HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 29 March 2018

PRESENT:

Councillors Colin Belsey (Chair), Councillors Phil Boorman, Angharad Davies, Ruth O'Keeffe, Sarah Osborne and Andy Smith (all East Sussex County Council); Councillors Barnes (Rother District Council), Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Susan Murray (Lewes District Council), Geraldine Des Moulins (SpeakUp) and Jennifer Twist (SpeakUp)

WITNESSES:

Councillor Robert Smart, Eastbourne Borough Council
Peter Finnis, Assistant Director Corporate Governance/Monitoring officer, Eastbourne Borough Council
Sarah Blanchard-Stow, Head of Midwifery, East Sussex Healthcare NHS Trust
Vikki Carruth, Director of Nursing, East Sussex Healthcare NHS Trust
Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens CCG
Dr Peter Birtles, Urgent Care Clinical Lead, High Weald Lewes Havens CCG
Sally Smith, Director of Delivery, High Weald Lewes Havens CCG
Dr David Warden, Chair, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Amanda Philpott, Chief Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Jessica Britton, Chief Operating Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Mark Angus, Urgent Care System Improvement Director, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

24. MINUTES OF THE MEETING HELD ON 30 NOVEMBER 2017

24.1 The minutes of the meeting held on 30 November 2017 were agreed.

25. APOLOGIES FOR ABSENCE

25.1 Apologies for absence were received from Cllr Bob Bowdler (substitute: Cllr Martin Clarke) and Cllr Johanna Howell (substitute: Cllr Jo Bentley).

26. DISCLOSURES OF INTERESTS

26.1 There were no apologies for absence.

27. URGENT ITEMS

27.1 There were no urgent items.

28. GP ACCESS

28.1. The Committee considered a report on the state of access to GP practices in East Sussex.

28.2. Dr David Warden, Chair, Hastings and Rother Clinical Commissioning Group (HR CCG); Amanda Philpott, Chief Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and HR CCG; Jessica Britton, Chief Operating Officer, EHS CCG/HR CCG; Ashley Scarff, Director of Commissioning/Deputy Chief Officer, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG) Dr Peter Birtles, HWLH CCG; and Sally Smith, Director of Primary Care and Integration, HWLH CCG responded to questions from HOSC.

Extent of GP vacancies

28.3. Amanda Philpott explained that the greatest number and highest proportion of GP vacancies are in the HR CCG area, where there are currently 16 vacancies out of 97 GP positions. In the EHS CCG area the vacancy rate is 11 out of 120. Sally Smith said that the greatest number of vacancies in the HWLH CCG area are in Newhaven and Peacehaven, but recent vacancies have arisen in Rotherfield, Crowborough, and Wadhurst.

Work to support individual GPs

28.4. Amanda Philpott explained that newly qualified GPs are increasingly looking for a 'portfolio career' where working as a GP forms part of a wider clinical role. To accommodate this new working practice and to tackle GP shortages CCGs in the East Sussex Better Together (ESBT) area have implemented the following initiatives:

- A GP portfolio fellowship scheme that allows junior doctors to work in a GP practice for 2-3 days alongside working, for example, in an acute hospital or within mental health services. This improves the variety of a GP's working week and improves the spread of knowledge between primary and secondary care.

- The availability of a GP bursary scheme for new GPs;

- The employment of physician associates to reduce the administrative burden on GPs; and

- The option for part-time, flexible mentoring work for older GPs who are otherwise planning to retire.

Amanda Philpott confirmed that work to support GPs had all begun to be put into practice and was either in a pilot stage, or in the process of being rolled out across the ESBT area.

Work to support GP practices

28.5. Amanda Philpott and Dr David Warden outlined some of the initiatives established by the ESBT CCGs to help GP practices, including:

- supporting the GP Federation to run a GP locum bank that administers requests for locum GPs centrally that would otherwise be made by individual GPs.

- Encouraging pharmacists in the ESBT area to work with networks of 3-4 GP practices, or be employed directly by a GP practice. Pharmacists perform medication reviews of patients in consultation with the GPs and perform care home visits. Most practices that have used pharmacists have achieved considerable savings in their prescribing budget.

28.6. Sally Smith outlined the initiatives established by HWLH CCG to help GP practices, including:

- The Enhanced Help in Care Homes team, which is a GP-led multi-disciplinary team (including a pharmacist) that supports patients in care homes and nursing homes. The team was established in November 2017 to cover five nursing homes and will cover all nursing homes in the High Weald Lewes Havens area by the end of March 2018.

