HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC)

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 17 February 2014

PRESENT:

East Sussex County Members
Councillors Michael Ensor (Chair), Frank Carstairs, Ruth O'Keeffe (Vice Chair), Peter Pragnell, Alan Shuttleworth and Bob Standley.

District and Borough Members
Councillors John Ungar (Eastbourne Borough Council); Angharad Davies (Rother District Council); Diane Phillips (Wealden District Council)

Voluntary Sector Representatives
Jennifer Twist (SpeakUp)

WITNESSES:

High Weald Lewes Havens CCG

Frank Sims, Chief Officer

Hastings and Rother CCG/Eastbourne, Hailsham and Seaford CCG
Catherine Ashton, Associate Director of Strategy and Whole Systems Working

East Sussex Healthcare NHS Trust
Dr Amanda Harrison, Director of Strategic Commissioning and Assurance
Lindsey Stevens, Head of Midwifery and Assistant Director of Nursing

Save the DGH
Liz Walke, Chair of 'Save the DGH'
Dr Tim Gietzen
Mr Brian Valentine, MB, FRCS, FRCOG

Friends of Crowborough Hospital
Richard Hallett

East Sussex County Councillors
Councillor Richard Stogdon (Crowborough Division)

Other speakers
Stephen Lloyd MP, Eastbourne and Willingdon

SCRUTINY OFFICER:

Paul Dean, Scrutiny Manager

34. APOLOGIES

34.1 Apologies for absence were received from Councillor Dawn Poole (Hastings Borough Council); Councillor Elayne Merry (Lewes District Council) and Councillor Michael Wincott (East Sussex County Council).

35. DISCLOSURE OF INTERESTS

35.1 There were none.

36. REPORTS

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

37. BETTER BEGINNINGS – MATERNITY AND PAEDIATRIC SERVICES IN EAST SUSSEX

37.1. The Committee considered a report by the Assistant Chief Executive to agree plans for HOSC to undertake a review of proposed changes to the provision of maternity and paediatric health services in East Sussex.

Evidence from the East Sussex campaign groups

37.2. **Liz Walke:** 'Save the DGH' has looked at what is best for health services for East Sussex, not just in Eastbourne. The campaign considers, along with 'Hands off the Conquest', that there should be midwife-led units and consultant-led units at both Eastbourne District General Hospital (EDGH) and at the Conquest, Hastings (Conquest). This configuration would serve East Sussex better than a single consultant-led site.

37.3. We said in 2007 that we could not support an option that "takes an essential service away from a large proportion of the population". The current consultation has no two-site option for full maternity services at both hospitals. We therefore cannot contribute to the Clinical Commissioning Groups (CCGs) public consultation because it pitches Hastings against Eastbourne.

37.4. There are 5,500 births per year in East Sussex, which the CCGs claim is too few to justify two consultant-led sites. However, throughout the country there are maternity units that have fewer than 2,000 births that are not closing. We believe that the CCGs have not looked hard enough at the viability of commissioning two consultant-led sites and East Sussex Health Care Trust (ESHT) does not have the will to continue to provide two sites.

37.5. We would like the Independent Reconfiguration Panel (IRP) to look again at how a two site service could work; the IRP does not have vested interests and has previously said that two sites should be maintained.

37.6. Many of the reports that are included in the evidence pack (for this meeting) were compiled by people who have "vested interests" so may not be independent. For example, the GPs who sit on CCG boards are in favour of the single site option.

37.7. In our view, the increase in the number of safety issues at the Eastbourne maternity unit since 2007 is due to management failure at ESHT. The board assurance framework report from the January 2014 ESHT Board meeting is evidence of this, with most assurance measures marked as amber or red. [The report to be included in the next evidence pack for 20 March 2014 HOSC].

37.8. We have received evidence from one mother who gave birth since ESHT made temporary changes to maternity services. She believes that having to transfer from the midwife led unit at Eastbourne to the Obstetric unit in Hastings affected her child's health and her own emotional wellbeing.

