recruitment to substantial posts, training of APNPs and an audit of inpatient stays at WCH. The CCG would also need to develop criteria by which ‘current initiatives regarding recruitment and wider system change’ are measured and decide upon the response to any failure to meet these criteria to ensure robust and sustainable service delivery.

4.12.2 Suggests that the quality impact assessments for the Paediatric Options 1 and 2 are revisited before a final decision is made to take into account additional information and discussions that have been held since they were written (e.g. from the travel impact assessment) and include mitigations for potential negative impacts.
5.0 Summary and Conclusions

5.1 Regarding maternity services, the Senate agrees with the Success Regime’s originally preferred option, i.e. Option 2. It is considered to be a transformational model that warrants testing, assuming the risks are robustly identified and mitigated against. The Senate does not support a decision that would lead to there being no MLU in Whitehaven.

5.2 Should Option 1 maternity be implemented then the Senate would suggest that the CCG seeks reassurance that there are clear timetables for recruitment to required posts (no more than two years). The CCG would also need to develop criteria by which current initiatives regarding recruitment and wider system change are measured and decide upon the response to any failure to meet these criteria to ensure robust and sustainable service delivery.

5.3 Regarding paediatric services, the Senate reiterates that clinically the preferred option is Option 2. This is consistent with the Clinical Senate’s original response in May 2016 but differs to the Success Regime’s originally preferred option, i.e. Option 1. If Option 1 is chosen then the Senate would suggest:

5.3.1 That the CCG seeks reassurance that there are clear timetables for recruitment to substantial posts, training of APNPs and an audit of inpatient stays at WCH (no more than two years). The CCG would also need to develop criteria by which current initiatives regarding recruitment and wider system change are measured, and decide upon the response to any failure to meet these criteria to ensure robust and sustainable service delivery.

5.3.2 That the quality impact assessments for the Paediatric Options 1 and 2 are revisited before a final decision is made to take into account additional information and discussions that have been held since they were written (e.g. from the travel impact assessment) and include mitigations for potential negative impacts.

5.4 The Senate notes that, with regards to interdependencies between maternity and paediatrics, its preferred options are deliverable but would require some detailed work to develop robust pathways for very sick children and babies who present at Whitehaven out of hours.

5.5 The Senate notes the diverse range of opinions regarding the range of both maternity and paediatric services. It should be noted that the Senate’s advice is based on the clinical challenges and the most robust clinical solutions.
5.6 The advice within this report is given in good faith and is correct at the time of writing. Moving forward the Clinical Senate extends the offer of further assistance should it be required.
### Appendix 1: Clinical Senate Recommendations Regarding Maternity Services (May 2016)

#### Recommendations: Maternity services

The Success Regime Leadership Team for Maternity Services is encouraged to:

