

RCPCH Invited Reviews Programme

Design Review

Dorset Clinical Commissioning Group

April 2016

RCPCH

Royal College of
Paediatrics and Child Health

Leading the way in Children's Health

RCPCH Invited Reviews Programme
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5-11 Theobalds Road
London WC1X 8SH
Tel: 0207 092 6000
Email: enquiries@rcpch.ac.uk
Web: www.rcpch.ac.uk

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Executive Summary

Background

The Dorset Clinical Services Review (CSR) proposed to consult on a range of developments for health services in Dorset, including options to redesign the paediatric service at Dorset County Hospital (DCH). These included switching full inpatient provision to a 16 hour (8am-10pm) Paediatric Assessment Unit (PAU) and merging the paediatric teams based in Dorchester and Poole to provide one inpatient site in east Dorset that would also care for very premature neonates. This model raised concerns amongst clinicians, primarily, around the impact on local people seeking emergency care for their children and local obstetric services and several people, for this and other reasons aimed to resist the change. Despite much discussion no resolution was reached as to how best to reach a safe, cost-efficient and sustainable service in Dorset. The CCG invited the Royal College of Paediatrics and Child Health (RCPCH) to give an independent view.

As paediatrics is intimately interdependent with other clinical specialities, the Review team incorporated representatives from the Royal Colleges of Nursing, Midwives, Anaesthetists and Obstetricians & Gynaecologists. The remit was to assess the current services and the two options in the CSR and in addition to include Yeovil within the review process. The key criteria for assessment were safety, quality and sustainability, taking into account current changes in clinical practice, the NHS Five Year Forward View and national standards in any service model proposed.

The Review team received much written information concerning all the units and visited for three days in October and three in December 2015 attending both Poole and Dorchester twice and Yeovil and Bournemouth once each. In addition they met key personnel from Southampton which serves as a tertiary centre for women's, children's and neonatal care, and those involved in strategic networks and medical training.

A highly committed workforce was providing excellent care in many areas but some significant concerns were identified

- all paediatric units failed on at least one *Facing the Future* paediatric service standard,
- there was a high level of activity and significant staffing gaps in Poole,
- all units were under-resourced for children's community nursing,
- uptake of midwife led care was low and birth was over medicalised in some cases,
- insufficient activity to support the complexity of neonatal care provided at DCH and
- poor physical environment on labour ward at Poole.

Some of the key conclusions and recommendations are as follows:

Potential Reconfiguration

Within five to ten years the maternity and paediatric services at both Dorchester and

Yeovil are likely to face significant challenge to recruitment and will be increasingly unsustainable financially. Medical advances, changes to medical training policy and a national drive to move care closer to home through investment in specialist community nursing and midwifery will reduce demand for consultant led facilities and availability of specialist staff in smaller hospitals.

With careful planning now, services for the populations served by Dorset County and Yeovil hospitals can be designed to meet the forthcoming longer-term challenges, and given their proximity, it is important that Dorset and Somerset CCGs work together across boundaries to explore whether strategic liaison is feasible. Both units are relatively small but their proximity suggests that combining into a single service, linked closely with a community nursing and midwifery model could provide the most appropriate care for the population. The combined provision in the west of Dorset / east Somerset would move towards consultant led obstetrics and inpatient paediatrics on one site and a PAU and Midwifery Led Unit (MLU) at the other, with the combined activity likely to attract outreach services such as surgery.

We recognise firstly that these are initial ideas, to be worked through with the respective CCGs and units, and that achieving this will be a significant task, requiring strong and supportive leadership right up the system as the units cross county, CCG, NHS England and Deanery boundaries, but also that any delays in decision are damaging to provision of a quality service. If within six months the Trust boards and CCGs have not developed an agreed plan and demonstrated commitment to this collaboration then DCH's maternity and paediatric teams would need to integrate with the east and move to the network model.

Neonatal provision for west Dorset should be at Special Care Unit (SCU) level for infants over 32 weeks' gestation, networked with both Poole and Southampton where there are experts available around the clock. These changes are not mutually exclusive and there may be other speciality skills that can be networked between the east and west sites.

The maternity and gynaecology services in the east (Poole and Bournemouth) should integrate immediately so together they can plan development of the service on a single site depending on which is selected as the Major Emergency Centre. This should be co-located with the paediatric and Local Neonatal Unit provision, taking infants from 27 weeks' gestation. This will also represent the major ED site so that children only attend where paediatric advice is immediately accessible if needed. If this site is to be located in Poole there must be urgent improvement to the physical environment of the labour ward.

Staffing

There needs to be an urgent plan to increase the number of consultant paediatricians and staff on the middle grade rota at Poole together with active steps to reduce urgent and unscheduled activity through implementation of the eleven 'Together for Child Health' standards. This presents a financial challenge in the short term, reflecting underfunding in recent years, Opportunities should be considered for rotation from DCH through Poole and/or Southampton to maintain competencies and develop a 'one Dorset' approach,

particularly around neonatal care. Investment is required in community paediatricians and community children's nurses across Dorset (and Yeovil) to reduce pressure on hospital services through community based chronic disease management and working with primary care to prevent some admissions and enable earlier hospital discharge.

Developing and increasing pan-Dorset midwife led care will require investment in training and recruitment of midwives. Such a model is generally easier in terms of recruitment and retention, but needs to evolve, albeit as swiftly as possible to provide the best care for women. Updating and urgent practical implementation of the CCG's maternity strategy for Dorset and the Clinical Senate's Maternity Vision for Wessex is required.

Changes in Practice

Maternity data for Dorset shows higher than average rates of Caesarean section and low VBAC (vaginal birth after Caesarean section) at both Poole and Dorchester, despite national and local policy drives to increase normalisation of birth. Reducing these rates is a whole-system issue that includes GPs and managing the expectations and information provided to parents. There are good initiatives across the county to strengthen midwife-led care and increase the home birth rate but these need increased impetus and support together with positive encouragement from primary care, the CCG and the obstetric teams, so the default pathway for women is for midwifery led care unless there are factors which preclude this. Creation of a midwife led facility at Dorset County Hospital and/or Yeovil is recommended in the short term irrespective of the longer term future of the units.

There is a clear benefit in keeping children out of hospital whenever possible, if safe advice and care can be provided more locally. This is facilitated by using short term assessment units, improving training in paediatrics in primary care and enhancing community paediatric nursing support. In the hospital setting an early consultant assessment improves decision making in clinical assessment and management.

The Process and its Management

Any structural change to how services are delivered requires a period of planning and development, particularly where physical building works are involved. Implementation of the CSR is likely to take between five and ten years, and services and the workforce will evolve during that time, with good planning meaning that the right specialist staff will be available to deliver the new arrangements safely and effectively. Staff engagement in the direction of travel, and what needs to be done when to achieve smooth transition is essential together with clear and honest explanation to primary care colleagues, the public and their representatives as to the rationale for change and the process involved. We would propose that an experienced project manager should be assigned to this work, supported by expert clinical advice, to lead the programme of change and associated communications across the four Trusts, with clear timescales and deliverables.

Previous attempts to create closer integration between local paediatric units have had only limited success but the CSR and Vanguard provide strong impetus. Bringing the teams together with skilled facilitation and clear respected leadership to focus on what is best for the whole population of Dorset is arguably the greatest challenge and most important recommendation of this report. If this can be successfully harnessed, with a clear, shared vision, the Review team is optimistic of significant long term benefits.

Dr John Trounce	RCPCH - Review lead- Consultant Paediatrician
Dr Anthony Falconer	RCOG - Consultant Obstetrician and Gynaecologist
Ms Kathryn Gutteridge	RCM - Consultant Midwife
Dr Nicholas Wilson	RCPCH- Consultant Neonatologist
Ms Carol Williams	RCN – Independent Nurse Adviser
Dr Clare VanHamel	RCoA – Consultant Anaesthetist
Ms Kate Branchett	Lay representative - Patient Voice and Insight Lead
Ms Sue Eardley	RCPCH Head of Invited Reviews

1 Introduction

1.1 The RCPCH was invited in August 2015 to conduct an evaluation and options appraisal of the maternity and children's services in Dorset as part of a Clinical Service Review (CSR) of all Dorset's hospital and community health services. The options proposed by the CSR for maternity, neonatal and children's services were felt by the clinicians to require more detailed analysis in order to reach a clinical consensus. The CCG therefore requested independent, professional advice from the Royal Colleges, led by the Royal College for Paediatrics and Child Health under its Invited Review programme.

1.2 The RCPCH is an independent membership organisation, established by the Privy Council as a charity and for this review is working in partnership with four other Royal Colleges which are similarly constituted, including:

- The Royal College of Obstetricians and Gynaecologists (RCOG)
- The Royal College of Anaesthetists (RCoA)
- The Royal College of Midwives (RCM)
- The Royal College of Nursing (RCN)

1.3 The Review team recognises and acknowledges the strength of feeling amongst maternity and paediatric staff and the general public about the changes proposed under the Clinical Services Review and their expectations and anxieties about their local health service. This review takes an independent look at current arrangements and makes recommendations around how care could be improved, including development of better local services and the right care as close to home as possible. It is crucial that clinicians, managers, patients and the public work together to co-design services based on strategic need, recognising the timescale for change and the importance of the whole range of care, not just hospital services.

2 Terms of reference

The terms of reference for the review, agreed by Dorset CCG and providers require the RCPCH together with the RCOG, RCM, RCM and RCoA to jointly:

- Conduct an independent review of the maternity, neonatal, and paediatric current models of care pan-Dorset, including Yeovil, evaluating the services based on safety, quality and sustainability
- Review the two CSR proposed models of care, using the evaluation criteria of safety, quality and sustainability, and considering for paediatrics and obstetrics¹
 - Remaining as at present - two separate services in east (merged) and west
 - A single networked service comprising two inpatient sites, using the Accountable Clinical Networks Approach)
 - Building resilience to enable proactive repatriation and outreach of tertiary services from Southampton including involvement of Yeovil in cross-border opportunities
- Recommend a safe, high quality and sustainable maternity and paediatric Dorset model of care(s) taking into consideration:
 - Risk factors on the current model
 - National Policy (the Five Year Forward View)
 - Best practice
 - Population health need/projections/demographics/inequalities
 - Workforce considerations
 - Financial sustainability

¹ this was originally agreed as “[Consider] A networked service for paediatrics and obstetrics (using the Simon Steven’s Accountable Clinical Networks approach), two inpatient sites in the east and west of Dorset – single integrated service with a commitment to ensure delivery of a two site model using the resilience of greater critical mass – this also offers the opportunity for proactive repatriation of services from Southampton and cross border opportunities (in particular Yeovil)” but has been redrafted for clarity

