A paper to dispel myths about the proposed reconfiguration of maternity and special care baby services in East Sussex

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Who am I?

- I am a consultant paediatrician working for ESHT[1]
- I also chair the EDGH[2] consultants' committee (CAC)
- I am a member of the BMA CCSC[3]
- I have also been a member of the BMA JDC [4] and of the governing Council. Involvement in these has given me extensive exposure to, experience of, and knowledge of: the EWTD, MMC, junior doctors' rotas, principles of reconfiguration, and examples of new ways of working.
- I have also been a member of the RCPCH (Royal College of Paediatrics and Child Health) Health Services Committee which also analysed these issues with respect to paediatrics.

These are my personal views, and I speak and write as an individual, not as a representative of ESHT or the BMA.

I have said since I became involved in this reconfiguration debate in Feb 2006 that I have an open mind, and that if I see a sound clinical (safety) case for single-siting consultant-led maternity services, or an overwhelming financial reason, then I will support that position publicly

I have not yet been convinced, and this paper explains many of my concerns.

1: ESHT = East Sussex Hospitals NHS Trust
2: EDGH = Eastbourne District General Hospital
3: CCSC = national central consultants and specialists committee
4: JDC = national junior doctors committee

Summary

Clinical Services Review (CSR) Aug 2004:

- Recommended two all-risk consultant-led obstetric units be retained
- Criteria set by CSR to trigger reconsideration have not occurred
- EWTD and its effects in 2009 considered and rejected as a reason to single-site

EWTD:

- Grossly misrepresented
- Major impact absorbed long ago
- Very little effect on ESHT obstetrics and paediatrics in 2009
- Can be easily coped with, without single-siting

MMC:

- Little impact on ESHT obstetrics, and none on paediatrics
- Far from requiring single-siting

The two tiers (i.e. full tiers of both middle grades and even more junior doctors)

- Currently there are not two tiers
- The units are safe
- Two tiers are not required by the RCOG or the new intercollegiate (RCOG, RCPCH, RCA, RCM) guidelines
- The “Worthing Report” is irrelevant now, and may never have had any validity
- The unwarranted insertion of a second tier into the calculations claiming to be the status quo is largely responsible for the hugely inflated costs ascribed to keeping two units open
- Introduction of a second tier cannot enhance safety
- Introduction of a second tier may make the units less safe:

10 doctors on a tier

- Not necessarily needed – far more detailed work needed

CNST:

- Both units have the highest level: 3
- So both are safe
- Few units nationally have this
- Changes to CNST could be coped with fairly easily, whilst remaining on two sites

40 hours of consultant presence :

- Can be provided by 5 consultants, therefore could be provided on two sites staffed as they were just a few years ago
- Hence no need to single-site to provide that

Midwifery staffing:

- No shortage locally of midwives who could be appointed – waiting list
- “Establishment” currently too low – i.e. more should be employed
- this is the major reason for unpredictable closures: hence we do not need to single-site to prevent unpredictable closures

“Economies of scale”:

- unlikely to occur to any meaningful extent

SCBU staffing:

- likely to worsen if single-site as at least some nurses will leave
- therefore closure of SCBU, and hence transfers out, even more likely
- hence no driver to single-site

SCBU service

- there will be no level 2 service: even if single-sited it will only be a level 1 service
- there will be no enhanced service
- CPAP is currently used at Conquest and could also be used at EDGH but has been blocked: CPAP provision is not a reason to single-site

Effect on regional intensive care neonatal units

- mothers refusing transfer of their babies to a unit in a town again not their own
- intensive care cots blocked at regional centre
- exacerbating regional problems

Retention of skills of consultant obstetricians:

- will not be enhanced by single-siting
- may in fact get worse
- hence no driver to single-site

Choice:

- clearly reduced
- choice of women of East Sussex well-proven: they choose two consultant-led units to remain

Access:

- improved for none
- worsened for some

Ante-natal care:

- will NOT continue to be delivered for all mothers on both sites
- hence access will reduce for some

RCPCH requirements:

- do NOT require SCBU to be single-sited
- both units have appropriate and relevant training recognition
- hence no driver to single-site

Finance:

- costs of status quo falsely and grotesquely inflated
- costs of single-sited options too low
- hence may be little or no saving from single-siting
- or may in fact cost MORE

Thus we have not been presented with any arguments for single-siting which stand up to analysis

And it is therefore likely that two units can be maintained safely, well-staffed, and at reasonable cost.

The 2004 Clinical Services Review (CSR)

Background

The CSR was a major, well-funded, extensive piece of work carried out by the local health economy to determine the local needs, and sustainability, of possible options for the delivery of maternity and gynaecological services in East Sussex. It was published 3 August 2004.

Its membership, listed below, included consultant obstetricians, anaesthetists, the clinical director of paediatrics, GPs, midwives, managers, patient representatives. Curiously, those members include several people who are now most prominent in arguing that our services must change to only having a single consultant-led obstetric unit – though that is exactly what the CSR said should not happen.

Appendix 1
Review Group Membership (March 2004)Co-Chair: Fiona Henniker, Chief Executive Sussex Downs and Weald PCT.
Co-Chair: Richard Hallett, Chair, Eastbourne MSLC
Project Manager: Doug Bailey, CSR
Barry Auld, Clinical Director O&G, ESHT
Wendy Beech-Ward, Focus group representative
Phyllis Bounds, Public Reference Group
Lorna Bray, Clinical Director for Paediatrics, ESHTLauren Brosson, B&R; H&StL PCT Commissioning
Sue Coekin, Public representative
Jeremy Davis, (EDGH lead anaesthetist for obstetrics)
Fiona Dutsford
Helen Dutchman, Health Visitor, Eastbourne
Amanda Federo, General Manager, Women's Health, BSUH
(Carol Drummond)
Javier Gonzalez, GP representative
Alison Grimston, GP representative
Dave Haggar, Sussex Ambulance Service
Beverly Hone, East Sussex Social Services
Helen O'Dell, Head of Midwifery & Gynaecology Nursing, ESHT
Sue Page, Gynaecology Sister, ESHT
Krishna Radia, GP representative
Gerry Rafferty, Consultant O&G
Ian Reeve, Consultant Anaesthetist & Obstetric Lead
Maureen Royds-Jones, Senior Midwife Crowborough
Linda Sheppard, Health Visitor, Hastings
Anne Singer, Child & Family Health Service Manager
Paula Smith, Gynaecology Sister, ESHT
Sally Smith, Senior General Manager, ESHT
Jane Sumner, Directorate Nurse Paediatrics, ESHT
Donna Taylor, Deputy General Mgr, ESHT
Mary Tonbridge, Head of Midwifery, Maidstone and Tunbridge Wells Trust
Ros Vinall , Hastings MSLC/NCT
Harry Walmsley, Clinical Director Anaesthetics ESHT
Michael Wilson, CSRCecilia Yardley, CSRDeborah YoungJamal Zaidi , O&G Consultant ESHT

The CSR and single-siting

We are now told that the CSR said single-siting might be needed "if the situation changes".

However, this is what it actually said (Section 7.4) (my highlighting in red):

"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"

And:
"East Sussex health community should strive to retain two all risk units with obstetrics input" (Section 8.1.3)

It did indeed recognise that it could not give a format for obstetric and SCBU services which would last for all time, and considered what might necessitate a reconsideration, and what contingency planning should be made (2004 CSR Section 8.1.5 Contingency):

"Circumstances could arise where two all risk units could no longer be sustained. A contingency plan should be developed to allow a move to a model of care based on a single all-risk unit with obstetric input, and several birthing centres, in an orderly and safe way. This will be a complex and difficult exercise.

These circumstances include:

- Inability to recruit sufficient medical staff to support two all risk units
- Inability to support two Special care baby Units"

Neither of those circumstances have occurred.

Staffing of ESHT

Regarding medical staffing of our two all-risk obstetric units:

- Mr Zaidi (Clinical Director for Obstetrics and Gynaecology [O&G] for ESHT) confirmed to HOSC (7 June) that he envisaged no problem recruiting to a soon-to-be-advertised consultant O&G post and Dr Scott (Medical Director of ESHT) repeated that on 22 June.

Thus there is no problem in recruitment to the most important posts: those of the permanent, fully-trained senior staff – consultants.
But what of middle grade doctors: those who are present on site at night, backed up by the consultants?

- Dr Scott stated to HOSC (22 June) that there were 2 middle grade posts filled by locums and 1 vacancy (out of 16).

Many, probably most hospital departments have a post or two filled by locums much of the time, as people move in and out of jobs. Also, I do not know of any field, medical or other, in which a vacancy rate of 6.25% (I out of 16) would lead to consideration of closure.
There has been a national recruitment scheme (MTAS) over the last few months, and junior doctors are concentrating their energies on applying for long-term recognised training posts through that chaotic process, whose failings have been well-publicised in the media. It seems to me that a post of uncertain duration in a unit which may well close

within 18 months is hardly a very attractive prospect, and not one which juniors are likely to divert their energies towards in the current situation, hence it is not surprising that we have one vacancy.

Thus I do not believe that the facts show an “inability to recruit sufficient medical staff to support two all risk units”, hence we should not even be considering reconfiguring for that reason.

The other reason given by the CSR to prompt reconsideration of its findings was to be an inability to support two special care baby units (SCBU). ESHT’s two SCBU are fully staffed and functional for SCBU – so there is no reason for us to be reconsidering the service on that account either.

Hence it is difficult to see why all of this should have been reopened a mere 16 months (August 2004 – Dec 2005 / Jan 2006) after the CSR had reported.

