HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC)

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 20 March 2014

PRESENT:

East Sussex County Council Members
Councillors Michael Ensor (Chair), Frank Carstairs, Peter Pragnell, and Bob Standley.

District and Borough Council Members
Councillors John Ungar (Eastbourne Borough Council) (until 1.00pm); Dawn Poole (Hastings Borough Council); Elayne Merry (Lewes District Council) (until 1.00pm); Angharad Davies (Rother District Council); and Diane Phillips (Wealden District Council)

Voluntary Sector Representative
Julie Eason (SpeakUp)

WITNESSES:

High Weald Lewes Havens CCG
Ashley Scarff, Head of Commissioning and Strategy
Dr David Roach, GP
Michael Rymer, Secondary Care Doctor Member, Consultant Gynaecologist, Western Sussex Hospitals NHS Trust

Eastbourne, Hailsham and Seaford CCG / Hastings and Rother CCG
Jessica Britton, Associate Director of Quality and Assurance
Amanda Philpott, Joint Chief Officer
Dr Martin Writer, Chair Eastbourne, Hailsham and Seaford CCG

East Sussex Healthcare NHS Trust
Darren Grayson, Chief Executive
Dr Amanda Harrison, Director of Strategic Commissioning and Assurance
Dr Andy Slater, Clinical Director (Strategy) and Clinical Unit Lead, Paediatrics
Dexter Pascall, Clinical Lead Obstetrics
Paula Smith, Associate Director of Nursing for Women and Children's Services
Lindsey Stevens, Head of Midwifery and Assistant Director of Nursing
Stuart Welling, Chair

Healthwatch
Julie Fitzgerald, Director East Sussex Community Voice

South East Coast Ambulance NHS Foundation Trust (SECAMB)
James Pavey, Senior Operations Manager

Public Health, East Sussex County Council
Martina Pickin, Public Health Consultant

SCRUTINY OFFICER:
Paul Dean, Scrutiny Manager

38. MINUTES

38.1 The Minutes of the meetings held on November 2013, 10 January 2014 and 17 February 2014 were agreed as correct records.

39. APOLOGIES

39.1 Apologies for absence were received from Councillors Ruth O'Keeffe, Alan Shuttleworth and Michael Wincott (East Sussex County Council) and from Jennifer Twist (SpeakUp).

40. DISCLOSURE OF INTERESTS

40.1 There were none.

41. REPORTS

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

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

42.1. The Committee considered a report of the Assistant Chief Executive which set out the evidence gathering process for the meeting and included submissions from witnesses who gave evidence at the meeting.

Evidence from the Clinical Commissioning Groups (CCGs) and East Sussex Healthcare NHS Trust (ESHT)

42.2. **Amanda Philpott:** We all have a common interest in achieving safe, sustainable and high quality maternity and paediatric services; we consider that the six options will enable us to deliver these services. There is a very strong clinical case for change that is supported by local clinicians and by national evidence.

42.3. The three Clinical Commissioning Groups (CCGs) in East Sussex are undertaking this consultation jointly to ensure that commissioning takes place on behalf of the whole population of East Sussex.

42.4. We are currently in week 10 of the consultation and have so far undertaken 40 marketplace events; we have had about 900 conversations with individuals or couples and have received hundreds of written responses to the consultation. All of this information will be included in the independent analysis to follow.

42.5. It is important to distinguish between the role of CCGs and providers. CCGs are responsible for commissioning safe services for the population and that is differentiated within the structure of the NHS from the service providers. Therefore, although we work closely with our main provider of maternity and paediatric services, East Sussex Healthcare NHS Trust (ESHT), we do not speak for them.

42.6. **Darren Grayson:** We can confirm that ESHT is a consultee in the *Better Beginnings* consultation. ESHT has a role in providing evidence to HOSC and we will provide a response to the CCGs' consultation also.

42.7. ESHT has a *Clinical Strategy* that has been in place for two years. It is based on improving the quality and safety of services within the resources available to the Trust. Its main tenets are:

- the expansion and improvement of community services to people in the community, especially those with long term conditions;

- the mantra for acute services is that of *one hospital on two sites* at Eastbourne District General Hospital (EDGH) and the Conquest Hospital, Hastings;
- the significant and radical improvements to Accident & Emergency (A&E) and Cardiology within the business model of *one hospital on two sites*.

42.8. We have reconfigured services only where it has been necessary to achieve the service improvements, and the quality standards, that local people have the right to expect and that our commissioners want us to achieve.

42.9. We took a temporary decision to reconfigure maternity and paediatric services in 2013 based on the safety of mothers and babies using those services. We discussed the details with HOSC at that time. We feel that that we can demonstrate, with hard evidence, the improved experience and improved outcomes for those mothers and babies who use that service.

42.10. The temporary reconfiguration was a good example of effective clinical governance in action. There was a problem; our systems showed us that we had a problem based on emerging evidence. We took external clinical advice on the nature of the problem and the solutions that were open to us. We then took a hard decision which we implemented quickly and effectively.

Why not two sites?

42.11. **Councillor Pragnell:** The Independent Reconfiguration Panel (IRP) report in 2008 recommended that there should be consultant-led services at both sites. What was done to implement that decision? In particular, how was the £3.5m extra funding used to improve that service? What then happened that led you to conclude that that structure was no longer safe and sustainable? Why can there not be two consultant-led sites?

42.12. **Jessica Britton:** Following the IRP report in 2008, an enormous amount of work and resource was put in to developing a maternity strategy by the Primary Care Trusts and ESHT to ensure safe and sustainable service across both sites (EDGH and The Conquest Hospital). Work included recruitment drives and looking at alternative models of care.

42.13. Despite all of these efforts, as has been clearly outlined in the pre-consultation business case and in the options that we have put forward for consultation, it has not been possible to sustain consistently safe services across both sites.

42.14. **Dr Dexter Pascall:** Service improvements delivered as part of ESHT's maternity strategy between 2008 and today are outlined on p92 of Evidence Pack 3. Despite these improvements, ESHT continued to face issues in delivering high quality and safe services throughout the period from 2008 to early 2013 (p93 of Evidence Pack 3 also refers).

42.15. Delivering a maternity service is not solely about the number of staff. It is about an optimum number of staff and the appropriate deployment of the skills of the individuals providing the service. The Kings Fund made this clear in a 2012 report.

42.16. Since 2008, the maternity service has been most affected by:

- The European Working Time Directive reducing the number of hours that clinicians may work to a maximum of 48 in a week.
- Changes to immigration laws that have reduced the number of doctors entering the service from abroad. Foreign doctors previously formed an essential part of the service.
- A 58% increase in complex, high risk pregnancies between 2006/7 and 2011/12 (p94 of Evidence Pack 3 refers).

- An increased prevalence of medical issues such as: diabetes, hypertension and kidney disease; and
- An increased percentage of women classed as obese and an increased number of women over the age of 40.

42.17. These changes have resulted in:

- More complex, lengthier and more specialised care.
- Fewer available medical staff.
- A higher percentage of medical staff who require greater supervision to perform their duties.

42.18. The key medical staff in obstetric units are ***middle grade doctors*** (which is a term used to describe registrars, staff grade doctors and associate specialists). These doctors can perform obstetric procedures such as caesarean sections and instrumental deliveries, and have the ability to manage women in the delivery suite with the indirect supervision of a consultant. A staff or associate specialist middle grade doctor *should be* 'non-training', meaning that they are competent doctors who have completed their training but who do not wish to advance to become a consultant.

42.19. There are also ***trainee middle grade doctors***. Trainee doctors are, by definition, required to have training and continue to improve the care that they provide. They have sufficient competence to work, but they require continual experience that, with low activity levels, is difficult for them to gain.

