HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC)

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 10 January 2014

PRESENT:

Councillor Michael Ensor (Chair), Councillors Frank Carstairs, Ruth O'Keeffe (Vice – Chair), Peter Pragnell, Alan Shuttleworth, Bob Standley and Michael Wincott (all East Sussex County Council); Councillor John Ungar (Eastbourne Borough Council); Councillor Dawn Poole (Hastings Borough Council); Councillor Elayne Merry (Lewes District Council); Councillor Angharad Davies (Rother District Council); Councillor Diane Phillips (Wealden District Council); and Jennifer Twist (SpeakUp).

WITNESSES:

Eastbourne Hailsham and Seaford CCG
Dr Martin Writer, Chair

Hastings and Rother CCG/Eastbourne, Hailsham and Seaford CCG
Amanda Philpottt, Joint Chief Officer: Eastbourne, Hailsham and Seaford CCG & Hastings and Rother CCG
Catherine Ashton, Associate Director of Strategy and Whole Systems Working
Jessica Britton, Associate Director of Quality and Assurance

High Weald Lewes Havens CCG
Dr David Roche, High Weald locality Chair
Frank Sims, Chief Officer
Ashley Scarff, Head of Commissioning and Strategy

East Sussex Healthcare NHS Trust
Dr Amanda Harrison, Director of Strategic Commissioning and Assurance

East Sussex County Council
Martin Packwood, Head of Joint Commissioning (Mental Health)

SCRUTINY OFFICER: Paul Dean, Scrutiny Manager

29. APOLOGIES

29.1 Apologies for absence were received from Julie Eason (SpeakUp).

30. DISCLOSURE OF INTERESTS

30.1 There were none.

31. REPORTS

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

32. ‘BETTER BEGINNINGS’ – MATERNITY AND PAEDIATRIC SERVICES IN EAST SUSSEX

32.1 The Committee considered a report by the Assistant Chief Executive which provided updates on the development of the future commissioning plans for maternity and paediatric services.

Amanda Philpott:

32.2 We have been reviewing maternity and paediatric services in East Sussex and have concluded that the options should be submitted to HOSC to determine whether or not these options constitute significant service change and thus to determine whether we should consult with HOSC and more widely with the public.

32.3 There has been a long history of challenge in sustaining safe and high quality maternity services in East Sussex. The Independent Reconfiguration Panel (IRP) in 2008 highlighted a number of areas that needed to be reinforced in order to maintain services. The local NHS has worked hard to try to sustain safe services in the configuration following the IRP decision. Despite all efforts, the need to ensure a safe and sustainable solution remains.

32.4 The challenge to sustain services has been too significant and that challenge is not unique to East Sussex. It is a pressure that applies to maternity services across the country. In Sussex, the Sussex Together Programme looked at how we can maintain safe and sustainable services across a range of a wider area. In 2012 the Sussex Together Programme focused on maternity and paediatrics and undertook a review of our services and of best evidence. This resulted in a clinical consensus.

32.5 The clinical consensus, drawn from a wide evidence base, identified a pressing need to change maternity services provided by East Sussex Healthcare Trust (ESHT). That need was reinforced by the findings of the National Clinical Advisory Team (NCAT) which recognised that services required urgent change in order to ensure safety. It was then reinforced by the decision, discussed previously by HOSC, about the temporary reconfiguration on 7 May 2013 that was introduced to enable us to continue to deliver safe services in East Sussex.

32.6 the three CCGs, as the commissioners of services, initiated the Better Beginnings’ review in July 2013.

32.7 The models of care have been developed based on Sussex-wide agreed standards. CCGs have reviewed our evidence from within East Sussex, tested our evidence with the Royal Colleges, spoken to other smaller units nationally and have had a wide programme of public and clinical engagement. CCGs have tested the models of care and the proposals that have emerged with the Sussex Clinical Reference Groups. That is important, as it has not only been in the development of the options but also in the assurance of our interpretation of the review.