The CSR and contingency planning

It is also important to note that the CSR went into things in even more detail. It made the very sensible recommendation that contingency planning be undertaken (Section 7.5: Contingency planning):

“Undertaking work specifically to increase the attractiveness of the ESHT maternity, gynaecology and paediatrics services as a place of employment. This would include the widest consideration of what makes employment attractive for doctors, midwives and nurses in these specialties and should focus on retention as well as recruitment.”

I have seen no evidence of such work, and none has been presented during the consultation.
We are, nevertheless, told that things have changed. Two things are cited:

- The European Working Time Directive (EWTD) in 2009
- Changes to medical training (MMC)[1]

1: MMC = Modernising medical careers – the new training structure for junior doctors of all specialties

The EWTD
Background

Firstly, it is essential to note that the EWTD was specifically considered in the 2004 CSR[1] and rejected as a reason to close a unit[2,3]

1:
CSR final report 3 Aug 2004:
•Introduction (page 3)
•Section 1.2.1
•Section 1.2.2
•2:
CSR final report 3 Aug 2004, section 1.2.1:
"Proposals involving a massive increase in the medical workforce or major reductions in the number of locations where 24-hour services are provided are unrealistic and undesirable. Solutions, therefore, need to be based on redesigning services and changing workforce patterns."
3:
Section 2.1.3:*"Keeping the NHS Local* notes that, 'The challenge facing maternity services is the need to identify EWTD-compliant models of care in the middle ground between large consultant obstetric units and midwife-led units.'"

The EWTD is health and safety legislation, designed to protect the worker. It has been law[1] in the EU and UK since the 1990s. The changes in 2009 have been known for many years, since at least 2000.

They are, in fact, of little relevance to us.

The only group of workers (aside from the military, seamen/fishermen and a few others) in the EU who have ever had any even partial exemption have been junior doctors in training

1: Relevant laws are as follows:
(EU) Council Directive 89/391/EEC of 12 June 1989
(EU) Council Directive 93/104/EC of 23 November 1993 concerning certain aspects of the organization of working time
(UK) Statutory Instrument 1998 No. 1833 The Working Time Regulations 1998
- this transposed EU law into UK law (note EU law applies in the UK without requiring specific transposition / enactment into UK law, but transposition/enactment streamlines the process of its application and appeals)
(EU) Directive 2000/34/EC of eh European Parliament and of the Council of 22 June 2000 amending Council Directive 93/104/EC concerning certain aspects of the organisation of working time to cover sectors and activities excluded from that directive
- this introduced the 1 August 2009 date for full implementation for doctors in training
(UK) Statutory Instrument 2003 No. 1684 The Working Time (Amendment) Regulations 2003
- and this transposed / enacted it into UK law and clarified the timetable of a staged reduction of hours to 1 August 2009

The EWTD and ESHT medical staff

The important phrase is "in training". It does NOT mean any doctor who is not a senior doctor (a consultant or a GP). It means anyone who is in a recognised training post. The vast majority of "junior" doctors in obstetrics and paediatrics on both sites are **not** in recognised training posts (they are either staff grades or "Trust grades"):

- Specifically regarding obstetric middle grades, Dr Scott told HOSC on 22 June: "a small number are in specialty training and the remainder are in non-training grades"
- According to figures provided to me by Drs Scott and Zaidi, currently 4 of 8 middle grades on each site are in training positions. From 1 August 2007 these will reduce to 3 of 8 on each site.

There is no proposition to change this staffing of pattern dramatically. Hence the EWTD has always applied in full to the majority of these junior doctors, and there is NO change in 2009. If they are currently working more than 48 hours (and I understand that they are either not working more than 48 hours, or only a little), then they must be doing so as a result of an opt-out: an allowance in the EWTD to opt out of the total hours limit. There is no change to this opt-out clause.

So the EWTD is not an overwhelming issue, and certainly is not a new issue since the 2004 CSR.

Hence it cannot be used to justify a reconsideration of those findings, which were to maintain two consultant-led obstetric units.

(For further information, see appendices 2 and 4doi)

MMC

Background

MMC was also well-known before the CSR reported in August 2004. The relevant national documents were:

- Aug 2002: CMO publishes “Unfinished business”
- Feb 2003: the 4 UK health departments publish “Modernising Medical Careers”
- April 2004: the 4 UK health departments publish: “The next steps: the future shape of foundation, specialist and general practice training programmes”

Thus nothing that was not known or planned in Aug 2004 has suddenly occurred.

Hence it is difficult to understand why the 2004 CSR’s findings that 2 consultant-led obstetric units should be maintained has been challenged.

Skills (or competency) of junior doctors under MMC - general

We are often told that new junior doctors will be less competent. We are not only told this locally, but some people and groups claim this nationally.

On the national level, that will not be the case.

Most colleges, including the RCOG, have produced curricula which in essence simply map the previous grades (SHO, SpR year 1, 2 etc) onto the new Specialist Trainee (ST) terminology.

The RCOG has ST1 to 7. And that comes after 2 years as a Foundation trainee. So effectively a minimum (as one must demonstrate competency before advancing, not simply not get fired) of 9 years from medical school to consultant-eligibility.

Whereas in the past the minimum was 1 year as a PRHO, then 2 years as an SHO, followed by 5 years as an SpR. That is a total of 8 years. Thus the minimum number of years in training will increase, not decrease.

Local effect of MMC – the "two tiers" of junior doctors would not be justified

However, we are told that the effect of MMC locally will be immense, and a serious driver to single-site the consultant-led service. It is argued that changes to medical training of junior doctors will mean that the doctors below the grade of consultant who ESHT would be able to recruit in future would be less experienced and less competent. The argument continues that this will require ESHT to employ lots more junior doctors in obstetrics to maintain safety.

Mr Zaidi advanced the argument to HOSC on 7 June (from the agreed minutes, provided to me by Mr Zaidi):
"68.8:
Mr Zaidi was asked why it was considered necessary to have two tiers of 10 doctors to fill a rota, in addition to the 5 consultants anticipated on each site. Mr Zaidi responded ..because junior doctors will be less experienced in the future under the new training regime, two tiers are required (one tier of more junior trainees and one tier of middle-grades) so that cover is provided by suitably experienced staff."

The proponents of single-siting continue the argument as follows
- To ensure safety we must have a 24/7 complete tier of even more junior doctors in addition (the 2 tiers)
- this will be a huge increase in the number of junior doctors
- and hence far too expensive on two sites
- So we must move to one site.

However, even if one were to accept that future trainee doctors who would come to ESHT would be less experienced, the conclusion drawn by those arguing for single-siting simply defies belief as it is so illogical.
It is not disputed that the crucial medical skill required 24/7 on a delivery suite is the ability to decide correctly that a caesarian section is needed, and then to do that section (there are of course many other skills, and these are defined by the RCOG, but caesarian section serves to explain the counter-argument). If a consultant is not present, then the middle grade doctor (the next tier down) must have those skills. Currently, the middle grades do. At night, the middle grades are present in the hospital, and there are no doctors more junior than them. Indeed, we only have 2 even more junior doctors in obstetrics employed on each site, as they are only present during the day, doing other tasks. Thus at present we do not have a complete second tier of these even more junior doctors.

We are given to understand that allocated to ESHT through MMC would be less experienced, competent and skilled.

But if the middle grades of the future cannot do caesarian sections (or the other emergency obstetric skills as defined by the RCOG), then an even more junior doctor will be even less able to do them.

So it is inconceivable that the addition of a second complete tier of even more junior doctors could provide those crucial emergency obstetric skills, and thus could not increase safety.

Thus the argument for the complete extra tier of junior doctors evaporates into a mist of nonsense[1,2]

and this vast extra expense attributed to two sites vanishes as well.

Other arguments made for "two tiers" are also incorrect

Aside from this main argument, other arguments are advanced by the proponents of single-siting.

Another argument advanced is that a second tier might be able to help with "simultaneous emergencies":
EDGH has been running with a single tier at night for many years, without problems, as do many other units of a similar size. It has been suggested to me that the more junior doctor might be able to help with things such as cannulation, blood taking, writing up fluids or blood. But those tasks could be undertaken by midwives, or nurses, with enhanced skills And of course emergencies similar to post-partum haemorrhage, or ruptured ectopic, present to A&E and to other specialties (e.g. post-surgical bleeding, trauma..) and will be dealt with by the Hospital at Night team, who would have all of the skills which a more junior doctor in O&G could contribute. Hence there is no need to introduce a whole extra tier of junior doctors onto the obstetric budget for this consultation.

The two tiers – the Worthing Report is not relevant

A further argument for a second tier of junior doctors which is advanced – for example at the meeting with Eastbourne GPs on 23 July, (though it has not been mentioned specifically in the consultation's public documents) is the "Worthing Report" .I believe this may have been what David Scott was referring to when he addressed HOSC on 22 June: (From 37 min 57 sec into the webcast)
"..we have been sailing close to the wind.. in terms of complying with the standards required by the RCOG whereas the recommendation is that there should be 2 competent middle grades and more junior doctors who are there to assist them. And we are going to find it very very difficult to meet the required standards unless we think very seriously about introducing this second tier of doctors…As you can see we would have to employ 20 doctors on each site – a total of 40 junior doctors – in order to meet the required standards and comply with the working time directive requirements – and that comes at a significant cost, which is currently calculated at an additional £2.3million."

However, this argument is also incorrect.