3 The Review process

3.1 The evaluation was conducted under the RCPCH's Invited Reviews process, including reviewer input from four other Royal Colleges. The project phases comprised:

a) Setup -

- two initial meetings with the CCG (three reviewers) to clarify the terms of reference, understand the progress of the CSR and finalise the approach and timings
- initial email/telephone approach to Chief Executives and/or clinical leads of the four units being visited (Yeovil, Bournemouth, Dorset County Hospital and Poole) explaining the review and seeking initial information about the services
- study of background documents, activity data and policies etc. relating to the services
- planning and setup of the first visit

b) First fact-finding visit – 12-14th October 2015 - comprising:

- interviews with staff, across the three services at the four Trust sites, including where available the community teams based at Poole and Dorset County Hospital.
- meetings / calls with other individuals who work with the services
- whole-team tour of the services at all four hospitals
- driving the journey between hospitals and towards the coast

c) Collating and reviewing evidence collected

- checking of facts, seeking additional data
- monitoring CCG progress in clarifying the options under review
- starting to draft the individual unit reports
- preparing for the second visit

d) Second visit – 7-9th December 2015

- Visits to Poole and DCH to explore in more detail the options for acute reconfiguration
- Whole-team meeting with CCG representatives to provide initial feedback and discuss approach and timescales
- Discussion with user representatives about their experience of services and understanding of the changes being considered.
- Visit to Southampton to meet network, senate and tertiary centre representatives.
- Driving the journey to Southampton

e) Report production

- Development of summary report outlining the options and the Review Team's views for discussion on 20th January 2016
- Development of other supporting documents
- Preparation of an overarching report suggesting a preferred option and steps required to implement it.
- Quality assurance and critical challenge (internal) of the report
- Draft report presented to client for accuracy checking
- Discussions with clinicians and management to clarify recommendations.
- Full report presented to CCG

4 Background and Context

4.1 The population and geography

4.1.1 This review focusses on the health needs of the women and children of Dorset, a county of around 750,000 people, with a skew in age profile towards the elderly. Pockets of significant deprivation are apparent in Portland and Weymouth on Dorset's south west coast (population 70,000) and around Bournemouth to the south east, and these communities have higher than average teenage pregnancy rates, poorer access to transport and arguably greater child and maternity health need. The child population (0-19) is around 157,000² with around 7,000 births per year. These figures are not projected to change significantly over the next few years although there is a programme of housebuilding in south west Dorset. Around two thirds of the population live near Bournemouth and Poole in the east of the county with one third living in largely rural settings in west Dorset. The review also includes consideration of Yeovil District Hospital, which has an all-age catchment of around 180,000 in South Somerset, North and West Dorset and parts of Mendip.

4.1.2 In terms of transport and access to services, there are good fast roads between Dorchester and Poole / Bournemouth, and relatively good access from Portland and Weymouth to those three major towns, but to the west and north of Dorchester access is more challenging with relatively few fast roads apart from the A37 to Yeovil and poor public transport.

4.1.3 A considerable amount of distance-to-services modelling work has been undertaken within the CSR and by DCH clinicians as part of discussions around reconfiguration. This data has been considered by the Review Team but is not reproduced in detail in this report. The data is helpful, but has limitations because:

- Patients do not always choose the closest services; although in theoretical planning terms proximity is important, in practice patients will travel to where they feel that the best and safest services will be provided, usually guided by health professionals.
- Arguments about service location tend to presume 'local is safe' – presuming every need is a time-critical emergency, neglecting the impact of modern paramedic ambulance teams. The counter argument that safety is improved by care being concentrated in fewer centres is supported by developments in management of stroke and myocardial infarction. With regard to maternity services the evidence to support decisions of proximity of care is not robust with more rigorous investigation needed³. All providers of service will remember individual cases where proximity of care improved outcome but finding objective evidence to support this is difficult.

² Public Health England child health profile June 2015

³ www.publichealthwales.org/maternityreview

Notwithstanding the above, equity of access is important and any redesign must recognise the impact of any changes on those families who will not or cannot travel long distances to services.

4.2 Current Services

4.2.1 There are four main hospital sites considered within this review.

- Dorset County Hospital NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Bournemouth and Christchurch Hospital NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust*

Other sites which care for, or could care for Dorset patients include

- Southampton University Hospital NHST
- The Royal Devon and Exeter NHS Foundation Trust, in Exeter*
- Musgrove Park Hospital, Taunton (Taunton and Somerset NHS Foundation Trust)*
- Salisbury NHS Foundation Trust

* within the South West Deanery, ODN and Strategic Clinical networks.

Table 1 - Distances between acute hospital sites - approx. miles (minutes*)

DCH						
25 (33)	Poole					
32 (51)	8 (17)	Bournemouth				
21 (32)	45 (58)	52 (77)	Yeovil			
55 (71)	79 (106)	86 (120)	50 (61)	Exeter		
46 (66)	70 (99)	78 (113)	28 (43)	31 (40)	Taunton	
40 (55)	31 (46)	24 (35)	48 (85)	93 (113)	73 (94)	Salisbury

*from Google, indicative only – minimum times are used

Table 2 - Activity 2014-5

Statistic / Unit	Bournemouth	Poole	Dorchester	Yeovil
Births	370	4400	1,957	1,538
ED attendance (0-18)	11,095	15,000	7,000	10,295
Emergency Admissions	N/A	7,600	,2869	1,969



Fig 1 – Map of Hospital locations.

4.3 The need for change and Clinical Services Review

4.3.1 In September 2014 Dorset CCG launched a review of all acute and community health services in the county to develop a strategy and plan for service change that would ensure all have access to care that is high quality and affordable.

4.3.2 The current arrangement is unsustainable in the longer term primarily in terms of the ability to recruit skilled specialist clinical staff across almost all medical specialties, but also financially in terms of staffing inefficiencies to maintain the current model. If suitable permanent staff cannot be recruited, either standards are not met, or expensive locum staff are recruited who may not provide full continuity of care.

4.3.3 The review process was clinically led and comprised five work streams including maternity and paediatric services. Each of the work streams looked across the whole 'pathway' of care including services in the community and what was, or could be available close to home as well as emergency and hospital care. As is usual in such reviews, however, the focus of public and clinical opinion tended to be on provision of hospital services, and the options for reconfiguring the three Dorset units.

4.3.4 At an early stage in development of the CSR there was agreement on out of hospital models for care including maternity and paediatrics:

- Multidisciplinary team working for antenatal care using community settings
- Single maternity clinical network with single point of access for telephone advice
- High quality consistent postnatal care, primary care and health visitors.
- Dorset-wide urgent paediatric network/service using NHS111 and integrated teams including specialist GPs or paediatricians to improve access to specialists including 'hot phones' urgent access clinics and access to diagnostics.

4.3.5 It was generally agreed by July 2015 that there should be one major hospital site in the east, (either Poole or Bournemouth site) with a large Emergency Department (ED) and 24hour access to emergency, trauma, diagnostic and inpatient care. The other east site may be a 'cold' unit with elective (non urgent) services, outpatients and day case care.

4.3.6 In the west it had been agreed that an ED and consultant led maternity care at DCH should remain, together with associated services to support their operation, but a 'networked' approach to paediatrics was proposed with the facility at DCH changing from inpatient care to a short stay paediatric assessment unit (PAU) open 16 hours daily with no overnight stays. Staff would be rotated across the east and west sites and children and young people requiring an overnight stay would be directed or transported to the eastern site.

4.3.7 Despite extensive clinical engagement at focus group and large meetings, the Dorset paediatricians as a whole were unconvinced that the proposals were either

workable or economically beneficial, due to the requirement for neonatal expertise to cover the maternity unit, concerns about the distances to access emergency paediatric care out of hours and the numbers of children who may need inpatient transfer late at night. The obstetricians recognised that the absence of 24hr paediatric / neonatal service would affect the range and complexity of obstetric care that could be safely carried out at the hospital, and reports and analyses were developed by the clinicians offering various points of view and proposals but without agreement. Progress on the CSR paused in July 2015 whilst input from strategic stakeholders was considered across a range of services and the opportunity was taken to approach the RCPCH to provide an independent view.

Vanguard

4.3.8 In parallel with the CSR and Review team visit, the opportunity arose in May 2015 for health teams to collaborate and seek NHS England 'Vanguard' funding, detailed in the Five Year Forward View. The application covering integration of several acute services including maternity and paediatrics was led by the Poole management team with agreement and support of the other Trusts and the CCG, and approval was announced in September 2015. The proposal supports the setup of integrated work programmes across healthcare providers with the intention that they were self-sustaining once established. At the time of the Review Team's visit the details of timescale and implementation were still to be confirmed, and the dichotomy of the DCH management signing up to a one Dorset model and the paediatric team looking to Yeovil was an interesting observation.

Developing One NHS in Dorset

Patient population: 850,000

The recent Dorset Clinical Services Review had a vision of sustainable models of care for in- and out-of-hospital care, to meet the needs of local people 24 hours a day, seven days a week. The three district hospital providers in Dorset (Dorset County Hospital NHS Foundation Trust; Poole Hospital NHS Foundation Trust; The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust) aim to use a multi-service joint venture to deliver this vision and ensure future sustainability of health services in Dorset.

Patients will benefit from a reduction in avoidable variations in care, the implementation of standardised best practice and the spread of service innovation. There will be a more equitable delivery of services to patients across the whole of Dorset, with the clinical network(s) organised to ensure that all patients have faster access to a consistent, high standard of care irrespective of where they live. It is envisaged that there will be movement to a single shared rota for some agreed clinical services across Dorset which will ensure the best use of senior clinicians. The creation of job plans that allow for the recruitment and retention of high calibre clinicians will facilitate the development of sustainable clinical models.

NHS England Vanguard website description

National and regional strategy

4.3.9 Alongside Dorset CSR, the Wessex region of NHS England has been developing (through its Clinical Senate and Maternity Children and Young People Strategic Clinical Network), a set of strategic principles for maternity and paediatric services in the region. These take into account national policy issues such as the NHS England 5-year plan. The maternity document has been released whilst the paediatric one remains in draft form pending further discussion and consultation but have been considered by the RCPCH in conducting this review.

4.3.10 Baroness Cumberledge led a national review of Maternity Services during 2015 which was published in February 2016. Where there are indications of a strategic view these have been taken into account.

Yeovil Hospital

4.3.11 The Review team was told that as part of the CSR proposals the CCG convened a discussion between senior clinical and managerial teams of DCH, Yeovil Hospital and Somerset CCG, but detailed strategic discussions had not taken place. Somerset CCG's key priorities did not include maternity and paediatric in the current plan, due to more pressing issues in the area. Inclusion of Yeovil hospital in the review terms of reference was proposed by Dorset CCG following comments raised by the Senate and by the clinicians at DCH.

5 Maternity and Gynaecology services

5.1 Obstetrics and gynaecology

5.1.1 The current provision for maternity services in Dorset comprises

- Consultant led obstetric units (CLU) in Poole and Dorchester (DCH)
- A freestanding Midwife led unit (FMU) in Bournemouth
- An alongside Midwife led unit (AMU) in Poole.

