HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DRAFT MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 29 September 2016

PRESENT:

Councillors Colin Belsey (Chair), Councillors Ruth O'Keeffe, Frank Carstairs, Angharad Davies, Mike Pursglove, Peter Pragnell and Alan Shuttleworth (all East Sussex County Council); Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Johanna Howell (Wealden District Council), Julie Eason (SpeakUp) and Jennifer Twist (SpeakUp)

WITNESSES:

Brighton & Sussex University Hospital NHS Trust

Lois Howell, Director of Clinical Governance

East Sussex Healthcare NHS Trust

Dr Adrian Bull, Chief Executive
Catherine O'Callaghan, Service Manager for Maternity

Coperforma

Michael Clayton, Chief Executive

High Weald Lewes Havens Clinical Commissioning Group

Wendy Carberry, Chief Officer
Alan Beasley, Chief Financial Officer
Ashley Scarff, Head of Commissioning and Strategy
Dr Peter Birtles, Urgent Care Clinical Lead
Sally Smith, Director of Delivery

Eastbourne, Hailsham and Seaford Clinical Commissioning Group/ Hastings and Rother Clinical Commissioning Group

Amanda Philpott, Chief Officer
Allison Cannon, Chief Nurse

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

12. MINUTES OF THE MEETING HELD ON 30 JUNE 2016

12.1 The Committee agreed the minutes of the meeting held on 30 June 2016 as a correct record.

13. APOLOGIES FOR ABSENCE

13.1 Cllr Sam Adeniji, Cllr Frank Carstairs (substitute: Cllr Mike Pursglove), Cllr Bob Standley (substitute: Cllr Peter Pragnell), Cllr Tania Charman and Cllr Bridget George gave their apologies.

14. DISCLOSURES OF INTERESTS

14.1 Cllr Ruth O'Keeffe declared a personal interest as an active member of Healthwatch East Sussex.

15. URGENT ITEMS

15.1 The Chair informed the Committee that the Care Quality Commission (CQC) had just published its inspection report on South East Coast Ambulance Service NHS Foundation Trust (SECAmb) which rated the Trust 'inadequate' and recommended that it be placed in special measures. He acknowledged that the Trust had been rated 'good' under the caring domain and said that was a reflection of the dedication of the staff at the Trust. The Chair added that he had attended the Quality Summit held by CQC and NHS Improvement on 28 September.

15.2 In recognition of the logistical difficulties of SECAmb reporting on progress to each of the six health scrutiny committees in the Trust area, the Committee RESOLVED to:

1) permit the Chair and Vice Chair to scrutinise SECAmb's response to the inspection report and overall recovery plan at a separate joint meeting with representatives of the other five HOSCs;

2) be presented with all of the information to be considered by the joint group before each meeting to afford Members the opportunity to propose questions for the Chair/Vice-Chair to ask SECAmb;

3) request that the joint group report its findings to HOSC; and

4) agree that the joint meeting be conducted publically as far as is practicable.

16. BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST (BSUH) CARE QUALITY COMMISSION (CQC) INSPECTION

16.1. The Committee considered a report on the findings of a recent Care Quality Commission (CQC) inspection of Brighton & Sussex University Hospitals NHS Trust (BSUH) and the Trust's response.

16.2. Lois Howell, Director of Clinical Governance, BSUH, provided an update and answered a number of questions from HOSC in relation to the CQC report and BSUH's quality improvement programme.

A&E Department waiting times

16.3. HOSC asked whether the improvements to the A&E Department made since the CQC's warning notice was issued in April had made any difference.

16.4. Lois Howell said that improvement in the A&E Department had been significant. BSUH has reduced the number of 12 hour waiting time breaches from 12 during April 2016 to five in total between May and the end of September 2016. The longest a patient had to wait since April had been more than 26 hours, but this had been for patient safety reasons and was now the subject of a serious incident review. BSUH had also improved 4 hour waiting times to 86% compliance, although the 95% target is unlikely to be met until after this financial year when building works at the Royal Sussex County Hospital (RSCH) – designed to improve patient flow and capacity in other wards – are completed.