37.9. The travel time from Eastbourne to either the Conquest or the Royal Sussex County Hospital (RSCH) in Brighton is more than 30 minutes. It takes 43 minutes to travel 21.3 miles between EDGH and the Conquest and 42 minutes to travel the 23.2 miles from EDGH to the RSCH.

37.10. The travel time for patients who need to transfer from the Crowborough Birthing Centre (CBC) is only 10 minutes to Tunbridge Wells Hospital in Pembury. They would not travel to EDGH in an emergency because it is too far.

37.11. **Dr Tim Gietzen:** The consultation does not reflect the cost and inconvenience of travel, not only for patients, but also for medical and nursing staff.

37.12. In response to a Freedom of Information (FOI) request, ESHT did not make it clear whether medical and nursing staff travel to Hastings in their own time or during their

contracted hours which would represent a loss to the Trust of 'clinical time' – a hidden cost. ESHT had responded that the cost of all staff travel over the last six months was around £200,000 per month but did not provide any further breakdown.

37.13. The views of GPs in the consultation documents are not necessarily representative of the views of GPs in Eastbourne and, presumably, Hastings. A confidential survey containing questions that are clear and not open to interpretation or bias is necessary to collect fully representative data.

37.14. **Brian Valentine, Save the DGH:** Based on the available data, ESHT had no choice but to temporarily single site the service in May 2013. However, the changes have become permanent and many people feel a loss of trust. The recommendations of the IRP report in 2008 are still pertinent. East Sussex is best served with the two district hospitals; they were built to a specification that allows for an expansion in population which is currently happening.

37.15. Figures show that first-time mothers have a 35% chance of needing consultant care. This means that a significant number of mothers will need to be transferred to Hastings. Combined with the poor road network, this increases the chance of mothers giving birth en route.

37.16. ESHT has to make sure it provides enough ongoing experience to doctors in all of the attributes of the discipline in order to continue with the specialist registration. ESHT should consider going back to having a consultant and career grade posts to ensure that full consultant cover can be provided on the obstetrics units, rather than on the telephone, in line with best practice from the Royal Colleges.

Staffing models and a 'two-site' option

37.17. **Cllr Alan Shuttleworth:** What could be done by ESHT to address the issues raised in the NCAT report (p 241/242 of the evidence pack refers) and the lack of insufficient middle grade doctors to justify a two-site option? What do other, smaller trusts do differently?

37.18. **Liz Walke:** ESHT needs to develop different ways of working and show initiative. The Trust did not adjust to accommodate the European Working Time Directive or the ongoing lack of middle grade doctors. ESHT cannot staff a maternity unit as if it were a London or city hospital; it must recognise that not only does it have two main sites in two separate towns, but also that access is very difficult between those towns due to the poor road network.

37.19. Other Trusts have adjusted, and some have successful units despite having fewer than 2,000 births. Yeovil District Hospital NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust have: succeeded by promoting services outside their catchment area; developed innovative ways to provide sufficient staffing levels and restructured staff grades. These trusts have a clear vision of what it is that they want to achieve. The provision of services at the hospitals should be seen from the perspective of safety for women and babies.

Staffing

37.20. **Cllr Angharad Davies:** The 2012 NCAT report raises serious concerns about safety and staffing. How can Save the DGH argue for a two-site option in the light of this report?

37.21. **Liz Walke:** We believe that ESHT's management caused the safety issues and that the service should not be run as it was before. ESHT should have staffed the EDGH consultant-led site properly. However, we recognise that the reputation of the Trust has led to difficulties in recruitment; many midwives are leaving and there is a national shortage. Things have got worse and that is why we need change but it doesn't mean to say that there cannot be two consultant units: not necessarily

consultant led, maybe consultant delivered. There may be different ways of staffing them, but there should be two units.

37.22. **Brian Valentine:** The NCAT report is damaging which is why the temporary reconfiguration was justifiable. During that time, ESHT said they were going to stabilise the situation, enhance recruitment and come back with another, safer model of care.

