Submission to The National Maternity Review

from the Save the DGH Campaign Group Eastbourne

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About the Save the DGH Campaigners

As a Campaigning Group since 2006 we feel passionate about keeping essential core services at our local hospital. Eastbourne DGH has a local catchment area of 320,000 people and the town is currently undergoing huge housing expansion. We have had virtually unanimous public support since we started, which has enabled us to continue our Campaign for almost ten years.

We believe it is essential for core services, services needed in an emergency, to be accessed locally, or at least to be reached within 30 minutes. The Conquest hospital is more than 30 minutes travel time even by blue light ambulance. To travel by car on a congested single carriageway for an hour or more whilst in labour is very unpleasant. The journey by public transport is much worse becausea person needs to take a train and two or three buses, which takes two hours or more.

It should be noted that before the reconfiguration of Eastbourne's Maternity services, the Trust was awarded a CNST (Clinical Negligence Scheme for Trusts) level 3 accreditation, which suggests the unit to have been very safe. However, in the recent CQC report published on 27th March 2015, the reconfigured Maternity services at the Conquest hospital (in Hastings) were rated inadequate. The lowest rating possible.

Just five days after obstetric services were removed from Eastbourne DGH, a woman gave birth in her car by the side of the road, with help from paramedics who were flagged down. This, and other births, which have traumatised women, are not recorded as untoward events, yet they are incidents which leave lasting damage mentally, if not physically. In early August 2015 one of our Campaigners (John Clarke, retired GP) told us about his friend's daughter who had a severe post-partum haemorrhage and had to be rushed to emergency surgery. She was low risk, second child, but fortunately she chose to be delivered at Pembury, which, unlike the Eastbourne DGH, has an alongside Obstetrics Unit (even though she lives in Alfriston over 30 miles away). Had she been at the DGH midwife unit, John Clarke said she probably wouldn't have survived.

Giving birth is a natural event and not an illness. Yet there can be totally unforeseen problems in healthy pregnant women, which require speedy medical intervention. It is catastrophic for any woman and her baby when an emergency arises and urgent help is further delayed by transport issues and the unavailability of an Obstetrician, Paediatrician and Anaesthetist.

In 2007 we produced Option 5 and then updated it in 2014 to Option 7, which were submitted during the public consultation periods respectively, and which gave evidence to support keeping our local Obstetric unit. We welcome this study taking into consideration smaller units and also looking at staffing models outside of the UK as well as within it. We hope it will provide innovative ways of staffing smaller units, which provide the safest care fora woman and her baby resulting in the best possible outcome.

Liz Walke, Chair of Save the DGH Campaigners

Save the DGH Campaigners

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Eastbourne 'Save The DGH' Submission for The National Maternity Review 2015

We received an invitation to attend forum discussions for The National Maternity Review but none of the venues are in our geographical area. We have, therefore, written this report for the review committee's consideration for presentation to Baroness Cumberlege at our meeting with her at the House of Lords on September 7th 2015

Introduction

The Save the DGH campaign was set up in March 2006 when it was suspected that A&E and Maternity services might be downgraded. In March 2007 an attempt was made to reconfigure obstetric services to the Conquest site in Hastings leaving a Freestanding Midwifery-Led Unit (FMLU) at Eastbourne DGH. The Paediatric services were to be similarly reorganised with Special Care Baby Unit (SCBU) facilities only available in Hastings. That reconfiguration was stopped by Mr Alan Johnson, Secretary of State for Health, following his Independent Reconfiguration Panel's(IRP) advice.The Save the DGH Campaign Group continued to monitor the situation because the East Sussex NHS Healthcare Trust (ESHT) management did not implement the recommendations made by the Independent Reconfiguration Panel(IRP).

There have subsequently been considerable changes to the provision of Maternity and Paediatric services, as well as other 'core services,' which we collectively felt were not beneficial to the population of Eastbourne and its neighbouring towns and villages, which historically provided the catchment area for patients attending Eastbourne District General Hospital prior to its amalgamation with The Conquest Hospital, in St Leonards on Sea, Hastings. Thus forming the East Sussex NHS Hospitals Trust in April 2002, then later becoming East Sussex Healthcare NHS Trust (ESHT) in April 2011, when community services were integrated with the Trust.