On the boundaries are small CLUs at Salisbury and Yeovil, larger CLUs at Taunton and Exeter and the tertiary service based in Southampton. There are neonatal units alongside each of the CLUs and these locations also provide gynaecology. Within the cancer framework Poole acts as a centre for surgical and radiotherapy treatment and planning for Dorset.

5.1.2 The quality of care received by women across Dorset appears high with examples of strong, dedicated and patient focused leadership for maternity services at all three sites. Despite the development of some good midwifery initiatives, it is, however, largely a medically orientated model with relatively high rates of intervention compared with national data and a focus on hospital-based care.

Table 3 - Birth statistics

	Bournemouth	Poole	Dorchester	Yeovil
Births	370	4400	1957	1482
Elective CS %	0	14.9	12.0	12.7
Emerg CS %	0	14.3	16.3	11.3
Total CS %	0	29.3	28.3	24.0
Instrumental %	0	14.0	13.1	10.5
Spontaneous	0	56.7	58.6	65.5
Induction	0	28.1	29.9	No data
Home Birth %	20	2	2	2
Baby Friendly accreditation⁴	Full	Stage 2	Full	Full

Source – BirthchoiceUK 2013-4 (2014-5 data awaited)

5.1.3 Healthcare is continually evolving with changing working practices of all healthcare professionals, progress in improving clinical care, greater expectation from the public and of professional standards, alongside demands for greater efficiency. Traditional infrastructures and working practices need to change to accommodate such progression and reconfiguration of some services may be one way to achieve this. Medical recruitment has not been an issue to date in any of the co dependent disciplines, reflecting the desirability of Dorset as a place to live and bring up a family, but the current modelling of medical staffing at Yeovil and Dorset County Hospitals,

⁴ A UNICEF indication of breastfeeding arrangements

either using non consultant staff or consultants to provide out of hours cover is not cost effective or sustainable, given the falling number of qualified consultants (CCT holders) and reduced opportunities for overseas doctors to work in the UK. Non consultant jobs are not attractive to the majority of the workforce.

5.1.4 There is general agreement that 45-50% of childbearing women in the UK could be cared for in a midwifery led environment without the need for immediate access to obstetric care, and the imminent unsustainability of the middle grade workforce means that the current model of obstetric service provision within Dorset is unlikely to be viable in the future. Regional vacancies and national workforce policy will further reduce the availability of non-consultant specialist doctors on whom the services rely, and there is a suggestion⁵ that in future training should only be provided in units delivering over 2500 women would make the units at Dorchester and Yeovil unviable as stand alone consultant led units in the longer term. The way forward was set out in Dorset CCG's Pan-Dorset Maternity Strategy 2014-19⁶ and the Wessex Senate Vision for Maternity Services.

5.1.5 Any change to services in Dorset must acknowledge the unusual demography of the population, the loyalty of staff and patients to their local unit and the important right of women to make choices about the location and type of care they would wish to have. For maternity care, most contact with health services is antenatally and there must be strong local provision of accessible, high quality out patient services that focus on scanning, early pregnancy assessment, ante natal monitoring and prompt access to clinical advice and decision making. Such provision is provided in Weymouth and Portland and needs to become a consistent Dorset-wide model to reduce the pressure on obstetric services and increase the take-up, consistency and confidence of midwife led and home births.

5.1.7 The presence of co dependent disciplines, neonatology, anaesthetics, surgery, medicine and imaging for maternity care in hospital are generally expected norms for consultant-led obstetric care, but whether such presence is needed as currently provided for 92% of the women delivering within the UK is very questionable. The NHS England Five year Forward View cites the Birth Place study⁷ which has demonstrated that midwife led provision is a safe option for many women with low risk pregnancies and that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so. It is important for all health professionals to 'normalise' maternity as the data suggests a strong medical influence on women's perception of safety and risk.

⁵ This is not a formal deanery requirement but 2500 is the threshold to recommend 60 hours consultant cover and was suggested in the 2012 strategic clinical network plan

⁶ see

<http://www.dorsetccg.nhs.uk/Downloads/aboutus/CCP/Maternity%20CCP/Pan%20Dorset%20Maternity%20Strategy%202014-19.pdf>

⁷ <https://www.npeu.ox.ac.uk/birthplace>

5.1.8. It is important to consider the elective and emergency provision of gynaecological services in any remodelling since these services are provided by the same consultants as obstetric care and separating such services reduces patient safety and creates on call complexities.

5.2 Midwifery Care

5.2.1 Within the Dorset region there is great potential to develop a strong culture of woman centred birth in all settings. The 7000+ annual births take place within traditional models of obstetrics and midwifery, but the current schedule of accommodation and site locations do not offer women and babies either a service or a vision for the sustainable future given changes to workforce. The draft Vision-Led Model for Maternity Services in Wessex supports a move towards a less medicalised experience for women and recognises the current unsustainability of the existing model.

5.2.2 The importance of good leadership in driving forward this vision should not be underestimated to secure and sustain the development of midwifery models alongside consultant led services. Women who receive midwife-led care are less likely to experience intervention and more likely to be satisfied with their care, and outcomes for women and their infants are similar or better than for those who received other models of care⁸

5.2.3 Future maternity services must be planned to address current challenges including the needs of vulnerable and disadvantaged families, the reduction in working hours of doctors as a result of the legislative, demographic and lifestyle changes. The principle that pregnancy and birth are normal life events supported by midwives should form the core of any service model.

5.2.4 Within Dorset there are examples of midwifery led care, but these appear to be limited and perhaps only available to the few rather than the many. Dorchester and Bournemouth have opted for a 'home birth' preference with the latter also running a freestanding birth centre. The women using these services self-select into the model and are cared for through integrated community midwifery, whereas Poole has developed a home birth team with an alongside birth centre and have adopted a low risk 'opt out' pathway.

5.2.5 The population of Dorset and south west Somerset need a range of maternity services that are accessible, safe and understanding of the geographical pockets of deprivation. The Review team suggest that future demand growth could ultimately be met with community based birthing units with care based on an ongoing assessment of social as well as clinical risk, and targeted outreach support for the most vulnerable women. Midwives should be the lead professional for normal pregnancies, with enhanced public health skills, a new support workforce and work within clear pathways to provide women with a network of social and clinical support. There should be rapid

⁸ Sandall J, Soltani H, Gates S, Shennan A, Devane D; Cochrane 2015
www.ncbi.nlm.nih.gov/pubmed/26370160

and equitable access to specialist services for high risk mothers and babies. This should result in improved satisfaction, stronger engagement with self-care support systems, fewer interventions and improved perinatal mortality.

5.2.6 This high level model is supported by clinicians and is in line with national policy and workforce modelling, but is dependent upon significant development and embedding of midwifery led care, an extensive programme of training and competence development, robust emergency transport services and a massive programme of engagement and re-education of clinicians and the public about risk, safety and the effect of distance on clinical outcomes.

5.3 Towards a remodelled service

West Dorset

5.3.1 There remains a need for consultant led care in labour for some women, although within 5 -10 years the current number of small units (such as Yeovil and Dorset County Hospital) is likely to become unsustainable, with obstetric units likely to centralise to cover a birth catchment of at least around 2500 or more each. For Dorchester this means that the obstetric team must integrate with either the eastern site team to offer a pan-Dorset model but may also link more closely with Yeovil in order to maintain a single sustainable consultant-led service over the next 5-10 years. With the capacity at Poole labour ward currently insufficient to accommodate significant additional activity until the creation of the new Major Emergency Hospital, there is a 'window' of 3-5 years to begin to work together in new ways, plan, recruit and train the relevant staff and implement a structured plan for women-focussed service change and improvement.

Working with Yeovil

5.3.2 Yeovil still maintains a traditional on call medical model with a consultant, middle tier (non-training grades) and Tier 1 (SHO) rotas. Such a model has many attractions but it is a high investment for a small unit and is unlikely to be cost effective or sustainable in the long-term. In contrast the DCH obstetric team use consultants to supplement out of hours presence and provide on-call.

5.3.3 The Review team explored the potential to join up Yeovil and Dorchester services in a formal collaboration with, in the longer term, one CLU and one MLU supporting west Dorset and south east Somerset. The units are 21 miles apart or 32 minutes by road, but traditionally Yeovil`s complex and/or tertiary activity transfers west towards Musgrove Park and Bristol and DCH`s patients go east to Poole or Southampton.. The total births currently is around 3500 which would be viable for a single unit, but depending upon the location some women would choose instead Poole or Taunton as a closer unit., and some would opt for midwife led care at the other site.

5.3.4 This option needs to be thoroughly explored with careful communication to see if it could provide the best overall care for the catchment of both units. It would offer the

opportunity to practise midwifery in larger teams with consistent policies and increased flexibility for practice. The hospital with the CLU could also perform all in patient gynaecology, reducing the consultant rota tensions, while the non-CLU unit could provide all other functions including AN assessment, EPU, Day theatre, colposcopy etc.

5.3.5 This vision is supported by Yeovil Hospital's Five Year Strategic Plan which states that whilst there is internal pressure to move to a Midwifery Led unit, it is proposed to work collaboratively with neighbouring trusts to offer a safe shared care type model for more complex cases.

5.3.6 In practice, achieving this change will take immense managerial and clinical negotiation. The two sites operate with very different cultures, and there is extensive evidence of failure of such service mergers associated with clinical differences and resistance to change. Some women (and staff) will feel aggrieved at having to travel further for consultant led care, and some on the periphery of the catchment may choose to go elsewhere. The external stakeholders (South West networks, Somerset CCG, South West Deanery) are likely to scrutinise change that affects pathways of care for Somerset residents. These two hospitals are vulnerable from a number of disciplines and therefore without the full support of both Trust boards such a move could be seen distractingly as a win-lose for one of the Trusts instead of focussing on the overall benefit to the population.

5.3.7 If a detailed feasibility study indicates that working with Yeovil is not viable, DCH and Poole / Bournemouth would need to move towards a single, networked obstetrics service with all consultants covering both sites, and contributing to the high risk labour ward rota. This would maintain the clinical skills of all staff, and utilise their expertise across all of Dorset. Flexibility in new consultant contracts, and phased implementation over two or three years, would allow the changes to be introduced in a positive manner. In the longer term the service at DCH would gradually move towards an MLU with daytime consultant presence perhaps carrying out low risk Caesarean sections⁹, antenatal and early pregnancy care and day case gynaecology services. Locally based staff could provide the majority of care at DCH, reducing the impact of travel and initially providing safety net on-call cover until the new arrangements are up and running.

East Dorset

5.3.8 The centralised model proposed within the CSR in the east would provide midwife-led and consultant-led care at the major emergency site for about 5000 women, with all the co dependent disciplines including co-located ITU, interventional radiology, anaesthetics, surgery and 24hr paediatrics/ neonatology in either a new build at Bournemouth or refurbishment at Poole. This catchment may be increased depending upon which site is chosen and whether the service at Dorset County Hospital continues to provide full consultant led care through integration with Yeovil.

