ANNEX 2

EAST SUSSEX DOWNS & WEALD PCT AND HASTINGS & ROTHER PCT

Unconfirmed Minutes of the Presentation of Consultation Options held on Monday 5th November 2007 at County Hall, Lewes

Present: Charles Everett, Chairman, H&R PCT
Rhiannon Barker, Non Executive Director, ESDW PCT
Jack Barnes, Non Executive Director, ESDW PCT
John Barnes, Chairman, ESDW PCT
Jeremy Birch, Non Executive Director, H&R PCT
Tim Brammer, Non Executive Director, H&R PCT
Peter Douglas, Non Executive Director, ESDW PCT
Simon Eyre, Chair, ESDW PEC
Peter Finn, Head of Commissioning (for Sarah Valentine)
Peter Greene, Non Executive Director, H&R PCT
Diana Grice, Director of Public Health and Well Being & Medical Director
Vanessa Harris, Director of Finance and Investment, H&R and ESDW PCT
Rita Lewis, Non Executive Director, ESDW PCT
John Kay, Non Executive Director, ESDW PCT
Stuart Welling, Non Executive Director, H&R PCT
Greg Wilcox, Chair, H&R PEC
Nick Yeo, Chief Executive, H&R and ESDW PCTs

In attendance: Lisa Compton, Director of Patient and Public Engagement and Corporate Affairs, H&R and ESDW PCTs
Helen Foreman, Hastings and Rother PCT (minutes)
Lynne Regent, Director of Development, H&R and ESDW PCTs
Michael Wilson, Programme Director, Creating an NHS Fit for the Future, H&R and ESDW PCTs

1. **Welcome:** Tony Gray, the independent Chair for the session, welcomed everybody to the meeting.

Apologies were received from Jayne Boyfield (Director of Community Services, Hastings and Rother PCT and East Sussex Downs and Weald PCT), John Kay (Non Executive Director, East Sussex Downs and Weald PCT), Keith Glazier, (Non Executive Director, H&R PCT) and David Lowe (Director of Human Resources, (Hastings and Rother PCT and East Sussex Downs and Weald PCT).

Tony Gray introduced the session and said that the Creating an NHS Fit for the Future consultation had resulted in a number of alternative options being put forward. The aim of today's session was to ensure that all options are fairly considered and to give the PCT Board an opportunity ask any questions regarding the options. Proposers would present their options and given the case as to why it is the best choice for the local community.

All those present were reminded that the meeting would be webcast.

2. **Option 13:** Keith Brent gave an overview of option 13 which was as follows:

Consultant led unit at EDGH and at the Conquest Hospital. Integrated Midwife Led Unit (MLU) at each site. Keep Crowborough but assess long term viability in the future. 5 consultants at each site, 8 middle grades as each site, 2 trainees at each

site.

Keith Brent added:

- Senior Officers at the Royal College of Obstetricians and Gynaecologists (RCOG) had said that a single consultant led unit would not provide an enhanced service to patients.
- Road links between hospitals were poor.
- The advantages of Option 13 were increased choice; increased levels of safety, women and babies remaining closer to their families, doctors able to sub-specialise, avoids the domino effect and enhances the service.
- There were no disadvantages to this option.
- This option would retain CNST level 3.

Jack Barnes, Non Executive Director at East Sussex Downs and Weald PCT asked *'What assumptions have you made about the number of high-risk births that would need to be planned for delivery outside of East Sussex under your proposed option?'*

Keith Brent responded that units which see less than 2500 births per year could still provide high risk care. This would not be all risk, however this level of care was not provided at present.

Peter Douglas, Non Executive Director at East Sussex Downs and Weald PCT asked *'How would a two-site option address the challenges of recruitment, retention, training and maintenance of skills of medical and other staff?'*

Keith Brent responded that recruitment to consultant posts was not an issue. No increase to the present level of middle grade doctors was needed.

Jeremy Birch, Non Executive Director for Hastings and Rother PCT asked *'How would your proposal enable us to realise the recommendations from HOSC that there should be 60 hours of consultant presence by 2009 and that CNST(Clinical Negligence Scheme for Trusts) Level 3 status be maintained?'*

Keith Brent responded that only 40 hours of consultant presence was needed to provide high risk care. The service already had CNST level 3 and how this would be retained was set out in the document previously circulated.