16.5. Lois Howell said that the improvements to the A&E Department included:

- changing staffing rotas at both hospital sites, in particular altering staffing levels at the Princes Royal Hospital (PRH) to match the increased attendance levels during the evenings;

- requiring staff to use a checklist to monitor patients' welfare and a checklist to monitor signs of patient's deterioration, based on the National Early Warning Scores. There is currently a 100% compliance with both checklists;

- carrying out audits of patients' notes to ensure that they are being treated properly and that staff are using checklists.

Patients in corridor area at A&E Department

16.6. HOSC asked whether it was acceptable to allow patients to wait in corridors, and what BSUH was doing to reduce or eliminate the need for this practice.

16.7. Lois Howell explained that a corridor area is used when there are no available cubicles for patients who have entered the A&E Department on ambulance trollies, or who are too sick to go into the waiting room; it is safer to have them in the corridor area where a nurse is allocated to them than to put them in the waiting area. She said that putting a patient in the corridor is a difficult judgement call based on what is the safest place for the patient within the circumstances. It is not a situation that the Trust is happy with and is one that the Chief Executive has apologised for.

16.8. Lois Howell said that if more than five patients are in the corridor a trust wide escalation policy is initiated. Less than 10% of patients now have to spend any time in the corridor, these patients have to wait in the corridor for about an hour on average, and it is rare for five patients to be there at any one time.

16.9. In response to the CQC's findings on the use of corridors, Lois Howell said that BSUH has:

- Replaced some offices with four new assessment cubicles to reduce the use of the corridor area;

- improved the privacy and dignity of patients by ensuring that all treatment and assessment is conducted in a cubicle area and not in a corridor;

- bought more substantial screens for patients to allow more privacy in the corridor area;

- begun building works in the A&E Department and work to improve patient flows elsewhere in the hospital and increase available beds; and

- improved ambulatory care areas so that some patients can avoid A&E and go directly to the newly opened surgical assessment unit, for example, those referred by their GP.

16.10. Lois Howell said that BSUH is working towards a target of patients spending no more than 15 minutes in the corridor. However, improvements to patient flows throughout the rest of both hospital sites would need to be completed before a target of no one waiting in corridors could be achieved. This is because a lack of available beds in the rest of the hospital is often the cause of A&E cubicles becoming fully occupied.

Leadership and clinical governance

16.11. HOSC asked whether the Trust's senior leadership has the capacity to address the findings of the CQC.

16.12. Lois Howell clarified that there had been significant changes to the Board since the inspection. There is a new Chair and Chief Executive in place, along with a number of new non-executive and executive directors.

16.13. She also said that clinical governance at BSUH is in the process of being overhauled. The Trust is aiming to achieve this by:

- developing a leadership programme for clinical directors and other clinical leads;
- holding monthly senior management team meetings of all clinical and executive directors to ensure that there is a better link between the two;
- Holding improvement meetings for senior nurses and ward managers.

16.14. Lois Howell acknowledged that there is a serious cultural issue at the Trust and previous attempts to address it have failed. The Trust is investing significant money in recruiting external assistance to help it work more effectively with staff with particular protected characteristics. Some of the projects underway include:

- a regular staff forum;
- a commitment by the senior management team to 1,000 hours of participation with staff in frontline services;
- the establishment of an equalities group to ensure that the needs of all staff with protected characteristics are looked after across the Trust;
- an Equalities Committee to seek assurance and generally provide governance around the question of service provision – to ensure that when it is delivering services, the Trust is doing so in fair and equitable ways for all patients with protected characteristics.

Sharing good practice from the Children's Services Department

16.15. HOSC asked why the Children's Services Department was outstanding when the rest of the Trust was not, and what lessons could be learned from it and applied across the Trust.

