Agenda

Meeting: Scrutiny of Health Committee

Venue: The Grand Committee Room, County Hall, Northallerton DL7 8AD (See location plan overleaf)

Date: Friday 12 June 2015 at 10.00 am

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Business

1. Minutes of the meeting held on 23 January 2015. (Pages 1 to 9)

Purpose of Minutes: To determine whether the Minutes are an accurate record.

2. Chairman's Announcements - Any correspondence, communication or other business brought forward by the direction of the Chairman of the Committee.

(**FOR INFORMATION ONLY)**

- Tees, Esk and Wear Valleys Foundation Trust – Results of CQC Inspection
- Yorkshire Ambulance Services – Update on CQC Inspection
- South Tees Hospitals NHS FT – Update on CQC Inspection
- York Teaching Hospitals NHS FT – Update on CQC Inspection

3. Public Questions or Statements.

Members of the public may ask questions or make statements at this meeting if they have given notice to Jane Wilkinson of Democratic Services *(contact details below)* no later than midday on Tuesday 9 June 2015. Each speaker should limit himself/herself to 3

Enquiries relating to this agenda please contact Jane Wilkinson on **01609 533218**
Fax: 01609 780447 or e-mail jane.1.wilkinson@northyorks.gov.uk
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minutes on any item. Members of the public who have given notice will be invited to speak:-

- at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes);
- when the relevant Agenda item is being considered if they wish to speak on a matter which is on the Agenda for this meeting.

4. **Healthwatch Update (Including results of "Enter and View" visits to Airedale, Harrogate and Scarborough Hospitals) –** Report of David Ita, Partnership Co-ordinator, Healthwatch North Yorkshire.

Pages 10 to 21)

5. **Fit 4 the Future - Transforming Care in Hambleton and Richmondshire** – Presentation by Dr Vicky Pleydell, Clinical Chief Officer - Hambleton, Richmondshire and Whitby Clinical Commissioning Group

6. **Update on Maternity and Paediatric Developments at Friarage Hospital, Northallerton –** Verbal Report by Vicky Pleydell, Clinical Chief Officer - Hambleton, Richmondshire and Whitby Clinical Commissioning Group. [Report considered by the CCG Board meeting on 28 May 2015 attached.]

(Pages 22 to 54)

Purpose of the report: To update the Committee on recent developments following the introduction of new arrangements last year.

7. **Realising Our Potential – Our New North Yorkshire – A North Yorkshire Approach to Integration, Prevention and New Models of Care –** Report of Dr Vicky Pleydell Chief Clinical Officer Hambleton Richmondshire & Whitby CCG.

(Pages 55 to 78)

Purpose of the report: To inform the Committee of work surrounding the development of new models of care.

8. **Developments at Scarborough Hospital –** Report of the Scrutiny Team Leader

(Pages 79 to 91)

Purpose of the report: To update the Committee on developments in relation to hyper acute stroke services, Neurology Services and Urology Diagnostic services

9. **Relocation of Hyper Acute Stroke Services from Airedale NHS Foundation Trust to Bradford Teaching Hospitals NHS Foundation Trust –** Report of Dr Phil Pue, Chief Clinical Officer, NHS Airedale, Wharfedale and Craven,

(Pages 92 to 118)

Purpose of the report: To provide an overview of current stroke services and proposals to relocate hyper acute stroke services.

10. **Work Programme –** Report of the Scrutiny Team Leader.

(Pages 119 to 123)

Purpose of report: To present the future Work Programme and to invite Members to comment/amend and suggest additional items to be included.

11. Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances.

Barry Khan
Assistant Chief Executive (Legal and Democratic Services)

County Hall
Northallerton

4 June 2015

NOTES:

(a) Members are reminded of the need to consider whether they have any interests to declare on any of the items on this agenda and, if so, of the need to explain the reason(s) why they have any interest when making a declaration.

A Democratic Services Officer or the Monitoring Officer will be pleased to advise on interest issues. Ideally their views should be sought as soon as possible and preferably prior to the day of the meeting, so that time is available to explore adequately any issues that might arise.

(b) **Emergency Procedures For Meetings**

Fire
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An intermittent alarm indicates an emergency in nearby building. It is not necessary to evacuate the building but you should be ready for instructions from the Fire Warden.

Accident or Illness
First Aid treatment can be obtained by telephoning Extension 7575.

Scrutiny of Health Committee

1. Membership

County Councillors (13)				
	Councillors Name	*Chairman/Vice Chairman*	*Political Party*	*Electoral Division*
1	ARNOLD, Val		Conservative	
2	BARRETT, Philip	Vice-Chairman	NY Independent	
3	BILLING, David		Labour	
4	CASLING, Elizabeth		Conservative	
5	CLARK, Jim	Chairman	Conservative	
6	CLARK, John		Liberal	
7	DE COURCEY-BAYLEY, Margaret-Ann		Liberal Democrat	
8	ENNIS, John		Conservative	
9	MARSHALL, Shelagh OBE		Conservative	
10	MOORHOUSE, Heather		Conservative	
11	MULLIGAN, Patrick		Conservative	
12	PEARSON, Chris		Conservative	
13	SIMISTER, David		UKIP	

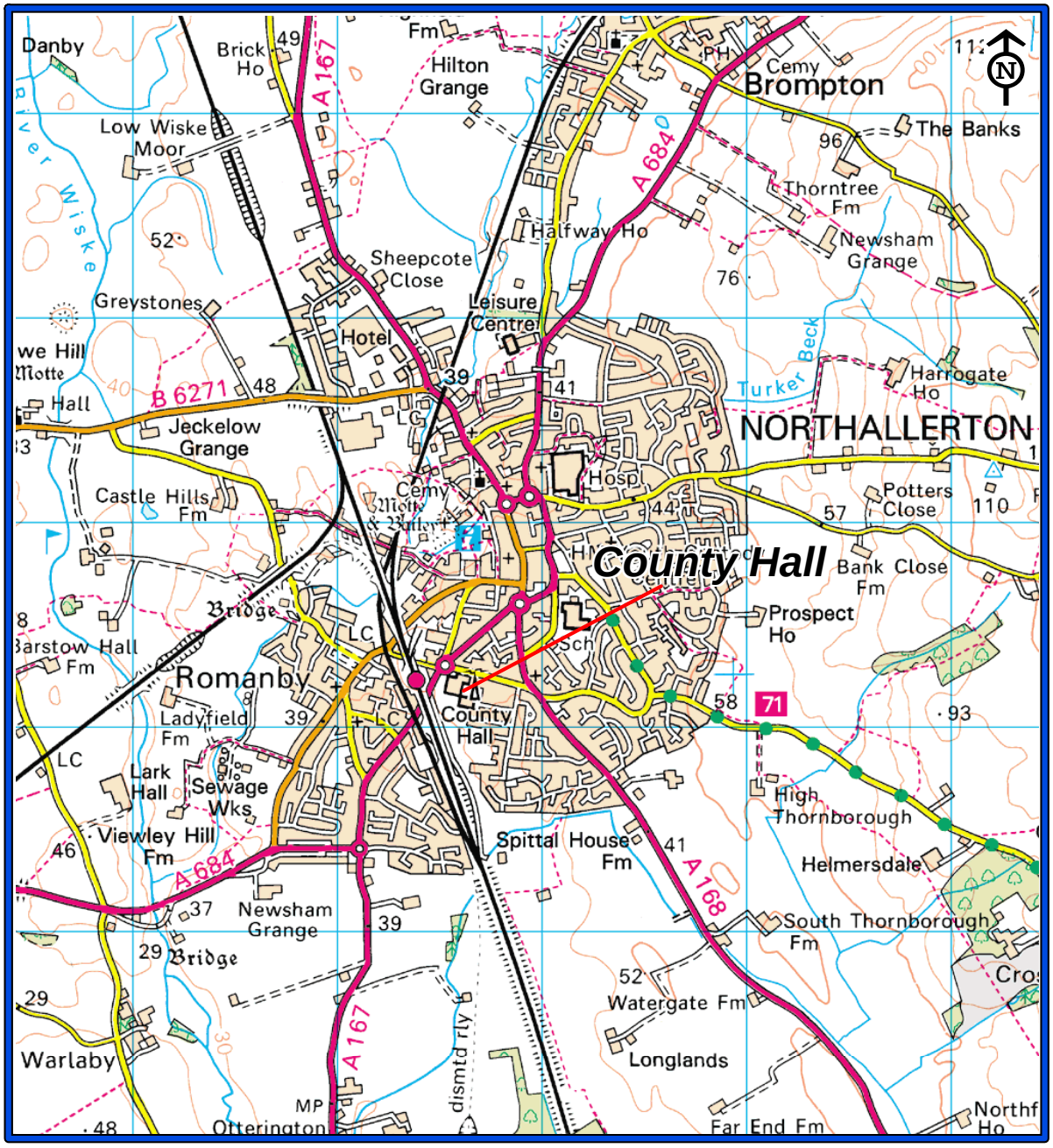
Members other than County Councillors – (7) Voting		
	Name of Member	*Representation*
1	VACANCY	Hambleton DC
2	VACANCY	Selby DC
3	VACANCY	Ryedale DC
4	MORTIMER, Jane E	Scarborough BC
5	VACANCY	Craven DC
6	VACANCY	Richmondshire DC
7	GALLOWAY, Ian	Harrogate BC
Total Membership – (20)		**Quorum – (4)**

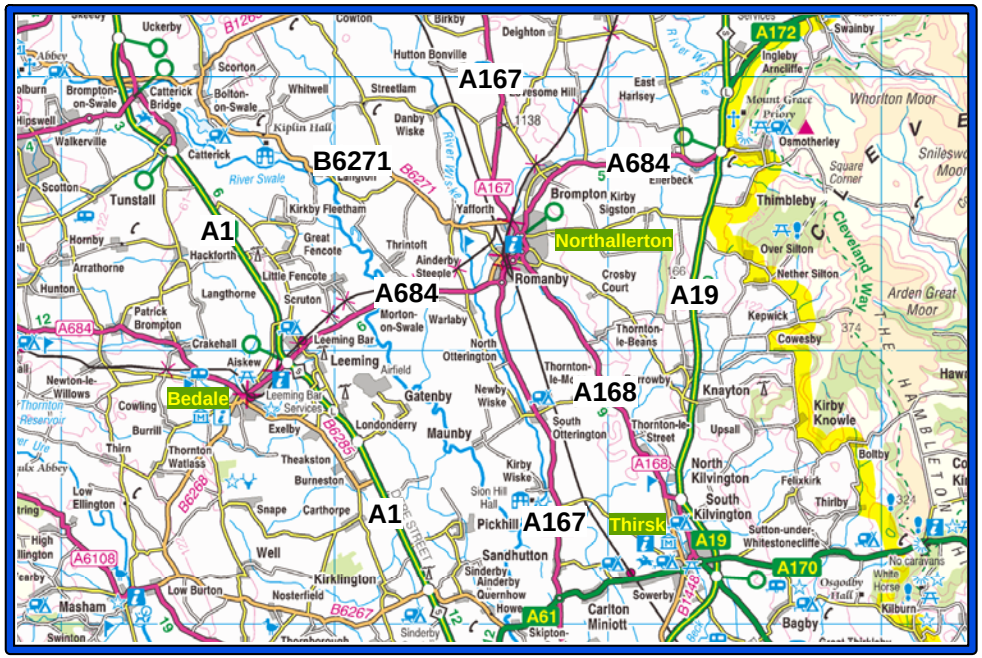
Con	**Lib Dem**	**NY Ind**	**Labour**	**Liberal**	**UKIP**	**Ind**	**Total**
8	**1**	**1**	**1**	**1**	**1**	**0**	

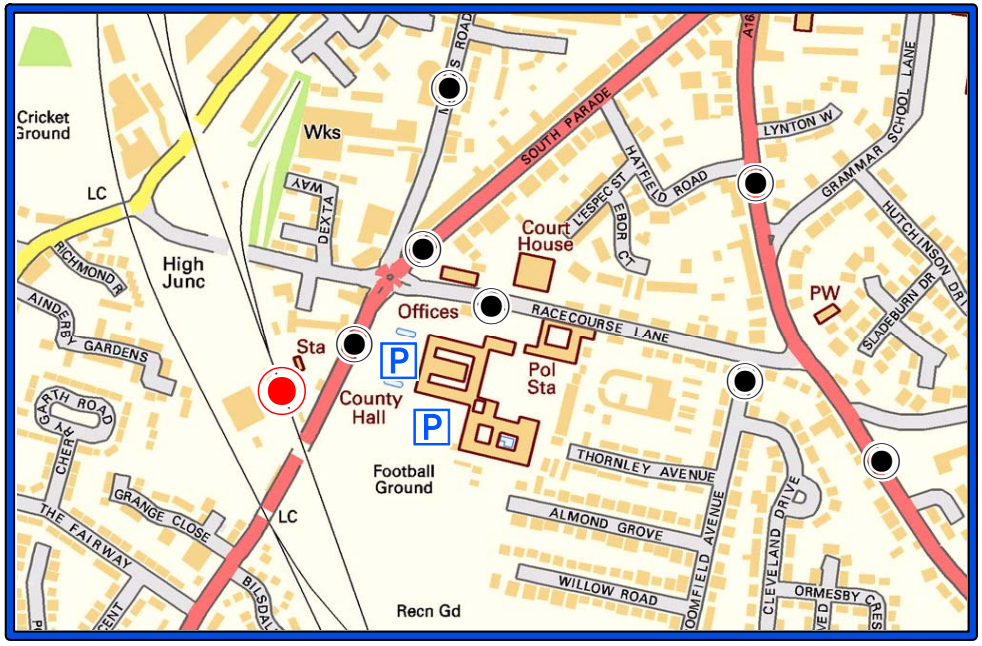
2. Substitute Members

Conservative		**Liberal Democrat**	
	Councillors Names		*Councillors Names*
1	HESELTINE, Michael	**1**	GOSS, Andrew
2	BUTTERFIELD, Jean	**2**	SHIELDS, Elizabeth
3	BASTIMAN, Derek	**3**	
4	SWIERS, Helen	**4**	
5		**5**	
NY Independent		**Labour**	
	Councillors Names		*Councillors Names*
1	McCARTNEY, John	**1**	MARSHALL, Brian
2		**2**	
Liberal		**UKIP**	
	Councillors Names		*Councillors Names*
1	SAVAGE, John	**1**	
2		**2**	

		Substitute Members other than County Councillors		
		1	VACANCY	(Hambleton DC)
		2	VACANCY	(Selby DC)
		3	VACANCY	(Ryedale DC)
		4	JENKINSON, Andrew	(Scarborough BC)
		5	VACANCY	(Craven DC)
		6	VACANCY	(Richmondshire DC)
		7	FLYNN, Helen	(Harrogate BC)







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North Yorkshire County Council

North Yorkshire County Council

Scrutiny of Health Committee

Minutes of the meeting held at County Hall, Northallerton on 23 January 2015.

Present:-

Members:-

County Councillor Jim Clark (in the Chair)

County Councillors: Val Arnold, Philip Barratt, David Billing, Liz Casling, John Clark, Margaret-Ann de Courcey-Bayley, John Ennis, Heather Moorhouse, Patrick Mulligan, Chris Pearson, David Simister and Michael Heseltine.

District Council Members:- Peter Bardon (Hambleton), Jane Mortimer (Scarborough), Tony Pelton (Richmondshire) and Ian Galloway (Harrogate).

In attendance:-

North Yorkshire County Council: Executive Members, County Councillors: Clare Wood and Tony Hall.
Healthwatch: David Ita, Partnership Co-ordinator.
Scarborough and Ryedale Clinical Commissioning Group: Simon Cox, Chief Officer for Scarborough and Ryedale CCG Commissioning and Dr Peter Billingsley, Lead for Urgent Care NHS Scarborough and Ryedale CCG.
Northern Doctors Urgent Care: Angela Frankish.
Hambleton, Richmondshire and Whitby Clinical Commissioning Group: Debbie Newton, Chief Operating and Finance Officer and Angela Barron, Senior Transformation Project Manager.
North Yorkshire and York Four Clinical Commissioning Groups: Janet Probert, Director of the Partnership Unit.
NHS England Yorkshire and the Humber: Geoff Day, Head of Co-Commissioning for Localities.

County Council Officers: Bryon Hunter (Scrutiny Team Leader), Mark Taylor (Project Officer), Mike Webster (NYCC Assistant Director – Health & Adult Services), Ruth Everson (NYCC Health Improvement Manager – Health and Adult Services).

Apologies: County Councillor Shelagh Marshall OBE, Councillor John Roberts (CDC)

Copies of all documents considered are in the Minute Book

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68. Minutes

Resolved

That the Minutes of the meeting held on 7 November 2014 be taken as read and be confirmed and signed by the Chairman as a correct record.

69. Chairman's Announcements

- **Temporary changes to the opening times of the Paediatric Short-Stay Assessment Unit at the Friarage Hospital –** On Monday, 12 January 2015 the South Tees Hospital Foundation Trust (STHFT) announced the opening times of the Short-Stay Paediatric Assessment Unit at the Friarage Hospital would be temporarily changed from Saturday, 17 January due to staffing pressures. The Unit is now open from 10am-8pm Monday to Friday and 10am - 5pm weekends and Bank Holidays. Doctors have stressed there will be minimal impact on patients. The Chairman has written to Tricia Hart, STHFT Chief Executive, expressing his serious concerns given the Trust's assurances that when the Unit opened it would provide better and safer service for patients into the future. The STHFT and have given no firm date on a return to its former opening hours. He advised the Committee that together with Cllr John Blackie he is seeking an urgent meeting to discuss the situation. He undertook to keep Members abreast of developments.

- **Scarborough Hospital A&E major incident and A&E waiting times generally –** The NHS in England has missed its four-hour A&E waiting time target with performance dropping to its lowest level 92.6% (Oct-Dec 2014) for almost a decade. Performances were significantly below the 95% target for our area – 86.3% Friarage and James Cook; 86.2% Scarborough and York; 89.2% Airedale and 75.0% Darlington. A number of hospitals across the UK have declared 'major incidents' in recent weeks. The major incident at Scarborough on 5 January 2015 was stood down after one day. He advised the Committee that he is going to attend the Health and Wellbeing Board 13 February as the Board is looking into Winter Planning and it might be that the Scrutiny of Health Committee can look at this issue in more detail in the coming months to assess preparedness for next winter.

