Maternity and Paediatric Service Proposals
Consultation Document

OPTION 7
THE CAMPAIGN OPTION

A Safe and Accessible Service for East Sussex
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A Safe and Accessible Service for East Sussex

Pride of the Community

Adapt, Develop, Evolve, Specialise

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

The clearly supported local need is for both Eastbourne District General Hospital and The Conquest Hospital (Hastings) to have the same essential core services:

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 7
THE CAMPAIGN OPTION

Eastbourne – Medium Risk Obstetric Unit
    Level 1/2 SCBU (Special Care Baby Unit)

Hastings – Medium Risk Obstetric Unit
    Level 1/2 SCBU (Special Care Baby Unit)

Crowborough – Midwife Led Unit

Brighton and Pembury – Very High Risk Obstetrics and Neonatal Intensive Care Unit, Subspecialist Gynaecology, Level 3/4 SCBU (Special Care Baby Unit)

Eastbourne and Hastings – Community Care Obstetrics and Gynaecology
Foreword

As a Campaign Group we feel passionate about keeping essential core services at our local hospital, Eastbourne DGH. It is essential that core services, those services you need in an emergency, are literally on the doorstep or at least can be reached within 30 minutes.

The local NHS have launched their public consultation on ‘Better Beginnings’ with proposals for the future reconfiguration of Maternity and Paediatric services in East Sussex. Their consultation document presents six options NONE of which include a TWO SITE option for Consultant delivered services, despite a successful campaign in 2008 which resulted in the then Secretary of State for Health, Alan Johnson, stopping an attempt by the local NHS to do exactly what the local NHS are now proposing.

The local NHS Case for Change is flawed

• Myth – The need for 2500 births per unit.
  Fact – this is not a national standard but one created by a local team. There were about 5,500 births in East Sussex in 2012 and this is expected to rise.

• Too many serious incidents
  This is the result of management failure to staff the units safely. This same management which removed consultant-led Maternity and Paediatrics from Eastbourne DGH in May 2013 is still in charge!

• Too many transfers
  Transfers should only happen if more specialised care is needed. Again management failure to staff units appropriately has resulted in this.

• High number of diverts
  Again this is management failure to manage units correctly. What was an unsatisfactory arrangement before the changes is now much worse. Using this as a reason suggesting this makes things better for women in labour is the opposite. Now the place where some women were previously diverted to (before the changes) is now where the majority of women are forced to go.

Once again we have had to explore other areas and units to see what is possible. There are many other smaller Maternity units with under 2500 births, which are very safe, so we know it’s possible. Option 7 – The Campaign Option provides the answer. It provides the safest option which we believe is what the majority of the population want.
The Trust implicitly argues that training/career development issue is satisfied by a mixed consultant/midwife unit with around 4,000 births per annum. By splitting this activity between two locations the same volume and variety exists and it is simply the inflexibility of the rotas that prevent individual clinicians from the same training/career development potential. What resources are required to adequately staff two such units? Surely this would then be implicitly safer than just one unit.

Eastbourne, compared with many places, is a very attractive option for anyone contemplating a consultancy. A teaching hospital is close, it is wealthy and there should be no lack of private gynaecology work. The only drawback is the hospital and the on-going problems in Obstetrics and Gynaecology. A clear, well defined vision for the future of the DGH as a whole would be a massive attraction.

No-one in training spends their whole time in one place - they would move to general units, like Eastbourne, for hands on experience and specialist units for greater experience in the narrow field they hope to specialize in. What is lacking is the will to make it work on two sites.

Option 7 – The Campaign Option provides a two-site solution for consultant-led maternity and paediatrics which is what the local population want. This is the safest and most accessible option which does not reduce choice. The CCGs must consider this!

Please feel free to contribute with your comments and feedback via our Campaign website www.savethedgh.org.uk. If you are completing the Better Beginnings survey, please do not tick any option (Option 1-6) but write in Option 7 in the comments box.

Chair – Save the DGH Campaign
The Save the DGH Campaign Group members are:-

Monica Corrina-Kavakli – Parent Campaigner and public representative
Richard Booth – Treasurer and Chartered Accountant (LMDB Accountants, Eastbourne)
Barry Davis - Legal Advisor and Solicitor (Mayo Wynne Baxter, Eastbourne)
Martyn Relf - Chair of Churches Together for Eastbourne.
Stephen Lloyd MP for Eastbourne and Willingdon (Liberal Democrat)
Vincent Argent – Consultant Obstetrician/ Gynaecologist and Medical Advisor
John Clarke - Community Dermatologist and Medical Advisor
Sandy Medway - Churches Together and previous East Sussex Hospitals NHS Trust non-executive Director
Tim Cobb - Public Relations Advisor (Cobb PR, Eastbourne)
Ian Lucas - Representative of Local Business and Director of Eastbourne & District Chamber of Commerce
Councillor David Tutt -Leader of Eastbourne Borough Council (Liberal Democrat)
Councillor Caroline Ansell – Conservative Prospective Parliamentary Candidate for Eastbourne and Willingdon
Councillor Colin Murdoch - Conservative
Lee Comfort - Labour Party Representative
Selene Edwards - Facebook and Social Media
Alan Thornton – UKIP Party Representative
Tim Geitzen - Retired GP and Medical Advisor
Brian Valentine – Retired Consultant Obstetrician/ Gynaecologist and Medical Advisor
Liz Walke - Chair
East Sussex Residents Deserve The Best

Communities put maternity and paediatric 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 residents and business community regard obstetric and paediatric services as the flagship of their community and essential for the retention and relocation of businesses.