42.20. Prior to 2008, all middle grade doctors gained their competencies quite quickly due to the number of hours they worked and because many of them came from overseas, already armed with basic skills and knowledge from their home country.

42.21. Since 2008, due to the changes in working practices and the increased complexity of patients, more of the non training middle grade doctors still required some training because of their relatively limited experience. So, amongst 10 middle grade doctors in 2008, there would have typically been 7 on non-training grades and 3 trainees. Conversely, in 2012, out of the 10 middle grade doctors, 8 would typically require a training level of supervision by the consultant body.

42.22. Consequently, there has been an increasing requirement of the consultant body to provide more direct supervision, or to be present on a more frequent basis. The Royal College of Obstetricians and Gynaecologists (RCOG) highlighted this issue in their reports.

42.23. **Lindsey Stevens:** Between 2008 and 2013, midwives took on certain roles that were traditionally junior doctor roles, for example, supporting surgeons in theatre. This was a great worry for ESHT managers because when the midwives were performing these tasks, they were not performing the 'at the bed side' midwifery tasks. This made us concerned that we were not providing the safest care that we could for mothers and babies in the unit. During this time, there were also a high number of midwives on sick or maternity leave.

42.24. Between 2008 and 2013, we tried to back-fill some of the 'at the bed side' roles by employing a large number of agency midwives across the Trust. This practice came with a number of concerns such as employing a large number of individuals who, whilst perfectly able to do the job, were unknown to the Trust and not part of the midwifery team.

42.25. Since the move to the temporary single site in May 2013, we have dramatically reduced the number of agency staff. We do use some agency staff on occasions to ensure that we retain a minimum of 9 midwives per shift at the Conquest Hospital.

42.26. Many midwives are young women who qualify with ESHT and then move to London or Brighton which makes it difficult for us to sustain numbers. We have seen a recent dip in our current funded establishment for midwives, but have also had a very successful recruitment drive where we have recruited 6 full time equivalent midwives and 5 band-5 nurses. The band-5 nurses will work on the postnatal ward, releasing midwives to the labour ward where they are needed.

42.27. **Amanda Philpott:** The decision to reconfigure services temporarily in May 2013 was ESHT's decision which they took on grounds of safety. The CCGs' clinical leaders met with ESHT's clinical team to test thoroughly the reasons why that temporary reconfiguration was required and why the actions taken by ESHT since 2008 were unable to sustain safe services in the long term. Through these clinical discussions, and a review of the evidence, the CCGs were assured that the Trust had done its best to maintain services in accordance with the IRP review; but sustaining two small sites was no longer safe.

42.28. One of the exercises that we undertook as part of our own evidence gathering for the development of our options was to talk to smaller maternity units around the UK to see if, and how, they were sustainable.

42.29. **Councillor Ensor:** The statistics on p94 of Evidence Pack 3 suggest that the clinicians' workload was increasing at the same time as consultant numbers were reducing because of factors such as the European Working Time Directive etc. Why have you not employed more consultants and junior doctors?

42.30. **Dr Dexter Pascall:** the number of consultants actually increased from 8 consultants in 2007/8 to 11. Across the country, the rate of consultant expansion is around 5%, with an average target of 7%. With 3 more consultants over 3 years, that equates to an average of 10% for ESHT. The European Working Time Directive has had more of an impact on the middle grade doctors, who have experienced a reduction in the number of hours they can work.

42.31. The blue line on the graph on p102 of Evidence Pack 3 is the budgeted number of middle grade doctors. The pink line represents the actual number of middle grade doctors in post, including locum staff who supplement those in substantive posts and help manage the increasing complexity of patients.

42.32. **Councillor Peter Pragnell:** If the European Working Time Directive means that middle grade doctors cannot not work as many hours, would that not mean you would need to employ more doctors? So, why does the blue line not show an increase in budget for employing more middle grade doctors?

42.33. **Dr Dexter Pascall:** A Trust must provide a certain level of activity for the doctors it employs in order for them to maintain their competence and gain experience. If a Trust employs, for example, 6 more doctors and does not have a level of activity within the unit that allows these doctors to maintain their competence, it will have created an additional risk.

42.34. During 2011/12, 4 of the 16 budgeted doctors actually required direct supervision or were not fully participating in the rota due to ill health. Consequently, the Trust hired locums to bring the functional number of doctors up to 16. We hire locum doctors either on an individual one or two night basis or on a fixed term contract for a few months. Locums bring a risk to the Trust due to the difficulty of integrating them into the team; teamwork in obstetrics is paramount.

42.35. Delivering an effective service is not just about the number of doctors or midwives. It is necessary to have the optimum number of medical staff with the optimum skills. During 2013/14, the number of doctors in post was less than that budgeted for. However, because of the interim changes in May 2013, the Trust now has an optimum number of doctors concentrated on one site, with reduced duplication of

effort, an increased consultant presence, and a level of activity for doctors where they can now improve their skills. This has led to an improved quality of service compared to 2012/13 when there were actually more doctors in post.

42.36. **Michael Rymer:** The role of the CCGs is to ensure that there are robust processes in place to predict, minimise and manage risk. We do not always state the risk in childbirth, which is a natural process. However, there are risks that normally occur in women with high risk pregnancies. We can predict most cases where a woman may have significant risk but we need teams who are practiced in managing emergencies whenever they occur.

42.37. The introduction of the European Working Time Directive has made it more difficult for hospitals across the country to train clinicians. This has led to nationwide difficulties in maintaining the skills of both the junior and senior workforce. Under these circumstances, it is recognised that smaller units increasingly do not have the volume of activity that enables whole teams to maintain the skills that they might suddenly require to manage what could be difficult and potentially life threatening complications.

42.38. The national response has been to introduce recommendations for consultants to increase the time that they are present on the labour ward, ensuring that they are delivering the service and not just supervising it. The presence of resident on-call consultants at night has also been discussed.

42.39. The structure of an obstetrics team may vary, depending on the particular circumstances of the emergency, but it is likely to include:

- A consultant obstetrician
- the knowledge of a haematologist
- senior midwifery care and advice
- The backing of experienced theatre team, which comprises one or two anaesthetists (a consultant and a trainee, or two consultants), and theatre nursing staff.

42.40. You would need to reproduce this team on two sites to have optimal two site conditions.

The performance of the temporary reconfiguration

42.41. **Councillor Davies:** Are the CCGs convinced that the temporary reconfiguration of consultant-led care in May 2013 has actually worked?

42.42. **Amanda Philpott:** All three CCGs have paid particular attention to the consequences of the temporary reconfiguration in terms of a reduction in serious incidents and improvement in safety outcomes. We put in place weekly meetings between our chief nurse and head of quality with ESHT's team; we have monthly reports to our boards that follow all the indicators in some detail; and we have a detailed quality report for the six months following the changes.

42.43. **Dr Martin Writer:** We have a wealth of evidence that supports the view that the single site appears to be delivering a higher quality of care and a better experience for women when they arrive at the hospital.

42.44. In addition to performance indicators, we rely on 'soft' intelligence, which is the intelligence we get from speaking to mothers during their six-week check-up. We talk to new mothers about their experience of giving birth and most of them say that it was positive.

42.45. We acknowledge that it can be uncomfortable and inconvenient for some women who now have to travel to the Conquest, but more clinical staff are present to take care of them when they arrive. Some women who have given birth since the

temporary reconfiguration and who previously gave birth at the EDGH obstetrics unit have noted the improved staffing levels. They have had more contact with their midwife and had a very good experience once they arrived at the Conquest Hospital. We have not heard from colleagues, or from patients, of anyone who has had a deleterious experience as a result of having to travel further.