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that the proposed clinical models build on NICE guidelines and quality standards.</td>
</tr>
<tr>
<td>Consider the clinical co-dependencies involved during the development of the proposals for maternity services. Sources of useful information about the process for identifying clinical co-dependencies are:</td>
</tr>
<tr>
<td>- The South East Senate report on clinical co-dependencies</td>
</tr>
<tr>
<td>- The Making It Better and Healthier Together Programmes</td>
</tr>
<tr>
<td>- The GM Devolution Specialised Services co-dependency assessment framework</td>
</tr>
<tr>
<td>- The Healthy Liverpool Programme</td>
</tr>
<tr>
<td>Consider and take account of the critical interface between maternity services and paediatrics in the further development of the proposals</td>
</tr>
<tr>
<td>Clarify how Cumbria responded to the concerns of the CQC. It would be helpful to see evidence of how the concerns raised from previous reports have or are beingaddressed.</td>
</tr>
<tr>
<td>Undertake further work to develop a robust and realistic workforce plan which addresses the following:</td>
</tr>
<tr>
<td>- models the proposed workforce roles and numbers and testing the assumptions re potential financial savings</td>
</tr>
<tr>
<td>- Clarifies the age profile and turnover of the staff</td>
</tr>
<tr>
<td>- Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic.</td>
</tr>
<tr>
<td>- Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic</td>
</tr>
<tr>
<td>- Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks</td>
</tr>
<tr>
<td>- Outlines plans for the ongoing training and development of staff</td>
</tr>
<tr>
<td>- Describes how professional isolation will be addressed</td>
</tr>
<tr>
<td>- Embeds Quality Improvement into workforce training and CPD</td>
</tr>
<tr>
<td>- Describes the extent that local commissioners have been engaged in the development of the workforce plan.</td>
</tr>
<tr>
<td>Clarify further the Enhanced Neonatal Nurse/Midwife roles in terms of:</td>
</tr>
<tr>
<td>- Training numbers</td>
</tr>
<tr>
<td>- Plans for supervision and ongoing training</td>
</tr>
<tr>
<td>- Proposed level of ongoing support from the wider staffing infrastructure to reduce professional isolation</td>
</tr>
<tr>
<td>- Proposed level of professional responsibility and accountability etc.</td>
</tr>
<tr>
<td>Develop robust quality metrics and standards which can be used as a marker of progress and or success</td>
</tr>
</tbody>
</table>
Appendix 2: Clinical Senate Recommendations Regarding Paediatrics Services (May 2016)

Recommendations: Children’s Services

The Success Regime Leadership Team for Children’s Services is encouraged to:

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make timely decisions and decide concurrently on models of care for both maternity and children &amp; families in order to maintain the viability of any future services.</td>
</tr>
<tr>
<td>- The requirements of a consultant led obstetric unit are such that the paediatric model of care needs to be robust to support it. This was considered by Dr Shortland in his review.</td>
</tr>
<tr>
<td>- The Senate Review Team recommend that his opinion is considered further i.e. a 14 hour SSPAU at the WCH site may be a more achievable and sustainable option.</td>
</tr>
</tbody>
</table>

Consider the following issues when modelling the effects of each option, reviewing achievability and making a decision:

- cross-border activity (e.g. the number of patients that would move to Barrow)
- Interim arrangements in terms of both staff resources and financial costs and likelihood of meeting target configuration.

Further develop a robust and realistic workforce plan which addresses the following:

- models the proposed workforce roles and numbers and tests the assumptions re potential financial savings
- Clarifies the age profile and turnover of the staff
- Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic.
- Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic.
- Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks
- Outlines plans for the ongoing training and development of staff
- Describes how professional isolation will be addressed
- Embeds Quality Improvement into work force training and CPD
- Describes the extent that local commissioners have been engaged in the development of the workforce plan.

Also See General Recommendations in Section 4.3

Employ novel recruitment models once a clear vision for the future of the service has been established. Suggestions include:

- Movement of clinical leaders between sites
- Secondments of senior well established clinicians who may also provide additional clinical leadership
- Working alongside universities to provide academic units

Consider CAMHS and other service interdependencies throughout the decision making process and when putting in place transitional arrangements.

Ensure that a whole systems approach is maintained by considering community services and general practice at the heart of the decision making process.

Support the Trust to continue to build upon its existing successes such as telemedicine.

Ensure that a robust engagement plan which builds on Sam’s House is developed and implemented. It also needs to address and explain the reasons why changes are required.

Further develop the standards and quality measures for the service.
Undertake an audit of likely number of patient transfers if the SSPAU model was implemented.
Appendix 3: Contributors to the Review

