OPTION 5 - SAVING LIVES

Maternity, SCBU,
Gynaecology Service Proposals

Eastbourne and Hastings Consultation Document

Save the DGH

HANDS OFF THE CONQUEST

A Safe, Accessible and Affordable Service for Eastbourne and Hastings

Pride of the Community

Adapt, Develop, Evolve, Specialise

This consultation document sets out the need for safe, accessible and affordable essential core services in Eastbourne and Hastings.

The clearly supported local need is for:

Consultant Delivered Obstetrics 24/7

Paediatric – Consultant Ambulatory Service with
In-patient beds 24/7

Acute Medical Admissions 24/7

Acute Essential Surgical Admissions 24/7

Accident and Emergency – Trauma Golden Hour 24/7

Acute Psychiatric Service 24/7

This is to be provided with sensible relocation of subspecialist services to the Regional Teaching Hospital at the Royal Sussex County Hospital, Brighton (and Pembury) together with an increase in Community Care and the General Practice Referral Management System.

OPTION 5 – SAVING LIVES

EASTBOURNE – Consultant Delivered Medium Risk Obstetric Unit

HASTINGS – Consultant Delivered Medium Risk Obstetric Unit

CROWBOROUGH – Midwife Led Unit

BRIGHTON AND PEMBURY – Very High Risk Obstetrics and Neonatal Intensive Care Unit, Subspecialist Gynaecology

EASTBOURNE AND HASTINGS – Community Care Obstetrics and Gynaecology

Foreword

I have been involved for some years in the re-configuration of clinical services, most recently as Medical Director for Eastbourne Downs PCT until October 2006, and before that as a member of the 2004 Clinical Services Review Committee, both for Paediatrics and Obstetrics & Gynaecology. I am now actively involved in the campaign to save NHS services under threat of closure.

I feel it right to make a public stand, alongside others with the same concerns, because we strongly fear that a wrong decision now will have serious consequences resulting in unnecessary loss of lives.

As a GP I am very concerned that essential core services are retained, both in Eastbourne and Hastings and it is imperative that residents of both towns have safe and accessible acute care.

We have to work within a complex climate of medical dilemmas and initiatives competing for limited resources. All of this makes finding the best solution and way forward very difficult, and any options being considered will naturally be subject to variation and interpretation.

Over the last five years, in my role as Chair of the Professional Medical Executive Committee for Eastbourne Downs PCT I worked alongside all clinicians in the community. Many of these professional colleagues, which include GPs, Midwives and Nurses have, without exception shared the same concerns as I, and have consistently encouraged me to continue to keep the debate in the public arena until the right local solution is found.

I hope you will read **OPTION 5 - SAVING LIVES** carefully and give it further serious consideration, as I feel it provides a good safe solution.

Please feel free to contribute with your comments and feedback, which you can do via the campaign website.

Cross-Party Support

The SavetheDGH campaign has support across the political divide. Conservative MPs have sat down beside a Liberal Democrat MP, borough councillors from all parties have worked together, and representatives from the Green Party and the Labour Party have worked tirelessly to make our voice heard.

Since we started the "Save the DGH" campaign a little over a year ago, I have been truly humbled by the support we have received. At an early stage, I invited all the other political parties to join; and I am delighted that we are a truly cross-party and cross-community campaign. Most of all, I am grateful for the support we have had from local people.

Now we face the real challenge. Sadly, the public consultation will not include the option of maintaining full consultant-led maternity units in both Eastbourne and Hastings. NHS bosses are trying to claim this is because of 'patient safety'; but the real reasons appear to be financial.

Our campaign have put in a major effort to produce our own option – Option 5 – contained in this document. I commend it to everyone who wishes to keep core services at our DGH. I would especially like to thank consultant gynaecologist and obstetrician Vincent Argent who has supplied so much of the medical expertise.

Now is the time for everyone who values the range of services we have at the DGH to make their voices heard. When you are asked for your views, please back Option 5. If enough people do so, we can force the NHS to include it as a serious option.

Nigel Waterson
EASTBOURNE MP

I think this is a very well put-together document. It has always been my view that this process should be medically, rather than the politically or financially, driven and Option 5 makes a very strong medical case. I certainly think it should be included in any consultation document.

Charles Hendry
WEALDEN MP

"The options for the reconfiguration of acute services in East Sussex may have avoided the nightmare that is the loss of A&E services at Eastbounre, but what is proposed still causes me considerable concern. It is not acceptable to tell my constituents in Seaford and Polegate that they may henceforth have to go to hastings for key maternity services currently delivered in Eastbourne. Nor can Brighton cope with any further pressure in this area. Furthermore, we are being asked to consider options without knowing whether the axe will fall on maternity services at the Princess Royal at Haywards Heath, which would add further to the pressures on Brighton.

"For these reasons, I strongly support the inclusion of Option 5 among the consultation options, and personally feel that that is the option that makes most sense."

Norman Baker
LEWES MP

The Save the DGH Campaign are united with the Hands Off The Conquest campaign group in Hastings. Its members are:

Baroness Fookes of Plymouth
(Patron, Friends of the Conquest)

Michael Foster DL MP
(President, Friends of the Conquest)

John Baker
(Chair, Friends of the Conquest)

Margaret Williams
(Chair, Hands Off the Conquest Campaign Group)

Elaine Wilkinson
(Vice Chair, Hands Off the Conquest Campaign Group)

Mike Parris
(Campaigner)

Fred Cullen
(Seniors' Forum Member)

Gerald Funnell
(Solicitor)

James Bacon
(Student)

Deidre White
(Campaigner)

Kathy Howroyd
(Consultant Paediatrician, Retired)

Media Support

Throughout this lengthy period of meetings in East Sussex and Parliament we have had the full support of all the media and local press. Their coverage has been of tremendous value to the campaigns and their action has been invaluable in informing the Public at all times of our joint strategies.