42.46. This does not dispute the fact that it is *inconvenient* to travel further, for both the patient and their family. But this is about balancing risk and creating a system with the least risk in it. We cannot take all risk out of the system, but reconfiguring the service to a single site has created a much lower risk environment than before. As CCGs, our six options have significantly lower risk than a 'two-site model'.

42.47. **Dr David Roche:** The temporary reconfiguration has been an ideal pilot project. All of the statistics show an improvement in service, particularly the drop in the number of serious incidents. People have focussed on born before arrival (BBA) statistics, which have not changed significantly since May 2013. However, babies born before arrival usually have excellent outcomes and we should concentrate more on the reduction of serious incidents.

Improvements in training since the reconfiguration

42.48. **Councillor Davies:** Could ESHT provide some evidence of how training has improved?

42.49. **Dr Dexter Pascall:** The Kent, Surrey and Sussex (KSS) Deanery is a group of senior clinicians who set the training curriculum, oversee the training of the junior doctors in accordance with Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, and visit wards at various times to determine whether training is being delivered. KSS Deanery allocates trainee doctors to ESHT and 25% of ESHT's junior registrars are trainees, which is a substantial number.

42.50. In 2008, the KSS Deanery report recommendations (p97 of Evidence Pack 3 refers) limited ESHT to providing only the first year of training (out of seven) to registrars due to the Trust's inability to deliver appropriate curriculum training beyond that point. The Trust was very disappointed with this outcome.

42.51. The KSS Deanery returned in 2011 (p98 of Evidence Pack 3) after various changes were made. We tried to implement, together with the Deanery, means of increasing the amount of training. The Deanery expressed considerable dissatisfaction at the activity and training levels that ESHT was able to provide.

42.52. The KSS Deanery returned in 2013 (p116 of Evidence Pack 3 refers), four months after the implementation of the interim changes. This visit demonstrated that since the interim changes, there has been significant improvement in training provision.

High risk patients and transfers

42.53. **Councillor Standley:** If a single consultant-led site is chosen, identifying complex cases early is paramount. Given the experience of the temporary reconfiguration, are the CCGs confident that the assessment of risk will be adequate? Are numbers of complex cases increasing nationally?

42.54. **Amanda Philpott:** We are not seeing anything in the evidence that the complexity of the population of East Sussex is significantly different to anywhere else in the country.

42.55. **Michael Rymer:** Increased clinical complexity is not confined to East Sussex. It is a national issue. It is possible to predict whether women are likely to have an increased risk based on levels of obesity, age, and socio-economic factors such as smoking prevalence. All the evidence we suggests that the right sort of 'scoring' is now in place to pick up the vast majority of those risks.

42.56. **Darren Grayson:** The increase in complexity, which is demonstrable in ESHT's statistics, is a national phenomenon. This makes it all the more important that we have expertise concentrated in a single site so that we can deal safely and successfully with higher risk women.

42.57. **Councillor Standley:** How many emergency transfers have been made to the Conquest Hospital since the temporary reconfiguration?

42.58. **Lindsey Stevens:** The overview of the Eastbourne MLU data (p115 of Evidence Pack 3) highlights how well we are risk assessing women in the early stages of pregnancy in East Sussex. The number of women transferred to the Conquest, based on a risk assessment during labour who end up having instrumental (5.2%) or caesarean (2.44%) deliveries are below the national average. Overall transfer rates from the MLU to the consultant-led unit are in line with the national average.

42.59. **Councillor Dawn Poole:** How do you cope if there is a very last minute medical emergency at the Midwifery Led Unit (MLU)? For example, an emergency caesarean section? Could an emergency caesarean section be performed at EDGH as a last option?

42.60. **Lindsey Stevens:** The likelihood of a sudden complication is exceedingly rare, but due to the inherent risk of pregnancy, could happen at any time and not just when a woman is in hospital. Staff at EDGH could not perform an emergency caesarean section, but since the temporary reconfiguration, we have not had a single incident where we have had to 'rush' a patient to the Conquest for a caesarean section. Only 2.4% of women transferred have had caesarean sections and all women have been transferred in adequate time. The average time from handover at the Conquest to delivery of the baby is 3 hours 15 minutes.

42.61. **Dr Dexter Pascall:** Midwives who work in an MLU, at home, or in an obstetrics unit are trained to detect early signs of possible complications or risk. If we identify a risk in an obstetric unit, we may continue to monitor and refrain from any unnecessary intervention. In a MLU or at home, risk is managed differently and the woman will be transferred at the first sign that a risk is developing.

42.62. **Julie Eason:** What percentage of 'low risk' pregnancies end up with an intervention?

42.63. **Dr Dexter Pascall:** The national figure is around 10-12% when you combine caesarean section and instrumental deliveries of women transferring from both MLUs and from home. The figure for transfers from Eastbourne MLU is 7.6%, which is below the national average, but this does not include figures for transfers from home.

42.64. **Dr Amanda Harrison:** Women can be high risk from the start of their pregnancy or develop risk during pregnancy. Midwives and obstetricians are trained to detect any risk facing a woman and they will inform her of these risks when discussing with her where she would like to give birth. The woman has a choice, even if she is high risk, to have her baby in an environment that clinicians would consider unsuitable.

42.65. Women who are considered high risk mostly end up having their babies in the obstetrics unit, but some will choose to have their babies in the MLU or at home. When they make those choices, clinicians make it very clear to them that there will be no access to an emergency theatre in that location if they need it, but will support the woman's decision.

42.66. When a woman is in labour at a MLU or home birth, the midwife will detect any emerging risks or respond to any requests that the woman makes for a transfer (for example, a need for pain relief, signs of rising distress or a long labour), and the woman will be transferred to an obstetrics unit. The data provided about the length of time between arrival at the consultant-led unit and birth of 3 hours 15 minutes demonstrates that those choices are made early on in the woman's labour before there is an emergency situation.

42.67. Some low risk women choose to go to the obstetrics unit where the aim would then be to manage that birth with the lowest possible intervention without the involvement of obstetricians. However, the Birthplace Study shows that, even for a low risk woman, choosing to have a baby in an obstetrics unit means that intervention rates are generally higher. Many women make the choice to accept the inherent risks of a MLU or home birth because they believe, and the evidence demonstrates, that their risk of an intervention is much lower. This explains why women choose to give birth in a place without onsite access to consultant-led care when given the choice.

42.68. It is important to recognise that interventions will not be carried out at home or in a MLU. Women are risk assessed all the way through the process and clinicians make decisions to intervene early on during labour.

42.69. Women who deliver in a consultant-led unit do end up being rushed into an emergency intervention. But it is a controlled situation and people understand and predict risk and manage it in an appropriate way. The reason they are giving birth in a consultant-led unit is because those risks were anticipated and understood beforehand and either the woman was advised to give birth in that location. Or they were transferred there early in their labour.

42.70. **Councillor Ensor:** How do you ensure the safe and appropriate transfer of a woman who suffers complications during labour at a MLU?

42.71. **Lindsey Stevens:** The decision that a woman takes to have a home birth or MLU birth is based on discussions with clinicians that they have throughout their pregnancy. We will have discussed the reasons that might necessitate a transfer and what indicators for risk we would look for. The vast majority of transfers are for women who want pain relief that cannot be provided at a MLU, such as an epidural.

42.72. Throughout the course of labour, the midwife makes a number of observations of the mother and baby, in particular the foetal heart, and there are very clear definitions of what is and is not normal. By closely monitoring mother and baby, we can see when there is a pattern of change that becomes concerning. As both our MLUs are quite a distance from the obstetrics unit, the midwife will make the decision to transfer sooner rather than later, in discussion with the mother and their partner.

