HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 28 January 2008

PRESENT: Councillor Tidy (Chairman); Councillor Rogers OBE (Vice Chairman), Councillors Healy, Howson, O'Keeffe, Taylor, Wilson (ESCC); Councillor Lambert (Lewes District Council); Councillor Martin (Hastings Borough Council); Councillor Davies (Rother District Council); Councillor Hough (Eastbourne Borough Council); Councillor Phillips (Wealden District Council); Professor Peter Cox, Chair, Hastings and Rother PCT PPI Forum,

WITNESSES:

East Sussex Primary Care Trusts:
Cllr John Barnes, Chairman of East Sussex Downs and Weald Primary Care Trust
Lisa Compton, Director of Patient and Public Engagement and Corporate Affairs
Charles Everett, Chairman of Hastings and Rother Primary Care Trust
Dr Diana Grice, Director of Public Health, East Sussex PCTs/East Sussex County Council
Nick Yeo, Chief Executive, East Sussex Primary Care Trusts

Proposers of alternative options:

Option 5:
Liz Walke, Chair, Save the DGH Campaign
Margaret Williams, Chair, Hands of the Conquest Campaign,
Vincent Argent, Consultant Obstetrician and Gynaecologist

Options 10 and 11:
Dr Geoff Leece

Option 12:
Richard Hallett, Co-Chair, East Sussex Maternity Services Liaison Committee

Option 13:
Dr Keith Brent, Consultant Paediatrician

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

LEGAL ADVISER: Angela Reid, Head of Legal Services

1. MINUTES

1.1 RESOLVED – to approve the minutes of the meeting held on 30th November 2007 as a correct record.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Ralph Chapman and Debby Matthews

3. INTERESTS

3.1 None declared.

4. REPORTS

4.1 Copies of the reports dealt with in the minutes below are included in the minute book

5. FIT FOR THE FUTURE

5.1 Cllr John Barnes, Chairman of East Sussex Downs and Weald Primary Care Trust, Charles Everett, Chairman of Hastings and Rother Primary Care Trust, Dr Diana Grice, Director of Public Health, East Sussex PCTs/East Sussex County Council, and Nick Yeo, Chief Executive and Lisa Compton, Director of Patient and Public Engagement and Corporate Affairs, East Sussex Primary Care Trusts were in attendance.

5.2 Mr Yeo gave a short update report on the background to the PCTs' decision on Fit for the Future. Key points included:

5.3 **Consultation process:**

- Consultation ran 17 weeks – March – July 2007 and was preceded by a number of pre consultation stakeholder events and clinical working groups.
- Independent evaluation of the responses completed and independent evaluation of the consultation process. New Options Assessment Panel chaired by independent expert.

5.4 **Assessment of new options:**

- Professor Field reviewed all evidence presented
- Work with all options proposers to clarify understanding and additional time beyond the end of the consultation to receive proposals – options 12 and 13
- Independent PCT research into alternative services nationally – 17 different locations in the UK
- PCTs considered if any alternative/hybrid options were viable
- Costings for each new option developed – although finance not the driver/determinant and most options grouped together in cost terms
- Each new option evaluated through option appraisal alongside options 1-4
- Information and evidence was circulated to Board members including the final days leading up to the 20th December 2007
- The PCTs took decisions in public, in the light of all the information available to the Boards

5.5 **Midwife led care:**

- A number of new options offered variations in midwife led care
- Research undertaken outside East Sussex included consideration of extended roles for midwifery care, location of midwife led units in relation to obstetric centres and consideration of national guidance that emerged through the consultation on best practice

- Local research included dialogue with local women, midwives and groups including the NCT plus experience and lessons learnt from Crowborough

5.6 **Midwife led care: additional recommendations approved:**

- Importance of outreach care to the most vulnerable
- Strengthening of ante natal care
- NICE (National Institute for Health and Clinical Excellence) advice implemented
- 1:1 care during labour
- Risk protocols for best care based on CEMACH (Confidential Enquiry into Maternal and Child Health) recommendations
- Maternity strategy

5.7 **Need for further consultation:**

- PCTs identified to HOSC that this would be undertaken if new options were favoured
- The option appraisal undertaken by the Boards and the subsequent Board decisions meant that these circumstances did not arise
- Post consultation communication plans are well advanced