37.23. **Cllr Angharad Davies:** How could the Royal College of Gynaecologists' (RCOGs) recommendations for fully staffed services be achieved when ESHT cannot attract training grade, staff grade and associate specialist doctors to the sort of unit envisaged in a 'two-site option'?

37.24. **Liz Walke:** Clinicians consider the local area when deciding where to work; the south coast is an attractive place to live. Therefore, if ESHT can develop thriving, innovative hospitals, then doctors will want to work in the Trust. However, ESHT has historically failed to do this and, as a result, doctors have not come here. Enhanced recruitment is only possible in viable units that are attractive.

37.25. **Brian Valentine:** It is possible to provide a good service with small catchment areas. However, it almost certainly would have to be staffed by doctors who did not want to go onto consultant grades. This is possible as not all doctors want to be consultants; some are content with continuity of income and without the pressures of being a consultant.

37.26. **Cllr Michael Ensor:** The CCGs and ESHT say they have attempted to recruit and money is not a 'limiting factor'. However, they do not consider that they can recruit the staffing needed as you indicate. What would be needed to resolve this?

37.27. **Brian Valentine:** ESHT has to make potential doctors aware that it has viable and stable maternity units that will not be moved, broken up and have their staff displaced. For example, staff at CBC were moved temporarily to the Conquest on one occasion. ESHT should re-plan the service and let its staff know that there is continuity. If the Trust has doctors who are in stable career grades, it would not have the problem of trainees coming through who do not have sufficient experience.

37.28. **Cllr Frank Carstairs:** You mentioned 'associate specialists': can you explain why they do not exist anymore? Can they be brought back in and would that help?

37.29. **Brian Valentine:** The 'associate specialist' was abolished in 2008 at which point 'career grade' staff came in who required several years' experience. Some of the career grade staff did not require a RCOG qualification and most would not have had their certificate of completion of training. This would have prevented them from progressing to consultant level. However, they would have had at least four years' training within the specialist field. This means they would have been similar to the associate specialist.

37.30. **Cllr John Ungar:** What are your views of the current temporary arrangements in terms of clinical outcomes and the use of temporary staff?

37.31. **Liz Walke:** Some staff who work for ESHT have contacted Save the DGH. They are very unhappy with the Trust. None of these staff say that they want to continue working for the Trust and a lot of them have left. The future supply of non training grade staff is uncertain and solutions need to be investigated.

37.32. We can speak with more authority about women who have had babies and the often horrendous experiences that they have had. These experiences do not figure in any report because they do not count as a 'serious incident'. However, the psychological damage and trauma caused has been immeasurable and, whilst there may be no long term physical problems, the emotional scars will live with them forever.

37.33. There have been physical injuries to women as well, with delays in treatment being one of the major causes of damage to a baby and mother. That is why we say that transfers to the obstetrics unit should not be more than 30 minutes. An onsite obstetrics unit at EDGH is what we believe is the safest option and believe all women should start with a midwife.

Journeys

37.34. **Cllr Ruth O'Keeffe:** The public are concerned about transport for mothers and families. Is the boundary between serious incidents and 'middling incidents', like Born Before Arrival numbers (BBAs), something that HOSC will need to consider?

37.35. **Liz Walke:** People have spoken out about issues that would not qualify as a serious incident such as having a baby in car. If you have to transfer, and the outcome medically is not a serious incident, then that does not get recorded.

37.36. **Cllr Peter Pragnell:** Is there an ambulance almost permanently on standby at CBC?

37.37. **Dr Amanda Harrison:** There are no ambulances permanently on standby at CBC. South East Coast Ambulance NHS Foundation Trust (SECAmb) has a very sophisticated modelling system that allows them to identify where their next call is likely to come from and they station their ambulances accordingly. If an ambulance happens to be parked nearby, it would not be specifically there to support CBC.