16.16. Lois Howell said that the performance of the Children's Services Department was in part due to factors that could not be applied across the Trust, for example, the modern Royal Alexandra Children's Hospital building was designed with modern patient flows in mind, whereas many other parts of the RSCH site were built during the Victorian era. In addition, there are different commissioning requirements for children's healthcare, for example, lower demand for children's A&E services, which could not be applied elsewhere. However, the Children's Services Department's governance, teaching, learning and supervision methods will be shared as part of the overhaul of clinical governance.

Staffing in clinical areas

16.17. HOSC asked what was being done to recruit staff to clinical areas, in particular critical care areas, and reduce the use of agency staff.

16.18. Lois Howell said that BSUH's neuro-intensive care unit was of most cause for concern to the CQC. In response, the Trust has reduced capacity at the ward by one bed, and developed an in-house training programme for neuro-intensive care staff. The additional capacity will be reinstated once the ward has developed the right staffing skills to meet patient needs and the demonstrable ability to provide that additional capacity safely.

16.19. Lois Howell said that BSUH is attempting to recruit additional staff but recruitment is a national problem, particularly for roles such as A&E doctors. By way of illustration, PRH already had 4 consultant vacancies in its A&E Department that have not been filled and, in response to the CQC inspection, BSUH has now committed to providing further senior medical cover creating an additional 5 vacancies in A&E. The Trust is therefore looking at alternatives, for example, using senior doctors who are not consultants but have significant medical expertise and have received additional training.

16.20. BSUH has increased nursing staff and healthcare assistants in key areas and is recruiting and training its own bank staff in key areas rather than relying on agency locum staff wherever possible. The Trust is also developing clinical fellowship roles in a number of posts that allow staff to work part time clinically and part time in a research role. Agency staff are used when there is not sufficient permanent staff available.

16.21. The Committee RESOLVED to:

1) note the reports and its appendices;

2) agree to establish a joint working group with West Sussex County Council and Brighton & Hove City Council HOSCs to scrutinise the BSUH Quality Improvement Plan;

3) nominate Cllrs Belsey, Howell and O'Keeffe to the joint working group;

4) circulate papers to the rest of the committee in advance of the joint working group meetings; and

5) report back the findings to HOSC at a future date.

17. PATIENT TRANSPORT SERVICE

17.1. The Committee considered a report which provided a further update on the performance of the Patient Transport Service (PTS) in Sussex.

17.2. Wendy Carberry, Chief Officer; Alan Beasley, Chief Finance Officer; and Sally Smith, Director of Delivery, attended on behalf of High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG). Michael Clayton, Chief Executive, attended on behalf of Coperforma.

Accuracy of PTS data

17.3. HOSC asked what the PTS data anomalies were; why there was a mismatch between the large improvements in the data and the continued negative anecdotes HOSC members have been receiving; how occasions when no ambulance arrived for a booked journey were recorded; and to what extent HWLH CCG trusted the data it received.

17.4. Michael Clayton said that all journeys which do not meet the standards agreed in the service level agreement are recorded by Coperforma as 'service exceptions'. They are then categorised on their severity and investigated accordingly – the categories are critical, high, medium or low. Medium or low exceptions are dealt with together whereas each high or critical level exception – for example, a vehicle not arriving at all – is investigated individually. The continuous improvement team works together with the operations team to record and resolve the service exceptions.

17.5. Alan Beasley confirmed that Coperforma is providing the data as requested by the CCG. The data is of a good quality but it requires further analysis, which is being undertaken by the specialist Patient Transport Advisor who has now been recruited by the CCG. The Patient Transport Advisor had identified data anomalies and is working with Coperforma to understand whether the anomalies represent issues with the service or faulty recording methods. These findings will be fed into the CCG's contractual discussions with Coperforma.

17.6. Wendy Carberry added that the PTS contract specifies exactly what information the providers must provide to CCGs, rather than this being determined by the provider. One of the performance notices issued to Coperforma was around the data being provided. The CCG also triangulates Coperforma data with other sources, such as feedback from Trusts, in order to gain assurance about its accuracy.