- **Yorkshire Ambulance Services (YAS), Care Quality Commission inspection –** In the middle of November Cllr Clark referred to two instances which had been brought to his attention of YAS staff expressing concerns over a number of service issues, including the way in which the Trust was calculating its compliance with the 8 minute emergency response target. On 24 November he had written to Della Cannings (YAS Chairman) about the issues raised. Ms Cannings provided information refuting the claims made. Cllr Clark met with Dr David Macklin, Interim Director of Operations for YAS on Monday, 8 December. At the same time UNITE Union wrote to all local authorities expressing similar concerns to those that were being discussed with YAS. On 10 December, Rod Barnes, Interim Chief Executive, wrote to all local authorities across the region answering UNITE's concerns. All correspondence has been forwarded to the CQC who are currently carrying out an inspection of YAS.

- **Leeds and York Partnership NHS Foundation Trust, Care Quality Commission Inspection –** On 16 January 2015 the Trust published the results of its CQC inspection. The Trust received an overall rating of "Requires Improvement". The Vale of York CCG are seeking to procure new mental health and learning disability services with a view to the service being introduced from October 2015.

- **Re-opening of Worsley Court from 11 January 2015 following the temporary closure; and changes to meet the Care Quality Commissions requirements –** In October 2014 the Leeds and York Partnership Foundation Trust temporarily closed Worsley Court, the community unit for the elderly in Selby. This action was taken to meet CQC requirements for mixed sex

accommodation and to significantly and rapidly improve the quality of nursing care through training. Worsley Court has now partially re-opened from 11 January 2015 and it will fully re-open from 15 February 2015.

- **York Foundation Trust –** is to be inspected by the CQC in March 2015.

70. Public Questions or Statements

There were no questions or statements from members of the public.

Cllr Clark advised the Committee that he had received a letter from a Mrs Stephenson regarding her "serious reservations about the whole remit of the Womens Royal Voluntary Service hubs being rolled out in hospital and community settings". Cllr Clark commented that he is consulting with local councillors and the York Hospital Foundation Trust to obtain a better understanding of the issues raised by Mrs Stephenson and then will reach a view as to whether these matters lay within the remit of the Committee. If they do, the Chair will bring this matter to the attention of the Committee with a view to deciding how to progress this matter.

71. North Yorkshire Healthwatch

Considered -

The Friarage Hospital, Northallerton report 'Enter and View' and the oral report of David Ita, Partnership Co-ordinator Healthwatch. The report provided background, methodology and the findings of the recent 'Enter and View' visit by Healthwatch into Northallerton's Friarage Hospital on 17 November 2014.

David Ita congratulated South Tees Hospital Foundation Trust for their proactive response to the recommendations in the report; noting that a lot of the changes have been made or are underway.

The Chair enquired how the visits work and how they tie into Care Quality Commission (CQC) inspections. Members were advised that Enter and View visits were not done by 'inspectors' but trained 'authorised representatives'. Healthwatch have a close relationship with the CQC to cooperate on planning. CQC inspections tend to focus on processes and procedures; whereas Healthwatch are more interested in experiences of the patients.

Members expressed their concern that the hospitals dementia policy was not seen to be applied across all service areas but were reassured to hear that as a result of the recommendations of the report the Trust is now acting on its dementia policy and enhanced training for staff.

A Member expressed his concern about the increased use iPads replacing paperwork. It was explained that iPads were already in place in the hospital as a response to staff concerns around the burden of paperwork. David Ita commented that iPads allowed staff to care for patients whilst inputting data as opposed to paperwork where it was found staff had to retreat to a separate office to complete paperwork. He acknowledged that there is a balance to be struck.

In response to questions regarding Healthwatch's role David Ita explained that Healthwatch was only interested in the patient's perspective, it was literally the voice of patients. There are no external opinions or ulterior motives, views expressed are wholly those of the patient. And when patients are not listened to that is when you get major incidents like some of the ones seen nationally across England.

A Member wanted to know if there were any indications of problems in staffing in Paediatric care. David Ita noted that there were no problems that Healthwatch noticed with staffing in that unit.

A member wanted to know how Enter and View reports tied in with the NHS Friends and Family test. It was explained that the test ties in well with the reports as Enter and View reports put a "human face" on the Friends and Family test.

Resolved -

That the reports be noted.

72. "Right Care First Time" - Improving Urgent Care Services in Scarborough and Ryedale

Considered -

The report and presentation of Simon Cox, North Yorkshire and Humber Commissioning Support Unit, and Dr Peter Billingsley, lead for Urgent Care NHS Scarborough and Ryedale; updating the Committee with the background and latest developments surrounding the procurement of new urgent care services in Scarborough and Ryedale. And the presentation of Angela Frankish, Northern Doctors Urgent Care, providing details about Northern Doctors Urgent Care and the new service they will deliver in Scarborough and Ryedale.

It was noted that the contract was for five years with a possible extension to seven years. Members questioned the relevance of urgent care models in Sunderland to North Yorkshire and the extent to which Northern Doctors will be able to access patient records. It was explained that the model for Scarborough and Ryedale is more like the model used in Bath where there is a greater emphasis on patient information and advice. All patients are given the option to allow access to their personal records; this will be asked as part of the initial consultation.

In response to questions regarding NHS111, especially if the caller was physically unable to travel, what would happen? Angela explained that "111" advisors would always refer someone to the most appropriate form of help needed and that were a home visit required, the "111" advisor would put the caller through to a local GP.

Members commented that a certain amount of self-diagnosis was needed to know the appropriate place to seek help, be that urgent care, emergency departments or wait to see a GP. It was also enquired as to whether or not Northern Doctors have ever lost a contract and if they do not meet the success criteria within the contract what would happen. Angela noted that the first response for most people when ill or injured is to go to emergency departments, but in some cases A&E was not the most appropriate route into care. Patients need more information on alternatives and to be confident that their needs are being met. Angela commented that Northern Doctors have never lost a contract when they have bid for one; however, there have been occasions where they have not retained a contract when it has been re-commissioned. There are a number of key performance indicators which are recorded and monitored on a monthly basis. Northern Doctors are accountable for performance against those indicators.

A Member commented that there was an increasing blurring of definitions and that a patient may not necessarily know what the difference is between 'urgent' and 'emergency' but they will know they feel unwell or injured. Dr Billingsley noted that the default position was for everyone to go to A&E, and that actually hospitals were removing the "Accident" from A&E as that was leading to high numbers of inappropriate referrals. Urgent care will now be seeing those minor injuries and

accidents that used to go to A&E. This should relieve some of the pressure on the emergency departments.

Simon Cox explained that dental care is not part of the contract. Urgent care can refer patients appropriately, however, dental care is provided by NHS England.

Simon explained that the major concern raised during the consultation phase was around the future of Castle Health Centre. The procurement for the Centre has just been completed; it will continue to be a GP list and will provide elderly care.

A Member described personal circumstances which had resulted in going to the Friarage for a suspected fracture. What would the procedure have been from the 1 April for one of these new Urgent Care Units? It was explained that for suspected fractures patients should go to an Urgent Care Unit. Patients would be seen by a specialist the following day for a fracture.

A Member commented that there needed to be more uniformity across the County across the range of different services. The Chair noted that due to the size and diversity of the County it was not possible to have a one size fits all approach, instead we should strive for uniformity of excellence.

The Chairman, on behalf of the Committee, thanked the presenters for the report and presentations and looked forward to working with the new arrangements and wished them well.

Resolved -

That the report be noted.

73. 'Fit 4 the Future' - Transforming the Care we deliver in Whitby and the Surrounding Area Whitby Hospital

Considered -

The report of Debbie Newton, Chief Operating and Finance Officer, and Abigail Barron, Senior Transformation Project Manager for Hambleton, Richmondshire and Whitby CCG updating the Committee on developments in Whitby and the surrounding area, specifically the procurement of Community and Out of Hours Services and the future development of Whitby Hospital.

Members were informed that the contract for Out of Hours service is seven years.

Access to pharmacies was highlighted as a big issue for Out of Hours patients in North Yorkshire. It was noted that pharmacies and Out of Hours services would be co-located within the Hospital and that the CCG were engaging with partners and providers to ensure there was adequate pharmacy provision across the area.

The Committee congratulated Debbie and Abigail on the report and the way in which the CCG had engaged with local communities and this Committee throughout the consultation and procurement process.

Resolved -

That the report be noted.

74. All Age Autism Strategy

Considered -

The report of Janet Probert, Director of the Partnership Commissioning Unit on behalf of four local CCGs updating the Committee on development of a Joint All Age Autism Strategy and on procurement of NHS adult and child autism diagnostic services.

Members were surprised at the different types and complexity of autism. For example they enquired as to whether Fragile X Syndrome was on the autism spectrum. Janet Probert undertook to report back to the Committee on this matter.

In response to Members' questions Janet Probert commented that the average waiting time in Harrogate between being referred for autism and receiving a diagnosis was 26 weeks. In parts of the County some children were waiting over a year.

Members noted that nationally children from military families were less likely to receive a diagnosis of autism and enquired why this was and also was there anything specific for military families within the strategy given the large military presence at Catterick? Janet Probert advised Members that this was the national picture and further work would be carried out to confirm whether or not this was the case in North Yorkshire. One possible explanation being put forward was that military families tend to move around and it may be that actually children are in touch with services for less time. An Equality Impact Assessment is being prepared with a view to assessing the impact that the strategy might have on all groups across the County.

Members noted that Airedale, Wharfedale and Craven CCG had been omitted from the list of signatories and sought assurances that the needs of the Craven area are being addressed. Janet Probert commented that this was purely an error in the list of signatories and that patients in the Craven area had been involved in the engagement work carried out to date.

Members were concerned by the statement in the draft strategy that Looked After Children were less likely to receive diagnosis of autism. Janet commented that this was also the national picture but understood Members' concerns and added that there may be similar reasons between looked after children and children from military families as to why they are not being referred for assessments. More work is being carried out to confirm the picture for looked after children in North Yorkshire.

Members requested that the Scrutiny of Health Committee be added to the list of groups who receive updates on the progress of the strategy.

In conclusion Members expressed broad support for the draft strategy as it represented a co-ordinated and holistic step in the right direction. They commented, however, that discussions had highlighted a number of queries in relation to some of the statistics which underpinned the strategy.

Janet Probert advised Members that the strategy was still very much in draft form and had sought to bring together information from across the NHS locally and the County Council. She welcomed the proposal of more detailed work by a task group from the Committee and the Committee being involved in the longer term with regard to how the strategy is actually delivered.

Resolved -

The Scrutiny of Health Committee welcomes and supports the way forward set out in the draft All Age Autism Strategy.

A task group comprising the group spokespersons be established to gain a better understanding of the statistics underpinning the strategy and to advise Janet Probert on further presentation of that information.

That Janet Probert, Director of the Partnership Commissioning Unit be invited to work with the task group on this work.

The Committee receive an update on the outcome of the task group's work no later than at the next meeting of the Committee on 12th June 2015.

That the Director of the Partnership Commissioning Unit be requested to add the Scrutiny of Health Committee to the list of groups to be consulted on the strategy.

75. NHS Health Checks: An Update on Performance and Future Developments

Considered -

The report of the Director of Public Health for North Yorkshire providing information on current performance of the NHS Health Check programme and planned actions to improve performance.

The report was presented by Mike Webster and Ruth Everson from Health and Adult Services.

A Member asked about page 65 (para 10+11) in the report, was there a district breakdown for the percentages and how is that percentage formulated? Ruth noted that they can circulate the annual report which contains a district breakdown of those percentages; the next annual report is due to be published in June. Anyone not on a health register already has the opportunity to receive a Health Check.

It was explained that the service is delivered through local GPs and that data is received monthly on the number of checks they had undertaken.

Members expressed their concern that not all GP's in the County actually offer the programme. Ruth acknowledged the concerns, to understand the reasons why they opted out there is a constant dialogue with the practices. They are also looking at the possibility of an alternate provider or potentially a "mixed model".

In terms of describing how GPs are incentivised to deliver this programme Ruth advised Members that GP's are paid in increasing amounts dependent on invites sent out, and if they hit their targets and for the checks and assessments they carry out. This is under constant revision.

Members were advised that their service is a separate programme to the national NHS Health Check.

Resolved -

That the report be noted.

76. Review of Personal Medical Services Contracts

Considered -

The report of Geoff Day, Head of Co-Commissioning for Localities, NHS England Yorkshire and the Humber briefing the Committee on the contracts review currently being undertaken by NHS England in conjunction with local Clinical Commissioning Groups.

Members enquired if the impact of funding revision for PMS contracts will be the same as it was when Minimum Practice Income Guarantees (MPIG) were phased out and what might be the impact on front-line GP services. Geoff Day assured the Committee that there would be less impact for PMS than there was for MPIG. The primary care services that will be affected are not high volume contracts and that any appropriate consultation would be a matter for the relevant CCGs to decide upon.

Members enquired how much GP's were being paid and commented that it is difficult to judge this report without that knowledge. Geoff Day explained he would like to be in a position where GP's salaries could be disclosed but that was not the case at the present time.

A Member wanted to know what was characteristic of a PMS contract and what distinguishes them. The Member also wanted to know what evidence there was to suggest that no service would be stopped. It was explained that there is no standardisation of service and there is a lot of variation across the County depending on what practices want to offer. There is a big mix between large and single handed practices and there is still the element that some practices are getting PMS money and some are not.

A Member wanted to know what the definition of essential service was, and, was it a "box ticking exercise" as to what practices must offer. Geoff Day explained that the official definition of essential services is very general and unspecific about what a GP must provide.

Members noted that this was a national programme. Geoff advised Members that the CCG's get the money to reinvest, however, there are three practices affected in their area, one will gain from GMS contracts, the other two will lose. He highlighted the need for every practice to be carefully scrutinised now to see what it is that it is doing over and above the essential services it must deliver.

The Chairman asked that the Committee is kept updated on these issues and progress.

Resolved -

That the report be noted.
The Committee is kept updated on the progress of the PMS review.

77. Work Programme

Considered -

The report of Bryon Hunter, Scrutiny Team Leader inviting comments from Members on the content of the Committee's programme of work scheduled for future meetings. The Scrutiny Team Leader invited Mike Webster to give the committee an update on item 10 of the Work Programme.

Mike Webster provided information on the current review of mental health services, the engagement process of the public and professionals and the proposal to replace Crisis Call for wider coverage. The plan will go to the Health and Adult Services Leadership Team in early February and that this will be reported back to this Committee.

Members highlighted wanted to know the scope for joint committee work between the Scrutiny of Health and Care and Independence Committees given the overlap of items and issues between the committees.

It was explained that the work programme item "Hambleton, Richmondshire and Whitby CCG – Fit 4 the Future" was an on-going area of involvement for the Committee.

A Member requested the NHS 5 Year Plan and the implications this has for North Yorkshire go onto the Work Programme.

Resolved -

That:

1. The content of the work programme and schedule are agreed and noted.
2. That possible links and joint working between the Care and Independence Overview and Scrutiny Committee and the Scrutiny of Health Committee be explored.
3. A report on the NHS 5 Year Plan be added to the work programme for consideration at the appropriate time.

The meeting concluded at 12:45pm.

MT/BH

healthwatch North Yorkshire
Improving Health & Social Care Together

Enter and View Report Recommendations and Provider Responses

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Service Visited	Report Recommendations	Service Provider Response
Airedale Hospital, Keighley.	1. Ensure Bradford Hospital informs Airedale Hospital when a consultant cannot attend a clinic at Airedale in order to avoid wasted outpatient attendances. 2. Regularly audit discharge times to identify any causes of delayed discharge 3. Investigate the quantity and frequency of physiotherapy and speech therapy sessions on ward 5 (stroke) 4. Regular communication with patients about their treatment/diagnosis could be improved 5. Consider asking all patients on admission and discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify appropriate support within the community for the cared for person. 6. Consider introducing a patient diary system that summarises (in simplest terms) the clinical interactions or interventions that the patient has with staff, as a way of keeping relatives or carers abreast of the care of their loved ones. This would particularly be useful for patients who are unable to communicate effectively, like those suffering from a stroke.	***Airedale NHS Foundation Trust have recently requested more time to consider submitting a revised response to this report, following feedback from their Governing Body. As a result, the following response may change in the near future: • Physiotherapy staffing is as it should be for the number of beds and specialty. However on that morning three of the staff were attending a Bobath course which is essential to support their skill development. We have standards of practice and clinical guidelines which state that people should have daily physiotherapy but nothing that says this should be more frequent. • Speech and language therapy are currently recruiting following a successful business case, this will enhance service provision. It is anticipated that within the next three months there will be a further speech and language therapist on the ward. • We are currently working in partnership with Bradford Teaching Hospitals to determine what the future pathway will be for stroke and will be reviewing the therapy staffing to support the new service model. • There is reference to a question about patients with dependent children within the nursing documentation booklet used on all adult inpatients.
Harrogate Hospital	1. Regular communication with patients about their treatment/diagnosis could be improved and also keeping rela-	**Bullet 1:** "Regular communication with patients about their treatment/diagnosis could be improved and also keeping

	tives or carers informed when they visit. 2. Consider asking all patients on admission and discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify appropriate support within the community for the cared for person. 3. The benefits that your nutrition assistants bring to the care of patients is invaluable, and hence it is worth considering increasing coverage beyond 3pm on weekdays by creating a potential job share post, to match out of hours and weekend hospital admissions. 4. A possible re-introduction of the end of life care facilitator would greatly provide the much needed expert support for nursing staff, and ensure that patients nearing the end of their lives have the very best care possible tailored to their needs. 5. A dedicated discharge lounge would greatly aid the patient flow (freeing up bed space) through the hospital and out into the community. It would also greatly improve patient experience as they prepare to return back to their homes and communities now that they are deemed medically fit. 6. Improved communication between wards and the discharge lounge in order to improve patient experience of discharge and enable a smooth patient flow. It is worth hearing the views of the duty nurse in the discharge lounge about how this can be improved. 7. Explore the suggestion of using the 'back door' of the hospital for discharging elderly patients to care homes to avoid blocking the ambulance bays, which are always busy. And to avoid elderly patients being confused and distressed, as much as possible, only transfer patients to	relatives or carers informed when they visit." The Trust is exploring the opportunity of how communication can be improved with patients and their families. **Bullet 2:** "Consider asking all patients on admission and discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify appropriate support within the community for the cared for person." There is an opportunity within the admission documentation to ask this question. **Bullet 3:** "The benefits that your nutrition assistants bring to the care of patients is invaluable, and hence it is worth considering increasing coverage beyond 3pm on weekdays by creating a potential job share post, to match out of hours and weekend hospital admissions." Care Support Workers cover the duties of the Nutritional Assistants out of hours and at weekends and we have 45 mealtime volunteers who predominately work at teatime and more are being recruited. Finally, the care of dementia patients including the use of the Butterfly scheme is being reviewed.