⁹ This is a model that is provided in some remote and rural units but would need very careful risk assessment and safety net planning.

5.3.9 According to RCOG standards¹⁰, a birth catchment of 5000 would still have insufficient activity to justify 24 hour consultant labour ward cover. However, despite the predicted fall in obstetric training places in future it is likely that sufficient numbers of trainees will be allocated there to provide a hybrid model of on call, where some duties are consultant delivered and some trainee delivered with consultants available on call.

5.3.10 This Review is not expected to identify the preferred site in the east for development of the hub service, as other factors will influence selection of the Major Emergency site. However we would make the following points.

5.3.11 Centred at Poole – Whilst Poole has significant clinical and operational management experience of running a maternity service; it would require considerable rebuilding and reconfiguration on the existing physically limited site plus enabling works for other services if this was the major emergency site. The maternity unit together with neonatal care would need to be relocated on the main hospital campus (whether the MLU should remain at St Mary's would be an early clinical decision). The site is closer to the deprived communities of Portland and Weymouth providing greater choice of care if DCH becomes unsustainable as a CLU, and reducing staff journey time for outreach clinics

5.3.12 Centred at Bournemouth - This would require a new build with the opportunity for bespoke design, and may be a financially more viable capital cost. The site is accessible and would be closer to areas of greatest deprivation, but adds another 20 minutes to the journey from western and southern extremities of Dorset compared with Poole. There is likely to be some drift of the population from Southampton due to its greater proximity. This option strengthens the importance of DCH as a local hub for the remote rural communities both in terms of emergency cover and for hospital –based assessments and investigations.

5.3.13 It is important to remember that the staff who have provided care in Poole will be the same staff in the new unit – negative messages on social media raise unhelpful anxiety in the public. Therefore effort is instead needed to ensure co-design of the ideal new unit with those who are likely to be anxious – namely the staff and women who may be using it in future. The experience gained by Poole Hospital of successfully managing maternity and paediatric services will need to be protected and harnessed for the future whatever the final model.

5.4 Looking to the Future for Dorset Maternity Services

5.4.1 In the shorter term there should be agreed targets and a clear, measurable plan for increasing home /midwife led /normal births and establishing a project specifically to tackle the CS rate. (e.g. NHS III packs). This work links to the Dorset Maternity strategy but will require investment and or inclusion in the Vanguard to provide initial resource.

¹⁰ <https://www.rcog.org.uk/globalassets/documents/guidelines/labourwardsolutiongoodpractice10a.pdf>

5.4.2 Midwives in the region should start to develop networks that enable women to choose their point of entry into maternity services from local venues which are accessible and conveniently placed such as children's centres, shopping centres, schools and sports/health clubs.

5.4.3 Midwives could accept self-referrals into maternity and also work with other professionals such as pharmacists, school nurses and a range of paraprofessionals who are part of the wider maternity health network. It is important to develop an IT infrastructure that allows midwives to document, record and access health information. There is a strong case for encouraging women to access e-booking systems allowing them to reach maternity quicker.

Suggestions for Midwifery Development:

5.4.4 In reaching consensus on the Dorset wide maternity service midwives and their leaders must begin the change process now, to make those transitions easier in the longer term. This may involve recruitment and/or training of additional staff. The workforce challenges for midwifery may seem less difficult given the proximity of Bournemouth University, with its national and international reputation in midwifery training, but there is much to do immediately to make these changes happen strategically. Discussions should start with the university to explore the challenges to produce midwives for community working, and courses for those with nurse training to become midwives. Support of the local LETB and wider support workforce would need to be considered in order to build a secure midwifery workforce that is committed to community working in Dorset.

5.4.5 Bringing midwives together to develop a shared/ updated maternity strategy/plan for Dorset (with/without Yeovil's catchment) should enable staffing, clinical development and leadership to be embedded alongside the other changes and ensure the involvement of women using the services.

5.4.6 The use of a Dorset wide midwifery model of care provides a great opportunity for the resurgence of a 'Domino' scheme where community/integrated midwives see women throughout the antepartum period, assess women at home when in labour and if they remain low risk go with them to the nearest birthing facility/centre. The midwife then cares for the woman throughout labour and manages her care at home once she is delivered. This has great benefits for outcomes and satisfaction levels, but the cost/benefit of such a service would need to be carefully examined.

5.4.7 In the meantime there are some practical suggestions to support a Dorset-wide midwifery service, including

- Specific Programmes of Care – optimising normal birth and midwife led VBAC.
- Involvement of Student Midwives in service development
- Community Midwifery Forum.
- GROW Programme
- Equity for Women
- Shared Governance
- Training and Development Events

6 Neonatal care

6.1 Neonatal Network

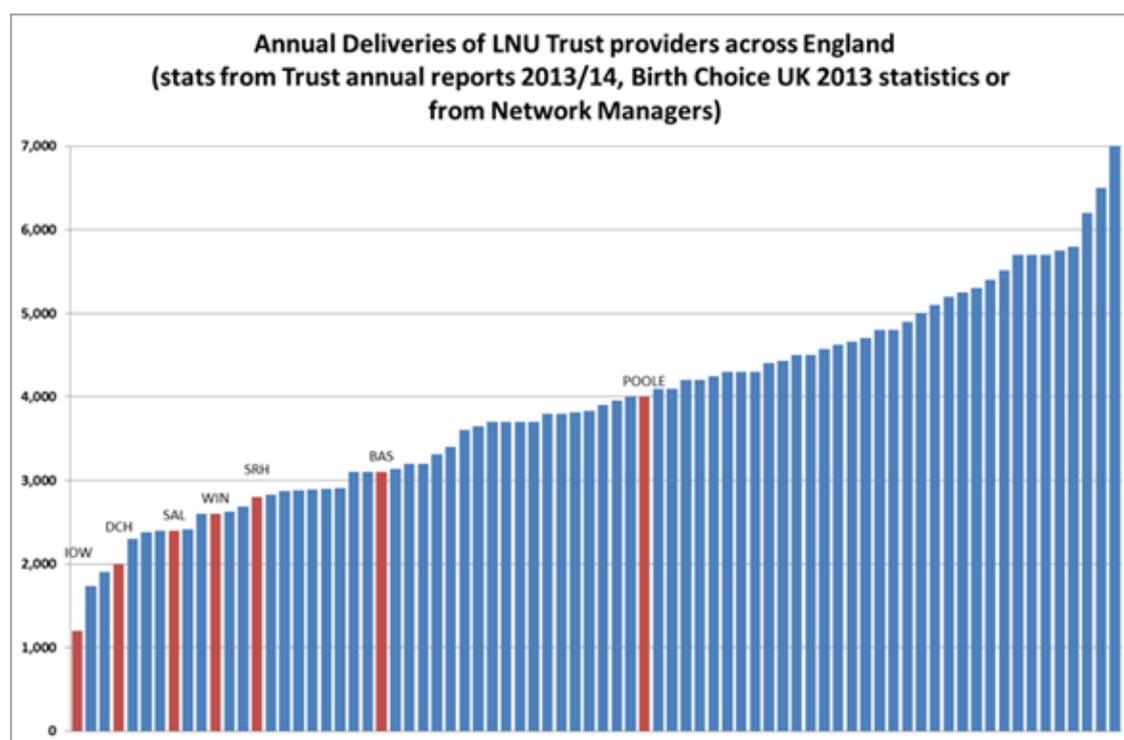
6.1.1 The Clinical Senate and the Thames Valley and Wessex Neonatal Operational Delivery Network (ODN) are well established with good governance systems and a clear vision for improvement across the network, to comply with BAPM and NICE professional service standards. The network comprises two NICUs in Portsmouth and Southampton and seven LNUs, which include some of the smallest such units (by birth-rate) in the country (see fig below). The neonatal retrieval service was recommissioned in July 2015 and is run out of Southampton (alongside the Paediatric Intensive Care service) and Oxford, with early indications that it is meeting all time-based targets.

6.1.2 The ODN have put forward clear and convincing arguments for the neonatal unit at DCH to be formally designated as a Special Care Unit, reaffirming the South West network designation from 2012 and supported by the Wessex Clinical Senate. This designation is based upon comparators for other small hospitals in the region, and work is under way at other sites towards centralisation or reclassification. The rationale cites

- Non-compliance with out of hours medical cover
- Concerns about maintenance of medical skills
- Low levels of activity including numbers of very preterm births to maintain skills

6.1.3 Although small units such as DCH may be cited as 'safe', i.e. not reporting any serious recurrent adverse events, they are not the best model of care and there is general discomfort amongst neonatal specialists regarding small units managing very low birth weight babies (less than 1500g). There is growing evidence that outcomes for these infants are better in level 3 NICU, and this is now on the basis of several large studies looking at survival and disability. These studies can be criticised for the statistical methods used and the lack of good long term data on normality post neonatal care. However consolidation of care for these babies is generally supported, including within the various standards which are referenced below¹¹ and in the Appendix. It provides a focus for clinical expertise and training, allows greater opportunities for research, more cost effective rolling out of new technology, and better access to specialist services such as Occupational Therapy, Physiotherapy and Psychological support.

¹¹ BAPM *Optimal Arrangements for Neonatal Intensive Care Units in the UK Perinatal outcomes for extremely preterm babies in relation to place of birth in England: the EPICure 2 study* - N Marlow,1 C Bennett,1 E S Draper,2 E M Hennessy,3 A S Morgan,1 K L Costeloe4,5 - Marlow N, et al. Arch Dis Child Fetal Neonatal Ed 2014;99:F181–F188. doi:10.1136/archdischild-2013-305555



6.1.4 Re-designation is likely to affect a relatively small number of infants per year. Current data shows the number of infants under 32 weeks gestation currently cared for in DCH numbers fewer than 25 per year, who would need to be cared for, at least initially, in Poole. Transfers in utero are best for the infant, so the obstetric and midwifery teams at both units would need to engage with the changed arrangements. A rule of thumb is that up to three times those that actually deliver are ‘false alarms’ with women transferring to the specialist unit with anticipated labour then returning without having delivered. Whilst Poole has capacity for the neonates within its LNU it faces some pressure on the capacity of the labour ward so close working will be required between the teams and clear communications with prospective parents to manage the pressure on Poole’s labour ward and provide care for those women in premature labour transferred from West Dorset.

6.1.5 The process of migration will require discussion and agreement amongst obstetric colleagues in Poole (for women in labour over 27 completed weeks gestation or 28 weeks for multiple births) and Southampton/ Portsmouth for women in possible labour under this gestation. These units have indicated that they are ready to co-operate with this networked arrangement and the recently recommissioned transport service has capacity to manage ex-utero transfers. Further discussions with the South West Ambulance Service are however still needed to model the in-utero urgent transport.

