Tees Valley Joint Health Scrutiny Committee

Date: 26 March 2015
Time: 10.00 am
Venue: Committee Room B, Hartlepool Civic Centre, Victoria Road, Hartlepool

Membership: -

Darlington BC: Councillors W Newall, H Scott and Taylor
Hartlepool BC: Councillors S Akers-Belcher, K Sirs and R Martin-Wells
Middlesbrough BC: Councillors G Cole, E Dryden and H Pearson
Redcar and Cleveland BC: Councillors M Carling, T Learoyd and W Wall
Stockton-on-Tees BC: K Faulks, N Wilburn and M Womphrey

Agenda

1. Apologies for Absence

2. Declarations of Interest

3. Confirmation of the Minutes of the meeting of 22 January 2015

4. NHS England - Durham, Darlington and Tees Area Team – Annual Update

5. Monitoring of the North East Ambulance Service

6. Tees, Esk and Wear Valley NHS Foundation Trust – Annual Update and Quality Account

7. Update on the changes to Children's and Maternity Services at the Friarage Hospital

8. Digital Health Care – Pilot work

9. Any urgent items which in the opinion of the Chair can be considered.

Date of next meeting – To be confirmed

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

MINUTES

22 January 2015

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor Ray Martin-Wells (In the Chair) (Hartlepool Borough Council)

Darlington Borough Council:
Councillors: W Newall and Taylor

Hartlepool Borough Council:
Councillors: J Ainslie (substitute for S Akers-Belcher)

Middlesbrough Borough Council:
Councillors: G Cole and E Dryden

Redcar and Cleveland Borough Council:
Councillors: M Carling

Stockton-on-Tees Borough Council:
Councillors: N Wilburn and M Womphrey

Also Present: Paul Liversidge, Chief Operating Officer, North East Ambulance Service
Mark Cotton, Assistant Director of Communications, North East Ambulance Service
Tracy Hickman, Head of Healthcare Procurement, NHS and Stockton on Tees CCG
Karen Hawkins, Head of Commissioning and Delivery, NHS and Stockton on Tees CCG
Joe Chidanyika, Health Improvement Specialist, Middlesbrough Borough Council
Alison Pearson, Scrutiny Officer, Redcar and Cleveland Borough Council
Elise Pout, Scrutiny Officer, Middlesbrough Borough Council
Peter Mennear, Scrutiny Officer, Stockton Borough Council

HBC Officers: Laura Stones, Scrutiny Support Officer
Angela Armstrong, Principal Democratic Services Officer

33. Apologies for Absence

Darlington Borough Council: Councillor H Scott
Hartlepool Borough Council: Councillor S Akers-Belcher
Stockton on Tees Borough Council: Councillor Faulks
Redcar and Cleveland Borough Council: Councillor W Wall.

34. Declarations of Interest

None.

35. Minutes

The following minutes were submitted for consideration:
(i) 3 March 2014 – confirmed.
(ii) 17 July 2014 – confirmed.
(iii) 11 September 2014 – confirmed.
(iv) 27 November 2014 – confirmed.

36. Protocol for the Tees Valley Health Scrutiny Joint Committee

The updated protocol for the Tees Valley Joint Health Scrutiny Committee had been submitted for consideration by the Committee. One of the key changes to the protocol was in relation to the quorum for meetings of the Committee. The quorum was amended to allow three out of the five authorities to be represented to form a quorum for meetings of the Committee. In addition, it was noted that the Joint Committee would hold quarterly meetings with additional meetings held with the agreement of the Chair and Vice-Chair or where at least six Members request a meeting.

Decision

The revised protocol for the Tees Valley Health Scrutiny Joint Committee was approved.

37. NHS England – Durham, Darlington and Tees Area Team – Annual Update

This item was deferred to the next meeting as the representative from the Area Team was unable to attend.

Decision

Deferred to the next meeting of the Committee.

38. Monitoring of the North East Ambulance Service

Representatives from the North East Ambulance Service (NEAS) were invited to the meeting to provide an update on performance of NEAS. The Assistant Director, Communications informed the Committee that the Chief Executive was unable to attend the meeting due to prior commitments.

The representatives from NEAS provided a detailed and comprehensive presentation which included information on the current performance of the Service. Further information was provided on a Mori Survey of overall patient experience which had been undertaken in October 2014. It was noted that a further breakdown of performance would be provided by Local Authority areas and circulated under separate cover.

Members were disappointed that a lot of the information included within the presentation had been provided already and referred to a number of requests for additional information made at previous meetings including: response times by all core types; where people were treated; workforce reliance on third party providers along with the location of ambulances across each Local Authority areas of partnership working. Members also expressed disappointment that the Chief Executive of NEAS had been unable to attend the meeting.

The Assistant Director, Communications indicated that establishment numbers had been provided within the presentation. It was noted that third party providers were utilised using winter pressure funding and that as recruitment reached the full establishment level, the use of third party providers would reduce. Members were reassured that the workload of the NEAS was manipulated to suit the resources available although this did increase pressure on the service. In response to a concern expressed by a Member, the Chief Operating Officer confirmed that 999 call takers did not make decisions on the transport and appropriate skills despatched to incidents. These decisions were made by a clinical hub which included ex-paramedics and ex-nurses among its staffing establishment.

A Member sought clarification on the support provided to ambulance staff. The Chief Operating Officer indicated that the new Chief Executive regularly updated a blog and communicated to the staff through that. Additional communication was provided by way of monthly bulletins and weekly updates. There were also mechanisms in place to support individual staff when required including through an occupational health function and counselling service which can be accessed independently of NEAS. In instances where staff had attended a particularly traumatic incident, they may be offered the opportunity to ‘stand-down’ or take a comfort break and where necessary specific support was provided to them.

A copy of the presentation which included the handover time issues was requested by one of the representatives from Darlington Borough Council as they were attending a meeting with the Health Trust for their area the

next day.

The Chief Operating Officer indicated that one of the key issues with recruitment was that the skills paramedics receiving during their training were attractive in a number other areas of employment. In view of this, NEAS was working with Teesside University to create a bank of staff utilising students and working around their University courses.

A discussion ensued on the additional pressures placed on Accident and Emergency services from patients taken there who could be treated elsewhere. The Chief Operating Officer commented that during the recent winter, Acute Trusts and providers had reached Level 4 whilst community providers were at Level 1 and this highlighted a big disconnect in services. In order to begin to examine the issues affecting performance, a Member requested information around the NEAS strategic plans and what plans were in place to deal with these issues including the working relationships with local hospitals. The Chief Operating Officer indicated that raising awareness of the 111 service that was available and ensuring clinicians directed patients to the most appropriate treatment were key issues to ensuring demand was managed and the patients who needed the full 999 service received it.

The Chief Operating Officer reassured Members that answers to their outstanding questions would be provided as soon as practicable.

Decision

(i) The Committee noted the information provided within the presentation.
(ii) The Chief Operating Officer to provide the answers to the questions previously raised by the Committee.

Councillors Newall and Taylor (Darlington Borough Council) left the meeting at this point.

The meeting was now inquorate.

39. Any Qualified Provider for NHS Services

Representatives from Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) to discuss the operation of the Any Qualified Provider (AQP) Scheme; commissioning arrangements; the quality of service provision; and the monitoring arrangements. A comprehensive presentation was provided to Members which showed how services were commissioned, what services were awarded though NHS contracts under AQP and how the quality of the delivery of services through these contracts was monitored.

In response to a comment from a Member, the Head of Healthcare

Procurement confirmed that AQP offered a broader choice of services as well as ensuring services were more accessible with shorter waiting times. The Head of Commissioning and Delivery informed Members that should any contracts not meet expectations, the CCG would work with providers to improve that service and should a contract be breached, the contact would be terminated although there had not been any instances of breached contracts to date.

The Head of Commissioning and Delivery indicated that the contracts issued through AQP were zero hours based contracts which were activity driven and had been developed with national groups and key national clinicians to develop a specification for the Tees area. Providers would market their services with the use of appropriate NHS branding through the NHS Commissioning Team. The Head of Commissioning and Delivery confirmed that AQP did not preclude smaller organisations from applying to provide any contract as due diligence was undertaken before procurement and the organisations would know what they can afford to provide and market themselves accordingly.

Councillor Jim Ainslie declared a personal interest in this item at this point in the meeting due to his involvement with the Dementia Working Group of the Audit and Governance Committee.

A Member sought clarification on the CCGs working relationship with community and charitable organisations. The Head of Commissioning and Delivery confirmed that the CCG had a really close working relationship with the voluntary sector and worked closely with the Hartlepool Voluntary Development Agency on the commissioning of adults and health services.

Decision

The presentation and discussion that followed were noted.

40. Tees Wide Suicide Prevention Implementation Plan

The Health Improvement Specialist and Public Mental Health Lead for Middlesbrough Borough Council was in attendance to provide an update to Members on the Tees Wide Suicide Prevention Plan which was attached to the report by way of Appendix.

A discussion ensued during which it was recognised that it was not impossible to remove the means and put additional obstacles in place for people contemplating suicide. It was suggested that enquiries be made with Local Authorities in the region to ascertain how they were working with local developers in this regard. The Health Improvement Specialist confirmed that work was ongoing with the Coroner's service to look at prevention and real time reporting of suicides to Local Authorities.

The importance of working closely with the Department for Work and

Pensions was discussed, especially in relation to when people with mental health problems were sanctioned for non payment or over payments. The Health Improvement Specialist confirmed that a campaign was undertaken in Middlesbrough around benefits and financial inclusion groups with people with mental health and emotional issues being fast tracked through the benefits system and ensuring people receive what they were entitled to. There was some concern expressed that people with mental health problems who were vulnerable were being sanctioned for minor issues when they should be receiving additional support through a multi agency approach to ensure their benefit entitlement was maximised. The Health Improvement Specialist added that this was an important point and would be reflected in the Plan.

Members discussed the balance required through the sensitive media exposure of any suicides and with this in mind, the Samaritans had developed a media pledge which could be promoted to all local media.

Decision

(i) The Tees Suicide Prevention Implementation Plan 2014-2016 was noted.
(ii) Each Local Authority to explore the issues affecting their local authority area and if appropriate make recommendations in line with the recommendations of Middlesbrough Borough Council.

41. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

42. Any Other Business – Pathway Challenge Review Event

The Scrutiny Support Officer confirmed that the Pathway Challenge Review Event would be held on the 27 January 2015 and further details were provided.

The meeting concluded at 12.04 pm

CHAIR

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

26 March 2015

Report of: Scrutiny Manager

Subject: NHS ENGLAND - DURHAM, DARLINGTON AND TEES AREA TEAM – ANNUAL UPDATE

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1. PURPOSE OF REPORT

1.1 To inform the Committee that representatives from the Area Team will be in attendance at today's meeting to provide the Committee with an Annual Update.

2. BACKGROUND

2.1 The Joint Committee agreed as part of its work programme to receive an annual update on the work of the Area Team. The last update from the Area Team was presented to the Joint Committee on 20 January 2014, which focussed on the first year's operation of the Area Team. This year the Committee will be updated on the Area Team's work/business, NHS England's organisational changes and future NHS plans.

2.2 The Area Team has the following core functions:

- Improving health, reducing inequalities and improving the quality of healthcare
- Clinical commissioning group development and assurance
- Emergency planning, resilience and response
- Quality and safety
- Service configuration oversight
- System oversight
- Direct commissioning e.g. primary care, specialised commissioning, some elements of public health

3. RECOMMENDATIONS

3.1 It is recommended that the Committee consider the information presented at this meeting and seek clarification on any relevant issues where required.

BACKGROUND PAPERS

The following background papers were used in preparation of this report:-

(a) Tees Valley Joint Health Scrutiny Committee – Report titled 'Update from Durham, Darlington and Tees Area Team' – 20 January 2014
(b) Tees Valley Joint Health Scrutiny Committee – Report titled 'Work Programme' – 17 July 2014

Contact Officer:- Laura Stones – Scrutiny Support Officer
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TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

26 March 2015

Report of: Scrutiny Manager

Subject: MONITORING OF THE NORTH EAST AMBULANCE SERVICE

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1. PURPOSE OF REPORT

1.1 To present to the Committee the requested information from the North East Ambulance Service (NEAS).

2. Background

2.1 At the Committee meeting held on 22 January 2015, Members received a presentation on performance from representatives from NEAS. As a result of the meeting Members requested information relating to the following areas :-

(a) Response times for all call types (i.e red and green calls), trends in calls along with total call volume/demand for each Tees Valley Local Authority area.

(b) Figures for where people are treated i.e 'hear and treat' and 'see and treat'.

(c) Workforce and reliance on third party providers, i.e St. John's Ambulance and the British Red Cross. Is there funding and a plan in place to increase NEAS's own core workforce to reduce this reliance? On occasions where third party providers have been sent as a first response, do NEAS ambulances also attend the scene within the target response time?

(d) The location and numbers of ambulances across each Local Authority area.

(e) Operational and partnership working with Cleveland Police.

2.2 NEAS has provided this information, which is attached at **Appendix 1.** In addition to this information, the Chair of the Committee agreed for representatives from NEAS to attend today's meeting to provide information on the following areas:-

(a) The triage call process including how a call is categorised and input from clinicians;
(b) Whether third party ambulance staff are trained to paramedic level; and

(c) Other national guidelines / standards that NEAS have to follow in addition to the performance indicators i.e. NHS England guidelines or NICE guidelines

3. RECOMMENDATIONS

3.1 It is recommended that the Committee consider the information presented at this meeting and seek clarification on any relevant issues where required.

BACKGROUND PAPERS

The following background paper was used in preparation of this report:-

(a) Report of the Scrutiny Manager entitled 'North East Ambulance Service – Monitoring' presented to the Tees Valley Joint Health Scrutiny Committee held on 22 January 2015

Contact Officer:- Laura Stones – Scrutiny Support Officer
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Hartlepool Borough Council
Tel: 01429 523087
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North East Ambulance Service NHS
NHS Foundation Trust

Ambulance and A&E report

Activity relating to patients in Hartlepool; Stockton on Tees; Darlington; Middlesbrough; Redcar & Cleveland

1. Introduction

1.1. This report provides an update on ambulance A&E activity to help Tees Valley joint health scrutiny committee to understand the overall current provision of emergency care services.

1.2. NEAS is commissioned to deliver emergency care and PTS ambulance services by Clinical Commissioning Group (CCG) areas and our data collection and monitoring is based at this level. This reports shows activity and response data by CCG area

- North Tees & Hartlepool – covering Stockton on Tees and Hartlepool local authority
- South Tees – covering Middlesbrough and Redcar & Cleveland local authority
- Darlington

1.3. The Tees Valley OSC also requested data for each local authority area. This is not routinely collected or monitored since the abolition of Primary Care Trusts whose boundaries were coterminous with local government. However, a special data extraction has been undertaken to assist members in seeing ambulance activity by local authority area. This appears in the appendices.

2. Summary of key findings

2.1. The Trust's performance over the latter part of 2014/15 has continued to deteriorate and without fuller analysis of the winter schemes, it is not possible to quantify how much they have protected performance from further deterioration as a result of system pressure.

2.2. There are signs of recovery, however given the acuteness of the deterioration of hospital capacity (as evidenced using the A&E 4 hour metric), there is a strong possibility that our schemes will only continue to minimise further deterioration of our own response standards.

2.3. The breach forecast is considerate of the range of factors and whilst misses the 75% and 95% standards, it remains a slight breach. The underperformance in Quarter 4 also leads to an annual breach of both the R8 and R19 targets.

3. Ambulance activity

<u>Category A response times by Ambulance Trust</u>

3.1. Potentially life-threatening calls are known as Category A calls. These are split into Red 1 and Red 2 incidents, depending on the nature of incident. All Red cases should receive an emergency response within 8 minutes in 75% of cases across the NEAS operational area. They should receive a patient transport response within 19 minutes in 95% of cases. The charts below show the proportion of calls meeting the response times for each ambulance trust for these time-related indicators.

3.2. Red 1 responses: cardiac arrest (figure 1). These cases relate to patients in cardiac arrest or at risk of going into cardiac arrest. Achievement of this measure for 2014/15 year to date is 69.7%.