Peter Greene, Non Executive Director for Hastings and Rother PCT *asked 'Could you explain how your proposal would help the upgrading of community maternity services at least to the standard of practice plus?'*

Keith Brent responded that two consultant led units would provide increased choice and access. The current service does not achieve birth rate plus and further work would need to be done to achieve this.

Jack Barnes stated that the key difference in option 13 was the use of consultant time and asked if there were any working examples across the NHS where this could be seen in practice.

Keith Brent responded that any well run unit in any speciality would give consideration as to how consultant time was used. Currently, the labour ward was given low priority. The latest guidance as provided by the RCOG had stated that only 5 consultants would be needed at each site to provide the required cover.

Jeremy Birch asked if there was any evidence to support MLUs and consultant led units being co-located.

Keith Brent reported that there was no direct evidence but that this would address any issues with risk. The RCOG had also made a statement that it was best to have consultant units and MLUs collocated.

3. **Options 1-4:** Michael Wilson gave an overview of options 1 to 4 which were as follows:

Option 1: Consultant led unit at Eastbourne District Genera Hospital (EDGH). MLU at Crowborough. No other MLUs in the area.

Option 2: Consultant led unit at the Conquest Hospital. MLU at Crowborough. No other MLUs in the area.

Option 3: Consultant led unit at EDGH. MLU at Crowborough and at the Conquest Hospital.

Option 4: Consultant led unit at the Conquest Hospital. MLU at Crowborough and at EDGH.

Michael Wilson stated that the reasons for change were due to urgent issues such as margins of safety, Modernising Medical Careers guidance and difficulties with recruitment. Challenges that would need to be addressed both now and in the future included patient choice, CNST, the European Working Time Directive (EWTD) and training.

Moving to a single consultant led unit would be the only way to achieve 60 hours of consultant presence on the labour ward, maintenance of skills, medical staffing requirements, the ability to see and treat complex cases, ability to provide sub specialisation, investment in better facilities, and dedicated anaesthetist cover for the labour ward. There were also concerns over the future maintenance of two Special Care Baby Units (SCBU); a move to one site may allow an increased level of care for the SCBU.

A one site option would also allow increased midwife led services. This would increase the number of normal births with less intervention, therefore increasing patient satisfaction.

Tim Brammer, Non Executive Director for Hastings and Rother PCT asked *'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?'*

Michael Wilson responded that safety was a complex issue; currently the two units do not have a sufficient level of expertise or volume of cases to support two sites. The two sites should therefore be brought together to provide the local population with safe care.

Rita Lewis, Non Executive Director for East Sussex Downs and Weald PCT asked *'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?'*

Michael Wilson responded that the need for choice is clearly set out in the Maternity matters guidance. A one site consultant led unit would ensure options were available and would continue to be available. Options 3 and 4 would enhance the choices available to women. Although some women would have to make a longer journey the

safety of the unit would be of a higher level than a two site option. Increased access to antenatal and postnatal care was also important, outpatient clinics would continue to be provided locally.

Stuart Welling, Non Executive Director for Hastings and Rother PCT asked *'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?'*

Michael Wilson responded that a single consultant unit would require a lower number of consultants and middle grade doctors and would also be easier to recruit to as the roles would be more attractive to potential applicants.

Rhiannon Barker, Non Executive Director for East Sussex Downs and Weald PCT asked *'Could you explain how your proposal would help the upgrading of community maternity services at least to the standard of practice plus?'*

Michael Wilson responded that the PCT Boards would have a commitment under the Strategic Commissioning Plan (SCP) to deliver services as per guidance in Maternity Matters.

Jeremy Birch, Non Executive Director for Hastings and Rother PCT asked *'What level of increased risk had been seen in the other units which had been looked at by the PCT?'*

Michael Wilson showed a graph showing the distances for 53 other midwife led units, which confirmed that the distance between Eastbourne and Hastings was not an exceptional distance for an MLU. He also reported that in conversation with midwives and obstetricians at other units, he had found that the distance they found comfortable tended to be conditioned by their own experience, and those who had worked with more distant MLUs were comfortable with this, while those whose experience was of closer MLUs were only comfortable with shorter distances.

4. **Option 5: Liz Walke,** Margaret Williams, Vince Argent, John Clarke and Nigel Waterson introduced options 5a and 5b. These were defined as:

Option 5a: 2 Consultants led units, at EDGH and the Conquest Hospital. MLU at Crowborough. All consultant medical staffing model.

Option 5b: 2 Consultants led units, at EDGH and the Conquest Hospital. MLU at Crowborough. 6 consultants at each site, middle grade tier, no junior doctor tier.