6.1.6 Even with the neonatal unit changes, most infants born at DCH who require neonatal care would continue to be cared for on the DCH site. Some highly skilled staff such as the consultant neonatologist and the ANNPs are likely to prefer to work in larger, busier units and rotation of staff between units should be part of job plans in order to maintain skills. The ODN has initiated a good scheme for recruiting and training neonatal nurses supported by HEE in Wessex and including a preceptor

programme and clear competency monitoring and development, and nursing staff work together well across the network. The NICUs were reported to be keen to support rotation of staff from smaller units through their facilities but there appears to be a challenge getting them released from their home unit.

6.1.7 The RCPCH concurs with the ODN view that Poole has the capacity and capability to extend its LNU activity and accommodate infants from Dorchester as well as providing step-down care from Southampton. At the present time, Dorset infants tend to go home directly from Southampton but the ODN is examining whether they could be transferred locally first as part of a network repatriation pathway, and DCH could of course have capacity to care for Dorset infants who are well enough to return.

6.1.8 Neither the Poole nor DCH neonatal services offer transitional care or neonatal outreach to encourage parents to confidently care for their infants and expedite discharge home. A networked arrangement of Dorset-wide neonatal nurses within the proposed community children's nursing team could reduce activity in the SCU and improve outcomes and quality of care for the infants.

7 Paediatrics

7.1 General

7.1.1 Across paediatric services there is an enthusiasm to provide the best care for children and families and recognise the evolution of health care. Amongst the population there is rightly an expectation of high quality, consultant delivered care, but this must reflect advances in practice, the challenges of staffing, evidence around out of hospital provision and financial constraints.

7.1.2 Across the nine CCGs in the region, the Maternity and Children Strategic Clinical network has been developing the 'Wessex Healthier Together' programme, designing pathways of paediatric care across primary and secondary services and focussing particularly on reducing acute admissions. Work to date includes fever, head injury, asthma and abdominal pain guidelines, and relaunch of a network for community children's nurses.

7.1.3 Following development of the maternity strategy, the network is developing a strategy for children and young people's health focussing on five key challenges including:

- Care for vulnerable families / public health
- Access to child and adolescent mental health services
- The changing demographic of the child population
- Decreasing confidence of parents and professionals in managing acute illness in U5s
- Ensuring effortless multiagency working to meet safeguarding needs.

7.1.4 The strategy is likely to acknowledge that provision of consultant-delivered care in district general hospitals is an 'expensive' model which cannot be justified in smaller units with low numbers of inpatients, and that across the Wessex area there should be four main inpatient units, with Dorset considering how services for the rural west of the county should be provided.

7.1.5 The original CSR process primarily raised two options for the east and west services, namely

- no change in current provision against
- reconfiguration to a single inpatient service in Dorset for paediatrics and obstetrics / gynaecology working in partnership with a PAU and MLU at the second site.

As part of this review process the Terms of Reference also asked the RCPCH to consider whether Yeovil Hospital could / should be part of a reconfiguration.

7.1.6 In policy terms the overall direction of travel is towards less care in hospital and much more provision closer to home. Indeed the RCPCH argues that

'Not only are some emergency department and hospital admissions unnecessary, they may even be harmful. Admission to hospital can result in additional morbidity such as hospital acquired infections as well as distress, disruption and cost to children and their families (separation, school absence, travel time and travel cost). They are an unnecessary and wasteful high-cost intervention in a resource-limited health service. We need to consider whether some episodes of acute illness could be safely and better managed without a visit to an inpatient ward by using alternative models of care and providing better connected care in the community'
(Facing the future together for child health RCPCH 2015)

7.2 Current arrangements

7.2.1 Details of the individual units are set out in separate reports. The paediatric service in DCH appears to be working well, with a positive approach amongst staff, few recruitment issues and patients seen relatively swiftly. DCH provides a high quality, largely consultant delivered service, with the paediatricians clearly committed to the service. They stress the merits of consultant opinion, and more judicious use of investigations, and consultant-led care should reduce admission rates and length of stay. There is good anaesthetic support for emergencies, with the Paediatric Intensive Care Network reporting good engagement with trauma care and skills and drills training, and DCH is a designated trauma unit for adults and children. The unit does not meet all of the Facing the Future Standards 2015, nor the networking implications of the RCPCH's 'Small and Remote' standards and given its role as the provider to the more socially vulnerable populace of Weymouth / Portland there is a natural reluctance to embrace any suggestion of change.

7.2.2 Poole is an extremely busy unit where services for children, in particular the acute and emergency admissions, are often over stretched, with the PAU full and long waits to see a doctor. There are serious middle grade recruitment difficulties, with the consultants needing to act down to cover gaps, and two consultants no longer cover overnight on call. The Trust has recognised these pressures, and is appointing an additional consultant and two clinical fellows to cover the on call arrangements but this will not address the overall demands on the service. There remains a positive culture despite the pressure on staff - there is an ethos of "going the extra mile" to keep the service going and the recent staff survey results reflect this, but the longer term pressure is unsustainable. Nurse staffing in children's services does not meet the Royal College of Nursing standards¹² with shortfalls in nursing numbers in all in-patient areas, risking burnout and high sickness levels in the nursing team. Overall the unit appears to be extremely stretched with insufficient resources to expand and develop significantly.

7.2.3 There are very limited services for children at Bournemouth Hospital with urgent and emergency paediatric cases attending the ED being referred or transferred to the

¹² (RCN (2013) Defining staffing levels in children's and young people's service

Poole site. Although we did not hear of any significant safety issues this arrangement is inappropriate. Whilst inpatient ophthalmology activity would best be located with other paediatric inpatients, day case activity needs to remain with the adult service due to availability of specific theatre equipment which is used for adults and children and support staff such as orthoptists who are based with the adult service.

7.2.4 Yeovil is the smallest of the paediatric services that we visited and the 22 bed inpatient ward includes a dedicated 8 beds for young adults up to the age of 24 years. There is a 3-bed PAU based in the ED department and a larger assessment unit is at the planning stage. The unit is relatively well staffed with Consultants, middle grade and SHO tiers and they report no difficulty with recruitment. There is an integrated acute and community service. The site is linked to the South West neonatal, maternity and child health networks and tertiary services are provided from Bristol.

7.2.5 The Review team saw only early stage initiatives at the three sites to increase acute work in the community, for example by specialist nurses for asthma, diabetes, epilepsy, oncology and palliative care, and acute hospital at home and GP support services were not well developed. There was an emerging scheme at DCH being developed by one consultant working with a GP partner in Blandford to look at better collaborative working, but the standards in the RCPCH's 'Facing the Future Together for Child Health' had not been considered meaningfully at either site. The nursing teams across Dorset have been developing some joint working in order to provide 24 hour palliative and end of life care but this is not yet fully operational in the west. They have signed up to joint standards and recognise the need to work more closely together, but the challenges of providing the day to day services prevent this due to limited nursing numbers and investment of around 15-18 community children's nurses is required to develop the services fully across Dorset. The nursing team from DCH have developed some limited links with Yeovil.

7.2.6 The current arrangements of paediatric provision are not viable in the long term. All units fail on at least one of the RCPCH Facing the Future standards and the alternative RCPCH 'Small and Remote' standards define a level of networking and rotation with other units that is not in place in DCH or Yeovil. There is an urgent need for investment in additional consultants in Poole to meet demand and centralisation of the paediatric emergency and elective service between Bournemouth and Poole to move to a single ED and co-located paediatric services has already been agreed. All units demonstrated a high level of commitment and pride in their services indicating a desire to provide the highest standard of care that they could, and most recognise the need to expand community paediatric and children's nursing services but cite insufficient resource to develop this service.

7.2.7 However as trainee numbers reduce over the next ten years, small units such as Dorchester and Yeovil are likely to lose the trainees that they currently have, and future consultants may be less amenable to a resident consultant model. Small standalone

units are likely to become unsustainable both financially and in terms of compliance with standards and creative approaches to staffing, together with effective partnerships with major providers will often be crucial to ensuring delivery of quality services¹³.

7.2.8 Financial pressures are predicted for all the units in Dorset over the next two years and although reconfiguration should not be viewed as a cheap option it may raise opportunities for future financial savings.

7.2.9 Although local provision is often seen as the gold standard of care this must be balanced with the importance of sufficient throughput of patients to help maintain skills and also recognition of improved outcomes for some conditions. Local provision should also be considered in terms of community and ambulatory models of care rather than focusing on in-patient provision. To this end some reconfiguration may improve quality and also support sustainability.

7.3 Services in east Dorset

7.3.1 It has already been accepted that significant improvement in quality and safety will result from co-location of all inpatient services treating children at Poole/ Bournemouth on the site of the major Emergency Hospital. Paediatrics will need to be collocated with the consultant obstetric service, neonatal unit, anaesthetics, surgery and diagnostics.

7.3.2 This would conflate children's ED into a single larger team and the high (23,000+) paediatric attendances would justify additional standards-based benefits such as a Consultant with subspecialist training in paediatrics and a play therapist¹⁴. In addition the current ophthalmological surgery in children would be best undertaken with full paediatric services on site as well. Combining emergency care at a single site reduces the current risk to children attending the Bournemouth unit who would benefit from a paediatric specialist opinion or further investigations. Depending on the provision designed for the 'cold' site, nurse-led minor injury care for children linked to the major emergency site would ensure timely care, closer to home for many families.

7.3.3 Whilst it is not within the remit of the review to determine the location of the Major Emergency site that would host paediatrics, there are benefits and risks to each.

- At Poole there is adequate clinical accommodation in the short term for current demand but rebuild may be required in the longer term depending upon the model in the west and community-based initiatives to reduce hospital attendance. This would not be easy or cheap, and accommodating the ED capacity is unlikely to be feasible on this site. The site is closer than Bournemouth to the deprived communities of Portland and Weymouth providing greater choice of care if DCH becomes unsustainable, and reducing staff journey time for outreach clinics. However access

¹³ See 'Facing the future - smaller acute providers Monitor 2013

¹⁴ Intercollegiate standards for urgent & emergency care for children and young people RCPCH 2012

to emergency care for Bournemouth's families would be more challenging, and may increase risk for those children.

- Centralising on the Bournemouth site would require a rebuilt unit, and provide the opportunity for clinically-designed creation of a spacious paediatric assessment and inpatient unit with capacity for parental accommodation and provision of the LNU. This may be financially more viable and efficient in capital cost/project terms compared with in-situ construction on the Poole site. The Bournemouth site is accessible and would be closer to areas of greatest deprivation, but would be less local for many of the families using the service and adds another 20 minutes to the journey from western and southern extremities of Dorset. Choice of this site, despite logical argument, would be perceived to be a significant take over by Bournemouth at the expense of Poole which has been providing outstanding care. Therefore, such a move would require outstanding managerial and medical and midwifery/nursing leadership. In addition the closer proximity to Southampton might be perceived to be a threat to tertiary services.