37.38. **Cllr Michael Ensor:** HOSC will ask SECAmb whether its modelling system changed because of the temporary reconfiguration. We will also ask how frequently there are transfers between Eastbourne and Hastings.

Consultation with GPs

37.39. **Cllr Alan Shuttleworth:** Should there be a confidential questionnaire for GPs about the options as part of the CCGs' consultation?

37.40. **Dr Gietzen:** A confidential questionnaire could indicate that not all GPs support the proposals for a single site. Due to all sorts of factors, the single site question is not easy for all GPs to answer honestly. So we would want to see a properly worked up questionnaire that was statistically valid.

37.41. **Catherine Ashton:** The CCGs considers that there is no need for a GPs' questionnaire to be done in secret. The CCGs are providing opportunities for all GPs to have their voice heard. We are attending all of the cluster meetings and the locality meetings and we are talking to individual practices and GPs about their concerns. The CCGs want the process to be transparent.

37.42. **Brian Valentine:** The important thing about a poll is that every person's views should be considered individually. As long as the people who are making the decisions read it, they will query the veracity of the decisions and statements they are making, fairly or unfairly. An independently led poll would not be a bad idea.

37.43. **Cllr Michael Ensor:** If there is a GP out there who has concerns and wants to raise those confidentially, they can make their comments known to HOSC.

<u>Evidence from Stephen Lloyd, MP</u>

37.44. **Stephen Lloyd MP:** A senior clinician at ESHT (to remain anonymous) made the following comments about the state of maternity and paediatrics:

- Concerns about the supply of middle grade paediatric doctors who keep the service 'alive'. They are not in as short supply as obstetric middle grade doctors. But it is not easy to keep the service going and there are always gaps in the rota.

- There are a number of older paediatric consultants who do not go out on call at night and who are blocking posts for younger consultants who could help middle grade doctors.
- It is questionable whether consolidating paediatrics services onto a single site will improve quality. Those giving this advice are senior consultants who are likely to have vested interests.
- Concentrating obstetrics on one site rather than hiring obstetric consultants on both sites would limit consultant numbers and dilute the competition for lucrative private consultant practice.
- The reduction of obstetrics units to a single site would force people living in towns that border two catchment areas, such as Seaford and Uckfield, to go to obstetrics units in Brighton and Pembury, where demand is already too high.
- For the last 18 months, the vast majority of babies at CBC who needed resuscitating went to Pembury, not ESHT hospitals; these figures are not included in the consultation.
- It is likely that activity and income will not return to EDGH and a lot of experienced staff will leave both sites.
- The outcome has already been decided by the CCGs and they will choose Option 6, the same as the current temporary reconfiguration.

37.45. **Councillor Michael Ensor:** The Better Beginnings consultation includes a questionnaire that is structured in such a way that members of the public and clinicians can leave comments for the CCGs to consider during their decision making process. This should provide a sufficient source of anonymous comments from clinicians who have concerns about the consultation as it has been widely publicised amongst medical practitioners in East Sussex.

Crowborough Birthing Centre (CBC)

37.46. **Cllr Bob Standley:** If consultant-led units were to be maintained in Eastbourne and in Hastings, would CBC be needed?

37.47. **Liz Walke:** Women throughout East Sussex should have the opportunity to give birth in an environment that does not remind them of a hospital. We commend the CBC. It has been under threat for a long time, and still is. Yet it has remained open. Due to continued uncertainty, they want to be aligned with Maidstone and Tunbridge Wells NHS Trust. We support this idea and understand that women at CBC might not want to travel to Eastbourne or Hastings in an emergency.

37.48. **Cllr Angharad Davies**: Save the DGH appears to be in favour of having midwife-led units alongside, or within very easy access to, obstetrics units. What does Save the DGH feel about the future of CBC?

37.49. **Liz Walke**: The safest option for a midwife-led unit would be to have it alongside an obstetrics unit. However, CBC is less than 30 minutes from the obstetrics unit in Pembury, so it is sufficiently safe. An obstetrics unit at CBC would not be viable because there are only about 300 births.