42.73. Transfer rates from the Eastbourne MLU for first time (primip) mothers are the same as the national average and transfer rates for women who are giving birth again (multip) are slightly less. All of our transfers have been made in a timely fashion. No babies have been born during transfer, and all of the outcomes have been good.

42.74. **Councillor Ensor:** Are any transfers done in a crisis?

42.75. **Lindsey Stevens:** The vast majority of transfers will be in a very controlled fashion. Midwives are alert to signs of where things have started to veer from the normal pathway and they will make a decision to transfer before the point is reached where there is panic.

42.76. **Julie Eason:** The transfer times (p115 of Evidence Pack 3) appear longer than the average journey length from EDGH to Conquest Hospital, which we were told was 30 minutes. Is this the case?

42.77. **Dr Amanda Harrison:** Transfer time is not the same as travel time. Transfer time is the total time from the midwife making the decision to transfer a woman to the woman arriving in the care of the consultant-led unit.

42.78. **Councillor Ensor:** The data says the average transfer time is 78.9 minutes. How can you be content that a transfer time of more than an hour is acceptable when the guidance from RCOG talks of “30 minutes”?

42.79. **Dr Amanda Harrison:** Women are transferred for a multitude of reasons, some more urgent than others. The level of urgency will influence the transfer time and South

East Coast Ambulance NHS Foundation Trust (SECAmb) responds brilliantly to the level of urgency required. If an urgent transfer is needed, the ambulance arrives within minutes and that transfer will be made in the shorter end of the time scale. If a transfer is made in the earlier stages of labour for pain relief, say, the transfer may be longer as SECAmb will prioritise other, urgent calls. We would expect SECAmb and the midwife to make this clinical decision about the urgency and that is why there is variation in transfer times.

42.80. The 30 minutes timeframe that RCOG recommends does not include transfer. This is the time taken from clinical decision to clinical intervention. In other words, the time from the obstetrician taking the decision (that a woman needs to have a caesarean section) to the caesarean procedure starting. This decision has to be made by a consultant, whereas the decision to transfer a patient from a MLU to a consultant-led site will be made by a midwife.

42.81. **Councillor Ensor:** Are you content with a travel time of an hour between Eastbourne and Hastings if the transfer is urgent?

42.82. **Dr Amanda Harrison:** We are content because the evidence tells us to be. We have had the benefit of running this service in this configuration for almost a year now so we now know that travel time has made no difference to the outcomes for women. We have meticulously monitored all transfers that have taken place and we have had no serious incidents in relation to transfers.

42.83. The evidence tells us that very few women require urgent intervention and, for those odd occasions where an unpredictable and potentially catastrophic event occurs, the transfer time makes very little difference. These events are vanishingly rare and can happen anywhere at any time. In these instances we would rely on the emergency services and the clinicians who get to these women quickly.

42.84. **Amanda Philpott:** Members of the public have raised this issue in the consultation events. We have explored the issue carefully and we consider that what matters is the travel time to the *right* clinical service, to ensure the best clinical outcome for the patient, rather than to the closest service. We are seeking to reduce risk whilst taking into account the implications of transfer time. We know that we need to explain the travel time and transfer times better.

42.85. **Michael Rymer:** We can overemphasise the problem with travel times. There are virtually no situations where a woman arriving 10 minutes earlier would have improved the outcome. The real issue is getting patients to somewhere with an expert, senior team who can deal with the situation there and then. Nearly always, a bad outcome occurs when there is an inexperienced, junior team that is unable to cope.

42.86. **Dr Andy Slater:** Obstetrics is not risk free. It is clearly safest to give birth in a consultant-led unit. This is because the full infrastructure is available to deal with a very rare, catastrophic event should one occur. The risk to a woman in an environment away from an obstetrics unit (such as a MLU) is inherently present and travel time to an obstetrics unit cannot be changed in order to decrease that risk.

Capacity outside of the county

42.87. **Councillor John Ungar:** Can you assure us that Tunbridge Wells Hospital, Pembury, Princess Royal Hospital, Haywards Heath and Royal Sussex County Hospital, Brighton have the capacity to pick up the extra obstetrics work for women in 'border' areas like Seaford who would previously have gone to EDGH for obstetrics care?

42.88. **Amanda Philpott:** Yes. In 2011/12 there were 5,500 births amongst East Sussex residents but fewer than 4,500 gave birth within East Sussex. So there is already substantial flow of patients to units outside the county.

42.89. We have continued to monitor out-of-county capacity since the temporary reconfiguration in May 2013. The number of additional women who choose to go to the Royal Sussex County Hospital is approximately 12 per month, slightly less than ESHT predicted. The Head of Midwifery at Tunbridge Wells Hospital has not reported any significant increase during that period.

42.90. **Dr David Roche:** People in the north part of the High Weald Lewes Havens CCG utilise the Crowborough Birthing Centre (CBC). If that unit were to close, it would not influence birth rates at the Conquest Hospital or EDGH as the women would instead go to Tunbridge Wells Hospital.

42.91. **Councillor Carstairs:** How many people go to their chosen place of delivery but have to be transferred elsewhere due to insufficient capacity?

42.92. **Jessica Britton:** We monitor when any unit is on divert, and a woman may have to be offered an alternative unit. We can provide those statistics.

42.93. **Dr Amanda Harrison:** Prior to the temporary changes, it was not uncommon for either one of the consultant-led units to find that, because of capacity and workforce issues, they had to tell an expectant mother to go to the other unit. Obviously, that was one of our concerns at the time of the reconfiguration, as *unexpected* travel was bad for women and for the service. We have not stopped admissions to Conquest Hospital at any point since the temporary reconfiguration.

GP views of the single-site service

42.94. **Councillor Ungar:** Have you asked GPs, as individuals, for their views on the options for a single site consultant-led service?

42.95. **Amanda Philpott:** Part of our obligation as CCGs and as GP membership organisations is to seek the views of our members. Whether or not they choose to give them is a different matter. We have taken many opportunities to elicit the views of GPs at regular locality meetings with practice representatives, through email, questionnaires, telephone calls, newsletters and face-to-face discussions.

Risk

42.96. **Julie Eason:** There have been six serious incidents in ten months since the temporary reconfiguration. How does that compare to the national average? How are you including the views of women in your risk assessments and safety procedures?

42.97. **Dr Amanda Harrison:** We expected the number of serious incidents to reduce because of the temporary reconfiguration; but this was not a universally held view. Some people expected that moving to a single unit would increase the risk and that we would experience more serious incidents than before.

42.98. There will always be serious incidents in maternity. ESHT is very rigorous at assessing any adverse event for whether or not a serious incident occurred, based on national definitions. We always report if we think an adverse event is going to be classed as a serious incident and, in discussion with our CCG colleagues, we will work to understand whether it constituted a serious incident and downgrade it if necessary.

42.99. The reason that we report serious incidents, other than that they are a requirement of all trusts, is that they are learning events. We carry out a root cause analysis on all serious incidents according to a set formula. We look at what happened, why it happened, who was involved and what might be done differently in the future. We listen to patients through informing them of, and involving them in, the root cause analysis.

42.100. All our clinical staff are trained to listen to women. During labour and antenatal period, staff impart information about the next steps and risks and listen to the woman's concerns. It is a process of shared decision making between the woman and the clinical staff. Quite often, clinical decisions are changed or amended according to what women think, but the clinical imperative remains the safety of the mother and the baby.

42.101. Labour and birth are quite often traumatic events and this can affect a woman's interpretation of the event. We listen to what women say, but we need to bear in mind that perceptions of what happened, although they may feel real, may not reflect what actually happened at the time.