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

The two campaign groups SaveTheDGH and HandsOffTheConquest have campaigned since 2006 and have received huge support from residents who have clearly expressed that essential core services must be kept in both towns.

Clinical Commissioning Groups – Buying the Service that People Need
Clinical Commissioning Groups which are GP-led decide and purchase the services needed by their patients and the local community. This should allow them to obtain the best high quality care based on clinical need rather than any reconfigurations which centralise services.

Maternity Units in Eastbourne, Hastings and Crowborough
In 2007, the Consultant Led Units in Eastbourne and Hastings, and the Midwife Led Unit in Crowborough were very popular. They were run by dedicated staff who provided a high standard of care to the local people.

The constant threat and rumours of single siting Maternity services in Hastings over the years has resulted in threatening the stability of a previously very safe unit. Threats and rumours which were realised by the centralisation of obstetrics in Hastings and a Midwifery-led unit in Eastbourne as a temporary measure in May 2013.

The ‘Worthing Report’ showed that both Eastbourne and Hastings had a very good safety record and that their perinatal statistics were equivalent to regional and national figures.
The high quality of these units was recognised at that time by the award of Level 3 Clinical Negligence Scheme for Trusts (CNST) Accreditation. Such high standards had only been achieved by 20% of maternity units in the South East.

Yet despite this, in 2007, there was an attempt by the local NHS to single-site Maternity services at the Conquest hospital in Hastings, removing the consultant-led Maternity service from Eastbourne DGH. The Save the DGH Campaign fought the proposals and received overwhelming public support, but despite this the local NHS pressed ahead. This was only stopped by the Secretary of State for Health at the time when the East Sussex Health Overview Scrutiny Committee referred the matter to him. The local NHS were told that consultant-led Maternity services MUST remain at BOTH Eastbourne DGH and The Conquest.

However, these services have been constantly under threat despite the Secretary of State for Health’s directive that the IRP decision be implemented. The management of Obstetrics has been under constant threat of single-siting and consequently job satisfaction and staff retention have been a problem with attraction to the unit for new applicants. Added to this instability and offer of short term contract has added to staff recruitment problems.

INDEPENDENT REVIEW BY THE INDEPENDENT RECONFIGURATION PANEL

The Independent Reconfiguration Panel (IRP) published its report on proposed changes to maternity, gynaecology and special baby care services in East Sussex on September 4th 2008. This report made clear recommendations for ensuring the delivery of safe, sustainable services in East Sussex. These were as follows:

1. The IRP does not support the PCTs’ proposals to reconfigure consultant-led maternity, special care baby services and inpatient gynaecology services from Eastbourne District General Hospital to the Conquest Hospital at Hastings. The Panel does not consider that the proposals have made a clear case for safer and more sustainable services for the people of East Sussex. The proposals reduce accessibility compared with current service provision.
2. The Panel strongly supports the PCTs’ decision to improve antenatal and postnatal care and associated outreach services. These improvements should be carried forward without delay.

3. Consultant-led maternity, special care baby, inpatient gynaecology and related services must be retained on both sites. The PCTs must continue to work with stakeholders to develop a local model offering choice to service users, which will improve and ensure the safety, sustainability and quality of services.

4. The PCTs with their stakeholders must develop as a matter of urgency a comprehensive local strategy for maternity and related services in East Sussex that supports the delivery of the above recommendations. The South East Coast SHA must ensure that the PCTs collaborate to produce a sound strategic framework for maternity and related services in the SHA area.

5. The PCTs working with all stakeholders, both health providers and community representatives, must develop a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the Panel’s recommendations.

   Alan Johnson, the Secretary of State for Health in September 2008, accepted the IRP’s recommendations in full.

**Safety**
Recommendation 1 clearly states:
The Panel does not consider that the proposals have made a clear case for safer and more sustainable services for the people of East Sussex.

**Must keep two Maternity Units**
Recommendation 3 states:-
Consultant-led maternity, special care baby, inpatient gynaecology and related services must be retained on both sites.

**Improving access for women**
Recommendation 1 states:-
The proposals reduce accessibility

**IRP Conclusion** stated
The IRP concluded that the proposals were principally driven by the Primary Care Trusts’ (PCTs) attempts to address future medical staffing issues, as perceived at the time of consultation. The strong focus on staffing concerns meant that less consideration was given to the issue of accessibility and choice of services for local people.

Arguments that a single site solution would have compensating improvements in safety and sustainability were also considered by the IRP. The IRP does agree that some changes to the staffing of the units is required to continue to deliver safe, sustainable services, however it does not accept that the single site solution is the only or best option to achieve this.

The PCTs should consider alternative staffing models which have not been explored so far, such as using advanced midwifery practitioners to support junior and middle grade staff. It is incumbent on the local NHS to explore the potential of these roles to develop midwifery careers and support doctors’ roles locally.

During the review the IRP considered the local geography and transport infrastructure, deciding that the journey from Eastbourne to the Conquest Hospital in Hastings posed a risk of incidents for women, especially during unexpected transfers.

The IRP also recognised the potential time consuming and costly journeys to Hastings for both staff and women’s families.

The PCTs must continue to work with stakeholders to develop a model of maternity care that provides choice for women and further enhances the safety, sustainability and quality of services. The IRP was impressed by the PCTs’ commitment to support home births, which is likely to be further enhanced by the retention of consultant-led maternity units at both sites.

The IRP decision and recommendations in response to the local NHS plans are as relevant today as in 2008.

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.
**Keeping the NHS Local - A New Direction of Travel**

The Department of Health published a 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. There is evidence that “small can work” and new models of care need to be developed. It is time to challenge the biggest is best philosophy.