Maternity Clinical Senate Review Team

<table>
<thead>
<tr>
<th>Forename</th>
<th>Surname</th>
<th>Job Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Helen Scholefield</td>
<td>(Review Team Lead)</td>
<td>Consultant Obstetrician Liverpool Women's Hospital,</td>
<td></td>
</tr>
<tr>
<td>Dr Ngozi Edi- Osagie</td>
<td></td>
<td>Consultant Neonatologist, Central Manchester FT</td>
<td></td>
</tr>
<tr>
<td>Dr David Rowlands</td>
<td></td>
<td>FROG, Associate Medical Director, Arrowe Park Hospital,</td>
<td></td>
</tr>
<tr>
<td>Kathy Murphy</td>
<td></td>
<td>Deputy Director of Nursing &amp; Head of Midwifery, Central Manchester FT</td>
<td></td>
</tr>
<tr>
<td>Judith Shaw</td>
<td></td>
<td>Volunteer Patient Cabinet member</td>
<td></td>
</tr>
</tbody>
</table>

Paediatrics Clinical Senate Review Team

<table>
<thead>
<tr>
<th>Forename</th>
<th>Surname</th>
<th>Job Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jeff Perring</td>
<td>(Review Team Lead)</td>
<td>Director of Intensive Care and Vice Senate Chair, Sheffield Children's Hospital</td>
<td></td>
</tr>
<tr>
<td>Dr James Bunn</td>
<td></td>
<td>Consultant Paediatrician, Alder Hey Children's Hospital</td>
<td></td>
</tr>
<tr>
<td>Angela Douglas</td>
<td></td>
<td>Scientist and Genomic Lead, Liverpool Women's Hospital</td>
<td></td>
</tr>
<tr>
<td>Kate McNulty</td>
<td></td>
<td>Patient Representative GMLSC Clinical Senate, Oversight &amp; Planning Group &amp; Patient, Carer Public Advisory Group GMLSC</td>
<td></td>
</tr>
</tbody>
</table>