5.8 **Summary:**

- The Boards' decisions were taken after extensive consultation and careful evaluation
- Alternative options were evaluated and considered on an equal footing
- The PCTs Boards took their decisions based on the criteria established through the consultation -
  - Clinical effectiveness and quality
  - Health gain and demographics
  - Sustaining two viable hospitals
  - Access and choice
- Considering the outcome of the option appraisal and all the evidence available, the PCT Boards believe their decision is soundly based and in the best interests of the people of East Sussex

5.9 Cllr Barnes made a short statement which highlighted the following four points:

Knock-on effect on other services

5.10 Cllr Barnes said that the public's fear of the 'domino effect' was not unreasoned given events in other parts of the country. However, the PCTs have committed to two viable hospitals and will continue to commission Accident & Emergency services at both sites. He noted that there would be cases where some services are already being provided from a single site e.g. Ear Nose and Throat.

Finance

5.11 Cllr Barnes stated that finance has not been a driver in the Fit for the Future process but is relevant to the objective of maintaining two viable hospitals. No option was found to make one or other site unviable. All the options cost more money than the current service, therefore the PCTs were not envisaging savings.

Option 5

5.12 Cllr Barnes said that people feel the PCTs should have either accepted or rejected option 5. In fact, the PCTs felt it was important to assess it in the same way as other options.

Safety

5.13 Cllr Barnes stated that all parties have a common objective of making the system as safe as possible but that there is a tendency to underrate some of difficulties which will develop in the current system in the future. He highlighted the PCTs' work on the safety of stand-alone midwife-led units which had not shown any evidence of the feared difficulties. He also drew attention to the CEMACH report which reviewed every death. Travel and distance did not feature in any case.

5.14 Mr Everett added these points:

The Boards' approach

5.15 Mr Everett said that the PCT Boards knew the decision would be complex and contentious and so tried to be as objective as possible by assessing options against the agreed criteria. He stated that the PCT Boards had met numerous times to consider evidence and confirmed that they did not feel bound to the original four options.

5.16 The PCTs' representatives then took questions.

Location of midwife-led unit in Eastbourne

5.17 Mr Yeo confirmed that the midwife-led unit to be located in Eastbourne would be sited in Eastbourne District General Hospital.

Loss of income resulting from the decision

5.18 When asked if loss of income had been considered, Mr Yeo confirmed that the PCTs looked at this for each option in terms of the viability of the two hospitals as this issue particularly affects East Sussex Hospitals NHS Trust. Mr Yeo confirmed his view that the recommended option is viable for the future.

Domino effect

5.19 When asked what barriers had been put in place by the PCTs to prevent the domino effect, Cllr Barnes stated that the PCTs would need to work out appropriate measures as time went on and consider each proposal for change in terms of how it may affect two viable hospitals. He confirmed that the PCTs will commission services at both sites, including Accident and Emergency, outpatients and day surgery, with relevant back-up services. He noted that the medical Royal Colleges had recently published reports on how to maintain services and that a model was being developed for the Princess Royal Hospital in Haywards Heath which may also be helpful.

Option 5

5.20 When asked who had asked the PCTs to assess option 5 separately, Cllr Barnes explained that nobody had formally asked for it to be analysed separately but there had been some comment that the PCTs had rejected option 5 prior to their decision making and this had given the impression that it had been assessed separately. He emphasised that the PCTs had assessed option 5 against the same criteria as the other options.

Transfer times

5.21 When asked about transfer times from the midwife-led unit in relation to standards such as the NICE recommendation for 30 minute access to emergency caesarean sections, Mr Yeo confirmed that the PCTs looked at the configuration of stand-alone midwife-led services in other parts of the country and found no evidence these configurations were unsafe. He acknowledged that the Royal College of Obstetricians and Gynaecologists (RCOG) prefer that midwife-led units are co-located with a consultant-led service. However, he also stated that the Department of Health and some other Royal Colleges place more emphasis on choice for women and that the CEMACH report had not identified distance or travel as a factor in cases of maternal or neonatal deaths.

5.22 Dr Grice added that there is no definitive standard on transfer time and that the PCTs' objective is to reduce risk as far as possible and to improve standards in the obstetric unit, for example increasing the amount of consultant presence on the labour wards as advocated by the RCOG. She acknowledged the need for clear protocols to ensure that transfers to consultant-led obstetric care can be undertaken if necessary.

