

**Meeting at the Royal College of Obstetricians & Gynaecologists
Friday, 12th October, 2.30 -4pm**

Present:

- (RW) Mr Richard Warren (Honorary Secretary RCOG);
- (HN) Dr. Hugh Nicholson (GP, Hastings);
- (MF) Mr Michael Foster DL MP,
- (MW) Mrs Margaret Williams (Hands Off the Conquest);
- (CD) Mrs Charnjit Dhillon (RCOG Head of Professional Standards);
- (G) Gregory (from Royal College connected with Brighton);
- (JB) Ms Jessica Britton from the PCT in an observer capacity;
- (KB) Dr. Keith Brent in conference by phone, (Consultant Paediatrician from Eastbourne)

(TM) Dr Tahir Mahmood (Vice President (Standards) RCOG) joined the meeting at 3pm.

Firstly each person introduced themselves and explained what interest they had in being there. **RW** noted his knowledge of East Sussex having lived and worked there.

MF then stated that although his main interest was in Hastings emphasising its demographic need that he was anxious to get to facts of the matter. There were conflicting things being said by the experts which mainly came down to **accessibility versus expertise**. He said he had been told that keeping two small units could result in losing up to 500 mothers out of the area. His main concern was safety. Would bigger units be more comprehensive?

RW stated that he did not understand where the figure of 500 had come from, however he thought that the midwife led unit would inevitably lose some mothers.

MF then asked what would happen with one unit.

KB stated that the 500 figure was either fictitious or came from the first draft of the Royal College Paper "Safer Childbirth".

MF said that was where the figure had come from.

KB said the PCT should have amended their information since that has not appeared in later versions or in the final version published this week. He said that therefore our two units could continue to serve all the mothers who are currently served and hence none would be lost out of area.

HN explained that the controversy had started over a statement that had formed the central plank in a document given to the PCT stating the local obstetrician's argument for change to a single site; was that there was a suggestion from an early draft of the intercollegiate paper that units of less than 2,500 births per year may not be allowed to perform emergency Caesarean Sections.

RW then emphasised that the College would never say that small units, i.e. fewer than 2,500 births per year would not be able to carry out emergency caesareans, and that for anyone to say that a baby would not be able to be delivered that way in a small unit was “**absolute madness**”, adding that draft documents in any case should not be used as guidance. He stated that if there were a small unit it should be self assessed as the expertise is with the clinicians.

MF then asked about the team, i.e. obstetrician, midwife, anaesthetist

HN raised the 30 minute access of obstetricians, noting that there was no difference between midwife-led care in the home or within a midwife-led unit.

MW asked **RW** how he felt about single siting when it would mean that mums from Camber may have to travel to Eastbourne and mums from Hailsham may have to travel to Hastings.

RW agreed this was a thorny subject and that there would have to be an adequate transport infrastructure in place.

HN reported that ambulance staff had raised concern regarding the difficulty of a patient in Rye who had waited an hour for an ambulance only to be diverted to Eastbourne due to closure of the Hastings Unit, due to staff shortage, and that the baby was then said to have been stillborn.

RW stated that the 30 minutes had always been a benchmark; however there was the time from **decision to incision** and that could be anything up to 2 hours. He said you must take into account the time from telephoning the ambulance, travel time, getting the patient settled to the time of medical intervention.

MF recounted his recent difficulty and delays experienced getting an ambulance to a friend in Rye.

HN then said that GP's were extremely concerned since if there were to be single siting they perceive this would increase the demand for home births. He said that GP's whilst still being involved in antenatal and post natal care had become deskilled in obstetrics over the years and were therefore worried about cover for home births. The Out of Hours service level agreement with the PCTs excluded intrapartum care, there were too few GPs with the qualification and that the personal liability for insurance would be prohibitive. He said that an obstetrician at a meeting with GPs regarding home deliveries had said that what they didn't know about was not their concern.

RW expressed concern that **obstetricians are there for all mothers** and they must look outside the box as a home birth may well become a hospital complication. He did acknowledge however, that outside the hospital environment for the management of normal pregnancy midwives were responsible.

It was then stated that both our Units have “Clinical Negligence Scheme for Trusts” (CNST) level 3 and **RW** could not confirm whether or not this status would be affected if two units remained, he suggested that we ask CNST for information.

MW asked **RW** to confirm that there was nothing in the intercollegiate report stating that there had to be “40 hour consultant cover” in smaller units.

RW agreed that this was so, saying it would be better if there was, but it was not a requirement, unless they were providing “all risks cover”

TM stated that there should always be a risk assessment for all mothers to be. He then stated that **1 in 5 pregnancies could require medical intervention unexpectedly**. There was much discussion around this as **MF** stated he had been given a different figure of just 1 in 100.