42.102. **Dr Andy Slater:** Direct comparison of the number of serious incidents between trusts is difficult. ESHT has traditionally been a high reporter and has been commended for that. High reporting means there is a responsive system, not an inherent problem.

42.103. **Julie Eason:** How many incidents are there that you have been alarmed at and consider serious?

42.104. **Dr Amanda Harrison:** Since the temporary changes, we are no longer having more serious incidents than would be expected to occur in a well run maternity unit.

Demographics and population

42.105. **Councillor Merry:** What is the anticipated growth in population in East Sussex?

42.106. **Martina Pickin:** We are expecting a decline in births between 2012-2021 due to:

- A decline in the number of women of childbearing age (15-44), which is dependent on migration levels and a fall in the number of women entering this age group compared to the number leaving it.
- A decline in the average number of children that women are having (the total period fertility rate).

42.107. The largest predicted decrease is around 24% in Eastbourne. The number of births for East Sussex as a whole is expected to decline by 9%. This is based on the 2012 East Sussex County Council policy based projections, run using a modelling tool called POPGROUP developed by the Local Government Association. All of the assumptions in that model are based on national guidelines and all of the data inputted was the most up to date when the population predictions were produced in July 2013.

42.108. **Councillor Ensor:** Why is birth rate declining if new primary schools are being built?

42.109. **Martina Pickin:** There is a lag. The predicted number of children starting primary school now is based on the birth rates of 4-5 years ago, or 11 years ago for secondary school pupils. The demand for school places has been increasing but is based on previous birth levels, not current levels.

42.110. **Councillor Standley:** The Wealden District Council strategic plan contains figures for new housing up to 2026, but there will be a review before then and the projections might change. Similar increases could occur in the other districts and boroughs. How do the models account for this?

42.111. **Martina Pickin:** With any modelling, the further away you predict from the inputs, the less accurate it becomes. The projections will be revised in the future, but these are the most recent based on the best evidence we have. The model is based on migration from the five previous years and includes the housing information supplied by the district and borough councils contained in their strategic plans.

42.112. **Councillor Merry:** If there is a further rapid increase in the number of high risk births, as there has been since 2008, how will maternity services cope and might there be a need to return to two consultant-led sites?

42.113. **Darren Grayson:** Currently, ESHT manages approximately 4,000 births. Births would need to increase by 50% to more than 6,000 before a case could be made for two consultant-led units. This would mean the total population would need to increase to 750,000.

42.114. **Dr Amanda Harrison:** Immigration levels at their current rate, and the population increase from the proposed housing plans, will not increase the birth rate from 4,000 to 6,000.

Paediatric services

42.115. **Councillor Davies:** How are you going to improve staffing levels in paediatric services?

42.116. **Dr Andy Slater:** The safety issues that demanded the temporary reconfiguration of obstetrics were not present in paediatric services. However, based on the recommendations of the 2008 IRP report, we felt that there was uncertainty about the staffing in paediatric services and a lack of confidence about whether we could maintain the staffing levels of the middle grade doctors in future. On that basis, we decided to reconfigure paediatric services to a single site along with obstetrics.

42.117. There are a number of staff vacancies in community paediatric services, not in acute paediatric services. To a certain extent, these were not affected by the temporary reconfiguration. We are to review paediatric services, in conjunction with the CCGs, to determine the type of service and the staffing model for community paediatric services. Depending on the outcome, we could fill those posts.

42.118. **Councillor Davies:** The previous criticism of paediatric services was standards, not safety. The national move in healthcare is towards fewer acute beds and more services in the community. Should the filling of these vacancies not be a priority?

42.119. **Dr Andy Slater:** Community services are important. The aim of the move in paediatric services, like many other services, is to move more towards a community setting. To ensure we have the right staffing levels we need to understand what model we want to use and what model our commissioners want us to operate. This work is undergoing but it does need to be done correctly to ensure that we have the right resource in the right place.

42.120. **Dr Martin Writer:** CCGs are leading the consultation on paediatric services and we are talking to our communities as part of the process. It is a work in progress and people at our stakeholder events are telling us which parts of the services are not working and what needs to improve. This will allow us to design the very best paediatric service that we can.

42.121. ESHT won't make this decision for us. ESHT will provide input into the design of the new system as the current provider. It is possible that ESHT could fill the two vacancies for community paediatric consultants now, but the service that we ultimately choose to commission may not require consultants within that particularly sub-speciality.

42.122. **Councillor Ensor:** Are you considering increasing the opening hours of the short-stay paediatric assessment unit?

42.123. **Dr Martin Writer:** Short-stay paediatric assessment units will probably become the standard model for paediatric urgent care across the country in the future. We are looking at the best, short-stay paediatrics assessment unit that we can develop, based on the most appropriate use of the resources available. We are looking at the model of extending opening hours so that children can be observed at the short

stay unit for longer, reducing the need for transfers to an absolute minimum. This may be the best model for East Sussex.

42.124. **Julie Eason:** What consultation took place with the service users of the paediatric units and their carers?

42.125. **Dr Martin Writer:** We have gone into children's centres at Seaford and Hailsham East (p47 of the agenda pack). We have held focus groups to glean experiences, particularly from those people who have been deeply affected by the temporary changes. This will help us to understand the issues and ensure that the service we finally commission is the very best.

42.126. **Julie Fitzgerald:** The CCGs undertook an equality impact assessment identifying those groups in the community potentially differentially impacted, including children with long term conditions. Through Healthwatch, they have commissioned specific focus groups from community and voluntary organisations who work with those people, although they have not all taken place yet.

Crowborough Birthing Centre (CBC)

42.127. **Councillor Ensor:** Will the complexities of the patient flows at CBC continue after the consultation?

42.128. **Dr David Roche:** Yes, it will be an ongoing pattern. The single unit at Conquest is a long transfer time from CBC, so patients will continue to go to Tunbridge Wells Hospital for easy transfers. We have discovered, through the consultation, that the patient flows are quite *perverse* at the moment. For example, some women have difficulty getting their choice of place to give birth. We will tackle these issues separately to this consultation.

42.129. **Councillor Standley:** If patients are transferred to Tunbridge Wells Hospital, are there any issues with the patient's notes? Does it affect how information is passed on?

42.130. **Dr David Roche:** During the consultation, we discovered that the issues with different patient notes and booking arrangements are worse than we thought. These issues will have to be addressed if patients are going to be routinely transferred to Tunbridge Wells Hospital from CBC.

42.131. **Councillor Standley:** Do women in Crowborough prefer to go to Tunbridge Wells Hospital rather than Conquest Hospital? Is the presence of an unused scanner at CBC a poor use of resources?

42.132. **Dr David Roche:** Women prefer to go to Tunbridge Wells Hospital. If they are booked in to give birth at CBC, they have their scan at Tunbridge Wells Hospital because it is closer and more convenient than Conquest Hospital. We have begun a piece of work looking at these issues and the link between CBC and Tunbridge Wells Hospitals.

42.133. **Lindsey Stevens:** The difference in the format of maternity notes between CBC and Tunbridge Wells Hospital does not cause any clinical risks for women who are required to make a transfer between the two sites. Due to the proximity of the two sites, there has always been a transfer arrangement. There are good communications between the midwives at the two sites and there are no issues with the transfer of notes at that part of the pathway. However, there are issues at other parts of the pathway, for example, around where women go for scans, which we are looking to resolve.

42.134. We have recently reviewed and update our notes. Neighbouring acute trusts with differently formatted notes is an issue nationwide. However, every set of maternity notes will contain the same information; it will just be laid out differently.