	care homes during daylight hours. 8. Your innovative use of volunteers to support meal times is very highly commended, but should be proactively increased as the demand for this service far exceeds the number of volunteers available to help. Harrogate and Rural Community and Voluntary Services will be best placed to assist you with recruiting the right volunteers.	
Scarborough Hospital	1. There is an urgent need to update the signage and environment to be more accessible and user friendly, as this would limit any distress to vulnerable patients, and inevitably lead to a better patient experience. 2. Standardise all procedures across wards, including dementia signs and compliment/complaints forms, as this allows for improved outcomes for patients and supports staff that may need to move between wards. 3. Personalise bed areas using patient names and not just numbers, as this forms part of your commitment to person-centred care, and reduces the perception that each patient is just a statistic. 4. Decide which wards are for what conditions and adhere to the plan as much as possible, as the frequent changes to ward functionality is potentially a real risk to patient/staff safety and improved patient outcomes. 5. As much as possible, reduce the reliance on agency staffing, which should hopefully save costs. Focus instead on improving staff benefits and morale. 6. There is a great need for a forum to be created for regu-	There are a number of recommendations where work is already underway and significant progress has been made. ***Recommendation 1:*** *There is an urgent need to update the signage and environment to be more accessible and user friendly* We are aware of the limitations of the hospital site and are investing significant funds in making improvements to the hospital and its facilities. In relation to comments about rest stops on the main corridor, we will explore the possibility of introducing benches, and we will consider how we might improve signage and way finding on the site. ***Recommendation 2:*** *Standardise all procedures across wards, including dementia signs and compliment/complaints forms* The Trust has recently agreed, following consultation with community groups, to standardise the Forget Me Not symbol across all wards in-line with national guidance and this will ensure that wards are consistent. A programme of Dementia Awareness has been rolled out across the whole Trust with a large number of staff having attended this

	lar senior management and staff liaison, where staff can be empowered to be involved in some of the decisions that will inevitably affect their day to day work. 7. Consider asking all patients on admission and discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify appropriate support within the community for the cared for person.	training. The programme of Dementia Awareness continues to be rolled out. All wards provide information leaflets on how to provide feedback, raise a concern or make a complaint. The Trust has recently produced a draft 'Your Experiences Matter' leaflet in collaboration with key stakeholders including Healthwatch York. The focus for the Trust is to seek, listen and respond to all feedback whether that is a concern, complaint or a compliment. Additionally, all wards now ask patients to provide feedback through the national Friends and Family Test. The inpatient wards at Scarborough Hospital consistently achieve a monthly response rate of above 40%, with positive feedback on the whole. In January 2015 wards began to display feedback from patients on 'Knowing How We Are Doing' boards and will feed back to patients and their family what has been done as a result of their feedback through 'You Said, We Did'. ***Recommendation 3:*** *Personalise bed areas using patient names and not just numbers, as this forms part of your commitment to person-centred care and reduces the perception that each patient is just a statistic* As a Trust we must strike a balance between confidentiality, privacy and dignity, and safety in terms of patient identification. This issue has previously been considered in some detail and the decision was taken not to display

		patient names above beds. This is consistent across the organisation. Whilst bed numbers are used to identify patients by those caring and treating them, we do not refer to the patient as a number when providing care and treatment, and would not address patients in this way. The view that there is a "perception that each patient is just a statistic" is in no way supported by feedback from patients or relatives, and is not something that we recognise. ***Recommendation 4:*** *Decide which wards are for what conditions and adhere to the plan as much as possible* The Trust has dedicated wards for particular specialties, as do all hospitals. Healthcare has changed and become increasingly specialised, and over time we have seen an increase in the number of patients we admit who are elderly and/or with complex medical conditions. At the same time, advances in surgical techniques mean shorter stays for many patients, and more day cases. This means that the current configuration of wards, which has been largely unchanged for some years, does not always meet the pattern of admissions. The impact of this is that when we are busy (and this happens regularly throughout the year, not just in winter) we have more elderly/medical patients than we have beds on dedicated wards. This results in patients being admitted to other areas, usually surgical, where there are beds

		available. This is not ideal for patients, or indeed staff. We are looking at our bed base to see what changes might be made to improve this, and we are also taking a number of steps to improve patient flow and reduce the pressure on beds. ***Recommendation 5:*** *As much as possible, reduce the reliance on agency staffing, which should hopefully save costs.* This is already a key priority for the Trust and work is well underway to address this. We have to ensure that we have safe staffing levels, both for nursing and medical staff, and using temporary and agency staff is one way of doing this. Our increase in spending on temporary staffing is due to difficulties in recruiting nursing staff and doctors within certain specialties. This is an ongoing issue, and it is not just our Trust that is seeing this trend, as Trusts are all attempting to recruit from the same pool of people and in some specialties this is increasingly difficult. This has been compounded by recommendations in the Francis Report that staffing levels should be increased nationally, and universities are responding by increasing the number of nurse training places, however, the benefit of this increase will not be realised for two to three years. We ran a number of 'one stop' recruitment events in

		October 2013 and again in March and September 2014, in both Scarborough and York, and recruited 47 nurses into permanent posts. In December 2014 the Board of Directors approved the recruitment of a cohort of nurses from Spain using an experienced agency. The training is of a high standard and there are high numbers of nurses who are looking for posts. Several other Trusts have successfully recruited nurses in this way. The first round will take place in early March followed by a second round in April, with the aim of recruiting up to 40 nurses. It is anticipated that these nurses will be in post late spring and early summer. ***Recommendation 6:*** *There is a great need for a forum to be created for regular senior management and staff liaison, where staff can be empowered to be involved in some of the decisions that will inevitably affect their day to day work.* As an NHS organisation, indeed in line with most of the public sector, we have well-established forums for staff and senior management to meet to discuss issues. Where these issues have the potential to affect staff and their day-to-day work, there are formal communication and consultation processes that are followed. There exists a wide range of other mechanisms for involving and engaging staff, and we have recently made several changes to our internal communications processes in response to staff feedback. This new approach was launched in September 2014. For example, the Chief Executive and the Chief Nurse hold

		regular drop-in sessions across the Trust. These began in November 2014. 'Blue Thursday' was introduced in September 2014. This is a new initiative whereby members of the senior nursing team work on the wards. The Staff Friends and Family Test was rolled out across the Trust during July 2014, which ask if staff would recommend the Trust to family and friends if they needed treatment and whether they would recommend the Trust as a place to work. The feedback received has been largely positive, and we are keen to increase the response rate so that we can gather further detailed feedback from staff. A confidential helpline has also been launched which allows any member of staff with a concern to leave a confidential message which will be escalated to the appropriate senior manager. ***Recommendation 7:*** *Consider asking all patients on admission and discharge whether they currently look after anyone and use this information to identify appropriate support within the community for the cared for person* Patients are, as a matter of routine, asked for information about their social circumstances when they are admitted, however this is an area that we would like to explore in more depth and we will take it to our Patient Experience Steering Group for discussion. Dependent on the outcome of that discussion, there is the potential to work in partnership with Healthwatch North Yorkshire on how we might better

		meet the needs of carers.
Friarage Hospital, Northallerton.	1. The paperwork for each process should be looked at with a view to streamlining, with more effective use of technology platforms like the IPads. 2. Dementia policy to be seen to be applied across all service areas, and staff training brought up to speed. 3. Discharge policy to be refined with a view to speeding up the discharge process. 4. More volunteers to be recruited, as well as family and friends encouraged to assist staff at mealtimes. 5. Consider introducing a Mental Health Specialist on site as a reference point to advice and support nursing staff with challenging dementia patients. 6. Stroke Rehabilitation equipment to be reviewed. 7. Yorkshire Ambulance Service to be requested to provide an exception report to cover any patient delivered to the Friarage who should not be there according to the current policy. 8. Paediatric & Maternity services to continue to be monitored. 9. Consider asking all patients on admission and discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify	**Bullet 1:** "The paperwork for each process should be looked at with a view to streamlining, with more effective use of technology platforms like the IPads". A rapid process improvement workshop was held in November to review the paperwork used on admission, and is currently being implemented and reviewed. The review looked to standardise and streamline the paperwork used across the organisation. The trust has implemented the electronic recording of physiological observations across the James Cook University Hospital and Friarage Hospital sites. In addition to this the trust is currently exploring the option of introducing clinical noting. **Bullet 2:** "Dementia policy to be seen to be applied across all service areas, and staff training brought up to speed". Please see previous comments in terms of the dementia strategy and click on the embedded link to see our Dementia action plan. http://www.healthwatchnorthyorkshire.co.uk/sites/default/files/friarage_hospital_ae_dementia_action_plan_0.pdf **Bullet 3:** "Discharge policy to be refined with a view to speeding up the discharge process". The discharge policy is currently under review by the Clinical Lead for the Case Management Team.

	appropriate support within the community for the cared for person.	**Bullet 4:** "More volunteers to be recruited, as well as family and friends encouraged to assist staff at mealtimes". Bay nursing has helped to alleviate some problems associated with feeding patients however the Friarage manager has contacted Head of Fundraising and Volunteering to explore if additional support can be provided at meal times. **Bullet 5:** "Consider introducing a Mental Health Specialist on site as a reference point to advice and support nursing staff with challenging dementia patients". In relation to employing Registered Mental Health Nurses on the wards at the Friarage Hospital, this has been considered, although it is felt that it would be difficult to attract staff and difficult to recruit. However, the ward staff are able to access the Hospital Mental Health Liaison Team from 8am – 8pm seven days per week, who offer support and advice to staff when nursing patients with an existing diagnosis of dementia or a newly diagnosed dementia. A referral system is used, however should emergency situations arise ward staff are able to bleep members of the team to attend the ward environment immediately. As alluded to above, the Trust is committed to continue educating all staff and increase their knowledge about dementia to ensure our patients receive high standards of safe care. **Bullet 6:** "Stroke Rehabilitation equipment to be reviewed".

		Please see previous comments on page 1. **Bullet 7:** "Yorkshire Ambulance Service to be requested to provide an exception report to cover any patient delivered to the Friarage who should not be there according to the current policy" It is expected practice for the A&E staff to complete an incident form for any patient who is transported by ambulance to the Friargae A&E department who should be taken elsewhere according to the current policy. This will be investigated and the outcome shared by the A&E manager with the YAS and CCG colleagues at the monthly SDIP meeting. **Bullet 8:** "Paediatric & Maternity services to continue to be monitored" The changes to the paediatric and maternity services were monitored by the Friarage A&E department, the maternity unit, the paediatric unit and the Yorkshire ambulance service. If any issues did occur these were investigated and the outcomes discussed at a weekly teleconference. Key personnel representing these areas participated in a weekly teleconference where if any specific issues did occur these were investigated, discussed and necessary actions taken to prevent any reoccurrences. There were very few issues raised therefore the teleconference was dissolved and these services are monitored and discussed monthly with the CCG. **Bullet 9:** "Consider asking all patients on admission and

		discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify appropriate support within the community for the cared for person". All nursing staff are encouraged to establish if the patient is a carer on admission and if this is identified the appropriate services would be contacted.

NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Hambleton, Richmondshire and Whitby Clinical Commissioning Group
Governing Body

Date of Meeting: 28 May 2015

Title: Friarage Maternity Centre and Supporting Transport Arrangements – 6 month review

Report for: Decision/Assurance/Information

This Report includes /supports the following CCG aims:

	Tick
1. Involve people in their care and as part of that we will encourage self-care	√
2. Buy quality services	√
3. Change services for the better and in doing so we will provide care as close to home as possible that is easily accessible	√
4. Use the money we have in the best possible way	√

The CCG values are:

Integrity

Transparency

Collaboration

Focus

Action

Energy

Courage

PAPER 12 A

NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Hambleton, Richmondshire and Whitby Clinical Commissioning Group
Governing Body

28 May 2015

Friarage Maternity Centre and Supporting Transport Arrangements – 6 month review

1. Introduction and Purpose

In February 2014 the Governing Body received a report detailing the final assessment for the future of maternity and paediatric services at Friarage Hospital Northallerton (FHN) which had been developed following extensive public consultation and a review by the Independent Reconfiguration Panel (IRP). The Governing Body approved option one which involved reconfiguring existing children's and maternity services to provide a short stay paediatric assessment unit and midwifery led unit with full outpatient services and enhanced community service provision.

This report provides the Governing Body with a 6 month evaluation of the changes post reconfiguration of maternity services in October 2014. Within the scope of the report are:

- maternity services; (Paper 12 A)
- the additional commissioned ambulance service; (Paper 12 B)
- and patient shuttle bus. (Paper 12 C)

The implementation of the short stay paediatric assessment unit is not included and will be evaluated once the service has been operating for a minimum of 6 months at the full commissioned level.

South Tees Hospitals NHS Foundation Trust's philosophy for the Midwifery Led Unit (MLU) at FHN is to offer holistic, family centred, flexible antenatal, low dependency labour, delivery and postnatal care which meet women's needs and provide choice as far as possible. This ensures that women have easy access and flexible choice of supportive, high quality, safe maternity services, designed around their individual needs and those of their babies. This report uses the philosophy as a framework to evaluate progress over the last 6 months.

2. Background Information

The reconfigured maternity services at FHN were renamed the 'Friarage Maternity Centre (FMC)' with the aim of transforming the service provided

there into the centre of maternity care for Northallerton and the surrounding areas and fully integrating intrapartum, community midwifery services, day care services and antenatal consultant led care. The new service opened on 06 October 2014 and now comprises of the following:

- A 24 hour midwifery led intrapartum unit
- A Maternity Day Unit (MDU) open Monday to Friday 09:00-17:00hrs
- An Early Pregnancy Assessment Unit (EPAU) open Monday to Friday 09:00-17:00hrs
- An Antenatal Clinic including Consultant clinics and ultrasound
- scanning
- Community midwifery services

3. Key Issues

3.1 Service Provision

The FMC provides women with five one stop, en-suite rooms with facilities for partners to stay. There are three clinical/consultation rooms, a breast feeding room, parent craft room, hearing screeners room and a waiting room.

3.2 Service Uptake

3.2.1 Community Midwifery Activity within FMC

The community team are now integrated with the FMC and a community midwife is available within the FMC Monday to Saturday 09:00 to 17:00hrs to provide a 3rd midwife if needed. During these hours planned antenatal and postnatal appointments are also conducted in the FMC. This activity was established from the onset of the reconfiguration and has remained fairly static over the 6 months. All women are advised to have an early bird appointment as soon as their pregnancy is confirmed and prior to their booking appointment with their midwife in order to be given relevant public health information about their pregnancy and ante natal screening so that they can make informed choices. Previously these appointments have been done by the community midwives at the GP surgeries. At James Cook University Hospital, these appointments are conducted by community Health Care Assistants within the Children's Centres. A review was undertaken and a new process implemented at the beginning of March in order:

- To ensure consistency of provision cross site
- To provide women with choice of timing for appointment including evenings and weekends
- To effectively utilise both community and FMC staff within the semi integrated model
- To fully utilise the FMC environment
- To expose as many women as possible to the FMC environment to encourage it as place for choice for intrapartum care for low dependency women
- To achieve 80% of `early bird` appointment to be undertaken by a Health Care Assistant at FMC.

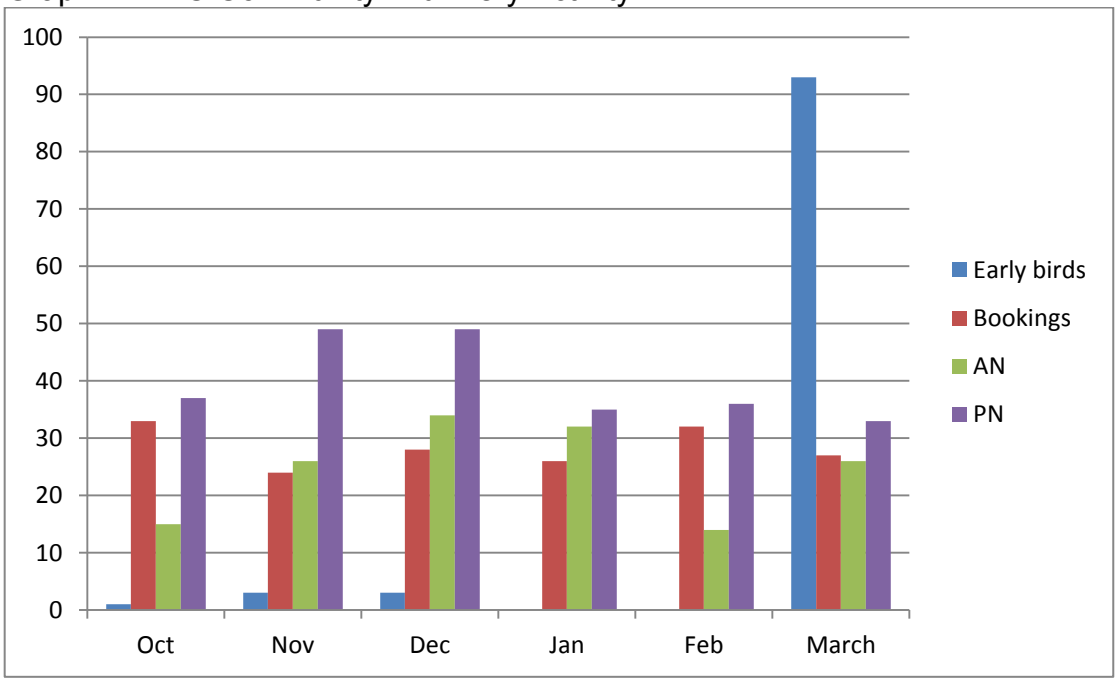
Early bird appointments will be provided by community Health Care Assistants in locality Children's Centres or GP surgeries for women who are unable to attend the FMC.

Table 1 shows the number of early bird appointments undertaken at FMC in the last 6 months and is presented graphically in Graph1.

Table1. Community Activity at FMC	Quarter 4 Oct-Dec	Quarter 1 Jan-March
Number of early bird appointments (% of total early bird appointments undertaken)	7 4.8%	93 58%
Number of booking appointments % of total booking appointments	85 58%	91 60%
Number of antenatal appointments	75	82
Number of postnatal appointments	135	104

(Data source: South Tees NHS Foundation Trust).