17.7. Alan Beasley said that HWLH CCG had not seen any evidence from the data that if one patient's pick-up slot is missed they are then de-prioritised in favour of a different patient on the grounds that the target had already been missed.

Complaints about PTS

17.8. HOSC asked how the CCGs are recording and addressing complaints about the PTS.

17.9. Sally Smith said that reports from patients about delays to their patient transport appointments are classed in the CCG's complaints process as 'incidents'. CCGs analyse the complaints through their Patient Safety Groups –whose remit is to investigate incidents and complaints. All acute trusts and other healthcare providers have an incident reporting process and any complaints about the PTS made to them are shared with Coperforma. HWLH CCG also holds a monthly forum with the patient transport leads of all acute trusts that use the PTS service to consider the number and nature of the complaints; whether there are trends; and how the acute trusts feel about the impact on the patients in their units and hospitals. Sally Smith said that the number of incidents has gone down and patients are generally reporting that the service improvement is being maintained.

Future procurement processes

17.10. HOSC asked HWLH CCG what lessons had been learnt from the PTS procurement which could be applied to similar future commissioning processes.

17.11. Alan Beasley said that the two key lessons for any future procurement process were:

- ensure that the commissioner has access to specialist advice from a provider perspective as well as on the commissioning side.

- when there is a change in both service provider and service delivery model, the service change should be implemented in phases to reduce the risk to the service.

Recognising impact on patients

17.12. HOSC asked whether the CCG recognised the stress the failures in service had caused patients.

17.13. Sally Smith said that although the ongoing investigation led by a GP had not identified any physical harm, HWLH CCG fully recognised the stress the quality of the service had caused patients.

Training requirements for subcontractors

17.14. HOSC asked what training is required of subcontractor staff, and how standards are monitored.

17.15. Sally Smith said that HWLH CCG has written into the PTS contract that Coperforma, as managed service provider, must fulfil certain training obligations. Michael Clayton confirmed that all subcontractors go through a training programme and they are assessed before the contract goes live, and assessed via random spot reviews after the service has commenced. The outcomes of service exception reports are also fed back to the relevant subcontractors, and performance data is reviewed with all subcontractors on a monthly basis. Michael Clayton confirmed that two subcontractors had contracts terminated since April (out of 22).

17.16. Sally Smith said that the CCG's monitoring arrangements require Coperforma to provide evidence that its subcontractors are registered with CQC and Monitor; quality and safety checks have been performed on the vehicles; and training records of staff are available. HWLH CGG's Patient Transport Advisor will also visit Coperforma and its subcontractors to corroborate this evidence.

ICT system used by Coperforma

17.17. HOSC asked whether the ICT system used by Coperforma was fit for purpose.

17.18. Michael Clayton said that there were no concerns about the ICT system and he was confident that it provided all of the information that is needed in a suitable format for both Coperforma's operations team and its commissioners. Sally Smith added that HWLH CCG's Patient Transport Advisor will check whether the ICT system is fit for purpose when he visits Coperforma's operations team.

Reason for continued delays

17.19. HOSC asked why vehicles continue not to arrive on time.

17.20. Michael Clayton said that there are a large number of reasons for vehicles running late, for example, heavy traffic, breakdowns, weather or staff sickness. He said that these are underlying issues with patient transport and would occur regardless of whether the service is provided in house or by subcontractors.

17.21. Michael Clayton said that any provider should track each and every incident and be diligent about identifying the route cause. He said Coperforma had recorded each incident of lateness as a service exception and analyse it to discern whether there are lessons that can be learned which had led to service improvements.

Contingency plans

17.22. HOSC asked what contingency plans were in place in the event of another major issue such as the loss of a subcontractor, or the failure of the overall contract.