37.50. As the age of women giving birth increases, more consultant-led births will be needed. However, it would be preferable for everybody to start with a midwife and then get referred to a consultant if necessary.

37.51. **Brian Valentine**: Midwives should be commissioned to continue to provide a home delivery style service at the CBC, rather than having to do it in a house where something might go wrong and they have no first line communication or evacuation. This would be preferable solution for residents in the north of the county as the CBC has demonstrated.

Evidence from Friends of Crowborough Hospital (Richard Hallett and Cllr Richard Stogdon):

37.52. **Cllr Richard Stogdon:** The people being served by Crowborough Hospital extend well beyond the boundaries of Crowborough and the High Weald. The evidence on pages 442 and 443 of the evidence pack ring exactly true with the discussions we have had with women living in the High Weald.

37.53. **Richard Hallett:** The CBC is a marginal issue compared to the issue of the location of an obstetric unit at either EDGH or Conquest Hospital. However, in the High Weald, concerns over the future of the CBC are very much at the forefront of women's minds.

37.54. Births are a small part of the workload for the midwife team and they spend about 70% of their time on antenatal care for the 800 pregnant women who use the service annually. This means that the midwife team is an integrated team, with the same midwives caring for women during their pregnancy and then helping to deliver their baby (if they choose to give birth there).

37.55. CBC does not operate in isolation and women who use it will need to use other maternity services during their pregnancy. These include 12-week and 20-week scans and a 28-week blood test that needs to go to a pathology lab to be analysed. Some women may also need to see a consultant, either for referral to higher risk consultant-led care, or to confirm that they can be placed on a low risk pathway.

37.56. Over the past few years, these support services provided by ESHT have gradually moved further away from High Weald, in part due to a series of crises at the Trust. This began in 2010, when ESHT stopped the scanning facility at CBC. Since the temporary changes in May 2013, the nearest consultant referral that ESHT provides is in Hastings. Due to the risks associated with being referred to consultant-led care at Hastings, most High Weald women are now opting out of the ESHT provided Crowborough maternity pathway and referring themselves to an alternative provider that has local facilities for maternity scanning.

37.57. Midwives at CBC find it frustrating that they cannot provide the full range of maternity care that the women using the facility expect.

37.58. The maps used to show patient flows are out of date as they do not take into account the changes that took place in May 2013. The maps that we have produced using midwives caseload data from July – December 2013 show that women in the High Weald are rarely using ESHT maternity services for their place of birth. ESHT is no longer in the position to provide joined up maternity care in the High Weald and fewer than 4% of women in the High Weald are using the obstetric services at Hastings. [NB the map was updated to fall in line with the postcode data presented by the CCGs – see revised submission for HOSC 20 March 2014 evidence pack 2, page 517].

37.59. Women in High Weald have described the disconnect that they experience with the maternity services in Hastings, yet this has not been fed into the consultation. None of the consultation options actually address these women's concerns.

37.60. Clinically robust alternative arrangements could re-join maternity services and be delivered more cost effectively without a subsidy of £400,000 each year.

37.61. In my view, the CCGs are not considering these options because ESHT has a monopoly on community-led midwifery and women cannot choose who provides this service. Until ESHT are prepared to relinquish their monopoly then the local CCG will find it very difficult to change the service to better suit women's needs.

37.62. High Weald Lewes Havens CCG should try to replicate the maternity pathway in the south of its catchment area. A woman living in Lewes will not have to travel further than Brighton to receive the full range of maternity services.

37.63. ESHT receives a £400,000 subsidy from the High Weald Lewes Havens CCG to run CBC. If Tunbridge Wells Health Care NHS Trust became the provider of the CBC, they would run maternity in High Weald so the CCG would no longer need to provide the subsidy.

Safety of standalone MLUs

37.64. **Cllr Michael Ensor:** Is it appropriate to have CBC such a long distance from consultant-led care?