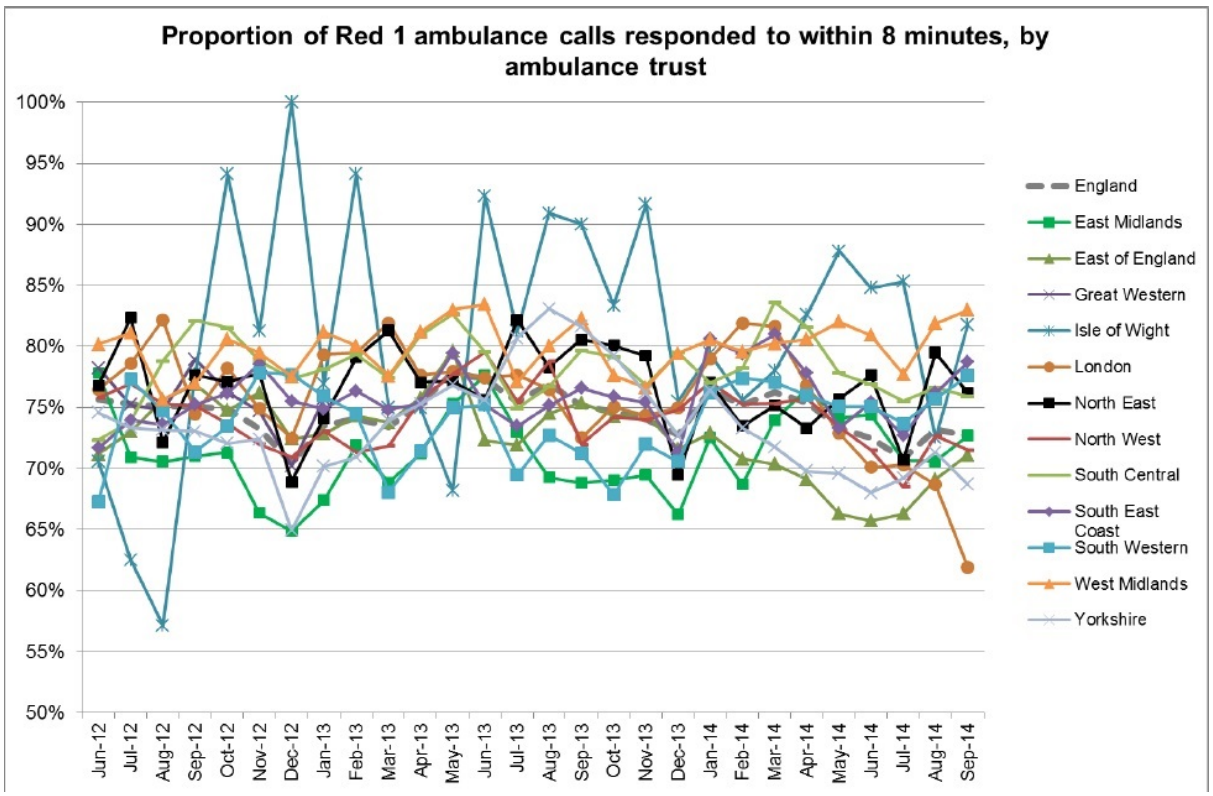


Figure 1: Red 1 calls

3.3. Red 2 responses: serious breathing difficulties, heart attack or suspected stroke (figure 2). The achievement for NEAS has varied over time, with an average 8 minute response rate of 80% between February and October 2013 to a low of 72.9% in July 2014. The NEAS rate in December 2014 was 66.4% and the year to date figure is 73.6%

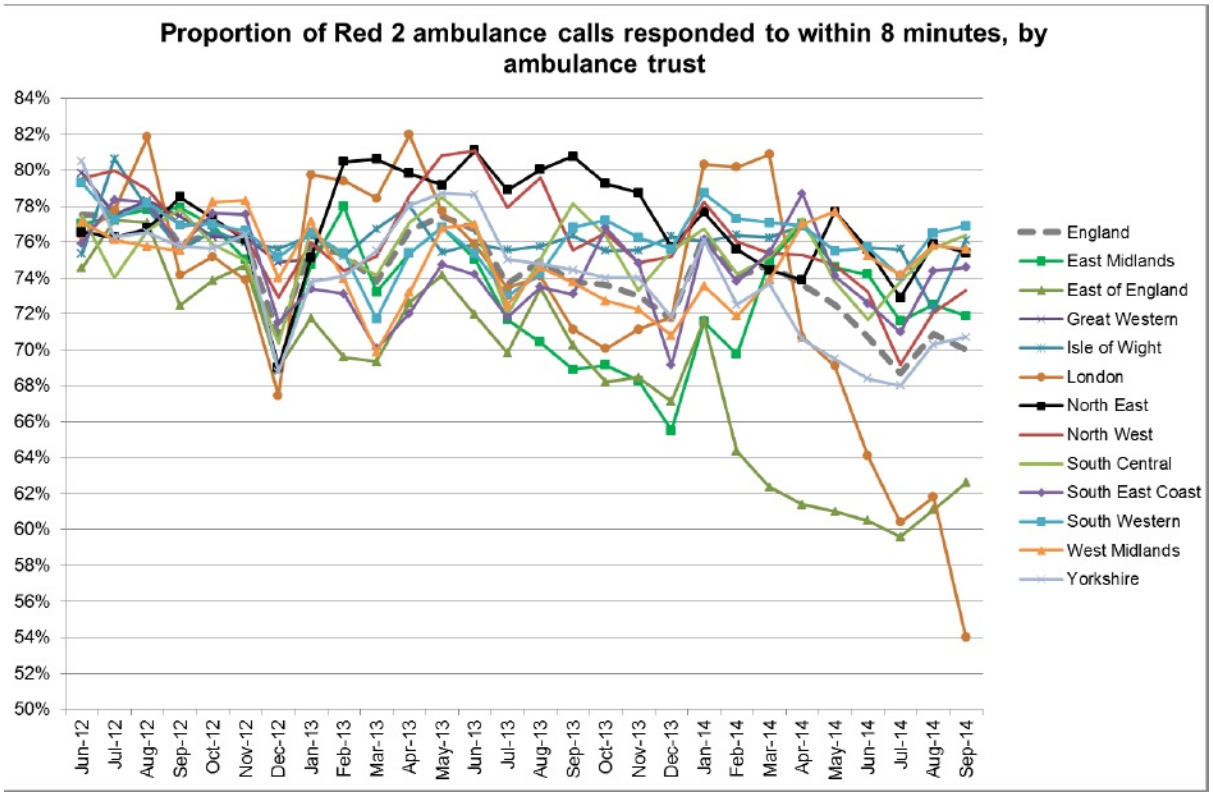


Figure 2: Red 2 calls

3.4. In September 2014, 95.0% of Red category ambulance calls were responded to within 19 minutes for NEAS (figure 3). Between February and November 2013, response times for NEAS were at an average of 97.5% achievement per month, and despite an increase in May 2014, the trend in performance since December 2013 has generally been down. The 2014/15 year to date rate for NEAS is 95.5%.

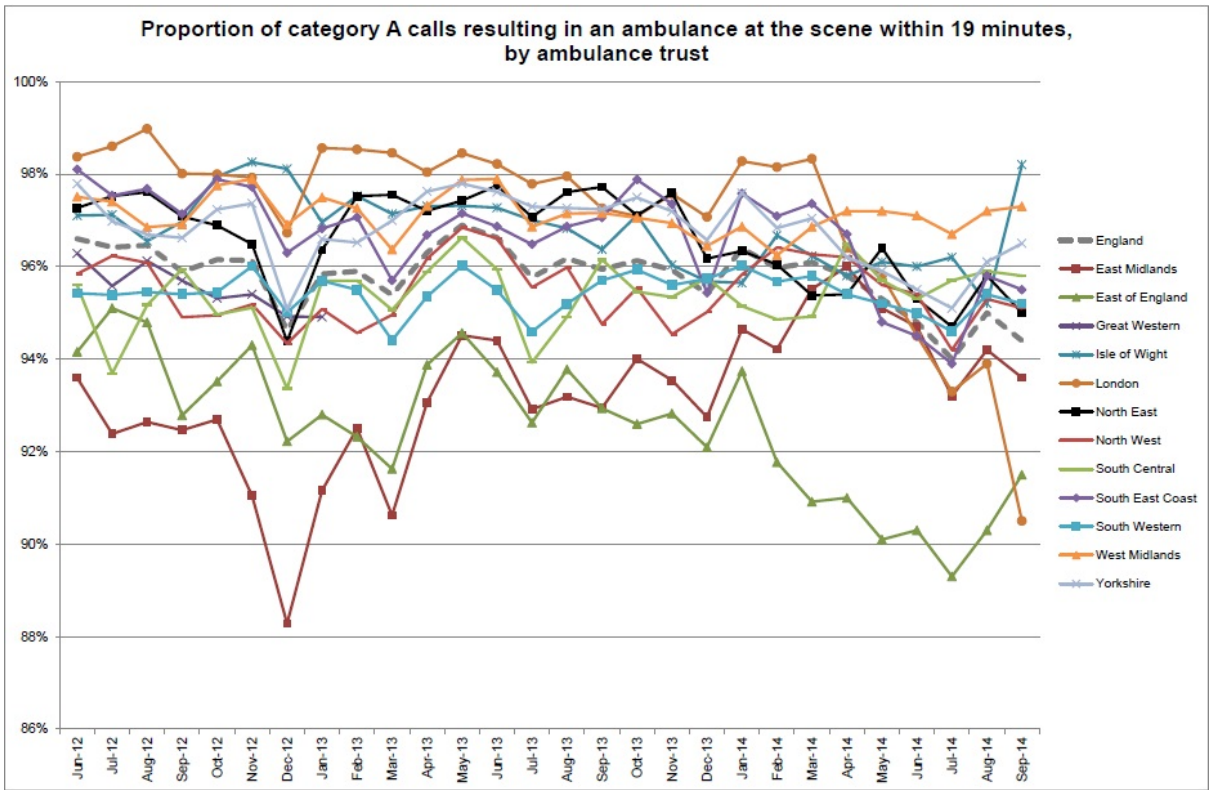


Figure3: Category A calls responded within 19 minutes

4. Clinical Commissioning Group (CCG) level data

4.1. NEAS response time reports for Red call in December 2014 and year-to-date (April 2014 to present):

4.1.1. North Tees & Hartlepool CCG

December	Red calls	% in 8 min	Red 1	% in 8 min	Red 2	% in 8 min
Achieved in 8 min	1213	66.2%	88	63%	1125	66.5%
Total number	1833		140		1693	

YTD	Red calls	% in 8 min	Red 1	% in 8 min	Red 2	% in 8 min
Achieved in 8 min	10466	73.9%	424	71.5%	10042	74%
Total number	14148		593		13555	

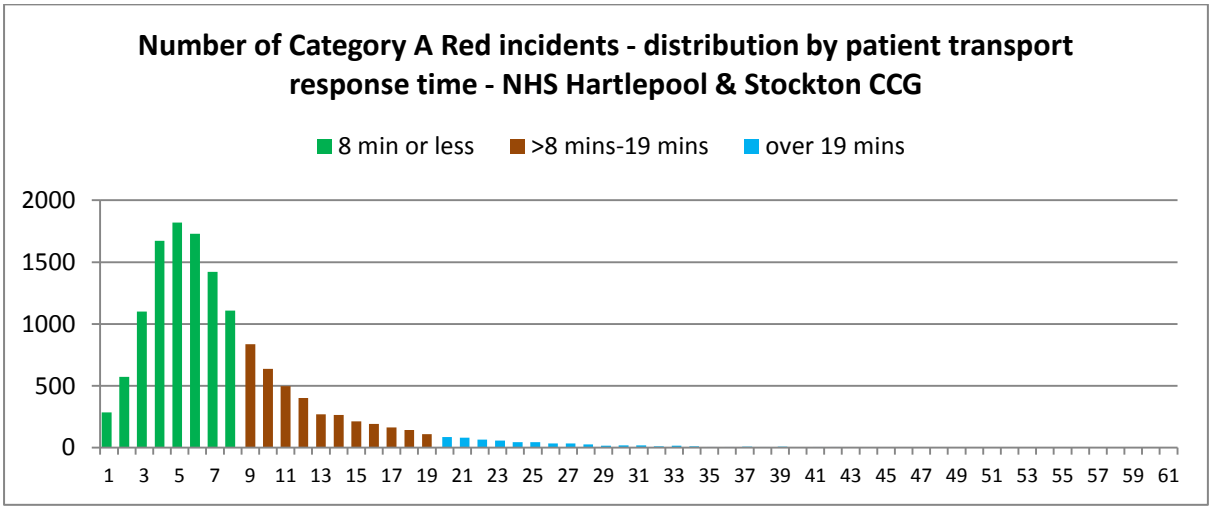


Figure 4: Category A best response times and transport arrival times

4.1.2. South Tees CCG

December	Red calls	% in 8 min	Red 1	% in 8 min	Red 2	% in 8 min
Achieved in 8 min	1246	65.3%	97	62.8%	1149	66.5%
Total number	1907		148		1759	

YTD	Red calls	% in 8 min	Red 1	% in 8 min	Red 2	% in 8 min
Achieved in 8 min	11768	73%	485	72.2%	11283	73%
Total number	16116		672		15444	

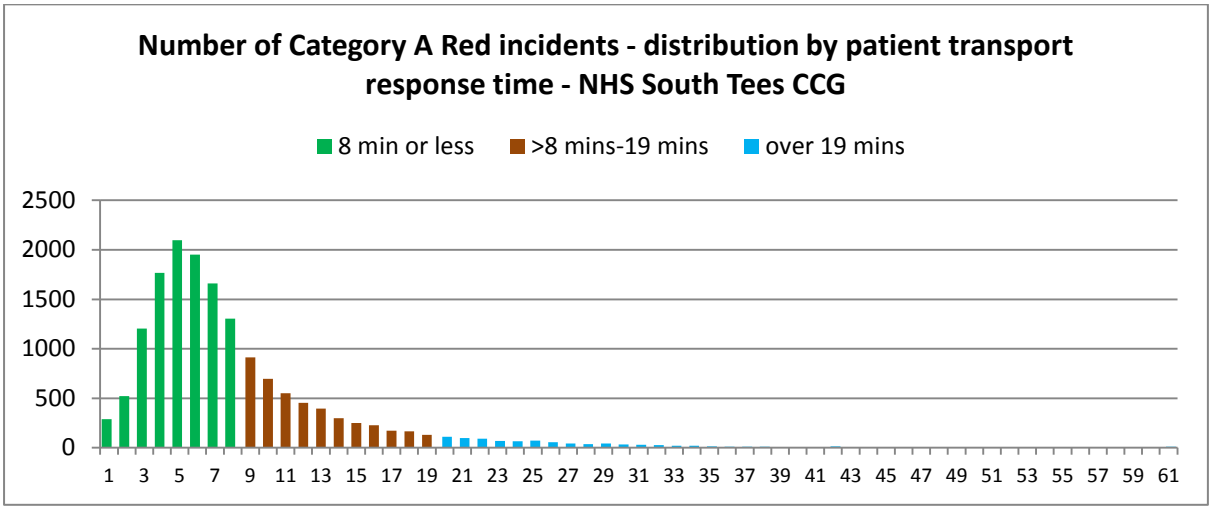


Figure 5: Category A best response times and transport arrival times

4.1.3. Darlington CCG

December	Red calls	% in 8 min	Red 1	% in 8 min	Red 2	% in 8 min
Achieved in 8 min	461	69.5%	30	62.5%	431	70%
Total number	663		48		615	

YTD	Red calls	% in 8 min	Red 1	% in 8 min	Red 2	% in 8 min
Achieved in 8 min	4018	78.2%	183	75.3%	3835	78.4%
Total number	5136		243		4893	

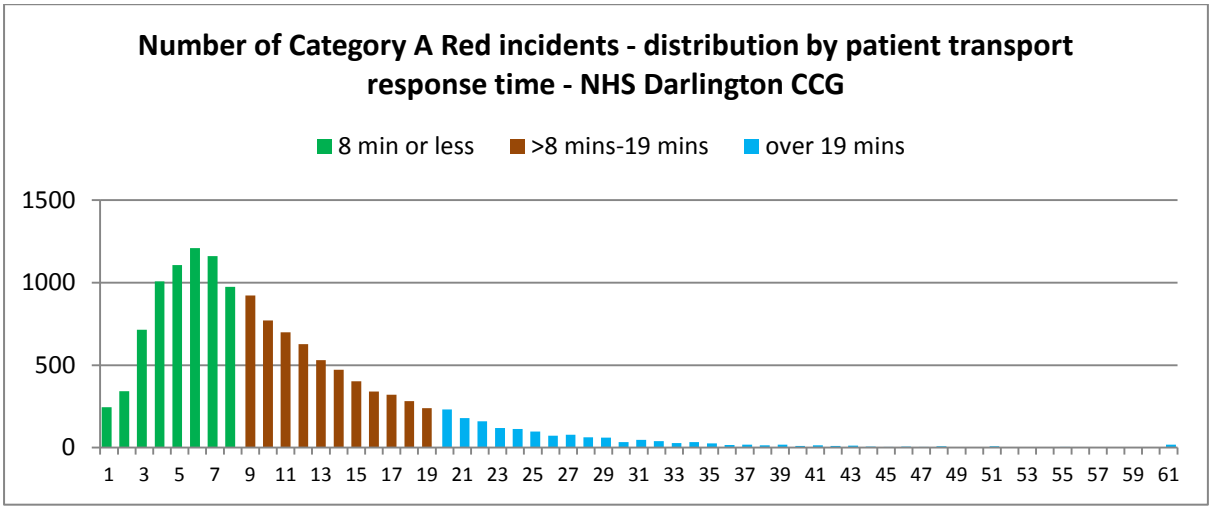


Figure 6: Category A best response times and transport arrival time

4.1.4. NEAS service area (year to date)

	Red calls	% in 8 min	Red 1	% in 8 min	Red 2	% in 8 min
Achieved in 8 min	101,229	73.3%	3772	69.4%	94,457	71.1%
Total number	138,175		5439		132,736	

4.2. Case mix by CCG area

4.2.1. North Tees & Hartlepool CCG

It can be seen in figure 7 that North Tees & Hartlepool area has a higher proportion of Red calls (blue column) and urgent calls compared with the NEAS north east region (orange column); and a lower proportion of green (less serious) cases.

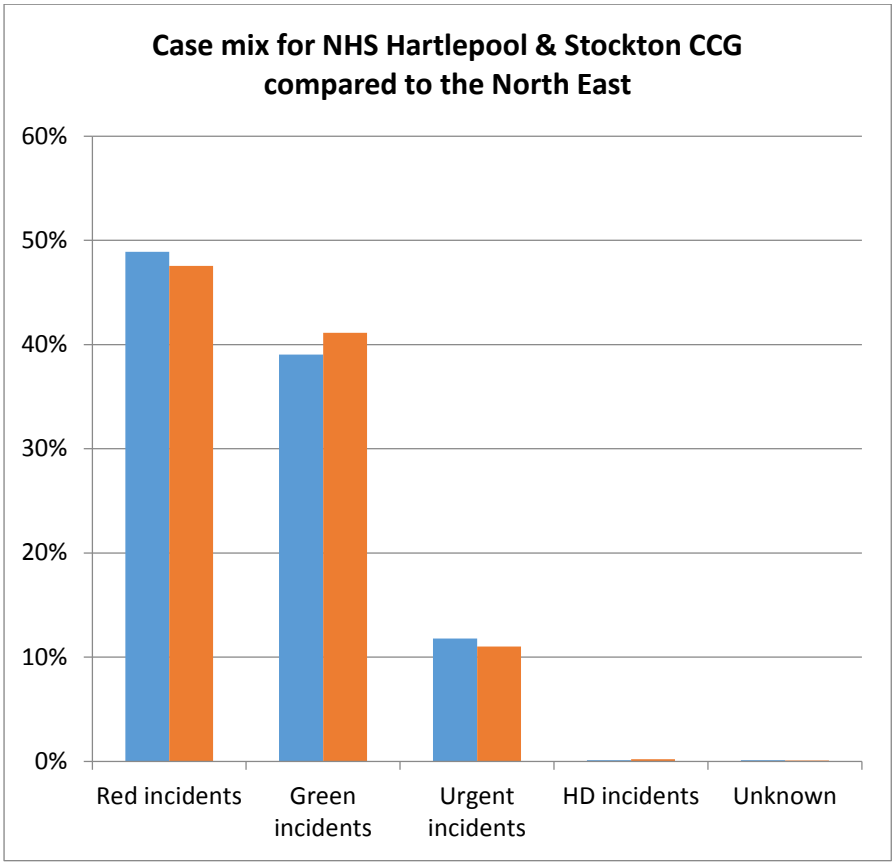


Figure 7: case mix in North Tees CCG

4.2.2. South Tees CCG

It can be seen in figure 8 that South Tees area (Middlesbrough and Redcar & Cleveland) have a higher proportion of Red calls (blue column) compared with the NEAS north east region (orange column); and a lower proportion of green (less serious) and urgent cases.