32.8 It is very difficult to significantly improve consultant presence in smaller units; ESHT have experienced consistent difficulties in recruitment and retention of middle grade obstetric staff. Guidance suggests that doctors should work in larger clinical teams to give patients the access to specialist, higher quality care at all times.

32.9 Paediatric services also need to be reviewed in East Sussex, but also across Sussex and nationally, with a view to consolidating services on a smaller number of sites. This is driven by the fact that most paediatric care can now be delivered in an outpatient, community or day care settings – ambulatory care.

32.10 Since the temporary reconfiguration, we can demonstrate that services have improved in terms of safety. Although this consultation and our options are based on moving from the services that were configured prior to the temporary change, we must learn the lessons of the outcomes and improvements in safety since the consolidation to a single unit in East Sussex. There are a range of indicators that demonstrate that the decision to temporarily reconfigure services was the right decision. The underpinning message is that a single consultant-led unit in East Sussex is safer.

32.11 We have undertaken a significant period of engagement in a genuine and transparent attempt to make sure that we are much more engaging than perhaps the NHS has been previously. We want to make sure that our services are not only safe but that we respond to and engage with the population that we serve in designing those safe services. People want safe services and women want choice in the range of options for birth environments. But also in wanting safe services, there is a perception that increased travel affects safety; that is a particularly significant issue for us to understand and address.

32.12 Some women require or want obstetric-led care. Some currently have to travel further than before to access this care. But we can demonstrate significantly better outcomes compared to when there were two smaller units. Transfer rates are in line with national indicators and there have been no adverse outcomes of women who have been transferred from midwifery-led to consultant-led units. The experience of travelling further may feel less comfortable, but we have to set that in the context of understanding the improvements in safety in terms of outcomes.

32.13 Each option includes the provision of obstetric lead maternity services, standalone midwife-led birthing units (MLU's) and overnight inpatient paediatric wards in East Sussex. We will also continue to have a short stay paediatric assessment unit at both main hospital sites: the Eastbourne DGH and the Conquest. Emergency gynaecology will be provided from one site and that would be co-located with the consultant-led obstetric unit.

32.14 Planned admissions, day case admissions and outpatient gynaecology would continue to be provided from both main hospital sites. So the main difference between the proposed options and the pre May 2013 position is that the options do not include provision for consultant-led obstetric services and inpatient paediatrics at both sites. We are not proposing a reversal to the reconfiguration of services prior to the temporary reconfiguration.

32.15 Options 1 and 2 are a mirror image of each other; options 3 and 4 are a mirror image and options 5 and 6 are a mirror image. There are three service proposals that are mirrored with the main consultant-led unit and inpatient paediatrics on one site or on the other. So there are three service reconfiguration options with a mirror image for considerations; this is why there are six options.

32.16 To conclude, the CCGs have assessed a long list of options with our partners. We are committed to safe high quality sustainable services. We have only short listed those options that we consider will deliver safe and sustainable services for East Sussex.

Born Before Arrival (BBA) data

32.17 Cllr Davies: Can you provide evidence showing outcomes have improved since May 2013 with single siting. For example: maternity figures dashboard; figures in relation to serious incidents.

32.18 Amanda Philpott: we (and ESHT) would be happy to give that information and we want to assure HOSC that the CCGs are working very closely with the Trust; our lead nurses and lead GPs have been looking at that data on a weekly basis.

32.19 Cllr Davies: There is discussion in the press about the babies born before arrival or assistance (BBAs); can HOSC have the numbers? Given there isn't a UK definition, it would be useful to know to the numbers in East Sussex and some indication to the numbers elsewhere.

32.20 Amanda Philpott: In the seven months prior to the temporary reconfiguration and seven months following the reconfiguration, BBAs at a maternity unit or before the assistance of a midwife dropped from 28 to 26: so there has been no real change. We will continue to monitor those figures which are very much in keeping with national figures as far as we can see. We are including that information in the consultation document as we anticipate that it is clearly an issue of concern.