GMLSC Clinical Senate Council

<table>
<thead>
<tr>
<th>Forename</th>
<th>Surname</th>
<th>Job Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donal</td>
<td>O'Donoghue</td>
<td>Consultant Renal Physician, Salford Royal Foundation Trust and GMLSC Clinical Senate Chair</td>
<td>Salford Royal FT</td>
</tr>
<tr>
<td>Caroline</td>
<td>Baines</td>
<td>Clinical Senate Manager</td>
<td>NW Clinical Senates</td>
</tr>
<tr>
<td>Ivan</td>
<td>Benett</td>
<td>General Practitioner</td>
<td>Central Manchester CCG</td>
</tr>
<tr>
<td>Maureen</td>
<td>Chadwick</td>
<td>Managing Director</td>
<td>Diabetes Complete Care Ltd</td>
</tr>
<tr>
<td>Irfan</td>
<td>Chaudry</td>
<td>Consultant Critical Care Medicine &amp; Anaesthesia, Divisonal Medical Director/Honorary Senior Clinical Lecturer Manchester Medical School</td>
<td>Lancashire Teaching Hospitals NHS FT</td>
</tr>
<tr>
<td>Julie</td>
<td>Cheetham</td>
<td>Associate Director</td>
<td>Greater Manchester &amp; Eastern Cheshire SCN</td>
</tr>
<tr>
<td>Nicola</td>
<td>Cook</td>
<td>Divisional Director</td>
<td>North West United Response</td>
</tr>
<tr>
<td>Robert</td>
<td>Coward</td>
<td>Consultant Physician &amp; Nephrologist</td>
<td>Lancashire Teaching Hospitals NHS FT</td>
</tr>
<tr>
<td>Ian</td>
<td>Donaldson</td>
<td>Consultant Anaesthesia/Critical Care</td>
<td>Lancashire Teaching</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Organization</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------</td>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Angela Douglas</td>
<td>Clinical Director</td>
<td>Hospitals NHS FT</td>
<td></td>
</tr>
<tr>
<td>Martin Hogg</td>
<td>Consultant Clinical Oncologist</td>
<td>Lancashire Teaching Hospitals</td>
<td></td>
</tr>
<tr>
<td>Helen Hurst</td>
<td>Consultant Nurse</td>
<td>CMFT Trafford</td>
<td></td>
</tr>
<tr>
<td>Karley Hurst</td>
<td>CQC Project Support Officer</td>
<td>Pennine Care NHS FT</td>
<td></td>
</tr>
<tr>
<td>Philip Jennings</td>
<td>Head of Clinical Innovation, Liaison &amp; Deployment</td>
<td>The Innovation Agency, AHSN</td>
<td></td>
</tr>
<tr>
<td>Sakthi Karunanithi</td>
<td>Director of Public Health</td>
<td>Lancashire County Council</td>
<td></td>
</tr>
<tr>
<td>Niall Lynch</td>
<td>Consultant Radiologist</td>
<td>Stockport NHS FT</td>
<td></td>
</tr>
<tr>
<td>Patrick MacDowall</td>
<td>Consultant Nephrologist</td>
<td>Lancashire Teaching Hospitals</td>
<td></td>
</tr>
<tr>
<td>Claire Maguire</td>
<td>Consultant Clinical Psychologist</td>
<td>Pennine Care NHS FT</td>
<td></td>
</tr>
<tr>
<td>Angela Manning</td>
<td>General Practitioner &amp; Deputy Medical Director</td>
<td>NHS England Lancs &amp; Gtr Mcr</td>
<td></td>
</tr>
<tr>
<td>Phil McEvoy</td>
<td>Managing Director</td>
<td>Six Degrees Social Enterprise</td>
<td></td>
</tr>
<tr>
<td>Kate McNulty</td>
<td>Patient Representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Javeed Mehran</td>
<td>Consultant in Old Age Psychiatry &amp; Clinical Lead Primary Care</td>
<td>Salford Royal NHS FT</td>
<td></td>
</tr>
<tr>
<td>Jane Ooi</td>
<td>Consultant Breast Surgeon</td>
<td>Bolton Foundation Trust</td>
<td></td>
</tr>
<tr>
<td>Vats Patel</td>
<td>Pharmacist</td>
<td>Manchester</td>
<td></td>
</tr>
<tr>
<td>John Patterson</td>
<td>Medical Director &amp; GP</td>
<td>Hope Citadel</td>
<td></td>
</tr>
<tr>
<td>Jaydeep Sarma</td>
<td>Consultant Interventional Cardiologist</td>
<td>South Manchester Hospital NHS Trust</td>
<td></td>
</tr>
<tr>
<td>Mohammed Sarwar</td>
<td>CEO Multicultural Arts &amp; Medica Centre &amp; Patient Representative</td>
<td>Rochdale</td>
<td></td>
</tr>
<tr>
<td>Graham Spratt</td>
<td>Consultant Clinical Psychologist</td>
<td>5 Boroughs Partnership</td>
<td></td>
</tr>
<tr>
<td>Ian Trodden</td>
<td>Director of Nursing</td>
<td>Pennine Care NHS FT</td>
<td></td>
</tr>
<tr>
<td>Jan Vaughan</td>
<td>Associate Director</td>
<td>NWC SCN</td>
<td></td>
</tr>
<tr>
<td>Stephen Watkins</td>
<td>Director of Public Health</td>
<td>Stockport Council</td>
<td></td>
</tr>
<tr>
<td>Irfan Zafar</td>
<td>GP</td>
<td>Blackburn</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Descriptions of Maternity Services Options 1 to 3

Option 1

- Maintaining consultant-led units on both sites, with ‘alongside’ midwife-led units and special care baby units.
- This option is not the status quo – some high-risk mothers will birth at Carlisle.
- This option will use new ways of working to maintain safe staffing – one team across two sites with an innovative staffing structure.
- There will be a full range of antenatal and postnatal services as well as gynaecological services both in Whitehaven and Carlisle.
- The option for home birth and Penrith Birthing Unit will be available.