The two hospitals are 20.5 miles or33 kms apart with an unpredictable and variable travel time, due to inadequate roads and traffic congestion, of between 32 to 120 minutes 'on the road.' The preferred route of the AA, and generally the local ambulance service, being via circuitous country lanes rather than by main roads, due to problems of delays from either congestion or accidents. A problem confirmed, recognised and experienced by both the Independent Reconfiguration Panel (IRP) in 2008 and more recently by the Care Quality Commission (CQC) in 2014/15.

The Save the DGH Campaign Group, in conjunction with 'Hands off the Conquest' (a Hastings Campaign) produced a document entitled *Option 5: Saves Lives*[1] suggesting the status quo of full Obstetric and Paediatric services at both Eastbourne and Hastings was in the best interests of the patient clientele. Whilst this option was not offered to the public, nor discussed in public by any of the NHS and County Council managerial committees, our Option 5 publication forms the main contribution alongside this submission.

During the last reconfiguration attempt in 2013, neither ESHT nor the local Clinical Commissioning Group (CCG) gave the public an option for dual site provision of Obstetric services, in their six options. Because of this we produced *Option 7: The Campaign Option*[2]. The local NHS refused to present both Option 5 and Option 7.

Although the reasons for this seem mostly locally relevant, we are aware the issues raised are not confined to our area. We continue to hear about the ongoing problem**s** for the patients/clientele in the Mid Staffs and other areas, such as Kent with the now closed FMLUs[3].

[1] "Option 5: Saves Lives" was produced and published by Save the DGH Campaign Group, and distributed to local NHS decision makers and members of the public, as the 'missing option', during the ESHT 2007 consultation period (attached with this submission).
[2] "Option 7: The Campaign Option" was produced by Save the DGH Campaign Group as the 'missing option' during the 2013 consultation period (attached with this submission).
[3] Royal College of Midwives report by Birth Choice UK "Trends in Freestanding Midwife Led Units in England & Wales 2001-2013" makes the point that all such units are vulnerable to closure.

Discussion

In 1942 William Beveridge was commanded to look into the requirements he felt necessary for the Country to reconstruct itself after the end of the Second World War. As he saw it, there were five giant problems which would need to be surmounted if the country was to succeed in peacetime, should it succeed in conflict. They were Poverty, Disease, Ignorance, Squalor and Idleness. From these five problems, the Welfare state evolved, and on 5th July 1948 the NHS was born with the opening of Park Hospital in Manchester by Aneurin Bevan.

Its ideals were to provide a safe and basic level of medical care across the UK, at a local level initially, and to facilitate access to a service that would be free at the point of delivery. Those ideals are still the basic tenets of todays NHS,as confirmed in The NHS Constitution for England published 26th March 2013.

Funding is always less than one would like, and that was certainly the case after the war, and whilst large conurbations were able to regenerate their war torn Teaching Hospitals and peripheral hospitals, and staff them with Consultants and specialists, the same was not possible across the country. Many smaller town's hospitals were staffed by General Practitioners with a Special Interest in various subjects. Some of them carried post graduate specialist qualifications though many had special levels of experience on their chosen subjects and provided their hospital facilities on that basis.

Thus a 'hub and spoke' health service was produced for everybody. Commencing at a local level with the important ideal of providing the best possible facilities for the next generation, who would be expected to continue the evolutionary reconstruction of the UK. Based on the care of their mothers during pregnancy, and then following delivery, and during their children's formative years, both medically and educationally. There had to be a referral system when the medical situation dictated it because of a lack of local knowledge or facilities, but generally people did not have to travel far to receive safe initial care/treatment, which was imperative for the greater portion of the population.

Barbara Castle, later Baroness, when given the Department of Health and Social Security in 1974 made it one of her objectives to train more specialists than was required to replace existing specialists in the larger hospitals so that the presence of specialist trained staff could be increased in the smaller peripheral hospitals as the GPs with a Special Interest came to their retirement. In Obstetrics and Paediatrics this had a very positive effect and resulted in even less people having to travel to specialist centres.