Graph 1. FMC Community Midwifery Activity



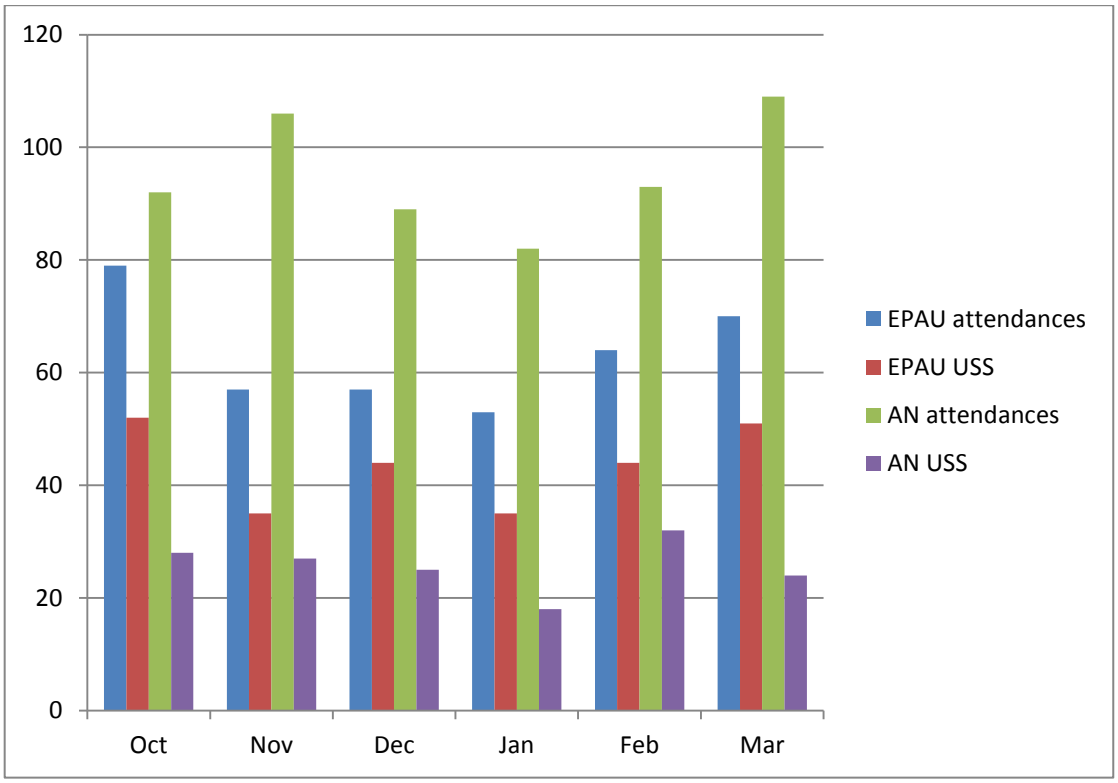
3.2.2 Maternity Day Unit (MDU) / Early Pregnancy Assessment Unit (EPAU) Activity.

The MDU activity and EPAU activity has remained fairly static over the 6 month period and a full EPAU service is provided during office hours when medical assistance is available within the clinics. The number of transfers has increased significantly in the second quarter although there were no themes identified and all were appropriate. This will be closely monitored. It is noted that there were no delays with ambulance transfers from the MDU.

Table 2 below reports the activity over the last 6 months and is presented graphically in Graph 2 along with antenatal attendances and ultrasound attendances.

Table 2. Total number of attendances	Oct-Dec 14	Jan- March15
Number of antenatal attendances	287	257
Number of early pregnancy attendances	193	187
Number of early pregnancy Ultrasounds	131	130
Number of antenatal Ultrasounds (other than routine via antenatal clinic	80	74
Number of transfers to James Cook University Hospital	4	13 (4 early pregnancy problems and 9 pregnancy complications) Pregnancy complications included:5 abnormal Cardiotocography (CTG) 1 abnormal USS 2 pregnancy induced hypertension (PIH) 1 abdominal pain

Graph 2 Attendances at FMC October 2014 - March 2015



(Data source: South Tees NHS Foundation Trust).

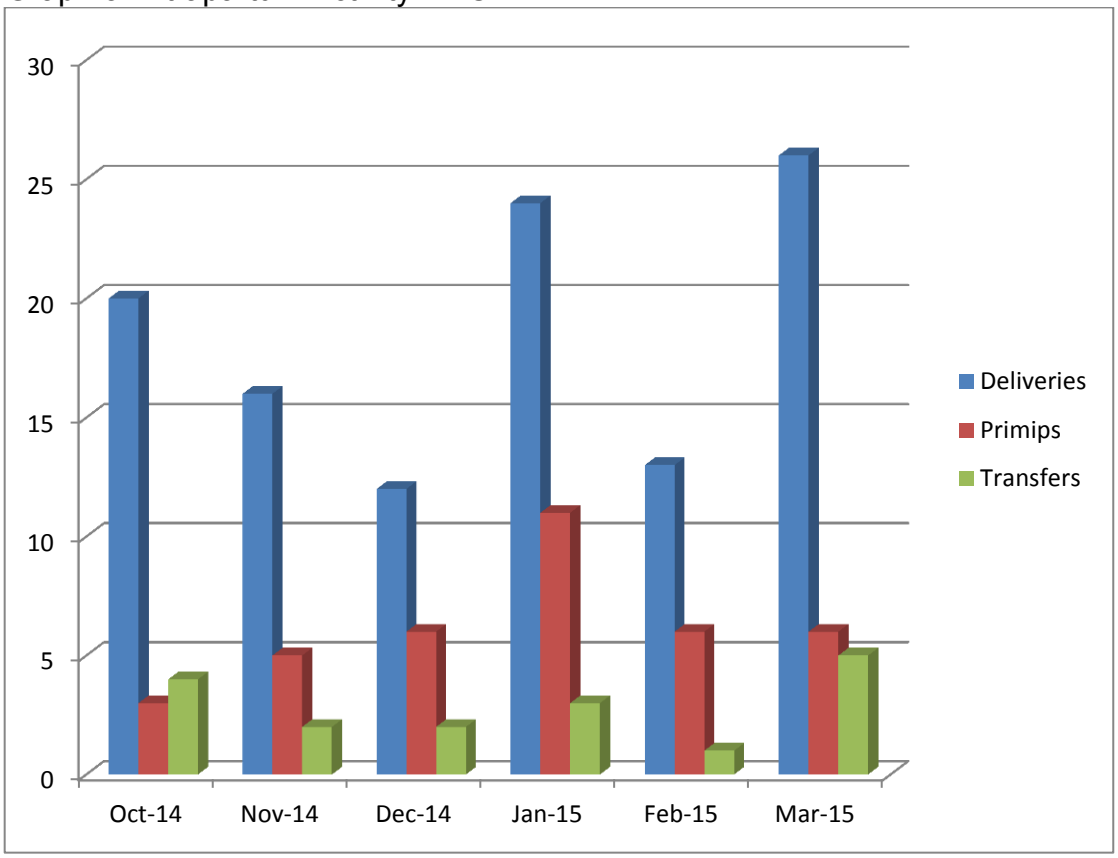
3.2.3 FMC Intrapartum Activity

In the last 6 months there have been 111 deliveries and 10 transfers in labour to James Cook University Hospital.

There were 7 transfers for maternal/infant postnatal complications.

Graph 3 indicates the intrapartum activity since October 2014.

Graph 3. Intrapartum Activity FMC



(Data source: South Tees NHS Foundation Trust).

The reasons for transfers from FMC to James Cook University Hospital are set out in Table 3.

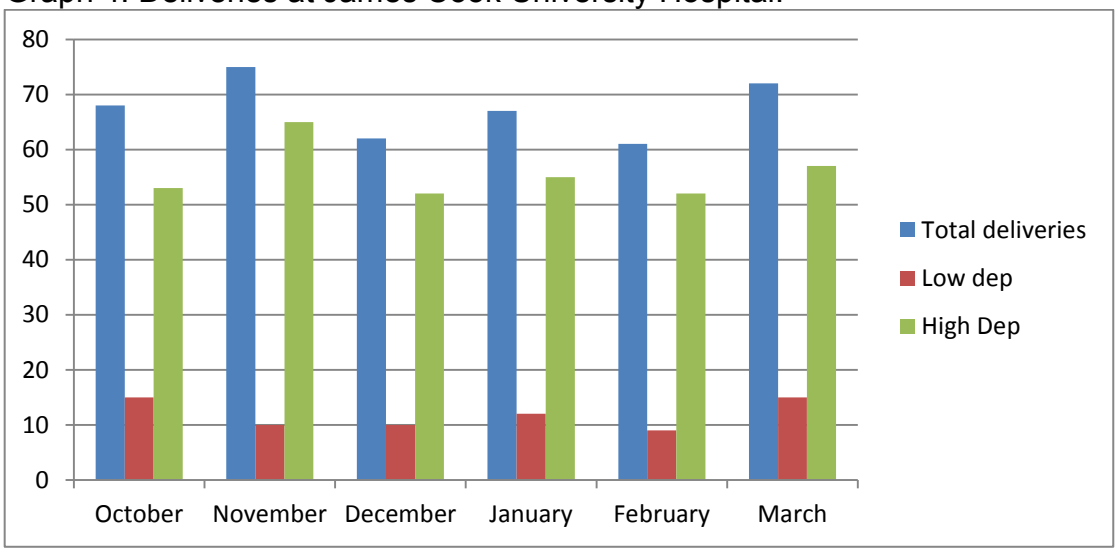
Table 3. Reasons for transfer from FMC October-Dec 2014	2 suboptimal Cardiotocography (CTG) 1 raised blood pressure 1 unwell
Jan-March 2015	2 3rd degree tears 1 4th degree tear 3 prolonged 1st stage of labour (all primigravida) 1 breech in labour 1 meconium liquor/abnormal CTG 1abnormal CTG

3.2.4 James Cook University Hospital Activity

The number of women delivering at James Cook University Hospital from FHN area has also remained fairly static over the 6 month period and as expected, is predominantly women who need high dependency consultant care. Just under a fifth of deliveries were low dependency (Table 4 and Graph 4).

Table 4. Deliveries JCUH	Quarter 4 October -Dec	Quarter 1 Jan-March
Number of deliveries at JCUH from FHN area	205	200
Number of low dependency deliveries	35	36
Number of high dependency deliveries	170	164

Graph 4. Deliveries at James Cook University Hospital.



Without more detailed analysis it is not possible to understand the reasons for these women choosing to birth at James Cook, but likely contributing factors could include proximity to their home address, their chosen birth plan and possibly confidence in the service.

4. Implications/Risks

Quality

4.1 Choice of place of birth

It would appear that intrapartum activity within the FMC midwifery led unit is steadily increasing in the last quarter. At present however, if the activity stays the same over the next 6 months, there would be 200 births per annum which is 100 short of the recommended 300 per year for the unit to be economically viable. Whilst the numbers are very small, there would appear to be some shift in women's choice of provider, with a year on year change (2013/14 - 2014/15) of 68% at Darlington Memorial Hospital, 160% at York Teaching Hospitals NHS Foundation Trust (York Hospital) and 13% at 'other' hospitals. Deliveries at Darlington Hospital peaked during October and November 2014 but have started to reduce. Deliveries at York Hospital increased during November and December and have returned to average activity levels since. Without knowing the reason for women choosing a provider other than the local South Tees Hospitals NHS Foundation Trust, there is no certainty that

the changes to local maternity services influenced their decision. However given that this occurred around the time of implementing the reconfiguration, it is possible that this was a contributing factor.

Paper 12 A Appendix 2 details HRW Deliveries by Hospital Site.

4.2 Ambulance Response Times

The main risk since the implementation of the service changes has been ambulance response times. Whilst the incidence of ambulance transfers has been small, there were some occasions where the ambulance response time was delayed (Table 5).

Table 5. Quarter	No of delays	Length of time from call to attendance
Oct-Dec 14	2	38 minutes 121 minutes
Jan-March 15	2	17minutes 13 minutes

Following a review of delays with ambulance response to requests to transfer, it has been agreed that all transfers from FMC are now classified as priority 1. Investigation of delays has been undertaken by the CCG and Yorkshire Ambulance Service (YAS). Standing Operating Procedures (SOP) have been formulated for use of the extra ambulance. A SOP from FMC is now in place for use of ambulance with/without paramedic. Additionally this has been added to the Trust's Women's and Children risk register, and all ambulance transfer delays will be reported and monitored.

4.3 Normalising Birth and Providing Choices

Through the provision of early bird appointments at FMC, women have the opportunity to attend for public health and screening information at an early stage of their pregnancy, which can improve the health outcomes for the woman and infant. Whilst the FMC acts as a 'hub' for the maternity service, women are able to make choices about antenatal and postnatal location should they choose not to attend FMC.

Services at the FMC are enhanced through the provision of a 24 hour breastfeeding advice and support telephone line. There are also infant feeding drop in sessions. The percentage of women breast feeding on discharge from the MLU has been very high, with 91.6% in the first quarter and 81% in the second. These will be monitored through the routine breastfeeding statistics.

Services provided at FMC will be further enhanced by the implementation of natal hypnotherapy and aromatherapy services which will give women further flexibility and choice to support their antenatal care, labour and delivery.

A 24 hour advice line for both high and low dependency women is also facilitated from the FMC.

4.4 Service User Feedback

Friends and Family Test (FFT) questionnaires continue to be distributed at the key service points at both James Cook and FMC sites. This enables the Trust to receive quantitative and qualitative feedback from service users and helps inform service delivery.

In addition to the monthly FFT, the Trust has developed 2 specific surveys to monitor service user feedback and to understand how the service changes at FMC are being received by local women. A survey is distributed to women during the antenatal and postnatal period to assess their experience of attending the FMC, and a second survey is distributed to women following delivery of their baby (intrapartum period) .

Patient experience questions for antenatal/postnatal service are:

- Did you find the FMC accessible?
- On arrival were the staff welcoming?
- Did all staff introduce themselves with their name and designation?
- Did you find the environment welcoming and comfortable?
- Did you find your privacy and dignity was respected?
- Have the staff given you full explanations of your care/did you feel involved in your care?
- What one area could have been improved/would you like to share a positive experience?
- On a scale of 0-10 how would you rate your experience?

Patient experience questions post-delivery are:

- Have you been happy with all aspects of your care and have you felt safe?
- Do you feel you were given the choice of place of care during your pregnancy?
- Did you feel supported in producing your own birth plan?
- Did all staff introduce themselves at each contact and were they courteous and respectful at all times?
- Did you feel you were given the right amount of information during your pregnancy?
- Have all staff given you full explanations of your care and did you feel involved in your care?
- What one area could have been improved/would you like to share a positive experience?
- Were you left alone in labour at a time that worried you?
- On a scale of 0-10 how would you rate your experience?

Service Users – Responses

Table 6 details the number of completed responses to the FMC survey and the FFT.

Table 6.	Quarter 4* October -Dec 2014	Quarter 1* Jan-March 2015
Antenatal	Not collected	33
Postnatal	Not collected	6
Delivery	21	25
Transfers	4	2
Average satisfaction score (out of 10)	9.6	9
FFT	Not collected	26

*The Trust reports on a calendar year basis.

Results from the FMC experience questions were very positive with an average satisfaction score of 9 out of 10. Women attending the community 'hub' in the last 3 months have been included in the survey and it is planned to expand this to the MDU/EPAU in the near future.

Comments received from the FMC antenatal, intrapartum and postnatal surveys include:

- ‘Lovely environment’, ‘Didn’t feel rushed’.
- ‘Extremely Accessible’ ‘Very WELCOMING’.
- ‘Staff very good with infection control’.
- ‘I needed a growth scan but was reassured at all times’.
- ‘I want to book to deliver here’.
- ‘Felt involved and my partner and toddler were considered too’.
- ‘Brilliant’, ‘Welcoming for husband and 3 year old son’.
- ‘Quiet room offered for breast feeding a drink and biscuit given’.
- 'The staff are the units best asset’.
- ‘Labour experience was amazing’.
- ‘Nothing needs improving’.
- ‘I would recommend’.
- ‘Couldn’t have asked for better staff’.
- ‘Amazing first time labour’.
- ‘Fantastic’, ‘Amazing Food’.
- ‘Everyone impressed me’ ‘family were welcomed after delivery’.
- ‘Most wonderful delivery supported by an amazing midwife’.

Where comments were negative or identified room for improvement, action planning is in place to address within the service. Examples of comments include:

- ‘Hub cramped, no TV’.
- ‘Only reading breast feeding reading material’.
- ‘Couldn’t deliver here as high dependency – should be able to be induced here’.
- ‘Scan payment could be better’.
- ‘Trouble taking blood’.

Feedback from the FFT at FMC includes:

- Pool birth was excellent, really helped with the level of discomfort. Calm and reassuring staff made the whole experience much better'.
- All equipment was on hand and staff were supportive and explained what was going on throughout.
- Everything was amazing! 5* care, treatment, advice, support and 110% dedication from the whole team.
- The Friarage Maternity Unit (MLU) is an incredible resource that has got to be maintained. Facilities are 10/10.
- The care was second to none. I felt safe and very looked after. I was initially worried about having my baby in a midwife led only unit, but the staff were fab.
- They kept me calm and everything went smoothly. The food was good and it was a relaxing stay!
- Everything was clean and organised.
- I received personalised, expert care and was made to feel like nothing was too much trouble for any of the staff. Staff were friendly and approachable. My questions were answered appropriately and I felt reassured. I cannot think of anything to improve upon.

A completed survey was returned from 2 out of the 6 women who experienced an intrapartum transfer between January to March 2015. Issues were identified regarding information and support and these are being discussed within the service to seek approaches to improving the experience for these women at what is a particularly distressing and vulnerable time. When asked would your transfer experience put you off having a baby at the MLU in the future, one of the women said that it had. When asked was there anything that could have been done to improve the experience, one commented "cleaner and better communication at JCUH – Wanted a pool birth." Other comments were "Concerns re dehydration and unable to site IV – Concerns re 3rd degree tear."

There have not been any complaints during the 6 months.

4.5 Governance

The governance structure and assurances for managing risks within maternity services at South Tees NHS Foundation Trust is documented within the Maternity Risk Management Strategy. The Maternity Service Risk Management Group will ensure there are robust mechanisms and processes for the management of risk and assurance in the Maternity Service. This will be achieved through consideration of clinical and non-clinical risks, health and safety requirements, complaints, incidents and claims ensuring that risks are appropriately reported through the Trust risk registers and to the Patient Safety Sub Group of the Trusts Quality Assurance Committee. The Patient Safety Sub Group supports the Quality Assurance Committee in assuring that the Trust delivers high quality, patient-centred care throughout its acute and community services, particularly with regard to patient safety. The group also monitors the delivery of patient safety improvement initiatives which support the Trust's objectives in relation to safety and quality.