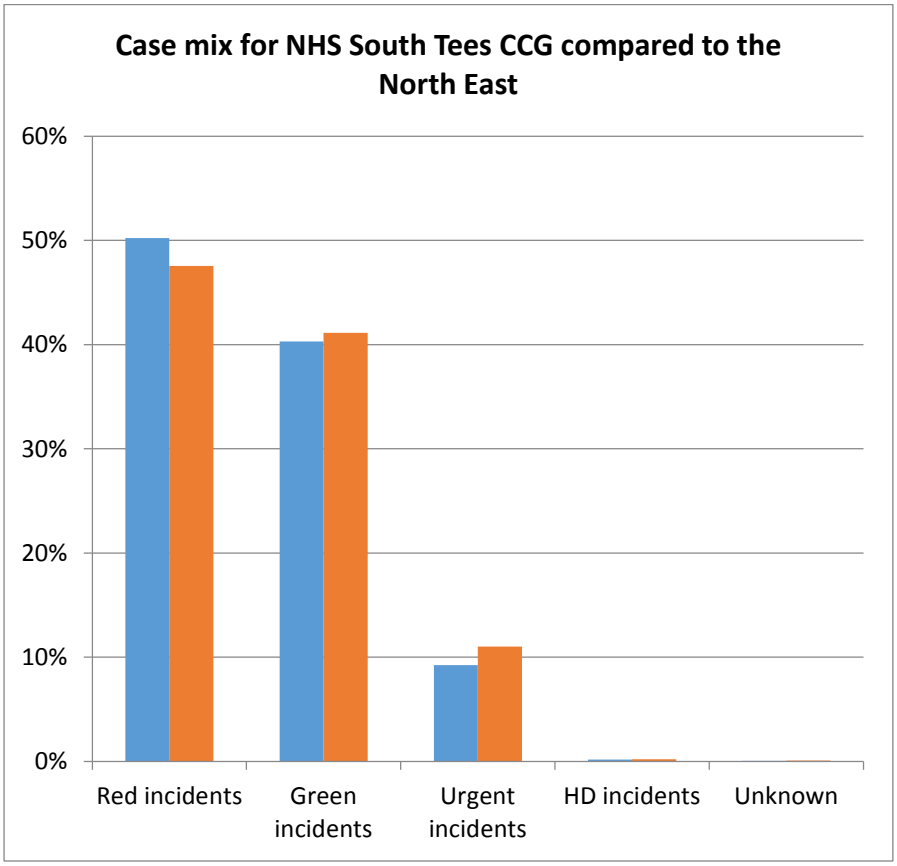


Figure 8: case mix in South Tees CCG

4.2.3. Darlington CCG

It can be seen in figure 9 that Darlington CCG area has a higher proportion of Red calls (blue column) and green calls (less serious) compared with the NEAS north east region (orange column); and a lower proportion of urgent cases.

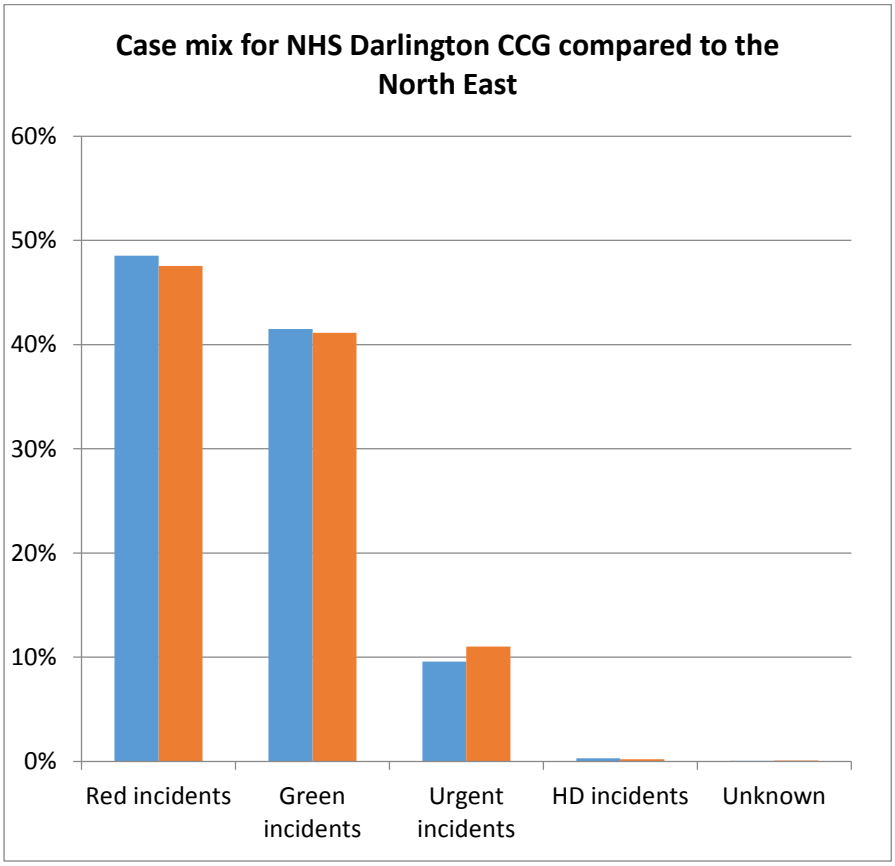


Figure 9: case mix in Darlington CCG

5. Incident volume by case mix

5.1. In addition to the Red category ambulance responses there are two other main types of call, which are green calls and GP urgent calls. The performance of these call types is intrinsically linked to Red performance due to the nature of the response allocation and the protocol for diverting a vehicle to a life-threatening Red incident from a lower acuity Green or Urgent. (see figure 19 on p19)

5.2. Green calls are for conditions that need to be attended quickly but where the patient will not deteriorate or suffer by a slightly slower response, or for non-life threatening conditions which are generally assistance calls in which someone needs help.

5.3. Urgent calls are requested by a doctor or midwife, with the response tailored to the needs of each individual patient, as determined by the GP. It may be that the GP may arrange an emergency admission to hospital but give the ambulance service up to two hours to respond to the call. The standard for urgent calls is to get 95% of patients to the hospital within 15 minutes of the time specified by the doctor when booking the ambulance.

5.3.1. **Number of GP urgent calls:** figures 10, 11, 12 show the profile of GP urgent calls made by day and time. The highest numbers of calls are made between 12pm and 3pm on weekdays.

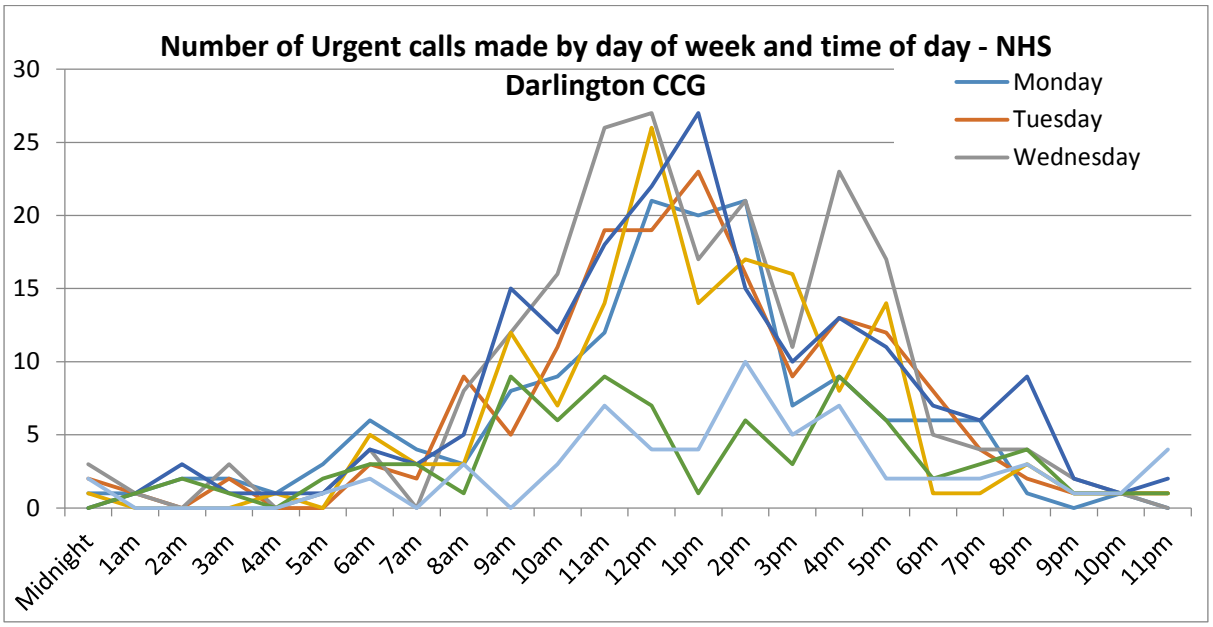


Figure 10: Profile of urgent calls in Darlington CCG

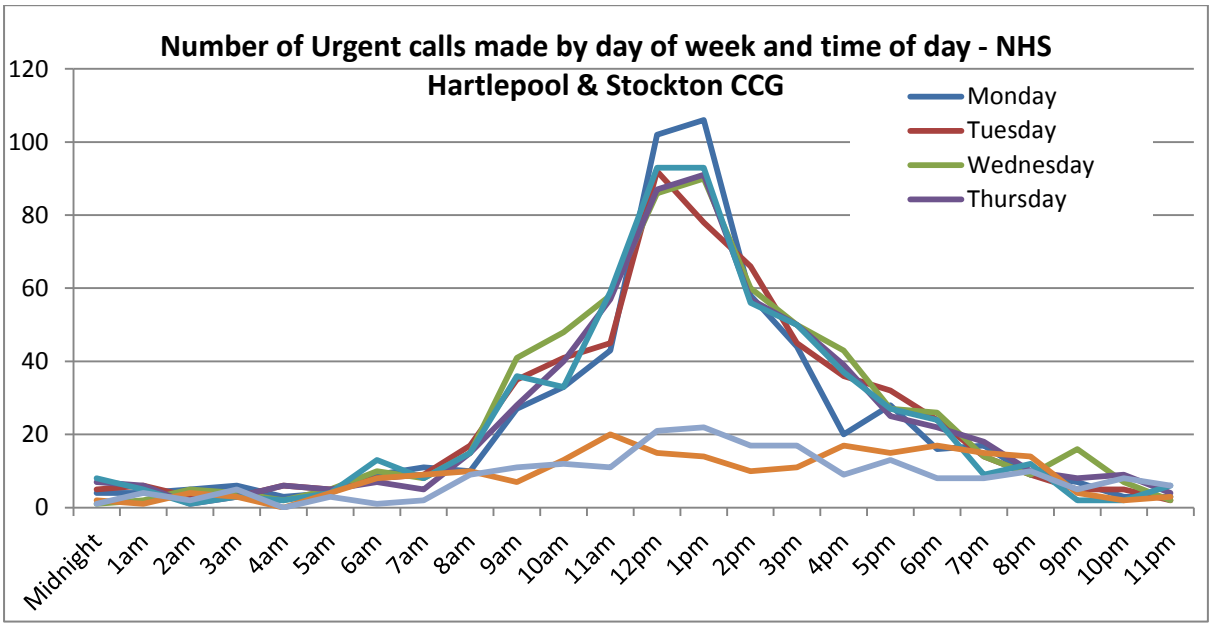


Figure 11: Profile of urgent calls in North Tees CCG

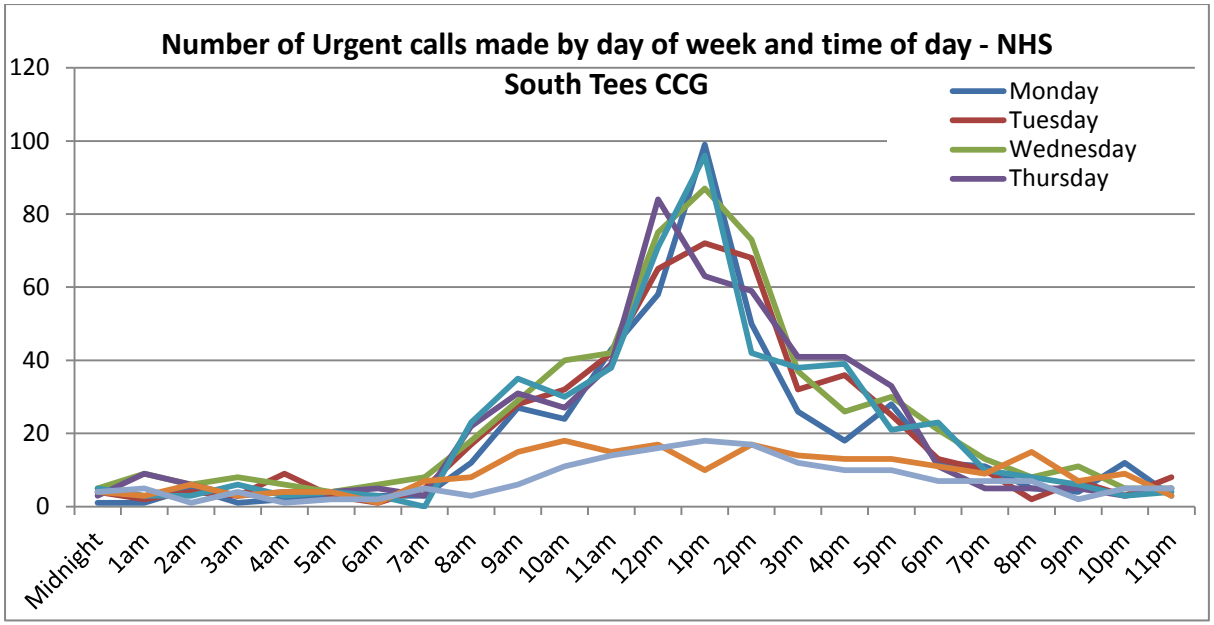


Figure 12: Profile of urgent calls in South Tees CCG

5.3.2. **Time to GP urgent call response**: The charts below (figures 13, 14, 15) show the variation in the length of time taken for a GP urgent call response to arrive at the patient location. According to the data a small number of patients (<3%) waited over 5 hours for a response, and there is a risk that it may then become necessary to escalate the call to a higher call category. It must be noted however that GP urgent call timelines can be up to four hours as standard but can be longer on agreement with GPs and patients.

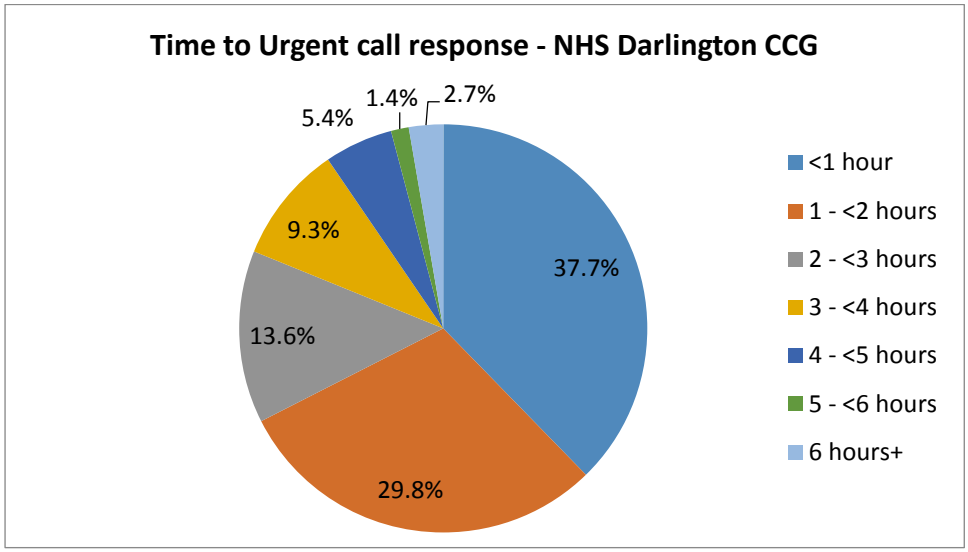


Figure 13: Profile of responses to urgent calls in Darlington CCG

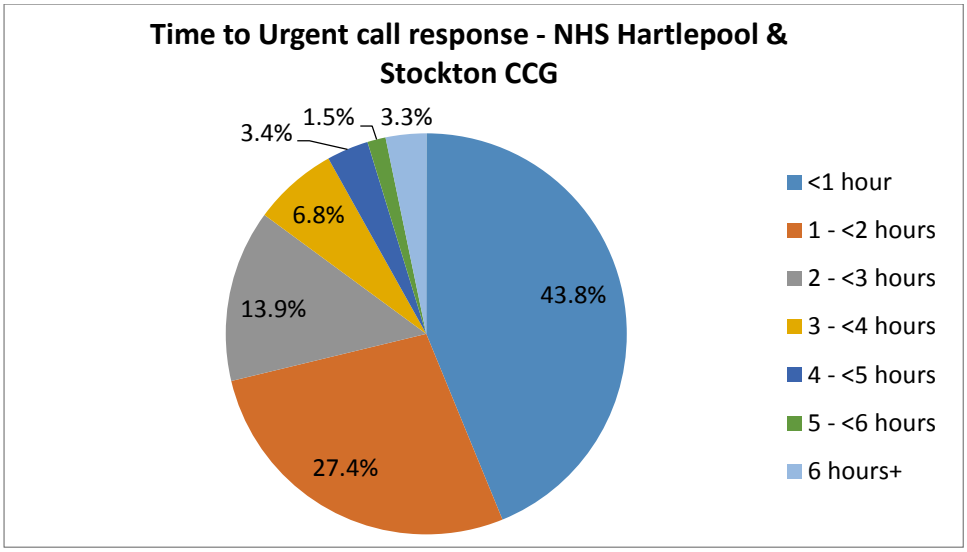


Figure 14: Profile of responses to urgent calls in North Tees CCG

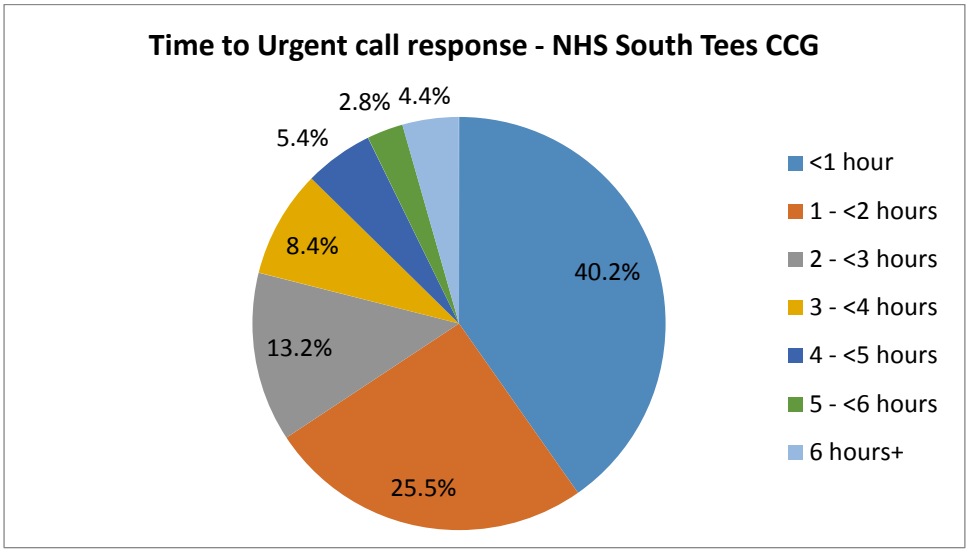


Figure 15: Profile of responses to urgent calls in South Tees CCG

6. Ambulance calls by closure type

6.1. There are three categories of closure for ambulance calls which are 'hear and treat', 'see and treat' and 'see and convey'. Calls originating from NHS111 are not counted in the 'hear and treat' or 'see and treat' figures but they are included in the 'see and convey' figures. There can also be variation in how call closure is reported in each ambulance trust as this depends on their A&E department classification and whether patient or incident level data is being reported. The charts below show the proportion of calls closed by each method for each ambulance trust.