**SAFETY**

**Serious Untoward Incidents**

This is what the local NHS said prompted the centralisation of Consultant-led Maternity at the Conquest. There were an increasing number of serious incidents – indeed a huge increase! What prompted this is unclear as the serious incidents have not been made public. Could it have been one member of staff or a particular staffing model, or something else which showed a risk which resulted in this massive increase? Had management decided to single-site services before these serious incidents occurred? If the local NHS Trust say there are significant safety issues, they can just remove services in the name of safety with absolutely no public consultation at all, which is exactly what happened at the beginning of 2013. Of course this was the same NHS Trust
who made an attempt to single site Maternity in 2007 and spectacularly failed when the Secretary of State for Health intervened, but there has always been a view held that the threat to single-site Maternity services at the Conquest never went away and the decision in 2007 had never been fully accepted.

After the temporary change was made a review was undertaken by the RCOG namely “Review of the Obstetric and Neonatal Services of East Sussex Healthcare NHS Trust at Conquest Hospital Undertaken by: Mr Paul L Wood MD FRCOG (Lead Assessor), Mr Andrea Galimberti FRCOG (Co-Assessor) and Professor Stewart Forsyth OBE MD FRCPCH (Co-Assessor) on 8 and 9 August 2013”

This review identified the main risk factors before the changes being:-

- Increased numbers of high risk pregnancies.
- Lack of 24/7 availability of medical and midwifery staff with the required competences.
- An ongoing dependency on temporary staff.
- Potential failure of the risk mitigations at short notice.
- The lack of availability of clinical leadership in a service delivered on multiple sites.

The themes identified from the serious incidents before the temporary changes were:

- Senior opinion not being sought in a timely manner.
- Women not being reviewed in a timely way.
- Poor care resulting in harm to babies at birth.
- Poor communication in relation to planning and communicating care plans.
- Poor liaison with senior colleagues.
- Care given by agency staff causing harm.
- Junior staff not recognising the deteriorating condition of a patient and escalating appropriately.
- Inadequate supervision of junior staff.
- Maternal risk factors.

The concerns raised by NCAT included:

- Delays in escalation.
- Lack of supervision of locum and middle grade staff.
- Validity of the interpretation of Serious Incident Reports.
- A very worrying culture of complacency in relation to risk within maternity and paediatrics.
- Poor record keeping.
• Poor communication.
• Lack of plan of care.
• Lack of documentation.
• Lack of appropriate level for opinion/planning.
• Inappropriate grades/level of staff undertaking or providing care.
• Where a serious incident involved a poor outcome for the baby there appeared to be a minimal review of obstetric care prior to the birth. The report also said that NCAT stated that they felt that the RCA (Root Cause Analysis) Enquiry Team did not appear to have asked the appropriate questions and therefore they felt the conclusions were likely to be incorrect.

All the areas highlighted reflect the dependence on a management who appear to have failed to fully explore alternative staffing models which was demanded by the IRP. The determination by the local NHS to succeed in single-siting consultant-led Maternity has been rewarded by management allowing a previously very safe service delivered on two sites to become unsafe.

It is this same organisation (ESHT), where these serious incidents happened, which allowed Maternity services to become unsafe to give them reason to single-site these services, who are to be trusted with the future reconfiguration of our services. This should be challenged and Option 7 does just that.

WHAT IS SAFEST?
You CANNOT predict obstetric emergencies
It is clear that many obstetric emergencies are not predictable. 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 occur during the 3rd stage of labour with no warning and require immediate action.

Sudden 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
Unstable lie/presentation

**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. Over 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 even in the best circumstances.

We believe that closure of local services and the increased travel times will lead to a large increase in legal claims, even if some litigation is based simply on the perception that the delay in transfer caused the problem. This 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 necessarily considered to be critical in influencing fetal outcome and up to 75 minutes may be reasonably be accepted for a Grade 2 Urgent Caesarean but it is not considered ideal and could not be defended should there prove to be fetal cerebral damage acutely or at a later date.

Conversely, it is generally agreed that ‘Crash’ Caesarean sections for unexpected emergencies such as a potentially 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 considered acceptable for difficult Caesarean sections to be performed by medical staff in training and a consultant presence is considered optimal risk management at any caesarean section.

**The Caesarean Decision**

Decision making is very important. There is concern about increasing Caesarean section rates which has been ascribed to a lack of senior presence on the labour suite during the decision making process. Some emergency caesareans might 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.

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 Caesarean sections which are left to middle grade staff although the previous paragraph described the RCOG’s stated wish and requirement 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 acceptably recognised specialised units.

**Travel**

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

Resuscitation and controlled fluid replacement prior to transfer is a cornerstone of immediate care in obstetrics as well as in major trauma as seen in RTAs (Road Traffic Accidents), major incidents and on the battlefield. Such cases are best supervised by an anaesthetist with Advanced Trauma Life Support (ATLS) certification.

Bleeding is a major threat to the survival of both mothers and babies. Advanced Trauma Life Support (ATLS) is also used to gauge obstetric shock as Classes 1-4 shock can develop both rapidly and unexpectedly in obstetric practice. Such emergencies require senior anaesthetic input as events can change rapidly and fatally if not recognised and immediately acted upon.

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 a planned expansion in the number of local consultant maternity units on the basis of enhanced safety. Subsequently it was assumed that Ambulance Paramedics would play an increasing role in transfers to and between hospitals but lack of resources has restricted the development of a comprehensive training programme for Paramedics in Emergency Obstetric Care, which is recognised for its stabilisation difficulties.