With the expansion of medical capabilities there is still a need to refer cases to specialist centres but with the growth of the population there is also the sensible requirement of keeping as many services as possible close to the local population. None more so than Obstetric & Maternity services and Paediatric services when the birth of a baby or the illness of a child can wreak havoc in the most organised of households. The need to travel long

distances for basic level specialist care only make matters worse, especially for those with financial problems or other children to look after. These issues form the basis of the Royal College of Obstetricians & Gynaecologists (RCOG) 'Each baby counts' initiative.[4]

Over the last 10 years there has been a progressive move towards breaking the basic tenet of the NHS to provide services locally wherever possible; with the development of large central hospitals with new disciplines & increased specialist facilities, but not necessarily with the increased bed capacity to cope with all the previous capacity in the smaller hospitals which have been closed or reduced in function, to help fund the new specialist centres. This trend has not been without problems for the populations previously provided with a locally based service.

This trend has also been seen as a way forward by local managers as a means of reducing the costs of care provision and staffing costs. Regardless of the financial and logistical detriment to populations, who have been affected by such changes. Always following a form of managerially acceptable 'public consultation' but never as a door to door survey, which would have been more likely to hear the voices of the people the NHS was originally set up to support; as recently confirmed in The 2013 NHS Constitution.

Maternity Care Provision

Historically the majority of midwifery care was provided in the community by midwives who provided a clinic based ante-natal service, generally in conjunction with a general practitioner and a home delivery service. There was little alternative in the circumstances prevailing at the time, and the service was both effective and caring for the patients, though not always easy for the dedicated & mobile midwives who were called upon to provide it.

Cases were referred to Consultant care where necessary, either ante-natally or intra-partum if there was time. When that was not possible a flying squad service was developed to send obstetric staff to the home address to effect a local solution or bring the parturient patient and her unborn baby into hospital. With small hospital facilities it was the best anybody could do, and provided an effective, if occasionally slightly chaotic service with the flying squads.

In 1962 Enoch Powell reorganised the NHS into its 3 constituent parts of Hospitals, General Practice and Local Health Authorities and stated that local District General Hospitals would

[4] Each Baby Counts is the RCOG's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. "In the UK, each year between 500 and 800 babies die or are left with severe brain injury – not because they are born too soon or too small, or have a congenital abnormality, but because something goes wrong during labour. The RCOG does not accept that all of these are unavoidable tragedies, and with the Each Baby Counts project we are committed to reducing this unnecessary suffering and loss of life by 50% by 2020."

be developed for populations of approximately 125,000. Meaning they would generally be 20 miles apart so that their catchment populations would have no more than 10 miles to travel into hospital either for care or to visit sick relatives.

This slowly allowed an increase in hospital births, although The 'Black Report' commissioned in 1977 by David Ennals, as Secretary of State, made much of the persistent inequalities of care in the NHS, especially for the poorer members of society. Highlighting the gap between the social classes and their ability to access facilities, which wasclearly reflected in the Maternal & Infant mortality rates. The Whitehead Report (1987) and Acheson Report (1989) supported Black's findings showing nothing had altered in a decade.

But in 1981 it was reported that with the increasing numbers of hospital births now available there had been a great improvement in the health of mothers and babies, because whilst most deliveries were uncomplicated and delivered by midwives, when there was an unexpected problem medical personnel were on hand as part of the Obstetric/Midwifery Team to deal with any intra-partum problems. The involvement of the paediatric teams were also increasingly being considered the norm and it was noted that 1 in 8 babies required some kind of paediatric special care. The commonest causes of need being prematurity, low birthweight or respiratory problems. Although, at that time, only 20% of 1kg (2lb2oz) babies survived, whilst today 80% would be expected to survive.

The development through a slow evolutionary process of a Midwifery Team consisting of Midwife, Obstetrician, Paediatrician and Anaesthetist provided a safe & locally provided service which was reflected in the continuing fall in both Maternal and Perinatal death rates, and, more importantly for the welfare of the next generation, a fall in protracted cerebral effects of a difficult birth for the baby.

The Midwife will always be the backbone of any service, as envisaged by the landmark Cumberlege Report[5]. It has, however, been clearly shown that when Obstetric, Paediatric or Anaesthetic input is required it is much more effective if it is readily available on the same site in which the delivery is taking place. This was epitomised by the recent Royal births in St Mary's Hospital's Lindo Wing where the delivery was conducted by the Midwifery professor, whilst in a room along the corridor was medical support should it be required. Such a system should remain the norm in the UK.