Executive Summary
OPTION 5 - SAVING LIVES

When we started campaigning last year we had no idea that we would receive such overwhelming support for what we were attempting to do. Now we find ourselves working alongside MPs, Clinicians and other professional people in taking positive action by jointly producing this document, which we have called **OPTION 5 - SAVING LIVES**.

It began with serious concerns last year about the threat to local core services (see footnote), and in particular those affecting Maternity, Paediatrics and Accident & Emergency provision at the Eastbourne District General (DGH) and Hastings Conquest hospitals, both of which are run by East Sussex Hospitals Trust. Rather confusingly, East Sussex Downs & Weald Primary Care Trust provides funding for Eastbourne DGH, while Hastings & Rother Primary Care Trust pays for the Conquest!

Sir David Nicholson (NHS Chief Executive) and Sir Ian Carruthers (NHS Acting Director of Commissioning) states in Recommendation 9 of their Service Improvement letter 28th February 2007, that PCTs should provide details of ALL options for change, with well-balanced pros and cons for each option, in their public consultation process. Because of this we felt enabled to contribute our own option.

OPTION 5 - SAVING LIVES is an option that both Save the DGH and Hands Off the Conquest campaign groups have produced with a focus on Maternity services, which the PCT is to about to consult the public on from March 2007 for 15 weeks. It has been a work of collaboration across both towns and between medical experts, Members of Parliament, local politicians of all the main parties, business men and women, members of the public and even our Bishop!! We are all committed to ensuring core services are kept at our local hospitals, which includes Eastbourne District General Hospital for residents of Eastbourne, Polegate, Seaford, Hailsham, Pevensey, etc, and The Conquest Hospital for residents of Hastings, Bexhill, St Leonard's, Camber and Rye etc [this is to embrace all our supporters].

It has taken a year of research to determine what we now consider to be the safest clinical option for local residents of both towns. It has been written by qualified medics from a safe, affordable and accessible perspective and it also includes the elements required by government for options to Adapt, Develop, Evolve and Specialise.

"Throughout this lengthy period of meetings in East Sussex and Parliament we have had the full support of all the media and local press. Their coverage has been of tremendous value to the campaigns and their action has been invaluable in informing the Public at all times of our joint stratagies."

"Save the DGH" campaign steering group members are:

Monica Corrina-Kavakli
(Parent Campaigner)

Liz Walke
(Parent Campaigner).

Wallace Benn
(Bishop of Lewes)

Nigel Waterson MP

Colin Belsey
(Mayor of Eastbourne)

Councillor Ian Lucas
(Leader of Eastbourne Borough Council)

Councillor David Tutt
(Opposition Leader of Eastbourne Borough Council)

Vincent Argent
(Consultant Obstetrician & Gynaecologist)

Dr John Clarke (GP)

Wendy Beechward
(Maternity Focus Group)

Sandy Medway
(former non-executive director of Eastbourne NHS Hospitals Trust)

Stephen Lloyd
(Lib-Dem Spokesperson)

Richard Goude
(Labour Spokesperson)

Clive Gross
(Green Spokesperson)

Tim Cobb
(Public Relations)

OPTION 5 - SAVING LIVES:

HOSPITAL A **Consultant Delivered Medium Risk Maternity Unit**

- ☐ Maternity Day Unit
- ☐ Special Care Baby Unit (Level 1)
- ☐ Emergency Gynaecology and Early Pregnancy Service
- ☐ Major Gynaecological Surgery

HOSPITAL B **Consultant Delivered Medium Risk Maternity Unit**

- ☐ Maternity Day Unit
- ☐ Special Care Baby Unit (Level 1)
- ☐ Emergency Gynaecology and Early Pregnancy Service
- ☐ Elective Investigation Centre and Day Surgery

BRIGHTON **Fully Integrated Regional Centre for Sub-specialist services in Women's Health and Neonatal Intensive Care**

- ☐ All High Risk maternity and potential deliveries requiring Neonatal Intensive Care
- ☐ Tertiary elective obstetric and gynaecology services – Foetal Medicine, Cancer, Assisted Conception, Complex and Radical Pelvic and Laparoscopic Surgery

CROWBOROUGH **Midwife-led Birthing Centre**

COMMUNITY GYNAECOLOGY **Elective Community Benign Gynaecology Service (Areas A and B)**

OPTION 5 - SAVING LIVES: meets the criteria from the Royal College of Obstetricians & Gynaecologists and the CNST (Clinical Negligence Scheme for Trusts) Maternity Standards, including 112 hours of consultant presence per week on each labour ward

OPTION 5 - SAVING LIVES: MEETS THE ALL IMPORTANT 30 MINUTE BENCHMARK STANDARD FOR THE DELIVERY OF EMERGENCY OBSTETRIC SERVICES

OPTION 5 - SAVING LIVES: would be fully integrated with the GP Referral Management Service, which addresses the need for more care in the Community

THE AMBULANCE PERSPECTIVE

CLUSTER COMMISSIONING CROSS-COUNTY REQUIREMENTS - RETENTION OF CORE SERVICES & TRANSFERS TO SPECIALIST UNITS

LITIGATION RISKS TO PCTs, HOSPITAL TRUST & INDIVIDUAL BOARD MEMBERS (Corporate manslaughter)

GOLDEN HOUR & PLATINUM HALF HOUR

TRANSPORT AND CONGESTION – Tony Blair's pledge to cut congestion!