17.23. Wendy Carberry said that HWLH CCG had put in place contingency plans for a number of scenarios including if the service were to cease immediately, or if a single subcontractor failed. These plans are built around the way the service was delivered previously and HWLH CCG has had discussions with transport providers to make sure that arrangements can be put in place.

17.24. Michael Clayton added that Coperforma had planned to have surplus capacity in the first year of the contract as a contingency and this had made it possible to absorb some of the issues that have emerged since the contract started, for example the loss of two subcontractors. However, not all reasons for lateness can be resolved by having surplus capacity.

Scheduling of travel times

17.25. HOSC asked whether the travel times allowed for vehicles to reach patients was causing problems with performance, and whether sending vehicles to patients closer to them would improve travel times.

17.26. Michael Clayton agreed that scheduling was a key aspect of the PTS. When the contract was set up, Coperforma estimated the average journey time based on road information provided by third party sources. As part of the process, when a service exception is caused by a vehicle arriving late, Coperforma reviews its proposed journey time and compares it to the actual time it took. After three months of the service being in operation the original estimates now appear to have been optimistic, particularly around the coastal area. As a result, most of the estimated journey times built into the software used by Coperforma have been increased by nearly 60%, allowing drivers longer to reach their pick-up point. The settings in the system can also be changed to account for potential bad weather to allow more precise scheduling.

Procurement process

17.27. HOSC asked a number of questions about the procurement process, the additional costs of the contract to the CCGs, and whether Coperforma was willing to pay for patients who have missed appoints to see a consultant privately.

17.28. Alan Beasley noted that the procurement process had been subject to an independent report and it had been discussed at HOSC previously. He reiterated that the previous contract had come to a natural end so it was not the case that a decision was made proactively to outsource the contract.

17.29. Alan Beasley said that HWLH CCG agreed a fixed cost envelope as part of the contract but some additional costs have been incurred for management, oversight and scrutiny of the contract, for example, for the independent investigation into the procurement process.

17.30. Michael Clayton said he would look into whether it is feasible to pay for private consultants. He said that Coperforma has paid considerable sums to reimburse patients who have had to make their own travel arrangements. Alan Beasley said that HWLH CGG agreed a programme budget with Coperforma that included an agreement that Coperforma would reimburse additional transport costs incurred by healthcare trusts as a result of the PTS performance issues.

Contract specification

17.31. HOSC asked what weighting was given to performance during the procurement process; and whether the CCGs believe that the budget was enough, or the service provided was as good as could be expected within the financial envelope.

17.32. Alan Beasley said that the ratification report has been published in full and that describes the weighting and scoring system: finance was 20% of the overall score and 80% was issues around service quality, clinical safety etc. The report also says that no potential provider chose not to submit a tender due to the financial envelope.

17.33. He reiterated that the financial envelope for the new PTS contract was the same as the previous contract, but there was an expectation that increased demand for PTS services over the period of the contract would be absorbed by the new provider by making efficiencies. The

contract did not allow the provider to deliver this efficiency by increasing the eligibility criteria for patients to receive patient transport.

17.34. Alan Beasley accepted that the increased demand for a service with the same budget amounted to a reduced expense by the CCGs for each person using the service. He explained that there was an inbuilt 2% efficiency in all new NHS contracts and this would be the same for any other contract.

Contract management

17.35. HOSC asked what the level of failure would need to be for the contract to be terminated.

17.36. Wendy Carberry said the NHS contract encourages the CCG and provider to work together to try and make the service work for the local population. CCGs do not want to change service providers as it has an impact on patients, but HWLH CCG is using all levers within the contact, for example, it has served some contract performance notices and a breach notice on Coperforma.

17.37. Wendy Carberry said that the Key Performance Indicators (KPIs) in the contract are not set at 100%, so even if Coperforma meets all targets, there will still be some people who do not receive the service that the CCGs want; this is similar to the 95% target for A&E waiting times.

17.38. Wendy Carberry said that the feedback from a visit by HWLH CCG to patients and staff at the renal unit in Crawley was that the service was getting better and was comparable to the service offered to patients from Surrey by a different provider.