The CCG will use its agreed quality assurance process to monitor this provision in addition to regular review meetings during the early phase of the project

4.6 Financial

Activity for the FMU is covered by Payment by results tariff and will be scrutinised and monitored within the financial process of the CCG.

4.7 Constitutional and Legal

There are no constitutional or legal issues for consideration.

4.8 Equality and Diversity

There are no implications for equality and diversity.

4.9 Other Risks

No further risks have been identified at this stage.

5. Conclusions

Women in the Hambleton and Richmondshire localities with a low dependency pregnancy now have the choice of booking a midwifery led delivery at FMC. The FMC environment promotes and supports the normal process of childbirth and empowers and encourages women to take control during their labour and delivery. This is associated with greater satisfaction of the birth process and therefore positively influences the long term health and well-being of women and their families (Midwifery 2020. [online] 2012).

It would appear that intrapartum activity within the FMC midwifery led unit is steadily increasing in the last quarter. At present however, if the activity stays the same over the next 6 months, there would be 200 births per annum which is 100 short of the recommended 300 per year for the unit to be economically viable. However, as this is year one of the reconfiguration, it is hoped that following the official opening of the unit at the end of May, subsequent years will see an increase in activity as service user confidence builds, and the reputation of the service strengthens. The Trust is actively promoting the service so that a robust and sustainable model is achieved. The 100th birth has recently been celebrated. The implementation of revised eligibility criteria will mean more women are able to choose the service. It is also hoped that there will be an increased throughput through the community 'hub.' The awareness and profile of the service is being promoted with midwives in the Langbaugh and Middlesbrough communities so that eligible women are offered choice of provider. Delivery activity data for the local population should be monitored on a regular basis to understand the choices local women are making, and if it is not the local service, to understand why.

The transfer intrapartum transfer rate is very low at around 8% over the past 6 months. The Birth Place Study (2014) cited intrapartum transfers of 36% for primiparous women and 9% for multiparous women. The FMC rates are below

this. The risk has been further managed through the development of a Standing Operating Procedure for the ambulance service, and all transfers from the FMC now categorised as priority one.

The effect at James Cook University Hospital has been as expected with the main increase being high dependency births. Following initial problems in October 2014 immediately following the opening with a substantially increased workload resulting in 4 unit closures, there have been no further problems. The antenatal ward/EPAU and the induction suite are working well and the three new delivery rooms were opened in March 2015.

All of the FFT responses had a net promoter score of 100 with very good comments. The Trust is to increase patient experience monitoring to include the MDU/EPAU, which will add greater breadth to understanding women's experience of the services offered at FMC. Negative comments will be investigated and addressed where necessary.

Currently there is no formal feedback from staff on how the service changes have impacted on them, and their perceptions of the service changes on expectant women and their families. The Trust intends to address this by undertaking a staff experience audit at the FMC.

6. Recommendation

The Governing Body is asked to:

1. Note the positive service user feedback as a reasonable indicator of the quality of the service at FMC, and support the further roll out across the service and including staff feedback.
2. Note the FMC intrapartum activity over 6 months and to receive updates and forecasted activity on a regular basis to actively manage the risk to financial sustainability. In addition delivery activity for the CCG population should be monitored on a regular basis to understand activity flows to the maternity providers local women choose.
3. Note that South Tees Hospitals NHS Foundation Trust will continue with internal quarterly reports to the risk management group and externally to Hambleton Richmondshire and Whitby CCG

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Title:	Senior Commissioning Specialist – Children and Maternity	Head of Midwifery South Tees Hospitals NHS Foundation Trust

PAPER 12 A – Appendix 1

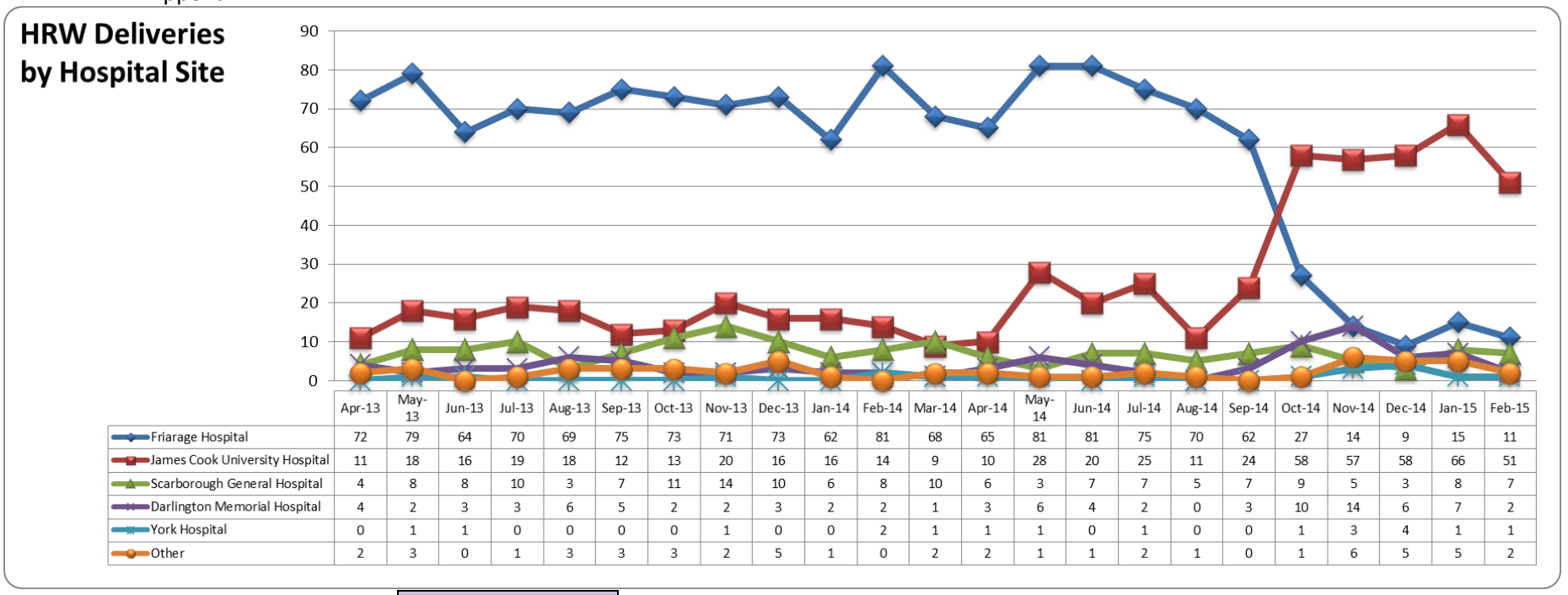
Date	Title	Headline	Story	Location
09/14	Northern Echo	Council reveals cost of fight to save maternity services at the Friarage Hospital	A COUNCIL has disclosed the amount spent on a hard-fought campaign to save **maternity** and children's services at the Friarage Hospital. Richmondshire District Council presented its own proposal on how the serves could be made viable – and when it was rejected a legal team was consulted as a last-ditch attempt to retain consultant-led services at the Northallerton hospital. The council spent about £11,000 on its battle – including £8,500 for a lawyer with the rest on travel and accommodation expenses	Page 8 & Link
10/09/2014	Yorkshire Post	Hospital fight bill defended by district council	Richmondshire Council leader John Blackie has defended the £11,000 cost of the authority's attempt to stop the downgrading **of maternity services** at the Friarage Hospital. The campaign led to a review by Health Secretary Jeremy Hunt but he eventually backed the Hambleton, Richmondshire and Whitby Clinical Commissioning Group's decision. Coun Blackie said " This is money very well spent- a small investment to try to save these key services for our residents." He said the move would have put the safety of patients at risk.	page 7

26/09/14	Darlington & Stockton Times	Award shortlisting fury and criticism	HRW CCG has been shortlisted for the redesign of paediatric and **maternity** services at the Friarage and for improved partnerships between health and local government. In addition, clinical chief officer for the trust, Dr Vicky Pleydell has been shortlisted in the clinical leader of the year category for the HSJ awards. Councillor John Blackie, leader of Richmondshire District Council and leading opponent of the changes to the Friarage, said: "I think the award should be given to those small hospitals that have continued these services for the benefit of local communities."	Page 108
17/10/14	Darlington & Stockton Times	New unit takes first baby steps	The **new midwife led** unit at the Friarage Hospital in Northallerton was officially 'christened' with the arrival of two baby boys.	Page 9
26/10/14	The Telegraph	The list of 66 A&E and maternity units being hit by cuts	Research by The Telegraph shows that dozens of NHS maternity and Accident & Emergency units have been closed or downgraded since the last election, with even more under threat. Here, details of the changes which have taken place, and the changes facing decisions in the coming months: Friarage, Northallerton, North Yorkshire, consultant-led unit closed October 6, being replaced with **midwife led unit**	Link

01/10/14	BBC News	Northallerton Friarage Hospital changes made despite protests	Changes to children's and **maternity** services at a North Yorkshire hospital are coming into force. The Friarage Hospital, in Northallerton, will now no longer provide overnight children's care. And from Monday, only women deemed low risk will be able to give birth at the hospital. Those assessed as high risk must go to Middlesbrough or Darlington.	Link
05/01/15	BBC News	Friarage and James Cook hospitals shuttle bus to expand	A free shuttle bus service connecting a hospital in North Yorkshire with one on Teesside, is to expand. **Maternity services** at Friarage Hospital were downgraded in October, so pregnant women or children with complicated medical conditions have to travel to Middlesbrough's James Cook Hospital. A mini-bus for patients and visitors, will be replaced by a 25-seater bus. During the pilot, which will run until 31 March, usage will be monitored to determine the future of the service. Hambleton, Richmondshire and Whitby Clinical Commissioning Group said it was investing £2,000 a month for the larger bus.	Link

			Dr Charles Parker, from the group, said: "We know from the consultation regarding children's and maternity services at the Friarage that transport links is a significant issue for local people. "We want to make sure that there is a large enough shuttle bus in operation to meet demand."	
25/2/15	D&S Times	Arrival of first "hypno baby" for North Yorkshire woman helping mums with natural births	A MOTHER and mental health worker who is helping women have natural births by teaching them hypnosis is celebrating after her first “hypno baby” was born. Nicky Logan, from Brompton, Northallerton began training in hypnobirthing after using it for the birth of the two youngest of her three children; now aged ten months and four years old. She said: “I can help people wanting a natural **birth at the Friarage hospital** because hypnobirthing gives you that confidence that your body can do it. “There’s the James Cook hospital if you need it, but I want	Link – Page 12 –

30/03/15	Minster FM	100th baby born at North Yorkshire maternity centre	**Friarage Hospital's maternity centre** in Northallerton has welcomed a very special delivery into the world – its 100th baby.Isla Grace Alderson was born at 8.55am on Saturday morning weighing a healthy seven pounds and half an ounce. She's the second child of proud parents Hayley and Paul whose son Isaac was also born at the Northallerton hospital in 2012.	Link
03/04/15	The Advertiser	100th baby marks rebirth of maternity unit	A **maternity unit** which last year lost its consultant led service in a controversial downgrading has marked a major centenary. The **Friarage maternity unit** in Northallerton, which was turned into a midwife led unit last October has marked the birth of its 100th baby	Link
5/4/15	Friarage and James Cook hospitals shuttle bus service extended	Friarage and James Cook hospitals shuttle bus service extended	A shuttle bus service connecting a hospital in North Yorkshire with one on Teesside is to run for another year following a rise in passenger demand. The pilot was set up in October after **maternity services** at Northallerton's Friarage Hospital were downgraded. Pregnant woman and children with complicated medical conditions now go to Middlesbrough's James Cook Hospital.	Link



	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	Jan-15	Feb-15
Friarage Hospital	72	79	64	70	69	75	73	71	73	62	81	68	65	81	81	75	70	62	27	14	9	15	11
James Cook University Hospital	11	18	16	19	18	12	13	20	16	16	14	9	10	28	20	25	11	24	58	57	58	66	51
Scarborough General Hospital	4	8	8	10	3	7	11	14	10	6	8	10	6	3	7	7	5	7	9	5	3	8	7
Darlington Memorial Hospital	4	2	3	3	6	5	2	2	3	2	2	1	3	6	4	2	0	3	10	14	6	7	2
York Hospital	0	1	1	0	0	0	0	1	0	0	2	1	1	1	0	1	0	0	1	3	4	1	1
Other	2	3	0	1	3	3	3	2	5	1	0	2	2	1	1	2	1	0	1	6	5	5	2

	Apr - Feb			
	2013/14	2014/15	YoY change	
Friarage Hospital	789	510	**-35%**	▼
James Cook University Hospital	173	408	**136%**	▲
Scarborough General Hospital	89	67	**-25%**	▼
Darlington Memorial Hospital	34	57	**68%**	▲
York Hospital	5	13	**160%**	▲
Other	23	26	**13%**	▲
Total	1,113	1,081	**-3%**	▼

Source : SUS data February 2015 (Flex).

PAPER 12 B

NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Hambleton, Richmondshire and Whitby Clinical Commissioning Group Governing Body

28 May 2015

Northallerton Locality – Additional Ambulance Resource Review

1. Introduction and Purpose

This paper summarises the quality, cost and performance (for the first six months of operation) of the additionally commissioned ambulance resource operating in the Northallerton area.

2. Background Information

Following the 2014 reconfiguration of Paediatric and Maternity Services at the Friarage Hospital an additional ambulance was commissioned (from Yorkshire Ambulance Service NHS Trust) to operate in the Northallerton area to ensure that any emergency maternity patient transfers to the James Cook Hospital in Middlesbrough could be carried out safely and without delay. The additional ambulance operates 24 hours per day, 7 days per week and is based in the Northallerton area.

The service commenced, as planned, on 01 October 2014 consistent with the service configuration changes at the Friarage Hospital.

3. Key Issues

Following two delayed responses in the initial weeks following reconfiguration (no adverse outcome for either mother or baby), the remit of the additionally commissioned ambulance was changed. Subsequently a further two delayed ambulance responses have been recorded between January 2015 and March 2015 (inclusive) and these are referenced in more detail earlier in the paper.

In order to minimise and mitigate against the chance of any further occurrences of a delayed ambulance response to the Friarage Hospital, the ambulance now operates within the Northallerton locality at all times and will only respond to Red (life threatening) calls and other high priority 999 calls in the local area.

This service development was introduced as a service quality improvement for patients and has been able to demonstrate a contribution to improvements in the following areas:

- Timely responses to emergency transfers for maternity patients between the Friarage Hospital and James Cook Hospital (on every occasion after the operational deployment changes for the ambulance were made).

- Contributing to the improved emergency response times to life threatening and other high priority 999 calls across the Hambleton, Richmondshire and Whitby area recorded during 2014/15.

- Contributing to the improved quality outcomes for Hambleton, Richmondshire & Whitby patients in the headline areas of:

    - Return of Spontaneous Circulation (ROSC) - 14% in 2013 rising to 24% in 2014 equating to 9 patients (January 2014 – November 2014 data).
    - Survival to Discharge (S2D) following cardiac arrest. 3% in 2013 rising to 14% in 2014 equating to 9 patients (January 2014 – November 2014 data).
    - Stemi Care Bundle delivery 85% in 2013 rising to 88% in 2014 (January 2014 – November 2014 data). This equates to 36 out of 41 patients in 2014.
    - Stroke Care Bundle delivery 97% in 2013 rising to 98% in 2014. (January 2014 – November 2014 data). This equates to 262 out of 268 patients.

- Provided reassurance for expectant mothers and staff working in the maternity unit at the Friarage hospital that an additional ambulance is nearby should this be required for an emergency transfer.

The planned number of emergency transfers required in respect of the maternity services reconfiguration was three per week and the actual number of transfers overall has been below that planning assumption at an average of one per week.

Following ongoing quality, performance and service reviews of the additional ambulance resource involving Yorkshire Ambulance Service, South Tees Hospitals NHS Foundation Trust and the CCG, the operational remit of this additional resource will be further changed from 01July 2015. From 01 July 2015 we are planning for the ambulance and a member of Yorkshire Ambulance Service staff (Emergency Care Assistant) to be based “in hours” at the Friarage hospital at all times.

This will further reduce any risk of a delayed emergency transfer from the Friarage Hospital to James Cook Hospital and will increase the effectiveness

of the Urgent Care Practitioner (paramedic with extended clinical skills) working on the ambulance.

The Urgent Care Practitioner will be based and working in support of “urgent” demand and other appropriate clinical work at the Mowbray GP Practice in Northallerton (with a Rapid Response Vehicle available to that member of staff). The Urgent Care Practitioner will also be available to respond to life threatening and other high priority 999 calls in the Northallerton area as required.

During the “out of hours” period the ambulance will respond from Northallerton ambulance station (as per “normal” ambulance procedure). The future plan is to work with South Tees Hospitals NHS Foundation Trust and Yorkshire Ambulance Service on developing an operational model and proposal on how they can support and integrate with the Accident and Emergency/Out of Hours and Clinical Decisions Unit (CDU) departments on the Friarage site as part of a wider urgent and emergency care service.

From 01 July 2015 if an emergency transfer is required the Mowbray practice based Urgent Care Practitioner will be deployed immediately to the Friarage Hospital to join up with the ambulance for the transfer to the James Cook Hospital. If that Urgent Care Practitioner is engaged in responding to a life threatening emergency in the area then another locally based paramedic will be deployed immediately to the Friarage Hospital.

In the unlikely event that all local paramedics are engaged at that particular time responding to other emergency calls then YAS will deploy another clinician to complete the ambulance crew for immediate departure. The Friarage staff have the option to release one of their maternity staff (based on their clinical assessment of the mother’s condition and medical support required for the transfer) to support the patient during their conveyance to the James Cook Hospital.

4. Implications/Risks

This service has been operational since 01 October 2014 and to date, with the exception of four ambulance responses taking longer than planned (two in the early weeks of operation and then two between January 2015 and March 2015 of thirteen minutes and seventeen minutes respectively when all responses were required within 8 minutes), has operated without any additional operational issues being identified.

Both delayed ambulance responses in the early weeks of the service were investigated in depth with the support and collaboration of Yorkshire Ambulance Service and South Tees Hospitals staff. The results of both investigations and the lessons learned from them led to the operational changes in the deployment of the ambulance described earlier in the paper.