POPULATION GROWTH

COSTINGS OF CONSULTANT-LED ALL RISKS MATERNITY UNIT

Just to clarify, the NICE (National Institute of Clinical Excellence) Guidelines on Caesarean section clearly state:

'The 30 minute decision to delivery interval should remain as the benchmark for service provision for Caesarean Sections of Grade 1 and Grade 2 urgency.'

This talks about the standards for service provision of emergency services rather than the clinical outcome. With regard to the latter, some cases eg severe APH, severe foetal distress, ruptured uterus etc, need to be delivered as soon as possible, and probably in less than 30 minutes, whereas other cases, eg delay in the second stage can probably wait up to 75 minutes. ' MOET ' Caesarean in collapsed women should be started after 5 minutes.

We commend this Option to you as something worthy of serious consideration and reassure all who read it that we are open to further and ongoing discussions about feasibility with those responsible for delivering core services. The debate must continue because lives are at stake and it should not be concluded until the best solution is agreed.

We totally support the dedicated and hardworking teams of professionals who deliver existing core services and appeal to the members of the PCT and hospital Trust to continue to dialogue with us. We know they too want the same safe affordable outcomes that we are campaigning for and we appreciate they have to work within parameters that we cannot fully understand.

Liz Walke
Chair of Save the DGH Campaign Group

Margaret Williams
Chair of Hands off the Conquest Campaign Group

Eastbourne and Hastings Demand The Best

Communities put maternity care at the forefront of their healthcare programmes. They expect the best for their future citizens. They are prepared to invest in high quality services.

The people regard obstetric services as the flagship of their community.

It is clear that the people of Eastbourne and Hastings and the surrounding rural areas have spoken.

There is no doubt that they demand high quality consultant delivered obstetric services on both Eastbourne and Hastings.

The two campaign groups SaveTheDGH and Hands Off The Conquest have amassed over 70,000 signatures from citizens who support the need for essential core services in both towns.

Practice Based Commissioning – Buying the Service that People Need

Practice based commissioning allows general practitioners to purchase the services needed by their patients and the local community. This will allow them to obtain the best high quality care based on clinical need rather than any reconfigurations designed to save money or centralise services.

Current Maternity Units in Eastbourne, Hastings and Crowborough

The current Consultant Led Units in Eastbourne and Hastings and the Midwife Led Unit in Crowborough are very popular. They are run by dedicated staff who provide a high standard of care to the local people.

The ' Worthing Report ' showed that both Eastbourne and Hastings have a very good safety record and that their perinatal statistics are equivalent to regional and national figures.

The high quality of these units was recently recognised by the award of Level 3 Clinical Negligence Scheme for Trusts (CNST) Accreditation. Such high standards have only been achieved by 20% of maternity units in the South East.

East Sussex Clinical Services Review

The East Sussex Clinical Services Review: Maternity and Gynaecology Services Review Final Report was published on August 3 2004. It was chaired by Fiona Henniker, Chief Executive of the Sussex Downs and Weald PCT.

Configuration of Obstetrics

Recommendation 8.1.3 clearly stated:

East Sussex health community should strive to retain two all risk units with obstetrics input.

The Summary 7.4 states:

The Review found no compelling reasons that suggested clear advantages under any of the following key parameters to support a change to the configuration of existing maternity services:

-Improving choice and access for women

-Offering a significantly higher quality of care

-Making a significant saving

-Only making that change would be sustainable in staffing

The Summary from the PCT continues:

Women want choice in maternity care, and ideally they wish to have the opportunity to opt for a birthing centre/home birth style of care, with the knowledge that the full range of hospital support would be available rapidly and seamlessly on the same site.

Women want as much care as possible to be delivered locally. The two main centres of population for East Sussex are Eastbourne and Hastings/St. Leonard's. Women living in or near to one of these population centres do not regard the other as local, and would regard the loss of an all-risk unit with obstetric support as a major and undesirable reduction in local choice.

Costs

Paragraph 7.3.3 – Costs – starts with the statement that figures supplied by the East Sussex Hospitals NHS Trust show very little difference between the options. Indeed, in some respects a single site option was thought to involve increased costs for extra anaesthetists, transport and capital development.

How Can Significant Savings Be Made

In view of the above, the **OPTION 5 - SAVING LIVES** group consider that the Primary Care Trust (PCT) and the Strategic Health Authority (SHA) will be unable to show conclusively that significant savings will be made from what they propose.

Keeping the NHS Local - A New Direction of Travel

The Department of Health has published the document: Keeping the NHS local – A New Direction of Travel.

The document sets a clear direction of travel for the NHS, especially when considering expansion and redesign. It will help the local NHS to work in a new stronger partnership with the public and staff to find high quality, sustainable solutions for local services, and deliver the agenda for reform.

The Report outlines an approach to local service design and consultation that reflects both the new requirements for partnership, the 'closer to home' model of care supported by the National Beds Inquiry and the new opportunities generated by service and workforce modernisation.