Coperforma shareholder

17.39. HOSC asked for comment on the Chair of Coperforma's position as a shareholder in a British Virgin Islands company.

17.40. Michael Clayton confirmed that the Chairman is an international investor who invests in hospital groups in China, USA and UK and that his details are on the Coperforma website.

Payment of Docklands Medical Services employees

17.41. HOSC asked for confirmation of when Docklands Medical Services employees will be paid.

17.42. Alan Beasley said that the matter was being treated by HWLH CCG with the utmost urgency. The CCG had funds available to make the payments but the payroll was being processed independently and it was the receipt of payroll information that would determine when staff were paid. Alan Beasley said he was working directly with the unions GMB and Unison who are collating the payroll information and engaging with the payroll provider.

Effect on emergency ambulance services

17.43. HOSC asked whether there had been an impact from the PTS issues on emergency ambulance services provided by South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

17.44. Wendy Carberry said that she had not had any communication from SECAmb to say that there had been any effect.

17.45. The Committee RESOLVED to:

1) Request that Coperforma provide the number of critical incidents where no transport has arrived for a booked journey.

2) Request that HWLH CCG provide figures for the number of incidents being investigated as safeguarding concerns

3) Request that HWLH CCG provide comparative figures for the number of service users before and after the new PTS contract.

4) Request a further update on PTS at the 1 December 2016 HOSC meeting.

18. SUSSEX STROKE REVIEW

18.1. The Committee considered a report which provided an update on the Sussex Stroke Review, specifically relating to services provided by Brighton and Sussex University Hospitals NHS Trust (BSUH) to residents in central Sussex.

18.2. The report was introduced by Dr Peter Birtles, Urgent Care Clinical Lead, and Ashley Scarff, Director of Strategy, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG).

Viability of other options

18.3. HOSC asked whether the preferred option to develop a fully compliant Hyper Acute Stroke Unit (HASU) with a co-located acute stroke unit (ASU) at Royal Sussex County Hospital (RSCH) was the only viable option and whether, as an alternative, it would possible to have a service where patients are stabilised locally before being transferred to a HASU.

18.4. Dr Peter Birtles said that all options were considered in significant detail but, taking into account a number of factors, the option being put forward was strongly favoured by clinicians because:

- centralising stroke units provided better outcomes as evidence suggests that, even if the journey time is 10-15 minutes longer, travelling to a properly resourced HASU is likely to result in a better outcome. Although the NICE guidelines recommend treatment of a stroke patient within an hour, in terms of actual outcomes the evidence suggests it is not as time critical as that;

- option 4 (the preferred option) would ensure that there was a stroke service caring for more than the 600 patients per year, which is the minimum number required to be able to gather sufficient clinical expertise to ensure that people have the best outcomes;

- interventional radiology is increasingly used for treatment of strokes and RSCH has a new radiology unit under development;

- neuro-surgeons need to be on site, and they are located only at RSCH where the intensive care unit is located – this cannot be located at two sites;

- guidance says that the HASU should be co-located with a major trauma site like the one being built at RSCH;

- only 50 HWLH CCG patients a year previously using the ASU at Princess Royal Hospital (PRH) would need to travel further. Patients in the east will generally go to Eastbourne District General Hospital and patients in the north will travel to Pembury Hospital.

Consideration of West Sussex stroke service proposals

18.5. HOSC asked how the proposed HASU at RSCH would align with services provided by Western Sussex Hospitals NHS Foundation Trust (WSHFT).

18.6. Ashley Scarff assured HOSC that HWLH CCG was working with colleagues in West Sussex CCGs and any future configuration of stroke services at WSHFT would not impact on the proposal for BSUH. However, the timing of the implementation of any WSHFT changes may be impacted.