32.21 Cllr O'Keeffe / Cllr Pragnell: Why have you chosen 8 months for the first comparison period (September – April) and 7 for the second (May – November)? There needs to be a like for like comparison including the time of year as weather conditions can vary and affect patient and staff travel. BBAs are affected by the weather if people can't get into their car or they can't get out of their drive for example.

32.22 Catherine Ashton: What will appear in our consultation document is a seven month before and seven months after the change comparison. For serious incidents, there were 14 serious incidents before the change and 4 serious incidents since the change in an equivalent seven month period.

32.23 Dr David Roche: In maternity services, the differences between winter and summer are minimal and flu outbreaks for example are very unlikely to influence the figures significantly, including staff access.

32.24 Dr Martin Writer: Some [of the BBAs] were planned home births and the child was born before the midwife arrived. So this isn't necessarily about women travelling. There are women that give birth between Hastings and the Conquest which will be a distressing experience. There are a significant number who don't make it past their front door. So it is not a case of them not being able to travel from their home to Eastbourne for example.

32.25 We do look at each individual case to understand what was behind it. So we can provide a more detailed data set.

Why not two consultant led units?

32.26 Cllr Shuttleworth: Why isn't there an option for consultant-led maternity at both the Conquest *and* the Eastbourne DGH? A significant number of people are expecting to see this following the Independent Reconfiguration Panel (IRP) decision of 2008. The report refers to evidence from the Royal College of

Obstetrics and Gynaecology (RCOG): *Reconfiguration of women's services in the United Kingdom* (December 2013) states in section 4 that talks about the 50% of women falling *outside* the low risk category:

> "The level of risk is unknown. This is largely made up of women having their first baby and those women who had some complications with their first baby but are not clearly high risk. Their antenatal care can start in a low risk environment but a quarter of this 50% of women will require step up care to specialist services prior to labour because of developing concerns such as foetal growth restriction or hypertension. Of those who continue as low risk and start labour in a low risk environment, over 40% will need transfer to an obstetric unit in labour. These transfers from low risk to high risk care need to be seamless. For ease of transfer, labour care alongside a midwifery led unit or a mixed obstetric service allows quick, easy and safe escalation of care."

32.27 By not providing a consultant-led service, effectively a higher level of care, at *both* DGH *and* the Conquest (using the evidence from the RCOG) it would appear that there is a high proportion of women who may not have such a seamless transfer?

32.28 The RCOG guidance suggests that there may be a higher level of risk to some women in labour if we do not provide a higher level of care at both Eastbourne and Hastings. Section 4.5 states that:

> "Every obstetric service must have close access to surgical backup for infrequent complications occurring during child birth which include damage to bladder, bowel or major blood vessels. In addition, major bleeding complications in obstetrics and gynaecology may need access to interventional radiology and close proximity to laboratory services providing blood transfusion."

32.29 Dr Martin Writer: Regarding access to surgical intervention, we are not discounting Eastbourne as a site for the obstetric service. The [RCOG] report says "access to" and not "on site" services. In the very rare cases where surgical intervention is required in an obstetric case (should Eastbourne be the chosen site) then the patient would be stabilised and the surgeon would travel to that site from the Conquest if necessary. We are confident that the options are absolutely safe and robust. We have confirmed with ESHT that is the case. We are confident that these are exceptionally rare cases and we would be able to provide the surgical cover necessary to ensure the safety of that woman and child.

32.30 In other clinical areas such as vascular intervention: this service will be 'super-specialised' in Brighton so there won't be vascular access at either Eastbourne or Conquest (because of a major reconfiguration of tertiary services). So it is already happening across the country.

32.31 Re transfers of women in labour to more specialist units, should that be necessary: this already happens and is successfully managed because it is anticipated; planning is important. We anticipate that a certain number of women will need to be transferred in labour, and we are monitoring that under the temporary reconfiguration. The numbers of women needing to be transferred from the DGH to the Conquest are well within the RCOG guidelines. Thus far, there have not been any adverse or significant events as a result of a transfer once labour has been established.