5.23 Cllr Barnes acknowledged that transfers are a key issue, but stated that the PCTs wish to offer a choice to women in the Eastbourne area. He noted that around one fifth of women were likely to need transfer and suggested that risk assessment could minimise the need for transfers. In response to HOSC's concern that transfer times could be upward of 40 minutes, Cllr Barnes acknowledged the travel issues but emphasised the PCTs concern to design services which maximise the safety of all women and babies. He stated that the PCTs are currently investigating the feasibility of Accident & Emergency assisting with certain emergency maternity cases.

5.24 Cllr Barnes stated that the proposed configuration of services may not be the most desirable but is the best option given the East Sussex geography. The PCTs' figures show that 90% of mothers will be within 40 minutes travel time of the consultant-led unit and he mentioned that 40% of people in East Sussex do not live in Eastbourne or Hastings.

Consultant presence

5.25 When asked why the Boards' evaluation criteria called for 60 hours consultant presence when only 40 hours would be required in a two site option, Cllr Barnes stated that the RCOG recommends increased consultant presence on labour wards and that clinical negligence standards are likely to set 60 hours as a standard in the future. He also suggested that HOSC had recommended 60 hours of consultant presence. However, the Committee clarified that HOSC's recommendation was for 60 hours presence if a single site option was chosen.

Car ownership and access

5.26 When asked about the impact of the PCTs' decision on access, Dr Grice confirmed that access to services was considered by the PCT Boards and it is recognised that many families do not have access to cars particularly in areas of deprivation. She explained that the PCTs' outreach programme is one response to this issue and that the PCTs would also look at ways to improve transport.

Paramedic training

5.27 When asked about training for paramedics on obstetric emergencies, Dr Grice confirmed that paramedic training is one of the issues being discussed with South East Coast Ambulance Trust. A basic level of obstetric training for paramedics will be put in place in addition to the training they already have in handling emergencies such as haemorrhaging. She also pointed out that a midwife is in charge of emergency transfers and travels with the mother in the ambulance.

Clinical support

5.28 HOSC expressed concern that although the PCTs' had stated their decision was clinically driven, a significant number of clinicians publicly opposed the single site option, including the Chairman of the East Sussex Downs and Weald PCT Professional Executive Committee (PEC) who had voted against it.

5.29 Dr Grice said that it was a clinically driven decision and that a wide range of clinical staff were involved in the consultation including midwives. She acknowledged the differing clinical views but stated that the PCTs had received strong views from obstetricians delivering the service about the potential safety risks of continuing with the current configuration. Dr Grice acknowledged that the two PCT PECs had given conflicting advice but that the PCTs had weighed a range of factors including the views of midwives, some of whom are very supportive of the new pathway.

5.30 Mr Everett said that the PCT Boards recognised they had received a divergence of views from clinicians. He said that the Chairman of Hastings and Rother PEC favoured the single site option and this was the view of the majority of consultant obstetricians in East Sussex Hospitals NHS Trust and the view of the Trust itself.

Deprivation

5.31 When asked why deprivation in the Eastbourne area did not appear to be a factor in the PCTs' decision, but deprivation in Hastings had featured strongly, Dr Grice said that deprivation was a complex picture. The PCT Boards had to weigh up the different factors and concentrate on those women most at risk. Their objective is to ensure as many as possible of the most at risk women book early so that any issues can be assessed at an early stage of pregnancy. This objective can be assisted through providing more ante-natal services in people's communities and homes. There are four times as many women in the higher risk groups in Hastings than other parts of the county.

5.32 HOSC questioned whether prioritising one area of deprivation over another meant further disadvantaging people in other areas. Dr Grice confirmed that the challenge is to provide a range of services which target the most deprived patients wherever they live. Cllr Barnes said that the biggest concentration of the most deprived

people is in Hastings and if the PCTs want to maintain a safe obstetric service they must choose one location for the main unit.

Location of midwife-led unit

5.33 When asked whether options 6 and 7 (which proposed a midwife-led unit located between Eastbourne and Hastings) had been considered viable, Mr Yeo confirmed that all options were looked at in detail. Ultimately, the Boards' preference was not overwhelming but the Eastbourne option did score more highly. The Boards were influenced by the ability to provide midwife-led care within the obstetric unit which would ensure women in the Hastings area are offered this choice.