7.3.4 Whichever site is chosen will require a rebuild of the facilities and integration of the ED teams and the management required to enable this must not be underestimated. Although at Poole and Bournemouth the quality of care, leadership and commitment of all medical and nursing staff is very high, the current arrangement introduces unhelpful barriers to communication and care pathways, particularly around emergency care and is organisation rather than child focussed. Given the longer term vision for one site in the east, the merger of the teams must begin now with a shared purpose to plan together the move to a single site, recognising the expertise within Poole for managing paediatric services. This would enable a single set of procedures and policies, and streamlined governance, with clear and consistent messages to families regarding what to expect.

7.4 Services in west Dorset

7.4.1 The communities in West Dorset feel remote and see DCH as the hub of healthcare for sick children and those with long term or acute conditions. Increasingly national policy direction is towards investment in community children's nursing and the principles of 'Facing the Future Together for Child Health' and 'NHS at Home' nursing standards to reduce dependency on hospital care and improve local access to paediatric advice for families in disadvantaged and rural communities.

7.4.2 The CCG should encourage and commission for a more integrated approach to child health pathways, including upskilling health professionals such as GPs and community children's nurses to support families with chronic or urgent healthcare needs, reducing pressure on the DCH acute service.

7.4.3 The proximity of Dorchester and Yeovil, both of which host small inpatient paediatric units, could lend itself to formation of a larger medium sized inpatient service

at one site and a PAU at the other. This would strengthen provision for west Dorset and east Somerset, improve quality and provide a more sustainable service, particularly when aligned with obstetric reconfiguration on the same lines. Yeovil and Dorchester are 21 miles apart or 32 min by road. There is potential to develop outreach paediatric surgical services from Southampton at the inpatient unit, provide cover for neonates as required and there would be sufficient activity for a middle grade tier of doctors. Consultant job plans would need to reflect availability for oncall and rotation and the units would need to link with the networks to develop arrangements that could be sustainable for both units, including paediatric surgery, cross-cover for remote telephone advice and skills/drills training. There has been some constructive discussion between the two units re working together but very limited progress towards a functional model.

7.4.4 The management and political challenges to implement such a model would be immense across both CCGs and Trusts to overcome the ‘competition’ culture and service boundaries and focus on the best care for the children in the combined catchment. The cultures of the two units are very different and working together would need to be a carefully facilitated longer term plan requiring strong leadership, good governance and commitment from all. Artificial barriers such as county and CCG boundaries should not be allowed to block such change if it is deemed to be beneficial for patient care¹⁵.

7.4.6 The inpatient site would depend on consideration of distance between the service in the east (Poole or Bournemouth) and Taunton as the next inpatient provision to the west. A consultant-led PAU and regular outpatient clinics could be provided at the other site with the PAU operating between 9 till 9 or similar service as numbers overnight are unlikely to justify provision when the other unit is 32 minutes away. Careful modelling of attendance times and numbers would allow definitive decisions on this.

7.4.7 This proposed collaboration should not inhibit units in the east and west working together with the opportunity for more subspecialty development and useful sharing of skills across the network. Currently one Poole consultant does sessions in DCH, and the community paediatric teams work closely together across the county but there may be further opportunities to extend this liaison.

7.4.8 If agreement for strategic liaison between YDH and DCH is not agreed by the Trust Boards and CCGs within six months then the plan should revert to the CSR proposal of a network across Dorset with a longer term goal of a single inpatient unit, likely placed in the East, and a PAU and MLU in the West at Dorchester. The prospect of a ‘children’s network’ which combines the acute and community paediatricians and children’s nurses in Poole and Dorchester, is an attractive vision for some of the Poole

¹⁵ NHS England Five Year Forward View October 2015

and Dorchester teams enabling a flexible arrangement across a range of services and is supported by national policy.

7.4.9 There is currently very good cross site working amongst community nursing teams across Dorset, with the Matrons liaising regularly and this must continue to be encouraged. There is a cross site bimonthly child death review meeting and end of life care is provided Dorset-wide with joint teaching and education. We were informed that there were good links between the CCN teams, especially for those children on the borders between east and west. Student nurses work across both sites and study days are offered across the county. The nurses reported that they recognise differences such as in the use of COAST and PEWS and have discussed these.

7.4.11 The CSR proposes development of the community children's nursing team towards implementation of national policy. Although it may not reduce costs in the short term, it would be based on provision of comprehensive community services across a wider timespan each day and reduce demand on acute services. Implementation of this model must consider what is best for the population, what would deliver a safe, responsive and high quality service and strengthen acute provision particularly for the deprived populations across Dorset. As the service develops, acute inpatient activity should fall. As a consequence the viability of full 24hr consultant presence at DCH would be questioned, with a shift towards advanced paediatric nurse practitioner-led low acuity overnight accommodation with a daytime consultant- led PAU and outpatient service.

7.4.12 Under this network arrangement, locally based staff would still provide the majority of daytime care at DCH, reducing the impact of travel and initially providing safety net on call overnight cover until the new PAU arrangements are up and running. For emergencies, a strengthening of ED skills and capabilities may be required in terms of stabilisation and spotting the sick child requiring transfer to the east site if presenting overnight. In this situation the greatest risk is availability of the ambulance service for emergency transfer and the Review team was unable to engage with the ambulance service within the duration of the review. If there is a risk, or public concern about emergency transfer, one solution could be provision of a dedicated ambulance service to transfer labouring women and children from DCH to the east site as a 'safety net'. Such a model has been working effectively with excellent data since July 2014 between units in Pembrokeshire and Carmarthen, a distance of 32 miles, 45-55 minutes but this is an expensive option to use in the longer term. .

7.4.13 Phased introduction of a strengthened community nursing service and PAU at DCH might help to support medical activity, but will require investment in development of advanced paediatric nurse practitioners which would take between 2 and 3 years unless APNPs can be attracted from elsewhere. Examples of effective community children's nursing services include Nottingham, Oxford, Newcastle, Liverpool and Islington which all provide 7 day services, using a variety of models.

7.4.14 At the east site, the increased activity could justify enhancement of a fully funded HDU¹⁶ (level 2 unit) and other more complex care, improving the ability to recruit and retain junior staff and reducing the need for transfer to the tertiary service at Southampton. The inpatient units would be large enough to develop high quality specialist services and achieve appropriate quality standards.

Facing the Future Together for Child Health Standards

1. *GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.*
2. *Each acute general children's service provides a consultant paediatrician led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made.*
3. *There is a link consultant paediatrician for each local GP practice or group of GP practices.*
4. *Each acute general children's service provides, as a minimum, six monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.*
5. *Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week for advice and support with visits as required depending on the needs of the children using the service.*
6. *There is a link community children's nurse for each local GP practice or group of GP practices.*
7. *When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers.*
8. *Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.*
9. *Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.*
10. *Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.*
11. *There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.*

¹⁶ See 'Time to move on' PICS 2014

7.4.15 Any reduction in inpatient facilities in the west could create some access difficulties, particularly for those in the Portland area where public transport is reported to be poor and car ownership relatively low. However, most children will not require an overnight stay. With clear arrangements for urgent and emergency care, communicated to all Dorset families and primary care staff, and facilities for parents to stay overnight if their child is a long way from home, then such a model would provide safe, high quality care, for those few children who require it.

7.4.16 Irrespective of the acute reconfiguration, investment is needed in community paediatrics to deliver timely assessments and statutory functions. A networked service aligned to the acute teams and community nursing would facilitate development of an efficient and effective service.

7.4.17 The Review team also considered the possibility that with low population and good community nursing and primary care services there may eventually be no need for an inpatient unit in the west, with both Dorchester and Yeovil reconfiguring to PAU / MLU status, a single large inpatient service in the east (Poole or Bournemouth) and inpatient services in the west based in Taunton. With some families being over an hour away from an inpatient service in this scenario, implementation would require significant investment in emergency and public transport services, and may affect the availability of staff prepared to travel.

8 Transport, emergency care and the safety net

8.1 Swift ambulance transport is critical to each of the models considered and the public tend to perceive close as safer irrespective of complexity. As reconfiguration, or rather evolutionary reshaping of services, proceeds, the impact on the ambulance services should be monitored closely in case additional training of staff, or redeployment of vehicle base stations is required. SWAST maintain detailed service statistics and it is important to ensure that the public and the clinicians requiring urgent transfer maintain confidence in the ability of the service to tackle emergency situations swiftly.

8.2 The public, and some clinicians including the Paediatric Critical Care network have expressed concern that the loss of in-patient paediatric beds at DCH could decrease the ability of staff to offer stabilisation of critically ill children. This was considered by the Senate Council and the Critical Care Network given that DCH is a designated Trauma Unit for children. Whilst overnight inpatient care is not a requirement to maintain Trauma Unit status the RCPCH would concur with their view that planned reconfiguration must include assessment of competencies and skills and where necessary would require strengthening of emergency teams and anaesthetic skills including simulation and rotation as part of their professional obligation to maintain emergency skills for all ages. There are examples of services elsewhere where critically ill children were stabilised by ambulance services and district hospital emergency teams, and the option of a 'Dedicated Ambulance vehicle' (see para 7.4.12) may alleviate this.

8.3 Whether or not the integration of maternity and paediatrics with Yeovil goes ahead, it is likely that one or both of the western sites will eventually become a PAU and Midwife led Unit. In such a situation, alongside emergency transfers it is important to ensure that there is sufficient ambulance transport availability to move children and young people requiring an overnight stay from the PAU to the larger unit. Numbers are likely to be relatively low as many more children tend to be sent home from a PAU with safety netting information when there is no inpatient unit on site, but this needs careful modelling, audit and resourcing, particularly in the first few months as the service beds in.

9 Involvement and support for families

9.1 Any major reconfiguration must involve the people who use services throughout the whole process from concept to implementation. The CSR process had carried out formal engagement with representatives according to technical good practice, with a range of contributions, but given that the CSR covered all ages and a wide range of services this process had been rather theoretical and the review team did not see evidence of impact within the maternity and paediatric workstream, nor meet the representative for maternity and children. The lock-in meetings did not involve any element of co-production with lay users present and the clinicians within the units had been advised that engagement was being led by the CCG through the consultation phase.

9.2 An action group 'Save Kingfisher Ward and SCBU' has been established since May 2015 and organises campaigns, marches and fundraising for the ward. Many of the parent-members have had traumatic experiences with the Health Service and the group provides a means to harness that energy, express appreciation to the ward and better understand the issues. The individuals organising the group appear to have sensible ideas and a good understanding of the current position of the CCG and Trust but had not felt listened to by either the Trust or the CCG at the time the Review team met with them.

9.3 At the time of the RCPCH's visit, the public perception of the changes being envisaged to paediatric services was very negative. The CSR was seen as, in effect, planning to 'downgrade' DCH's inpatient services, with no apparent consequent benefits, and those we spoke to were extremely anxious about the impact of the loss of overnight beds on the safety of their families should an emergency occur. They were not aware of the timescales proposed for change, nor had they understood the relatively small numbers of children likely to be affected or the risks of not proceeding. They cited personal experience, some going back several years, as examples of their anxiety, and had little confidence in the ambulance service's speed of response. Several explained that healthcare professionals had directly or indirectly implied that their child could have had much more dire outcome had the DCH service not been available but none had any actual evidence or statistics to justify such emotive words.