32.32 The RCOG guidelines are accommodated in the options that we have put forward for consideration, which is why we are confident that the safest and highest quality service is one that we can deliver on a single site. We cannot find an option that allows us to have safe, sustainable, high quality services delivered by obstetricians on two sites.

32.33 Prior to the temporary reconfiguration we saw a significant number of serious incidents (SIs) which are events where women and children have suffered harm. Since the reconfiguration we have seen a dramatic drop of these serious events.

32.34 The services that were delivered on the two-site model before the temporary reconfiguration occurred were not sustainably safe. As responsible clinicians we could not allow this to continue. We cannot commission a service that is not safe and not of the highest quality. If we believed that there was a way we could deliver a two site model we would have put it 'on the table'.

32.35 However there is no point in going out to consultation that has a false promise. We need to look at the position of all women and families that are going to deliver at those two units not just now but in three or four years' time.

32.36 We have been to smaller sites to learn from them. Many have already made the change: Salford's obstetric unit has moved to another site in Greater Manchester for example. Many small units have issues so we are not alone in East Sussex in having these discussions. We have to be safe and we can only go to a consultation which is honest and open and it would be wholly disingenuous to put an option that we knew we could not deliver at the end of it.

32.37 Cllr Wincott: Why do you think that the two-site option is not sustainable? If central government provided a lot more money so that you could take on more consultants, doctors and midwives, would it be safe then?

32.38 Dr Martin Writer: Factors include: changes in training of doctors, hours that doctors work, the number of graduates being trained, and changes in immigration such that it more difficult to recruit in the high quality doctors to provide middle grade cover.

32.39 The CCGs have supported ESHT to provide the two-site model with approximately £3 million additional funding each year since the IRP report in 2008. The issue is purely a quality and safety issue. If money was a key factor we could have a debate with our communities about how we spend the resources we have. It is not money.

32.40 Cllr Ensor: Why are you unable to recruit the staff?

32.41 Amanda Harrison: Doctors need to maintain their skills to help women with increasingly complex pregnancies and births. For example, women who previously wouldn't have had babies because of, say, long term medical conditions are now receiving more effective treatment for those conditions and can now have babies albeit often with complicated pregnancies. We have an increasing number of women with complex pregnancies and a large number of women who want to have normal births so we have to get the balance right.

32.42 The most important thing for our medical workforce is that they are able to maintain their skills. In order to do that they have to have a minimum volume of work. It is the volume of work that attracts a particular consultant workforce and

we need to make sure that all our consultants, and junior doctors, are getting the experience needed to maintain their skills.

32.43 With the number of births in this area, the number of consultants and junior medical staff that we want, even if we could recruit to those posts all the time, doesn't support the amount of time that we want those doctors, particularly our consultants, to be on the labour ward.

32.44 There is a problem with recruitment and filling those posts. There are a basic number of doctors required for a safe rota under the European Working Time Directive. Two sites require high doctor numbers with low numbers of birth. So their experience falls off; doctors don't want to come and train here because they don't get the experience they need to be consultants. It is not about just trying harder to recruit, it is about being able to provide those people with the work experience that they need to maintain their skills.

32.45 We have been successful in reducing medical interventions in labour, reducing the assisted deliveries, and reducing the number of caesarean sections. This is all good, but every time we reduce one of those it is an opportunity missed for a doctor in training. Successful service provision further reduces the opportunities for doctors to get experience.

32.46 We need a 'critical mass' of patients for doctors to maintain their skills and be able to intervene in the most serious cases which is what we want them to do. We are confident that with the number of patients that will come to one site that we can maintain that. The evidence that we have provided, and that the CCGs have sought from elsewhere, suggests that is the case. This is why the option of splitting the service between two sites cannot be sustained.

