Questions about the MATERNITY proposals:

The National Maternity Strategy – Better Births document I think stated that in 2014 there were 1970 consultants in obstetrics maternity and 1630 trainees (obstetrics and gynaecology). Where have these trainees gone if there is a shortage?

Specialty trainee doctor posts for obstetrics and gynaecology have been unavailable at South Tyneside District Hospital since 2014. The trainee provision ended after the service could no longer continue to satisfy junior doctors' education, training and supervision needs.

Furthermore, Sunderland has seen its allocation of trainees reduced due to the low number of doctors wishing to train in Obstetrics & Gynaecology. It is also very important to note that when trainees are coming out of the system and looking for a Consultant job they value a work-life balance and an ability to see enough patients to maintain and develop their specialist skills to maintain a high job satisfaction.

Hence, they will be looking to work in relatively large specialist units where the on-call frequency allows a better work-life balance and there is better provision for specialist skill development. The options put forward by the clinical teams will improve the frequency of the on-call rota and give more exposure to specialist areas and hence be a more attractive model for trainees to come and work as Consultants.

If goes to midwifery led unit (MLU) how will they sustain this as most end up being closed?

Midwife-led units operate safely and successfully in many other parts of the country without a consultant-led unit alongside. National research evidence – the Birthplace cohort study findings - demonstrates the safety of both alongside and free-standing midwife-led birthing units. The study found that for 'low risk' women there was low risk of negative clinical outcomes for the baby (4.3 per every 1,000 births) wherever they give birth. The study showed no significant difference in negative clinical outcomes for babies born in midwife-led or consultant-led units (3.4 and 3.1 incidents in every 1,000 births, respectively). Should this option be implemented, midwives would be responsible for ensuring women were aware of all choices and that they had sufficient information about all options with which to make a fully informed choice. Every effort would be made to ensure that the MLU was viable and sustainable.

Why is high risk maternity going to Sunderland? South Tyneside is already a big unit with approximately 1,300 deliveries and deals with high risk deliveries – so why does it need to go?

We are having difficulties in meeting clinical standards across both of our hospital sites which is creating some risks to current service provision and may prevent us

from offering the highest quality care in future. We do not have enough doctors working each shift to make sure women get medical care when they most need it.

We are also currently providing the minimum level of senior doctor (consultant) cover. This means that we are unable to provide the same level of high quality care at all times of the day and week and medical staff may not always be as readily available to spot healthcare problems early or speed up recovery.

Without being in a unit with the right level of medical care, women may experience complications during labour, babies may need a period of special care and more women may have to stay in hospital longer.

While we use temporary staff to boost staff numbers, this means that we also struggle to make planned, long term quality improvements in the same way that we can when we have permanent staff.

The national maternity strategy, Better Births, is also telling us to make a range of quality improvements to maternity care, including healthcare organisations working together across bigger populations of at least 500,000.

Where is the option for maternity and children's unit in the middle of South Tyneside District Hospital and Sunderland Royal Hospital?

The only way of creating new maternity and children's services in between the two current hospital sites would involve building a new hospital site.

This would not be affordable and it would not be achievable in the short term so therefore would not address the pressing staffing and service vulnerability challenges that our services currently face.

Option 1 and 2 for South Tyneside have no consultant led unit at all. Women won't choose to use it if no consultant so you're setting up to fail anyway.

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Every effort would be made to ensure that a MLU was viable and sustainable.

How have staff been consulted on the options?

The clinical service reviews for the three areas currently being consulted upon began in late summer 2016 and from the outset this has involved a small number of key senior clinical leaders in both hospitals working together to discuss how they think services should be delivered in the future.

This process began with a 'case for change' being developed which incorporated all the clinical evidence base and data available in order to develop potential future options. Design teams made up of representatives from the consultants, senior nurses, midwives and therapy staff groups (where appropriate) working in the three service areas in both hospitals were invited to get involved with dedicated time to discuss and develop potential future models.

External clinical views from national and regional clinical leaders have also been sought.

We are continuing to seek the views of as many staff as possible as part of the consultation process who can feedback at the forthcoming staff consultation events in September or by completing the online survey at www.pathtoexcellence.org.uk/ Paper copies are also available.

The language being used does not instil confidence – you need to be honest
We are really sorry if there is a perception that we have not been honest, we believe we are being transparent and are putting all the information we can into the public domain.

All the NHS organisations are genuinely keen to hear the views of local people and the full consultation feedback will be considered, alongside a whole range of other data, as part of the final decision. No decisions have yet been made.

From the start we have tried hard to give as much information as possible and to run a good consultation process to give lots of ways and opportunities for people to give their views. There is a lot of background information available and this is has all been published on the programme website. If you feel these if something in particular we are not being honest about we would welcome that question being raised with us and we will answer it.

Why can't we rotate the staff to give them the exposure to keep skills up?
While rotating staff can often appear to be a sensible solution to give them exposure

to more cases to develop their skills, there simply is not enough medical staff working within obstetrics and gynaecology for staff to enable this to happen safely.

To operate all services across two sites would still require two sets of rotas/shifts and current numbers of permanent medical staff mean consistently staffing these is a challenge.

We regularly use locums (temporary) at both hospital sites to meet the minimum number of doctors who should be working at any one time. We also have some senior doctors approaching retirement age and know that attracting replacement staff is difficult.

Services that involve working across multiple hospital sites are often not attractive to potential new staff members as they involve more on-call commitments and less attractive working hours. We are therefore keen to act now and make changes in a planned and inclusive way rather than have to make rushed decisions about service provision if we suddenly find our services short of critical medical staff.