- The Integrated Pharmacy Teams that work across several GP practices to improve their standard of prescribing. These teams have been in operation for the last 2 years in the Havens area and were rolled out to the Lewes, Uckfield and Crowborough areas during the last six months.

- A community-based Frailty Service comprising 1.5 FTE consultant geriatricians and frailty nurses. The initial service has been in place for two years but in the last year the capacity has been increased.

Workforce Plan

28.7. Amanda Philpott acknowledged that staff applying for jobs within the local system that they find more attractive and the fact that there are more specialist consultant trainees than GP trainees entering the system are both workforce issues. Ms Philpott explained that ESBT organisations have produced a Workforce Plan to help co-ordinate and plan the best use of available nursing and clinical staff.

Clinical Governance in GP Practices for non-GP staff

28.8. Dr David Warden explained that strong clinical governance for non-GP staff should be in place for each GP practice in the ESBT area. He said that advanced nurse practitioners and paramedic practitioners have professional indemnity insurance and will perform clinical work that is within their own skill level. Amanda Philpott added that each practice has had a Care Quality Commission (CQC) inspection, and the CCGs' Chief Nurse, alongside other team members, performs 'quality visits' to support practices.

28.9. Dr Warden clarified that whether clinical pharmacists can prescribe medicine to patients or not depends on their license, which is not issued by the CCGs.

New housing developments

28.10. Amanda Philpott explained that housing developments include section 106 monies that the developer provides to improve local services. CCGs can make a bid for section 106 funding for additional GP practices, or GP capacity in existing practices, if they are made aware of proposed housing developments sufficiently in advance, and the housing development is of sufficient size that a new practice would be necessary to accommodate the additional residents. She said that for this reason the CCGs' Capital and Estates Team works with planning authorities to ensure that they proactively inform the CCGs of any proposed developments. Ms. Philpott cautioned that S.106 funding is also sought by other public organisations and there needs to be sufficient workforce available to be able to recruit to any new facilities.

28.11. Amanda Philpott confirmed that the proposed new Hailsham Health Centre and the Beaconsfield practice in Hastings are two of 16 potential practice developments within the ESBT

area. The construction of these facilities are contingent on other factors such as planning permission and capital funds, but there is a CCG officer focussed on capital works whose role is to ensure that the developments are supported as much as possible.

28.12. Ashley Scarff explained that local authority housing teams inform HWLH CCG through their involvement in the Connecting 4 You programme of the demographics of people who may be moving in to new developments, i.e., younger or more elderly people, which helps to determine the necessity for new GP practices, as demand is based partly on age.

Effect of Brexit

28.13. Amanda Philpott said that Brexit is a factor in the workforce recruitment difficulties facing the NHS locally, albeit one whose long term implications remain unknown until the terms of negotiations with the EU become clear. She explained that a significant percentage of the workforce in East Sussex – like the rest of the country – comes from Europe and many are taking the decision to leave early, or not come in the first place. Dr Peter Birtles added that the whole health and care system is going to be effected by Brexit, in particular the nursing and care home sector. He said this will have a knock-on effect on the willingness of trainees to specialise as GPs.

28.14. Despite the uncertainties, Amanda Philpott said that the CCGs in East Sussex are preparing for Brexit by supporting the ongoing work of the Chief Executive of NHS England, Simon Stevens, to secure the 'special status' of NHS workforce post-Brexit. She said that the actions the CCGs can take directly are to retain the existing GP workforce and make the role more attractive, which is what they have been working on doing.

GP Federations

28.15. Amanda Philpott explained that GP federations are voluntary and comprise GP practices that wish to become more resilient to crises by joining together. She said that there are currently four GP federations in ESBT but this could reduce to one or two in the future if they come together. She added that the introduction of Extended Hours will increase the likelihood of GP practices federating because the requirement to provide extended hours is based on localities and not individual GP Practices, so by federating GP practices can share the responsibility for providing the quota of extended hours.

28.16. Dr Peter Birtles reminded HOSC that GP Practices are independent contractors whose contracts are held by NHS England and that GP federations are legally binding arrangements between individual GP practices. Guidelines call for CCGs to support federating but ultimately the decision is with individual practices themselves. Within the HWLH area there is not much appetite for federations, however, they are only one way of working co-operatively to improve sustainability, for example, the Lewes GP Practices have come together to form the Lewes Health Hub.