9.4 Once concerns such as these have been raised, the community is understandably very susceptible to any information that 'fuels the fire' of anxiety which can be damaging for their confidence in services, support for change and the morale of staff. The CCG has appointed a new Head of Communications, who is developing an engagement strategy but the Review team felt the long term anxieties of the public must be rectified swiftly so they become advocates for change rather than anxious about loss of services. We would suggest:

. a) more open dialogue, listening to the direct experience of individual users and their representatives and taking time to provide them with clear explanations of why change is needed including where decisions are difficult.

b) appointment of a named, senior individual who is the point of contact for the project, personally available to communicate proactively with individuals and groups and with authority to brief politicians and clinical leaders and ensure their views are accommodated.

c) a clear communications plan which includes all clinical and managerial staff within the four acute trusts, community teams and GP practices. The plan must include consideration of what the changes actually mean for each type of stakeholder and how from their perspective this will improve the quality of services. For example, more children's nurses will mean that parents of children with urgent care needs can call the nurse based at the GP practice rather than have to attend the PAU. Recognise the risks in clinicians providing perhaps biased advice to the public and ensure there are clear agreed factual 'lines' to use.

d) proactive celebration of current services and new developments; the drive towards increased homebirth should include regular features in local papers about successful midwife led care and personal stories to raise awareness of 'normality'

10 Overview of Potential Reconfiguration

10.1 A key driver to our Review was the question of potential reconfiguration or not of services at Dorchester to form a Dorset network with the east. Throughout the text of this document we have described how we consider reconfiguration could best serve the population in terms of quality, safety and sustainability. In this section we aggregate for clarity our views on this process.

1. Do Nothing: Current services in the east are severely tested with a heavy workload related to staff numbers compounded by recruitment difficulties. In the west both Dorchester and Yeovil have relatively low patient numbers but are well endowed with staff and are currently providing high quality care. However, with trends to provide more care out of hospital (NHS Five Year Forward View) and develop more midwifery led services (RCOG) there will be further decline in inpatient paediatrics and consultant led obstetric care which will challenge the financial sustainability of both units. The status quo is therefore not an option and the Review team consider that all four units should proactively look at reconfiguration rather than await a potential crisis.

2. Networking of Services between Yeovil and Dorchester in the West and Single Site Poole-Bournemouth in the East: The Review Team deemed this the favoured option as it would eventually bring together the two small and potentially vulnerable units into a single service. This could provide a critical mass of patients for a single inpatient facility for a Consultant led obstetric service, paediatrics and a special care baby unit at one site and midwifery led unit and short stay paediatric assessment unit (12-16 hours daily) at the other.

It is not within the gift of the Review team to determine where the larger unit would be as this would need careful analysis of demographics, transport facilities between sites and potential knock on to other clinical services.

3. Networking of Services between East and West Dorset: This model would work towards a single inpatient site most likely sited in the east, either Poole or Bournemouth depending on that favoured for the unified major acute hospital. Alongside consultant led obstetrics and inpatient paediatrics would be a LNU provision for neonates, merged ED for paediatric cases and a MLU in the East. Paediatric provision at DCH in the west would evolve to being via a PAU (12-16 hour opening) and a MLU.

Timescales: The Review Team would anticipate that if the Yeovil-Dorchester option is agreed and pursued by all parties then this should be clear and with initial planning in place within six months. If this is not the case then the One-Dorset Network should be pursued.

Whichever model is agreed upon there will need to be a process of gradual evolution towards the endpoint as outlined above. We would anticipate that it could take between

three and five years to achieve this depending upon the reconfiguration of other services and physical build in the east.

Key Points of Progression: Some of the important goals to be achieved in the reconfiguration process should be initiated as soon as possible. A steering group would help to facilitate this.

- Change in ethos to support more midwifery led care and setting up a unit in the West
- Enhanced paediatric community nursing services at all sites. The recent RCPCH document "Facing the Future: Together for Child Health"(2015) lists 11 key recommendations of which No 5 is for a 24 hour, seven day community paediatric nurse team and No 6 is for the attachment of a community paediatric nurse to every GP practice or group thereof. This process of enhanced community nursing should be instigated swiftly.
- Advanced Nurse Practitioner (ANP) role development with training of staff as key members of a PAU.
- Upskilling ED staff in paediatric emergencies and ensuring anaesthetists sustain skills in children for recognition and management of occasional emergencies especially out of hours. The securing of paediatric surgical lists will allow an opportunity for anaesthetists to sustain airway skills.
- Discussions with ambulance staff as to optimal provision of transport.
- Developing care pathways for common acute conditions involving primary care, ED staff and paediatrics (No 10 in the "Together for Child Health" document)
- A programme of public and professional information, engagement and involvement.

11 Recommendations

We have themed the recommendations. Whilst some will take time and resources to implement fully, work to plan for them should start quickly. A few recommendations can or should be acted on immediately; these are marked “urgent”.

Moving forward

11.1 Develop a clear plan to implement existing strategies

Lead: Dorset CCG

Appoint an experienced, dedicated project manager, fluent with the issues to drive forward the delivery of the proposals in this document and review progress after one year. The project manager should be supported by an external advisory group comprising an obstetrician, paediatrician, Head of Midwifery and user representative to provide challenge and support. The principles outlined in the 2014-19 pan-Dorset maternity strategy, Wessex maternity and child health strategies underpin this work .

Involving everyone

11.2 Talk and listen to staff, users and the public

Lead: Dorset CCG with local clinicians and Trusts

Draw up a strong communications plan, backed by statistics and evidence, involving clinical staff to explain the plan and timescales.

Engage staff and GPs, then women and families, stakeholders and the public, clearing up misunderstandings, listening carefully to concerns and emphasising the importance of providing the right care, and the longer-term vision for the future.

11.3 Engage with site selection in the east of Dorset

Lead: All clinical and management teams

Contribute to the CSR discussion on choosing a single site for hospital services in the east of Dorset. Wholeheartedly support the ultimate selection, and work together towards a smooth transition, for the benefit of women, children and families.

Making birth a normal part of life

11.4 Increase normal birth and midwifery-led care in line with existing strategies

Lead: Obstetric and midwifery teams with CCG support

Each Trust should have a clear plan to increase home births, midwifery-led care, and normality. Focus on reduction of caesarean section and intervention and invest in antenatal care and training across all health professions, including primary care. Set targets and monitor progress through CCG commissioning and leadership.

Making care safer and more sustainable

11.5 Improve care for sicker and more premature infants - urgent

Lead responsibility: Neonatal and Obstetrics teams supported by the network

Re-designate the Local Neonatal Unit (LNU) at Dorset County Hospital, converting it to a Special Care Unit (SCU) for infants born after 32 weeks gestation. This transition should start as soon as possible, with an urgent target date for completion. Work with Poole Hospital and the transport services to ensure safety, and with BLISS for parent communication and support.

Move more children's care closer to home and away from hospitals

11.6 Implement the Together for Child Health' standards - urgent

Lead responsibility: Trust paediatric (and nursing) teams with CCG support

Develop a plan to improve advice links with GPs and provide and audit impact of rapid access clinics, telephone advice and swift discharge information. Identify and support a clinical champion at each hospital to lead this work and provide regular dashboard reports to the CCG and senior management at each Trust.

11.7 Develop a Dorset-wide community children's nursing service

Lead responsibility: Trust nurse managers supported by the CCG

Plan to implement seven day community-based acute nursing care, in line with NHS at Home working together between Trusts. This is key to the reconfiguration of acute services and will require considerable investment in nurse specialists with between 14 and 18 nurses potentially required. There will be longer term financial and quality savings from reduced hospital attendance.

11.8 Ease the transition home after neonatal care in hospital

Lead responsibility: Neonatal teams supported by network and CCGs

Develop transitional care for newborns and a pan-Dorset neonatal outreach service within the community children's nursing team. This will reduce the length of hospital stays, and improve care for infants and their families. Infants cared for in Southampton should be transferred close to home as soon as clinically appropriate.

In western Dorset and south eastern Somerset

11.9 Hospital care for local people - urgent

Lead responsibility: DCH and Yeovil clinicians with CCG support

Confirm feasibility or otherwise, of service integration between DCH and Yeovil Hospital, to achieve the best services for maternity gynaecology and child health in five

years' time. This would require a public commitment by both Trust Boards, their clinicians and commissioners to support the proposals within six months, otherwise the RCPCH recommends pursuance of a One-Dorset model.

11.10 Rotate staff to build skills and consistency

Lead responsibility: Clinical Directors / medical directors and networks

Given the relatively small size of DCH and Yeovil, introduce a system of staff rotation through larger, busier units, for medical and nursing staff. This will sustain skills, and embed protocols and practice.

In east Dorset

11.11 Start merging east teams across services

Lead responsibility: CCG with Trust teams through the Vanguard

Begin merger of teams in eastern Dorset across maternity and paediatrics, perhaps under the Vanguard model, to improve continuity and efficiency, build resilience and foster co-operation. Use those teams to focus on positive actions that will make the selected site successful, for the sake of women, children and families. This will require strong leadership and vision.

Establish one joint gynaecology service in eastern Dorset, based on one site. This will concentrate the outstanding postgraduate training currently delivered in obstetrics and gynaecology. The current arrangement, which splits four consultants between Bournemouth and Poole for gynaecology responsibilities, is a potential risk for women who experience complications of gynaecological surgery out-of-hours.

Appendix 1 The Review team

Dr John Trounce MD MRCP FRCPCH DCH was a Consultant Paediatrician in Brighton for 25 years, retiring in 2015. He covered general paediatrics and epilepsy, neonatal intensive care in the first ten years and more recently seven years as Named Doctor for Child Protection. He was Clinical Director for Women & Children for five years during which time he oversaw the reconfiguration with a neighbouring service, commissioning of a new Children's Hospital, transformation to teaching hospital status and innovation such as neonatal nurse practitioners and an ambulatory care service. Dr Trounce was a member of the RCPCH Council for six years.

Dr Anthony D. Falconer is the immediate past President of the Royal College of Obstetricians and Gynaecologists (RCOG) and has been Senior Vice President and International Officer. Dr Falconer qualified in Bristol, and trained at the Simpson Memorial Maternity Pavilion in Edinburgh. In his 28 years as a consultant in Plymouth he made a major contribution within the region, to the development of cancer services and hysteroscopy. Dr Falconer was Clinical Director and Divisional Director and maintained a major interest in training young doctors.