I understand that the Worthing Report was an advisory report by obstetricians invited from Worthing hospital asked to consider certain clinical incidents at Conquest. am told that it went beyond its remit when it included in its recommendations mention of (a return to) 2 tiers of junior doctors. This would have reversed the advice given in 2000 by Mr Milligan of

the RCOG. It is important to note that the Worthing Report does not have the status of a College "standard". Indeed, it was inconsistent with national advice from the RCOG published in June 2004:
'The European Working Time Directive and Maternity Services'
http://www.rcog.org.uk/resources/Public/pdf/ewtd_and_maternity_services.pdf.
The advice contained in that report has been outlined to me by the first-named author, the then President of the RCOG, Professor William Dunlop. (Professor Dunlop now holds another of the most senior medical positions in England, as Chairman of the Joint Consultants Committee, which is the statutory, and only, body, at which senior representatives of the BMA, all medical Royal Colleges, and the Department of Health, meet to discuss all aspects of secondary [mainly hospital] health-care provision). His communication to me (e-mail of 24 July 2007) explains:
"The document which I wrote in 2003 was based upon staffing norms agreed at that time by the Maternity and Neonatal Workforce Working Group, and included provision for two non-career grade doctors to be on call in all units. However, when we subsequently looked at staffing arrangements in units which had made alterations in order to be compatible with the 2004 targets for the European Working Time Directive, it became clear that some units were functioning safely without specific obstetric SHO cover at night. Examples of these new ways of working in two medium sized units (Gloucester and Rotherham) were published in an annexe to the RCOG publication
'The European Working Time Directive and Maternity Services'
(http://www.rcog.org.uk/resources/Public/pdf/ewtd_and_maternity_services.pdf).
What was of the utmost importance, we suggested, was that there should be resident at all times a doctor with sufficient expertise (defined in the document) to be able to cope immediately with obstetric emergencies."

It therefore would appear that the Worthing Report was in fact out-of-date even when it was written.

Most recently, the intercollegiate guidance (Safer Childbirth – a report covering all aspects of maternity care, produced by the RCOG, Royal College of Midwives, Royal College of Anaesthetists and Royal College of Paediatrics and Child Health – currently in a late-stage draft) restates that units delivering fewer than 2500/year need only have one trainee on site.

(I note that some local proponents of single-siting claim that the relevant table (Figure 6) in "Safer Childbirth is not telling us how many doctors should be actually present on a site, but is merely telling us the number of specialist obstetric trainees the 4 colleges would recommend be allocated to the staff of units of different sizes. In other words, they think that the table is saying that each of our 2 units could only have one specialist trainee allocated to them.

That seems a very odd reading of the table to me, as it is clearly talking about how many hours of consultant presence there should be, so it would make more sense to me that the next column be talking about trainee presence, and not the entirely separate issue of allocation of recognised trainee posts. Also, it would seem to make little sense to me, as clearly no-one can write a 168-hour week-long rota with just one, or even 2 or 3 trainees, so even with imaginative use of consultant time, one would have to add other doctors to the rota who presumably would be non-training grades.

Also, from Aug 2007 we have been allocated 4 specialist trainees on one site, and 3 on the other (at varying ST levels), so it would seem amazing to me that the 4 colleges would be recommending both those allocations should be slashed to one.

It also seems amazing to me that the 4 colleges could be suggesting that even the country's biggest units

could have a maximum of 3 specialist trainees allocate to them.
I can't see how we could train the obstetricians of the future nationally with such low allocations.

Finally, I note that the text of the Safer Childbirth draft states (5.2.14):
"In Figure 6 for Category A units there should be a consultant obstetrician plus one Specialist Trainee who should have at least 12 months' experience in Obstetrics and Gynaecology. In the bigger units the consultant obstetrician should be backed by two or three Specialist Trainees. These units will have a significant responsibility in both basic and advanced training in high-risk obstetric practice and the extent of junior cover will depend on workload and training opportunities. Protected time should be made available for consultant obstetricians to carry out their supervision and assessment duties. The decision on the seniority of the trainees will depend on regional training requirements".

Most importantly, my view of "Safer Childbirth" is corroborated by Professor Dunlop:
"You will notice that the total staffing complement for both Gloucester and Rotherham includes several trainees. While I was not involved in the most recent revision of 'Safer Childbirth' and have only seen a very early draft, I cannot imagine that the table which you have appended relates to total staffing. Rather, it seems to me to be describing the minimum staffing necessary for labour ward cover at any time. Certainly, the consultant staffing described relates to the minimum number of hours per week during which a consultant should be immediately available for labour ward cover without any other clinical commitment. I therefore think that your interpretation of 'Safer Childbirth' is likely to be the correct one."

Thus I think we can conclude that the Worthing Report is of no relevance to us now on this issue of two tiers.

The "two tiers" may in fact make things worse

One might actually need the complete extra tier if the two units were combined, as there might be too many caesarian sections and other work requiring obstetric skills, plus the less skilled work such as clerking in patients (both obstetric and gynaecological), inserting cannulae, writing up drug charts, etc, for one middle grade to do this alone at night on the bigger unit. Thus a single-site option would need all those extra junior doctors – and their extra costs – without adding to safety.

But the second tier of even more junior doctors might actually make the service less safe, by reducing consultant involvement. This was warned against by the CSR (Section 7.3.2):

"With obstetric support concentrated on one site, out of hours medical cover would be provided by two tiers of doctors – middle grade + SHO, with back-up from an on-call consultant. Under this model most care would be delivered by the junior doctors, and the consultant would be less involved. With obstetric cover to two sites, out-of-hours cover would be provided by a single tier of middle grade doctors, as is currently the case at Eastbourne. Under this arrangement the consultant is inevitably more involved because they are called more often to provide back-up. There is evidence that when senior doctors are more involved in decision making, better quality decisions are made, and therefore quality of care is enhanced."
It continued:

"While the consultant body has mixed feelings about a higher intensity of involvement out-of-hours, this can be expected to enhance quality of care."

The local effect of MMC

The only changes due to MMC, as explained to me by Mr Zaidi and Dr Scott are:

- One post on each site, previously an O&G "senior" SHO, will become one GP VTS[2] trainee post and one ST1 (the first year of specialist training after the two foundation years) in O&G
- Thus one post on each site, previously for someone to work on the middle grade rota, will now be for a less experienced doctor, so one more middle grade on each site might need to be recruited
- And one post on each site, previously "senior" SHO, will become ST3[3,4] (who may or may not need more supervision)

These are surely not overwhelming changes, and surely not changes which can only be reacted to by single-siting.

1: This was also outlined to HOSC by Dr Scott on 22 June (at 35min 45sec into the webcast):
".. 2 of our doctors who are currently on the middle grade rota will be replaced by two doctors in more junior positions, who will be unable to undertake unsupervised work and deal with obstetric emergencies. We therefore have a reduction in numbers of junior doctors who are capable of working at middle grade level from 8 to 6, though one of them [he is referring to the new ST3} may possibly be able to fill that role."
2: VTS = vocational training scheme – the training programme for junior doctors wishing to become GPs
3: ST3 = specialist trainee year 3, i.e. a doctor who has done the two Foundation Years after graduation from medical school, and done two years of specialist training in O&G. However, the person coming into that post in August 2007 or 8 may actually have done much more O&G training as previous SHOs, who may have done several years of O&G, can apply to enter at ST3. This discrepancy is due to doctors who have been training under the former training programme now having to enter the new training programme.

4: Mr Zaidi told the meeting with GPs on 23 July that one of these ST3 posts may now be an ST2.

Safety

At present both units have a very good reputation with the local population and with GPs. And both have CNST level 3, achieved by very few Trusts (Kim Hodgson[1] stated just 12 Trusts at present[2]). So by subjective and very objective criteria, both are VERY safe

1: Chief Executive of ESHT
2: Statement to HOSC 22 June 2007

CNST

CNST may change its scoring system. But it has nothing to do with EWTD or MMC or any other of the issues which have been muddled into this. Dr Scott at HOSC on 22 June stated that the issues would be:
•Consultant availability/presence (40 hours)
•Midwife numbers

40 hours of consultant presence

It is not necessary to single-site in order to provide 40 hours of consultant presence on the labour ward.

We are 5 consultant paediatricians in Eastbourne, and 4.5 full-time equivalents at Conquest, and we provide ~ 46 hours of consultant presence and availability on the paediatric units.

So it can be done with 5 consultants

And this was confirmed, the day after I had met with him, by Dr Scott to HOSC on 22 June, regarding obstetrics (this is at 40min 25sec on the webcast).

So we would be able to meet the 40-hour requirement, and therefore would not lose CNST level 3 status on that account.

Hence we do not need to single site for that reason

(For further information, see appendix 5)

Midwifery staffing

It is said that there is, or will be, a shortage of midwives at the national level. However, there is no shortage locally, nor will there be.

Deborah Young, Head of Midwifery for ESHT, told HOSC (~1 hr 48mins into the webcast) on 22 June that ESHT has "absolutely no problem recruiting midwives" and that locally we actually have a "waiting list" of recently-qualified midwives waiting to be employed. And her problem is that the "establishment" is insufficient (this is despite us being told that money is not a driver in this reconfiguration debate).

Unpredictable closures of labour ward

As Dr Diana Grice (Director of Public Health for the two E Sussex PCTs) has stated at several public meetings, these do occur, and that is not good.

But as Mr Zaidi told HOSC on 7 June, that is almost always because of shortage of midwives (illness etc). And we now know what the real story about midwives is.

Economies of scale

We are sometimes told that single-siting will allow economies of scale in terms of staffing. (Though we are also told that money is not a drive in this reconfiguration debate). There may be some economies of scale, but these are likely to be small:

As an example:

- Our 2 SCBUs each try to run with 2 +1 nurses per shift
- And if we were to combine we could run the double-size unit with 4 +1, not 4 +2.
- So a small economy.
- But, at present during the day we often only have 2 nurses, and at night almost always only have 2 nurses
- So no economising can occur. We will go from 4 to.. 4

I suspect that the same analysis would apply to midwifery staffing, but I do not have access to the relevant data.

Covering sickness of staff

It is hard to see how single-siting could enable us to cope with sickness more easily, as we will need the same number of nurses on shift, as explained above.