A revised model to be implemented from 01 July 2015 further reduces the risk of a delayed maternity transfer ambulance response to the James Cook Hospital.

There remains a small risk that two maternity transfers are required at the same time. Given this eventuality the nearest available ambulance will immediately be deployed to the Friarage Hospital to complete the second transfer.

5. Quality

In addition to delivering its primary duty of emergency maternity transfers the additional ambulance resource has contributed to an improvement in the quality outcomes for Hambleton, Richmondshire and Whitby patients reported during October 2014 and November 2014. Examples of improvements are:

- 8 (42%) patients (out of 19 where resuscitation was attempted) successfully achieved a return of spontaneous circulation (ROSC) during October 2014 and November 2014 compared to 19% (14 out of 74 where resuscitation was attempted) during the January 2014 to September 2014 period.

- During November 2014 3 Hambleton, Richmondshire and Whitby patients who, following a cardiac arrest and attendance by Yorkshire Ambulance Service survived to reach hospital, were then ultimately successfully discharged from hospital. This is the highest individual month during 2014.

- The overall response times (following a 999 call) to life threatening or other high priority emergency calls have improved significantly across Hambleton, Richmondshire and Whitby during 2014/15.

- For life threatening (Red calls) emergencies on 66.6% of occasions during 2014/15 a response was received during 8 minutes compared to the 2014/15 “stretch” target of 66.0% (2013/14 outturn was 64.3% in 8 minutes).

- Response times to Green 1 calls (20 minute response target in 95% of cases) also improved from October 2014 onwards across Hambleton, Richmondshire and Whitby recording 73.1% for the first half of the year (April 2014 – September 2014) and then an average of 83% per month for the second half of the year (October 2014 – March 2015).

Although the additional ambulance resource cannot be credited with direct responsibility for these quality and performance improvements, in collaboration with the other ambulance service supporting initiatives introduced by the CCG and Yorkshire Ambulance Service during 2014/15, it will undoubtedly have helped considerably.

6. Financial

The 2014/15 additionally commissioned ambulance (01 October 2014 – 31 March 2015) cost £220,000.

The 2015/16 service (01 April 2015 – 31 March 2016 cost is £500,000 with the full year effect (once all Urgent Care Practitioners are added to the rota) estimated at £600,000.

7. Constitutional and Legal

There are no constitutional or legal issues for consideration.

8. Equality and Diversity

There are no implications for equality and diversity.

9. Other Risks

No further risks have been identified at this stage.

10. Conclusion

The CCG has undertaken an ongoing review of the additional ambulance resource and based on the evidence contained within the review has extended the contract with Yorkshire Ambulance Service NHS Trust, (with the revisions described in the paper) until at least 31 March 2016 with a joint commissioning intention for the service to be recurrent.

The service model will continue to be monitored for quality, activity and performance and updates will be reported to the Governing Body.

11. Recommendation

The Governing Body is asked to:

1. Note the content of the report and the contribution towards improvements service quality and performance during 2014/15.

2. Note the revised service model planned from 01 July 2015 onwards.

Author: John Darley
Title: Delivery Manager

NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Hambleton, Richmondshire and Whitby Clinical Commissioning Group
Governing Body

28 May 2015

Friarage Hospital to James Cook Hospital Shuttle Bus Service Review

1. Introduction and Purpose

This paper summarises the quality and performance (for the first five months of operation) of the daily shuttle bus service operating between the Friarage Hospital in Northallerton and the James Cook Hospital in Middlesbrough.

2. Background Information

Following the 2014 reconfiguration of Paediatric and Maternity Services and further recognising the wider challenges faced by patients, their families, carers and staff in travelling between the two hospital sites (within the same acute Trust) a shuttle bus service contract was competitively tendered for to support convenient (and free of charge) travel between the two hospital sites.

Procters Coaches were awarded the initial shuttle bus service contract operating from October 2014 to March 2015, with a further one month extension subsequently agreed to include April 2015. The service commenced, as planned, in October 2014.

The twenty-five seat shuttle bus service operates on a two hourly cycle, non-stop, Monday to Friday (excluding bank holidays) and commences at 8am from the Friarage departing for the final journey of the day at 5pm from the James Cook Hospital.

3. Key Issues

This service development was introduced as a quality improvement for any person who had a requirement to travel between the Friarage and James Cook Hospital sites during the day.

The service has been able to demonstrate a significant improvement for passengers in the following areas:

- Improved and increased convenience for patients, families, carers and NHS staff travelling between the two hospital sites.

- More cost effective travelling for patients, families, carers and NHS staff.

- Assists in mitigating against the very congested car parking on the James Cook site.

- Reduced carbon footprint in the geographic area as car utilisation is reduced.

Following a quality, performance and service review of the initial contract a re-tendering exercise for the shuttle bus was completed and as a result the service has been extended for a further 11months (01 May 2015 until 31 March 2016) with Procters Coaches successful in retaining the contract.

Between October 2014 and April 2015, over 3,000 passengers have travelled on the shuttle bus service, with an average of over 200 passengers per week now regularly using the service.

Passenger numbers are evenly distributed across the days of the week with the first and last journeys of the day being in greatest demand.

The average number of passengers travelling per day has increased from 17 to 38 within the review period and consequently the average cost per passenger journey has reduced from £21 to £8 over the same period.

The split between NHS staff and non-NHS passengers utilising the service is currently evenly distributed with the non-NHS cohort of passengers growing steadily as the communication, marketing and promotion of the service has increased.

4. Implications/Risks

This service has been operational since October 2014 and to date with the exception of some minor concerns over the relief drivers (when the regular driver is on holiday) and their adherence to the timetable, no formal complaints or concerns have been raised regarding the service. The issues regarding the relief drivers and potential service delays have been followed up directly with the service provider.

No further implications or risks are identified at this stage.

5. Quality

Appendix 1 to this report details the results of the qualitative review of the service which has been undertaken during March 2015 and April 2015.

6. Financial

The 2015/16 service has been contracted with Procter's coaches for £89,000.

The 2014/15 contract with Procters Coaches was valued at £37,000

7 Constitutional and Legal

The contract tendering and award process for the 2014/15 and 2015/16 contracts have been completed in line with all the requirements for NHS statutory bodies.

8 Equality and Diversity

There are no implications for equality and diversity as this is an equal access service.

9 Other Risks

No further risks have been identified at this stage.

10. Conclusion

The CCG has undertaken a review of the shuttle bus service and based on the evidence contained within the review has extended the contract, in its current form and operational timetable, for a further eleven months until 31 March 2016.

The service will continue to be monitored for quality, activity, performance and passenger experience and the outcomes will be reported to the Governing Body again towards the end of the contract extension period.

11. Recommendation

The Governing Body is asked to:

1. Note the content of the report and the qualitative assessment of the service in Appendix 1.

Author: John Darley

Title: Delivery Manager

Appendix 1

Friarage Hospital to James Cook Hospital
Shuttle Bus Service Review

Purpose

To review feedback received from passengers using the cross-site bus service (operated by Procters Coaches of Leeming Bar), which runs between the Friarage Hospital, Northallerton (FHN) and James Cook University Hospital (JCUH) in Middlesbrough.

Background

A number of trips were undertaken by an officer from the CCG to coincide with the re-commissioning of the shuttle bus with Procters Coaches (to 31 March 2016). The trips covered each weekday and a sample of various times. The full list of trips with numbers of passengers on each trip is as follows:

Date	Time from FHN	Passengers	Time from JCUH	Passengers
Fri 17 March	08:00	8	09:00	0
Mon 23 March	10:00	3	11:00	1
Thu 26 March	14:00	2	15:00	0
Mon 30 March	12:00	4	13:00	3
Wed 01 April	14:00	7	15:00	4
Fri 10 April	08:00	9	09:00	2
Tue 14 April	08:00	11	09:00	0
Fri 17 April	10:00	2	11:00	2

Passengers were invited to complete a questionnaire which asked them to rate various aspects of the service, as well as offering the opportunity to provide any other relevant feedback. The CCG officer was also able to speak individually and collectively with a number of passengers, to answer questions and in some cases, gather “soft” intelligence about the service.

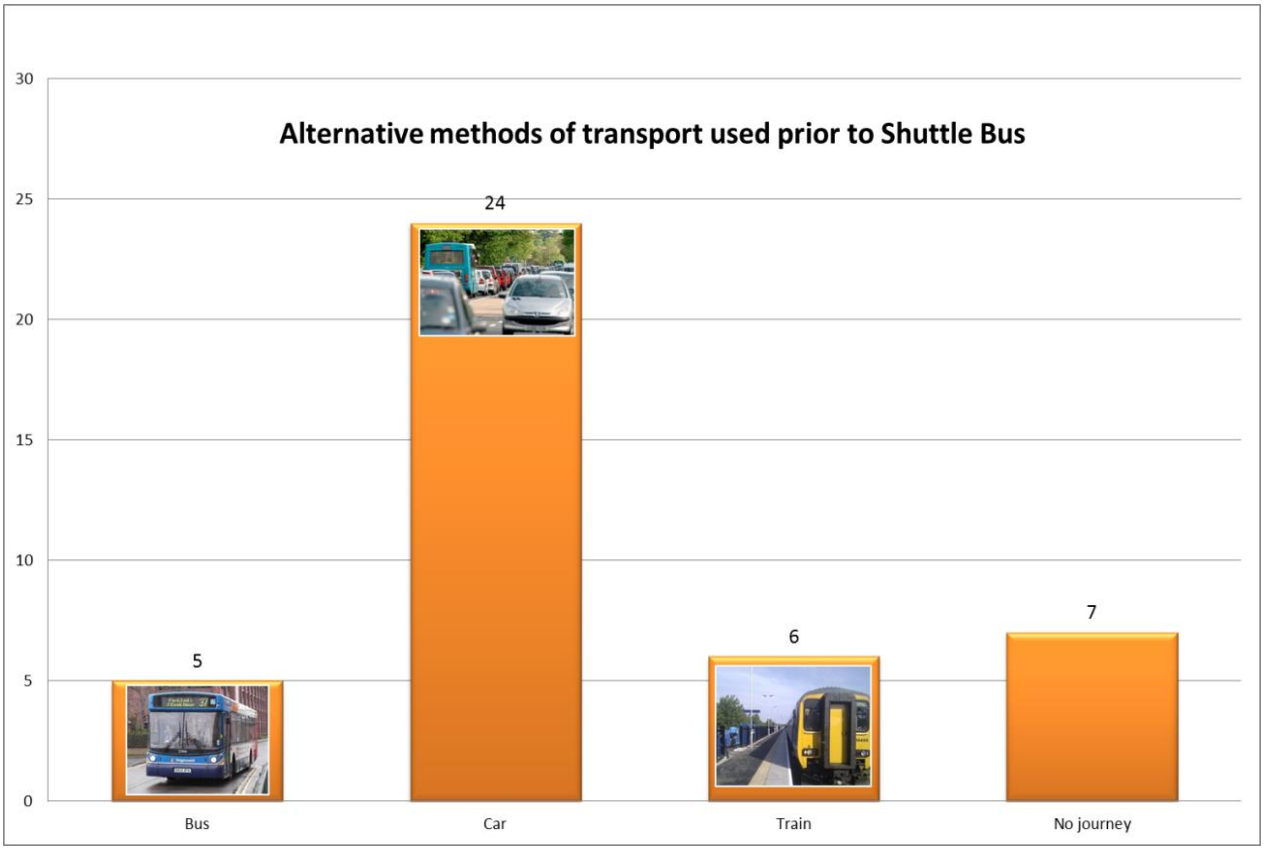
The generic questions related to:

- Previous method(s) of transport between hospitals?
- Rating of the timetable/the size and cleanliness of the bus/the attitude of the driver?
- How the passenger found out about the service?
- Regularity of use?
- Convenience of pick-up/drop off points?
- Purpose of journey?
- Any other comments?

Data

Feedback was obtained from 42 separate passengers (the total of 58 passengers on the previous page includes a number of children and some staff whom the CCG officer met on more than one trip).

Results



The majority of passengers would have travelled to JCUH by car without the availability of the service.

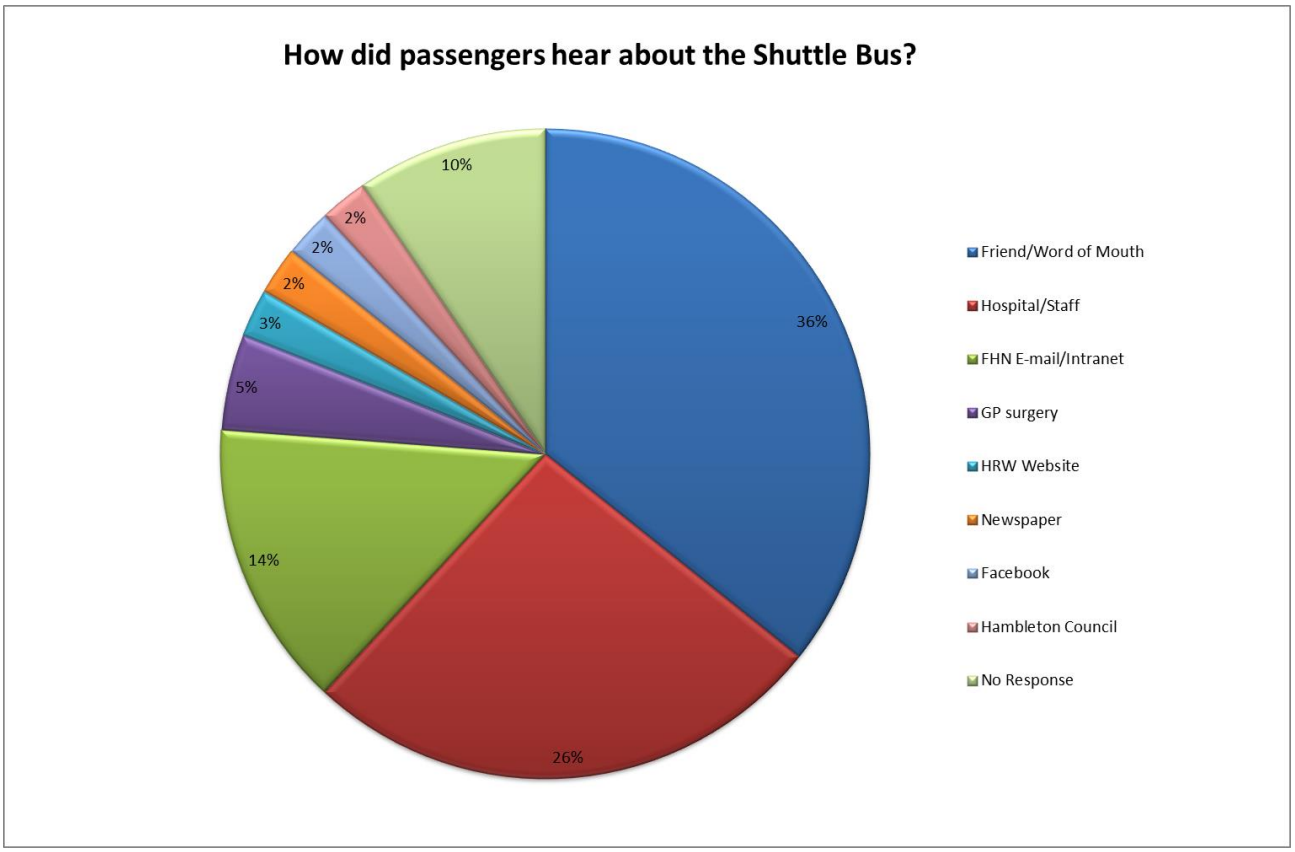
Relevant comments included:

- "It would be good to keep this service for people that don't drive."
- "Excellent service. Don't know what I'd do without it."
- "Best thing that's happened. Saves the stress of finding a parking space."
- "I would be happy to pay for this service. It is vital."
- "I have to pay £13 each way on a Saturday and Sunday to visit my husband."

Some positive soft intelligence has also been received regarding the "regular" driver:

- "He took chocolates to one of the wards on behalf of a discharged patient".

- “He remained with members of a family that had become separated, providing reassurance and company, whilst also informing security”.



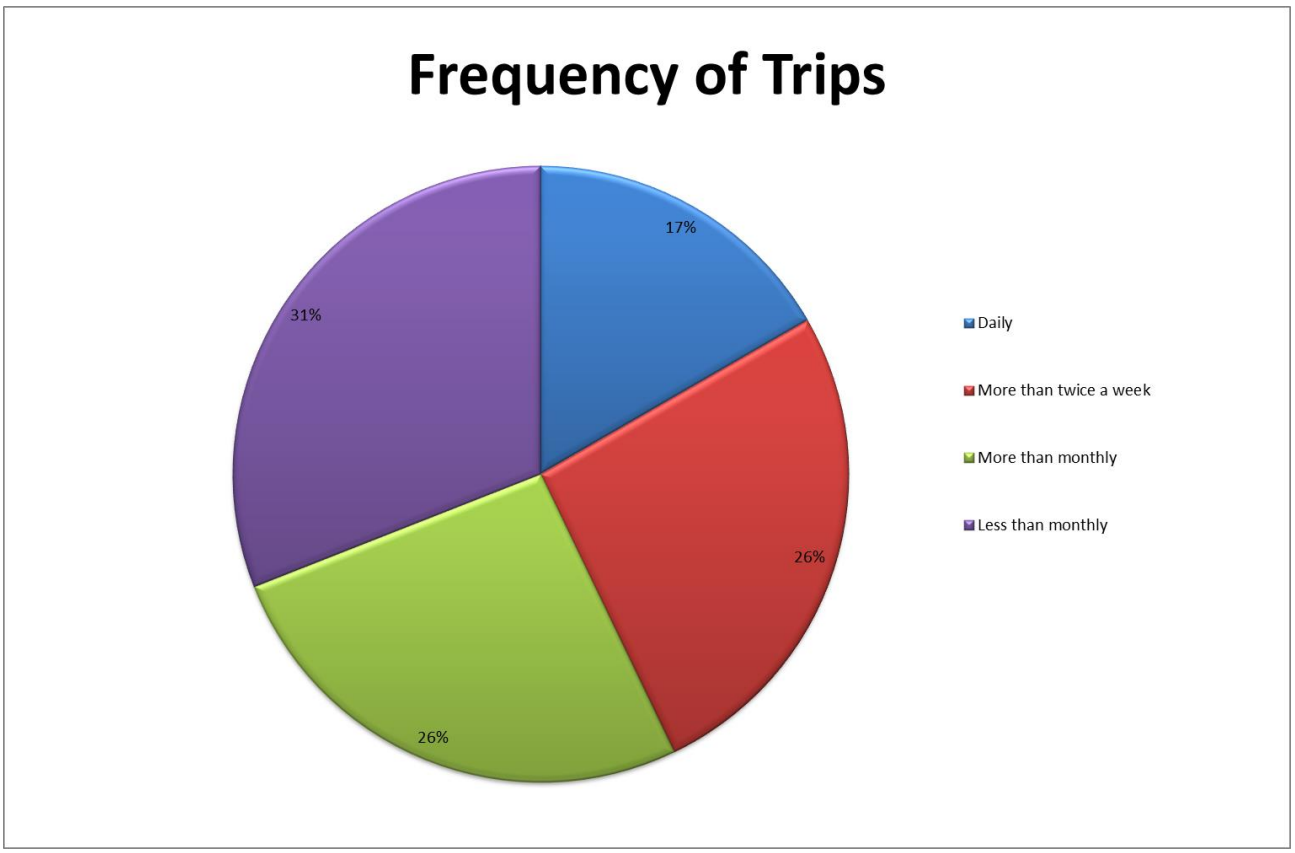
Whilst 62% of all passengers found out about the shuttle bus through a friend or hospital colleague, it is encouraging that a growing number of other communication methods have been noted, including via the HRW CCG website, newspaper, and social media.