Number of midwives

5.34 Questioned on whether there are sufficient midwives to deliver the outreach strategy, Lisa Compton confirmed that recruitment of midwives in East Sussex is not a problem. The Hospitals Trust is looking at training hospital based midwives to work in midwife led units and in the community.

Funding of ante-natal services

5.35 Asked about funding the planned ante-natal services, Mr Yeo said that the PCTs will be in a more stable financial position from April 2008 and able to invest in these services without impacting on existing services. He commented that the development of a single site obstetric unit would take between 15 and 18 months and measures to enhance ante-natal services will be in place by then. Cllr Barnes confirmed that the PCTs would be making a significant investment in outreach services in the 2008/09 financial year developing to full funding in 12 to 18 months.

Princess Royal Hospital, Haywards Heath

5.36 Asked to comment on the impact of the potential loss of maternity services at Princess Royal Hospital, Mr Yeo confirmed that the PCTs had included this scenario in their modelling (both with or without a midwife-led unit remaining at the hospital). The PCTs believe, based on travel times data, that most of the women who would have used the Princess Royal would instead go to Tunbridge Wells or Brighton. The PCTs estimated that between 50 and 60 mothers would choose to go to Eastbourne or Hastings.

Future birth rate

5.37 When asked about potential future population increases, particularly due to immigration and new housing, Cllr Barnes said that the housing picture is complex, for example smaller families and more single households. Population forecasts show a declining population in East Sussex. However, the PCTs planned for two scenarios: a stable birth rate and one where the number of births increased (mainly due to immigration). The latter scenario would mean an additional 50 to 150 babies but this increase does not give the number of births the PCTs believe are necessary to sustain two viable units.

Paediatrics

5.38 Ask to comment on the future of paediatrics services, Cllr Barnes confirmed that the PCTs had evaluated the status of the paediatric services prior to the consultation on obstetrics and had concluded that there was no immediate change required.

Survey of women's views

5.39 Asked if there had been a survey of women of child-bearing age before the consultation, Lisa Compton confirmed that there had been a survey completed amongst 5,000 women of childbearing age in mid-Sussex in 2004. Some of the women were from East Sussex (especially the west of the county) but the survey had not covered the rest of East Sussex. A key finding was that women supported choice. Ms Compton said that the PCTs have not completed another survey but had considered the Mid-Sussex survey results during deliberations.

5.40 RESOLVED to

(1) Note the decision made by the PCTs in relation to the Fit for the Future proposals.

(2) Note the PCTs response to HOSC recommendations of October 2007, and to monitor implementation of these recommendations as appropriate.

6. FIT FOR THE FUTURE – ASSESSMENT OF ALTERNATIVE PROPOSALS

Option 5a and option 5b

6.1 Liz Walke, Chair, Save the DGH Campaign, Margaret Williams, Chair, Hands off the Conquest Campaign, and Vincent Argent, Consultant Obstetrician and Gynaecologist represented option 5 and answered questions including the following.

Assessment of option 5

6.2 When asked about the assessment of option 5, Ms Walke confirmed that option 5 proposers would have liked the opportunity to work with the PCTs on a two site option but felt that the PCTs had not been open to a two site option and therefore had not prioritised work on this.

Risk assessment

6.3 When asked to clarify the previous risk assessment referred to in her paper, Ms Walke confirmed that she was referring to the Clinical Services Review of 2004 which concluded that the safest option was to retain two obstetric units. Ms Walke said that option 5 proposers believe that the majority of the evidence from the 2004 review still holds. The one change is the next stages of the European Working Time Directive and this does not prevent a two site option.

Safety issues

6.4 Asked to highlight safety issues which he believed had not been addressed in the PCTs assessment, Dr Argent said that the risk assessment should have included a 'dummy run' between Eastbourne and Hastings to check transfer times from bed to bed. Dr Argent said that the single site configuration cannot meet national guidelines for transfer times. He cited Lord Darzi's view that the transfer time should be 10-15 minutes which was based on advice from the RCOG. The College's president has said the transfer time should be 20-25 minutes. Dr Argent said that relevant evidence had not been considered by the PCTs such as the Sheffield study (which does not cover obstetric cases but has relevance in Dr Argent's view) and the UKOSS study on haemorrhages. Dr Argent said that the latter study had identified two main factors in adverse outcomes - delay and the fact that even low risk women may haemorrhage. He stated that 30 minutes is the bench mark standard 'decision to delivery' interval and 75 minutes is the upper limit.