6.2. Across the latest 30-month period the proportion of NEAS calls recorded as being closed by telephone advice (figure 16) has increased from 3% to almost

6%, compared to the England level which has ranged from 5.4% to 7.7% in the same period. South East Coast Ambulance Trust steadily increased their proportion of 'hear and treat' calls to almost 13% by March 2014 however for 2014/15 the average proportion of calls closed by telephone advice is 10.8%. The London Ambulance Service has the highest proportion of calls closed by telephone advice, at 14.5% in September 2014.

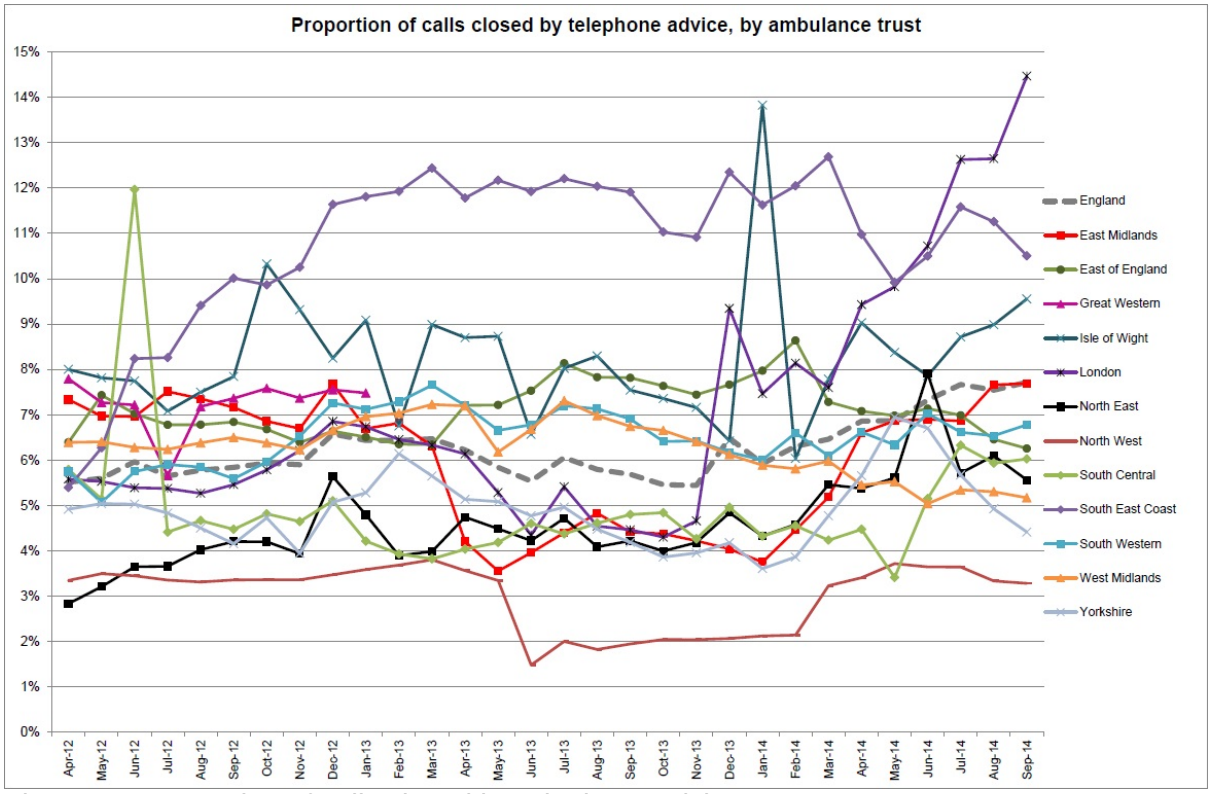


Figure 16: Proportion of calls closed by telephone advice

6.3. In 2014/15, the England average for the proportion of calls closed without transportation to A&E ('see and treat') was approximately 37%. Although these patients are not conveyed to a type 1 or 2 A&E department it is still possible for these patients to be referred to another care pathway or to a type 3 A&E department. The national definition of 'see and treat' is calculated as the number of patients treated on scene divided by the number of incidents responded to, and therefore can result in a rate of greater than 100% for some incidents.

6.4. Figure 17 shows the 'see and treat' rates for each ambulance trust. Within NEAS this is currently nearly 33% and this proportion is relatively stable. There are five trusts where the 'see and treat' rate is consistently above 40%, with the average rate for South Western Trust at 51.9%. Due to the way in which ambulance calls are reported, in terms of included calls, incidents and the number of patients treated, information is not available to accurately report the proportion of hear and treat, see and treat and see and convey rates per ambulance trust although the proportion of incidents where transport to A&E is required can be understood from Figure 17 which shows the proportion *not* transported.

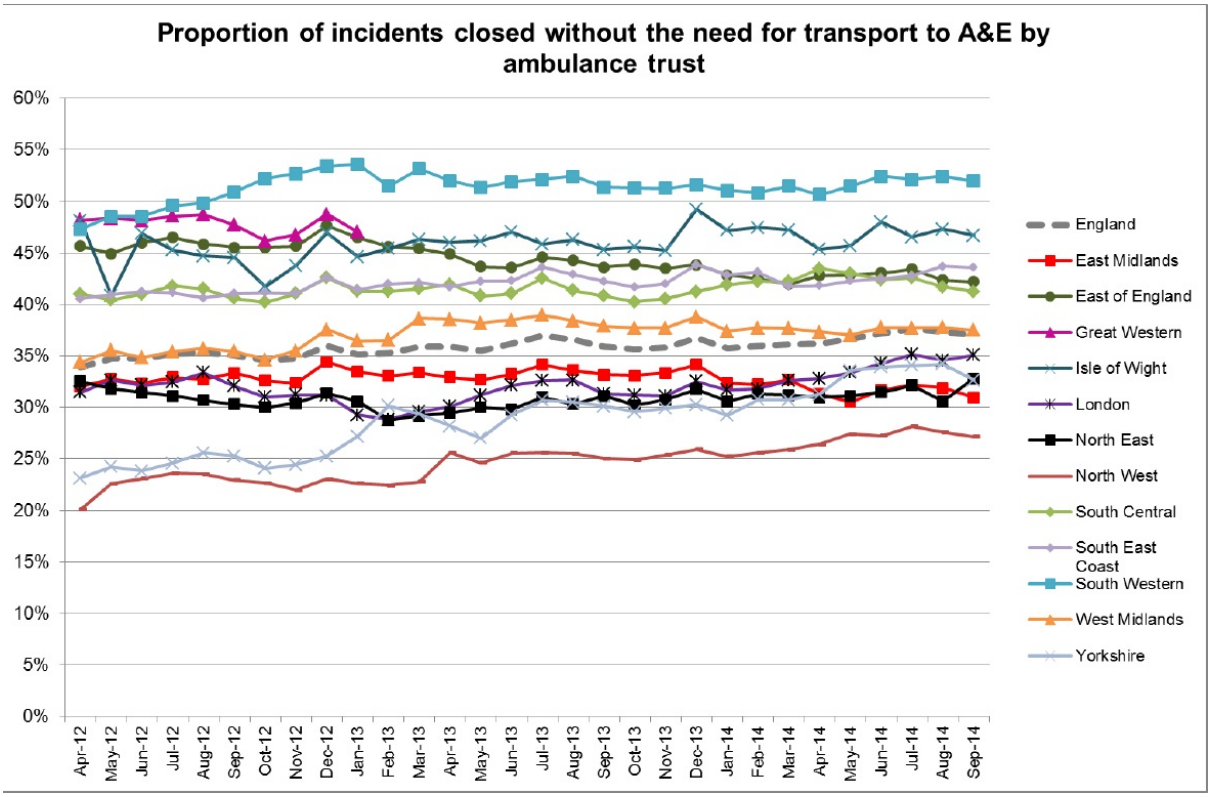


Figure 17: Proportion of calls closed by ambulance crew without transport to hospital

7. NEAS Action plans

This section provides an update on the following four areas:

- Update on actions taken to improve performance
- Assessment of the impact of the actions
- Latest performance figures
- Actions planned/assurances regarding delivery during Quarter 4 and beyond

7.1. <u>Update on actions taken to improve performance</u>

7.1.1. NEAS has been implementing a range of actions throughout the year to improve performance including:

7.1.2. A task and finish group to expedite recruitment which has resulted in:

- the direct recruitment of 16 qualified Paramedics since October

- recruitment of 4 qualified agency Paramedics (to be operational in next couple of weeks)
- an increase of the student paramedic intake in February 2015 from 24 up to 49
- ongoing development of a corporate staff bank
- the redeployment of Advanced Technicians as the lead clinician (subject to individual staff discussions regarding rota moves)
- start of discussions with Armed Forces to recruit Medics returning from duty
- a proposal to Teesside University to increase the three year degree programme intake from 50 to 75, subject to placement assurances and available mentors and finances
- The start of international recruitment.

7.1.3. Increase in staff in the Clinical Hub to support call takers and provide Patient Safety Support.

7.1.4. The Consultant Paramedic spent time within the Contact Centre to review deployment practice and support clinical staff with decision making on scene.

7.1.5. Production of call taker level reporting to target additional coaching to those outliers with high ambulance dispositions.

7.1.6. Continued use of overtime and additional PTS resource used to support Emergency Care

7.1.7. Improved GP communications regarding transport booking

7.1.8. Sickness actions plans compiled by each area of the business (target continues to be 5%)

7.1.9. A range of winter initiatives which has included:

- Hospital Ambulance Liaison Officers (HALO) in place at hospitals around the region to assist with patient flow and to reduce handover/turnaround delays at hospitals, this has proven to be a positive move with acute trusts and requests have been received to increase this resource.
- Increased use of third party resources (for Emergency Care and PTS)
- Increase cover within the Fleet department to ensure that vehicles are available and repairs are expedited, leading to a reduction in lost time due to vehicle unavailability.
- Increase Ambulance Resource Assistant (ARA) cover to assist with cleaning and restocking of vehicles at hospital along with completing minor vehicle repairs.
- Advice line for Paramedics to support ‘see and treat’ decision making
- NHS 111 Validation of Ambulance Dispositions - Pilot of the validation of specific 111 ambulance dispositions with a view to reducing the volume of inappropriate ambulance dispatches working with our partner NDUC (went live in January).

7.2. Assessment of the impact of actions

7.2.1. The winter schemes are currently being assessed for their impact and many of the schemes were mobilised at the end of Quarter 3/start of Quarter 4 and data is in the process of being collated.

7.2.2. Our recruitment activity has released some pressure to cover shift shortfalls, but there is still reliance being placed on overtime and third party. We are able to evidence that just has many hours are being resourced this year, as last.

7.2.3. Third party activity has significantly increased in December, now attending 1,042 incidents, compared to 503 in November. We are continuing to monitor back up responses times to third parties and at this present time, they are not causing concern. The following chart shows the volume of reds they are responding to and their contribution to Red performance. This shows that the majority of incidents attended by community first responders (CFR) and third party ambulances are low acuity, meaning NEAS resources are available more often for the high acuity incidents.

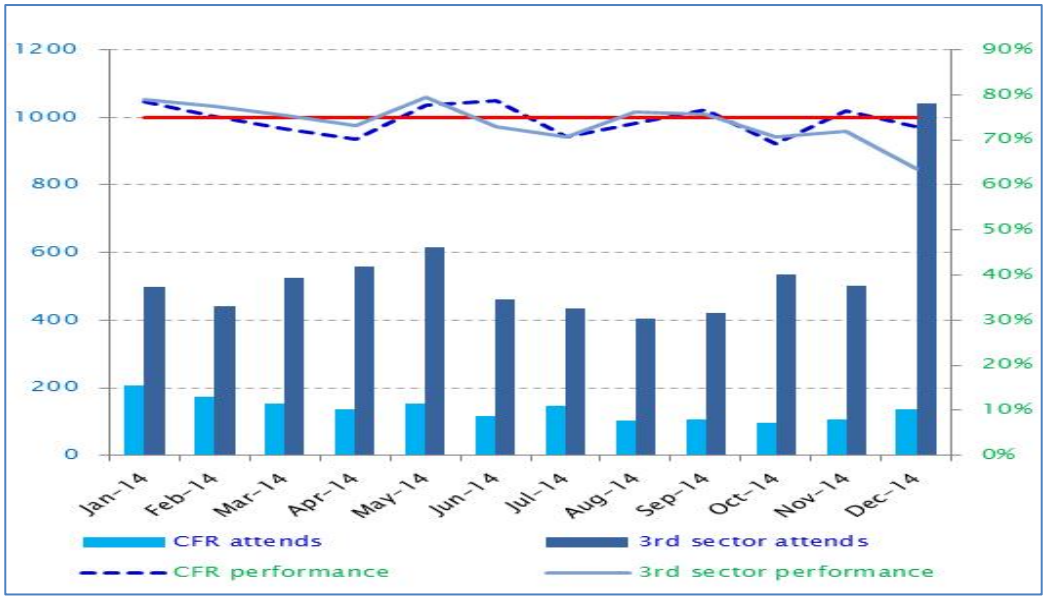


Figure 18: CFR and 3rd Party RC Performance and Activity Jan 14 – Dec 14

7.3. The increase in clinical hub staff is helping to drive the growth in hear and treat and see and treat activity by directing the right resource. We are forecasting an additional 5,671 hear and treats, growth of 46%.

7.4. The roll out of our Enhanced CARe training also appears to be contributing to the growth in see and treat activity. We are forecasting an additional 2,533 See and Treats, growth of 3.2%.

7.5. The change in the Trust's activity profile has resulted in more than 5,000 fewer conveyances in 2014/15 compared to 2013/14. Whilst the collective impact of our actions has not yet led to a significant improvement in emergency care or urgent response performance, they are more likely to have impacted by minimising the level of deterioration experienced, and specific schemes are inevitably contributing to helping dampen system pressure.

7.6. The schemes can, and will be measured in terms of activity undertaken. It is more difficult to assess their impact on emergency care response performance against a back drop of system pressures which is covered in Section 8.

8. Latest performance figures

8.1. Red performance for NEAS has been regularly below the national standards in the later part of the financial year and is below the Red 1, Red 2 and Red 19 standards for the year to date.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Red 1	77.05%	77.15%	75.66%	82.18%	78.31%	80.56%	80.07%	79.22%	69.50%	77.05%	73.48%	75.15%	73.28%	75.73%	77.58%	70.73%	79.47%	76.24%	65.85%	67.43%	62.37%
Red 2	80.28%	79.65%	81.54%	79.35%	80.53%	81.27%	79.77%	79.20%	76.50%	78.32%	76.35%	75.07%	73.91%	77.75%	75.59%	72.91%	75.90%	75.38%	71.26%	71.57%	66.44%
Red 19	97.22%	97.46%	97.75%	97.13%	97.64%	97.74%	97.13%	97.60%	96.23%	96.36%	96.07%	95.42%	95.43%	96.41%	95.27%	94.69%	95.78%	95.05%	93.39%	93.64%	91.26%

8.2. Red activity has also increased significantly over the last year as shown below, putting additional pressure on the Trust and adversely impacting on green call and urgent response performance as we actively direct resource to emergency cases.

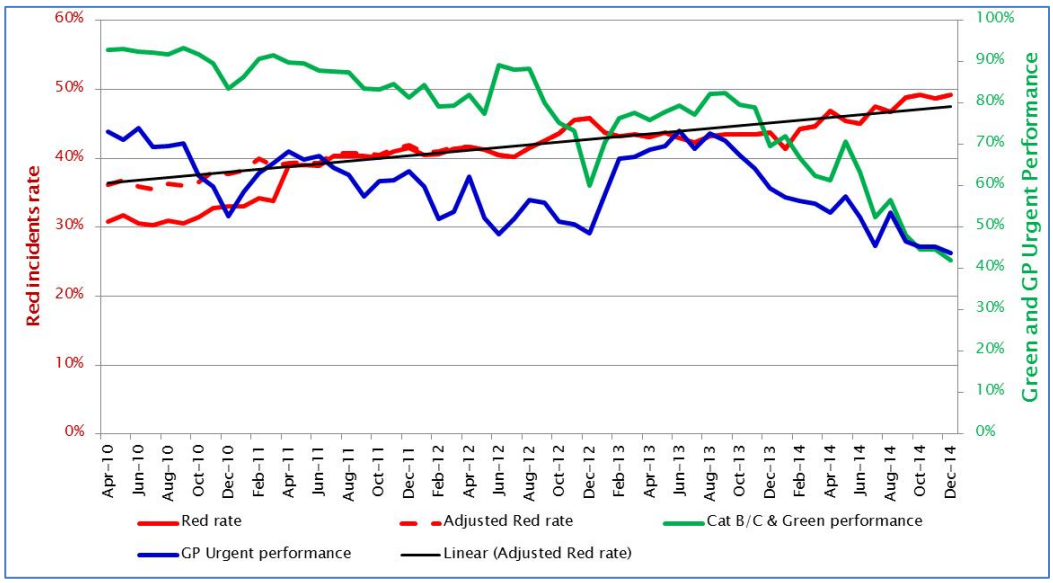


Figure 19: Red rate as percentage of all incidents

8.3. The additional hours/resource deployed and 'work arounds' have not been sufficient to account for the loss in hours due to system pressures. The following chart shows a notable increase in the daily hours lost just due to hospital delays for December. The hours that we plan for do not account for this level of loss in hours, enabling demand to easily outstrip our resource. The most significant delays are experienced at UHND, Sunderland and James Cook.