28.17. Dr Birtles explained that the development of federations and other joint GP working has developed more slowly amongst GP practices in the HWLH area as the area has only been affected by GP shortages in the last year or so. Elsewhere in the country there have been shortages for much longer, so GP practices have had to band together earlier in order to increase resilience.

Responding to GP practice closures

28.18. Amanda Philpott explained that NHS England provides best practice advice to CCGs on responding to the closure of a GP practice. She said that GP practices are funded on head count, so the money that would have gone to Cornwallis Plaza practice in Hastings will be redistributed to other practices that took its patients. The only additional funding is a small

amount of transitional funding to provide capacity to those practices that take on a large tranche of patients in a short timescale to review patients' medical records, as well as undertake medication reviews and referral reviews for certain patients.

Monitoring potential practice closures

28.19. Amanda Philpott explained that there are always going to be vulnerable GP practices; not always because they are financially challenged but sometimes a GP has become unwell, or the practice is small and the GP is planning to retire. She said that CCGs always attempt to stay aware of the health of the GP practices in their areas and offer support where appropriate, for example, supporting GP practices with action plans to improve their standards where the CQC has inspected them and recommended that they make improvements.

Support for patients after a GP closure

28.20. Jessica Britton said that the ESBT CCGs are confident that they do all they can reasonably do to contact vulnerable patients in the event of a practice closure. In the case of Cornwallis Plaza, HR CCG identified all patients flagged as 'vulnerable' by the former GP practice and specific actions were put in place to ensure that all, as far as possible, were contacted and re-registered. This included direct contact from someone in the CCGs' team to assist them with the process of registering.

28.21. Amanda Philpott explained that there are some patients with out of date information who would be uncontactable following a GP closure, although this amount is very small. In the case of Cornwallis Plaza it totalled about 50-80 out of 17,000 patients.

28.22. Sally Smith said that there have been two closures in Peacehaven in the last four years, and in both cases a list dispersal process was undertaken by HWLH CCG in line with NHS England's published process. Ms Smith said that GP practice boundaries tend to overlap, so there is an element of patient choice in which practice they can opt for and an appeals process that can be followed if needs be. She added that Practice Participation Groups assist with communicating with vulnerable patients, as can other NHS or care organisations that may be in contact with these patients.

Armed forces personnel recruitment into health and social care

28.23. Amanda Philpott explained that HR CCG hosts the Armed Forces Network for the Kent, Surrey and Sussex area. The purpose of the Network is to ensure that a) armed forces personnel and their families receive rapid, priority access to appropriate health and care services; and b) provide appropriate job opportunities to people leaving the armed forces within the health and care sector. East Sussex is currently rated 'silver' for job opportunities and is working towards 'gold'.

The use of digital technology in GP practices

28.24. Sally Smith confirmed that HWLH CCG has not received any complaints from the public about the patient administration systems used by GP practices. Amanda Philpott said that there has been a lot of positive feedback from patients in the ESBT area about text reminders, particularly in relation to the reminder to request a repeat prescription, which is a common reason for contacting the Out Of Hours (OOH) team.

28.25. Sally Smith said that issues with digital technology tend to arise where GPs are using different systems for the same purpose, for example, the 20 GP practices in the HWLH area are using two different the systems – EMIS Web and System One – to administer patient records. To help mitigate this issue the CCG is providing ICT and digital assistance to GP practices. She

confirmed that the three GP Practices comprising the Lewes Health Hub are using the same system to share patient records.

28.26. Dr David Warden said that digital technology has benefited GP practices by:

- Significantly reducing the number of missed GP practice appointments, particularly nurse practitioner appointments.

- Ensuring consistent templates are used by GPs to record patient data into a central system. All GP practices in the ESBT area use EMIS-Web and there is a central ICT team that designs the template.

- Allowing GP practices in GP Federations to match demand from patients in one locality with available timeslots in another locality of the federation.

- Allowing GPs to access patient records remotely through an iPad. GPs having remote access to clinical information makes a significant difference to decision making and caring for patients outside the GP practice.

28.27. Amanda Philpott explained that the NHS Locally Commissioned Schemes provide individual CCGs with the opportunity to specifically commission a particular digital technology for a GP practice if it is beneficial to do so.

28.28. Dr David Warden said that it would be a potential breach of data protection if a GP practice contacted a carer via text on an ad hoc basis and GP practices would not do this. However, it is possible to text the carer when it has been recorded that an individual has given them permission to do so.