We also want to increase the amount of time that senior doctors are available to provide as high a quality service as possible – we currently provide the minimum level of consultant cover at both of our hospitals. We cannot make these improvements without changing the way our services are provided. There is evidence that increasing the number of hours a Consultant spends on a delivery unit reduces the complications from labour for women. In both options there is a significant increase in the number of hours of Consultant input on the delivery unit and that this would be provided consistently 7-days a week.

Many of the potential options presented as part of the consultation would however provide opportunities for both medical and nursing staff to rotate across both hospital sites in future. This would provide many opportunities for learning and development for individuals and teams.

Why can't extra maternity staff work across both hospitals? There is no additional funding to recruit extra staff and even if money available, we know that recruitment to services which are split across two sites are not attractive to potential new staff members as this involves more on-call commitments and less attractive working hours.

To operate all services across two sites would still require two sets of rotas/shifts and current numbers of permanent medical staff mean consistently staffing these is already a challenge. We regularly use locums (temporary doctors) at both hospital sites to meet the minimum number of doctors who should be working at any one time.

Both of the maternity and women's health service proposals will involve current South Tyneside and Sunderland midwifery teams coming together to work as a single team.

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Discharge from hospital with GP follow up – are there resources in place for this?
Patients would not experience any change in how they are discharged from hospital under the proposals. GP follow-up would still be available if required within local communities. Any hospital follow-up through outpatients would also continue to be provided from both hospitals.

Has option 1 been benchmarked against other MLUs in the region? National policy, underpinned by evidence, shows free-standing midwifery led units to be safe, with no evidence of serious negative clinical incidents or outcomes for women living within four hours of their nearest consultant-led birthing unit. As part of pre-consultation work to make sure the proposals were safe and able to offer high quality services, this view was also endorsed by maternity clinical leads from the North of England Clinical Maternity Network and we are also seeking a formal network view on both options. We are looking at information from other free-standing MLUs across the region in order to inform the CCGs' final decision as well as working with the ambulance service to understand likely transfer times and processes.

Where is the choice if you are not low risk?

Women who are classed as having a high risk pregnancy will have the choice of giving birth at any local hospital where there is a consultant (doctor)-led obstetrics (maternity) unit. Under the proposed changes this would include Sunderland Royal Hospital, the Queen Elizabeth Hospital at Gateshead, Newcastle's Royal Victoria Infirmary or The Northumbria Hospital in Cramlington.

Women who choose to give birth at Sunderland Royal Hospital will be able to do so in the confidence that amongst other enhancements consultants will, with either option, be physically present on the delivery Suite for more hours each week. The aim of this is to provide improved cover across seven days each week at peak activity times, this will result in quicker decision making and improved management where problems arise.

Staffing of free standing Midwife Led Unit (MLU) – will it be supported by Sunderland midwives?

The proposed free standing MLU arrangements involve the creation of community midwifery teams. One of these teams will be a South Tyneside-based community midwifery team and midwives from this team will support women who give birth either in the free standing MLU or at home as well we providing postnatal and antenatal care in the community. These teams may include midwives form both South Tyneside and Sunderland – and midwives may be offered a choice of workplace. Depending on the decision by the clinical commission group, we would wish to work with staff side and staff on mobilisation for a new model and consult on any changes to working arrangements as needed.

Does Sunderland Royal Hospital have the capacity to deal with increased 'high risk' births?

Yes, we have assessed total numbers of births each year and expect that current Sunderland facilities can accommodate all high risk births (option 1). Should option 2 be the preferred option, we would invest in the creation of two additional labour, delivery and postnatal recovery rooms to accommodate the additional low-risk patients also this would result in a minimum of 4 extra beds.

Questions about MATERNITY TRAVEL and TRANSPORT

How long will it take to get a woman from South Tyneside Hospital to Sunderland Royal in the case of an emergency?

We are working with the North East Ambulance Service to understand what the emergency transfer time will be between the two hospital sites. We are also looking to learn more about how quickly the ambulance service responds to emergency transfers from other MLUs across the North East together with learning about how common emergency transfers are from MLUs.

How long does a baby in distress have before brain damage/death?

The safety of both alongside and free-standing midwife-led birthing units is confirmed by the Birthplace cohort study findings which answers many questions about the risks and benefits of giving birth in different settings. The study found that for 'low risk' women there was low risk of negative clinical outcomes for the baby (4.3 per every 1,000 births) wherever they give birth.

The study showed no significant difference in negative clinical outcomes for babies born in midwife-led or consultant-led units (3.4 and 3.1 incidents in every 1,000 births, respectively).

Further information about this study is available on this study.
www.npeu.ox.ac.uk/birthplace/results

In first launch meeting Dr Shaz Wahid said he thought there was no negatives on move to Sunderland.

Does he not think that expecting newly delivered mothers to travel 45-50 minutes a negative?

It's likely that Dr Wahid was speaking in reference to being any clinical negatives.

The travel impact on patient, carers and visitors is and will continue to be considered by the CCGs throughout the consultation and into the decision-making phase.

The personal impact of travel is not underestimated and is something that has been highlighted by both the travel and transport impact assessment and the Equality, Health and Health Inequalities Impact Assessment.

The final assessment of service accessibility will be considered in relation to the anticipated clinical benefits that local clinical leaders believe will result from consolidating high-risk maternity and gynaecology services at Sunderland.