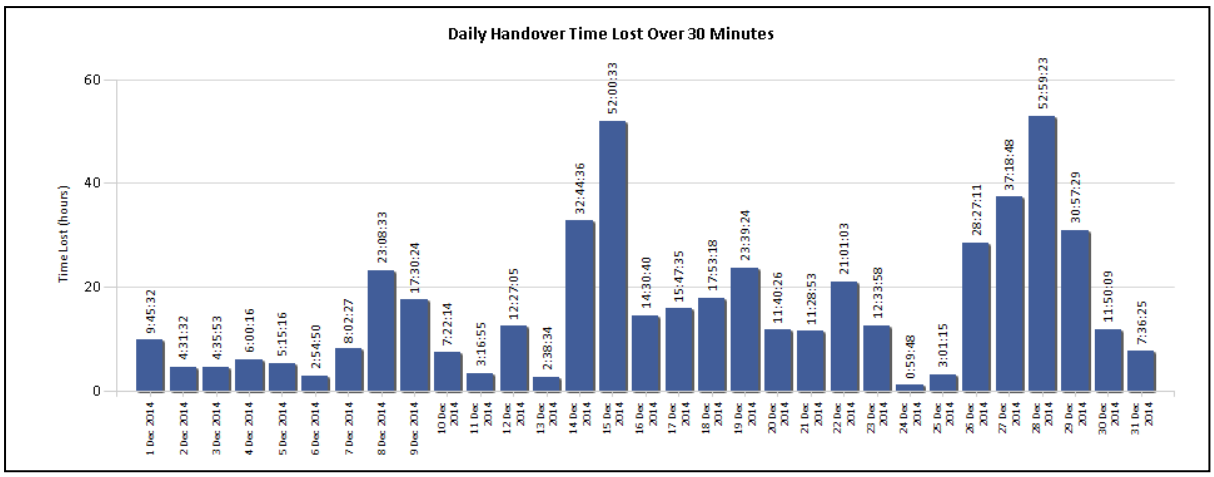


Figure 20: Hours lost daily due to delayed handovers over 30 minutes Sept – Dec

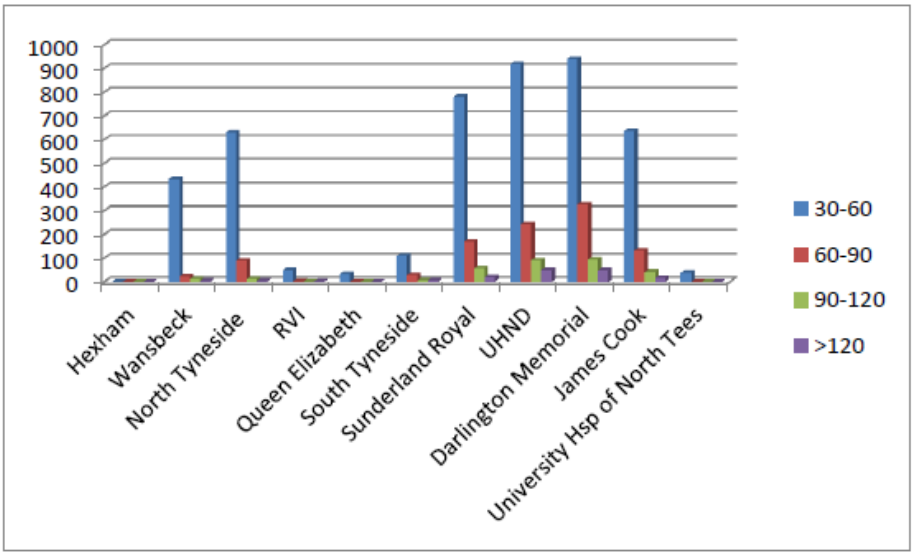


Figure 21: Total delays by hospital and time period 1/4/2014-27/1/2015

8.4. The following chart shows a visual correlation between increased handover delays and our Red performance.

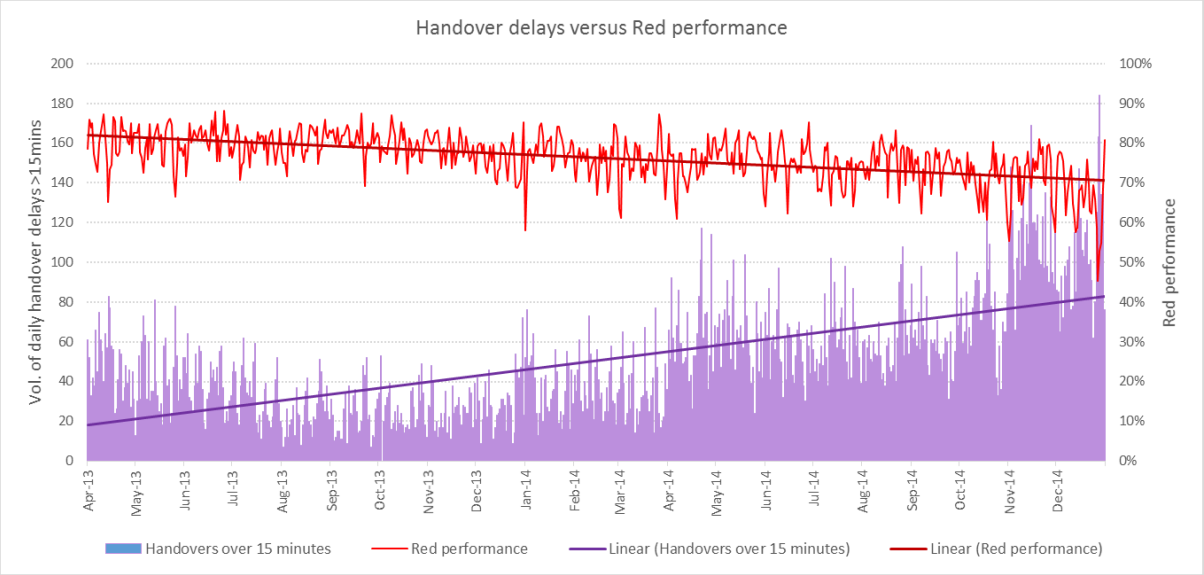


Figure 22: Relationship between handover delays and red performance

8.5. We also lose hours due to hospital diverts being put in place and increased travel times. Not all are declared and recorded therefore we have estimated our hours lost based on the CCG report postcode of the patient and linked hospital. In December 2,189 patients were taken to a hospital outside of their own locality and based on increased travel times; we estimate a further 39 hours per day are lost.

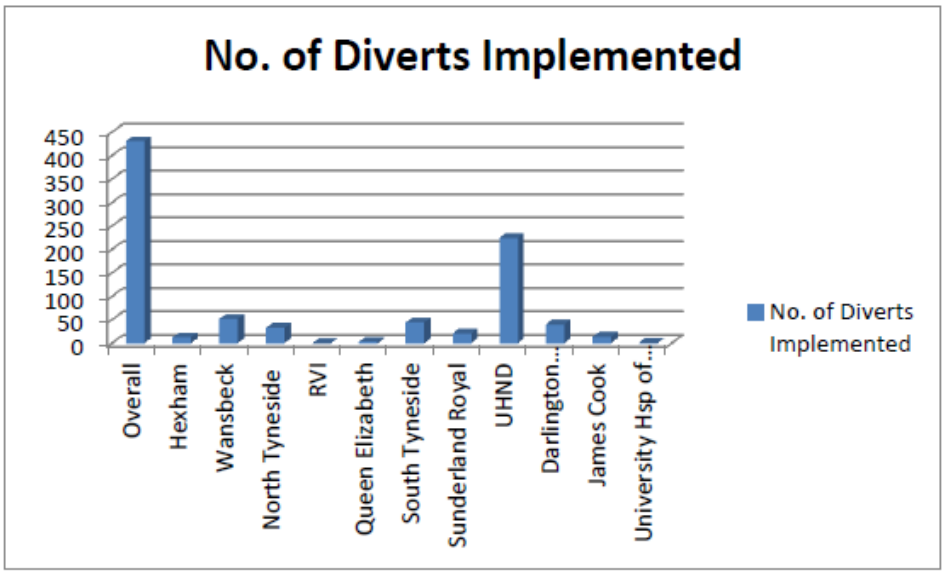
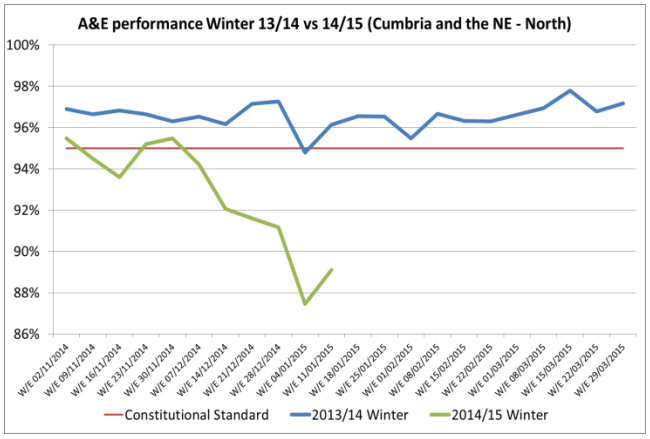
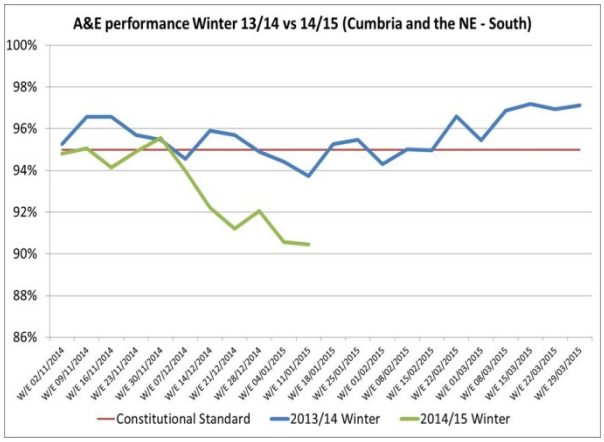


Figure 23: Total diverts recorded by NEAS 1/4/2014-27/1/2015

8.6. Winter in the North East has been severe in terms of hospital pressures. The four hour A&E target is consistently being breached in our region, a stark symptom of the system pressure this winter as shown below. We have also escalated to REAP 4 in response to system pressure.

A&E 4 hour wait target





9. Actions planned/assurances regarding delivery during Quarter 4 and beyond

9.1. January performance has shown positive signs of recovery and the daily SITREPS has shown some relaxation of the system pressure.

9.2. The reduced pressure evidences the levels of performance that can be achieved supported by all of the actions detailed in this paper. Should pressure continue to lift and we are able to sustain this of improvement, Quarter 4 performance may be

attainable.

9.3. The Trust's actions continue to be implemented throughout Quarter 4 providing some mitigation of any further deterioration.

9.4. It is the longer term actions that will support recovery of the Trust's key response targets into 2015/16. These include:

- Ongoing recruitment strategies deployed
- Development of supporting courses to counteract the impact of the move to a three year degree programme for Paramedics, this is a high risk area for NEAS given the extended lead time and potential to lose the ability to 'grow our own'
- Tackling sickness absence (an external review has been commissioned for 12 February)
- Attraction and retention plans to be developed
- The Organisational Development plan to help to tackle our own inefficiencies associated with breaks and downtime and electronic Patient Report Form (e-PRF) record completion and look at different ways to support staff and improve morale.
- A new e-PRF solution from April 2016
- Further development, in particular growth, of the staff bank
- Completion of the external review of our 'red rate' and procurement of CQI system for call handlers
- Management of the bed availability sitrep and taking control of diverts.
- Ongoing roll out and evaluation of Integrated Care and Transport project
- Resuming Enhanced CARe training (currently cancelled due to REAP 4 actions)
- A consistent handover process at hospitals to be agreed and implemented
- Recruitment of the front-line emergency care managers

10. Partnership working with Cleveland Police

10.1. We have a number of ongoing initiatives between the services and it is important that we continue to work closely with police locally and at a national level with the Association of Chief Police Officers, to explain the ongoing challenge we face in our service response and quality.

10.2. Chief Executive Yvonne Ormston gave her apologies for absence at the Tees Valley Scrutiny Committee meeting on 22 January as she was meeting with chief constable Simon Cole, ACPO lead on ambulance liaison, to discuss the national issue of ambulance/ police partnership working and response times.

10.3. Seven and a half percent of all 999 incidents that NEAS attend come from calls by the Northumbria; Durham and Cleveland police services. This is the highest proportion of emergency incidents originating from the police of other ambulance trust in the country. All our calls are prioritised on the patients' clinical need and requests from police officers do not take preference if other callers have a greater

need.

10.4. We meet regularly with all police services and are open and honest with all our partners about the issues we are facing. The national shortage of paramedics is particularly acute in the North East; less serious cases are experiencing delayed responses from us because of the increase in the number of potentially life threatening emergencies we are being called to; delays at hospitals mean that we have fewer crews available to respond.

11. Appendix 1:

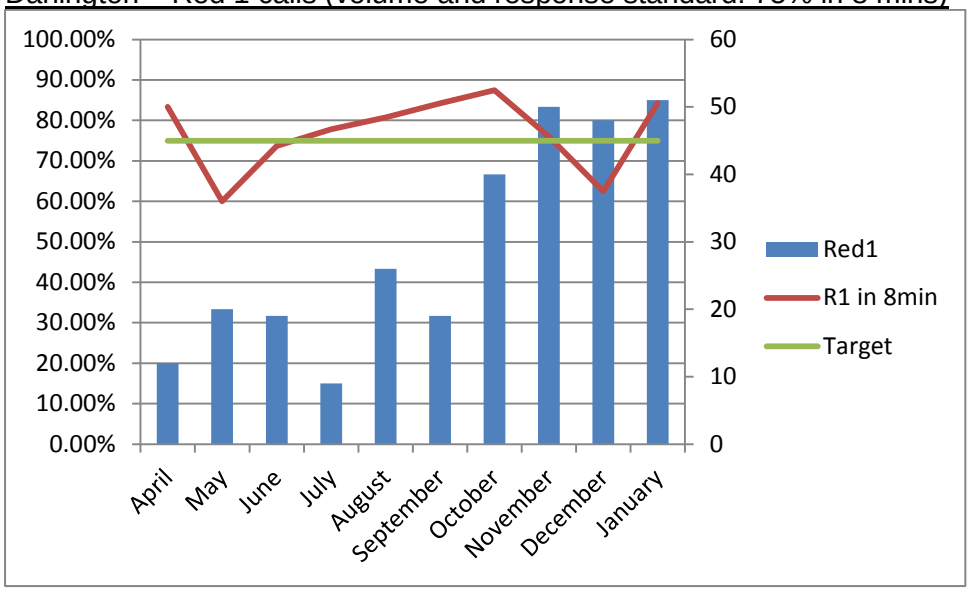
Location and numbers of ambulances across Tees Valley local authority areas

Appendix 2:

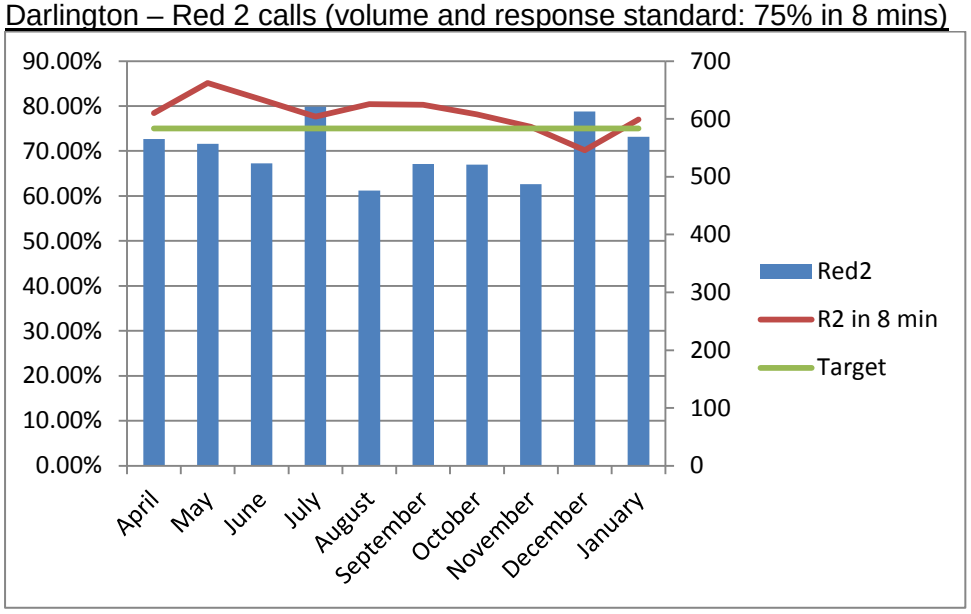
12. Local authority level performance data

NEAS performance is commissioned and monitored at CCG level. However, the CCG boundaries do not assist members in understanding the response times in their local authority area. This section provides NEAS responses by local authority area; however, it should be noted that NEAS is not commissioned or monitored at this level.