37.65. **Richard Hallett:** The 2011 Birth Place Study of 65,000 women showed that not only are midwife-led units very safe for women to use, there are benefits for low risk women being in a midwife-led unit compared to those same women being in a consultant-led obstetric unit. Midwife-led units also offer better value for money for low-risk women than obstetric units.

37.66. CBC works well because it has a very clearly defined and thorough pathway that allows women to be transferred to consultant-led care if needed. On average during 2013, there was less than one transfer per week and most transfers were for failure to progress in labour. The safety record of CBC, dating back to 1997, is very good.

37.67. In 2010, the number of births at CBC was 322 and rising. After the scanning facility closed, the number of births began to fall. This shows that the way the CCGs structure maternity pathways makes a significant difference to whether women choose a midwife unit.

37.68. A 2011 review of CBC shows that 35% of the women registered at the GP surgeries in Saxonbury, Beacon, Groombridge, Mayfield, Ashdown, and Forest Row were having their birth at CBC. In Eastbourne, it was closer to 20% of women using midwife-led units. If the maternity pathways were improved so that the majority of women could be encouraged to use midwife-led units, it would make the obstetric units less crowded. That is good for the women who did not need to be there and good for the women who need that service.

Transfers

37.69. **Cllr Michael Ensor:** It sounds as though CBC has worked out the significance of high risk to low risk patients and is able to minimise the need for transfers. Is that scenario equally applicable to birthing units elsewhere, for example, at the midwife-led unit at EDGH?

37.70. **Richard Hallett:** All maternity pathways must consider a critical non-medical factor: whether women and midwives perceive that there is a quick and efficient pathway to obstetric help for situations where complications develop during labour. If they perceive that they are too far from help, even if medically they are not, it will affect their confidence and the woman may not choose the midwife-led unit. Many of the women who have submitted comments to HOSC say that they are concerned about the closures due to staff shortages and the lack of certainty that this generates.

37.71. Currently, if a woman in the High Weald area chooses ESHT's maternity pathway and chooses to give birth at CBC, she will be offered a scan at EDGH or the Conquest. If she needs a referral to a consultant, she will be referred to the Conquest. Many women see this as inconvenient, so a significant number of women in the High Weald now opt for Pembury to have a consultant-led birth simply because they can receive all of their scans and blood tests at a single hospital near to where they live.

37.72. We need local, midwife-led care for the 800 women in the High Weald. Women can have a local community midwife as their named midwife; they can have a local scan at Pembury or Princess Royal, Haywards Heath; they can see a consultant locally and it would encourage many more women in High Weald to use non-obstetric facilities for birth. Although it sounds paradoxical, with the High Weald being linked to the local obstetric providers, it would actually give more women greater confidence to choose to try for a low risk midwife-led birth. Women in High Weald should be able to choose a midwife-led unit that can provide a local scan and have access to local consultant-led care.

37.73. Women must now choose to go to a maternity unit with scanning facilities (as they are not available at CBC) for a considerable amount of their pregnancy. After the final scan, they then have to be encouraged to opt-in to continue their maternity pathway at CBC (rather than remain at the other unit or go to an obstetrics unit). If CBC had scanning facilities, then local women could receive all of their care at the Centre from the beginning and only opt-out if they needed consultant-led care.

37.74. CBC requires very little upgrading or updating to accommodate this new model. Fundamentally, the only real problem is that the 16 midwives and 13 full time equivalent midwives are employed by the 'wrong trust'. Inevitably, when trusts have access to different information systems there is a built in disconnect: a scan at Pembury will be put onto their system, but the midwives in Crowborough work for ESHT and are on a different system. The tensions this creates in maternity pathways for local women is recognised but is not addressed in the consultation options. The problem is that the consultation is about maternity services provided by ESHT rather than maternity provided to the inhabitants of East Sussex.

37.75. The maternity landscape in the High Weald has changed. A maternity service for women on the south coast and a separate service for the women in the High Weald ought to be considered. However, the predominant issues that ESHT has to contend with are on the south coast. What goes on in land in the High Weald is a 'distraction' to the main issue.