The need for Emergency Domiciliary Obstetric Services and a prompt competent response was recognised by the RCOG in their 1990 publication entitled: The Future of Emergency Domiciliary Obstetric Services (‘Flying Squads’).
Any single site arrangement requires an obstetrician, anaesthetist and midwife as in the old flying squads. Even then it would not be as safe as a core competent static unit in both towns.

**Time between Eastbourne and Hastings**

This is a crucial issue.

Emergency transfer times should include ambulance call up time, pick up time, actual road transfer time and then the download time and diagnostic assessment time. That will always be in excess of RCOG and NICE 30 minute rule and this clearly breaches the national benchmark standard of 30 minutes for the management of obstetric emergencies.

AA road distance and times are as follows:
Eastbourne DGH – Conquest Hospital 20.5 miles – 37 minutes

However, it is well known that the actual travel time taken is often far longer up to an hour or more 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. Total gridlock is not an unusual occurrence. The journey west to the Royal Sussex County Hospital in Brighton is often quicker as in parts there is a dual carriageway.

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.

**The Royal College of Obstetricians and Gynaecologists (RCOG)**

**Reconfiguration of women’s services in the UK – Good Practice No. 15 Dated December 2013**

**Capacity and size of Obstetric units**

This newly published report recognises that there is no optimum number of births to make a unit safer. It says that in smaller units (between 2500 and 4000 births per year), 24-hour presence may not be cost-effective and *Safer Childbirth* suggested a 60-hour-per-week presence as a minimum standard. It states “There is no published evidence on the ideal size for a maternity unit.”
Geographical access to units
It also states “Women who choose to give birth out of hospital must have access to ambulance services for quick transfer to hospitals in the event of emergencies. The Birthplace study conducted by the National Perinatal Epidemiology Unit (NPEU) has revealed that the transfer rates vary between 9% and 45%, depending on the mother’s parity.” For clarity a Birthing unit such as currently temporarily reconfigured at Eastbourne DGH and Crowborough would be considered as out of hospital. The document also states that other circumstances such as geography and location of units must be carefully considered.

Workforce Planning – Obstetric staffing
The report states “Of those who continue as low risk and start labour in a low-risk environment, over 40% will need transfer to an obstetric unit in labour. These transfers from low risk to higher risk care need to be seamless. For ease of transfer, labour care in an alongside midwifery unit (AMU) or a mixed obstetric service allows quick, easy and safe escalation of care.”

Co-Dependent Emergency General Surgery
The report mentions Co-Surgical support. The Save the DGH Campaign has consistently said about the need to have all core services at Eastbourne DGH. It says “Every obstetric service must have close access to surgical backup for infrequent complications occurring during childbirth, which include damage to bladder, bowel or major blood vessels. In addition, major bleeding complications in obstetrics and gynaecology may need access to interventional radiology and close proximity to laboratory services providing blood transfusion”.

The local NHS should listen
This report also adds under the heading “NHS reform and change” the recent RCOG report Tomorrow’s Specialist found a difference between what doctors perceive women need from healthcare services and what women actually want. There is therefore the need to ensure close working with women so that patient-centred care can be delivered.
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.’ Remember there are supposed to be 2 midwives at a homebirth or 1 midwife with a doctor, but in these litigation conscious days, most GP’s do not undertake home deliveries.

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 and using multi carriageway motorways:

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 – 37 minutes

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, were often transferred to Eastbourne but Hastings is too far and therefore Pembury is used.
There has been some concern about the relative safety of stand alone MLUs. In November 2005, the National Institute of Clinical Excellence published a warning that evidence suggested that MLUs were slightly less safe.

**Consultant numbers**

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

By 2007 the PCT and ESHT stated that there were only 7 substantive consultants. There was no attempt to explain why the consultant workforce had been reduced by 30\% in complete contravention of the RCOG requirements for consultant expansion and a consultant delivered service. The Trust appeared to make no attempt to advertise for new substantive consultants yet consistently stated that there was a national shortage of eligible consultants. There was not a shortage and, as was stated at that time, there was, in fact, a large number of fully trained doctors who had 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.

Prior to the changes in May 2013 there were 5 consultants on each site providing obstetrics and gynaecology. The consultants provide 40 hour presence on each site (ie 20 PA’s) but this is not prospective. ESHT said that emergency measures had been required in September 2012 due to a middle grade vacancy of 37.5\% and the retirement of 1 consultant and emergency leave for another at Eastbourne DGH. There were 16 “middle grade” staff, 8 on each site. Of these 4 were Specialist Trainees and 12 were non training grade doctors.

There has been increasing difficulty recruiting and retaining adequate middle tier doctors. This has been compounded by legislation surrounding employment of overseas doctors, the availability of training grade doctors partly out of choice but also the national reduction in specialty trainee numbers and ST3 recruitment. This is further challenged by the reputation of ESHT with a history of the prospect of reconfiguring Maternity and other core services over the last 10 years or more.
**Midwifery staffing**

ESHT has stated a ratio of 1:31 (range 1:30 - 1:34) over the last 7 months against their target of 1:28. In only 2 months during this period was the target reached. NCAT said this should be RAG (Traffic Light - Red Amber Green) rated as Orange and at times Red.

Staffing is particularly challenging as many midwives are leaving due to work pressures and increased travel time to work. And considerable unrest has been caused with staff being transferred at short notice to the Conquest even from Crowborough.

Prior to the changes in May 2013, use of bank staff had been particularly heavy at the Conquest to cover the acute care (150 hours/month) and surprisingly at Crowborough which averaged 85 hours/month.