The desire to have Midwifery Led Units (MLU) distanced from obstetric, paediatric and anaesthetic backup is a step backwards in time, and can only be deprecated, and basically needs to be reviewed by your committee. All forms of medical care have clearly shown that without inter-disciplinary teamwork you cannot expect to provide the best service, and to

[5] The Changing Childbirth report was produced in 1993 by the Expert Maternity Group, chaired by Baroness Cumberlege, and built on the recommendations of the 1992 Winterton Report.

suggest otherwise is to be disingenuous to both the parents and their unborn child, who has always been at the core of the NHS's and RCOG's thinking and actions.

To transfer a woman in labour to another unit over 20 miles away, or in excess of 30 minutes travel time, because of a problem in parturition with either her or the baby, is not a rapid business when one takes into account the call up time for an ambulance and its loading time, followed by the journey time and then the discharge time on arrival at the new location and definitive intervention. Neither is it comfortable for the mother's mind or her body, and occasionally there is the roadside delivery with or without a midwife present and certainly no paediatric backup. Babies have been known to die on such journeys. Husbands or family are generally not allowed to travel with the patient, and if they have no transport or money for a taxi, often costing in excess of £30, the mother is isolated in the worst possible circumstances.

Such a system also breaks the Royal College of Obstetricians & Gynaecologists (RCOG) and National Institute of Clinical Excellence (NICE) Guidelines[6]on decision to delivery time for Caesarean sections of 30 mins, unless you ignore the time of the initial emergency which has generated the transfer, and the actual transfer and arrival times, before the clock starts ticking; as ESHT[7] seemed to do quite openly with other monitoring committees like the local Health Overview and Scrutiny Committee (HOSC). Members of the public would find this lack of professionalism abhorrent, and such clarification of this standard should be made clear in this National Review.

Transfers of mothers from a Midwifery unit with post delivery haemorrhagic problems, vulval haematomas and third degree tears or complicated vulval lacerations, is both very uncomfortable, unkind and inherently dangerous. As is having to transfer a mother with an unsutured vulvo-vaginal tear because the baby has a problem and requires urgent paediatric care not available in a Freestanding Midwifery Led Unit (FMLU).

If you have to have a designated midwifery unit, it should be run within or next to a combined unit, the Alongside Midwifery Led Unit (AMLU), with minimal distance to be covered by medical staff should an emergency situation develop. Accepting the historical evolution that has shown combined team care on one site to provide superior care for both mother and child.

Whilst it is appreciated that medical staff do require 'hands on' practice or experience, according to grade, there is generally a doubling of staff numbers in amalgamated units,

[6] NICE Guidelines December 2014, Table 5: Primary reason for transfer to an Obstetric Unit quotes, "Presumably combined Nulliparous & Multiparous Transfers - from Home 32.4%; FMLU 37.1%; AMLU 35.2%. Source Birthplace 2011 (updated 5 June 2015): Birthplace in England Research Programme - from National Perinatal Epidemiology Unit, Nuffield Dept of Population Health, Oxford University. Nulliparous Peri-Partum Transfers to a hospital unit - Planned Homebirths 45%; FMLU 36%; AMLU 40%. Second and subsequent births - Planned Homebirhts 12%; FMLU 9%; AMLU 13%.

[7] ESHT Minutes 8 March 2013, page 16 of 36

often at all levels, so the chances of obtaining increased exposure to cases is simply reduced by the numerical increases in staff. Indeed, if all levels of staff require ‘deliveries’ it should be remembered that a person can only do one thing at a time and only one person can be getting that experience.

This is just as relevant to midwives in a midwifery unit with a reduced number of births, where the numerical figures of staff numbers against deliveries do not match up to ensure continuing professional development in all aspects of their profession, especially as deliveries often tend to occur like the arrival of London buses, leaving many sessions devoid of clinical experience.

To maintain the locality of delivery services and comply with the required hours and experience criteria expected today, it may be necessary to look at the staffing arrangements and accept that some units will be run by Consultants, rather than a Consultant team. As it used to be before the substantial increases in consultant numbers and middle grade staff, although their middle grade junior staff might also have to be replaced with consultants, or fully trained specialists, to comply with the RCOGConsultant presence arrangements and the European Working Time Directive (EWTD). With Midwives fulfilling their coordinating role of being the first recipient of the patient in a numerically reduced hospital team, and fulfilling the role at present provided by a junior doctor, that could be covered by the Consultant presence on the labour suite. It would also ensure his/her presence.