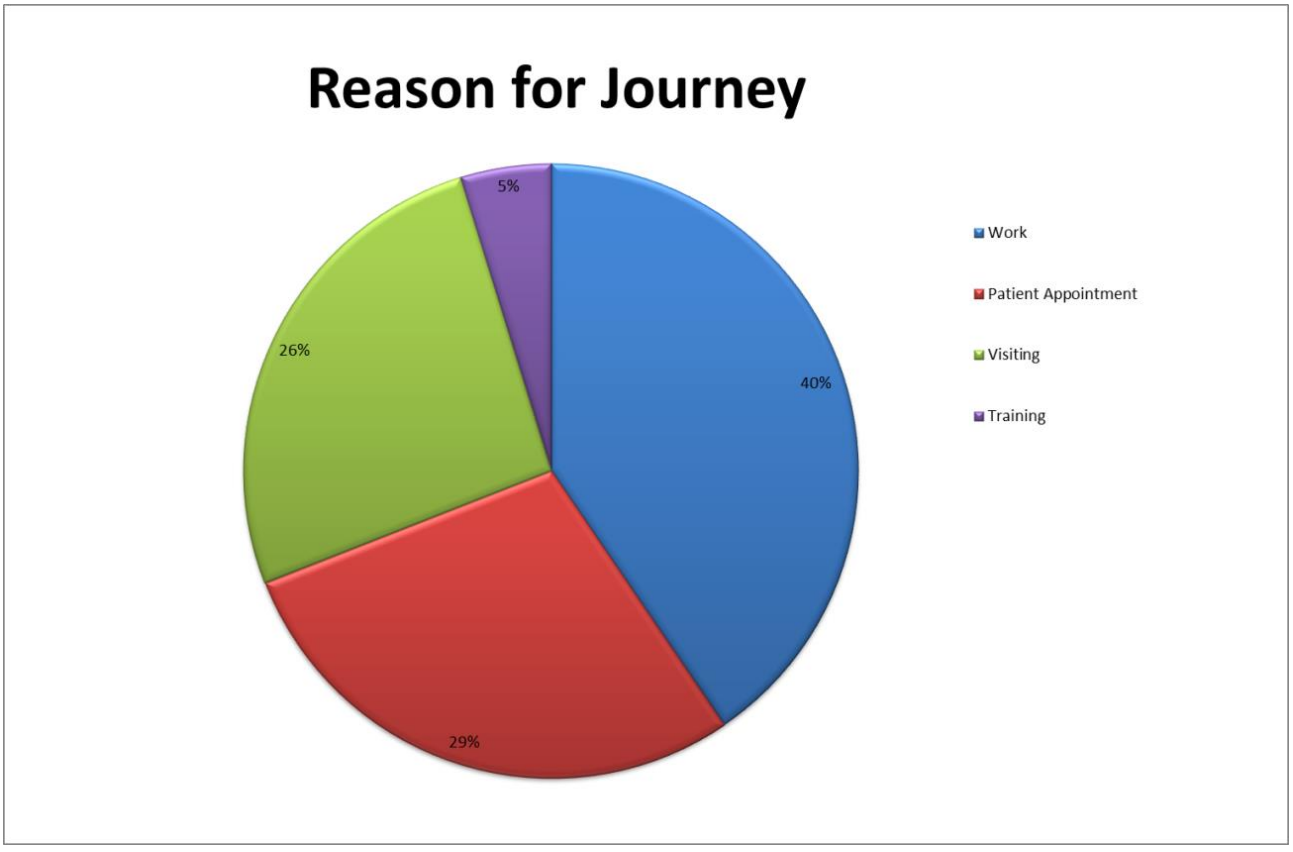
Further thought is being given as to how the service can be promoted, although the responses clearly offer some obvious hints. Other suggestions from passengers included marketing the service in churches, Women’s Institutes and supermarkets.

On one of the trips the CCG officer spoke with a lady who suggested that a number of people based at RAF Leeming may have missed appointments at JCUH because of travel constraints. The CCG officer subsequently made contact with a civilian Personal Family Support Worker on the base, who confirmed the service would be of benefit, and a supply of the new leaflets will be provided. The CCG would be unlikely to receive such “soft” intelligence without the face to face contact, and a second round of trips is being planned for later in the year.

The frequency of trips (chart on page 4) shows that the most regular trips are made by less than half the passengers. As NHS staff are likely to be the most frequent users, the inference is that a good percentage of non-NHS staff are using the bus, but on a more intermittent basis (i.e. a larger number of less regular passengers). This assumption is supported by the chart detailing reasons for the journey, with 53% of passengers travelling for appointments or

to visit relatives. These sample figures are comparable with the overall NHS/non-NHS split which currently stands at 51% / 49% respectively.





11 of the 42 passengers left additional comments, almost all relating to departure times.

- Four people suggested that the last bus should leave from JCUH at 17:10-17:15 instead of 17:00
- Three people requested a bus from FHN before 08:00
- Two people mentioned more frequent trips
- One person advised that the service does not run in line with visiting hours
- One commented that the timetable was not clear in the leaflet

North Yorkshire County Council

Scrutiny of Health Committee

12 June 2015

REALISING OUR POTENTIAL - OUR NEW NORTH YORKSHIRE

A North Yorkshire Approach to Integration, Prevention and New Models of Care June 2015

On behalf of: *NHS Airedale, Wharfedale and Craven CCG / NHS Harrogate and Rural District CCG / NHS Hambleton, Richmondshire and Whitby CCG / NHS Scarborough and Ryedale CCG/ NHS Vale of York CCG*

Background

This paper is designed to be the starting point for a discussion with the Health and Well-being Board and across organisations. It is deliberately written in a 'green paper' style so that HWB can be involved in the development of these the models going forward. It focuses primarily on the adult population.

The NHS Five Year Forward View (5YFV) was published in October 2014 and describes an ambitious challenge to the NHS and Local Authorities to develop robust and resilient services that meet the very different needs of our population into the future:

> *It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948 between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details. One organised to support people with multiple health conditions not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we can't deliver the necessary change without investing in our current and future workforce.*
>
> ***5YFV***

Likewise in March 2014, the Association of Directors of Adult Social Services, which works with local authorities, the Local Government Association and the Government, to shape, co-ordinate and deliver adult social care policy, published it's equivalent forward look prospectus: Distinctive, Valued, Personal – why social care matters: the next five years. This prospectus sets out:

- Protecting the NHS also requires the protection of social care: together, both services need to be protected, aligned and re-designed, with greater use of pooled budgets
- Outcomes, rather than structural solutions, should be the focus of integrated services
- Health and Well-being Boards offer the best prospects of crafting local solutions tailored to local needs and circumstances
- Personalisation should be at the heart of public services and the voices and views of people who use services are integral to shaping services and to making individual decisions about care

- The core components of adult social care services should be good information and advice; building supportive relationships and resilient communities; services that help us get back on track after illness or support disabled people to be independent; care and support services that address our mental, physical and other forms of well-being and are much better joined up
- Health and social care should be seen as much greater contributors to a stronger economy and as sources of potential economic growth – social care alone contributes £43bn annually to the national economy through employment and goods and services

The recent devolution package for Greater Manchester ('Devo Manc'), which includes health and social care, offers new opportunities for developing approaches to investment and service delivery which combine both critical mass and local prioritisation - the mantra of Devo Manc is 'no decision about Greater Manchester, without Greater Manchester' and it was encouraged by the fact that, prior to the deal, only 16 percent of health and social care spend in the area was determined by organisations based in and directly accountable to Greater Manchester. Whilst the communities, service models and political landscape in North Yorkshire is very different to that of Manchester, the learning is significant, including the opportunity to develop a way of working which combines size, scale and reliability with the ability to make local, place based decisions.

The scope of change required to meet these challenges is huge and requires the participation of every sector of care. The ingredients that underpin successful change are complex but key ingredients are:

- Clarity of purpose and ability to describe the journey and the destination
- A motivated skilled resilient workforce
- Real involvement and ownership of change by staff
- The development of an ongoing conversation with the public and with patients and carers that fosters real co- creation.
- Capacity to make change happen (tools and time) for every organisation involved.

Together, each CCG in North Yorkshire and the County Council cover the full range of differences in demography and geography. Although there is great synergy around the over-arching vision, delivery of their objectives will be local and different. Each CCG put in a bid to become a Vanguard site for the 5YFV. Harrogate and Rural District CCG working with NYCC, Harrogate District Foundation Trust, TEWV and Harrogate Borough Council, were successful. The Vanguard sites will attract central NHS investment and expertise to facilitate their plans. The other CCG'S are committed to progressing their programmes of work and will continue. Each CCG has outlined their local plans in the appendices.

What we have achieved so far

All of the CCG's emerging from the former NHS North Yorkshire and York Primary Care Trust faced inherited financial deficits in their first year of operation. All of the 5 main CCGs have been able to repay inherited deficits and remained in surplus in 2015-16, providing the most stable NHS financial situation for over a decade.

Since the implementation of the 2012 Health and Social Care Act the county has seen significant advances across the health and social care communities. Some examples of these are:

- Large-scale improvements in Mental Health services such as:
    - The creation of health-based places of safety for those detained under section 136 of the Mental Health Act

    - Dramatically increased access to community based talking therapies (IAPT) from 2% of the potential population served to nearly 15%
    - Mental Health Liaison has been commissioned to support staff both in the Emergency Department and on Inpatient wards to provide the best possible care for people with mental health problems, with the aim of reducing inappropriate A and E attendances, unnecessary admissions and the length of inpatient stay for people with complex problems.

- Investment in community based services to prevent hospital admission and speed up hospital discharge including:
    - FAST response/intermediate care teams
    - Home from hospital schemes commissioned from the voluntary sector
    - Paramedics working in primary care and closer working between the ambulance service and GP's so that people are not automatically taken to hospital when they dial 999 if their problems can be managed locally.
    - Case finding in primary care to develop care plans to actively manage frail and vulnerable patients more effectively.

- Significant investment in, and commissioning of prevention and independent living services, including the roll-out of new extra care schemes, locally based weight management services and the healthy child programme

- New, comprehensive Public Health services for sexual health and substance misuse

- Implementation of the first phase of the Care Act, including new services for carers

- Greater use of personal budgets and direct payments, including the first personal health budgets – putting more people in control of their care and the funding that provides it

- The emergence of new ways of working as organisations and with the public, including through Health and Well-being Board, Healthwatch, provider partnerships , GP federations etc

Our approach to integration

The Better Care Fund has been a catalyst for new ways of working together in North Yorkshire. However, in many ways, it has been practical steps, like the management of winter pressures, which has begun to build confidence and to improve what we do and how we do it. These relationships and ways of working are still at an early stage.

The North Yorkshire Commissioner Forum has identified a series of principles which it believes should underpin how we develop our model of working together in the future.

We want to make the step from responding to national policy to, with local people, shaping policy and taking a step towards self-determination. We know that what works best is when we combine local knowledge and delivery with county-wide collaboration and scale. We want to combine together to be able to plan for the next ten years and beyond. We are therefore starting work on what a devolution deal might look like for North Yorkshire's health and social care services which:

- Reaffirms the importance of place based commissioning, centred around GP's in the County's main localities, and partners in local government and the voluntary sector

- Delivers services around clusters of GP practices and / or identifiable communities: Team around Primary Care or Team around the Community
- Commits to reinforcing this model irrespective of any subsequent changes to NHS – or even – local government boundaries and responsibilities
- Emphasises the increasing role of the public and particularly people who use services in having more choice and control over decisions which impact on their care and their lives, as well as in co-creating the plans and models which are developed for services in the future
- Makes sure the North Yorkshire Pound – and indeed, the Ryedale Pound, and the Scarborough Pound and the Hambleton Pound etc. is spent well and, where appropriate, more of it is pooled to get better impacts across the NHS and local government
- Focus on outcomes as the basis for change, rather than structural solutions
- Empowers local people to take control of their own health and well-being through expert programmes, peer support and inputs from the stronger communities programme
- Shifts focus and investment towards prevention, self-care and care at home, rather than hospitalisation and 24 hour care, so that patients only are admitted to hospital because they are too unwell to be managed at home. No one should be in hospital unless their care cannot be delivered safely in the community 24/7
- Ensures no-one should be discharged to long term care without the opportunity for a period of enablement
- Ensures that the County continues to have 3 sustainable general hospitals within its boundaries at Harrogate, Northallerton and Scarborough, which deliver high quality safe local services as well as hospitals in Darlington, Keighley, Middlesbrough and York which serve the County well. The ethos on which the hospital services are built is that all that can be delivered locally safely is and that only services that need to be delivered from specialist centres because of compelling quality and workforce issues are provided from more distant larger hospitals
- Improves health and reduces the variations in health outcomes and access to services experienced in some urban areas and the remotest rural areas

Our Emerging models of prevention and care

Whilst each local area has different needs and circumstances, there are some common approaches emerging in how we are developing models of prevention and care across the County.

<u>Prevention, self-care and community resilience</u>

Our aim is to keep people healthy and self- reliant for as long as possible: none of us wants to use services unless we really have to do so. We believe that we should focus more energy and investment towards enabling people to live healthily, to get the information and advice any of us need.

Examples include:

- Plans to introduce a network of prevention officers and village agents, working with the voluntary sector and statutory agencies to support people to remain independent and well at home
- Action to promote warm homes and reduce fuel poverty
- Falls prevention services
- Mental First Aid and suicide prevention
- Better information and advice for people on-line and in person about health and social care issues

- Good neighbours schemes, village hall hubs, carers support and other grassroots initiatives funded through the Stronger Communities programme and borough and district councils
- Work with pharmacists to support prevention around minor ailments
- The roll-out of extra care and supported living developments across the County

Re-designing the space between services

Whilst recognising that most of us would rather not use services unless we have to, when we need to do so, then we expect services to be high quality, responsive, in the right place at the right time, and, increasingly, taking account of our convenience, our views and making decisions with us rather than for us.

There are many examples of how we plan to re-model these services from around the county. These include:

- Integrated urgent care services, based in care hubs with staff from primary and secondary care working together to meet the needs of patients
- Physicians assistants and urgent care practitioners working alongside GP's and practice nurses in primary care together
- Intermediate care and reablement services coming together to develop seamless services
- GP hospitalists working in Acute Care medical assessment units to enhance medical capacity in small hospitals and bring a GP focus
- GP practice nursing reaching out into nursing homes and working to better manage frailty
- Individuals with long term conditions owning comprehensive care plans designed with them and there family/carers to support and maintain independence and reduce the need for an urgent intervention.

Building the foundations for new models of prevention and care

To integrate services effectively we need to consider a move away from traditional funding mechanisms including payment by results (PBR). An example of this would be an integrated hospital "front of house". At present patients can access both GP Out of hours services and A&E services which are often located very close to each other. GP out of hours services are commissioned as block contracts where as A&E is on a tariff. WE also need to consider if pooling budgets between organisations gives us increased flexibility and economies of scale. If the service is to be truly seamless we need to develop a single funding mechanism which rewards the best outcomes for patients.

Developing an appropriated skilled and motivated workforce to take forward this ambitious vision for the future is perhaps our biggest challenge. The reasons are complex and include:

- A history of poor workforce planning in the NHS
- A reduction in the hours worked and a desire for a better work –life balance by the clinical workforce over the last 15 years
- Preference for newly qualified professionals to work in larger towns and cities, making it hard to attract them into rural areas
- Preference for younger professionals to live and work in the south
- Relatively expensive housing costs in North Yorkshire when compared to surrounding areas (Co Durham, West Yorkshire etc.) and a perceived lack of local services in a deeply rural county
- Very localised labour markets, with significant differences in supply and demand, for example between Filey, Scarborough and Whitby

- Competition for those undertaking caring roles which are relatively poorly remunerated compared with the retail sector etc.

North Yorkshire Delivery Board has already started to look at these issues on behalf of the HWB and will report back in due course.

To deliver new models of care we will also need to develop new roles: physician's assistants, GP hospitalists, primary care emergency practitioners and generic care workers. The individuals filling those roles cannot simply be taken from those who at present fulfil other roles locally as that only creates another pressure, so we will need to make North Yorkshire a beacon of NHS and Social Care innovation attracting people into the area for the first time, or encouraging those originally from the county to return home to work in an energetic and forward thinking environment. Hosting local education and skills development opportunities together which will also bring together health and social care teams will be an essential component to success.

We will need to use new technologies to their maximum. Where better to really explore the benefits of e-consultation, supporting palliative care patients in their own homes, smart working, and enabling patients to better manage their own illness through technology than a deeply rural community such as ours?

We are committed to involving the public in a very different way from how we have done in the past. We want the patients, their carers and the public to work with us from the beginning to create our vision. This means we need to develop new ways of having those conversations, to welcome the public as team members into every piece of work we do. We will need to reach out to groups already in existence, fully exploiting social media, find ways of involving children and young people and find those who have traditionally been seen as hard to reach by thinking creatively beyond our normal models of working. This will take time. It is far away from a simple traditional "consultation". It will also require energy and real commitment from the public themselves to be active participants in both managing their own health and in service development. Across the county we have started those conversations but we know we have a long way to go.