42.135. **Councillor Davies:** If women who book at CBC are required to have their scan at Tunbridge Wells Hospital, and then decide to deliver at that hospital, will the number of births at CBC be sustainable?

42.136. **Dr David Roche:** We strongly consider that with scanning provided on site at CBC, and easier pathways utilising Tunbridge Wells Hospital, the number of births at CBC can be increased and the unit can be made sustainable. The number of births has dropped at CBC in recent years because scans are not available and patients have been drawn into perverse arrangements where they have scans at Tunbridge Wells Hospitals and book to give birth at CBC.

42.137. Consultation in Crowborough amongst the public and medical community has overwhelmingly supported the CBC. The GP practice vote in the northern High Weald area was unanimous in support of maintaining the CBC.

42.138. **Darren Grayson:** Separate from the commissioners decision about whether or not to continue to commission a MLU at CBC ESHT, as the current provider will take a view as to whether or not it wishes to continue to provide a service at CBC in future.

42.139. **Dr David Roche**: A major component of the work at Crowborough is the antenatal service. As a CCG we will be looking carefully at this.

Financial viability

42.140. **Cllr Ungar**: We have been told that money isn't the motivating option behind the proposed reconfiguration. However, we do want assurance about the viability of future services. So I would like HOSC to receive the financial viability of the different options.

42.141. Based on our site visit, the Conquest seem sufficiently well equipped to be a single consultant-led unit, albeit temporarily. However, EDGH has a decommissioned theatre and an apparent lack of space for any further expansion. So if a consultant led unit were to be at EDGH, would the necessary capital be available to ESHT to develop the necessary equipment, infrastructure and space?

42.142. Are there any major financial issues that would colour the CCG decision in terms of Hastings or Eastbourne for a single site unit?

42.143. Thinking generally about the health service budget overall not increasing, could we receive a discounted cash flow (DCF) statement for the next few years from the CCG to help us understand better how the CCGs intend to monitor and secure the long term sustainability of the options.

42.144. **Ashley Scarff**: This reconfiguration is about safety and sustainability. Finance is a very important consideration along with all the other different aspects when reaching a decision on this. There is a national tariff for 'payment by results' which sets the amount we would expect to pay for services including maternity and paediatrics and most other specialties. There are some public indications about the capital options available on the website. The more detailed elements of this question, including the DCF, can be looked at.

42.145. **Darren Grayson**: The financial appraisal of each of the options is in the public domain. There is a differential capital impact in terms of the infrastructure and estate of the two relevant buildings which are very different.

42.146. The funding of any capital will be considered by the board against affordability. We have approximately £10 million a year of capital to spend on the whole of the estate, IT, medical equipment etc needed to run an organisation of our size. It is not a lot and therefore it is likely that we would have to apply to the Department of Health for an additional loan to fund all or the majority of any investment required. We are happy to hold a separate conversation about the financial appraisal.

42.147. **Ashley Scarff**: In the normal scheme of things the costs associated with any capital investment would normally be met by the providers. The key question is around safety and sustainability.

42.148. **Stuart Welling**: DCF is a measure used to evaluate the economic benefit of a capital investment. CCGs are allocated money based on a capitation formula which increases or decreases depending on population size and other factors. What needs to be understood are the changes in the CCGs' spending power that vary from year to year, which is determined by a range of factors such as inflation, demographics, or technological changes. We do not use DCF to look at that. We use a series of different measures to evaluate what CCGs can or cannot afford. We need to take care here with the terminology being used.

42.149. **Cllr Standley**: It is my understanding that the cost to ESHT of running CBC is above tariff but that the Maidstone and Tunbridge Wells NHS Trust (MTW) could provide the service at tariff. Can we clarify whether the cost of running CBC is different depending on which trust is running it.

42.150. **Ashley Scarff**: We would expect to see this point coming out during the process in terms of the responses from ESHT and other providers. To say at this point what that differential might be would be misleading.

42.151. **Stuart Welling**: Crowborough is an integral part of ESHT. The ownership of Crowborough War Memorial Hospital is vested in ESHT. Whether MTW run it or whether ESHT runs it, the income we get for the service will be based on the tariff as part of the contract that is agreed with the commissioners. The level of spend for the CCGs should be comparable whether the service lies with ESHT or MTW. There has been no decision by ESHT not to continue to see Crowborough as an integral part of its provision of healthcare facilities.

42.152. Clearly, if the CCGs wish to operate the contracts in a different way, then we would have to make a judgement about that. The only difference will be about how the apportionment of overheads is agreed in terms of the financials. This consultation is not about the future of Crowborough War Memorial Hospital, it is about the MLU component there.

42.153. If there is to be a discussion about the provision of the totality of services from Crowborough War Memorial Hospital, that is for a different discussion at a different time.

42.154. **Cllr Standley**: It is difficult to separate the sustainability of the MLU from the rest of the services being provided at Crowborough and to ignore the potential differences in cost depending who provides the midwife service. Two of the options under consideration involve no maternity services at Crowborough. Therefore it is important to have answers to questions around sustainability in different scenarios.

42.155. It is unclear, for example, whether there would be genuine savings if one trust were to provide the service as against another. Or whether the differences would mean a shift of overheads from one to the other without any real overall difference in net spend.

42.156. **Dr David Roche**: That discussion is not part of this consultation. We cannot include (as part of the consultation) consideration of who provides that service or whether one provider is better able to deliver it than another.

42.157. **Darren Grayson**: The £400,000 suggested difference is evidence from 'Save the DGH', not from ESHT and I am unsure whether it is evidence that the CCGs have provided. Competition law strictly governs this whole area which impacts on the NHS whether we like it or not. This is not a conversation we should pursue.

42.158. **Cllr Standley:** The £400,000 figure came from the HOSC in Tunbridge Wells, not Save the DGH.

42.159. **Cllr Ensor**: We need to focus on the medical need for a midwife led unit at Crowborough.

42.160. **Julie Eason**: There is a general point about the *tipping point* re the long term sustainability of hospitals which has been reflected in the consultation and therefore it is reasonable to ask about it. Taking services away from a particular hospital may affect the sustainability of other services there. Whether this is true or not in this case, there are certainly public perceptions surrounding this point.

Alongside or standalone MLUs?

42.161. **Cllr Pragnell**: Why are the CCGs only looking to commission two MLUs? What factors will determine whether an MLU should be co-located with the obstetric unit, or whether they should be stand-alone?

42.162. **Ashley Scarff:** The decision to opt for two rather than three is based on numbers. An MLU doesn't have a *critical mass* requirement that applies to a consultant led unit. We looked at choice and the likely number of users and we would struggle to justify three.

42.163. Regarding the criteria, this is one of the key parts of the consultation. We are hearing about what is important and understanding that people want the stand-alone versus the alongside options and seeing the extent to which these views come through the consultation.

42.164. **Dr David Roche**: The other point would be the availability of midwives to staff those units given that midwife provision is stretched. You would be drawing from the same pool of midwives that exists in East Sussex, South Kent etc currently.

42.165. **Cllr Pragnell**: At the visit to the Conquest I heard the suggestion that if you have an MLU alongside the consultant led facility, there may be the temptation to cry help to a consultant earlier than you might actually need to.

42.166. **Dr David Roche**; There is evidence that in co-located MLUs units there are more interventions in the birth of the child compared to a freestanding MLU. There are more natural births even in a co-located MLU compared to an obstetric unit.

42.167. **Dexter Pascall**: That is correct and is backed up by evidence from the national birthplace study.

42.168. Amanda Harrison: The model of care provided in an MLU is the same as previously described regardless of whether that unit is separate or alongside an obstetric unit. But the tendency to move patients from one unit to the other is increased if the transfer process is easier.