Dr Nicholas Wilson has been a consultant at Whipps Cross Hospital for 15 years; initially as lead for the Neonatal Unit. He subsequently became the lead clinician and then Clinical Director for Women and Children, a role he held for six years. He has wide experience in leadership and management, participating in several rounds of proposed service reconfigurations and mergers. Nic was an external adviser to the health care commission and is the Trust Named Doctor for Safeguarding Children. He is also the Clinical Lead for the North East London Neonatal Network and has been involved in the review of neonatal services in the region.

Dr Clare VanHamel has been a consultant anaesthetist at the Great Western Hospital, Swindon since 1997. Working in a department without fixed lists she is fortunate to have a diverse anaesthetic portfolio including paediatrics and obstetric anaesthetic cover. Clare has a keen interest in medical education and has been Severn Foundation School Director since 2009. Clare is Clinical Advisor to the UKFPO since 2012, and an important component of her education role is participating in Quality Assurance visits and reviewing Quality data submissions.

Carol Williams MSc BA (Hons) RGN RSCN RNT is an Independent Nurse Consultant and Healthcare Advisor who established her business in August 2010, since which time she has led a number of compliance projects and service reviews across a range of services, including community services and complex care, emergency care and hospital based children's and adult services. Carol was an Area Manager at the Healthcare Commission and the Care Quality Commission and has worked at the Evelina Children's Hospital London, as Consultant Nurse in Paediatric Intensive Care, Acting Head of Nursing for Children's Services and Lead Nurse for Children's Critical

Care. Carol has been Nursing President of the European Society for Paediatric and Neonatal Intensive Care and as Chair of the Royal College of Nursing and Paediatric & Neonatal Intensive Care Forum, provided written and verbal evidence to a House of Commons Select Committee on Child Health.

Kathryn Gutteridge RN, RM, Supervisor of Midwives, MSc, is a Consultant Midwife, Clinical Lead for Low Risk Care and Psychotherapist at Sandwell & West Birmingham Hospitals NHS Trust. She is an RCM Council Member, RCM Policy Member, RCOG Undermining Champion and the past Chair of the UK Consultant Midwives Forum. Kathryn is a well-established consultant midwife being one of the first appointed in 2003. Originally at the University of Leicester NHS Trust Kathryn was instrumental in developing the midwife-led model of care and an alongside midwifery unit.

Kate Branchett BA is Patient Voice and Insight Lead for the West Midlands Strategic Clinical Networks and Senate. Kate has a real passion for improving the experience and care of all patients and their families. Kate is married and is mum to Ben, 9, Molly, 5 and William, 1. Her interest in healthcare and improving services was sparked by the extremely premature birth of her twin daughters. Izzy was born at 22w4d and did not survive. Molly was born 8 days later and she spent 101 days in neonatal care, but is now a happy, healthy 5 year old. Kate has worked with SANDs, BLISS, NCT, her local Maternity Services Forum and the SW Midlands Maternity and Newborn Network as a patient/ parent representative.. Kate was vice-chair of the RCPCH Parent and Carer Panel and was also a member of the West Midlands Clinical Senate Council.

Sue Eardley joined RCPCH in 2011 and since 2012 has led the Invited Reviews programme. Originally an engineer /project manager in the oil and gas industry Sue spent 13 years as a non-executive and then Chair of a London acute trust, and various voluntary work including national and local user representation and as a Council member of the NHS Confederation. Before joining the RCPCH Sue spent six years full time heading up the Children and maternity strategy team at the Healthcare Commission and then CQC, overseeing strategy, design and delivery of all inspections and reviews in England of maternity, child health and safeguarding.

Jenni Illman is the Operational Lead for Invited Reviews at RCPCH. She has a background in project management and since joining the College in 2014 she has been involved in the development of clinical guidance for the management of children with a decreased conscious level, and the introduction of the new patient voices platform, RCPCH & Us. Previously she worked at The Royal College of Physicians and the Worshipful Society of Apothecaries in examination management roles with a focus on process improvement. Jenni is particularly interested in improving education and well-being for children and young people around mental and sexual health, and has been an active volunteer with both SANE and Brook.

Additional QA support and advice was provided by Professor Andrew Cant, FRCPCH, Dr Sheila McPhail FRCOG and Dr Graham Stewart FRCPCH

Appendix 3 Standards and Reference Documents

Maternity services

[Safer Childbirth](#) – minimum standards for the organisation and delivery of care in labour (RCOG/RCPCH/RCM/RCoA 2007) sets out UK standards for obstetric intrapartum care including consultant staffing arrangements and availability of facilities such as interventional radiology. Paediatric staffing is covered on pages 37-39 and links to BAPM 2001 standards which have since been updated.

[Standards for Maternity Care - Report of a Working Party](#) (RCOG/RCPCH/RCM/RCoA 2008) defines 30 clinical and service standards for the maternity care pathway including for neonatal care and assessment, care of babies born prematurely or requiring additional support and child protection ,

[Safe midwifery staffing for maternity settings CG4 \(NICE 2015\)](#) The guideline focuses on the pre-conception, antenatal, intrapartum and postnatal care provided by midwives in all maternity settings, including: at home, in the community, in day assessment units, in obstetric units, and in midwifery-led units (both alongside hospitals and free-standing).

[Responsibility of Consultant On-call](#) RCOG Good Practice No. 8 (RCOG 2009) provides interim guidance to support locums and trainee doctors pending redesign of consultant led services.

[Standards for Birth Centres in England](#), (RCM, 2009) sets out requirements for midwife-led birth centres and [Birth Centres Resource – a Practical Guide](#) follows on from the Standards and is aimed at all who are developing a birth centre including; commissioners, managers, clinical leaders, third sector organisations, midwives and users. It is a practical tool based on actual experiences. It promotes normality and prioritises safety within midwifery practice, valuing skills by confident and competent midwives in delivering woman-centred care and autonomous decision making

[Neonatal Support for Standalone Midwifery Units](#) – a framework for practice (BAPM 2011) refers specifically to the provision of neonatal support for delivery units that are not co-located with obstetric services and where there is no immediate access to neonatal or paediatric staff.

[Maternity Clinical Risk Management Standards 2011/2](#) (NHSLA/CNST 2011) define the thresholds for achievement of assessed levels of risk management and consequently reduced premiums payable to CNST. These standards are currently not being updated pending review of the NHSLA function and approach but provide a basis for assessment of safety and risk reduction.

[NICE guidance CG62](#) Antenatal care

[NICE guidance CG190](#) – Intrapartum Care

[NICE guidance CG37 / QS37](#) – Postnatal care

[Evidence note for freestanding MLUs](#) (Healthcare Improvement Scotland 2012) explains safety considerations and factors for service design

Maternity Dashboard – Clinical performance and governance score card RCOG good practice advice No. 7 Provides guidance to urge all maternity units to consider the use of the Maternity Dashboard to plan and improve their maternity services

National service framework: children, young people and maternity services (DH England 2004) a ten-part comprehensive set of standards from conception to 19 years, Section 10 covers maternity

Maternity care facilities DH Health Building Note 09-02 (DHEngland 2013) Sets out requirements for labour ward and other facilities suitable for effective care.

Staffing in maternity units – Getting the right people in the right place at the right time. (King's Fund 2011) The King's Fund commissioned research to answer a fundamental question on staffing and safety in maternity services.

Guidance on the provision of obstetric anaesthesia services RCoA 2014 sets out requirements for staffing and procedures for maternity units.

Reconfiguration of women's services in the UK RCOG good practice advice No. 15: (RCOG 2013) addresses current issues around staffing and service redesign

High Quality Women's Health Care – A proposal for change (RCOG 2011) This report looks at how NHS women's health services could be configured to provide high quality, safe and timely care against a backdrop of NHS reform, financial and workforce pressures and increasing complexity of women's health care, all of which means the current structures cannot be sustained

Neonatal care

Categories of Care (BAPM 2011) sets out the definitions of intensive, high dependency, special and transitional care for neonates.

Specialist Neonatal Care Quality Standard (NICE 2011) addresses care provided for babies in need of specialist neonatal services including transfers. Compliance will be measured by collection of data against the [Neonatal National Quality Dashboards](#)

Service standards for hospitals providing neonatal care 3rd edition (BAPM August 2010) defines medical and nursing staffing levels and links closely with the NICE and DH documents and Quality Standard and Toolkit.

Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing A Framework for Practice (BAPM June 2014) Sets out staffing and activity criteria to which services should be designed. Includes evidence based standards alongside wide consensus.

The BLISS Baby Charter and Audit Tool (BLISS 2012) provides a framework for units to examine key aspects of their service provision and to help staff make family centred care a reality

Paediatrics

Medical Workforce Census 2013. (RCPCH January 2015) The census data provides detailed national information on staffing grades and service provision in community services, collected by biannual member survey.

Quality and Safety Standards for small and remote paediatric units sets out particular considerations for paediatric provision where the demography requires interpretation of normal acute standards. It covers service, clinical and workforce standards and considers training, sustainability and finance.

Facing the Future – a review of Paediatric services (RCPCH 2015) updates the original 2011 guidance and details ten service standards relating to clinical cover, expertise and child protection.

Facing the Future Together for Child Health (RCPCH 2015) sets out eleven standards to reduce pressure on hospital services in improve the quality and effectiveness of care closer to home

Urgent and Emergency care

Intercollegiate Standards for care of CYP in emergency care settings (RCPCH 2012) covers staffing, training, facilities, communications and interfaces set out in a clear style and agreed by all professional colleges involved with urgent and emergency care.

High Dependency Care for children- Time to Move on RCPCH-PICS 2015 defines Level 1,2,3 Paediatric Critical care (PCC) units and sets out standards for care in Level 1 and 2 units including network working and commissioning arrangements for England.

Short Stay Paediatric Assessment Units advice for commissioners and providers (RCPCH 2009) sets out models for provision of observation and assessment facilities to complement emergency care and reduce pressure on inpatient services.

Nursing

The Future for community children's nursing – challenges and opportunities (RCN 2014) sets out the current policy direction in the UK and internationally and the requirements for appropriate services to deliver improved outcomes closer to home

Maximising Nursing Skills in Caring for Children in Emergency Departments (RCN, RCPCH 2010) is for emergency department managers, lead consultants and lead nurses. It provides detailed guidance on competence development for nursing staff.

NHS at Home; Community Children's Nursing Services (DH 2011) reviews the contribution community children's nursing services, as a key component of community children's services, can make to the future outcomes of integrated children's services.

The Review team also considered the Dorset Maternity Strategy, the Wessex Maternity and paediatric strategies (in draft)

Appendix 4 List of abbreviations

CCG	Clinical Commissioning Group
CLU	Consultant Led (obstetric) Unit
CQC	Care Quality Commission
CS	Caesarean Section
CSR	Clinical Service Review
DCH	Dorset County Hospital
ED	Emergency Department
LNU	Local Neonatal Unit
NICU	Neonatal Intensive Care Unit
ODN	Operational Delivery Network
PAU	Paediatric Assessment Unit
SCU	Special Care Unit
WTE	Whole Time equivalent