Most importantly, the Report states 'The mindset that "biggest is best" that has underpinned many of the changes in the NHS in the last few decades, needs to change. **The continued concentration of acute hospital services without sustaining local access to acute care runs the danger of making services increasingly remote from many local communities**. With new resources now available, new evidence emerging that " small can work " and new models of care being developed, **it is time to challenge the biggest is best philosophy**.'

Safety

Predicting Obstetric Emergencies

It is clear that many obstetric emergencies are not predicted. It is perhaps the only part of medical practice where a fit young woman undergoing a normal life event suddenly becomes seriously ill with an emergency that threatens the life of her baby and even her own life.

Skilled obstetricians and midwives can prepare and predict some problems and can plan ahead for high risk cases. Despite this action, many emergencies arrive with no warning and need immediate action.

Severe fetal distress

Placental abruption

Placenta and vasa praevia

Ruptured uterus

Collapse from epidural complications, tocolytic drugs

Shoulder dystocia

Prolapsed cord

Malpresentation of second twin

Undiagnosed breech

Post-partum haemorrhage

Post-natal collapse

Litigation

Litigation for medical accidents is at an all time high despite the dedicated work of health care professionals who do their best to avoid adverse outcomes. 50% of all claims in medical practice concern obstetrics and gynaecology. These claims account for about 85% of the overall costs in compensation because of the high value of brain damaged baby claims. Obstetrics is unpredictable and brain damage is not always avoidable.

The closure of local services and the increased travel times will lead to a large increase in legal claims that will be difficult to defend and the costs to the NHS will far exceed any savings made.

Medico-legal experts will use the 30 minute standard described below to support claimants.

Timing – The 30 Minute Standard

Time is crucial in the management of obstetric emergencies.

A decision to delivery interval (DDI) of less than 30 minutes is the accepted audit standard for response to emergencies within maternity services.

The 30 minute standard is laid down in the National Institute of Clinical Excellence (NICE) Guidelines on Caesarean Section. This time period was accepted by the Joint Committee of the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Anaesthetists (RCA) Joint Committee in their response to the Yentis criteria for the urgency of Caesarean Section.

It is generally accepted that a Grade 1 Emergency caesarean section should be performed within 30 minutes. A Grade 1 emergency section means that there is risk to the life of the mother or baby.

A DDI of less than 30 minutes is not in itself critical in influencing baby outcome and up to 75 minutes may be reasonable for a Grade 2 Urgent Caesarean.

On the other hand, it is generally agreed that 'Crash' Caesarean sections for emergencies such as a terminal fetal heart trace, ruptured uterus, severe ante-partum haemorrhage and a trapped second twin must be done as soon as possible with target DDIs of less than 15 minutes.

In the rare cases of maternal collapse e.g status eclampticus, APH with catastrophic hypovolaemic shock, RTAs, then Caesareans may have to be done within 5 minutes according to the Managing Obstetric Emergencies Trauma (MOET) protocols.

Consultant Presence

It is no longer acceptable for difficult Caesarean sections to be performed by medical staff in training.

The Caesarean Decision

Decision making is very important. There is concern about increasing Caesarean section rates which is partly due to the lack of senior decision making on labour ward. Some emergency caesareans could be avoided if a Consultant is actually physically present to assess the situation, examine the woman and make a decision.

The Caesarean Operation

The RCOG Caesarean Section Sentinel Report and other guidelines require a Consultant to be present for the following whether they occur day or night:

Caesarean at Full Dilatation

Placenta Praevia

Previous multiple caesareans

Sever APH and surgical bleeding

Tearing of the uterine angle

Concern about the ureter

Malpresentations

Consultants and Core Skills

All fully trained consultants in obstetrics and gynaecology are able to carry out the core skills of Caesarean section and interventions for vaginal delivery. They are also trained to deal with emergency gynaecology especially the management of ectopic pregnancy. These are not subspecialist skills.

Virtually all essential core procedures in obstetrics and gynaecology can be performed by any trained consultant at any time of the day or night.

Traditionally consultant obstetricians and gynaecologists rarely attend night time Casearean sections which are left to middle grade staff although the previous paragraph described the need for far greater consultant input.

Nearly all subspecialist procedures which are only performed by those with appropriate subspecialist training are elective gynaecological procedures carried out during normal working hours e.g laparoscopic hysterectomy, radical gynaecological cancer operations, chorionic villous sampling and in-vitro fertilisation egg collection.

This situation is very different from other fields of practice e.g. vascular surgery and neurosurgery. Highly complex major operations may need to be performed only by subspecialist consultants as emergencies during the day or night e.g. aortic aneurysm repair, craniotomy for head injury. In the case of aortic aneurysm, this would only be performed by a specialist consultant vascular surgeon and not by a generally trained surgeon. Likewise, best results are obtained by a dedicated consultant vascular anaesthetist. These procedures are usually only done in teaching hospitals or very specialised units.

Travel

It is well established that transfer of obstetric patients should be avoided wherever possible. It is potentially unsafe. This is particularly so with bleeding and hypovolaemic shock.

Resuscitation and fluid replacement before transfer is a cornerstone of immediate care in obstetrics as well as in major trauma and on the battlefield.