Option 2

- At Cumberland Infirmary in Carlisle: a consultant-led unit and ‘alongside’ midwife-led unit for births. There will be a full range of antenatal and postnatal care and a special care baby unit serving all of west, north and east Cumbria.
- At West Cumberland Hospital in Whitehaven: a 24-hour standalone midwife-led unit for low risk births and a daytime consultant service offering antenatal and postnatal care and some gynaecological services (non-emergency cases) (8am-8pm). There will not be a consultant-led service for births. There may be the ability to offer elective caesareans in this new staffing model in the future. It is anticipated women will not be transferred back to WCH for postnatal care as NICE guidance supports discharge to home as soon as possible. Women requiring medical treatment will remain in Carlisle. There will be an antenatal day assessment unit (8am-8pm) provided five days a week (Monday-Friday) and could be staffed by midwives with telemedicine support.
- Consultant obstetric and gynaecology input would be solely during the day but would include day case services across gynaecology (including day case surgery), outpatient investigations, emergency gynaecology unit, fertility, colposcopy and urogynaecology. All inpatient emergency gynaecology and complex elective gynaecology as well as the consultant-led obstetric unit would be at CIC.
- The option for home birth and Penrith Birthing Unit will be available.
- There will be a Dedicated Ambulance Vehicle (DAV) for maternity and paediatric transfers.

Option 3

- Cumberland Infirmary in Carlisle: a full obstetric service and a special care baby unit serving all of west, north and east Cumbria. Consultant-led service and ‘alongside’ midwife-led unit for births. There will be a full range of antenatal and postnatal care.
- West Cumberland Hospital in Whitehaven: no births at West Cumberland Hospital. Consultant and midwife out-patient antenatal and postnatal care available.
- There will be an antenatal day assessment unit (8am-8pm) provided five days a week (Monday-Friday) and could be staffed by midwives with telemedicine support.
- Consultant obstetric and gynaecology input would be solely during the day but would include day case services across gynaecology (including day case surgery), outpatient investigations, emergency gynaecology unit, fertility, colposcopy and urogynaecology. All inpatient emergency gynaecology and complex elective gynaecology as well as the consultant-led obstetric Unit would be at CIC.
- The option for home birth and Penrith Birthing Unit will be available.
Appendix 5: Descriptions of Paediatrics Services Options 1 to 3

Option 1
- Full service at Cumberland Infirmary Carlisle and short stay paediatric unit and low acuity beds at West Cumberland Hospital plus Dedicated Ambulance Vehicle and consultant on-call over night

Option 2
- Full service at Cumberland Infirmary Carlisle and 14 hour short stay paediatric unit at West Cumberland Hospital plus Dedicated Ambulance Vehicle

Option 3
- Full service at Cumberland Infirmary Carlisle for West, North and East Cumbria. No beds or short stay paediatric unit at West Cumberland Hospital
Dear Stephen,

Many thanks for your e-mails dated 7th and 15th November, 2016 asking the Maternity Network to look at correspondence received from Mr John Eldred and Councillor Rebecca Hanson.

A network group comprising Stephen Sturgiss, Anne Holt and Vicki Smith, supported by myself and Suzanne Thompson met recently to discuss the content of their correspondence, including the 3 papers referenced in the document from Mr Eldred. Subsequently we have also looked at a further article (Grzybowski et al, 2011) arising from details contained in the Australian meta-study (reference 2 in Councillor Hanson’s paper).

During the course of our deliberations we felt it was not going to be appropriate to comment on the arithmetic calculations in the correspondence because we feel certain aspects of the evidence not mentioned lead us to consider that, on balance, there is not a strong enough link between travel times and outcomes.

The papers from Councillor Rebecca Hanson and John Eldred include a series of statements in relation to an increased incidence of adverse outcomes amongst women who live far away from consultant-led obstetric care.

In addition, a series of calculations have been used to describe a theoretical increase in the numbers of neonatal deaths if WCH were not to have ‘obstetric services’. These calculations are based on the notion that ‘for every 15 extra minutes women have to travel the neonatal mortality rate increases by 15%’.