28.29. Amanda Philpott explained that online consultations are undertaken by an individual and are not automated. She said that Skype consultations are carried out by a GP as part of their core business as an alternative to a patient vising their practice; they are based on patient choice and used when appropriate.

Access for people not using digital technology

28.30. Sally Smith explained that the purpose of digital technology is to increase the range of methods people can use to book their GP appointments, and people would still be able to access services using conventional methods such as the telephone. She added that the CCGs, in conjunction with the CQC, monitor and support GP practices with their response times to telephone calls and other methods patients use to contact them.

Physical Access to GP Practices

28.31. Dr Peter Birtles explained that CQC inspections take into account physical access to GP practices. Sally Smith added that the HWLH CCG Estates Strategy includes a survey of the condition, accessibility, and lease arrangements of the 20 GP practices in the area. Ms Smith said that some GP practices might not meet the requirements of the Disability Discrimination Act, but the CCG is working continually with them to identify opportunities to improve the premises or move to new ones.

28.32. Ms Smith said that NHS England provides minor improvement grants that GP practices can apply for. There is also a national Estates and Technology Fund that HWLH CCG has submitted a bid for on behalf of its GP practices – as have the ESBT CCGs. This fund will support the move of the three GP practices in Lewes to the new building in the North Quarter development.

General Data Protection Regulations (GDPR)

28.33. Dr David Warden confirmed that GP practices in the ESBT area have undergone considerable training in preparation for the introduction of the new GDPR. Sally Smith said that the HWLH area GP Practices are also prepared for GDPR because protecting and safeguarding individual patients' records is an area that they take very seriously.

28.34. The Committee RESOLVED to:

1) Note the report;

2) request to be provided with further details of the CCGs' approach to workforce planning in primary care in relation to the impact of Brexit;

3) request a briefing on the use of digital technologies such as Skype, including the timelines for roll out, and what is done to ensure patients with disabilities can use the technology.

29. EAST SUSSEX BETTER TOGETHER URGENT CARE REDESIGN

29.1. The Committee considered a report providing an update on the redesign of the urgent care system as part of the ESBT programme, with a focus on the development of Urgent Treatment Centres (UTCs).

29.2. Mark Angus, Urgent Care System Improvement Director, EHS/HR CCG; Jessica Britton, Chief Operating Officer, EHS/HR CCG; and Ashley Scarff, Director of Commissioning/Deputy Chief Officer, HWLH CCG responded to questions from HOSC.

Capital requirements

29.3. Mark Angus explained that during 2017/18 £1.7m was invested in the A&E Departments at both East Sussex Healthcare NHS Trust (ESHT) hospital sites to create the Primary Care Streaming Services. He said that he believed the capital works were completed effectively and with little disruption to the A&E Department.

29.4. Mark Angus said that the Primary Care Streaming Services have been assessed and it has been agreed that the Conquest Hospital site can provide a UTC in its current configuration, however, the Eastbourne District General Hospital (EDGH), whilst able to support a UTC, requires some additional capital investment to optimally provide the service. Mr Angus said that the CCGs are in the process of sourcing the capital funds and are confident that the necessary works can be completed by the 1 April 2019 deadline.

Procurement process

29.5. Mark Angus confirmed that the decision about the UTC procurement process will now be formally considered by the CCGs' Procurement Committee in May.

Patient access to the UTC

29.6. Mark Angus explained that the UTC will include a bookable service. In order to book an appointment to the UTC, patients will be triaged by their GP, ambulance service, or the NHS

111 Clinical Assessment Service. He said that walk-in patients will use the triaging system established for the Primary Care Streaming Service, which is led by fully trained senior nurses who can call on the support of doctors and consultants if necessary.

Reason for co-location of UTCs

29.7. Mark Angus said that the decision to develop co-located UTC was informed by what local people had said what was important to them when accessing urgent care services together with the outcome of engagement with local stakeholders and providers. The plans would provide 24/7 access to urgent care services, including access to a broad range of simple diagnostics where required and immediate access to co-located emergency and specialist acute assessment services for sick patients. Audit work undertaken indicates that approximately 20% of current attendees at the local A&Es would also benefit from primary care delivered services. The proposed UTC model addresses this need and should take pressure off of the A&E departments.

Risk of staffing shortages

29.8. Mark Angus agreed that the development of UTCs faces similar workforce challenges to the rest of the healthcare system, however, the UTCs should mitigate workforce challenges somewhat by providing existing services in a single location more efficiently and effectively. He said that feedback from staff suggests that the proposed model offers a better work-life balance.