32.47 Dr Martin Writer: We have worked to ensure that we have a huge evidence base to convince us that this is the only sensible thing to do. To get to a position where the GPs on all the CCG governing bodies have reached an absolute consensus that these are the safest and best options, has taken a huge amount of hard work to acquire the right evidence and data. We have researched it extensively; we have visited Hinchingbrooke Hospital for example and have spoken to many other units and drawn upon national experience to shape our view that this is the only right and sensible thing to do.

32.48 Amanda Philpott: It is the evidence that has leads us to the options, not the options that lead to the evidence.

32.49 Dr David Roche: Of all the clinicians I have met through this process (obstetricians, gynaecologists, general practitioners), none have denied the strong clinical evidence supporting a single site option.

32.50 Cllr Shuttleworth: I understand that in West Sussex they meet their expected middle grade numbers with 16 middle grade staff, 8 on each site. In addition there are 6 doctors for the first tier rota at St Richards and 8-9 at Worthing, supported by maternity care assistants. The Trust states that the use of a variety of posts, including clinical fellows, has provided sustainable middle grade rotas.

32.51 The plan is that overseas doctors will contribute to the first tier rota in year one and the second tier rota in year two. Difficulty in recruiting middle grade doctors for obstetrics and gynaecology was reported by the Trust to be the biggest difficulty, which was addressed through redesigning the medical rotas to provide more direct consultant-led care through the resident of a call system etc. If other

areas have been able to address that issue, which we have said is central to all of this, what work has been undertaken since the IRP and what work is currently going on to try and get to grips with that issue?

32.52 Catherine Ashton: Since the IRP a maternity strategy has been developed from which a number of areas were delivered. But what has come across again and again is the inability for us to sustain the medical rotas that are required to deliver services safely. There was found to be an increased reliance on agency staff and locums.

32.53 We have looked at other areas and where we can we have used the best practice that they have developed. But there is nothing that we can see in other areas and their staffing models and how they operate that we could use successfully in East Sussex.

32.54 West Sussex has a number of births so has a different number of consultants and a different number of registrars. It has not got the same issues and a completely different set of factors.

Safety of midwife-led units

32.55 Cllr Merry: If increased consultant presence on labour wards improves outcomes, is it the case that the consultant-led site is the 'safe site'? What is the supporting evidence that the midwife-led unit is as safe? Who makes the decision? A pregnant woman hearing evidence that in order to have a safe delivery you need to be at a consultant-led site wouldn't be encouraged to go to a midwife-led unit.

32.56 Dr David Roche: The key to a safe midwife-led maternity service is down to very careful selection of patients early on in pregnancy. This has been developed to a high degree in places such as Crowborough and elsewhere. This minimises problems developing in labour which would then need transfer. So that is how midwife-led units are safe.

32.57 The consultant safety net comes about because of sudden events, or where high risk women with other medical complications need careful and very thoughtful intervention. It's a matter of filtering those out in the midwife-led units. It is not an exact science: there are some transfers that do take place as we have seen in the evidence, but that is how it is made safe.

32.58 Amanda Harrison: The published Birthplace Study looked at the safety of women giving birth in midwife-led units and consultant-led units. It demonstrated that for low-risk women giving birth in a midwife-led unit is safe. So for the right women it is the right choice. We need to be able to provide women with that choice, because if you are able to give birth without medical intervention then that is the right thing to do. We want to make sure that all women are offered the safest possible option. For some women that will be a midwife-led unit and for other it will be a consultant-led unit. They are both safe for the right women.

Factors affecting choice of consultant led unit at either Eastbourne or Hastings?

32.59 Cllr Ungar: Can a consultant-led unit be provided either at Eastbourne or Hastings? The reason I ask is because I have heard comments that made me question whether or not those services could be provided in Eastbourne. If that were the case and they could only be provided in one centre then the

consultation is flawed. We need to see the financial viability of the different options.

32.60 Amanda Philpott: This consultation is based on movement from services as they were configured prior to the temporary change. Services are funded through a national payment mechanism. The commissioners in East Sussex, following the IRP in 2008 and following further discussions with ESHT as a provider about how to sustain those services in recent years, have paid £3.1 million over and above the national tariff in order to be able to sustain consultant-led units on both sites. As stated earlier, 'throwing lots and lots' of money at it will not resolve the issues.