Such a system would serve all the ideals of the NHS from its inception up to the present NHS Constitution but possibly more importantly it would overcome the access problems that many people are finding all too common with the reduction in acute local facilities, across all the core services, especially Maternity where the requirements of the whole integral family should not be ignored. Too many committees do not seem to understand that not everybody is blessed with the financial protection of their members. The original reasons for the setting up of the NHS are as relevant today as they were in 1948 although the anxieties of Black, Whitehead and Acheson regarding limited access for the poorer sections of society would seem to have been addressed, whilst core services are provided locally.

Recorded access problems

Whilst the transfer of clinical problems is easy to consider it should not be forgotten that access to any unit more than 10 miles away can be fraught with problems, especially in a rural setting. These problems are not always recorded correctly either because the computer program will not allow it or on management instructions.

We have seen cases of births in a car or ambulance by the roadside recorded in the statistics as a normal hospital birth.

Cases that have been seen in Eastbourne to confirm it was safe to continue on to Hastings have not been accepted as the responsibility of the hospitals during the interim period of

travel between the two hospitals when a problem has occurred. Presumably because of the possible legal responsibilities; but the instruction to visit Eastbourne Midwifery Led Unit, prior to trying to reach Hastings whilst in labour for those who live in the vicinity or west of Eastbourne, was an ESHT instruction. In an attempt to reduce the number of roadside deliveries one supposes, although the break in journey loses about 40 minutes before the journey is recommenced.

Blockage of the single carriageway road due to an accident or congestion, beyond the point where a secondary route can be taken when trying to reach Hastings in one's own transport, can result in a roadside birth, or foetal or perinatal death; withno medical input being available should the baby have respiratory problems, or for that matter, if the mother develops haemorrhagic problems.

Staffing safe and efficient models of maternity units – locating obstetricians

Your terms of reference give prominence to a survey conducted by the Women's Institute (WI) and the National Childbirth Trust (NCT).

82% of the 5,031 respondents[8] chose to give birth in either an Obstetric Unit or an Alongside Midwifery Led Unit (one with obstetric, neonatal and anaesthetic care available in the same building or on the same site.) Almost half of the remaining 18% who chose either birth at home or in a Freestanding Midwifery Unit changed location because of medical reasons.

This survey confirms our understanding that the overwhelming majority of mothers either choose or need to give birth in a location with obstetricians on site.

In East Sussex, given the transit times between Eastbourne and Hastings and their hinterlands, as described above, this conclusion demands the presence of obstetricians in both locations.

A Freedom of Information request reveals the following numbers of blue light maternity transfers from Eastbourne District General Hospital (EDGH) to the Conquest Hospital in Hastings (this would not include transfers to Brighton or non blue light).

Financial year	Number of Maternity transfers from EDGH to the Conquest
2011/12	6
2012/13	2

[8] Page 74 of "Support Overdue: Women's Experiences of Maternity Services"

2013/14 (Reconfigured May 2013)	199
2014/15	229

Of the significantly reduced number of mothers initially presenting themselves at EDGH in 2014/1015, 229 represents a very high percentage. Despite the huge amount of time devoted to this subject by many people and the voluminous reports written on the subject, the key issue of the location (and working patterns) of a dozen or so obstetricians has never been properly analysed. In any other professionally managed activity it would be a priority to define the resources required, including detailed staffing rotas, particularly of obstetricians, to deliver the estimated demand. With these basic tools a rigorous analysis could be made of the achievability and comparative costs of providing what is clearly the safest option and the choice of the overwhelming majority of mothers.

We believe that it is achievable and at relatively little extra cost, if any.No doubt you will demand such rigorous analyses as part of your review and we would be delighted if you were to use East Sussex as an example with the specific characteristics of a coastal and rural community.

Summary

Every woman and her baby needs a Midwife, some will require immediate medical support. The safest form of maternity care is provided by integrated team care involving a Midwife, Obstetrician, Paediatrician and Anaesthetist.

Obstetric units should be available within approximately a 10 mile radius from the outer limit of their hospitals catchment population.

Smaller units may need to be staffed differently to comply with legislative and College directives.

Inter disciplinary squabbling must be actively discouraged and converted into constructively managed teamwork, as happens in the majority of units. Morecombe was not unique by any stretch of the imagination.

Midwifery Led units should be integral or alongside an obstetric unit, as at the Norfolk & Norwich Hospital. The recent closures of Freestanding Midwifery Led Units (FMLUs) and reinstatement as Alongside Midwifery Led Units (AMLU), as reported by The Royal College of Midwives, should be centrally advised as ‘best policy’. The reduction of recorded deliveries in FMLU suggests that most of the general public do not have confidence in such staffing arrangements in isolated units.