42.169. **Lindsey Stevens**: It does come down to patient choice. The transfer rates are higher for women in an alongside MLU to the acute unit than from a stand-alone MLU to an acute unit because it is easier to make that transfer. So the temptation is there to ask for an epidural for example. However, the outcomes for low risk women in stand-alone MLU's are better generally because of the lack of interventions. There is an argument also that stand-alone birth centres are better in some ways in terms of intervention as women stay out of acute units.

42.170. **Cllr Philips**: When will the consultation results and analysis be available to HOSC?

42.171. **Dr Martin Writer**: the governing bodies intend to make their decision at the end of June and in time for the HOSC meeting on 10 July. The data will be available soon and we need to take account of purdah happening around the Hastings elections. We will confirm when the data will available to HOSC.

42.172. **Dr Martin Writer**: By way of summary, this is all about balancing risks. We cannot create a risk-free healthcare solution. But we are tackling a system (the two site option) that has had too much danger in it for mothers and their unborn children. This is why we have chosen to pursue a single site option because that balances the risk. It does not mean that it is a no risk situation. The risks are better for us as CCGs, for our communities and the people who are delivering in those units than they were before the emergency reconfiguration occurred. With our extensive research, we believe that these six options are the lowest risk options.

42.173. **Dexter Pascall**: Following the consultation in 2007 and the IRP report of 2008, the majority of the consultant body was of the opinion that moving to one site was the safer option. In October 2012, the consultant body and senior midwives were unanimous that the situation we were in was not safe or sustainable. Since the interim changes, we have stabilised the situation and improved a lot of parameters and allayed a lot of the concerns about moving to one site. Our present configuration comprising one consultant led unit is safer.

Evidence from East Sussex Healthwatch

42.174. **Cllr Ensor**: Pleased to welcome Julie Fitzgerald, Director of East Sussex Community Voice (the community interest company that delivers Healthwatch) and the summary of the outcomes of the Question Time meetings. I attended all three Healthwatch meetings which were all very different.

42.175. **Julie Fitzgerald**: Healthwatch is a national service introduced in April 2013. Our report is available (Evidence pack 3 p13). Part of our core work involves gathering and understanding the views of the public and patients, making those views known and promoting and supporting the involvement of the public and patients in commissioning decisions. The Better Beginnings reconfiguration is a key decision for the people for East Sussex. We don't want to duplicate the work undertaken elsewhere, particularly by the CCGs, we did want to work with them to ensure that the information reach all communities and that people had the best possible chance of participating.

42.176. We have worked with the CCGs on their programme board and on their community and engagement working party as an independent advisor. We have asked the questions that we felt the public would be asking. We have assisted with the equality impact assessment which identifies communities that may be differentially impacted by the proposals. The CCGs have commissioned, through us, specific focus groups to inform and gather evidence from potentially affected groups. This work is not yet complete and will follow.

42.177. We considered that it would be useful for the public to attend an independently chaired session where they could hear from the CCGs about the thinking behind the consultation and how they had arrived at the six options. They would be able to get answers from a wide group of people all with the aim of enabling the public to be active participants in the consultation – something that we are all seeking to achieve. We invited campaign representatives, local MPs, colleagues from CCGs, clinical leads, senior officers, and the patient and public involvement leads from CCG boards. At the Uckfield event we had two independent clinicians who were maternity and paediatric specialists.

42.178. The three meetings were all quite different which is to be expected when considering geographical locations and local community interests. There was a balance between discussion of maternity services and paediatric services. Three common key themes emerged:

- Travel and transfer times and the perception that longer journeys increase risk and therefore impact on safety.

- The robustness of the evidence and data used prior to the temporary reconfiguration (in May 2013) in building the CCGs' case for the consultation
- Decision making processes from then on – where public views go and the extent to which they are taken into account when making the final decision; what happens where there isn't unanimity about the chosen options amongst the CCGs. (The meetings were advised that the CCGs are seeking legal advice on this point).

42.179. Overall, all the public questions were answered comprehensively at all the events. However, not every member of the public accepted all the answers necessarily.

42.180. At the Eastbourne and Hastings meetings there was quite a lot of discussion about why there weren't going to be two obstetric units, one in each town.

42.181. At the Uckfield event there were concerns raised about current choices available to women and how they work in practice. Here there were issues around notes and the compatibility of formats, and how patient flows feel to women in that CCG area – we would recommend that HOSC addresses these issues.

42.182. In Eastbourne there was more of a discussion about paediatrics with key concerns being raised about the transfer of children especially those with longer term conditions; this was primarily around how this was working for individual families and also information being given to the public; the discussion reflected some public confusion in this area. Some of these issues we are taking up with the CCGs to take up immediately.

42.183. The tenor at the Eastbourne meeting also reflected concerns about the long term future of the hospital. Some people felt that the decisions relating to maternity, paediatrics and gynaecology would impact on the long term future of the hospital.

42.184. Overall, we felt it was important and productive to hold the three events. In Hastings there were only ten people present but there was a good quality debate around the unit in Hastings and the staffing issues there and how we could contact local communities there who weren't fully engaged at the moment. This was part of a wider piece of work and wasn't, by any stretch, the only way the public could get involved.

42.185. **Cllr Ensor**: Thank you to the members of the public and several babies who attended! The paediatric discussion at the Eastbourne event was helpful as it was the first time I had heard about the possibility of extending the opening hours of the special care baby unit.

42.186. **Julie Eason**: I am really glad these events happened. I was concerned at first that the process might have seemed intimidating for members to the public to ask questions. However, they often need to not just hear but also be heard also. Re paediatrics: what are the detailed concerns of parents of children who need longer term support discussed at the Eastbourne event?

42.187. **Julie Fitzgerald**: The discussion focussed on transfer times and associated anxiety, especially at night time. A couple of parents had moved home to be close to EDGH and then subsequently found that at certain times of the day they needed to travel to Hastings. We felt that some issues like these could be picked up straight away and are working on those with the CCGs.

42.188. **Cllr Standley**: Why were the numbers of participants at the Hastings event much lower than the others? At Uckfield, did you get a feel as to whether it was Crowborough residents coming to the event or whether the questions were coming from people in Uckfield? Are Uckfield mothers looking to use CBC?

42.189. **Julie Fitzgerald**: It is hard to fully understand the Hastings turnout and what motivates people to turn out on the day. It was the first of the events albeit the others followed within a two week period with a range of publicity and media coverage. From the floor, the question was raised as to whether it might be because there is already an obstetric unit at the Conquest and an assumption that that would continue.

42.190. It was a mixed audience (at the Uckfield event); a blend of people who had used the CBC, with tremendous support for the unit from all age ranges, The consensus was that mothers from this area would not travel to EDGH or the Conquest as a natural pathway.

42.191. **Cllr Carstairs**: Did you get a sense of how many people support the one-unit option?

42.192. **Julie Fitzgerald**: No, because that wasn't a question we asked. Our role wasn't to take a vote or gain a consensus on the different options. We were there to ensure people get the information they needed to form their own view. It was hard to quantify, but more people in Eastbourne than in Hastings said they were unhappy with a one-site obstetric option.

42.193. We are glad that there has been clarity today about the 30 minute issue – that needs to be "out there" a bit more so the public can understand that.

42.194. **Cllr Ensor**: Your written submission identified the list of questions asked at the event but will you be matching that with the answers provided?

42.195. **Julie Fitzgerald**: the primary purpose was to provide HOSC with a checklist. On the whole they are the questions that have already been raised with HOSC throughout the process. If HOSC wishes Healthwatch to catalogue responses to questions we are happy to do that. We did feel questions were answered but not necessarily to the satisfaction of individuals.