Vince Argent added the following points:

- Option 5 was not maintenance of the status quo.
- Option 5 was safe, accessible and affordable.
- Option 5 met the 30 minute standard travel time, which was the benchmark standard.
- A major obstetric haemorrhage could result in a fatality if there was any delay in reaching a consultant run unit. This could occur even in low risk cases. The RCOG had quoted that 'prompt transfers are vital'.
- The RCOG advises that units which see fewer than 2500 cases per year can still perform caesarean.
- Local GPs support a two site option.
- The most deprived members of the community must have local access as the most deprived women are 20% more likely to suffer from complications.

John Clarke added that

- The public want to retain two consultant led units.
- A move to a single unit would mean job losses.
- GPs in the West of the County could not support the PCT if a one site option is chosen; this may results in a vote of no confidence.
- Midwives were also not keen on a move to a single site.
- There were numerous sanctions against the PCT that could very quickly begin to affect the local health economy financial well being if a single site option were chosen. These include GPs not doing OOH care, and changing from generic to branded rugs which would increase prescribing costs.

Jack Barnes, Non Executive Director at East Sussex Downs and Weald PCT asked *'What assumptions have you made about the number of high-risk births that would need to be planned for delivery outside of East Sussex under your proposed option?'*

Proposers of Option 5 responded that the number of transfers would be no different from the level seen at present. Some patients would still be transferred to Brighton or Guys.

Peter Douglas, Non Executive Director at East Sussex Downs and Weald PCT asked *'How would a two-site option address the challenges of recruitment, retention, training and maintenance of skills of medical and other staff?'*

Proposers of Option 5 responded that there is no problem recruiting and that there are approximately 100 consultants looking for jobs. Smaller units would allow skills to be retained as doctors would be more involved in the patients care. If the majority of the work as undertaken by consultants they would easily retain their skills.

Jeremy Birch, Non Executive Director for Hastings and Rother PCT asked *'How would your proposal enable us to realise the recommendations from HOSC that there be 60 hours of consultant presence by 2009 and that CNST Level 3 status be maintained?'*

Proposers of Option 5 responded that the Safer Childbirth report recommends 40 hours of consultant presence was only essential to provide high risk care. Smaller units would still be able to achieve CNST level 3.

Peter Greene, Non Executive Director for Hastings and Rother PCT *asked 'Could you explain how your proposal would help the upgrading of community maternity services at least to the standard of practice plus?'*

Proposers of Option 5 responded that additional midwives would need to be employed to achieve birth-rate plus.

Stuart Welling asked whether consultant travel time was the only issue preventing 1 unit. The proposers of option 5 responded that this was not the sole criteria but that consultant travel time between the units would be in excess of 30 minutes.

Stuart Welling asked how two consultant units would affect junior doctors training. Option 5 proposers stated that there would not be much difference as this training was modular. The RCOG had also previously stated that small units could sometimes provide better training.

Rita Lewis asked how many women would need to be transferred out of area if a two site option was chosen due to the level of risk. This number was identified to be approximately 50 per year.

John Barnes asked what the risk assessment carried out by smaller units was designed to achieve. The proposers of option 5 responded that this would ensure high quality care, increased safety; the risk assessment was also designed to ensure that the service meets clinical standards.

Tim Brammer asked if Options 5a and 5b allowed for dedicated anaesthetist cover. The proposers stated that this may be possible and that dedicated anaesthetist cover is already provided in the form of an on call anaesthetist.

5. **Options 10 and 11:** Geoff Leece was unable to attend the meeting to present options 10 and 11 which were described as below:

Option 10: Consultant led unit at EDGH. MLU at Crowborough, Eastbourne and Hastings.

Option 11: Consultant led unit at the Conquest Hospital. MLU at Crowborough, Eastbourne and Hastings.

The list of questions to be asked at today's meeting had been sent via post and responses provided in writing. Despite proposing a 1 site option, 2 sites would be preferred. Geoff Leece had previously stated that options 10 and 11 would provide more choice for women.

A copy of the written responses to the questions would be circulated to Board members.

6. **Options 6 and 7: David Chui introduced options 6 and 7. These were described as:**

Option 6: Consultant led unit at EDGH. MLU at Crowborough and at a point in-between Hastings and Eastbourne, serving the population of Hastings.

Option 7: Consultant led unit at the Conquest Hospital. MLU at Crowborough and at a point in between Hastings and Eastbourne serving the population of Eastbourne.