In fact, it may well be harder, not easier, to staff the units. Several senior SCBU nurses have stated they will retire early if single-siting occurs – and I understand some are already reducing their hours - and several more junior nurses have stated they will have to resign as they cannot for family/childcare reasons travel across the marsh.

- So there is a very real likelihood that our pool of SCBU nurses will actually diminish
- So closure will be more, not less likely
- So the service to women and babies may decline not rise, safety may be put more at risk, and more (not fewer) mothers may have to be transferred out of the county

I note that Dr Lorna Bray (Clinical Director of Paediatrics, ESHT) told HOSC on 25 July that she had spoken with the SCBU nurses and she believed that changes of rota and shift timing could prevent these problems. I have since then spoken with SCBU nurses at both Conquest and EDGH, and have yet to find one who can recall having spoken with Dr Bray. Several did not know who she is. I have not spoken with all the SCBU nurses, and I am sure Dr Bray has spoken with some, but the facts remain as I have stated.

Retention of the emergency obstetric skills of consultant obstetricians

An argument has been advanced by those who support single-siting that it is only by so doing that we can ensure that our consultants retain their emergency obstetric skills. The argument is that on two sites, the numbers of deliveries are so low that consultants cannot see enough cases.

However, simple mathematics proves that single-siting will not lead to any significant increase in the number of deliveries per consultant, and may in fact lead to a decrease, as women choose to deliver elsewhere. Thus the exposure which we are told consultants need in order to retain their skills cannot increase, and may in fact decrease.

The mathematics is explained on the following two tables with their accompanying notes.

Consultant-exposure: this table uses PCT figures[1] to show numbers of deliveries for each option, and then derives numbers per consultant

	Status quo	Option 1	Option 2	Option 3	Option 4
Royal Sussex			345		224
Pembury		77		50	
William Harvey		87		57	
ESHT total	3704[2]	3543[3]	3359[4]	3597[5]	3480[6]
Per consultant[7]	EDGH: 390 Conquest: 350	442	420	406[8]	391[8]
With Brighton predictions[9, 13]			388		344[10]
With Eastbourne GP predictions[11]			338		338[12]

1: Agenda item 10, HOSC 17 May 2007
2: 1952 + 1752 = 3704
3: 3704-(77+84) = 3543
4: 3704 – 345 = 3359
5: 3704 – 50 – 57 = 35976: 3704 – 224 = 3480
7: 4 consultants currently on each site. If two consultant-led units remain, should be 5 on each site, as per David Scott to HOSC on 22 June. If only 1 consultant-led unit, 8 consultants.8: ESHT total reduced by 350 as these are the women who will deliver in the midwifery-led unit and therefore cannot be included in a calculation of consultant-exposure. Thus (3597-350)/8 = 406
9: If no obstetric unit in Eastbourne, 600 women will go to Brighton (letter signed by CEOs of PCT and acute Trust, dated 3 May – see note 13 for full text)
10: ESHT total of 3704-600 reduced by 350 as these are the women who will deliver in the midwifery-led unit and therefore cannot be included in a calculation of consultant-exposure. Thus (3704-600-350)/8 = 344
11: Eastbourne GPs state that no Eastbourne (and westwards) women will choose to go to a consultant-led unit in Hastings if there is none in Eastbourne. I have not accepted that, but have approximately halved it such that 1000 women choose not to go to Hastings
12: Assumes 1000 women choose not to go to the ESHT consultant-led unit in Hastings, but of those 1000, 350 go to the midwifery-led unit in Eastbourne, the rest to Brighton (note this gives 650 going to Brighton, a remarkably similar number to that predicted by Brighton)

13:
This is the text of the letter to which I refer:
3 May 2007

Prestamex House
171 – 173 Preston Road
Brighton BN1 6AG

Peter Griffiths

Direct Line: 01273 545303
*Amanda.Fadero@bhcpct.nhs.uk

Dear Peter

Title East Sussex Consultation on Creating an NHS Fit for the Future
Thank you for your correspondence of the 27th April 2007 and your request for clarification on Maternity Services

I can confirm that there has been close working across East Sussex, West Sussex and Brighton and Hove, this work has included extensive meetings with clinicians in order to harness the principles of service redesign.

The focus of the redesign work has considered the whole spectrum of maternity services, ranging from women who require intensive support during labour to those who prefer to deliver at home or in a midwifery led unit.

The modelling that we have undertaken based on babies born in 2005 – 2006, and public health data demonstrates that in all the options of potential reconfiguration, Brighton and Sussex University Hospitals Trust will be able to provide capacity for between 4000 – 5000 obstetric deliveries within the hospital, whilst also continuing to provide care for women wishing to deliver at home. Consideration is also being given to the development of a midwifery led unit which could be situated adjacent to the hospital or as a standalone unit.

I have liaised with Peter Coles and the Trust and have detailed below the response to your specific questions.

1. Details of the current capacity of Royal Sussex County Hospital in terms of births per year, and the current annual number of births

In the calendar year 2006 BSUH had 3304 births at Royal Sussex County Hospital site and 2196 births at Princess Royal Hospital (total = 5500). These numbers are broadly consistent with previous year's activity and are in our view a reasonable reflection of activity levels.

2. Clarify what potential there is to increase capacity to meet the lower and higher number of additional births which could result from the East Sussex PCTs' proposals

The Trust Clinicians feel that that they could accommodate the additional births from East Sussex. The modelling undertaken suggests that if Eastbourne no longer provided Obstetric services then the likely flows of women to Brighton would be 600. These women could be accommodated within the current facilities. .

3. How the Trust will be able to accommodate additional demand which may result from the forthcoming West Sussex and Brighton and Hove City PCT proposals, given that as yet the PCTs have not made clear (at least in public) exactly what this might amount to.

The proposals from West Sussex have not been agreed but in considering the worst case scenario the modelling suggests that if there were no Obstetric units in Eastbourne, PRH or Worthing approximately 2500 women could potentially flow to Brighton. The expectation, based on our modelling assumptions, is that approximately 1000 of these women would deliver out of hospital either at home or in a Midwifery led unit, meaning that approximately 1500 women would need to be accommodated within the hospital. This would take the total hospital births to approximately 4800 at the RSCH site. This would require additional capacity and options have been detailed by the Trust which could if required deliver this.

In conclusion Brighton and Sussex University Hospitals Trust has capacity for accommodating additional births currently and have developed plans to increase capacity to accommodate the range of potential flows from the options of both East Sussex and West Sussex as part of Fit for the Future. These options do not just focus on deliveries within a hospital setting but reflect Maternity Matters and considers the whole spectrum of delivery and care from home to hospital.

Please do not hesitate to contact me if you require any further details.

Yours sincerely

Darren Grayson
Chief Executive
Brighton and Hove City PCT

Peter Coles
Chief Executive
Brighton and Sussex University Hospitals Trust

Consultant-exposure: this table uses the other, worse (!) PCT figures which were included in the same document to HOSC[1] to show fewer deliveries for each option, and derives lower (!) numbers per consultant

	Status quo	Option 1	Option 2	Option 3	Option 4
Royal Sussex			?		?
Pembury		?		?	
William Harvey		?		?	
ESHT total	3704	3339	2937	3466	3206
Per consultant[2]	EDGH: 390 Conquest: 350	417	367	390[3]	357

And we now know that The Princess Royal, Hayward Heath, hospital's maternity unit is to close. Eastbourne DGH might receive up to 500 extra deliveries as long as it remains a consultant-led unit[4]

1: But there are a completely different set of figures, with much higher projected losses of deliveries in the same PCT paper, a few pages later!
(Agenda item 10, HOSC 17 May 2007, Appendix 4, page 1c)
Option 1: -365
Option 2: -767
Option 3: -238
Option 4: -498

2: 4 consultants currently on each site. If two consultant-led units remain, should be 5 on each site, as per David Scott to HOSC on 22 June. If only 1 consultant-led unit, 8 consultants.8: ESHT total reduced by 350 as these are the women who will deliver in the midwifery-led unit and therefore cannot be included in a calculation of consultant-exposure. Thus (3597-350)/8 = 406
3: ESHT total reduced by 350 as these are the women who will deliver in the midwifery-led unit and therefore cannot be included in a calculation of consultant-exposure.
4: 2004 CSR section 3.8.1

Royal College of Obstetricians and Gynaecologists (RCOG) - requirements

Mr Zaidi told HOSC on 7 June (~ 1hr 33mins into the webcast):
"The latest College guidance is that under 2500 (deliveries) one can continue to perform all risk-care"[1]

I have been informed that the (latest) 7th draft of "Safer Childbirth" (the new intercollegiate guidance) includes paragraph 6.2.6: ' In obstetric units supporting relatively few births (less than 2500 per year) a consultant continually present on the labour ward may be difficult to justify. However in units with >1000 and less than 2500 births a year this document strongly recommends 40 hours of consultant (or equivalent) obstetric presence and this should be mandatory if the unit accepts high risk pregnancies. To ensure the best use of resources, both financially and in terms of manpower, individual units with less than 2500 births a year should perform a risk assessment exercise, and plan labour ward presence compatible with the needs of the unit. For rural and remote areas there should be clearly defined criteria for the type of patients considered to be suitable to give birth in local units and transport arrangements agreed.'

Thus both our units could continue to provide all risk-care.

Mr Zaidi further stated that the requirement would be for 40 hours of consultant presence – and we have seen that can be provided by 5 consultants

It should be remembered that one of the RCOG's major responsibilities is in the setting of standards for the training of junior doctors wishing to become obstetricians. But it is important to note that training issues for junior doctors are not the same as safety or quality standards for the users. Thus the two issues must be teased out carefully from RCOG statements.