Out of Hours GPs involvement in UTCs

29.9. Mark Angus explained that the current Out of Hours (OOH) GP service will be changing as part of the broader Urgent Care Redesign programme. The telephony and home visit aspect of the OOH will become part of NHS 111 and the face-to-face visit aspect that is currently based at the hospital sites will become part of the UTCs.

29.10. Mr Angus said that one of the benefits of this new service is that the current OOH GPs have manage the challenge of answering calls, seeing patients and responding to home visits, whereas the new delivery model will separate them into different and distinct services. The new urgent care model will also use a broader range of clinical staff to provide urgent care, such as primary care trained nurses, that will mitigate GP shortages by reducing the areas within the healthcare system where those skills are required.

Equality Impact Assessment and impact on vulnerable patients

29.11. Jessica Britton explained that, based on the CCGs' engagement to date, the majority of people who use the current walk-in centres would be able to use a walk-in service in a different location, or access the services they need in a different way. However, a small but important and vulnerable cohort – including homeless people, people with chaotic lifestyles, and people with mental health issues – who tend to prefer town centre facilities are more likely to be affected by the proposed change in location.

29.12. Ms Britton confirmed that the CCGs have and will be talking to people to understand how the changes might impact them and what the CCGs can do to ensure they are able to access the right services for them . . She said that whilst this vulnerable cohort may access current town centre services they may not be the best services for them, so the CCGs are also, for example, working with homeless groups to consider the best services to provide for this cohort.

29.13. Jessica Britton confirmed that the CCGs have undertaken a full Equality Impact Assessment (EqIA) that includes the impact of the relocation of walk-in centres on a range of individuals with protected characteristics and the plans to mitigate these impacts.

29.14. Ms Britton added that the development of the proposals has been guided somewhat by the fact that UTCs have nationally set specifications, although the ESBT proposals offer a slightly better specification due to the proposed location of the UTCs on hospital sites.

Consultation plans

29.15. Jessica Britton explained that the consultation information will be available online and in leaflets available at locations such as GP practices. The CCGs will also attend specific events to discuss the proposals – either forums that they are already members of, or specific focus groups of people likely to be affected assembled for the purpose of the consultation. She said the proposal is for the formal consultation to begin in May and last for 8 weeks.

UTC at Victoria Hospital in Lewes

29.16. Ashley Scarff explained that the proposed UTC at Victoria Hospital in Lewes will be fully compliant with the standards set out by NHS England, including that it is GP-led (by the Lewes Health Hub) and contains the prescribed facilities.

29.17. The Committee RESOLVED to:

1) note the report;

2) agree that the proposed relocation of the walk-in primary care service as part of the development of Urgent Treatment Centres in Eastbourne and Hastings constitutes a 'substantial development or variation' to services requiring consultation with the committee under health scrutiny legislation;

3) establish a Task Group comprising – Councillors Mrs Barnes, Belsey, Coles, Turner and Jennifer Twist – to consider the proposals in more detail and prepare a HOSC response for consideration by the committee in June; and

4) request a copy of the Equality Impact Assessment to be circulated by email.

30. MATERNITY SERVICES IN EAST SUSSEX

30.1. The Committee considered a report on the quality and performance of maternity services for East Sussex residents, including feedback from local women obtained from a survey undertaken by Eastbourne Borough Council.

30.2. Councillor Robert Smart, Eastbourne Borough Council; Peter Finnis, Assistant Director – Corporate Governance, Eastbourne Borough Council; Amanda Philpott, Chief Officer, EHS/HR CCG; Jessica Britton, Chief Operating Officer, EHS/HR CCG; Vikki Carruth, Director of Nursing, ESHT; and Sarah Blanchard-Stow, Head of Midwifery, ESHT were present for this item.

30.1. In addition to the written report submitted to HOSC by Eastbourne Borough Council, Cllr Robert Smart made the following additional points:

- The Eastbourne Borough Council survey is the most extensive of its kind and was sent to all mothers who gave birth in East Sussex during 2016, based on Office of National Statistics (ONS) data. The response rate was 35%.

- The survey provides evidence that 93% of mothers in the EHS CCG area who responded to the survey would wish to give birth at EDGH if there were a full obstetric service available.

- There should be an independent review to consider whether the ONS figures for stillbirths in Eastbourne are in any way correlated to the single siting of obstetrics services at Conquest Hospital, Hastings, and the related travel times.

