ANNEX 3

Answers to questions posed by the Boards in relation to Options 10 and 11

Perhaps before trying to answer your questions I should make it clear that I would prefer a two site option, subject of course to its feasibility. Neither the consultation document nor the documents on the website have persuaded me that a two site option is not possible.

I put forward Options 10 and 11 because they will provide women with an additional choice of place of birth than in Options 3 and 4. If a two site option had been included in the list of options, I would have suggested a further option: the addition to that option of midwife-led birthing centres in both Eastbourne and Hastings.

- *How can your proposal, which involves a single site, be safer than two sites given that a single site would clearly mean that some women have to travel longer distances*?

Assuming that two sites can be adequately staffed, I consider that my two options are considerably less safe than two sites would be. They share this with Options 3 and 4 and indeed they are somewhat less safe than these options.

- *How would this option support improved access of care, and choice for women and their families given there will only be a single obstetric unit?*

If the single consultant-led obstetric unit is in Hastings, and a woman living in or near Hastings chooses to have her baby in a midwife-led birthing unit, the unit will be much more readily available to her than would be the case under Option 4. Indeed, I believe none or very few Hastings women will be prepared to book for delivery in a midwife-led birthing unit in Eastbourne. Option11 therefore effectively provides a woman with the choice of an additional place of birth to those that would be available to her under Option 4

- *Can you quantify the advantages of a single obstetric unit in terms of recruitment, retention, training and maintenance of skills of medical and other staff?*

I would need to be an operational manager to answer this quantitatively. However, I will raise a few issues relating to this. Essentially I think this is a safety issue. Your Chairmen in the Foreword to the Summary Version of the Consultation Document said “The fact that bigger maternity units are safer and more effective is an important issue to consider in this consultation.” In preparing my response to the consultation document I spent a few days researching safety issues on the internet. I was

unable to find any evidence to validate the Chairmen's assertion. For procedures such as pancreatic and oesophageal cancer, abdominal aortic aneurysm and paediatric cardiac procedures, there does appear to be reasonably strong evidence of a relationship between volume and improved patient outcomes. I was unable to find any studies relating volume and outcome in obstetrics. I suspect that a study examining the relationship between the size of an obstetric unit and outcome would fail to show that larger units are safer. One of the reasons for this is that maternal deaths are rare events and intrapartum stillbirths and neonatal deaths are uncommon. Another is that the procedures carried out in obstetrics are not highly technical like those surgery procedures mentioned above.

If the safety of a consultant-led obstetric unit does not depend on the number of births in the unit, what does it depend on? The investigations into Ashford and St Peter's Hospital NHS Trust, New Cross Hospital in Wolverhampton and Northwick Park Hospital are very revealing. These clearly show that it is the level of staffing and the behaviours of the staff that are important. It appears that if the staffing level is adequate and leadership and team working are good, then safety will follow.

I would expect recruitment of consultants to be easier in a larger unit. But has the East Sussex Hospitals Trust with two units experienced difficulty in appointing consultant obstetricians? As far as midwives are concerned, I understand the requirements are based on workload and so the total number required will be similar for two units or a single unit. When mergers have occurred many midwives previously working in the closed unit do not transfer to the single remaining unit. I therefore would expect recruitment of midwives to be more difficult with a single unit. Recruitment of junior medical staff to two units will I suspect become increasingly difficult and they may well lose recognition for junior doctor training. A single unit will be more able to retain this recognition.

I think it is important to decide how important it is to continue training junior doctors. I understand that in the future they will be less skilled than at present. Has the feasibility of retaining two units staffed by consultants and staff grade doctors been considered? I would expect staff grade doctors to be more skilled than doctors in training and the staffing would be more stable. Also with two units staffed this way it would be easier to meet the CNST standards "*that an obstetrician who has completed a minimum of two years training in obstetrics should be available on the labour ward within 5 minutes. Where this doctor requires supervision or help, the consultant obstetrician must be available within 30 minutes."* It seems to me that with say a single unit at Hastings there is little chance of a consultant living in Eastbourne being awoken from sleep and getting to the labour ward within that time scale!

As far as staff retention is concerned, this will be very dependent on morale which will in turn largely depend on adequate staffing, leadership and team working. My

experience leads me to believe that leadership and team working are more difficult to achieve in larger units.

Training depends on level of staffing, leadership and team working and I don't think a single unit has any advantage over two units.

I think too much is being made of skill retention in obstetrics. As I said earlier, obstetric procedures are relatively straightforward and therefore do not require a high volume of patients to assure patient safety.

- *Could you explain how your proposal would help the upgrading of community maternity services at least to the standard of practice plus?*

My understanding is that this is about Improving Working Live and therefore a Human Resources issue. However, I believe the PCT has to show that good practice has led to improvements in the quality of services being delivered. Options 10 and 11 will enhance the work of community midwives and patients will have an additional choice when booking their delivery. The requirements of "Maternity Matters" will also be met.

Geoff Leece
2nd November 2007