It is of course likely that our two units would not be busy enough to train very advanced trainee neonatologists. But that does not reflect on any way on the quality or safety of the unit for women and babies. This was recognised by the 2004 CSR (7.3.2 Quality of care):
"No evidence was found that reducing the number of all risk units offered a significant quality improvement… The Royal College's support for larger units was thought to be primarily driven by the need to offer good training experience to junior doctors. Local expert opinion was that there could be unintended negative effects on quality from concentrating obstetric services. At most it is an issue for national training allocations: it cannot be used as an argument to close or merge our units unless it could be shown that we could not staff the units. "

Finally, it is entirely possible to staff a unit with non-training grades acting as the more senior "junior" doctors.

Department of Health guidance

The 2004 CSR quoted (Section 2.1.3):

"the NHS policy paper *Keeping the NHS Local* [1] which states,
"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"."

1: Keeping the NHS Local – A New Direction of Travel. Department of Health (England), Feb 2003

Other similar (small) units exist and are safe

I am informed that there are about 90 consultant (caesarian-section-capable) obstetric units with fewer than 2500 deliveries in the UK, UK Crown Dependencies (e.g. the Isle of Man) and the British Overseas Territories (e.g. Gibraltar).

Several of these units (e.g. Huntingdon) have specifically requested and received confirmation from the RCOG that they meet safety standards.

Which begs the question: if safe units of less than 2500 deliveries can be maintained there, then surely they can be maintained in both Eastbourne and Hastings?

View of the Royal College of Paediatrics and Child Health (RCPCH)

The agreed minutes of HOSC on 7 June provided to me by Mr Zaidi state:

68.13 Mr Zaidi believes there would be some advantages to a single Special Care Baby Unit (SCBU) such as economies of scale, concentration of skills and opportunities to develop an enhanced service (if funded). He explained that the Royal College of Paediatricians (sic) does not currently recognise the existing units for training and has recommended a single SCBU. This is a driver behind the proposals, alongside the obstetric issues.

That (sentence highlighted in blue) is incorrect (as confirmed to me by the RCPCH college tutor).

- Both paediatric units are recognised in their entirety for training by RCPCH and RCGP
- Both have had recent training assessments confirming their training status
- Time on SCBU is included and accepted in the training of the allocated SpR
- Of course neither SCBU is recognised for advanced sub-specialty neonatal training as that must occur in level 3 (full NICU) units!

Thus that purported driver for single-siting must be rejected.

A larger SCBU will not offer an "enhanced service"

This was clearly stated by the 2004 CSR[1] (section 3.6.1) & we paediatricians have repeatedly reiterated this.

Even a combined unit would only be a level 1 unit. To have a level 2 unit we would need[2,3]:

- More SCBU nurses (high dependency requires ratio of 1 nurse: 2 babies, whereas special care only needs 1 nurse: 4 babies)
- Consultants with different training (with at least one year of higher specialist neonatal training)
- Immediate availability of the middle grade to the SCBU even if the general paediatric service is simultaneously busy – this might require a 2nd middle grade at night
- A dedicated SHO 24/7 – so we would need more SHOs on that site

2: Source:
British Association of Perinatal Medicine (BAPM):
Standards for hospitals providing neonatal intensive and high dependency care(Second Edition) and Categories of Babies requiring Neonatal CareDec 2001http://www.bapm.org/media/documents/publications/hosp_standards.pdf
3: Also stated in the 2004 CSR, section 3.6.1

"Providing the same service to all mothers in East Sussex.." has been mentioned by proponents of single-siting at many public meetings).That refers to nCPAP[1] – which at present is only available at Conquest. But in truth provision of nCPAP at EDGH has been blocked over the last 2 years. And there is only 1 machine at Conquest, so a second would have to be bought if there were a combined (therefore busier) unit. So it could just as well be bought for Eastbourne! (It is actually not very expensive.)

1:
CPAP:
Continuous positive airways pressure: useful for treating mild/moderate respiratory distress syndrome of the newborn and other neonatal respiratory conditions, without needing ventilation and thus reducing side-effects
nCPAP:
CPAP via tiny prongs at the tip of the nostrils. Simple to apply and monitor. And avoiding endotracheal intubation with all the difficulties and risks of that procedure and its maintenance, and all of the possible short and long-term side-effects

An issue which has not, to my knowledge, been mentioned by anyone, is the likelihood that single-siting the SCBU may in fact lead to level 3 neonatal intensive care (NICU) cots in our regional centres (in particular Brighton) being blocked for longer, and so actually worsen the situation for all units, including ours. This can be understood by considering an example:

Our units single-site at Conquest in Hastings

A baby, whose parents are from Eastbourne, is born at 28 weeks. That baby will be transferred (in- or ex-utero) to a level 3 NICU, for example Brighton.

A few weeks later, that baby no longer needs the full level 3 or even 2 service, and could be transferred to a level 1 cot.

However, is it at all likely that the parents, who live in Eastbourne, would consent to their baby being transferred to another hospital, Conquest, which is no more convenient to them than Brighton, which is at least a hospital that they will by then know and be comfortable with?

Thus it is likely that the baby will have to stay in the regional centre, blocking a cot which would not have been blocked if we still had SCBU in both Eastbourne and Hastings. Thus

the next baby we have who needs level 3 care may actually have to be sent much further away if Brighton's cots are full.

Choice

The PCTs' options 1-4 cannot increase choice as women already have the choice of a midwifery-led unit in Crowborough: and it is not oversubscribed.

Moreover, the petitions and public meetings have shown what is the choice of the women of East Sussex, and it is to retain two consultant-led units. This choice has also been stated during the appearances before HOSC of representatives of user-groups and midwives – and was also clearly stated by the focus groups and stakeholder events for the 2004 CSR[1]

1: 2004 CSR section 4.3
Notably (page 33):
Preference2 all risk offering midwife led (with x 2 birthing if it was possible)

Access

Clearly access cannot be said to be enhanced by any of the PCT's options 1-4. No woman will have to travel a shorter distance, as there will be at best one unit in Eastbourne and one in Hastings, as there are now, with the other option being Crowborough. But a woman who wishes to deliver in a consultant-led unit as opposed to a midwifery-led unit, and who is unlucky enough to live in the town that loses such a unit, will obviously have to travel further in labour.

Maintenance of ante-natal services

Contrary to what is generally said, at least some women will have to travel further for ante-natal care as well, as there will only be one high-risk pregnancy day-assessment service[1]

1: Sources:
Item 10 on agenda of 17 May HOSC meeting, report of Director of Law and Personnel, paragraph 3.6, & Appendix 4, paragraph 26 of PCT paper

Money

I accept that money is limited, and we ought not simply to pump loads of money into maternity as that might leave other services under-funded.

But the headline figure put into the public domain of an extra £2.3million being needed each year to maintain the status quo is, to my analysis, false

This is because it is derived from several misrepresentations of reality.

I have shared these analyses with the PCT and ESHT, and am entirely happy to engage with anyone to analyse these, and will of course be happy to be corrected and to apologise if I have made an error. I make these analyses in the spirit of reaching the right outcome for the people of East Sussex and the whole health community, especially my employer, ESHT.

Misrepresentation 1:

- It was calculated on the basis of two full tiers of junior doctors on each site as being the status quo
- But that is **not** the status quo – and hence should not have been so stated
- Nor would it be necessary – as we have seen

- Thus a cost of £933408[1] needs to be removed from that given for the "status quo"

1:
Source: Figures supplied by ESHT to PCT and passed to HOSC as item 10 on agenda of 17 May HOSC meeting, page 8
Calculation:
The figures state that there are currently only 2 SHOs working at the junior grade on each site ("Current budget": please note that 2 of the 4 SHOs given for eqch site are working as senior SHOs on the middle grade tier, with only 2 on each site working on the junior tier)
This has been increased to 10 on each site ("Required budget")
As explained, that is not the status quo, nor would it be necessary in future
Thus 8 extra doctors have been included on each site, a total of 16
The cost of each is given as £58338
Hence a total unjustifiable addition of 16 x £58338 = £933408

Misrepresentation 2a:

If the middle grade rotas were to be increased to 10[1], as is stated to be needed, then we would no longer need to pay each middle grade overtime. But that has not been stated, and the same costs per doctor have been given for the larger number of doctors on the two sites in the "status quo".