**Maintaining skills**

A lot has been made of the need for staff to maintain ‘hands on experience’ even when fully trained as Consultants. Attainment of which has always been difficult. Especially in big training units when there are several levels of staff looking for that experience/training numbers as in Teaching Hospitals. Even with small Consultant lead units, with only Senior House Officers [SHO] on their first basic introductory experiences, the Consultant may only accrue his numerical requirements if the training events with the juniors are double accounted. Otherwise the junior member of staff might not be able to get his experience and training.

So to contend that increasing the delivery numbers on one site, whilst at the same time increasing the numbers of Consultant and Junior staff at Registrar and SHO level, does not mean there will be greater personal hands on procedural experience in all the interventive obstetric procedures. As this requirement is stated to be so important one has to consider whether the present method of delivering the service might be less than ideal to fulfil all the criteria for Continuing Professional Development for the staff that require numerical confirmation of continuing experience.

Whatever the size of a unit the dilutional effect of overstaffing on personal involvement is a problem and the anxiety has always been that Consultants seldom perform assisted deliveries once appointed, unless they work privately where there is a personal contract. But in most NHS units who have a middle
grade Registrar staff layer and an SHO layer the Registrar is generally tasked to
teach the SHO whilst increasing his/her own experience in both teaching and
experience.

It is for this reason the Royal College of Obstetricians & Gynaecologists [RCOG]
have for at least 15yrs been attempting to ensure and increase Consultant
guaranteed presence on the labour suite with the absolute ideal being 24 hr
presence 7 days a week. [168 hrs]. Most units achieve 40 hrs/ wk availability,
but not necessarily presence, and some 60 hrs but with the European Working
Time Directive [EWTD] that is only achieved by increasing the numbers of
Consultants. Which again reduces their chance of experiencing the unusual
even in the largest of units.

So no system is perfect but in a small unit it would seem sensible to consider a
staffing module that only consists of Consultants or Senior Specialist staff who
are fully qualified and competent. There may be junior staff who require
initiation or onward experience training in the presence of a trained Consultant
or Specialist but if events were double accounted for both participants then
the reduced numbers should not be a problem with the RCOG.

As the CCG’s and ESHT have stated that finance is not a consideration the
staffing of 2 units in this manner would be feasible and safer for all the patients
in the catchment area. It would also comply with the original inception of
having a hospital in both towns so that services were both composite and as
easily accessible to patients as was possible, especially from the fringe areas.
The paediatric and anaesthetic services would have to be similarly available.

All units should be Midwifery led in that midwives have historically met and
triaged patients as they arrived. They have, in most places, worked
harmoniously as a team with the medical staff doing joint rounds every 4 hours
so that everybody is appraised of the workload and the possible cases that
might give a problem later when the midwife would decide that medical
assistance or consultation is sensible in the patient’s interest even if that
simply involved being a spare pair of hands when necessary due to the
workload at the time, and that can occur in both very big and small units.

The Trust implicitly argues that training/career development issue is satisfied
by a mixed consultant/midwife unit with around 4,000 births per annum. By
splitting this activity between two locations the same volume and variety exists
and it is simply the inflexibility of the rotas that prevent individual clinicians from the same training/career development potential.

**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, in 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
It has been mentioned previously in the section under the newly published RCOG report headed “Reconfiguration of women’s services in the UK – Good Practice No. 15” that it states “There is no published evidence on the ideal size for a maternity unit.”

Another article: Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women was 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 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 7 - THE CAMPAIGN OPTION clearly provides the greatest choice between consultant delivered services in both Eastbourne and Hastings as well as care in the community, midwife-led care in the AMUs (Alongside Midwifery Units) at Eastbourne or Hastings and a MLU (Midwife-led Unit) at Crowborough, supported home birth and care of very high risk problems in the Brighton Teaching Hospital.

Removing consultant-led Maternity reduces choice for the majority of women who previously used Eastbourne DGH. Prior to the temporary changes in May 2013, there were on average 38 births a week in Eastbourne. Since May 2013, on average, there has been less than one birth a day.

**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, Hampden Park, 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 mothers had a higher rate of low birth weight babies but Eastbourne historically had more induced births for clinical reasons, 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**

Birth rates in East Sussex are projected to rise over the next ten years. According to the latest statistical data provided by East Sussex County Council:

“In 2012, there were about 5,500 live births in East Sussex, the highest number since 1994. The number of births last fell in 2002 and has increased by 20% since then. Over the last five years the number of births has risen by almost 6% in the county, higher than nationally (3%) and regionally (4%).

The largest increase was seen in Eastbourne (9%) followed by Lewes (8.5%) and Rother (7.6%). At the same time the number of births in Wealden has increased by only 1% in the last five years and in Hastings by almost 5%.”

Eastbourne is an area of increasing population growth and housing development. There are also several areas around Eastbourne and the Weald where there is further proposed housing development with the prospect of several thousand MORE homes being built.

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 most popular age to have a baby has now passed 30.

**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. Brighton might do private deliveries, though women may go to London.

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

**Diverts and Temporary Closures of Maternity Units**
Eastbourne and Hastings Maternity Units occasionally shut for temporary periods for various reasons eg. 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 numerically large units would be better off when the unit itself has not been enlarged exponentially (in terms of more beds, facilities and space).