6.5 Dr Argent said that Crowborough Birthing Unit is one of the best in the country but ambulance access is good and any emergency transfers are to Pembury which can be reached within 30 minutes. Only less urgent cases are transferred to Eastbourne. Dr Argent argued that a single site configuration will put a small number of women at risk and given that the current situation is very safe he questions the need to create this risk.

Sustainability of a two site configuration

6.6 Asked whether he believed a two site configuration is sustainable in the longer term, Dr Argent confirmed that he did. Dr Argent anticipated that in 3-4 years time the majority of clinical care would be undertaken by consultants. He pointed out that private hospitals run a high standard of consultant based service in small units.

Choice

6.7 When asked how option 5 would facilitate choice, Dr Argent said that the Crowborough unit offers choice and that Eastbourne is already effectively operating as a midwife-led unit backed up with a consultant-led care if needed.

Level of care available

6.8 When asked to comment on the level of care which would be available in a 2 site configuration and whether it would be the best way to provide the highest levels of care within East Sussex, Dr Argent commented that the vast majority of women are medium risk which includes such procedures such as forceps delivery, epidurals and caesarean. Low risk mothers require no medical intervention. High risk covers very specialist cases such as premature babies born below 34 weeks. He stated that high risk cases already go to Brighton or London, often to access level 2 or 3 neonatal care. Dr Argent indicated that the single site option will not mean that these high risk cases can be cared for in East Sussex as the special care baby unit will remain a level 1 unit.

Levels of medical intervention

6.9 When asked whether the emphasis on consultant-led care in option 5 would encourage more, perhaps unnecessary, medical intervention, Dr Argent said there was evidence of increased medical intervention in consultant-led units but that it is debatable

whether this is undesirable. He suggested that consultants on-call who live further from the obstetric unit in Hastings may be more inclined to advise middle-grade doctors to undertake caesareans in a situation where complications have arisen as they would take longer to get to the unit to provide alternative care in person.

Views of Hastings residents
6.10 When asked whether people in Hastings supported the PCTs' decision to site the single obstetric unit at the Conquest Hospital, Ms Williams, who works in the Hospital as a volunteer, said she had met no-one in Hastings who favoured a single site option. The consensus view amongst Hastings residents was that nobody wanted mothers to be deprived of a maternity service in Eastbourne.

Options 10 and 11

6.11 Dr Geoff Leece represented options 10 and 11. Dr Leece answered questions including the following:

Response from Non-Executive Directors

6.12 When asked what response had been received to Dr Leece's letter to the Non-Executive Directors, Dr Leece said that he had not received one nor was he expecting one. The letter was intended to provide information to the Non-Executive Directors.

Costings

6.13 Dr Leece confirmed that he made it clear in submitting his option that there were different variations of it which he would have expected to see reflected in different costings. Dr Leece quoted from the notes of the New Options Assessment Panel meeting at which he presented Options 10 and 11. The notes indicated that it was left open as to whether the midwife led unit was free standing or at a hospital site.

Involvement in assessment

6.14 When asked how involved he had been in the assessment of options 10 and 11, Dr Leece pointed out that the PCTs did not make the option appraisal available to proposers of alternative options and that it was not on the PCT website, nor could Dr Leece find any information on any alternative options on the website.

Evaluation criteria

6.15 Dr Leece said that specifying 60 hours consultant presence on the labour ward within the evaluation criteria immediately excludes any two site option. Based on the PCTs' figures on staffing and caseload in the current configuration and their proposed single site in Hastings, Dr Leece argued that the number of births per consultant was actually higher in a two site option.

Non-financial option appraisal

6.16 Dr Leece highlighted a number of differences in the unweighted scores within the non-financial option appraisal which he could not understand as the options 3 and 4 and options 10 and 11 are very similar. Dr Leece was critical of the option appraisal in comparison to the option appraisal carried out for the Clinical Services Review in 2004.

Dr Leece suggested that the option appraisal should have included the status quo or a 'minimal change' option and he confirmed that he now supports a two site configuration.