- Thus a very large amount of money needs to be removed from the cost of the status quo:
- ~ £534095[2]

1: The figure of 10 doctors being needed for a rota is based on a Royal College of Physicians statement:
"The case for a 'cell of ten' to provide 24/7 cover by junior doctors"
www.rcplondon.ac.uk/news/statements/ewtd_caseforten.asp
It is important to note that:

a)The document was intended for rotas of registrars covering general medicine, not obstetrics
b)It states that rotas could have just 8 doctors
c)It is intended for rotas where are doctors are in training positions and therefore attempts to maximise the proportion of their working pattern each doctor is present during the normal "working day", in order to maximise training opportunities when consultants are also present
d)But most of our junior doctors are not in training positions
e)And new ways of working, including changes to consultant working, offer many alternatives
f)As stated in a document produced by the Department of Health with the BMA and NHS Confederation "Guidance on working patterns for junior doctors" 2002
www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPOlicyAndGuidance/DH_400957

For further information, see appendix 3
2: Source: Figures supplied by ESHT to PCT and passed to HOSC as item 10 on agenda of 17 May HOSC meeting, page 7
Explanation:
Currently at Eastbourne DGH we have 7 doctors working on the middle grade tier. They are working more than their basic hours, and hence being paid more than their basic salary.
6 of those doctors are being paid as staff grades
They are each working, and being paid for 12 sessions, whereas their basic salary would be for 10 sessions
For simplicity, let us assume that all 7 are being paid for 12 sessions (though 1 is actually being paid on a different scale, as a senior SHO).
Thus ESHT are paying for 7x12 sessions = 84 sessions
If we add more doctors to the rota as Dr Scott argues is needed to meet EWTD requirements, well those requirements are met by reducing the hours each doctor works
And therefore reducing how much each is paid
If 10 middle grades are employed, then if each is only paid 10 sessions, a total of 100 sessions is paid for
But there is actually no more work to be done, so 100, as compared to the previous 84, gives a huge margin, so it is clear that none of the middle grades would any longer have to be paid for more than 10 sessions
But the cost per doctor in "required budget" is the same as that for the "current budget"!!
This must overstate the cost of each by 20%
The EDGH "required budget" middle grade costs are given as £401639 + £61516 + £194085 = £657240
Thus the overstatement must be ~20% x £657240 = £131448
I do not know the situation at Conquest in as much detail, but suspect that it is even more dramatic, as I know that one staff grade has been being paid for 16 (!) sessions
But for simplicity I will apply the same 20% overstatement factor to Conquest's paediatric middle grades:
20% x (£219484 + £138217 + £61516 + £258780) = 20% x £677997 = £135599.4
I know the staffing and pay of the obstetric middle grades less well, but do know that currently they too are paid for more than their basic salary.
But there is no adjustment for that in the figures given for O&G doctors staffing budgets either (page 8)
So for simplicity, I will simply double the figure we have arrived at for paediatrics, to take account of obstetrics as well:
2 x (£131448 + £135599.4) = 2 x £267047.4 = £534094.8

Similarly, no account appears to have been taken of the possibility of reduced hours (and hence pay) of each consultant obstetrician if their numbers were increased to 5 to maintain the status quo. I do not have enough data to calculate any potential saving which ought to be subtracted from the cost of the "status quo".

I understand that the consultant obstetricians are paid for 11Programmed activities (PA). Thus at present, as each site has 4 consultant obstetricians, the total work being paid for is 4 x 11PA = 44PA
5 consultants, each working a 10PA basic contract, would be able to do 5x1 0PA = 50PA work
Hence it may be possible to reduce each consultant's pay, but I cannot calculate whether that would be so without more detailed data, as all job plans will need to be carefully redone to give the 40hours on labour ward.

Misrepresentation 2b:

Similarly if the more junior doctors in paediatrics were to be increased to 10 on a tier on each site, as is stated in the PCT's documents, then each would work fewer hours, so the cost of each would reduced. But that has not been stated, and the same costs per doctor have been given for the larger number of doctors on the two sites in the "status quo".

- Thus another large amount of money needs to be removed from the cost of the status quo:
- ~ £74000

Explanation:
The paediatric SHOs and FY2 doctors are currently paid an additional banding supplement of 50% of their basic salary. It is likely this would reduce to 40% if their numbers were increased to 10.
The current cost of each of these junior doctors is given as follows (item 10 on HOSC agenda of 17 May): £55159 at EDGH and £55954 at Conquest.
Thus the overstatement of the cost is:
At EDGH: £55159 x 1/15 (1/15 being the difference between a 50% and 40% supplement) x 10 = £36773
At Conquest: £55954 x 1/15 x 10 = £37303

I note that there might also be a reduction, though considerably smaller, in the cost of options 1-4 by the same reasoning.

Misrepresentation 3:

Increased administrative costs are given for the obstetric "status quo". Those appear to be extra secretaries for the extra consultants. But extra secretaries will not be needed[1] , as there will be no more secretarial work to be done.

Thus an extra cost of £45762[2] has been added in unnecessarily

Source: Figures supplied by ESHT to PCT and passed to HOSC as item 10 on agenda of 17 May HOSC meeting, page 8
1: There will be no more clinics etc generating typing: the extra consultants are merely in order to reduce the rota frequency. Existing clinic etc work (the work which generates typing and Personal Assistant activity) will presumably be re-shared amongst the consultants, so the resulting secretarial work will also be rep-shared amongst existing secretaries. Thus no more secretaries are needed.
2:
Admin FTE (full-time equivalent) cost given as £22881
1.25 extra given as "required budget" on Conquest site
0.75 extra given as "required budget" on EDGH site
Hence total = (1.25 + 0.75) x £22881 = £45762

(Probable) Misrepresentation 4:

All single-sited options include a reduction in paediatric staffing of 2 Trust grades, and 2 SHOs, With consequent savings. However, I can conceive of no justification for that. I believe the true figure would be a reduction of 1 doctor of each type.

- This would mean an extra ~£119855 to be added to the annual costs of all options 1-4

Source: Figures supplied by ESHT to PCT and passed to HOSC as item 10 on agenda of 17 May HOSC meeting, page 5
Explanation:

EDGH currently have 1 middle grade, and 1 SHO, dedicated to the SCBU + labour ward from 8.30am – 4.30pm, Monday – Friday. At all other times there are no medical staff dedicated to SCBU (it is covered by the same staff who are covering A&E, the day assessment unit, and the paediatric ward).
The situation at Conquest is similar.
If there were only 1 consultant-led obstetric unit, then one SCBU would and labour ward would close.
Thus there would no longer be a need for that 1 middle grade and 1 SHO slot on the rota, for those 40 a hours a week.
Other slots on the rota would be unchanged
Thus there would be a saving of 40 hours of middle grade time a week (which is provided by 1 full-time equivalent)
And a saving of 40 hours of SHO time a week (which is provided by 1 full-time equivalent)
Hence there is a saving of the cost of 1, not 2, middle grades (given as Trust grades in the document)
And 1, not 2, SHOs.
The cost of 1 Trust grade is £64695 (page 7)
The cost of 1 SHO is £55159 (page 7)
Hence £64695 + £55159 = £119855 has been incorrectly removed from the cost of each of options 1-4

So what is the real cost of maintaining the status quo?

The PCT stated this as £2.3million (£2313000)[1]

But this must be reduced by ~£1.6million (~£1587340)

Giving a true extra cost of, at most, ~£725660 i.e. just £726k / year

1:
Source: Item 10 on agenda of 17 May HOSC meeting, report of Director of Law and Personnel, paragraph 2.2

And what are the real costs of options 1-4?

The costs given by the PCT excluded:

- Capital
- Redundancy
- Relocation
- Travel for patients by ambulance
- Travel for staff – though Dr Bray told HOSC that she believed that ESHT would provide this, hence a cost must be added to all of options 1-4 but not to any option retaining two sites.

But did include the possibility of needing an extra tier of anaesthetists on the single (hence much busier) site.

Capital costs of rebuilding and new building: now stated as £105K- £218K/year[1]

And we can now assume that an extra tier of anaesthetists would indeed be needed, at a cost of ~£500-550k/year[2,3]

1:
Capital costs (PCT document tabled for HOSC 25 July 2007 under agenda item 14):
Option 1: £2.642m
Option 2: £1.32Om
Option 3: £2.742m
Option 4: £2.621m
Revenue costs (i.e. the annual cost of paying for those loans):
Option 1: £209k/year
Option 2: £105k/year
Option 3: £217k/year
Option 4: £207k/year
2:
Sources:
Item 10 on agenda of 17 May HOSC meeting:
Report of Director of Law and Personnel, paragraph 2.3
Appendix 4, page 1a
Agenda item 9: Perspective of RCOG, tabled for HOSC meeting of 25 July 2007
3:
2004 CSR Section 7.3.3
"Dr Walmsley, Clinical Director, Anaesthetics, Theatres and Critical Care, ESHT, has summarised the position of the ESHT anaesthetists:*Although there are no figures stating the number of deliveries requiring a separate rota, approaching 3000 appears to be the norm if you want to run a pain relief epidural service and*

immediate access for LSCS. Currently our middle grades who cover obstetrics also cover the 1st on (theatres, critical care) and trauma calls and are already exceptionally busy. It would therefore not be possible without an extra tier of Drs or closing one of the 2 sites to all emergencies."

..

"an additional staffing cost of £550 000"

Real costs of options 1-4

	PCT (provisional) costing[1]	Likely cost[2,3,4]
Option 1: Consultant-led service at Eastbourne only	Saving of £120,000 per year	Saving of £145/year[5]
Option 2: Consultant-led service at Conquest only	Extra cost of £213,000 per year	Extra cost of ~£333,000/year[6]
Option 3: Consultant-led service at Eastbourne and midwife-led unit at Conquest	Extra cost of £406,000 per year	Extra cost of ~£743,000/year[7]
Option 4: Consultant-led service at Conquest and midwife-led unit at Eastbourne	Extra cost of £622,000 per year	Extra cost of ~£949,000/year[8]

1:
Source: Item 10 on agenda of 17 May HOSC meeting, Report of Director of Law and Personnel, paragraph 2.1
2: I have made no analysis of the nursing/midwifery staffing and cost figures as I do not have the expertise to do so, so I have left them as in the figures from ESHT to the PCTs to HOSC
3:
All provisional costs have had £119885 added to them, as explained previously owing to the mistaken doubling of the saving in paediatric trust and SHO grade doctors
All capital costs are from "Further information requested from East Sussex PCTs for HOSC evidence gathering meeting on 25/7/07", tabled for HOSC meeting of 25 July 2007 under agenda item 14, section 1. These capital revenue costs ((i.e. the annual cost of paying for that capital loan) have been added to the cost of each option
4: It is possible that the costs of options 1-4 have been overestimated, perhaps by up to £250k, by over-estimating the cost of the middle grades in the same way as has been explained in slide "False 2" which discussed the costs of the status quo. I have not made any such reduction as I am uncertain of the figures
5: Capital revenue of £209k has been added
6: Capital revenue of £105k has been added
7: Capital revenue of £217k has been added
8: Capital revenue of £207k has been added

So what is the real financial saving of single-siting?