The basic tenets of the NHS to protect the unborn and new born child can best be upheld with the continuation of smaller local units with designated referral centres when required.

The RCOG policy of "Each Baby Counts" must be pursued both for the baby's wellbeing and also to reduce the enormous costs of litigation when babies are damaged at birth.

Isolated midwifery led units a distance away from operative facilities are inherently flawed when medical intervention is required,be it pre, intra or post-partum. They also can make it difficult to decide to transfer in the hope that 'if we wait a little longer transfer might not be necessary' and the mother, and father, saved the anxiety and discomfort of such a journey.

In concluding, it is our view that the issue of "institutional blindness" cannot be ignored as a contributing factor to our ten year experience.[9] It seems many successive local senior NHS representatives from ESHT, PCT, HOSC, CCG and Healthwatch colluded in a mistaken desire to 'support one another'. Had it not been for the diligence and honesty of the Care Quality Commission, who did listen and investigate, they would have been successful in their dishonesty. Apologies from local NHS bodies have not been forthcoming. Unfortunately the CQC and Samantha Jones articlesabout institutional blindness (see footnote for links) appears to confirm this is a national rather than a local problem, and fits with input we have received from other areas of the country.

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Additional material by Robert Smart and other members
for and on behalf of Save the DGH Campaigners
September 2015

[9] CQC article on "institutional blindness" at
http://www.cqc.org.uk/content/peeling-back-layers-%E2%80%93-what-onion and one manager's comment at
http://www.nhsmanagers.net/guest-editorials/operation-onion-2/

Appendix 1

KeyPoints

1. The RCOG Good Practice guide, dated December 2013, states “There is no publishedevidence on the ideal size for a maternity unit.”
2. Eastbourne is the 67th largest town in the UK. Other smaller towns have essential core services, including consultant-ledObstetrics with the exception of a few similar size towns that are part of the same conurbation e.g. Poole – Bournemouth, which are 6 miles apart.
3. Withdrawal of core services makes Eastbourne the most disadvantaged town in the UK (possibly Europe) with the worst population access factor (size of population against the distance to core services).
4. Large towns require essential core services – Consultant Obstetrics and Gynaecology, Consultant Acute Paediatrics, Emergency Medicine (Accident and Emergency), Acute Medicine, Acute Surgery and Acute Psychiatry, with full anaesthetic facilities to ensure the ability to undertake any necessary interventions.
5. ESHT has never implemented the recommendations of the 2008 IRP Report. Little effort was made to make two sites work. It can be done. Yeovil is an example of an outstanding financially stable Foundation Trust which is fully committed to maintaining the essential core services as its fundamental goal.
6. Nearly 20% of all the Consultant-led units in England have under 2500 deliveries - 28 out of 160.
7. There is no evidence that larger units are safer for the great majority of standard emergencies.
8. The Total Transfer Time from Eastbourne to Hastings is about 94 minutes. This is the ‘down time’. This far exceeds the acceptable safety limits for many interventions e.g. emergency Caesarean section.
9. Freestanding Midwifery Units are failing across the UK. In East Kent, the Trust has closed Canterbury and Dover FMUs because pregnant women have serious concerns about access to emergency procedures and because of concerns about safety. The costs are around twice the NHS tariff. The RCOG recommends that first time mothers should not use such FMU units as they are safer in a co-located CU/AMU.
10. The Ambulance Service (SECAMB) is not trained in pre-hospital Obstetric emergencies.
11. People within the Eastbourne area are fully committed to the retention of essential core service in both Eastbourne and Hastings. Eastbourne Borough Council, the Eastbourne Business Community, local Churches and Voluntary and Community Organisations all support the need for modernised networked essential core services.
12. Essential core services should not be withdrawn just because of staffing problems, training problems or to suit consultant working hours.

Our District General Hospital is located in a wonderful seaside location and would be an attractive prospect for Obstetricians & Gynaecologists to apply for posts were it not for the problems created by local NHS bodies in single siting core services. This appears to now be a national problem where reconfiguration of services have occurred. Local NHS sources continue to insist everything is wonderful, further confirming the institutional blindness and disingenuous attitude referred to in Samantha Jones article.