Option 12

6.17 Richard Hallett, Co-chair, East Sussex Maternity Services Liaison Committee (MSLC) represented option 12 and answered the following questions:

Viability of option 12

6.18 Mr Hallett said he believed Professor Field had confirmed in writing that he considered option 12 to be 'viable'.

Location of midwife-led unit in relation to the obstetric unit

6.19 Mr Hallett commented that there has been undue emphasis on the obstetric unit and not enough on the midwife-led unit. Mr Hallett felt that the PCT Boards have not recognised that the single site option with a midwife-led unit at a distance is introducing risk. He stated that the decision has been unduly influenced by potential risk relating to the recruitment of doctors in the future and the views of a small number of clinicians. Mr Hallett believes it is necessary to achieve the best balance of risk across the whole maternity service. He said that the risk of the decision now falls unevenly on Eastbourne women and that the PCTs are exchanging a possible future risk for an immediate one. Mr Hallett suggested that the PCTs should have undertaken more detailed work on midwife-led units elsewhere and not only focused on their distance from an acute unit.

Costings

6.20 Asked to comment on the costing of option 12, Mr Hallett said that he thought the figure was far too high and had been based on a misinterpretation of the make-up of the first tier of staff on call. In option 12 these are Advanced Midwifery Practitioners, not doctors, and therefore not any more expensive that the midwife-led unit costs. Mr Hallett's own costing showed a £250,000 increase in medical staff costs but he was not given the opportunity to challenge the PCTs' costings.

Assessment of option 12

6.21 When asked to suggest how the PCTs could have done more to assess option 12 effectively, Mr Hallett stated that they should have checked their understanding of the option with its proposers to check it was in line with expectations. He noted that the proposal was from the MSLC which does have a good knowledge of maternity issues.

6.22 When asked what he understood as the reason option 12 had not been selected, Mr Hallett said it was hard to know. He pointed out that option 12 could have provided 60 hours consultant presence if the proposers had known this was one of the criteria required. Option 12 was based on the current requirement of 40 hours consultant presence but 60 hours would be manageable with some adjustments to staffing.

Option 13

6.23 Dr Keith Brent, Consultant Paediatrician represented option 13 and answered the following questions.

Assessment of option 13

6.24 When asked what he understood as the reason why option 13 was not selected, Dr Brent said that the PCTs had fixed on the single site solution 18-20 months ago. He commented that the PCTs had not engaged in a dialogue with him.

Consultant presence and safety issues

6.25 When challenged on the advantages of 60 hours of consultant presence, Dr Brent said he has been unable to discover any evidence of a clear rationale for this amount of cover and the PCTs have not responded to his request for their evidence. He believes that the PCTs have been influenced by the early statements of some clinicians. He argued that the two site options meet more of the safety criteria than the single site option. Dr Brent is convinced that there are two key safety requirements of the Royal Colleges 'Safer Childbirth' guidance which the single site option cannot achieve:

- Consultant on-call available within 30 minutes – many consultants live more than 30 minutes from Hastings.
- Two tiers of junior doctors with at least 12 months experience – the PCTs' model includes a less experienced first tier.

Dr Brent said that the single site will not achieve the Clinical Negligence Scheme for Trusts (CNST) level 3 requirements.

6.26 He acknowledged that option 13 does not meet one criteria – 40 hours consultant anaesthetist presence per week - but stated that no option meets this, including the PCT options. Dr Brent believes that the PCTs have been influenced by changes to junior doctors' training but he argues that this is not a key factor. He stated that the RCOG had said that a single site would not improve the service. Dr Brent also said that it appears that a two site option could meet Birthrate Plus midwifery staffing levels and possibly do this more easily than a single site.

Options 6 and 7

6.27 HOSC noted the written responses regarding options 6 and 7 from Dr Roger Elias and Mr David Chui, who had not been able to attend the meeting (appendix 6).

East Sussex Hospitals NHS Trust

6.28 HOSC also noted the written response from East Sussex Hospitals Trust (appendix 7).

7. FURTHER DISCUSSION WITH PCTs

7.1 The committee posed further questions to the PCT representatives on matters arising from the contributions of the witnesses representing alternative proposals:

Location of Obstetric Unit

7.2 When asked why Hastings was chosen for the obstetric unit when it is at the eastern edge of the county, Cllr Barnes said that the PCT Boards had considered the geography. However, the PCTs also had compelling evidence relating to deprivation in Hastings.