At most, there would be a relatively small saving (option 1 may be £800K cheaper per year than the status quo – but many more costs of single-siting remain to be added in, as well as potential losses of income[1]).

1: Possible losses in Gynae (elective inpatients), SCBU income and possible consequent loss of paediatric activity/income for children who are treated in SCBUs outside ESHT
-source: PCT paper for HOSC as item 10 on agenda of 17 May HOSC meeting, paragraph 28 of appendix 4

But there may well in fact be no saving at all but actually a greater cost if we single-site: (option 4 may be at least £150k/year more expensive than the status quo)

Which is interesting, as that is the conclusion which the 2004 CSR arrived at![2]
2:
Section 7.3.3:
This gives (in a table) the medical (excluding consultant) and midwifery costs of the status quo as being £5.15million, whereas the cost of one all-risk unit with two birthing units would be £5.45million

My conclusion

I know of no other reasons which have been given for single siting (i.e. any of options 1-4) other than those which I have discussed in this paper. And I believe that I have demonstrated that all those reasons which we have been offered are wrong

So we should not single-site

Unless someone comes up with a new reason, which actually stands up to analysis!

And my recommendations?

•I believe we could maintain 2 consultant-led units

•With just 1 more consultant on each site – as there were just a few years ago

•And perhaps 2 more middle grade doctors on each site – but much more detailed work is needed – and in fact should have been done long ago – to determine precisely how many middle grades would be needed

•And by recruiting the midwives who are anyway needed to meet Birthrate Plus

•And perhaps considering some of the new ways of working commended for maternity by *Keeping the NHS Local* and described in the 2004 CSR – only 1 of which appears anywhere in this consultation[2] …

1: 2004 CSR section 5.4
2:
2.1.5 New Ways of Working For maternity services *Keeping the NHS Loc*al commends examples of changing working patterns, and service redesign as ways of ensuring that local services can be maintained. Examples of new ways of working being developed and tested at present, looking at extended roles, changing working patterns and increasing flexibility within current services are reported by the National Configuring Hospitals Project: •Neonatal nurses with extended roles in areas such as transport, transitional/special/high dependency/intensive, family care •Neonatal nurse practitioner who can instigate investigations and treatment, perform some practical procedures previously only undertaken by doctors in training, carry out many SHO duties and replace or partially replace them on on-call rota•An obstetric technician who can assist with caesarians in theatres and on the delivery suite•Midwife who can carry out ventouse deliveries•Midwife/gynaecology nurse who runs Early Pregnancy Unit/gynae A&E and can diagnose and scan •Obstetrician and gynaecologist who joins the middle-grade on-call rota, works a block of nights and does a twilight shift once a week•Obstetrician and gynaecologist who works in special interest teams across sites and is resident on call 8 till late. •Non-medical epiduralists (who would probably have to work in units with obstetric cover) would be of particular benefit to areas where anaesthetic services are under pressure.•Midwife-led units currently only cater for a relatively small proportion of women, partly due to the lack of epidural provision and the risk of transfer to a remote unit in case of complications. But there is a counter view that these units offer clinical advantages through lower caesarean rates and reduced complications related to epidurals. There is also some evidence that continuity of midwife care during pregnancy is associated with lower caesarean rates, and continuity of care during labour is associated with

lower pharmacological pain relief. This suggests that there may be scope to develop midwife-led units by:o Making them centres for all ante-natal and post-natal care, whatever the planned or actual place of birth, with the option of delivery for non-high risk caseso Introducing midwife caseloading, in which the same midwife (through pairing arrangements) sees the mother throughout pregnancy and delivers the baby wherever the mother chooses or needs to go – shifting the focus from the place of delivery to the midwifeo Promoting the benefits of a non-medicalised model of maternity provision

A final thought..

..how much money have we wasted on this entire process?
Off the top of my head: McKinsey, other outside consultants, thousands of hours of clinician time, senior management time, PCT employees' time.., printing, organising and hosting consultation meetings..and the list goes on and on and on
How many midwives could we have employed for that money??????

Addendum 1: where would a single-sited unit be?

Kim Hodgson said to HOSC on 22 June:

“ One point I can commit to: it is my belief that the Trust will lose substantially more income if a single-site obstetric option is chosen for the Hastings site.It is my personal belief and it is a view that I will be providing to my Board. I believe Eastbourne women will travel out of East Sussex for birth delivery.”

Addendum 2: The EWTD as it applies now to ESHT, and changes which will be needed in 2009

I have sought to explain that the EWTD in 2009 is not a major challenge to either obstetrics or paediatrics, and hence why it cannot be considered as a reason to radically change our services.

I now have further information.

In the 1980s and 1990s, almost all departments in almost all hospitals in the UK were staffed by junior doctors working an “on-call” system. This meant that after hours they were resident in the hospital, not necessarily working all the time, but awake much of the time. They could be at the hospital on duty for long periods: for example it was not unusual for a department to be covered by the same doctor working from 8am on Friday until 5pm on Monday, i.e. a period at work and on duty of 83 hours. This led to an individual working over 100 hours a week.

It was widely recognised that this was not fair to junior doctors, and risky for patients as they were being cared for by doctors who might not have slept for over 24, 48 or even 72 hours.

In 1991, a deal was negotiated by the BMA and the Department of Health, to reduce these hours. It was called the “New Deal”.

Hours did reduce, though not greatly, until a new contract for junior doctors was agreed in 2000. Under the old contract, each hour a junior doctor was contracted beyond the standard working week of 40 hours, was only remunerated at a rate of 33-50% of the basic hourly rate. Note that this was not 133-150% - i.e. more than the basic rate – but was just one third to one half of the basic hourly rate. In other words, this compulsory overtime was paid at a rate much lower than the basic rate, entirely the opposite to most other workers.

The new contract brought in a new system of overtime payment. The detail of this is not easy to explain, but in summary, in addition to basic pay, each junior doctor received a supplement, the “banding supplement”. This supplement was not paid per hour, but was a total additional amount. The banding supplement originally ranged from 20%-62% of basic pay, with the actual banding supplement for an individual doctor determined by a flow chart which included factors such as: total number of hours worked, length of individual periods on duty, how anti-social those duty periods were, and the intensity of the work during those periods of duty (in other words whether one could expect to get any rest during a period of duty).

The new contract, agreed between the BMA and Department of Health, was also designed to reduce the working hours of junior doctors. It did this by a series of increases to the banding supplements, making employing doctors for very long periods increasingly expensive. The highest supplement rose to 100% in Nov 2002: in other words employers would have to pay double total pay for doctors whose working hours and pattern were the most onerous. To further reinforce this it became illegal to contract a doctor beyond the limits of the New Deal on 1 August 2003. This meant that by 1 August 2003 junior doctors (with very few exceptions) could not be contracted for more than 72 hours per week, and

could not actually work for more than 56 of those hours. (The other hours they could be at work, resting but ready to work).

The BMA and the Department of Health gave a great deal of guidance as to how staffing patterns could be changed to allow individual doctors to be contracted for fewer hours. This did involve employing more junior doctors, but also other changes such as shifting work to the daytime when there are anyway more doctors available, streamlining work, removing duties from junior doctors, cross-covering between junior doctors working in related specialities, and employing more consultants, so that care would be provided by the most expert doctors, rather than those more junior.

Thus huge reductions in hours had occurred by 1 August 2003, with huge changes to the ways all types of hospital units and departments were staffed.

Alongside these changes resulting from new ways of wishing to provide care (such as employing more consultants), the new contract, and the New Deal, were the EWTD laws. The EWTD is health and safety legislation, intended to protect the worker from working too long and thereby damaging their health, or putting themselves at risk, such as accidents, by being too exhausted so that mistakes might occur. Junior doctors in training in the UK had been exempted from some aspects of the EWTD. But in 2000 they were brought under the protection of the EWTD, with its protective limits to be brought in for them in a staged fashion.

The first staging of the EWTD limit was in August 2004 with a limit to total working hours per week of 58 hours. That, however, was of little relevance, as by then the New Deal had meant that junior doctors could not work for more than 56 hours a week. Of more relevance was that the other parts of the EWTD came into force for junior doctors in training. These require minimum rest periods between periods of work, and the most important issue was that for almost all junior doctors no period of work could be longer than 13 hours. This limit was reinforced by judgements of the European Court of Justice (called the SiMAP and Jaegar judgements).

This limit to a maximum shift length of 13 hours, meant that working patterns were redesigned.

Thus by 1 August 2004 no doctor could be working more than 56 hours, and no individual shift could be more than 13 hours.

Thus the huge challenge to staffing of individual units had to be met by 1 August 2004, not 1 August 2009!

The change on 1 August 2009 is that the EWTD limit on total hours per week will reduce from 56 to 48.

Thus it has never been clear to me why that should be such an overwhelming challenge as to require us to close one of our two obstetric units, whereas we were able to cope with the much greater change which occurred prior to 1 August 2004.

Most Trusts have continued to reduce the working hours of junior doctors below the 56 hour limit because of the pressures of the junior doctors' contract. Thus by now few junior doctors are working more than 50 or so hours a week

Hence it has been even less clear to me why a need to reduce from ~50 hours per week to 48 would mean that we would have to close a unit.

However, the situation is no longer theoretical, but we now have the facts.

Dr Lorna Bray told HOSC on 25 July that the hours of junior doctors in paediatrics have been reduced to 48 hours. Thus the limit needed on 1 August 2009 has already been reached.

I understand that some of the junior doctors in obstetrics have been working 52 hours a week, but that will reduce to 48 hours a week in August 2007.