32.61 Since the temporary change, we have maintained a level of resources over and above PBR going to the Trust in order to be able to sustain configuration arrangements that would enable the centralised consultant-led service to be provided on *either* site. We have a close working relationship with the Trust and they have given us that assurance.

Numbers of births / sustainability

32.62 Cllr Davies: The numbers of deliveries, compared to West Sussex, are significantly fewer and the number of deliveries is apparently going down in East Sussex whereas in the rest of the country it is going up. In relation to the option for a midwife-led unit alongside an obstetric unit and a separate midwife-led unit, will there be sufficient deliveries for that option? Will an 'alongside' midwife led unit be sustainable?

32.63 Dr Martin Writer: Both the DGH and the Conquest had extremely small numbers of deliveries comparatively and that has compounded the workforce recruitment issues.

32.64 We are proposing two midwife-led units in East Sussex rather than three. We are looking at numbers of deliveries in standalone midwife-led units compared to co-located units. This is all being shared as part of the consultation process to achieve the best reconfiguration possible.

32.65 Amanda Philpott: A lot of people with whom we have engaged have said that they would be more reassured by an alongside-unit. There are a number of women who like a standalone midwife-led unit that provided more of a 'home' environment. It is an important issue to address during the consultation.

Crowborough and north Wealden

32.66 Cllr Standley: We are talking about a 'two site' option, but there are three sites. Are you going to consider a suggestion that Crowborough be transferred to the Pembury Trust? It is of concern that from the north of Wealden, Eastbourne and Hastings are fair distances away but Pembury is a lot closer.

32.67 Dr David Roche: At the moment we are considering the geographical provision of services in East Sussex, not who is going to provide those services.

32.68 Cllr Standley: Crowborough has on occasions been closed of late; why? Can we have assurance that the staffing levels will be set at a point where the unit won't close, which does cause some distress to mothers in the area.

32.69 **Dr David Roche**: There have been some closures of the birthing unit at Crowborough. This was due to a lack of availability of midwives which were moved to Eastbourne DGH and Conquest to fill in with difficulties with midwife rotas there. Any future service would have to be able to provide those midwives for a sustainable service.

32.70 **Cllr Standley**: There were occasions where Crowborough was closed and staff moved to Hastings where it was found they weren't needed. Is that hearsay or fact? And how can you avoid that in the future?

32.71 **Dr David Roche:** I haven't got any detail about that particular piece of information. It is not my understanding but we can check.

Consultation arrangements

32.72 **Amanda Philpott**: We propose to start consultation on Tuesday 14 January 2014 concluding on 8 April 2014. The parameters will be the geography of East Sussex and the lead consulting bodies statutorily are the three CCGs of Eastbourne, Hailsham and Seaford, Hastings and Rother, and High Weald, Lewes Havens.

32.73 NHS bodies are required, for any form of public consultation, to have considered four conditions: 1) support from GP commissioners; 2) strong public and patient engagement; 3) clarity on the clinic evidence base, and 4) consistency with current and prospective patient choice.

32.74 Re: 1) we have unanimous decisions by the three CCG governing bodies. There has been widespread engagement of our GPs through surveys and forums. We have used our locality meetings with our GPs as part of a continuing programme of engagement with our GP membership for all three CCGs.

32.75 Re: 2) in terms of strengthened public and patient engagement, we are ensuring that we continue to build on the earlier public engagement. HOSC, campaign groups and other bodies have provided channels to a range of different communities and we will continue to do all that we can to make sure that we get as wide engagement as possible.

32.76 Re 3) the pre-consultation business case is very clear on the clinical evidence base; the clinical consensus is very strong both nationally and locally. In drawing its evidence HOSC may want to consider the views of the clinical chairs of the reference groups for Kent, Surrey and Sussex, the children in young families' clinical network and the maternity network.