- The extensive Netherlands study (of over 700,000 mothers) simply concludes that a travel time of over 20 minutes increases risk.

- The National Maternity and Perinatal Audit published in 2017 shows that maternity services are not performing as well as is set out in the CCGs' report.

- Any complete review of maternity services should look into its share of ESHT's reported clinical negligence liabilities of £80 million, with £13m being paid out. Nationally, maternity accounts for 50% of payouts, according to NHS Resolution, so this would amount to approximately £6.5m maternity payments.

30.2. A number of questions from HOSC were answered by witnesses.

Transfers during labour

30.3. Councillor Robert Smart said that a figure of 90 patients transferred during labour referred to the number of respondents to the survey who had been transferred to the Obstetric Unit at Conquest Hospital during labour. He said that 55 came from the EHS CCG area, 15 from the HR CCG area and 20 from the HWLH CCG area.

30.4. Peter Finnis observed that the survey findings indicated more Eastbourne mothers experienced transfer than the rest of the county put together and suggested that this was an inequality of service that is an ongoing concern to the Eastbourne community.

30.5. Sarah Blanchard-Stow said that the Midwife Led Unit (MLU) at Eastbourne District General Hospital (EDGH) is staffed solely by midwives. Normal, low risk labour can take place at the MLU, but if at any point there is a deviation from normality or the woman requests more pain relief then a transfer will take place. A lack of other MLUs in the local area makes comparisons of transfer rates difficult, but the figures are compared to those published by the Birthplace Study.

30.6. Ms Blanchard-Stow explained that there were 63 transfers from the MLU in 2017 on safety grounds. She said the outcomes for all patients who were transferred were followed up and none had an emergency caesarean section within an hour of arriving at the Conquest Hospital. This indicates that the decision was the correct one to have taken and none of those patients were put at risk by either using the MLU in the first place, or being transferred when it became necessary.

30.7. Jessica Britton said that there will always be a certain level of transfers from an MLU to an obstetric unit, as the decision to transfer is based on clinical need and national guidelines on when people should be transferred.

Definition of 'near miss'

30.8. Councillor Robert Smart said that he had no information available on the 150 near misses mentioned in the Eastbourne Borough Council presentation but suggested that such information was difficult to obtain from ESHT. Peter Finnis added that Eastbourne Borough

Council did not have enough information on near misses, serious incidents, or transfer times, which is why the report concluded that more work was needed to understand those issues.

30.9. Vikki Carruth said that the 150 near miss figure was not one that ESHT recognised. She said that such a figure would, however, indicate a good reporting culture and ESHT encourages all staff to report all near misses including those that are relatively minor.

Born Before Arrival (BBA)

30.10. Councillor Smart said he had not had time to review the additional Born Before Arrival (BBA) figures submitted by the CCGs after the publication of the agenda that indicated a higher BBA rate in Hastings.

30.11. Sarah Blanchard-Stow explained that BBAs refer to a birth before a midwife is in attendance and do not necessarily refer to hospital births as the mother may have intended to give birth at home, for example, the 20 BBAs in Eastbourne between January 2016 and December 2017 included 6 planned home births.

30.12. Ms Blanchard-Stow said that it is not always possible to reach a woman with a precipitate labour in time, however, each BBA case is reviewed to ensure that the correct pre-natal advice was given to the mother beforehand. The review records whether the BBA was avoidable or unavoidable, with any lessons learned taken on board where it was avoidable. Ms Blanchard-Stow confirmed that there were no adverse outcomes from any BBA in the previous year, and a midwife or ambulance crew attended each incident.

Stillbirths

30.13. Councillor Smart referred to the ONS statistics for 2016 stillbirths which reported eight for Eastbourne, which he suggested is close to double the national rate. He recognised that stillbirths were not necessarily reported as serious incidents but suggested that the public may consider it an oddity that there were reportedly eight stillbirths in Eastbourne in 2016 and only one had been deemed a serious incident. He added that part of the problem is that hospital trusts report their own serious incident figures and that the Secretary of State has suggested an independent review of stillbirths would be necessary in the future. He also raised concerns about the different still birth figures supplied by the CCGs compared to those provided by the ONS which are quoted in the Eastbourne Borough Council report.

30.14. Jessica Britton explained that the discrepancy in the stillbirth figures provided by Eastbourne Borough Council and the CCGs is due to how the NHS and ONS are required to report their data in different ways.