We examined in detail the statements in Councillor Hanson’s paper – and have analysed each comment in relation to the reference from which it has been taken. We also looked in particular at the ‘15 minute’ statement – as this is the key assumption within the theoretical modelling (in relation to neonatal deaths). This statement needs to be statistically valid in order for the rest of the conclusions to be credible.

This analysis of the references is written in the order they appear in Councillor Hansen’s document – and under the same sub-headings. The three papers referenced in John Eldred’s correspondence are included.
What is happening in Europe?

The first publication referred to in the ‘Key Findings’ section of this paper is the ‘Dutch study on travel time in labour’ (page 2 – reference 3). In fact, the reference is to a review paper from the Public Health Wales Observatory (PHWO), in which there is a conclusion (page 4) that:

‘This research evidence review did not find conclusive evidence to support a causal link between increasing distance, or the time, required to travel from mother’s residence to maternity services and adverse birth outcomes. All the studies finding any evidence of such an association were limited by their inability to account for important contributory factors and confounders (e.g. referral to specialist maternity units) and their reliance on a number of unsupported assumptions (e.g. women are at home at the onset of labour).’

This PHWO review paper refers to the findings of the ‘Dutch study’ (on page 10), but as we’ve already mentioned in a previous email (and as acknowledged in other papers on the subject), the Dutch system of maternity care involves women staying at home until they are confirmed to be in labour. This is not a feature of the UK (or other) system(s) of maternity care, in which women present to hospital when they suspect that they might be in labour.

Neonatal deaths: an extra 1.4 each year

The paper from Councillor Hanson refers to page 43 of an ‘Australian meta-study’, from which it appears that the Councillor has taken the statement that ‘for every 15 extra minutes women have to travel the neonatal mortality rate increases by 15%’. This paper is another review of the subject, and includes the following statements in their conclusions about the association between distance to care and outcomes:

‘Distance to Care: Key Points

1. For BC women, neonatal mortality is three times more likely for births in which the women had to travel four or more hours to services;

2. For BC women who have to travel more than 1 hour, induction is 1.3 times more likely due to travel logistics;

3. International evidence shows that increasing numbers of women travelling longer distances to care is creating greater resource usage to compensate for greater rates of morbidity;

4. An unequivocal relationship exists between distance and outcomes: as distance goes up, so do negative outcomes.’

This meta-review draws these conclusions from several publications, relatively few of which have analysed the numbers of stillbirths and / or neonatal mortality in relation to distance from place of birth and / or the nearest maternity unit. The findings from each of the studies looking at perinatal mortality rates are summarised below:
Gryzbowski et al (2011)
This is a study of pregnancy outcomes for women carrying a singleton baby in rural Canada. The authors noted that:

‘For those few women who had to travel the longest distance (greater than 4 hours to care), neonatal mortality was three times more likely (OR=3.17, 95% CI 1.45-6.95) (Grzybowki, Stoll and Kornelsen 2011)’

However, the study group also found that the perinatal mortality rates for women living either 60-120 minutes or 120-240 minutes from a specialist centre (5 and 6 per 1000 births, respectively) were very similar to those for women living within an hour of specialist services (6 per 1000). Hence, the findings from this study do not support the argument that the proposed reconfiguration of services in Cumbria would be associated with a greater number of perinatal deaths.

Paranjothy et al, 2014
It’s certainly the case that this (Welsh) study showed a statistically significant increase in the risk of both early and late neonatal death with every 15-minute increase in travel time to the place of birth. This study appears to have been the source of the claim that that ‘for every 15 extra minutes women have to travel the neonatal mortality rate increases by 15%’

The authors, however, suggested that this finding was unsurprising as the most vulnerable babies are likely to be transferred to the nearest tertiary centre. For example, a preterm neonate or a baby with a congenital anomaly at term will be transferred to a tertiary centre for birth.