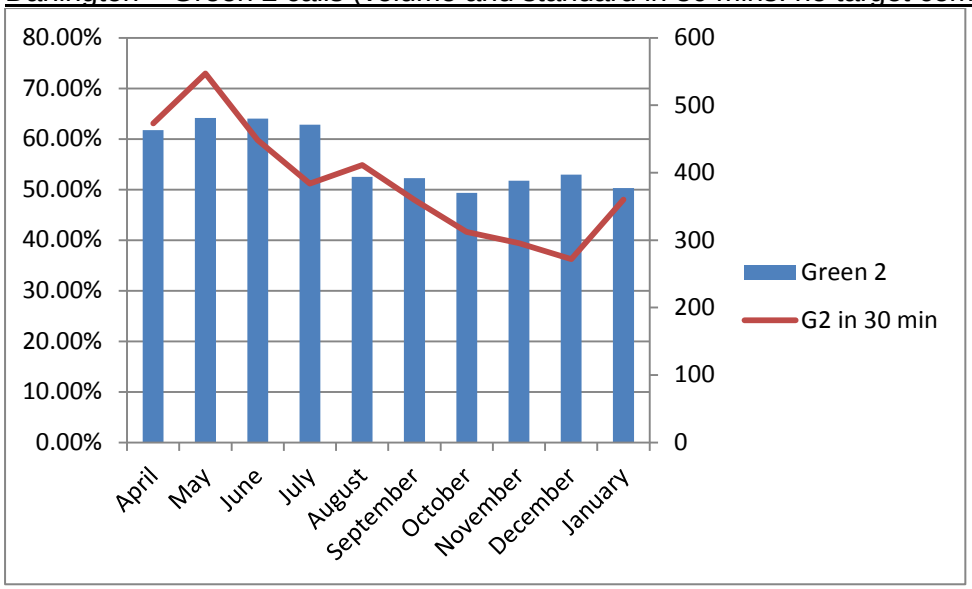
Darlington – Red 1 calls (volume and response standard: 75% in 8 mins)



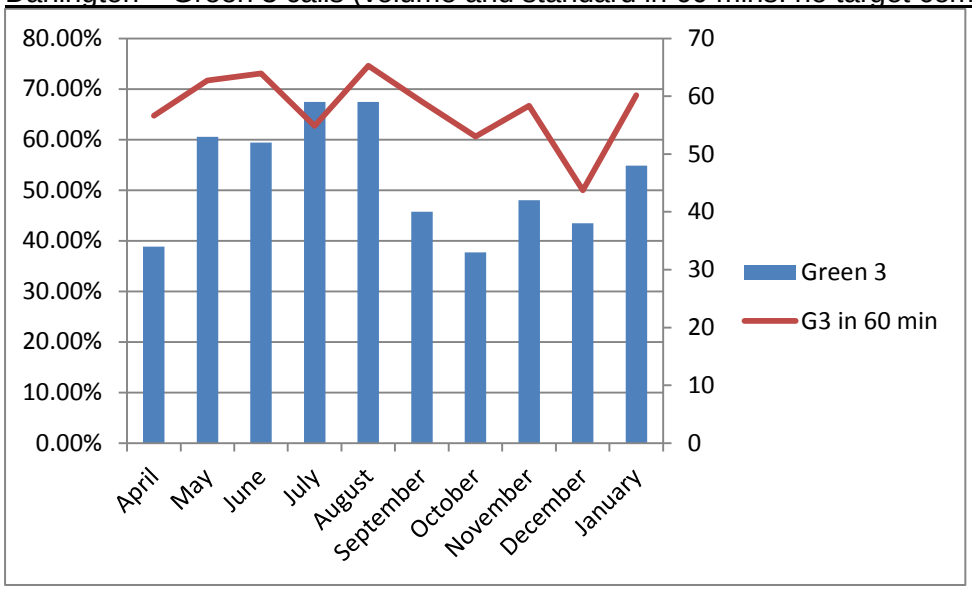
Darlington – Red 2 calls (volume and response standard: 75% in 8 mins)



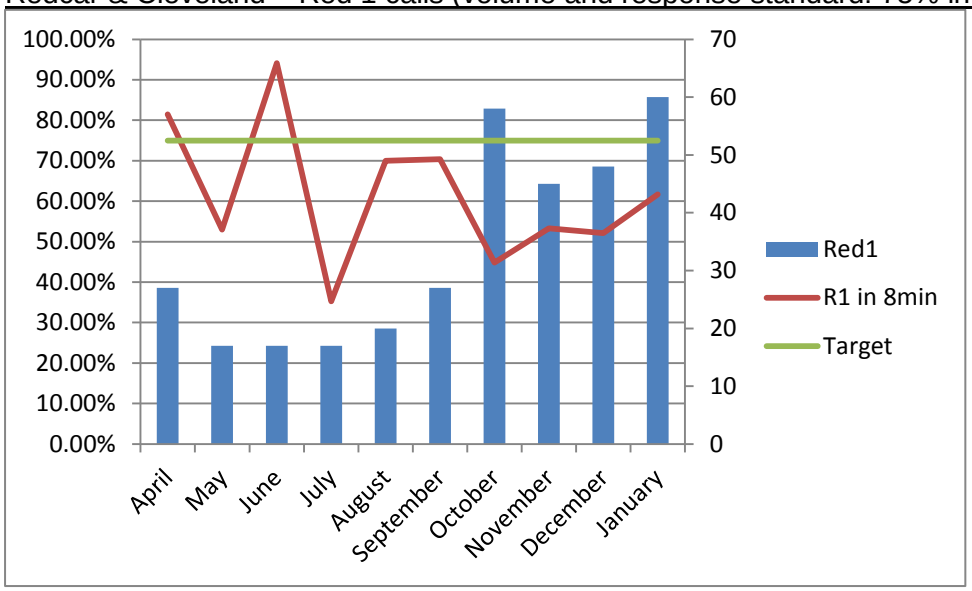
Darlington – Green 2 calls (volume and standard in 30 mins: no target commissioned)



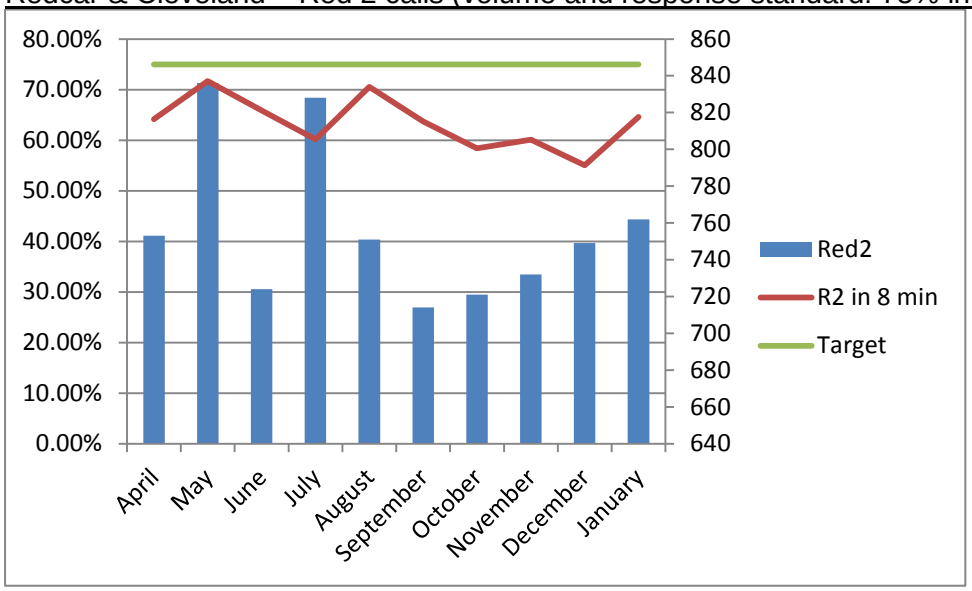
Darlington – Green 3 calls (volume and standard in 60 mins: no target commissioned))



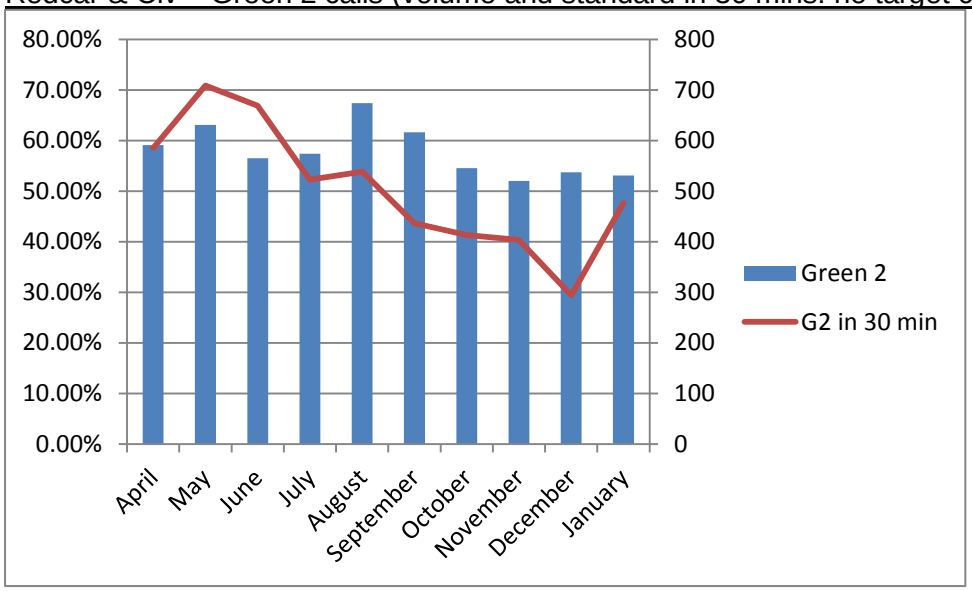
Redcar & Cleveland – Red 1 calls (volume and response standard: 75% in 8 mins)



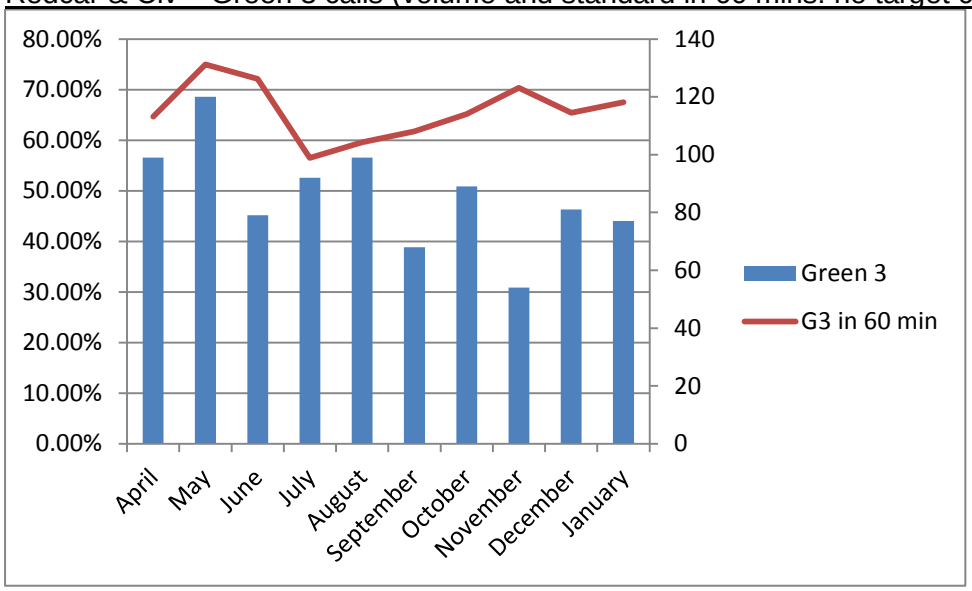
Redcar & Cleveland – Red 2 calls (volume and response standard: 75% in 8 mins)



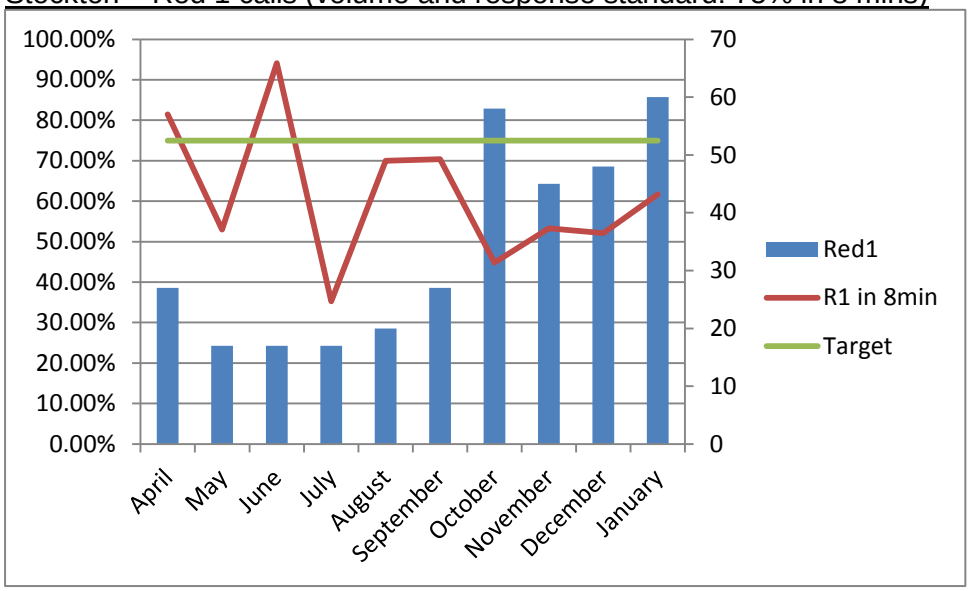
Redcar & Clv – Green 2 calls (volume and standard in 30 mins: no target commissioned)



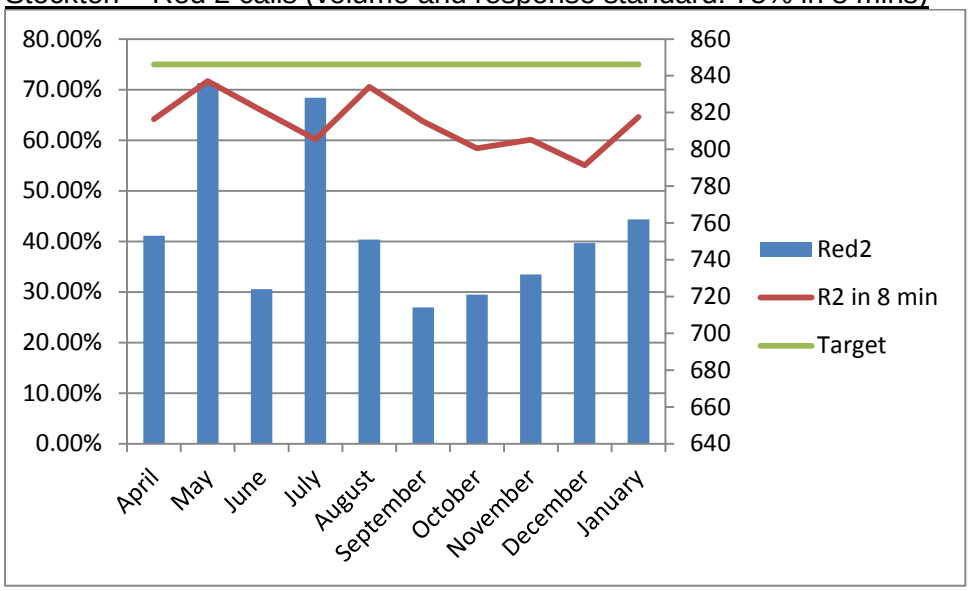
Redcar & Clv – Green 3 calls (volume and standard in 60 mins: no target commissioned)



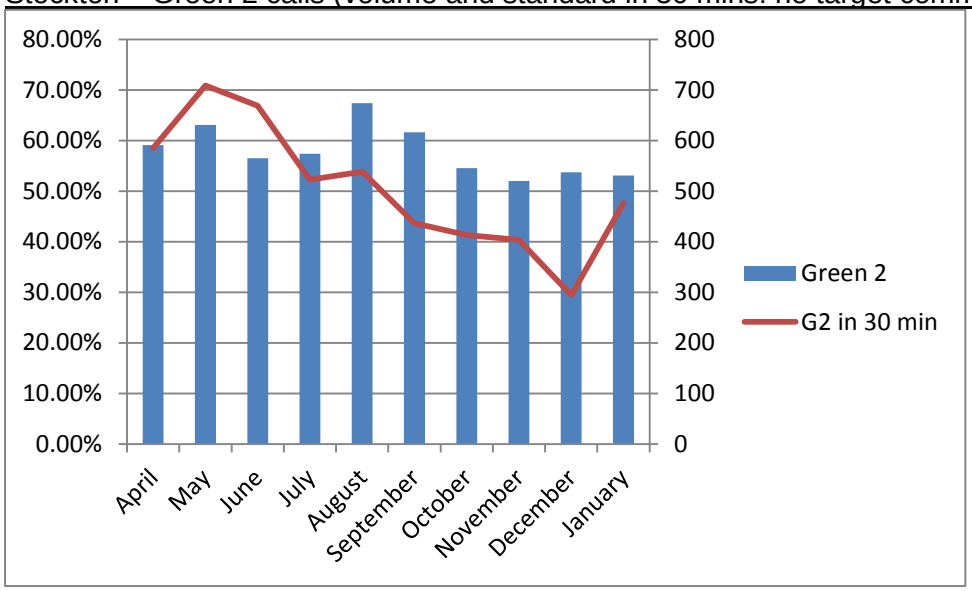
Stockton – Red 1 calls (volume and response standard: 75% in 8 mins)



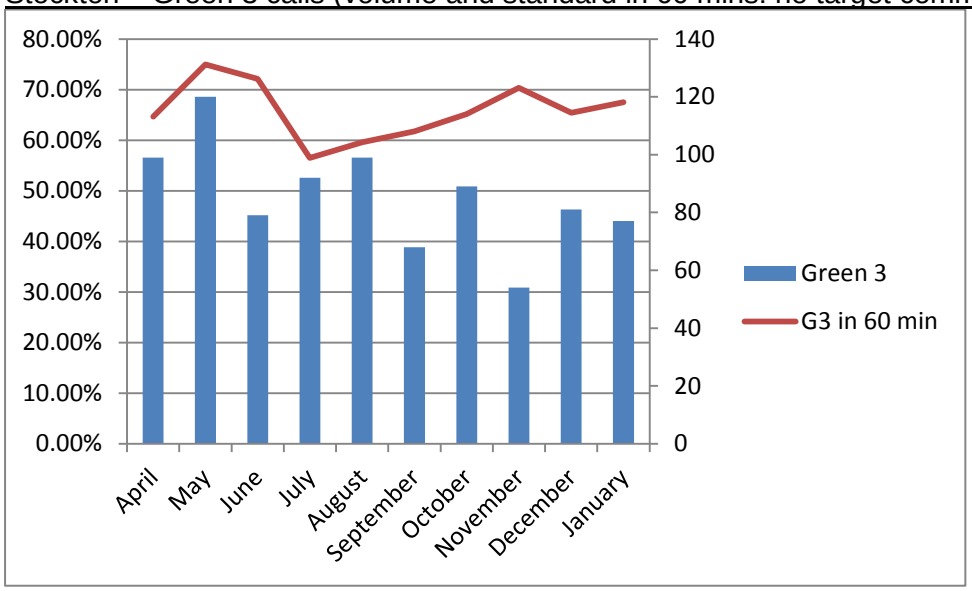
Stockton – Red 2 calls (volume and response standard: 75% in 8 mins)