37.76. **Cllr Ruth O'Keeffe:** The biggest problem appears to be an organisational one: because people cannot be booked at CBC for scans and then automatically transferred to Pembury in the event of a problem, or the identification of increased risk, people do not book at CBC in the first place. This leads to a drop in births at CBC, which then leads to a case being made that there are insufficient births there for it to be a viable unit.

37.77. The figures for 2012 in the evidence pack show that 77% of the women attending CBC who did transfer to an obstetric unit went to Pembury. We need to look at the how to make this a more formalised route. Women who receive scans at ESHT's Lewes Community Hospital are booked to give birth in the RSCH. This demonstrates that maternity pathways that cross trust borders are possible.

37.78. **Richard Hallett:** CCGs need to ensure that women have a choice of the type of birth they want, and that women who do not need to be at an obstetric unit have an easily accessible place at a midwife-led unit.

37.79. ESHT could provide a Midwife-Led Unit at Eastbourne and Hastings and let a different provider run CBC because the High Weald sits in the natural catchment area of other obstetrics units. These types of arrangements will help to stop staff shortages that have occurred periodically at CBC, as staff will not need to be transferred from CBC to make up shortages at the Conquest.

37.80. **Councillor Alan Shuttleworth:** The RCOG good practice report (December 2013) states that "40% of first time mothers who are identified as low risk need to be transferred to obstetrics units when in labour. These transfers need to be seamless".

Is CBC close enough to other obstetrics units (in Pembury and Haywards Heath) for this not to be a concern?

37.81. **Richard Hallett:** In an emergency Pembury is the unit that women are sent to because it is closer. The problem is that, at no notice, Pembury has to take on a woman whose medical records have only been entered on ESHT's databases. Transfers are done well and there have been no incidents, but this is because the midwives work well together rather than because the pathway is working well.

37.82. Contractual issues are making it difficult for the CCGs to act and change the provider, even though ESHT is not in a position to service the High Weald. Contract for maternity should be constructed around patient flows and the needs and choices of women. This might not be in the remit of this consultation, but it should not be let slip and the problem should be resolved for the long term.

37.83. **Councillor Michael Ensor:** It is not part of this consultation process but we will have a comment in our final report about the future provision of maternity in the High Weald. We will also look at this issue in the future if it is not resolved satisfactorily.

37.84. **Lindsey Stevens:** The reason we have made decisions to close CBC in the past is because we have the obstetrics unit at Conquest Hospital that has the vast majority high risk births, so at those times when we have difficulties with staffing, we have to prioritise Conquest Hospital. It is not ideal, or an easy decision, but safety has to be paramount.

37.85. **Frank Sims:** The prime reasons for the consultation are patient safety and choice, not the needs of providers. One of the big issues that has been raised is how the patient experience links with choice and patient flows. We will pick up some of the issues raised around women's transfers from the CBC with the providers immediately to ensure that operational elements of the service flow properly. We would do this even if there was not a consultation.

37.86. **Lindsey Stevens:** CBC is closer to Pembury than EDGH is to Conquest Hospital. This has led to the assumption that the closer a midwife-led unit is to an obstetrics unit, the safer it is. Maidstone Trust also has another midwife-led unit that is equal distance from Pembury that has had an increasing birth rate year on year. National evidence suggests that 'alongside' midwife-led units do not have the good outcomes that 'standalone' units do.

37.87. **Amanda Harrison:** ESHT is not inhibiting change. Our clinical staff and management have looked at, and continue to look at, any option that would benefit women in the local area and we would not stand in the way of that. It will not be income that drives us, it will be safety, quality and the experience that our patients receive that will drive us.

37.88. ESHT cannot make the consultation about something that we cannot legally make it about, the consultation cannot be contingent on an outcome of a procurement process that has not taken place.

The meeting concluded at 12.57pm.