30.15. Sarah Blanchard-Stow confirmed that of the eight stillbirths being quoted for Eastbourne during 2016:

- two were classified as anomalies, one of which was a woman due to give birth at Maidstone and Tunbridge Wells NHS Trust who reported problems whilst on holiday in Eastbourne that were classified as ‘no foetal heartbeat’; the other was classified as an ‘intrapartum stillbirth’ that went through a vigorous serious incident process during which the midwife was referred to the Nursing and Midwifery Council (NMC);

- three were classified as ‘reduced foetal movements’, and

- three were classified as ‘abruptions’.

30.16. Ms Blanchard-Stow explained that reduced foetal movements and abruptions cannot be prepared for but ESHT has done considerable work to raise awareness amongst pregnant

women to monitor foetal movement; and the Trust is looking for links between communities with high rates of cocaine use and incidents of abruptions, due to the increased likelihood of cocaine use causing an abruption.

30.17. Ms Blanchard-Stow reiterated that ESHT's maternity service has not been an outlier in any national indicators, including stillbirths, for the past three years. Furthermore, the small numbers mean statistically it is difficult to compare year-on-year rates of stillbirths. However, ESHT has a stillbirth rate of 3.45 per 1,000 compared to the national average of 3.46 for comparably sized units and 3.96 for larger units.

30.18. Sarah Blanchard-Stow said two bereavement midwives and a consultant are employed to investigate all stillbirths and monitor local stillbirth rates against national trends.

30.19. Ms Blanchard-Stow explained that the maternity services operate an after care service that involves the bereavement midwives visiting bereaved parents. The after care service has close ties with East Sussex SANDS charity and was shortlisted for an award by the Royal College of Midwives.

Performance of maternity services since the reconfiguration

30.20. Councillor Smart said that it was possible that the maternity services appeared to be improving due to how statistics had been presented in the CCGs' report to the Committee.

30.21. Amanda Philpott said she had no doubt about the integrity of all people who are involved in providing and monitoring maternity services. She also welcomed HOSC and Liz Walke, Chair of Save the DGH campaign, consistently holding the CCGs to account.

30.22. Amanda Philpott clarified that the CCGs report data to the national maternity databases in a different way to how it is reported locally, and there is a difference between actual numbers of incidents and rates of incidents per 1,000.

30.23. Jessica Britton said that during the 'Better Beginnings' reconfiguration of maternity services in 2014 the CCGs critically reviewed the evidence base to determine the safest service that could be provided based on a number of indicators. She said that these indicators are still used for reporting the quality and safety of the service, and the data is provided in good faith and accurately to the best of the knowledge of those who compile it.

30.24. Jessica Britton said that the CCG can provide some assurance that the safety and quality figures provided demonstrate that the reconfiguration has made sustained improvements, for example, quality indicators around staffing levels of midwifes and consultants, and the number of locums being used have all improved.

30.25. Ms Britton said that there will always be areas where further improvement could be made, and indicators such as those around serious incident numbers and BBAs in Hastings are kept under review.

30.26. Vikki Carruth said that all decisions that ESHT takes are first and foremost about ensuring the safety of mothers and babies. She acknowledged that these decisions might not be what local mothers want and that they may well want services that are closer to homes but the priority is to provide the best possible service that is safe. If a service cannot be staffed safely, ESHT will not want to provide that service.

Satisfaction rating

30.27. Councillor Smart said that the Eastbourne Borough Council's report had been relatively objective in reporting the survey respondent's satisfaction levels. He quoted the Secretary of

State's November 2017 statement saying "there are high levels of satisfaction from parents, however, there is still too much avoidable harm and death" and argued that the report potentially reflected this concern by showing a 6% dissatisfaction rate amongst mothers alongside comments from survey responses that appeared more negative than the overall satisfaction levels would suggest.

Sustainability of MLU

30.28. Sarah Blanchard-Stow said that since the reconfiguration staff at the MLU are much happier and there is a better retention rate. A recent staff survey has shown an increase in satisfaction levels amongst staff over the past year, including feeling that management are listening to their concerns and taking action to address them.

30.29. Ms Blanchard-Stow explained that the MLU has some of the best staffing levels of midwives in the south coast at a ratio of one midwife to every 26 births – compared to 1:35 on average.

