Whether you agree that the PCTs have undertaken an adequate assessment (in comparison to their own options) of your proposal(s) and your specific reasons/evidence for this opinion.

No. I do not believe that the PCTs have even carried out an adequate assessment of their own proposals. My reasoning includes the following:

- They have never been prepared to release details of their option appraisal criteria
- Their financial data has multiple errors and distortions. A detailed critique sent by me eventually received a very brief reply saying my points would not make a material difference, despite my having pointed out differences of hundreds of thousands of pounds, and of up to 60% of total figures. A follow-up e-mail from me has not been answered.
- They have continued to mention difficulties with the EWTD, despite the rotas already having become compliant at ESHT
- They have continued to refer to problems with MMC, despite Sir John Tooke's report making it clear that MMC will undergo massive changes
- They have never quantified the risks inherent in additional travelling etc for their single-site option, and have simply declared that the supposed benefits of single-siting will outweigh the risks.
- When directly challenged to produce their detailed evidence of the advantages of 60 hours of consultant presence over 40 hours in our specific set-up, they have failed to do so.
- They have chosen selectively from Safer Childbirth, and used standards which do not apply to our current units. However, they have ignored an absolute safety standard: the response time of consultant paediatricians and obstetricians coming in for emergencies from home
- They have proposed increased training for paramedics, with no quantification of the resources required and whether they could ever be found, and given no detail of the skills to be acquired, and how that would occur, nor of how such skills would be maintained.

If you do not believe the assessment was adequate, the specific aspects of your proposals where you believe the assessment is inaccurate or incomplete

It is unclear to me what, if any, assessment of my proposal has been carried out. The PCT have not engaged in dialogue.

However, in PCT documents and statements, vague doubts were expressed, usually in the passive tense (and hence unattributable) regarding the adequacy of the staffing arrangements I have proposed. These aspersions continued despite my providing multiple detailed and referenced sources of evidence.

Furthermore, the financial advantages of my proposal were not engaged with in any way. The PCT appear to now assert that finance is not a driver. This is nonsensical, as it is clear that the financial cake is finite, and their own stance has been inconsistent. For example, when questioned on November 5th by his own Boards about plans to increase community midwifery provision, the only response given by the spokesperson for the PCTs' single-siting options, was that his options were (supposedly) cheaper than dual site options and so money could be available for community midwifery.

Great play has been made by the PCT of 60 hours of consultant presence. They appear not to have been deterred by the striking change in Safer Childbirth such that the final draft makes it clear that 60 hours are not necessary for safety for high-risk units of our current size. The PCT have asserted that 60 hours would provide a clear and significant safety advantage over 40 hours, but when challenged, have failed to provide the asserted evidence.

The PCT have asserted that dedicated anaesthetic presence – of junior anaesthetists – would be a significant advantage of single-siting. This is despite such anaesthetic cover not being required for units of our current size by Safer Childbirth, evidence by senior obstetricians of there having been no significant local safety issues, and evidence from the clinical director of anaesthetics that there is no service problem with our current units but that extra anaesthetists would simply be needed to provide the <u>same</u> service if single-siting.

The PCT appear to have chosen selectively from the standards of Safer Childbirth, whereas my option does not. For example, their option completely ignores the absolute requirement that both obstetric and paediatric consultants must be able to arrive in an emergency on the labour ward within 30 minutes. Many (perhaps all) of the ESHT consultants who currently work on the Eastbourne site live too far from Conquest for that to be possible. However the PCT have asserted that there will be no relocation. A detailed request by me for an explanation of their plan was met by a vague and, I felt, dismissive brief response, sent only on the evening before the PCT Boards' joint meeting.

Similarly, the PCT single-siting options hold that two tiers of junior obstetricians will be needed. Safer Childbirth makes it clear that is not required for my option. Moreover, the PCT have ignored the absolute requirement in Safer Childbirth that in a unit of their combined size, all doctors on those two tiers would have to have significant obstetric experience. That is not possible under the PCTs' staffing proposals, could not be delivered by the Deanery as training posts, and would clearly run at least as much of a risk of non-recruitment as the PCT assert would be the problem for dual-siting options.

Another example of incorrect assessment was apparent even at the joint PCT Board meeting, when a non-executive director of the PCT maintained the stance that single-siting could allow a higher level of neonatal service, despite this having been refuted by 11 of the 14 ESHT paediatricians (the other 3 being on leave) at a meeting with officers of the PCT in late September. This included the neonatal specialist from the Conquest Hospital

Whether you had opportunities to provide input to the assessment process (for example, clarifying the nature of your proposal) and the opportunity to comment on the final assessment of it.

No. There has been no meaningful dialogue with the PCT. They have never agreed to meet with me to discuss my or other options, and have never responded to my offers to help flesh out the detail of different options. There has been no meaningful dialogue. Many of my e-mails have gone unanswered, and some were only answered on the day (even the evening) before the PCT Boards combined meeting, precluding any further dialogue. It appeared to me that the PCT were simply attempting to tick a box of having apparently engaged with me.

My only chance to discuss my proposal with the PCT was in the formal, constrained atmosphere of the November 5th meeting. We were given totally inadequate time to present – indeed my presentation was cut short. There was no dialogue. We were given no notice of issues which the PCT might wish to discuss with us.

I have certainly had no opportunity to comment on any final assessment of my option: indeed, I am not clear that there has been any such final assessment.

For example, had I known that the PCT was so convinced of the additional benefits of 60 hours of consultant supervision, then we could have together considered how this could be provided by a dual-site solution. I would have had two suggestions:

- Employing just one or two more consultants (in total) across the two sites. This would be feasible given a proper consideration of the financial advantages of my option, as well as the numbers of cases per consultant showing that single-siting actually produce worse skill-retention.
- Cross-covering. It is early consideration by consultants of labouring mothers which is beneficial – but that this does not require the consultant to actually examine the mother him or herself. Hence, if the 40 hours of consultant presence on each site were not simultaneous, it would be possible for the consultant at one site to regularly liase with the middle grade at the other site, discussing all current cases and reviewing the CTGs remotely, allowing timely decision-making.

I note that the PCT have continued to maintain that they have clinical support for their proposal, despite:

- all GPs of the western side of the county supporting dual-siting;
- the overwhelming majority of GPs of the eastern side of the county supporting dual-siting;
- A meeting between 11 of ESHT's 14 paediatricians (the other 3 being on leave) opposing single-siting at a meeting with the PCT in late September;
- 3 of ESHT's 8 obstetricians supporting dual-siting;
- The Consultants' Advisory Committee of EDGH supporting dual-siting

all on the grounds of safety and overall services to the whole population.

My personal view remains that I am open to consideration of the idea of single-siting, but so far I have been unconvinced by the arguments advanced. I believe that further, more detailed, and more collaborative discussion and consideration is required before a change of this magnitude is made, and thus it would be entirely appropriate for HOSC to refer the matter to the Secretary of State to ensure that the very best possible decision is reached.

I append 4 documents with further information which may be of value to HOSC members. 3 of these were sent to the PCT, and 1 to the SHA.