32.77 Re 4), we have already talked about current and prospective patient choice and the importance of making sure that the options include stand alone midwife-led units and a consultant-led service.

32.78 The first phase, from July to September 2013, was about raising awareness of the issues that we needed to address. This helped us to make sure we understood the case, raised awareness about the case and indicated the language we would need to use to make things easily understandable and engaging. The second phase ran until late October 2013 and explored the ways in which we might address the issues that arose in the first phase. That process informed the development of the delivery options that have been developed.

32.79 There are to be eight market place events with day long stalls in shopping centres, community centres and hospitals etc, and a further 20 mini market places in different locations. All the details are on our website. Organisations are helping us to make sure we are acting as conduits and advisers to make sure we target different communities.

32.80 We are making sure that elected members are appropriately briefed and engaged to be able to inform the discussion. We will be working closely with the media and providing extensive written and verbal information and we are using social media.

32.81 We need to make sure materials are available such as the Birthplace Study referred to already. All our evidence will be available on our website and, where appropriate, in hard copy.

32.82 We will have a range of feedback mechanisms in terms of survey forms, but also making sure those are in hard copy and through social media as well. We want the consultation to be meaningful and we have carefully explored how our options are meaningful and realistic:

32.83 We will have a range of ways to engage people. There will be interpreting and advocacy in place for communities that need to be engaged with differently. We will ensure we have a targeted focus group for people with disabilities. Other voluntary organisations may represent other parts of our community. A telephone line will be available.

32.84 We will have an independent analysis of the consultation responses: findings will be included un-edited in their entirety and will be made available to HOSC. Following the conclusion of the formal consultation in early April 2014, we currently anticipate that we will be in a position to make a decision in July 2014.

32.85 **Cllr Ungar:** What I am concerned about is that we don't have a very narrow consultation. Child birth is not just for the woman and baby, but it is also a family event. It is important that prospective grandparents are involved and have the ability to say where services are provided and the type of services. Can I have an assurance that we are going to have a look at the full spectrum of the public and not just the age bearing women in our communities?

32.86 **Amanda Philpott:** I can give you that assurance. In terms of grandparents we don't have any plans to have a specific focus group for grandparents but we would strongly encourage all members of the public with an interest in paediatric and maternity services to take the opportunity to join in with all of the planned events. It is important that we understand the range of perspectives from as much of the population as possible.

32.87 **Cllr Phillips:** You don't give a date for Crowborough market place event?

32.88 **Jessica Britton**: This will be clarified in the publicity on our website of events and we will continue to update that should any other events become available. Crowborough Community Centre will have its event on 10 February.

32.89 **Cllr Wincott:** Are you confident that the language used in the consultation would meet the crystal mark criteria for plain English? How many questions will there be?

32.90 **Jessica Britton**: The primary consultation document is currently being checked with a wide range of people for accessibility and language. There is always a balance between the complexity of information and making enough information available to people and making it readable and accessible. I am confident that we have checked that as far as we reasonably can to make sure that is going to be accessible to as wide a range of people are possible.

32.91 Everybody will have access to the same information that we have and that HOSC will have. In the survey there are about 5 questions. The questions are relatively simple but there are a lot of other ways that people can feed back if they have a greater level of detail or information that they would like to share with us.

32.92 **Cllr O'Keeffe:** Could councillor events be early on in the process to enable elected representatives to better handle questions about the consultation from members of the community? Could a more central location be used for the Lewes engagement?

32.93 Could you provide for a minimum time for people to respond after they have been to a briefing: 13 days versus 74 is quite a big difference?

32.94 **Jessica Britton**: The Councillor events are all happening within the next few weeks to make sure they take place as early as possible. The dates are now available and will be published on the website.

32.95 The big market place events are happening at the beginning and also further on in the consultation. The mini market place events will be held in a different range of venues such as leisure centres, children's centres and places where people will be already visiting.