**The Midwife Crisis**
Historically midwife staffing in Britain has been in crisis with huge shortages. However locally, the over-riding fact which is affecting the local maternity service is the reputation of East Sussex Healthcare Trust (their employer) with their expectations. Midwives who previously worked at Eastbourne DGH now have nearly 2 hours added to their working day for travelling time to the Conquest. There have also been sudden closures of the Crowborough Birthing Centre due to staffing shortages at the Conquest many miles away with midwives having not only to travel but working in a completely different environment. Midwives who previously had enjoyed their vocation are leaving as a result of the current situation.
ESHT and the (European Working Time Directive) and Modernising Medical Careers

The EWTD has been a great challenge to all NHS management however the implications locally are even more severe since the temporary changes were instituted. Staff travel from Eastbourne DGH to the Conquest (or Brighton) in their contracted hours, and with women being transferred in labour accompanied by midwives, this will erode clinical time and deplete unit staffing even further.

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) and the Care Quality Commission (CQC).

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

In 2007, the new system for training doctors ‘Modernising Medical Careers’ came into being and meant that there would be less experienced doctors who would therefore require greater supervision. Is this where ESHT failed to provide adequate supervision which led to the serious incidents which resulted in the temporary removal of the consultant-led obstetric service at Eastbourne DGH?

The then Chief Medical Officer, Liam Donaldson, stated in 2007 that MMC will enable more service to be restricted to fully qualified doctors. Implications locally are even more severe since the temporary changes were instituted. From 2009, the European Working Time Directive (EWTD) will restrict doctors to a 48 hour week and this reduced the availability of junior doctors to cover maternity services. The combined effect of MMC and the EWTD was acknowledged but the clear response from the RCOG was that more consultants must be appointed and that they should provide a consultant supervised service on the labour suite. The junior doctors in training would no longer be required to provide unsupervised service but would work alongside
their consultants. **All decisions and procedures should 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.

**Midwives**

The role of midwives is very important and there should be an 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.

NHS England and the NHS Trust Development 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 that can benefit from subspecialist centres can include 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 could be required if there are areas without excellent basic core services as proposed by ESHT and the 3 CCG’s. Family travel then becomes a problem both financially and with family disruption etc.

But at present with Eastbourne being an MLU only the statistics suggest a move away from Eastbourne DGH to Brighton from Seaford and Haywards Heath from the High Weald area. These changes could only be altered by a return to 2 Consultant-led units (CLU) as promised by ESHT when they temporarily closed the Eastbourne (CLU) in May 2013.
TRANSERS TO BRIGHTON

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 full Level 3 NICU (Neonatal Intensive Care Unit).

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

Historically, Brighton has had major problems in accepting in-utero and neonatal transfers from Eastbourne. This situation should not happen.

In 2008, in about 50% of requests, there was no room and the unit was shut to admissions. Staff in Eastbourne wasted many hours when trying to find a suitable available unit and neonatal cot. Consequently, mothers and babies were transferred to many other hospitals across the South East and London and even as far afield as Southampton and Cambridge.

If this is still a problem this 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. The situation is dangerous and likely to lead to heavy litigation costs in the future due to cerebrally damaged babies at birth or antenatally.

Care in the Community

There has been an increase in care delivered in the community. Community Ante-Natal, Post-Natal Clinics and clubs are held regularly in centres throughout the area and these must continue and expand if demand is not met.

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 Referrals with triage of patients should allow 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 and Yeovil 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.

**WHAT ABOUT PAEDIATRICS?**

It has been made clear by the local NHS that the only reason the Paediatric service and Littlington Ward (at Eastbourne DGH) was downgraded was a direct result of the inter-dependency with Maternity services. It is absolutely essential that consultant-led Paediatric services are brought back to Eastbourne DGH.

Currently, under the temporary arrangements a very sick child who cannot be discharged home as they are so ill cannot stay at Eastbourne DGH, they are transferred to the Conquest. It is these children who have to undertake an ambulance journey whatever the weather and road conditions outside the comfort of the hospital when they are too sick to go home!
This is a terrible testament to the local NHS who have inflicted this on the most vulnerable members of our society – our children! This must NOT continue.

OPTION 7 – THE CAMPAIGN OPTION is clearly the most popular option and should be worked on to produce an excellent service which meets the needs of the local population.

Appendix 1 shows a proposal in full made to ESHT by the Paediatricians who worked at Eastbourne DGH and their recommendation. Although not ideal, we would support their recommendation.

AFFORDABILITY
The Clinical Commissioning Group insist that safety is the factor and not cost. Interestingly previous studies in 2007/08 have shown that the retention of essential core services on both sites may be the most cost-effective option with the correct staffing models. It is important to note that travel costs to staff, hotel accommodation for Eastbourne consultants (in all specialities) on call plus additional ambulance journeys must be accounted for in the single-site options.

East Sussex Clinical Commissioning Groups (CCG) forecast expenditure is shown below and split into each CCG. EHS (Eastbourne, Hailsham and Seaford), H&R (Hastings and Rother) and HWLH (High Weald, Lewes and The Havens).

<table>
<thead>
<tr>
<th>Service Description</th>
<th>2013/14 Forecast Expenditure</th>
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<tbody>
<tr>
<td></td>
<td>EHS</td>
</tr>
<tr>
<td>Obstetrics and Midwifery</td>
<td></td>
</tr>
<tr>
<td>In-patient obstetrics and midwifery</td>
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</tr>
<tr>
<td>Other Obstetrics and Midwifery</td>
<td>3.2</td>
</tr>
<tr>
<td>Total</td>
<td>6.2</td>
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</tbody>
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Gynaecology
| Emergency In-patients                  | 0.4  | 0.4  | 0.0  | 0.8   |
| Total                                   | 0.4  | 0.4  | 0    | 0.8   |
Paediatrics
Emergency & Elective In-patients  2.5  2.6  0.3  5.4
Total  2.5  2.6  0.3  5.4

All Services  9.1  9.5  1.3  19.9

The two big points on finance are:
(1) The Trust argues everything on “safety” grounds and say it’s not about finance.
(2) Any modest savings from centralisation are small in comparison to the Trust’s overall deficit.