Thus it appears that no, or very little challenge, remains for ESHT in obstetrics and paediatrics – and we are running two units, and that has been achieved without the increase to 10 doctors on each tier which the proponents of single-siting have repeatedly claimed is needed.

As I have stated, there is also the fall-back that doctors can opt-out of he 48 hour limit – though I agree that it would be foolish for a department to rely on all of its doctors opting out, as that has to be a voluntary decision, which can be reversed by the individual.

References:

http://www.bma.org.uk/ap.nsf/Content/jdhandbook~hoursofwork?OpenDocument&Highlight=2,new,deal,2003

http://www.bma.org.uk/ap.nsf/Content/Finalagreementspayband

Addendum 3: are 10 doctors required on a tier?

A tier of doctors is a group of doctors working at the same level and covering the whole 168 hours of a week between them.

Consultants provide one such tier – though a considerable portion of the 168 hours a week are with the consultant at home (for example at night) but ready to return to the hospital rapidly to help to deal with difficult emergencies.

Another tier is middle grades: there are experienced doctors, but not consultants, who have many skills and can manage most emergencies. They provide, between them, 168 hours of on-site work. This is the case for both obstetrics and paediatrics on both sites. These doctors have titles including staff grade, Trust grade, senior SHO, and from 1 August 2007: ST3, ST4 and so on.

Even more junior doctors, with even less experience and skills, could provide a further tier. In obstetrics, on both sites, there is not a complete tier of these even more junior doctors. There are only two, and they are present only during the standard working day. They are, in the main, doctors gathering some obstetric experience as part of their training to become GPs. They have titles such as GP VTS, SHO, and from 1 August 2007: ST1 or ST2.

Proponents of single-siting claim that 10 doctors will be required on each tier. This was most recently stated by Dr Lorna Bray to HOSC on 25 July. That is not completely correct. It is based on a short publication by the Royal College of Physicians, (http://www.rcplondon.ac.uk/college/statements/ewtd_caseforten.asp) which tried to determine the optimal number of middle grade junior doctors, all in training positions, required to cover a department of general medicine. Thus it is not to be taken as applying directly to an obstetric department, or a paediatric department, as the work is different, and also should not be taken as applying directly to departments in which not all of the doctors are in training positions. That is because the aim of the Royal College of Physicians work was to optimise the proportion of their working week that the doctors in training could be present during the standard working day, and thus hope to receive direct supervision and teaching by consultants. These requirements clearly do not apply in the same way to doctors in other specialities, nor to doctors who are not in training positions.

Moreover, that very Royal College of Physicians document actually gave a range of numbers needed for a tier, from 8 to 10.

The statement by Dr Bray to HOSC on 25 July (23mins 11 secs into webcast) that advice had been received from Dr David Black, Dean Director, that a tier should contain 10 doctors, needs to be taken with the information I have provided, and with one further piece of information:
Deans, and their Deaneries, are only concerned with the training of junior doctors and postgraduate medical education, (http://www.kssdeanery.ac.uk/primaryframeset.html) thus their advice can only be for tiers of doctors where all are in training positions. And it is not disputed that the majority of doctors in both paediatrics and obstetrics on both sites are not in training positions (I have quoted Dr David Scott's evidence to HOSC on 22 June 2007). . Thus the advice is being misapplied.

Dr Bray (Clinical Director of Paediatrics ESHT) advanced a new argument to HOSC on 25 July: that 10 doctors are needed on a tier to avoid the expense of paying for locums. That is economic nonsense, as can be clearly demonstrated. Dr Bray told HOSC on 25 July, and reiterated in a letter to the PCT, "there needs to be 10 doctors in each tier to achieve this and avoid locum use for sickness and emergencies. It is possible to cover with fewer doctors but these extra costs will be incurred at times." This needs to be considered in a little detail. Dr Bray stated that our current rotas would comply with the EWTD in 2009, and we currently have 7 doctors on each tier in paediatrics. The cost of increasing each tier to 10 doctors would be:
An extra 3 SHOs on each site at £58338 = £175014
An extra 3 middle grades on each site ~ 3x £66940 = £200820
(Costs from PCT document to HOSC, agenda item 10, page 7)
This gives a total of 2 x (£175014 + £200820) = £751668

This is approximately 10 times the likely cost of paying for locums (based on the figures given to directorate by our accountant over the last year) to cover sickness. Thus this argument, which is only an argument about money, makes no economic sense at all.

Addendum 4: How many middle grades will be needed in obstetrics/gynaecology on a site?

A rota compliant with the EWTD 2009 can be written with only 5 doctors (standard calculations, and also consistent with Royal College of Physicians publication, http://www.rcplondon.ac.uk/college/statements/ewtd_caseforten.asp previously discussed, readjusting it for a 48 rather than 56 hour weekly limit). That allows holiday and study leave, but will only give 1 middle grade on site at any time. That is sufficient for the out of hours period, but the department would need more during the normal working day, to help with clinics, surgery etc, and to attend audit, teaching etc. Also, those are the times that middle grades can most easily receive direct supervision from consultants. But how many extra doctors are needed on the rota depends on a careful analysis of what the service and the individuals need. And that will include reconsidering the current staffing of clinics, for example, as the number currently staffing a clinic may not be the optimal number nor the number needed in future. And taking account of other issues, such as the proposed shift of gynaecology outpatient work into even more local community settings.

Hence I cannot give a precise number: it will be between 6 and 10. More detailed work is needed (and indeed should have been done long ago) to determine the precise number.

It is far too simplistic to say that 10 doctors will be needed without having done such detailed work.

Addendum 5: How to provide 40 hours of consultant presence and availability on the labour ward

I have already pointed out that this can be achieved by 5 consultants, as demonstrated by the greater than ~46 hours per week achieved in paediatrics.

One criticism of this fact is that the work of obstetric and paediatric consultants is different. That is of course true, but not relevant.

The principles of job-planning are the same for all consultants, and whether or not 40 hours of consultant presence and availability on labour ward can be achieved depends only on the priority given to achieving it.

If this is the priority, then job planning for each obstetric consultant would proceed as follows. Let us assume there would be 5 consultants working on each site.
1st priority: There must be a consultant on-call from home for all of the non-standard working week (loosely evenings, nights and weekends). An amount of actual working time needed for that is derived from diaries: for example it might be 2 hours each night. That amount of time is multiplied by the number of times a consultant will be on-call a year (1 in 5 x 365 days).
2nd priority: 40 hours of presence and availability on the ward each week. However, we know that though the consultant would need to be on labour ward for all of those 40 hours, he/she would not actually be needed to be doing hands-on obstetrics all of those 40 hours. For example, there might only be 15 hours of acute obstetrics a week. The actual acute obstetric work will occur in portions of time, at unpredictable times. For the remainder of the 40 hours, the consultant will be on labour ward, ready to help immediately. But clearly the consultant need not simply sit doing nothing. There are many things which could be done whilst being in the office, and which could be interrupted instantly to help on out on the ward. These are activities such as dictating letters, reading and checking letters, dealing with correspondence, reading journals etc, audit – all of these are tasks all consultants have to do, and which have to be fitted into the job plan. By slotting them flexibly into the labour ward 40 hours, maximum efficiency is obtained – almost like getting double value for the time.
Then the other tasks of the obstetrician-gynaecologist consultants come lower in the order of priority.
Perhaps:
3rd priority: elective gynaecological surgery
4th priority: antenatal clinics
5th priority: gynaecological outpatients
etc
Thus the decision about what can and cannot be provided will be made regarding one of those lower priorities roles. For example, instead of the challenge being whether 40 hours of labour ward time can be covered, the decision would be how much elective gynaecology outpatient time can be given (which in reality, will mostly depend on how much time the local health economy wishes to pay for.)

Thus it is entirely false to argue that 40 hours of labour ward time cannot be provided. It simply depends on the priority that is accorded. So in fact, the debate ought to be about how much elective gynaecology time (i.e. work or activity) the local economy health

economy wishes to commission and pay for. Also, this may mean people working differently to what has happened before.

I cannot work out the details of this sort of overall service planning, and hence individual planning without much more data and support – but it is that level of sophistication which is needed.

Addendum 6:

The consultation with the GPs of Hastings and Rother:

- Greg Wilcox[1] before HOSC 7 June[2]
- Q: "how many of your colleagues[3]…"
- A: " We've had conversations with not all of our local GP colleagues but with a number of them.. PEC.. about 8 GPs.. meetings with other GPs.. over towards Eastbourne.. other meetings with GPs in Hastings outside our PEC..
- Q: "You say many or most GPs. Could you give us numbers on that, please?"
- A: "No I couldn't.. there have been as I said a number of meetings, as I said, they have been not large numbers of GPs.. we did initiate a discussion .. at our last PC Forum at which there must have been about 20 or 30 GPs, there was not a, well there was not a response actually, people I think accepted where things were going.., but to be honest we need to have that conversation again and intend to do so early in July, I think it is 11 July, at our next Primary Care Forum, where we will be able to speak to GPs in rather more depth about the issues."

1: Greg Wilcox is the chairman of the Hastings and Rother PCT's Professional Executive Committee (PEC)
HOSC = Health Overview and Scrutiny Committee
2: Starts at 12 mins 3 secs
3: The line of questioning by HOSC members concerned how far his views reflected those of GPs in Hastings and Rother

So what happened at the Primary Care Forum on 11 July?

- "where we will be able to speak to GPs in rather more depth about the issues"[1]

- The agenda was of education and other issues, and had just 15 minutes set aside for the reconfiguration, to consist of a presentation by Michael Wilson for the PCTs
- And no other time for reconfiguration discussion at all
- After some insistence, supported by a GP, but against resistance by the organisers, I was allowed to speak with the GPs after they had been asked if they wished to hear from me

1: See previous slide – this statement was made to HOSC on 7 June.