32.96 We are aiming to cover all the geographical areas as far as possible in the first month of consultation cycle. We are trying to ensure that there are opportunities for everybody at all stages and opportunities later on in the consultation if people want to come back and hear a more or if they weren't able to attend the first time around.

32.97 In terms of market places for Lewes and Seaford I am happy to have a further conversation.

32.98 **Cllr Ungar:** Are you seeking the views of the views of the Health and Wellbeing Board?

32.99 **Amanda Philpott:** Yes. However, we are keen to ensure that we don't confuse the role of the Board with HOSC.

32.100 **Cllr Poole:** When will HOSC see the more detailed format of the consultation questions? Will you avoid questions that are very much driven towards a particular answer? Can you assure us that the consultation it is going to be objective?

32.101 **Amanda Philpott:** The questions are very broad and open and are not skewed towards any particular option. The questions seek the degree of understanding of the options, the indication of any preferred option and an open box for rationale.

32.102 **Jennifer Twist**: I welcome that you plan to work with the voluntary sector. Voluntary sector partners are going to be key in reaching a wide variety of

groups, in particular less heard groups and in cascading information out to those groups. Have you thought about specific briefing events for the voluntary sector?

32.103 **Jessica Britton**: We have been advised by a number of voluntary sector organisations about what would be helpful. Not only are we offering to provide information and presentations to existing forums and networks, we are asking the voluntary sector whether briefings would be helpful to provide information that could then be cascaded to wider communities. Any other wider support or suggestions would be welcome.

32.104 **RESOLVED** to:

(1) agree that the service change proposals set out in appendix 1 of the report constitute 'substantial variation' to health service provision requiring statutory consultation with HOSC under health scrutiny legislation.

(2) undertake a detailed review of the proposals from February to June 2014 in order to prepare a report and recommendations

(3) agree to take evidence from all interested parties including:

- East Sussex campaign groups
- MPs and councillors (stressing the need to provide 'evidence' as opposed to 'opinion')
- East Sussex Healthcare NHS Trust
- East Sussex CCGs
- NCAT
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Royal College of Midwives (RCM)
- Royal College of Paediatric and Child Health
- Trade unions
- Independent clinicians including: neonatal consultants / midwives
- Ambulance service
- ESCC Highways / economic development (road / travel issues)
- Healthwatch – evidence from the public 'question-time' events
- Public Health – verification and clarification of demographic projections/impacts

(4) note the CCGs' plans for undertaking public and stakeholder consultation and submit HOSC's initial comments (detailed above) to them for consideration.

33. PROVISION OF NHS BEDS IN EAST SUSSEX FOR THE ADMISSION AND ASSESSMENT OF PEOPLE WITH DEMENTIA

33.1 The Committee considered a report by the Assistant Chief Executive which provided HOSC with an update on the decisions made by the three East Sussex CCGs with regards to the future provision of NHS beds for the assessment of people with dementia.

33.2 At its last meeting on 21 November 2013, HOSC approved the report of the Task Group report that had been delegated the task of sifting through evidence on a number of options. That report was included as part of the evidence considered by the CCG governing bodies alongside the results of an options appraisal panel.

33.3 The three governing bodies met and decided that option 4 was the way to go forward: Option 4 is to close both sites and create a new model of bed-based dementia services.

33.4 In response to Member questions, Catherine Ashton and Martin Packwood commented as follows:

- Regarding proximity of the dementia beds to acute hospital services, it is difficult to assess until there is greater clarity about what that service looks like and where the facilities might be located. If the advice is to locate closer to acute units because of the co-dependencies around the particular cohort of patients, then that will be included in the planning.

- In the interim, the services will continue on both the current sites; neither of the ward environments is ideal in terms of the facilitation of good quality dementia care. The Trust has responded to some of the difficulties by increasing some of the staffing ratios.

- A key task for the business case being developed is to establish the number of beds that will be needed.

33.5 RESOLVED to welcome the interim progress report of the Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG, and consider the business case in six months time.

The Chair declared the meeting closed at 12:25pm