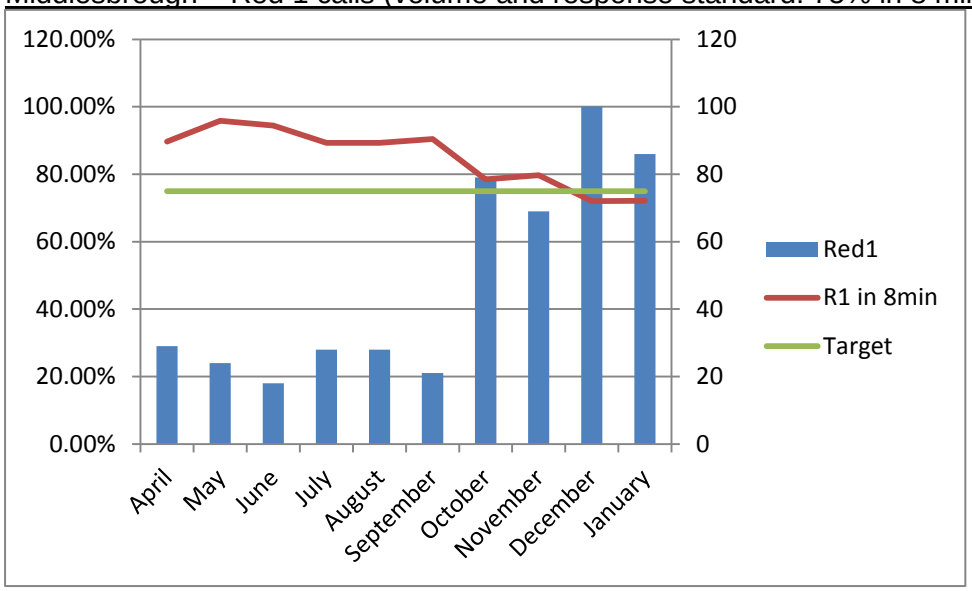
Stockton – Green 2 calls (volume and standard in 30 mins: no target commissioned)



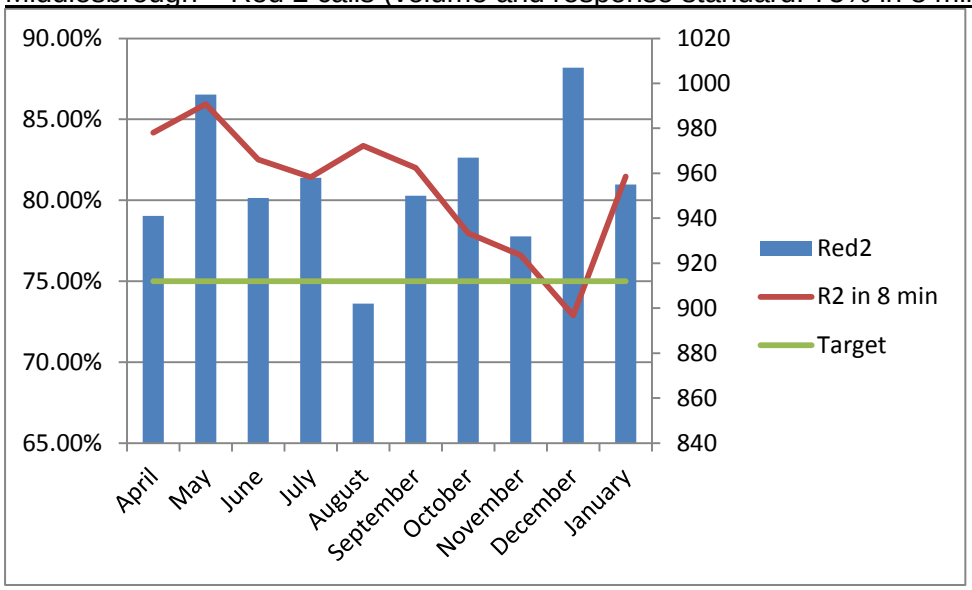
Stockton – Green 3 calls (volume and standard in 60 mins: no target commissioned)



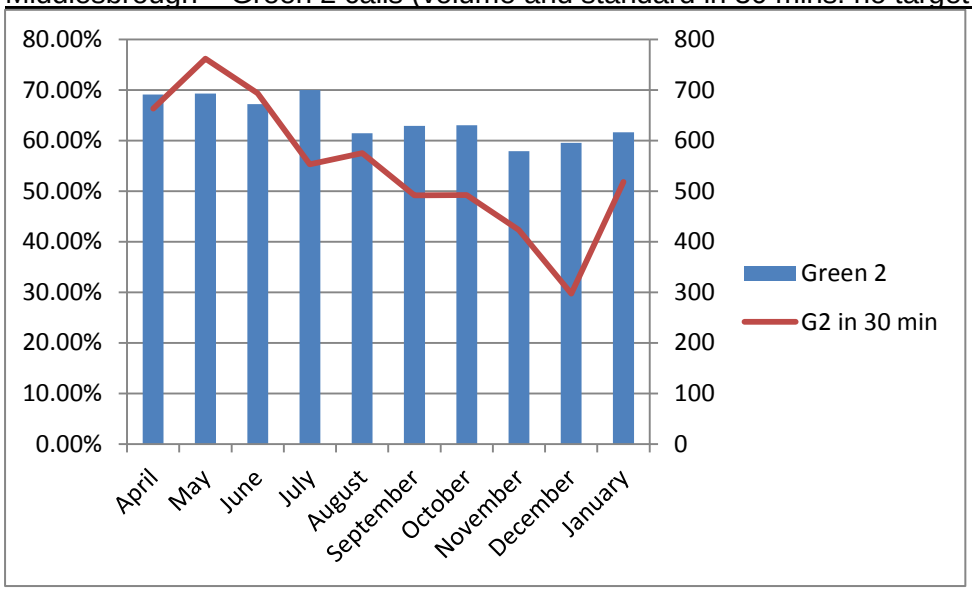
Middlesbrough – Red 1 calls (volume and response standard: 75% in 8 mins)



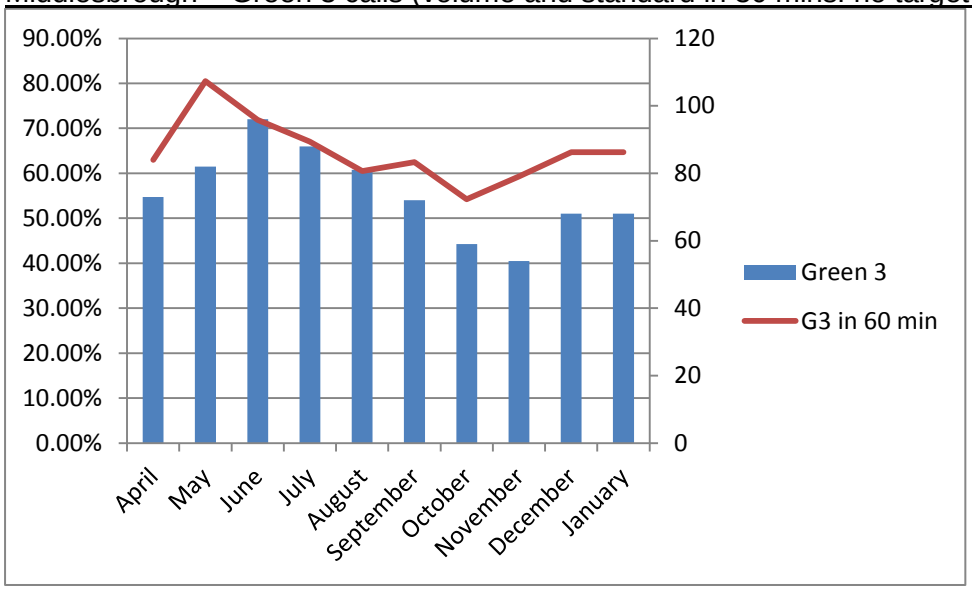
Middlesbrough – Red 2 calls (volume and response standard: 75% in 8 mins)



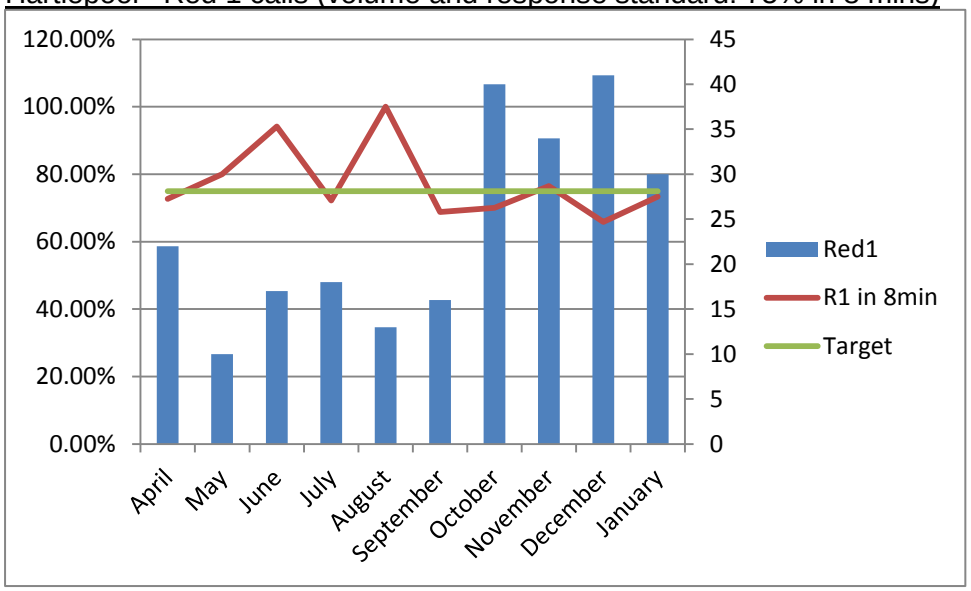
Middlesbrough – Green 2 calls (volume and standard in 30 mins: no target commissioned)



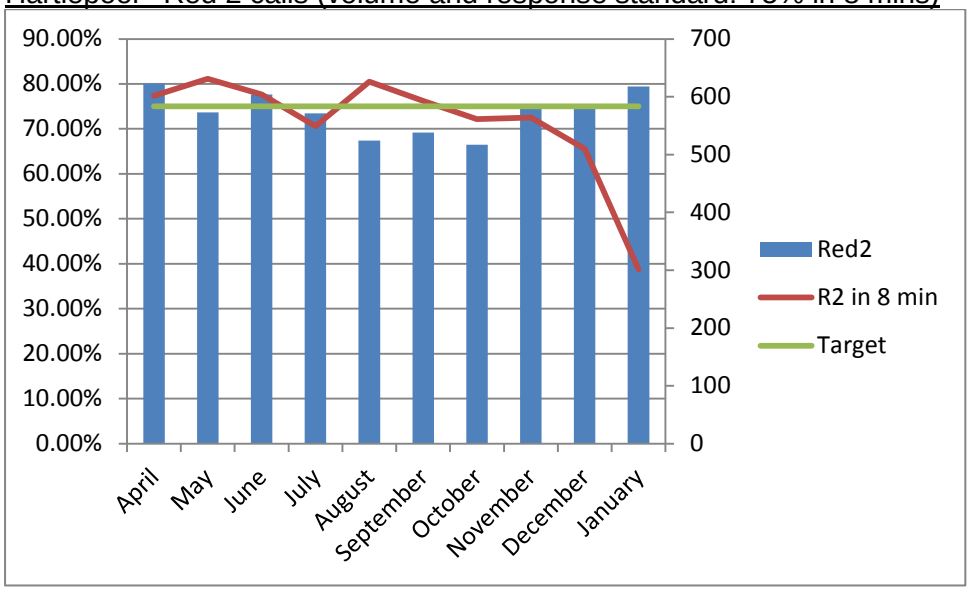
Middlesbrough – Green 3 calls (volume and standard in 30 mins: no target commissioned)



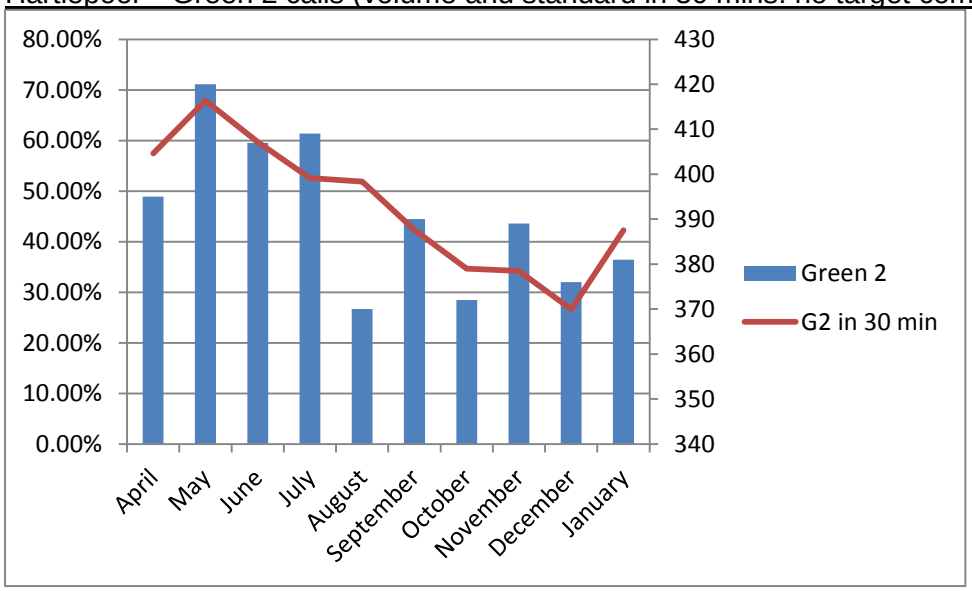
Hartlepool– Red 1 calls (volume and response standard: 75% in 8 mins)



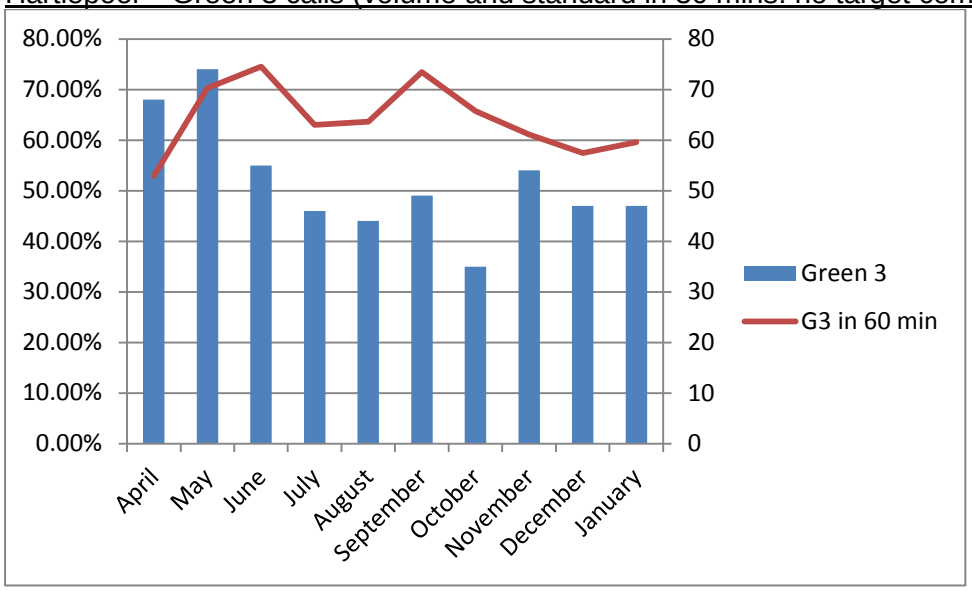
Hartlepool– Red 2 calls (volume and response standard: 75% in 8 mins)



Hartlepool – Green 2 calls (volume and standard in 30 mins: no target commissioned)



Hartlepool – Green 3 calls (volume and standard in 30 mins: no target commissioned)



TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

26 March 2015

Report of: Scrutiny Manager

Subject: TEES, ESK AND WEAR VALLEY NHS FOUNDATION TRUST – ANNUAL UPDATE AND QUALITY ACCOUNT

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1. PURPOSE OF REPORT

1.1 To inform the Committee that representatives from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) will be in attendance at today's meeting to provide the Committee with an annual update on services and also their Quality Account.

2. Background

2.1 Representatives of TEWV will be in attendance at today's meeting to outline performance against the Trust's quality priorities for 2014-15, and inform the Committee of the emerging priorities for 2015-16. Quality Accounts were introduced following the NHS Next Stage Review in 2008 in order to inform stakeholders and the wider public about the quality of the services provided by NHS Trusts. They set out:

- what an organisation is doing well;
- where improvements in service quality are required;
- what the priorities for improvement are for the coming year;
- how the organisation has involved service users, staff and others with an interest in your organisation in determining those priorities for improvement.

2.3 Quality in the NHS consists of three 'domains': patient safety, effectiveness of care, and patient experience. As part of the assurance process draft Quality Accounts are circulated to key organisations including commissioners, patient groups and relevant overview and scrutiny committees. These groups have the opportunity to submit a statement for inclusion in the published version setting out their views on a Trust's performance and priorities.

2.4. Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust Quality Account process and related information is therefore being considered by the Committee, as the Joint Committee covers a large proportion of the population served by the Trust.

2.5 TEWV's draft Quality Account itself will be produced in mid- April in line with the availability of end of year data, and this will be provided to Members in due course. If the Committee agrees, a statement will then be produced to reflect

Member comments. It is suggested that final sign off be delegated to Chair and Vice-Chair as this will need to be finalised by mid-May.

2.6 TEWV will also provide the Committee with an annual update on services.

3. RECOMMENDATIONS

3.1 It is recommended that:

(a) The Committee consider the information presented at this meeting and seek clarification on any relevant issues where required;
(b) The Committee consider and comment on the update on performance in 2014-15 and the priorities for quality improvement in 2015-16; and
(c) A statement of assurance be prepared and submitted (following the circulation of the draft Account) with final approval delegated to the Chair and Vice-Chair.