30.30. Ms Blanchard-Stow said that work is underway to improve the quality of the service provided by the MLU and increase awareness that the MLU is a safe place to give birth. This includes:

- Reviewing staffing levels to determine whether they are sufficient to provide continuity of care for mothers.
- Developing an Integrated Community Model of care involving community midwives and midwives within the MLU working together as a team.
- Providing reflexology at the MLU.

30.31. Ms Blanchard-Stow argued that there has been a slight increase in the number of births in recent years, but a lot of mothers who are low risk and could birth happily at the MLU are choosing to go to the Conquest Hospital instead due to local perceptions about safety and availability of a service at Eastbourne DGH.

Purpose of the Eastbourne Borough Council report

30.32. Peter Finnis said that the report was not intended to be scientific but was instead Eastbourne Borough Council, as a community leader, deciding to ask the recipients of the maternity service what they thought about the service in order to understand how the service change brought in four years ago has impacted mothers in Eastbourne.

30.33. Mr Finnis added that the survey questions had to be approved by the ONS and so were not deliberately slanted in a way to get a particular answer.

Netherlands study

30.34. Councillor Smart said that he would seek advice but disagreed that the Netherlands study of transfer times he had quoted from was not academically accepted.

30.35. Peter Finnis said that the Netherlands study looked at the impact on outcomes from a 20 minute travel time, whereas the travel time for patients from Eastbourne was 40 minutes.

Involvement of NHS with Eastbourne Borough Council's scrutiny committee

30.36. Councillor Smart said that he had expected more involvement from NHS organisations. He said that EHS CCG was invited to two Eastbourne Borough Council scrutiny committees and declined to attend.

30.37. Amanda Philpott responded that she heard about the survey via Facebook and the first invitation to a scrutiny committee for the CCGs came via a hand written note attached to the paperwork for the meeting. Ms Philpott said that it was felt more appropriate to attend the HOSC meeting to ensure continuity, due to the Committee previously having considered the Better Beginnings reconfiguration.

Independent review of maternity services

30.38. Councillor Smart said he believed that there was enough evidence for an independent review of maternity services provided by ESHT to be commissioned in order to bring the issue to a conclusion.

30.39. Vikki Carruth questioned the value of a further independent review given the range of independent reviews that ESHT is subject to, for example, recent Care Quality Commission (CQC) inspections, and upcoming reviews of serious incidents by the Healthcare Safety Investigation Branch.

30.40. Amanda Philpott added that it is already the case that it is not a self-assessment that determines the quality and safety of services provided by ESHT but a range of independent inspections and reviews by independent organisations.

30.41. Ms Philpott said that there is a case for independent review when a Trust is an outlier in national indicators of quality and safety, which is what drove the reconfiguration in 2014. However, most of the indicators are now at the better end of the range and so it would be unusual to call for an independent review in those circumstances. Commissioners, she said, would also consider that in a time of great pressure on services and resources the prospect of an independent review would unsettle the existing workforce and make it more challenging to attract additional staff.

30.42. Sarah Blanchard-Stow raised concerns that the maternity service has been reviewed so frequently that staff are beginning to question whether they are doing a good job. Furthermore, the Eastbourne Borough Council and CQC surveys both indicated a high level of satisfaction from women in relation to the MLU. The only element they are not as happy with is the post-natal service, but ESHT considers this a priority area for improvement and has commissioned a workforce review to address this.

30.43. The Committee Resolved to:

1) note the report;

2) request future briefings on progress with preventative pre-natal measures to reduce stillbirths and actions taken to improve post-natal services

31. KENT AND MEDWAY REVIEW OF STROKE SERVICES

31.1 The Committee considered a report providing an update on the Review of Stroke Services in Kent and Medway and establishment of a joint HOSC.

31.2 The Committee RESOLVED to:

1) confirm that the proposed reconfiguration of stroke services in Kent and Medway constitutes a 'substantial development or variation' to services for East Sussex residents requiring formal consultation with HOSC;

2) note that a Joint HOSC has been established to respond to the NHS consultation; and

3) agree that the nominated HOSC Members undertake local evidence gathering as required to inform the East Sussex contribution to the JHOSC process.

32. HOSC FUTURE WORK PROGRAMME

32.1 The Committee considered its work programme.

32.2 The Committee RESOLVED to:

1) note its work programme; and

2) Request that NHS work undertaken to tackle Delayed Transfers of Care (DTOC) is included as part of the Urgent Care report at the June 2018 meeting.

The meeting ended at 1.25 pm.

Councillor Colin Belsey
Chair