Option appraisal scores

7.3 When asked why the option appraisal scores differed for similar options, Cllr Barnes said that the option appraisal was not a pure statistical exercise. The appraisal used a numerical assessment of each option by individual Board members and it would be necessary to ask each member for the reasoning behind his/her score. He acknowledged that there was a range of scores but noted that the bulk of scores fell into the middle range with a few outliers which were discussed individually. Cllr Barnes pointed out that the appraisal scoring was an informing process and that it was never intended to be the final determinant in the decision.

7.4 Mr Yeo added that the assessment of options 10 and 11 was influenced by the fact that midwife-led care could be provided within a consultant-led unit and a stand alone midwife-led unit was not needed to provide this.

Inclusion of two site option in the consultation

7.5 When asked why the PCTs did not include a two site option in the consultation, Cllr Barnes said that clinical discussions before consultation concluded that a two site option providing the current (or better) level of care would not be viable. However, the PCTs had specifically invited new options to ensure that two site alternatives were fully considered.

Pre-determination of decision

7.6 Mr Everett countered the suggestion that the decision to single site had been a 'foregone conclusion'. He explained that, as Chairman of the Hastings and Rother PCT Board appointed only in February of last year, he only agreed to go forward with the consultation on the basis that it was a genuine consultation with no pre-determined outcome. He also pointed out that a majority of Non-Executive Directors had joined the Boards after the initial discussions and so there could be no pre-determination by these people.

7.7 Cllr Barnes echoed these points and commented that although even if there had been some pre-determination by East Sussex Hospitals Trust, this would not pre-determine the PCTs' decision. They had approached the issue with an open mind.

7.8 Mr Yeo added that the Boards had received all the evidence available and the key issue for them was the weighing of the various pieces of evidence. Mr Yeo said there had been real debate between the Boards and that the PCTs had found the HOSC process constructive.

Risks

7.9 On Mr Hallett's comments relating to risk, Mr Everett said that the PCTs were aware that the decision would change the balance of risk. However, the PCTs believe that it will change the balance for the better.

Medical intervention

7.10 In relation to the comments about increased medical intervention, Cllr Barnes commented that it is important to avoid unnecessary caesarean sections due to risks

later on in life and during further childbirth. He also argued that the key role of senior doctors is to make judgements and that a larger unit will offer a greater number of cases which will maintain confidence in the skills of doctors to make these judgements.

7.11 RESOLVED to

(1) Note the views of the proposers of alternative options, and the views of East Sussex Hospitals Trust, on the assessment of alternative proposals.

8. FIT FOR THE FUTURE – HOSC CONSIDERATION OF PCTs' DECISION

8.1 HOSC welcomed the PCTs' decision to improve outreach ante and post-natal care, particularly in deprived areas.

8.2 HOSC identified a number of outstanding concerns in relation to the PCTs' decision to establish a single obstetric, special baby care and inpatient gynaecology service in Hastings with a midwife-led unit in Eastbourne including:

- Evidence relating to the impact of longer travel times to the obstetric unit on the safety of women and babies.
- Evidence of safety concerns relating to the distance of the midwife-led unit from the consultant-led unit and questions over whether this is the best configuration for midwife-led care.
- A lack of convincing evidence that patient outcomes will be improved with a single site configuration for consultant-led care.
- Evidence that there may be a reduction in choice due to the geography and the proposed configuration of services, which may be compounded in areas where there is significant deprivation
- Evidence that possible alternatives which could maintain services on two sites may not have been fully explored and considered.
- The divergence of clinical opinion on what configuration of maternity and obstetric services will be best for the residents of East Sussex.

8.3 RESOLVED

1. To support the PCTs' decision to improve ante and post-natal care as there is strong evidence that this is in the best interests of health services for East Sussex residents.

2. That the PCTs' decision to establish a single obstetric unit in Hastings and a midwife-led unit in Eastbourne is not in the best interests of health services for East Sussex residents.

3. That HOSC will refer the PCTs' decision to the Secretary of State for Health subject to three conditions:

   i) The improvements to ante and post natal care being excepted from the referral.
   ii) The PCTs' being given the opportunity to respond to HOSC's agreed position.

iii) The PCTs' response confirming their intention to proceed with implementing their decision <u>or</u> no response being received from the PCTs within 28 days.

The meeting ended at 7.20pm.