42.196. **Cllr Ensor**: we shall await the CCG responses to see whether we need to pursue this.

42.197. **Ashley Scarff**: On behalf of all the CCGs, we would like to record our formal thanks to Healthwatch for organising these events. The objectivity and impartiality was very important to us and we welcome what they have done.

Evidence from South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

42.198. **James Pavey:** Apologies from Dr Jane Pateman who is with a patient on the top of the Downs at the moment.

42.199. SECAMB is independent of all the discussions that have been going on but is a key player as a provider service. SECAMB's stance on all reconfigurations can be summed up thus:

> *We support safe services for patients that produce the best clinical outcomes for patients based on evidence.*

42.200. Whatever Trusts decide to do in terms of reconfiguration of services must be in line with this statement from our perspective.

42.201. **Cllr Ensor**: what is the travel time between Eastbourne and Hastings?

42.202. **James Pavey:** I have reviewed a few dozen actual travel times from EDGH to the Conquest ('wheels start' to 'wheels stop'), in particular paediatric cases or obstetric/maternity type cases. This is a snapshot of those results:

- With blue light/siren
    - Monday afternoon, 3.30pm: 33 minutes 18 seconds
    - Tuesday morning rush hour, 8.00am: 34 minutes
- Without blue light/siren
    - Night time, 2.00am: 30 minutes
    - Wednesday afternoon, 2.00pm: 52 minutes
    - Friday evening 8.00pm: 46 minutes.

42.203. The variation is wide with 30 minutes being the quickest. The average is probably between 45 minutes up to one hour without using blue light. It is reasonable to assume that journey times would be roughly the same in the opposite direction.

42.204. **Cllr Davies:** Would blue light normally be used for an obstetric patient?

42.205. **James Pavey**: The crew would decide based on the needs of the patient. The decision would be taken jointly with an accompanying midwife or other medical professional. The decision needs to strike a balance between making the journey bearable and transporting the patient as quickly and as safely as possible. There is no hesitation in using blue light whenever this is appropriate.

42.206. **Cllr Pragnell**: What effect will the Bexhill Hastings Link Road have on journey times?

42.207. **James Pavey**: We are optimistic that it will reduce journey times, especially at peak times. At present we are unable to put a figure on this.

42.208. **Cllr Standley**: What has been the impact of the single siting decision (in May 2013) on SECAMB? Has any additional demand taken up from 'slack in the system' or has additional capacity been introduced?

42.209. **James Pavey**: the temporary change has increased the demand on the ambulance Service. Based on data accumulated during the period May – October 2013 there have been approximately 2 additional patient journeys per day (equating to 4 or 5 hours of ambulance time per day) that can be put down to the reconfiguration; this covers all paediatric, obstetrics and gynaecological related cases.

42.210. In a wider context, activity and demand for ambulance services is constantly changing because of a range of factors. Additional demands that are required because of a reconfiguration become a matter between SECAMB and the commissioners; demand capacity planning is happening all the time. A significant challenge is that the lead in time required to expand services is so great that it is very difficult to expand capacity quickly. We try to look ahead as best we can.

42.211. **Ashley Scarff**: Swale CCG (North Kent) acts as lead commissioner for Ambulance Services on behalf of Kent, Surrey and Sussex. More locally, HWLH leads on behalf of Sussex. We recognise the impact that reconfigurations such as this can have on the Ambulance Service. We have monitored this through the period of the temporary changes and through our normal contracting cycles. Depending on the ultimate configuration, the impact may differ from the current position.

42.212. **James Pavey**: we are learning from the temporary changes to see what impact any permanent change may have. The temporary change happened rather quickly and wouldn't have given us time to plan for in the normal commissioning cycle processes.

42.213. **Cllr Ensor**: how do you cope with the paediatric transfers?

42.214. **James Pavey**: the majority of the calls are paediatric cases. There are fewer gynaecological transfers – maternity accounts for about a third of the total.

42.215. **Cllr Carstairs**: Do SECAMB ambulances stand by at Crowborough War Memorial Hospital waiting to pick up patients?

42.216. **James Pavey**: No because there are very few transfers per week or even per month from there. There is a stand by location in Crowborough (a community response point) where an ambulance might sometimes be observed.

42.217. **Cllr Davies**: How much training do paramedics get? Presumably some transfers will have an accompanying midwife but many will not?

42.218. **James Pavey**: There is confusion about what ambulance staff/paramedics do. We are generalists in emergency medicine. The quantity of gynaecological, obstetric and paediatric work is very small overall. We rarely if ever see emergency deliveries. Therefore, equipping all ambulance staff with high level skills to deal with obstetric emergencies is entirely wasted because they are generally unable to use those skills.

> *"I've been in the ambulance service for 20 years and I've never delivered a baby"*

42.219. An individual paramedic might see an emergency delivery once every few years. So the numbers of these highly specialist situations are small making it difficult for us to be experts. We provide expert care in resuscitation for all people including children and babies. But when there are medical emergencies related to obstetrics, we look to the experts to provide support. So for transfers we would expect support from the appropriate medical professional, which would be a midwife for example.

42.220. The Joint Royal College Ambulance Liaison guidelines set out the methodologies by which ambulance staff operate.

42.221. We carry a delivery pack in the ambulance just in case. Most births we deliver in the community go very well and tend to happen quite rapidly. So we rarely see complex and difficult deliveries. When we do, we often rely on midwife support who are there when things start to go wrong.

42.222. **Cllr Ensor**: How does SECAMB control know where to take a patient? Is there real time information about the opening times of the different units?

42.223. **James Pavey**: The closest receiving unit gets the patient that's appropriate to the medical condition. So for an obstetric emergency in Seaford for example, it is highly likely that the patient would go to Brighton – the nearest suitable unit. This often means that we would drive past somewhere that isn't suitable to take a patient. We do this because we know that the outcome for patients is better when we take them to the specialist unit. This approach also applies to many conditions, such as stroke, trauma and cardiac conditions. The mantra is "right place, first time". Taking a patient somewhere that then requires a further transfer always leads to a worse outcome.

42.224. Our plea is for *simplicity*. A system doesn't work if there are multiple options for different times of the day or different days of the week. Our experience, not just in maternity and paediatrics, is that when you introduce complexity into a system it ends up creating problems. The systems need to be simple for humans to operate.

42.225. We have examples across the region where services have been set up in such a confusing way that ambulances have had to travel back and forth between sites until a decision has been made. This is not acceptable for patients as well as being difficult and stressful for ambulance crews.

42.226. We have a directory of services available but generally it is best if services are 24/7 so the choice is always simple to make – it's always the nearest appropriate unit. Crews come from all over the region and therefore this is even more important.

42.227. **James Pavey**: I will circulate a briefing of what I have covered together with some other points which may be helpful.

Next steps

42.228. **Cllr Ensor**: Thank you to all the witnesses. We have received a wealth of information today. Minutes of today's meeting will be produced and circulated to witnesses to confirm them for accuracy before publication.

42.229. Our next step will be the report preparation stage. HOSC will not be inviting any further witnesses unless we discover a 'hole' in our evidence. We will however await the results and analysis of the consultation from the CCGs and other evidence promised today.

42.230. Over the next few weeks a HOSC Task Group will sift the evidence to help assemble our report. The draft report and recommendations will then be discussed and confirmed at the next public HOSC meeting on Thursday 19 June 2014. (An erroneous date of 12 June for the next HOSC has inadvertently crept into the work programme; this will be corrected.)

42.231. We will receive the CCG decisions on 10 July 2014 and reach our conclusions on whether they are in the best interests of the health services in East Sussex.

The meeting concluded at 2.55pm.