Bleeding is major threat to the lives of babies and even to the mother herself. Advanced Trauma Life Support (ATLS) (also used to gauge obstetric shock) Classes 1-4 shock can easily develop quickly and unexpectedly in obstetric practice. This emergency quite rightly frightens even senior experienced obstetricians who may see a patient's life ebb away in front of them unless they take immediate action.

The need for close essential life saving services is discussed in the leading text book: The Principles and Practice of Immediate Care by Greaves and Porter.

This was the basis of the obstetric flying squads. These were generally replaced in the late 1970s and early 1980s when there was an expansion in the number of local consultant maternity units to replace the older style GP maternity units. It was assumed that Ambulance Paramedics would play an increasing role in transfers to hospitals but lack of resources has restricted the development of a comprehensive training programme for Paramedics in Emergency Obstetric Care.

The need for Emergency Domiciliary Obstetric Services and a prompt competent response was recognised by the RCOG in their publication entitled: The Future of Emergency Domiciliary Obstetric Services ('Flying Squads').

Any single site arrangement would require a dedicated Obstetric Paramedic Ambulance staffed by experienced practitioners including doctors and midwives but even then it would not be as safe as consultant units in both towns.

Time between Eastbourne and Hastings

This is a crucial issue.

Emergency transfer time between the towns of Eastbourne and Hastings is well in excess of 30 minutes and this clearly breaches the national benchmark standard of 30 minutes for the management of obstetric emergencies.

The official AA distances and times are as follows:

Eastbourne DGH – Conquest Hospital
20.5 miles – 32 minutes

It is well known that the actual time taken is often far longer up to 50 minutes because of the poor roads which are very busy at peak times and during the holiday season. Ambulances do have problems with emergency transfers because cars cannot always 'pull over' on the poor narrow roads.

The actual bed to bed patient transfer time is often double the travel time so that total transfer time would be well over 1 hour.

Making It Better: For Mother and Baby – the Shribman Report

In 2007, Sheila Shribman, National Clinical Director ('Tsar') for Children, Young People and Maternity Services in her paper making It Better: For Mother and Baby states:

The Report recognises that there is no optimum number of births to make a unit sustainable.

She says that 'Proposals for change must be developed in consultation with local people' and 'What will be right for Whitechapel will not necessarily work in Whitehaven'. She notes the need for a balance between accessibility and the need for specialist care.

The Report states 'reconfiguration that provides an opportunity to improve access to the full range of care and specialist services through networks is to be encouraged 'adding' change is vital if we are to ensure the safety and well-being of all mothers and babies and that pregnancy and birth are as normal an experience as possible for the majority of women, whilst those with risks and complications also receive the best possible care wherever they live'.

The Shribman Report focuses on the sensible move of consultant maternity services from Calderdale Royal Hospitals to Huddersfield Royal Infirmary Hospital while maintaining midwife-led services and ante-natal clinics in Halifax. The hospitals are only 5 miles apart and both in the Halifax-Huddersfield conurbation. They are connected by a very good A road with a consequent travelling time of 10 minutes. The very large maternity units in Leeds, Bradford and even Manchester are also within 30 minutes travelling time. This is a very different situation form the relatively isolated towns of Eastbourne and Hastings in East Sussex.

Whitechapel is in the heart of urban London close to the City and there are a large number of big consultant maternity units within a 5 mile radius.

Eastbourne and Hastings are like Whitehaven, being rural seaside towns well over 30 minutes from their nearest hospital.

With the trend for Care in the Community, there may be many more home births and Shribman adds ' Any woman giving birth at home should have the assurance that if something goes wrong she can be transported to a consultant led unit safely and quickly. Every woman needs a midwife which means that there must be enough midwives for one-to-one care.'

The following official AA times and mileages are also of interest in the context of this report:

Calderdale Hospital – Huddersfield Hospital (the merger mentioned in the Shribman Report)	5.3 miles – 10 minutes
Which is less than:	
Eastbourne DGH – Hailsham	6.5 miles – 14 minutes
and the same time travelling as:	
Eastbourne DGH – Stone Cross	4.4 miles – 10 minutes
Halifax is also quite close to other major hospitals in Leeds and Bradford:	
Halifax – Leeds	16.3 miles – 27 minutes
Halifax – Bradford	9 miles – 18 minutes
These are all within 30 minutes and are less than;	
Eastbourne DGH – Conquest	20.5 miles – 32 minutes

Consultant Numbers

The number of fully trained consultant obstetricians and gynaecologists in Eastbourne and Hastings needs to be greatly increased in order to comply with national standards and the need for a consultant delivered service.

In 2002, there were 10 substantive consultant obstetrician and gynaecologists in Eastbourne and Hastings with an imminent advertisement for an 11th and plans for a 12th.

The PCT and Trust have stated that there are now only 7 substantive consultants. There has been no attempt to explain why the consultant workforce has been reduced by 30% in complete contravention of the RCOG requirements for consultant expansion and a consultant delivered service.

The Trust has made no attempt to advertise for new substantive consultants.

The PCT and the Trust have stated that there is a national shortage of eligible consultants. This is not true and there is, in fact, a large number of fully trained doctors who have been unable to secure consultant posts because of the downturn in much-needed consultant expansion and the all too common practice of not replacing retiring and relocating colleagues.

There are about 100 eligible specialists with CCT/CCST/Article 14/EEA equivalence who are looking for posts and few will be successful. In Eastbourne alone, there are 5 eligible doctors who are currently working in staff grade, locum consultant and other posts. Any advertisement for a substantive post is likely to attract a large field of good quality candidates.