18.7. Dr Peter Birtles said that having a single stroke site at RSCH would mean that no matter what configuration is chosen in West Sussex, RSCH will have above the minimum threshold of patients. However, it is only if the West Sussex HASU was to be located at Worthing Hospital that a HASU at PRH would be viable in terms of numbers of patients.

Capacity at RSCH

18.8. HOSC asked whether, in light of BSUH's Care Quality Commission (CQC) report which raised concerns about the capacity of the RSCH site, it was feasible to set up a HASU there.

18.9. Dr Peter Birtles said HWLH CCG considers the ongoing situation at BSUH at its monthly quality meetings. He said that most of the major problems at RSCH relate to its A&E Department and in a fully functioning stroke service patients would bypass A&E and be admitted directly to the HASU.

18.10. The Committee RESOLVED to:

1) note the report and its appendix;

2) agree that the change proposed is considered a 'substantial development or variation to services' requiring formal consultation with HOSC;

3) agree that a proportionate public consultation on this proposed change should be targeted at the areas particularly affected and on groups with special knowledge and interest in the issue; and

4) request that a report be circulated by email on the current performance of the stroke services provided by East Sussex Healthcare NHS Trust.

18.11. Cllr Mike Turner abstained from voting on whether the change proposed was a substantial development or variation to services.

19. <u>EAST SUSSEX HEALTHCARE NHS TRUST (ESHT) QUALITY IMPROVEMENT PLAN (QIP) - MATERNITY SERVICES</u>

19.1. The Committee considered a report which provided an update on the work undertaken to develop maternity services as part of East Sussex Healthcare NHS Trust's (ESHT) Quality Improvement Plan (QIP) and the current performance of the services.

19.2. The report was introduced by Dr Adrian Bull, Chief Executive, and Catherine O'Callaghan, Service Manager for Maternity, ESHT.

19.3. Dr Adrian Bull apologised for some incorrect figures supplied in the Births Before Arrival (BBA) statistics and agreed to provide the amended figures.

Number of transfers

19.4. HOSC asked whether 40% of patients having to be transferred from the Midwifery Led Unit (MLU) at Eastbourne District General Hospital (EDGH) to the obstetric unit at the Conquest Hospital was too high.

19.5. Dr Adrian Bull clarified that the 40% referred to those women transferred from the MLU who are having their first baby. Of the 320 women who started their birth at the MLU 62 were transferred, which is closer to 20%, and less than 10% of women having a second or third baby needed to be transferred. Of those 62 who did transfer, 52 transferred before they had gone into full labour, and the other 10 transferred in second stage labour after having been individually reviewed. These 10 women then spent considerable time at the Conquest Hospital before delivery or caesarean section.

19.6. Dr Bull said transferring patients is a managed and controlled process and the likelihood of transfer to the obstetric unit is part of the discussion clinicians have with women during the antenatal period. They will also be aware that when choosing to have their first baby at the MLU there is a reasonable chance they may be transferred to the obstetric unit.

Configuration of services

19.7. HOSC asked how many additional births would be necessary to support two viable consultant –led services in East Sussex; and whether a minimal consultant-led service could be returned to EDGH.

19.8. Dr Adrian Bull said the total number of births across both sites is 3,300 per year and the recommended minimum number for a single sustainable obstetrics unit is 2,500. Dr Bull said ESHT has agreed that it will continue to look at whether circumstances are changing and whether this means that there is a case for service reconfiguration.

19.9. Dr Adrian Bull disagreed that a minimal consultant-led service could be provided safely at EDGH as the low number of births would only support a part-time consultant service. One of the biggest risks to patients is to blur the lines between a MLU and an obstetric unit by having a part time consultant presence. This is because a MLU monitors emerging risks more closely than in an obstetric unit.

19.10. Dr Bull said that under the current maternity configuration, if an emergency transfer for a caesarean had to be made then it would indicate that the risk management protocols put in place at the MLU had gone badly wrong, and this has not happened over the past three years. He said that the MLU is an excellent option for women and those who go there have less need for intervention.