RW stated categorically that:- For first time mums the risk of complications was **25 – 30 percent** and that for mums with 2 or more children the risk was **10 – 15 percent**. He made a vivid statement **normality = midwife abnormality = obstetrician**. He emphasised that midwives only dealt with normal pregnancies and that as soon as the situation became abnormal that it became an obstetrician’s responsibility, He explained the tier system of emergency Caesarean Sections depending on the reason for the surgery, that while some can wait for more than an hour or so, some have to be done almost immediately.

KB then asked if, given our numbers, a combined single-sited unit would offer a significant advantage in terms of the service to mothers and babies than our current units.

RW and **TM** stated that a unit of just over 3000 would not offer any significantly greater service than units of our current size, except that there may be cost savings for a single site; however they added that the midwifery site would be more expensive but that RCOG (as policy) does not comment on finance. They also stated that there may be a slight advantage in better equipment, etc., if this could be funded however there would have to be extra capacity and therefore would the capital costs outweigh this? Much larger units of 5,000, 6,000, and 8,000 births per year were those that could offer more. They talked of working with Brighton for some of the higher risk or more difficult and rarer cases which cannot locally and currently be dealt with. They reiterated that there was **not likely to be any significant difference in the service** which could be provided by a combined unit (which will lose women to other places) than the current local units.

RW stated quality assurance must be clinically managed and that smaller units would have to make sure their systems of clinical governance and risk management were really good with clinicians having a willingness to do it. He gave an example of the South West of England where they have to have small units.

HN then questioned the local argument that putting the two units together would give obstetricians more experience. He thought individually they would probably see fewer patients.

RW agreed that **they would see no more patients and hence get no more experience as the combined numbers would be diluted** by the increased number of obstetricians on the rota (1 in 8 instead of 1 in 4)

RW (continued): He again came out with a quotable phrase “**good skills and drills**”. He said **in a small unit there must be good communication**.

Obstetricians and in fact junior doctors would gain experience if there were, say, a 30 minute hand over time when experiences of the last shift were shared with those coming on duty. There might be some advantage to training of juniors in a combined unit, but there was not likely to be any added experience or skill retention for consultants. Smaller units might produce more consultant involvement and hence potentially better training for juniors.

RW then asked the very pertinent question; “**Why are we doing it?**” He said possibly to gain a midwifery unit, and maybe get more resources into one unit. However he did then say **I think we have a consensus around this table, don’t we?** He said that to get to the right place we probably would not have wanted to start from where we are but we should keep on going but look at it carefully and improve. There would be no major impact on improved standards with single siting and also staff might not get on if relocated.

KB suggested the juniors on separate sites could gain from combined handover and training, for example, by video conferencing which is already available for meetings between the sites. He suggested that perhaps a video link could be set up between the departments to discuss cases every morning

RW stated that this would not be necessary so often really, he would be happy with a meeting, say, once a month or once a week.

MF said that as **MW** had stated earlier the public want two sites. Is there any significant benefit in single siting?

RW stated that he felt that it is unlikely that obstetricians would see a greater variety of cases just by changing their rotas. Unless paediatrics could offer a higher level service, then single-siting would not lead to fewer mothers and babies having to be transferred out. It again came down to finance and if a great deal more money was ploughed in then maybe.....

KB stated that even if we went to single site we would never qualify for Level 2. (**HN** sitting next to **RW** pointed him to paragraph 4.4.4 of the Guidance to illustrate the point)

TM then stated that we must think about sustainability in the future, and that junior doctors training could be affected if kept as two units.

MW suggested that perhaps this could be overcome by networking and it was agreed this would work.

HN in complimenting the College regarding the now published intercollegiate Guidance noted that they said that it was imperative for units to be well staffed. He described how both units over the last couple of years had had not been replacing retiring doctors or midwives, risking the safety of each unit despite the availability of employable trained staff.

RW agreed that recruiting more staff was essential but suggested that some good obstetricians may not necessarily want to go to small units,

KB, however, stated that Eastbourne had just recruited a new consultant and that life style, was as important a choice.

RW agreed and stated that he had in fact done just that and chosen a better life style in Norwich since his wife worked there.

MW asked about the “domino” effect.

RW replied that if paediatrics is lost then the domino effect takes place, and he acknowledged that if obstetrics is lost and of course SCBU, then paediatrics will follow. He thought it may be possible to keep A & E, but said there would be risks to women presenting with obstetric and acute gynaecological problems (such as an ectopic pregnancy) to the hospital left without 24-hour obstetric medical cover

Meeting ended 4pm