The Healthcare Commission Inquiry into Northwick Park clearly showed that larger units cannot skimp on consultant numbers and that even more consultants are needed to provide the service. The Report showed that merger of units does not allow Trusts to reduce the need for fully trained staff.

There is no evidence that consultant skills will be diluted by the appointment of more consultants. On the contrary, the new breed of consultants will work with a ' sleeves rolled-up ' approach directly delivering patient care. This will, in fact, increase their expertise in essential core skills.

Stand Alone Midwifery Units

Women should be allowed the choice of Midwifery Led Units (MLUs). MLUs are either attached to consultant units (e.g. Addenbrooke's, Cambridge) or are 'stand-alone' at a nearby location or in a more distant town.

Crowborough is a stand alone MLU. It has proved both popular and successful. It is actually far closer to Pembury and Haywards Health rather than Eastbourne and is a long way from the Conquest. Serious emergencies are usually transferred to Pembury while less urgent emergencies, e.g. delay in the second stage, are often transferred to Eastbourne.

There has been some concern about the relative safety of stand alone MLUs. In November 2005, the National Insitute of Clinical Excellence published a warning that evidence suggested that MLUs were slightly less safe.

NICE Guidelines – Intrapartum Care

The National Institute of Clinical Excellence (NICE) has published the Final Draft for Consultation of the guidelines – Intrapartum care: care of healthy women and their babies during childbirth.

NICE recommends that women should be offered the choice of planning birth at home, n a midwifery-led unit or a consultant unit. Before making their choice, women should be informed of the potential risks and benefits of each birth setting.

NICE states:

Birth outside a consultant led unit is consistently associated with an increase in normal vaginal birth, an increase in women with an intact perineum and an increase in maternal satisfaction. The quality of evidence is not as good as it ought to be for such an important health care issue, and most studies have inherent bias. The evidence for stand-alone MLUs and home births is of a particularly poor quality.

The only other feature of the studies comparing planned births outside consultant units is a small difference in perinatal mortality that is very difficult to accurately quantify, but is potentially a clinically important trend. Our best broad estimate of the risk is an excess of between 1 death in a 1000 and 1 death in 5000 births. We would not have expected to see this, given that in some of the studies the planned hospital groups were a higher risk population. Several factors may play a role in this observation, including study design, effect size, statistical precision and rareness of these events. Geography may be important, as may organisation of services and communication between all involved.

The evidence in relation to perinatal mortality is not strong enough to support past or currently planned policies of increasing or decreasing current provision outside consultant units.

Size of Units

There are many studies which show that smaller consultant maternity units are safe and that merger into large units may carry increased risks as well as increased costs.

The article: Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women was recently published in 2006 in the British Journal of Obstetrics and Gynaecology. The study was carried out in Australia but the conclusions are valid in the UK. It was found that lower hospital volume is not associated with adverse outcomes for low risk women. It questions the view that there is a volume threshold below which quality of care may be both inferior and economically unsustainable and notes that local obstetric services are a vital component of the community.

The article : The true cost of the centralisation of maternity services published in 2006 in the Midwifery Digest MIDIRS actually demands that we stop and question the strategy of centralisation as there is no evidence for the assumption that large hospitals are cost-effective and lead to better patient outcomes.

The Report from the Reform Group has emphasised the need for **'An end to the drive towards larger, more centralised delivery units across the UK'**. The Report stresses the need for integrated networks between high, medium and low risk providers and the necessity for the actual presence of consultants on labour ward in line with the situation in the rest of Europe and the USA and Canada.

There have been some recent high profile disasters in large merged obstetric units in Northwick Park and St Peter's/Ashford and in other large units which have had major problems e.g Wolverhampton. The Healthcare Commission held enquiries into these three large hospitals. They found major problems of poor communication, poor change management, poor levels of midwife and consultant staffing combined with widespread client dissatisfaction. In Northwick Park, these problems led to an unacceptably high level of avoidable maternal death.

Accessibility

Choice

The policy of the Government is to allow choice as paramount to the provision of accessible services. **OPTION 5 - SAVING LIVES** clearly provides the greatest choice between consultant delivered services in both Eastbourne and Hastings as well as care in the community, midwife-led care at Crowborough, supported home birth and care of very high risk problems in Brighton Teaching Hospital.

Deprivation

Eastbourne and Hastings are both areas of relatively high social deprivation and disadvantage compared with most areas in the affluent Home Counties. The Income Deprivation Affecting Children Index map shows that Hastings has many of the poorest areas in the County. The map also shows that the largest area of deprivation is in Hailsham near Eastbourne. The social housing estates of the Diplocks and the Town Farm Estate in Hailsham are very deprived and have one of the highest birth rates in the area. Additional problem areas in the Eastbourne catchment are in Seaside, Shinewater, Kingsmere, Willingdon Trees and parts of central Eastbourne.

The Boles Report has shown that both Eastbourne and Hastings have similar areas of deprivation with very little difference between them.

Currently, birth rates are far higher among this group of clients. They have high rates of teenage pregnancy, smoking, poor ante-natal clinic attendance, psychiatric problems, pre-term labour and maternity complications.

Hastings mother have a higher rate of low birth weight babies but Eastbourne has more induced births, Caesareans and admissions to the Special care Baby Unit.