Of interest, and in the same paper, there was no statistically significant association between intrapartum stillbirth, early or late NND and travel time to the nearest hospital. In fact, the odds ratios for such outcomes were very close to 1

The authors concluded that ‘reconfiguration of maternity and neonatal services may have little impact on birth outcomes, provided there are appropriate neonatal transfer services in place’

Combier et al, 2013
In a study from the Burgundy region of France, the authors reported that FHR abnormalities, meconium-staining of the amniotic fluid, hospitalisation of mothers, and out-of-hospital deliveries were significantly more common in mothers who lived further away from maternity units, but none of the women who lived more than 46 minutes away from the hospital gave birth out-of-hospital.

Stillbirths and perinatal deaths were more frequent in mothers with longer travel times, but the differences between the mothers living closest to and furthest away from the maternity units weren’t statistically significant.

The author’s acknowledge the contradictory findings in the evidence base – and (in fact) quoted 2 studies from Cumbria that apparently found no associations between perinatal mortality rates and travel time to the nearest maternity ward.
In another large study from France, longer distances to a maternity unit had no impact on stillbirths or neonatal deaths when adjusted for confounding variables such as social risk factors.

There was a significant increase in the numbers of neonatal deaths in out-of-hospital births, but these were said to be very rare.

**Seriously ill babies**

The statements in this section of the paper - relating to a potential increase in the numbers of babies admitted to neonatal intensive care - are taken from the article by Grzybowski et al (2011), in which the authors reported that:

‘Newborns from catchments 2 to 4 hours, and 1 to 2 hours from services generated rates of 179 and 100 NICU 3 days per thousand births, respectively, compared to 42 days for newborns from catchments served by specialists’

The relevance of these findings, however, to the potential reconfiguration of services in Cumbria is questionable. The authors acknowledged difficulties in properly controlling for the potentially confounding effects of ethnicity and socio-economic status. Moreover, there are fundamental differences between the healthcare systems in Canada and those in the UK.

**Better Births**

It is noted that within Better Births (p90) a proactive approach to addressing issues relating to remoteness and rurality is offered.

‘Remote and rural areas can introduce innovative working practices such as:

- Robust triage and transferring the care of women with more serious complications at an appropriate time in the pregnancy to a more specialised unit
- Defining which types of women should be advised to give birth at which units across the local maternity system
- Providing transport facilities for women needing to travel to more specialist units and enhanced transfer services for women or their babies experiencing unexpected serious complications
- Making use of technology, e.g., consultations by video link between the centre and smaller unit.’

**Summary**

Overall, we do not feel that there is sufficient evidence in the papers referenced to justify a conclusion that increased travel times to the nearest maternity unit (at less than 4 hours distance) are associated with an increased risk of either stillbirth and / or neonatal death. Hence, we could find no justification in the references contained within the paper from

*High quality care for all, now and for future generations*
Mr Eldred and Councillor Hanson for the theoretical modelling of increased neonatal mortality rates according to stepwise 15-minute increments in travel times to the nearest unit.

There is evidence within the references quoted that longer travel times might be associated with an increased incidence of interventions such as inductions of labour and / or hospitalisation, as might be expected when clinicians and parents might be taking decisions with the intention of minimising potential problems caused by longer travel times.

The evidence that longer travel times might lead to an increase in the numbers of out-of-hospital births is consistent across several studies, and is plausible. It is, therefore, particularly reassuring that even if out-of-hospital births are more frequent, overall perinatal mortality rates in these studies – when controlled for confounding factors – aren’t significantly affected by longer travel times (at < 4 hours from the nearest unit).

Detailed consideration of infrastructure issues such as transfer arrangements and accommodation near Cumberland Infirmary, Carlisle would help mitigate any potential increased risks.

Yours sincerely

Roy McLachlan
Associate Director

cc  Stephen Sturgiss, NUTH
     Anne Holt, CDDFT
     Jonathan Slade, NHS England
     Robin Mitchell, Northern England Clinical Networks
     Suzanne Thompson, Northern England Clinical Networks