GOING FURTHER...
East Sussex Healthcare Trust who provide Maternity and Paediatric services have failed the local population not only by removing consultant-led Maternity and Paediatrics, but by removing emergency General Surgery, Trauma and emergency Orthopaedics from Eastbourne DGH which has, in our opinion, threatened the future of our local hospital. Removing any core service undermines the others and the domino effect happens.

TIME TO CHANGE
Relying on a local NHS Trust who have removed core services from our local hospital and have consistently not met quality standards or financial budgets does not make for a bright future.

ESHT have had to delay becoming a Foundation Trust hospital several times because they have not met the requirements set down by the Department of Health. Currently they are being overseen by the NHS TDA (Trust Development Authority) with constant financial problems not being solved despite employing Turnaround directors and teams over the years at great expense.

ESHT admitted its failure by downgrading Maternity and Paediatric services at Eastbourne DGH for reasons of safety, in May 2013 and against IRP recommendations. This Trust had failed to ensure a safe service was provided.
The Save the DGH are leading in the call to the NHS, nationally and locally, to explore the following:

1. The possibility of a de-merger of East Sussex Healthcare NHS Trust into:
   - Eastbourne & District Foundation Trust with community hospitals/services
   - Hastings & Rother Foundation Trust with community hospitals/services
2. The possibility of dividing East Sussex Healthcare Trust into:
   - EDGH with Brighton & Sussex University Hospitals Trust, with separated Community Services if necessary.
   - CHH with Pembury or Ashford, with separated Community Services if necessary.
3. Creating a ‘new structure’ similar to Hinchingbrooke Hospital in Huntingdon
4. Other models for services similar to Yeovil District Hospital which has embraced alternative financing solutions to keep emergency core services.

Our one requirement under any new proposal is that ALL CORE SERVICES ARE PROVIDED AT EASTBOURNE DGH.

The core services for clarity are:
24 hour A & E full service (including Trauma & Orthopaedics), 24 hour in-patient Paediatric beds, 24 hour Consultant - led Obstetric service, 24 hour acute Medical and Coronary care beds, 24 hour acute Surgical, Intensive Therapy Unit & High Dependency Unit beds and 24 hour Acute Psychiatric Service.

CONCLUSION

OPTION 7 – THE CAMPAIGN OPTION provides the best high quality health care for pregnant women, babies and children by maintaining consultant delivered services in both Eastbourne and Hastings. It is the option that is clearly favoured by the people of both towns and will provide for the future with resident populations being expanded with increased industrialisation and working facilities for the reproductive age groups.

If the local NHS had shown the same degree of enthusiasm in getting it right as has been shown in getting it wrong, Eastbourne and Hastings could be the Gold...
Standard units against which others were judged. Option 7 will hopefully start the process.

Public confidence is at an all time low and one expectant Mum called for the hospital board to resign because ESHT has been unwilling to listen to local concerns over 6000 members of the public signed up in 2 weeks!

On May 7th 2013, ESHT downgraded Consultant-led Maternity services at Eastbourne District General Hospital (EDGH) to a Midwife-led unit. Local women who are not low risk, as well as those who chose the safety of a Consultant-Led Unit, now travel over 20 miles to give birth. As a Campaign Group we vehemently opposed this as we believe it will seriously compromise women and babies lives. A few days later, our fears confirmed, on May 10th a baby was born in the back of his parents car on the way to the Conquest Hospital (Hastings). This did not even register as a serious incident and was ‘unfortunate’!

Option 7 – The Campaign Option is safe and accessible and addresses the needs of our local population and will provide the best outcome for our future.

Have your say

If you want to have a say on the future of Maternity and paediatric services, please respond to Better Beginnings before 8th April 2014. What is important to you? Is there anything else you think they should have considered? Have you got any experiences they should know about?

For more information visit our website www.savethedgh.org.uk. You can also go straight to www.betterbeginnings-nhs.net and complete their online questionnaire. Please remember not to tick any box for Option 1-6 but enter Option 7 in the Other information/comments box.

Responses to be received by Better Beginnings before 8th April 2014
You can send your comments to us as well at info@savethedgh.org.uk even if it’s just “We want Option 7 – The Campaign Option”

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IRP: Report Appendices (410kb)
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IRP: Report Recommendations

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INTRODUCTION

The paediatric staff at Eastbourne District General Hospital (EDGH) have proposed changes to the recently reconfigured paediatric service on the grounds of patient safety and access. The service has recently been reviewed by the Care Quality Commission (CQC) and the Royal College of Paediatrics and Child Health (RCPCH). The CQC were content that the service was safe. The RCPCH has expressed concerns about children presenting to the Emergency Medicine Department (EMD). The final RCPCH report is awaited.

The paediatricians are concerned that winter pressures will impact on service delivery and an urgent decision with regard to any service change is therefore required. However it is acknowledged that the current configuration is temporary and any permanent changes are subject to public consultation during the coming year. Any future changes will need to take account of work that is being undertaken in the rest of Sussex.

It is known that the majority of paediatric inpatient admissions last less than 24 hours and that the majority of admissions take place between 17:00 and 21:00. Services are changing to become more patient focused and need to reflect the requirement for local access.