The Confidential Enquiry into Maternal and Child Health (CEMACH) has shown that the maternal death rate is as much as twenty times as high among the most disadvantaged groups. CEMACH recommends that services target these groups and improve access to local care both in the Community and with local Consultant services.

Many of these clients do not have cars or cannot afford transport costs and research has shown that they are far less likely to attend appointments in distant hospitals.

Increasing Population

Eastbourne and Hastings are areas of increasing population growth and housing development. The most popular age to have a baby has now passed 30. Many couples who moved to the area in the last ten years will now be entering their 30s and will be in a more stable financial position to start a family. The government has also identified several areas around Eastbourne and Hastings for further housing development. A large increase in births is expected in the near future.

Private Care

Unlike most areas of secondary and tertiary care, women do not have the option of private care. This is one of the few areas where choice is restricted to the NHS. The majority of pregnant women would not be able to afford the high costs of private obstetric care which is not usually offered by private health insurance companies. The clients are young and include a large number who are socially deprived or who are just managing to pay their rent, mortgage and living expenses with little to spare.

Obstetricians and gynaecologists rarely undertake private obstetric care because of the very high costs of medical indemnity and they tend to restrict their private practice to elective gynaecological services.

There is no provision for private obstetric care in Eastbourne or Hastings.

Independent midwives are expensive and few in number. In reality, the nearest areas for private obstetrics are in Guildford and London.

Temporary Closures of Maternity Units

Eastbourne and Hastings Maternity Units occasionally shut for temporary periods when there is a high workload and shortages of staff. This problem also happens in Haywards Health and other medium size units around the country. Temporary closures are also common in large units such as Brighton for the same reasons. There is no evidence that larger units would be any better off.

The main underlying problem is a shortage of midwives and, more rarely, shortages of other staff because Trusts generally do not employ enough staff to cope with fluctuations in workload.

The Midwife Crisis

Midwife staffing in Britain is in crisis. Experts are warning that 10,000 more midwives are needed to prevent a further rise in blunders and deaths. The scale of the maltreatment has led to soaring medical negligence claims from mothers. The bill to the NHS has hit £1 billion for the last five years. Professor Jason Gardosi from the NHS Perinatal Institute has warned that failings in British maternity care are severe and endemic and that substandard care was going undetected because of a lack of proper monitoring.

Louise Silverton, deputy general secretary of the Royal College of Midwives has said that midwifery services are on a knife edge and the Government needs to take measures to address this.

They criticise the increasing tendency of Trusts to use well-meaning Health Care Assistants to undertake work which should be done by midwives.

The RCOG agrees that there is an urgent need to appoint more fully trained midwives as well as the need for more fully trained consultant obstetricians and gynaecologists.

The European Working Time Directive and Modernising Medical Careers

The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives have produced ample evidence that future maternity care must be delivered by fully trained consultants and midwives around the clock. At all times, trainee doctors and trainee midwives must be closely supervised. This approach has been ratified by many reports from the NHS Litigation Authority (NHSLA), the National Patient Safety Agency (NPSA), the Healthcare Commission and the NHS Institute for Innovation and Improvement.

In particular, junior medical staff must not be expected to make difficult decisions and undertake difficult procedures even at night without consultant presence. This is bad practice and is dangerous and it must be stopped.

In 2007, the new system for training doctors 'Modernising Medical Careers' will come into being and will mean that there are less experienced doctors who require greater supervision.

The Chief Medical Officer, Liam Donaldson, has stated that MMC will enable more service to be delivered by fully qualified doctors. From 2009, the European Working Time Directive (EWTD) will restrict doctors to a 48 hour week and this will reduce the availability of junior doctors to cover maternity services. The combined effect of MMC and the EWTD is acknowledged but the clear response from the RCOG is that more consultants must be appointed and that they should do the work on labour ward. The junior doctors in training will no longer be required to provide unsupervised service but will work alongside their consultants. All decisions and procedures will be closely supervised by fully trained consultants.

In 2004, the RCOG published: The European Working Time Directive and Maternity Services – Advice from the Royal College of Obstetricians and Gynaecologists. The Report stated 'The need for an experienced obstetrician to be resident in the Maternity Unit throughout the 24-hour period was universally recognised. '

The Report makes no recommendation about the size or location of consultant units. The Report describes the Rotherham Initiative stating 'The Rotherham Initiative provides a solution to the difficult problems of middle grade cover at night, an issue that remains unresolved in units around the country'.

The major change at Rotherham is on how the consultant works. 'We have expanded consultant numbers and embarked on night-time duties normally assigned to doctors in training. Although the changes are radical they have been manageable and at times enjoyable'. Consultants essentially do direct work at the coal face without the constant need for a middle grade doctor.

A return to a two junior doctor on-call rota on a single site or any site would be a retrograde step which may hinder progress and endanger patient safety.

The role of midwives is very important and there will be increased use of fully trained Advanced Midwifery Practitioners (AMPs) and Advanced Neonatal Nurse Practitioners (ANNPs). These colleagues will work alongside consultants and will practice extended skills such as clinical decision making and practical procedures such as Ventouse delivery. AMPs must only be developed when attention has been given to the present need for an increase in midwifery staff to deliver the essential skills of midwifery practice in ante-natal care, normal deliveries and post-natal care. AMPs and Midwife Consultants will reduce the need for junior doctors to provide service and will allow them to spend more time being trained by their consultant supervisors.