David Chui added that these options wee very similar to options 3 and 4, although the MLU would be at an intermittent site, in order to allay concerns over travel times.

Tim Brammer, Non Executive Director for Hastings and Rother PCT asked *'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?'*

David Chui responded that the main arguments had been over travel times but that as a Consultant other risks within the acute unit must also be taken into account. If the unit was to continue as present then there would reach a level when it becomes unsafe. There must be a balance of the risks travel versus quality. A move to a one site Consultant led unit would improve quality and safety.

Rita Lewis, Non Executive Director for East Sussex Downs and Weald PCT asked *'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?'*

David Chui responded that an additional MLU was not available at present in addition to Crowborough.

Stuart Welling, Non Executive Director for Hastings and Rother PCT asked *'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?'*

David Chui responded that there are currently 4 Consultants based at each site. There were 8 middle grade staff at each site, this tier are the only on-call at night. If a move to 1 consultant led unit was made this would involve 10 Consultants including training posts selected by the Deanery and high quality Staff Grades. The Junior tier would not be required to make any unsupervised decisions and would be there mainly to provide support. David Chui added that training programmes were difficult to implement and that a single unit would attract better candidates. The recruitment of midwives in Eastbourne was not problematic and midwife training is good. This would not diminish with a decrease with the number of midwives.

Rhiannon Barker, Non Executive Director for East Sussex Downs and Weald PCT asked *'Could you explain how your proposal would help the upgrading of community maternity services at least to the standard of practice plus?'*

David Chui responded that a range of acute and midwife led services would be more attractive to midwives.

Peter Greene, Non Executive Director for Hastings and Rother PCT asked *'What were the principle reasons in why it was difficult to recruit to 2 sites?'*

David Chui responded that 2 sites had a major impact on the number of training doctors, lower tier jobs, and having to appoint to Trust doctor posts. Although this was a similar post it was not attractive to junior doctors as it was not recognised as a part of training. Previous recruitment drives had also failed to attract high calibre applicants.

Jack Barnes, Non Executive Director for East Sussex Downs and Weald PCT asked *'Could Consultants time be more focused on Labour Ward presence?'*

David Chui responded that there would need to be a significant increase in the number of Consultants to maintain 2 units. Elective work in Gynaecology was very high; time was also taken up by acute gynaecology work. If less work were done in this area then East Sussex Hospitals Trust would lose income and posts would become unattractive to prospective Consultants as well as the retention of existing Consultants.

7. **Option 12:** Richard Hallett introduced option 12. This was described as:

Consultant led unit at EDGH and at the Conquest Hospital. Form of MLU at Crowborough and co located with consultant led units. 5.5 consultants at each site, 7 middle grade staff and a full tier of first on calls.

Richard Hallett stated that single site consultant led unit was a major and undesirable reduction.

Regulatory pressures, financial stability, consultant presence, training and sub specialisation were all reasons to change the existing service. Single siting would provide a unit with 4000 births per year which provides a better critical mass than at present. This would also provide a better skill mix on the labour ward.

However, Option 12 also provided maximum bed capacity and midwifery care close to the community whilst maintaining two units. This also responded to all of the

pressures above.

Jack Barnes, Non Executive Director at East Sussex Downs and Weald PCT asked *'What assumptions have you made about the number of high-risk births that would need to be planned for delivery outside of East Sussex under your proposed option?'*

Richard Hallett responded that there would be no change to the present figures which are 50 or 60.

Peter Douglas, Non Executive Director at East Sussex Downs and Weald PCT asked *'How would a two-site option address the challenges of recruitment, retention, training and maintenance of skills of medical and other staff?'*

Richard Hallett responded that detailed work has shown that option 12 is EWTD.

Jeremy Birch, Non Executive Director for Hastings and Rother PCT asked *'How would your proposal enable us to realise the recommendation from HOSC that there be 60 hours of consultant presence by 2009 and that CNST Level 3 status be maintained?'*

Richard Hallett responded that achieving level 3 would become more of a problem if a change was made to one site. The 60 hours consultant presence was designed to ensure there was good supervision in place; this would be achieved across two sites.

Peter Greene, Non Executive Director for Hastings and Rother PCT *asked 'Could you explain how your proposal would help the upgrading of community maternity services at least to the standard of practice plus?'*

Richard Hallett responded that 1:1 care in labour was needed and that this would be an enormous step towards improved safety.

8. Close of public session