19.11. Amanda Philpott, Chief Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Clinical Commissioning Group (HR CCG), said that the Better Beginnings maternity and paediatric reconfiguration was undertaken on the grounds of the quality and safety of services. The population projections carried out at the time went forward 20 years and estimated a 5% increase in the number of births; there would need to be a 40% increase to make two consultant-led sites viable. The current number of births, the current advice around safety, and difficulty in recruitment and retention of staff remain the same as they were at the time of the decision, and it would not be reversed whilst these circumstances persist.

19.12. Amanda Philpott added that the CCGs' remit is to keep services safe, high quality and, where possible, locally accessible. Consequently, the CCGs will always keep the number of births under review, as well as the advice and guidance about best practice for obstetric units.

Criteria for transfer

19.13. HOSC asked whether ESHT should review its criteria for transferring first time mothers to the obstetrics unit during the second stage of labour.

19.14. Dr Adrian Bull agreed about the need to review the criteria for the transfer of first time mothers and said that HOSC's comments would be fed in to that process.

19.15. Catherine O'Callaghan disagreed that second stage transfer decisions were bad midwifery practice. She said that the midwives at the MLU were highly trained and experienced; they make decisions throughout the labour process about whether a transfer is necessary using their clinical knowledge and judgement, including when issues arise during the second stage of labour.

19.16. Dr Adrian Bull clarified that transfers from the MLU to the obstetrics unit are managed transfers made in a controlled way for women who have been assessed as having a requirement for consultant input or the administration of additional pain relief; they were not emergency, last minute transfers.

Number of births at MLU

19.17. HOSC questioned whether the MLU was fully operational if only just over 300 births were taking place and the capital funding for improvements was not yet in place; and what was being done to improve the number of births.

19.18. Dr Adrian Bull agreed that there is potential to increase the number of births and suggested that the low birth rate was due to a perception in Eastbourne that all maternity services transferred to the Conquest Hospital following the Better Beginnings consultation; as well as a lack of the same level of local support and promotion of the MLU as the Crowborough Birthing Unit enjoys. He added that it was generally not understood that there was still a full obstetric led postnatal unit at EDGH and that women who delivered at Conquest Hospital could transfer back here for postnatal care if it is more local for them.

19.19. Dr Bull said that there are more than enough women who are eligible to give birth at the MLU to sustain the unit. ESHT is determined to change the perceptions which are discouraging women to use the service. He agreed that the number of births at the MLU should be included as one of the 'indicators of success' for the service.

19.20. Catherine O'Callaghan said that there is a working party from the MLU that is working with the Maternity Services Liaison Committee, patients, and staff to promote the MLU generally, which will help to increase the number of births.

Classification of BBAs

19.21. HOSC asked for clarification about the difference between an avoidable and unavoidable BBA.

19.22. Catherine O'Callaghan said that an avoidable BBA is where incorrect clinical triage advice is given over the phone to a woman, for example, being inappropriately told not to come to the MLU or obstetric unit. Most BBAs are classed as unavoidable and sometimes relate to women who had not attended antenatal care or booked with the Trust to deliver their baby. The 61 BBAs in 2015/16 will be reviewed to discover the reasons for them and whether there are any lessons to be learned, for example, asking community midwives to encourage women

during their antenatal period to book their delivery, or provide them with advice on accessing services sooner. Dr Bull said that ESHT was not a national outlier in terms of BBAs.

19.23. The Committee RESOLVED to:

1) Request revised BBA and 'transfer of women in labour' statistics taking into consideration the difference in transfer rates for mothers giving birth for the first time, comparative figure to the national rate, and if possible the percentage of BBAs that took place during transport;

2) Request further information about the impact of the reconfiguration – specific questions to be agreed by the Committee outside of the meeting.

20. HOSC FUTURE WORK PROGRAMME

20.1 The Committee RESOLVED to note their work programme.

The meeting ended at 1.20 pm.

Councillor Colin Belsey
Chair