BACKGROUND PAPERS

No background papers were used in the preparation of this report.

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TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

26 March 2015

Report of: Scrutiny Manager

Subject: UPDATE ON THE CHANGES TO CHILDREN'S AND MATERNITY SERVICES AT THE FRIARAGE HOSPITAL

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1. PURPOSE OF REPORT

1.1 To inform the Committee that representatives from South Tees NHS Foundation Trust will be in attendance at today's meeting to update the Committee on the changes to children's and maternity services at the Friarage Hospital and the impact of the changes on the Tees Valley area.

2. Background

2.1 At the Joint Committee meeting of 8 October 2012 (minutes attached at **Appendix 1**) the Committee was updated on proposals to change children's and maternity care at the Friarage Hospital which is managed by South Tees NHS Foundation Trust.

2. 2 Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG) consulted the public and stakeholders between 2 September and 25 November 2013 on the options for the future delivery of services. Senior representation from the CCG were in attendance at the Joint Committee on 28 October 2013 in order to brief members on the proposals and consultation process (minutes attached at **Appendix 2**). The Joint Committee's response to the consultation is attached at **Appendix 3**.

2.3 The response back to the Committee from the CCG is attached at **Appendix 4,** which provides a link to the full consultation report and also to the Assessment of Future Services document that explains in detail the option for the future that the CCG's Council of Members has decided to take forward.

2.4 From 1 October 2014, children's and maternity services at the Friarage Hospital changed, representatives from South Tees NHS Foundation Trust will be in attendance at today's meeting to update the Committee on the changes to the services and the impact of the changes on the Tees Valley area.

3. RECOMMENDATIONS

3.1 It is recommended that the Committee consider the information presented at this meeting and seek clarification on any relevant issues where required.

BACKGROUND PAPERS

The following background paper was used in preparation of this report:-

(a) Proposed changes to children's and maternity services at the Friarage Hospital and wider impact on Tees Valley area presented to the Tees Valley Joint Health Scrutiny Committee on 28 October 2013

(b) Minutes of the Tees Valley Joint Health Scrutiny Committee held on 8 October 2012 and 28 October 2013

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Extract from minutes of 8 October 2012

19. OPTIONS FOR PAEDIATRIC AND OBSTETRIC SERVICES AT THE FRIARAGE HOSPITAL, NORTHALLERTON – The Director of Planning, South Tees Hospitals NHS Foundation Trust submitted a report (previously circulated) briefing Members on the options for paediatric and obstetric services at the Friarage Hospital, Northallerton. The report also addressed Members concerns at the impact the decision would have on James Cook University Hospital (JCUH).

The Director of Planning Jill Moulton, reassured Members that the Trust in making the case for change to services at the Friarage, was very conscious of the need to ensure that services offered at James Cook Hospital would not be adversely affected and considered in detail the number of patients likely to seek their services from JCUH and other hospitals in future and the implication of the change for staffing and facilities. It was noted that the Trust is facing challenges in staffing its paediatric and maternity departments in a way which meets increasingly stringent standards on a consistent basis. The pooling of medical staff which will occur from the changes being consulted on will place the Trust in a stronger position to recruit, retain and deploy staff appropriately across both sites.

Ms Moulton reported that it was difficult to estimate the increased patient flow at James Cook Hospital as a result of the proposed changes and assumptions had been made based on travel times to the nearest hospital and other factors which might influence patient choice. Staffing numbers at James Cook Hospital would also be increased to cope with the transfer of activity. The paediatric and obstetric departments at James Cook Hospital deal with high volumes and the change in activity proposed is comparatively small in relation to total activity, however, there would be a transfer of medical and nursing staffing establishment from the Friarage to ensure that extra activity is safely managed and that patient experience is not compromised.

Ultimately some physical changes would need to be made to James Cook Hospital to deal with the increase in patient numbers and the Trust is working up plans for areas to provide the additional space required. It was reported that the estimated annual costs of the capital investment needed were taken into account when costs for each option were prepared.

The additional requirement for car parking at James Cook Hospital would be small but the Trust recognised that concerns about parking add considerably to the stress of a hospital visit. Plans are being developed with Middlesbrough Council to increase the number of car parking spaces available on site for patients (and for staff) and it is hoped that implementation will begin in 2013.

Mrs Toller responded to questions on the training of doctors, explaining the complexity of the current arrangements by which the Royal Colleges attempt to balance the number of doctors being trained against the number of consultant posts available.

In response to a question from a Member, it was noted that the Friarage Hospital is one of the smallest maternity units on the country.. It was noted that maintaining the safety standards at the Friarage was becoming difficult and based on the low numbers of women seen it would become difficult to sustain the skills set of consultants over the long term, based on the number of births. It was acknowledged that it was difficult to 4

sustain and apply national standards in small hospitals, as it was difficult to recruit, maintain competencies and skills, ultimately this would impact on safety standards and put patients at risk. Investment in more doctors would not address these issues. It was noted that the Friarage has maintained standards so far due to the dedication of the consultants and other staff.

Discussion ensued about the proposal for a freestanding Midwifery Led Unit which would be staffed and run by midwives, offering care during delivery to low dependency women at low risk of complications in labour. Midwifery Led Unit births have not declined although, the number of problem births have risen and culturally some women just don't want to make a choice. Selling the benefits of a Midwifery Led Unit is sometimes tricky as women always remember the negative incidents. Within the Friarage catchment area it is estimated that 500 births could be delivered at the Unit but in reality it was estimated to be more likely to be 300 births. Mr Aitken advised that he was a strong supporter of Midwifery Led Units and believed that the Unit at Bishop Auckland General Hospital worked extremely well. He reported that there had never been a major incident there and acknowledged that the difficulty was selling the service. Mr Aitken said that Midwifery Led Units operate successfully if there is good ambulance support if emergency transportation is required, a high number of good well trained staff and a high number of births to deliver a model care experience of very high quality. It was commented that discussions needed to be held with both Trusts about whether CCGs would commission Midwifery Led Units or whether money could be spent elsewhere.

Senior Delivery Manager Designate, Hambleton, Richmond and Whitby Clinical Commissioning Group, Sarah Ferguson agreed that women should be able to choose where to give birth and that the Trust need to market the Midwifery Led Unit carefully. The CCG would be seeking views of new mums following their visit to the Friarage and a needs assessment would be carried out to assess the level of demand.

The Associate Director Communications and Marketing, County Durham and Darlington NHS Foundation Trust discussed how the proposals would impact on Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND), highlighting that maintaining quality and safety of service is paramount, ensuring that new standards are continually achieved and the services are sustainable for the future. He acknowledged that the proposals would strengthen the offer that the Trust can provide for women.

The Associate Chief Operating Officer, Tracy Hardy reported that the Trust have been having conversations with South Tees Hospital NHS Foundation Trust about the impact of the decision of the Friarage. Members were reassured that the Trust could manage the additional obstetrics and gynaecology and paediatric patients based on the estimated numbers and there was capacity at DMH to do so. In the short term arrangements would need to be out in place such as investments into a Pregnancy Assessment Unit, greater consultant presence on labour ward and the number of neonatal cots would need to be increased. Mr Aitken acknowledged that sustainability of services was the main concern and reliance about maternity networks will shape the future services and Trusts will be forced to work together. He suggested that continuing release of new guidance from the Royal College of Nursing and introduction of new initiatives, mean standards and practices continue to change and make services difficult be sustainable in the long term.

Mr Aitken advised that at DMH senior consultants were assisting junior doctors on night 5

shifts to pass on their skills and knowledge, he said this was working well and hoped that it would future proof the younger generation of Consultants. He believed that DMH has a role to play in the options for viability of the future and raising standards.
Members queried whether there is value in creating networks, such as maternity networks across the Tees Valley given the direction of travel. Mr Aitken reported that there has always been successful working and networks across the Tees Valley, for example Gynaecology Caner Network has existed for years and has been successful.
Members agreed that this was emotive subject which needed to be handled carefully and there needed to be clear consultation information. Members agreed that the consultation should be considered at the Joint Committee.
AGREED – (a) That Officers from County Durham and Darlington NHS Foundation Trust and South Tees Hospital NHS Foundation be thanked for their attendance at the meeting.
(b) That the presentations be noted; and
(c) That the consultation document be brought before the Joint Committee for consideration and a response.

Extract from minutes – 28 October 2013

Consultation on proposed changes to children's and maternity services at the Friarage Hospital

Members were provided with a copy of the papers and DVD used for the Consultation on proposed changes to children's and maternity services at the Friarage Hospital. It was explained that the issue was raised in regard safety issues for patients by the clinicians in the Friarage hospital and not at management level. The units at the Friarage were under increasing pressure from staffing difficulties, the need to meet ever improving standards, and the need to maintain skill levels.

This lead to an independent review by the National Clinical Advisory Team of the services supporting the case for change and highlighting the need to discuss the possible options for making it safe for patients. A number of options were considered and it was now down to two options:

- Option 1 – Establish a midwifery led unit (MLU) that would only deal with low risk births and paediatric short stay assessment unit that would run during the day but no in patients, with a full outpatient service.
- Option 2 – Establish a midwifery led unit that would only deal with low risk births and provide paediatrics on an outpatient basis (with urgent appointments available)

The consultation on the two options was open until 25th November 2013.

It was also explained that for a six month period after the proposed change to the services a shuttles bus would operate from Friarage Hospital to the other hospitals for patients and their family and friends. Along with the shuttle bus there would be an ambulance for emergency transfers for patient safety. The Friarage Hospital received approximately 1200 births, it was anticipated after the proposed changes 500 of these births could continue at Friarage if the expectant mothers wanted. Some mothers would choose to attend a different hospital where consultants were available on site. 700 of the expectant mothers would not be deemed suitable due to being high dependency and possibly requiring consultant led care.

The Committee raised the following comments/questions:

- Concerns were raised regarding travel times to nearest hospitals that would be providing the consultant-services which would be removed from Friarage;
- Capacity of ambulance services to undertake emergency transfers from the Friarage to consultant-led units and the assurances given in this regard;
- The need to avoid the situation at the Bishop Auckland MLU which had seen services suspended, pending reassurances on the availability of ambulance cover for emergency transfers;
- Plans needed to be made for women travelling from what could be a long distance being sent home because they are not in established labour. In response it was explained this would be taken into account and appropriate action would be taken i.e. rooms available for them;
- The benefits of mid-wife led units for appropriate cases;
- The need for the shuttle bus to be available for during visiting times to allow family and friends to visit patients;
- The need to ensure that sick children were cared for at the right place once the in-patient unit closed, including public information surrounding the correct use of A and E.

The Committee thanked officers for attending and presenting the information.

The Committee agreed:

1. that the above comments be included in a response to the consultation
2. that a draft response be circulated to the Committee prior to sign off by the Chair and Vice-Chair

Tees Valley Joint Health Scrutiny Committee

Response to consultation on changes to children's and maternity services at The Friarage Hospital

The Committee considered the matter at its meeting of 28 October 2013 and was pleased to be able to discuss the issues with Hambleton, Richmondshire and Whitby CCG, South Tees Foundation Trust, and County Durham and Darlington Foundation Trust. The proposals impact upon the Tees Valley area due primarily to the potential for increased demand on James Cook and Darlington hospitals.

The consultation outlines two options for the future of services:

- Option 1 – Establish a midwifery led unit (MLU) and paediatric short stay assessment unit, with a full outpatient service and enhanced services in the community.

- Option 2 – Establish a midwifery led unit, and provide paediatrics on an outpatient basis and enhanced services in the community.

The Joint Committee agrees with the overall case for change at the Friarage due to the concerns over the safety and sustainability of current children and maternity services. The units at the Friarage have already been subject to a temporary suspension of services and it would not be acceptable to continue with the ongoing risk of this happening again.

Currently the Friarage provides care for approximately 1200 births per annum, and it is projected that following these changes, approximately 700 expectant mothers would need the support provided at consultant led units. The CCG reported that 2010-11 saw approximately 1100 children's in-patient admissions that required no overnight stay, 800 inpatient admissions with an overnight stay, and 9840 outpatients or day attendances.

It is clear from the public consultation feedback that most concern relates to the potential increase in travel times for some patients, visitors, and ambulances when required. The Committee welcomes the introduction of the shuttle bus for visitors and appointments, and the availability of a vehicle linked to Accident and Emergency for transfers. As this is planned to be available for a trial period of six months, it will be important to keep this under review and provide for longer if necessary.

Midwife Led Units are a safe and attractive option for many women with lower risk pregnancies. It is important however that they operate to the best standards available including strict criteria as to who should be admitted, and the availability of ambulances for patients needing transfer to consultant-led units.

NICE guidelines state that a class 1 emergency caesarean section, for example, should be performed within 30 minutes of a decision to deliver. This highlights the importance

of having a robust process for emergency transfers in place. As part of its work the Committee has monitored the work of the Bishop Auckland MLU. At the Bishop Auckland Unit, around 30% of cases required transfer to the consultant-led units at either Durham or Darlington.

The Committee is aware that the unit at Bishop Auckland is currently suspended due to concerns over the arrangements for emergency transfer. The Joint Committee would wish to ensure that arrangements at the Friarage are sustainable to avoid any similar suspensions of service.

The Joint Committee would therefore seek assurances from Yorkshire Ambulance Service (and North East Ambulance Service where applicable) that they can guarantee a safe outcome for those women and unborn babies who will need transferring in an emergency situation for consultant care.

Some patients may attend a maternity unit but be sent home if they are not in established labour. This may involve substantial travelling for those women who would in future be due to give birth at James Cook, instead of a more local hospital. The Committee would therefore be reassured if provision could be made for women travelling long distances from North Yorkshire to stay at the hospital with no need to leave and return later.

Consideration may also be given to improving the range of information provided to higher-risk expectant mothers so that they can choose from the full range of consultant led units open to them, as alternatives to James Cook and Darlington may be more appropriate in individual cases.

In relation to children's services, although most children do not require a long stay in hospital, clearly there will be an impact on some families, and consideration should be given to ensuring that visiting times are flexible.

The Committee's preferred option would be number one (ie. inclusion of a Paediatric Short Stay Assessment Unit (PSSAU)), as this is clearly the better option out of those available and would ensure that the greatest number of children would be able to be seen at the Friarage in future.

The survey outlines that there are options for the opening hours of the PSSAU. The Committee would support the unit being as accessible as possible, and would support 10am-10pm opening on weekdays, and 10am-4pm on weekends. This was also supported by the National Clinical Advisory Team as most children present between 10am and early evening.

The impact of the changes to paediatric services will be heavily contingent on the initial triage of children, and some acutely sick children would be taken straight to James Cook or another appropriate hospital once they had been assessed by a GP or out of hours arrangements/999.

The Committee was reassured that protocols would be put in place to ensure that ambulance services do not inappropriately handover sick children to the Friarage A and E department in future, and the triage of sick children should work smoothly if the initial contact is always via the GP or NHS111/999.

However this may not be the case should parents take children direct to the A and E department. It will be important that there is work to improve public awareness about what families and carers should do if their child is very unwell. It will also be important that the team at the Friarage is supported to be able to treat these children, prior to transfer to a more appropriate hospital.

The Committee were provided with reassurance that there will be work undertaken to increase capacity at both James Cook and Darlington to cope with the increase in admissions. This will need to be kept under review to ensure that all patient outcomes and experience are not adversely affected.

As with all service reconfigurations, the opportunity to increase the range of services closer to home is strongly encouraged. The Committee is therefore pleased to see the proposal to improve the range of outpatient clinics in the locality, primarily due to the release of staff from overnight duties.

Hambleton, Richmondshire and Whitby Clinical Commissioning Group

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By email

20 February 2014

Dear Councillor Javed

Re: Children's and maternity services at the Friarage Hospital, Northallerton

Thank you for the response letter from the Tees Valley Joint Health Scrutiny Committee, in relation to our consultation on children's and maternity services at The Friarage Hospital. As always, we are very keen to hear the views of all of our stakeholders and I'm grateful for the time the committee has taken to get involved, and for the invitation to attend your committee meeting on 28 October to discuss the consultation.

All the comments that we received were recorded and analysed in our full consultation report, which is now available to view on our website here:
www.hambletonrichmondshireandwhitbyccg.nhs.uk/board-meetings-agendas-and-papers/27-february-2014/

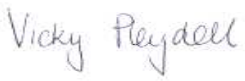
In addition to the consultation report, you can also read our Assessment of Future Services document that explains in detail the option for the future that our Council of Members (a representative from each GP practice in our area) has decided to take forward.

This decision will be discussed at our Governing Body Meeting held in public, on Thursday 27th February at 10am at the Golden Lion Hotel in Northallerton.

The response letter picked up some important points and I'd like to reassure you that we are working closely with our colleagues at South Tees Hospitals NHS Foundation Trust to ensure that the implementation of the new service is carried our seamlessly and that strict policies and protocols are in place. Further details on all aspects of the new service can be found in the full options appraisal document here, however, if there is anything in particular that you would like clarity on, we would be happy to attend a further committee meeting at your convenience.

As we have said throughout this process, we want to ensure that The Friarage Hospital remains at the heart of local healthcare in our area. We believe that by making changes to children's and maternity services now, we will ensure that they are safe and sustainable for the future, which as the local commissioner of health services, is always our number one priority.

Yours sincerely



Dr Vicky Pleydell
Clinical Chief Officer

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

26 March 2015

Report of: Scrutiny Manager

Subject: DIGITAL HEALTH CARE – PILOT WORK

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1. PURPOSE OF REPORT

1.1 To provide information to the Joint Committee regarding the pilot work on digital health care.

2. Background

2.1 The Joint Committee agreed as part of its work programme to receive information regarding the pilot work on digital health care.

2.2 Digital health service provider, InHealthcare, is working with County Durham and Darlington NHS Foundation Trust to pilot a new remote monitoring technology designed to improve the clinical outcomes and quality of life of patients on long-term anticoagulation therapy.

2.3 Patients who have suffered a stroke or pulmonary embolism, or who have recently undergone surgery, are often prescribed the anticoagulant, warfarin, which requires regular blood tests at clinics to monitor their International Normalised Ratio (INR). The new service removes the need for these weekly or monthly visits by allowing them to self monitor their INR from home.

2.4 Members will be provided with an update on the pilot work at today's meeting.

3. RECOMMENDATIONS

3.1 It is recommended that the Committee consider the information presented at this meeting and seek clarification on any relevant issues where required.

BACKGROUND PAPERS

No background papers were used in preparation of this report.

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