Subspecialist Care in Brighton and Pembury - Networks

Tertiary subspecialist care should be relocated in regional teaching hospitals and special units to allow secondary DGHs to concentrate on core services.

This is not a new idea and, in fact, very difficult cases have always been referred to London Hospitals e.g Guy's for anticipated neonatal cardiac surgery and Great Ormond Street for rare children's problems.

The Royal Sussex County Hospital, Brighton, is now the regional teaching hospital for Sussex and home to the Brighton and Sussex Medical School.

The recently approved new build PFI Pembury Hospital is likely to become a regional centre for tertiary services for patients from the Hastings area.

The Strategic Health Authority should network health care in the South East. The Scottish Network provides an excellent model for networking whereby essential core service are kept at local level with innovative staffing patterns where needed. Larger hospitals provide a broader range of services while subspecialist tertiary services are centred in the major urban teaching hospitals. The Scottish Network has maintained the provision of consultant obstetric services even in very small units in isolated areas such as Caithness, the Hebrides and the Borders.

Networks in Obstetrics and Gynaecology

Major gynaecological cancer operations are already centralised in Brighton with an excellent Sussex Cancer Network. Other procedures would benefit from centralisation e.g. assisted conception, complex laparoscopic surgery for hysterectomy and endometriosis, complex urogynaecological procedures and fetal medicine.

High Risk Obstetrics

A small number of women would benefit by transfer of their obstetric care to the regional teaching hospital e.g. extreme prematurity, intra-uterine growth retardation and congenital anomalies where Neonatal Intensive Care is likely to be needed. This often happens already but more robust arrangements are desperately needed. There is also evidence that cases of severe pre-eclampsia and severe diabetes may be better off in a regional unit.

This may involve the transfer of about 50 high risk obstetric cases each year from Eastbourne and Hastings. In exchange, it would make sense for Eastbourne to receive more medium and low risk cases from Lewes, Newhaven and Uckfield and for Hastings to do the same for areas closer to Pembury and Ashford.

THE BRIGHTON PROBLEM
Neonatal Intensive Care – NICU – Level 3

The tertiary level Trevor Mann Neonatal Intensive Care Unit in Brighton is the designated NICU for Eastbourne and also takes transfers from Hastings. Some Hastings cases are transferred to Pembury which provides a Level2/3 service and it is likely that the new Pembury Hospital will be a full Level 3 NICU.

The redesign of obstetric services must improve prompt access to high risk care within the region.

For many years, Brighton has had major problems in accepting in-utero and neonatal transfers from Eastbourne.

The situation is a disgrace.

In about 50% of requests, there is no room and the unit is shut to admissions. Staff in Eastbourne waste many hours when trying to find a suitable available unit and neonatal cot. There has been a chronic lamentable failure to deal with this problem. Consequently, mothers and babies have been transferred to many other hospitals across the South East and London and even as far afield as Southampton and Cambridge.

The Brighton Problem must be addressed. The obstetric and neonatal services in Brighton must be properly resourced and staffed so that the unit can always accept admissions from neighbouring areas.

Care in The Community

The future of obstetric and gynaecological services should also see a big increase in care delivered in the community. Community Ante-Natal Clinics in Hailsham, Seaford, Uckfield and Heathfield should be reinstated. An improvement in midwifery staffing levels will allow more community care, home births and support for schemes such as Sure Start.

Much benign elective gynaecological care could be managed in the community by General Practitioners with a Special Interest in Gynaecology (GPSIs) and Community Gynaecologists (Consultants in Sexual and Reproductive Health).

General Practice Referral Management Schemes with triage of patients has allowed up to 50% of GP referrals for benign gynaecological problems to be managed in the community. This allows implementation of NICE Guidelines on the management of heavy menstrual bleeding and infertility in primary and secondary care with significant savings in the cost of health care. The savings can be re-invested in the provision of essential core services at local level and subspecialist services at secondary and tertiary levels.

Consultant Maternity Services in other areas

Many Communities have bent over backwards to design local high quality consultant delivered maternity services which suit their health care needs.

In many areas, the consultant body have supported the need to change their working practices, appoint more colleagues and redesign their work patterns to meet these needs.

These range from slightly bigger units such as Hinchingbrooke, Huntingdon to slightly smaller units such as Withybush, Pembrokeshire to very small units in Caithness, Elgin, Gibraltar and the Isle of Man.

In these areas, local women have expressed a very high degree of satisfaction with a consultant delivered local service and these units have a high level of safety. They are all sensibly networked with major tertiary hospitals in their regions.

Affordability

The Clinical Services Review has already shown that the retention of essential core services on both sites may be the most cost-effective option.

OPTION 5 - SAVING LIVES is clearly affordable within the current financial envelope. The **OPTION 5 - SAVING LIVES** will produce a separate paper demonstrating the financial benefits of their proposal.

CONCLUSION

OPTION 5 - SAVING LIVES provides the best high quality health care for pregnant women by maintaining consultant delivered services in both Eastbourne and Hastings. It is the option that is clearly favoured by the people of both towns.

It is safe, accessible and affordable and addresses the needs of our people and will provide the best outcome for our future.

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*Core services include 24 hour A & E full service, 24 hour in-patient Paediatric beds, 24 hour Consultant - led Obstetric service, 24 hour acute Medical and Coronary care beds, 24 hour acute Surgical, I.T.U. & H.D.U. beds an any downgrade in Maternity and Children's services.

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