Closer working with Brighton and Sussex University Hospitals NHS Trust (BSUH) and the Royal Alexandra Children’s Hospital (RACH) is felt to be desirable and the transfer of more Eastbourne children to the RACH rather than the Conquest Hospital is an option worthy of consideration. This would provide additional choice and access for Eastbourne families and would enhance working relationships with the Children’s Emergency Department at BSUH; This could subsequently reduce the flow of patient referrals from the Eastbourne and Seaford areas to Brighton.

No change to the current service at Hastings including the Special Care Baby Unit (SCBU) is proposed.

This paper summarises the results of the discussions that have taken place to date.

AIMS:

- To improve patient safety and access.
- To reduce the number of unnecessary transfers of children.
- To enhance local confidence in paediatric services whilst ensuring the safety and stability of future services.
- To improve working relationships with BSUH (RACH).
- To improve choice and accessibility for patients.
• To utilise the skills and experience of the existing health professionals and extend their roles and training.

• To enhance the current Children’s Emergency Medicine service

• To encourage GPs with an interest in paediatrics, and EMD staff to help develop and deliver the service.

OPTIONS FOR EASTBOURNE

Although several other alternatives were considered the options thought worthy of further consideration are as follows:

Options:

1. A return to the original paediatric service prior to reconfiguration.

2. Continuing with the current reconfigured service (with revised opening times of Eastbourne SSPAU to reflect the demand on the service).

3. Co-locating the Eastbourne SSPAU with the EMD with a 24-hour 7-day a week service staffed by both paediatrics and emergency medicine.

SERVICE DESCRIPTION

Option 1: In-patient service with three tiers of doctors and full nursing provision. 15 beds. No neonatal/SCBU services.


Quality & safety: Considered safest option for Eastbourne paediatric patients, no change for Hastings.

Clinical sustainability: Challenges with recruitment & retention of middle-grade doctors remain. Staff would need to rotate to Hastings for SCBU experience. A consultant 1 in 5 rota will be increasingly difficult to comply with WTD.

Deliverability: Probably not possible long-term.

Risks & interdependencies: Provides support for EMD, overnight surgical patients, safeguarding, unexpected deaths etc

Option 2: Current reconfigured service with SSPAU open on weekdays and at weekends Eastbourne, inpatients transferred to Hastings or RACH. Seriously ill children should not taken by ambulance to EMD. Children are transferred to Hastings for overnight admission if not suitable for home discharge when SSAPU closes. Day surgery would continue but children may need to be transferred to Hastings if not fully recovered.
EMD is currently staffed by locum paediatric middle-grade responsible to EMD. Middle-grades spend two weeks out of 12 in Eastbourne. Two middle-grades are present during the day, one for OPD clinics and one for SSPAU/EMD. Staff are underemployed.

**Access & choice:** The reduced access and choice for Eastbourne patients is unpopular. There is a risk of reducing activity due to increased referrals from Eastbourne to Brighton (RACH).

**Quality & safety:** The increased numbers of inpatients in one unit is good for training, experience, maintenance of skills and teaching of nurses and doctors.

**Clinical sustainability:** Some middle-grades and experienced nursing staff are leaving. Significant senior nurse experience is being lost; replacements are being recruited but may be much less experienced. There is a need to continue with the EMD paediatric locum middle-grade which is a cost pressure. Training objectives for EMD are not being achieved due to dependence on locums. There are concerns about a possible reduction in activity with implications for income and long term referral patterns.

**Deliverability:** An increase in nursing acuity has been noted in Hastings. An increase in nurse staffing in Hastings might impact on the service available to EDGH.

Nursing acuity is a technical way of documenting the clinical intensity of patients admitted in terms of nursing input. It appears that nursing acuity has increased a factor of 4 since the reconfiguration. Much of the nursing work is at the time children are admitted or discharged. Arranging transfers for sick children or trying to get them well enough to go home before a SSPAU shuts has dramatically increased the intensity of work.

This has serious implications for required numbers of nurses, and is affecting morale and retention of experienced staff.

**Risks & interdependencies:** the main concern is the safety of children attending EMD. The continuing dependence of EMD on locum staff and the cost pressure is also a major concern. There is sometimes a delay in SECAMB transfers in the evening after the SSPAU closes and this impacts on staff working patterns.

**Option 3:** A 10-bed 24-hour SSPAU co-located with EMD. This would be staffed and supervised by paediatricians until late evening and then by EMD staff overnight with support from paediatric nurses and medical staff.

Elective admissions and the assessment of children referred by GPs or attending the EMD would continue and be seen by the paediatric middle-grade and/or consultant during the day. Training could be offered to GPs undertaking ‘Out of Hours’ duties to enhance their ability to deal with sick children and contribute to the future running of the service. Experienced nurses could also be given training to enable them to function as advanced nurse practitioners who could replace medical staff.

**Access & choice:** Provides better and safer access for Eastbourne patients. No change for Hastings patients.

**Quality & safety:** Should lead to fewer transfers of potentially unstable patients who may deteriorate en-route.
Clinical sustainability: Will depend on the ability to involve other specialties and the need for nursing/medical staff to also run the inpatient service in Hastings. Should enhance working relationships with BSUH by using shared protocols, increase referrals and attract high quality staff through the link with BSUH.

Deliverability: Should be possible within current budget (medical & nursing). Paediatric consultant rotas would continue at 1 in 10, with consultants working at times of peak activity on both sites.

Risks & interdependencies: Close working with EMD and anaesthetic staff would be required. Engagement with GPs as participants and commissioners would be needed. Should help to reduce the number of SECAMB transfers. Is likely to be popular with the local community and enhance the safety and future of local services.

RECOMMENDATION

The CYPCU recommends Option 3 as the preferred Option and that a Business Case is developed to progress this option as soon as possible.

Dated: September 2013