We also need to ensure people are more in control of their own care and their own lives – shared decision making between people using services and professionals, personalisation, personal budgets and direct payments, across health and social care, are not the only ways of achieving this ambition, although they are important factors.

As we develop our new services it is vital we weave services which address mental health issues and which promote well- being and mindfulness into all our services from the foundations upwards rather than as an addition later in their design. Remembering every aspect of illness and care has a psychological component which needs to be addressed effectively.

<u>Developing new models of primary care through greater commissioning responsibilities</u>
The document 'Next steps toward Primary Care Co-commissioning' (NHS England 2014) was published in November 2014 and gave clinical commissioning groups (CCGs) the opportunity to choose the co-commissioning model they wish to assume for primary care. Primary Care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View and is an enabler in developing seamless, integrated, out-of-hospital services, based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning models CCGs could take forward:
Level 1. Greater involvement in primary care decision making
Level 2. Joint decision making

Level 3. Delegated commissioning arrangements

Each CCG submitted an application to NHS England on the 9th January 2015. The table below shows the level in place from April 2015.

Clinical Commissioning Group (CCG)	January Submission
Harrogate & Rural District CCG	Level 3 - Delegated commissioning
Scarborough & Ryedale CCG	Level 3 - Delegated commissioning
Vale of York CCG	Level 3 - Delegated commissioning
Hambleton, Richmondshire & Whitby CCG	Level 2 - Joint decision making

The scope of primary care co-commissioning in 2015/16 is General Practice (GP) services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. The terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

The CCGs who are undertaking Level 3 (Delegated) commissioning of primary care have established specific Governing Body committees. These will take the responsibility for decision-making on primary care commissioning and have been established to manage conflicts of interest and to involve wider stakeholders where appropriate. The Primary Care Commissioning Committees (PCCC) will manage the formally delegated responsibilities provided from NHS England (NHSE) including the financial budgets from GP contracts. (Some elements of primary care commissioning already sat with CCG financial resources, such as that for GP Out of Hours services and Local Enhanced Services. These will continue as before but now forming part of a wider responsibility for primary care.) The PCCC will be formal CCG committee with their main decision-making committees meeting in public, with agendas and papers accessible through the relevant CCG. Those CCGs engaging in Level 2 commissioning will cover the same areas of responsibility as level 3, but without the formally delegated budgets from NHSE. Furthermore, whilst Level 2 CCGs will still commissioning jointly with the primary care commissioning function from NHSE, for those at Level 3 the relationship with NHSE will be primarily that of providing assurance. The effective distinctions between the co-commissioning levels may become clearer as CCGs engage in actual GP primary care commissioning.

The development of primary care commissioning should be seen as part of the wider development of CCG service strategies, including service redesign and new models of care, rather than being treated in isolation as a discrete element of service commissioning. As such the emergence of commissioning new models of primary care fits within the local implementation of the NHS 5YFV. At this early stage it is unclear as to the specific changes in primary care that may come forward in the short and medium terms. CCG primary care commissioning will, however, need to respond to the evident challenges in GP services:

- The need to move to 7 day service provision
- The difficulties of maintaining and developing a primary care workforce
- The public sector financial environment in an age of austerity
- Increasing demand for fast access to healthcare

Responding to the challenges may require redesign of service provision, including:

- the skill-mix of primary care workforce;
- the offer of services to patients across 7 days;

- rationalisation and consolidation of service delivery models;
- greater promotion of self-care; and
- community models of care and support.

Enablers

To move the work forward a set of enablers may need to underpin progress:

1. A commitment to an overarching strategy for delivering new models of prevention and care, with an explicit agreement that localities will play a key role in the service design and architecture of delivery, whilst making best use of countywide economies of scale and critical mass
2. An agreement to work together to make North Yorkshire a more attractive place for people to come to live and work. We need to consider:
    a. Making care a positive career choice (New roles, remuneration, pay policies across organisations, market conditions, academic links etc).
    b. Housing policies.
    c. Other ideas?
3. A commitment to develop new funding models and risk pooling both in localities and across the county.
4. Development of new technologies.
5. Willingness to explore greater sharing of resources, such as capital estate.

Vicky Pleydell

Clinical Chief Officer
Hambleton Richmondshire and Whitby CCG

Appendix 1

Airedale, Wharfedale and Craven CCG

New Models of Care Briefing – Work to Date

Strategic Approach; Five Year Forward View

Our Vision is to create a sustainable health and care economy that enables people to be healthy, well and independent.

In order to achieve this vision we will:

- Promote self-care and illness prevention and improve the general health and well-being of the population
- Transform primary and community services and place the patient at the centre of their care
- Implement a 24/7 integrated care system across health and care economy
- Develop and deliver a sustainable system wide model for urgent care services
- Develop and implement a system wide model for delivery of planned care interventions

Integrated Care for Adults Programme (ICfA)

The Integrated Care for Adults programme is a programme across Bradford, Airedale, Wharfedale & Craven (AWC) with shared objectives and outcomes. Delivery is undertaken through separate programme arrangements in AWC to reflect local nuances and approaches. Please see governance diagram on Page 3.

Work to date - to transform the delivery of care

There is system-wide commitment to transform care and join up services. Significant progress has been made in developing integrated care teams based around local communities formed around clusters of GP practices. This has been undertaken through the ICfA programme.

There are 17 GP practices within AWC. **Integrated community teams** have been developed within 8 communities configured around clusters of GP practices.

Integrated Intermediate Care Teams have been established at locality level. Airedale Collaborative Care Team (ACCT) covering Airedale and Wharfedale locality and Craven Collaborative Care Team (CCCT) covering Craven locality. The teams are made up of health and social care professionals and include mental health workers and support for carers.

When the integrated community teams are unable to meet the needs of individuals in the community they could refer to the integrated intermediate care teams who would pick up care with a focus on admission avoidance. Depending on need assessment GP's may refer directly to the integrated intermediate care teams. The integrated intermediate care teams also accept 'step down' from acute hospital to facilitate earlier discharge. They provide a 'virtual ward' type service.

The integrated community and intermediate care teams will form the basis of wrap around health and social care teams supporting delivery of new models of care whether these are evidence based, enhanced primary care, both or a different model.

Intermediate care services have been in place for some time but have been strengthened and expanded and deliver an integrated offer across health and social care enablement services. Appendix 2 gives more detail of development of 'wrap around' community services at community and intermediate care level.

It is important to note that there are plans to deploy an 'intermediate care hub' mid-November. This will be staffed through current health and social care staff establishment and will oversee utilisation of the IC service capacity, undertake joint assessments and manage IC bed capacity, acting as a bed bureau.

Predictive Risk Stratification

Predictive risk stratification is now available in all practices and enables integrated multi-disciplinary teams at community level to identify people most at risk of hospital admission, undertake joint assessment and develop joint care plans. Lead practitioners are assigned to coordinate care to enable the person to remain at home and manage their condition more proactively.

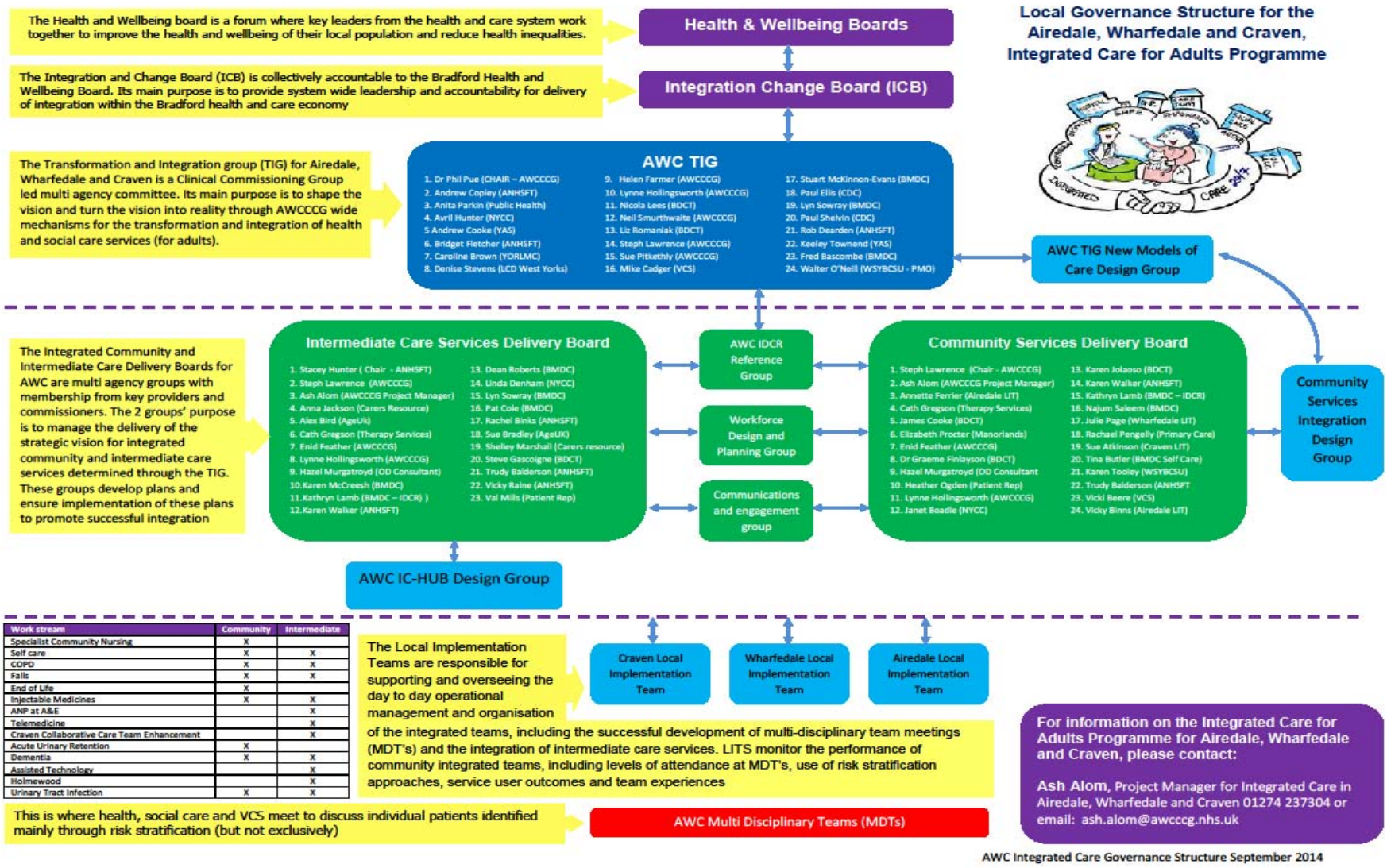
Self-care and preventative approaches are being developed and over the next five years will be adopted at scale and become the norm. The Third Sector will be central to this, supported by technology.

Governance Structure

Diagram 1 sets out the governance structure for the delivery of the Integrated Care for Adults Programme. This programme forms a firm foundation upon which to develop new models of care and has established work streams and projects which will form a delivery mechanism.

It will be necessary to review the programme to avoid duplication including the 'Delivery Support Programme' which is undertaking infrastructure work as there will be co-dependencies. Development of new models of care may be undertaken through this existing programme, work streams within it or done separately with links/communications being maintained to ensure any conflicts are avoided. This is to be determined.

Diagram 1



AWC Integrated Care Governance Structure September 2014

Introduction

HRW CCG has been working on a programme of engagement and subsequent service transformation over the past two years. Branded as Fit 4 the Future this work has now developed into an ambitious programme of work across the three localities, informed through on-going engagement with the local population, clinicians and partner organisations. This whole system partnership working is led by the HRW Transformation Board.

Whitby

Following a rigorous and in-depth procurement process Virgin Care has been selected as the preferred bidder to provide community and out of hours services in Whitby and the surrounding area. Virgin care will provide services from 01 July 2015 and a range of key service improvements will be implemented including;

- Enhanced medical input and continuity of medical cover
- Involvement in the development of a health and wellbeing hub
- Innovation fund to work with the local voluntary sector
- Rapid assessment for frail and elderly
- More streamlined district nursing with the use of mobile working

The CCG is now preparing for the transfer of services to Virgin care and continues to engage with the community regarding the re-provision of the community hospital to ensure the long term sustainability of services.

Hambleton and Richmondshire

The outcomes of the Fit 4 the future engagement programme in 2013/14 enabled the CCG to outline its vision and case for change, regarding reconfiguring older people's services in Hambleton and Richmondshire. Key themes and messages included;

- Keeping people in their own homes for as long as possible
- More information for patients and their carers
- Better patient transport
- Facilitating social interaction
- More support for carers
- Utilise new technologies as part of the solution
- Where acute hospital care is needed, our communities want to receive care locally whenever possible, understanding that specialist services have to be provided in centres of excellence.

This work has now evolved and Fit 4 the Future in Hambleton and Richmondshire has been developed into an overarching programme and the key objectives are;

- To keep the Friarage Hospital at the centre of healthcare for the people of Hambleton and Richmondshire

- To address the immediate issues of the urgent care pathway
- To ensure that treating people at, or near to home, is a viable option wherever possible
- To work together across the system to shift the focus from illness to wellness
- To assess the future purpose of the community hospitals
- To create a step change in the integration of health and social care
- To radically re-think the delivery of health and care in rural areas, including the use of technology
- To radically rethink and take opportunities to reform our workforce

The partnership has developed an approach that seeks to co-create solutions with the local community and key stakeholders across the localities and has embarked on a further period of engagement over the course of the summer.

Work on the key objectives has commenced and new models of care are emerging and being tested in the following areas;

- Urgent care
- Integrated intermediate care
- Diabetes pathway
- Rural community services

Workforce redesign, technology and estates have been identified as key enabling themes across all areas and over the next 12 months we will have developed a vision, shaped and supported by stakeholders, implemented our infrastructure and embedded the model, mapped our services and understood our data, and tested out ideas and innovations on a small scale before proposing them as possible system wide solutions. By spring of 2016 we will hope to have designed in partnership with our communities our blueprint for beacon of health and care and will be in a position to undertake any formal consultation process that will be necessary to implement the redesign and reconfiguration of services across Hambleton, Richmondshire and Whitby.

The programme of work is led by our Transformation Board which brings together all our local stakeholders including all Health Trusts, District and County Councils, the voluntary sector, and the GP Federation and is informed by an Advisory Board of independent Experts and The Engagement Reference Group which leads public and patient involvement.

G Collinson

Associate Director Transformation

May 2015

NHS Harrogate and Rural District Clinical Commissioning Group

Vanguard Summary

The focus within Harrogate and Rural District has been upon co-creating a radically different model to secure a comprehensive integrated, locality based solution which makes best use of technology, skills and local infrastructure. This has been based upon robust stakeholder engagement with public and professionals.

The New Model of Care will introduce:

Community Hubs and Integrated Care Delivery
Each hub will integrate primary and community teams including GP's, community nursing, adult social care, occupational therapy, physiotherapy, mental health and the voluntary sector. A central Hub will offer access 24/7, with a number of smaller rural hubs offering advice, access and care on an extended basis. We will engage with local communities to design these.

Embedded and shared use of Care Plans
Multidisciplinary professionals will have access to and development of shared care plans for our patients which will enable more informed and consistent decision making. We will integrate and share IT systems to ensure this.

Virtual Hub
This will introduce a consistent information source for both professionals and the public regarding services in the area, ensuring "any door" access to services. The alternatives to Acute Secondary Care will be clear and accessible.

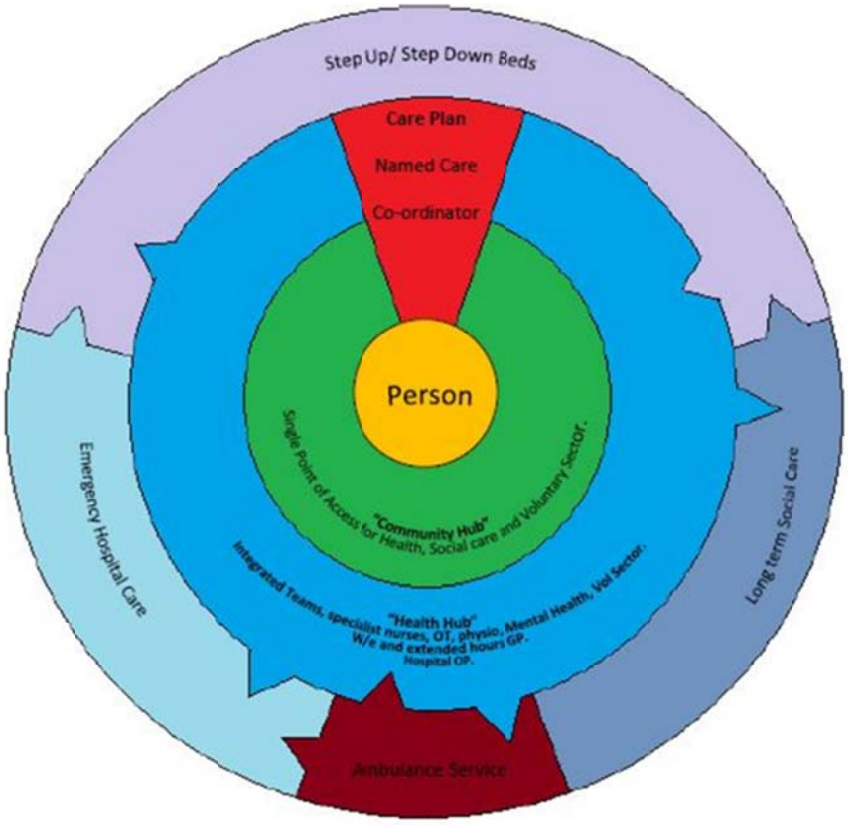
Benefits for people using services

- Access to advice and information for individuals in crisis/acute situation 24/7, without defaulting to A&E
- Resolution of issues at first point of contact wherever possible
- Personalised, accessible, holistic care designed around their needs with a single assessment process
- Support to remain independent, safe and well at home
- Care provided by a team they know and trust
- Access to telehealth / telecare solutions
- Targeted prevention work to support people on the cusp of care
- Common universal care plans

Principles of the model

- Care at home is the default position
- Involve people who use services and carers in decision-making
- Focus upon Prevention agenda
- Locality based integrated teams
- An acute bed is only used when only an acute bed will do

The involvement in the Vanguard New Models of Care Programme is intended to accelerate the development of the new model of care delivery. We will access expertise from the national team in areas of; new contracting vehicles, workforce development and system modelling. The delivery of the New Model of Care is overseen through the Harrogate Health Transformation Board. We have established a New Models of Care Delivery Board to lead delivery of the new system locally.

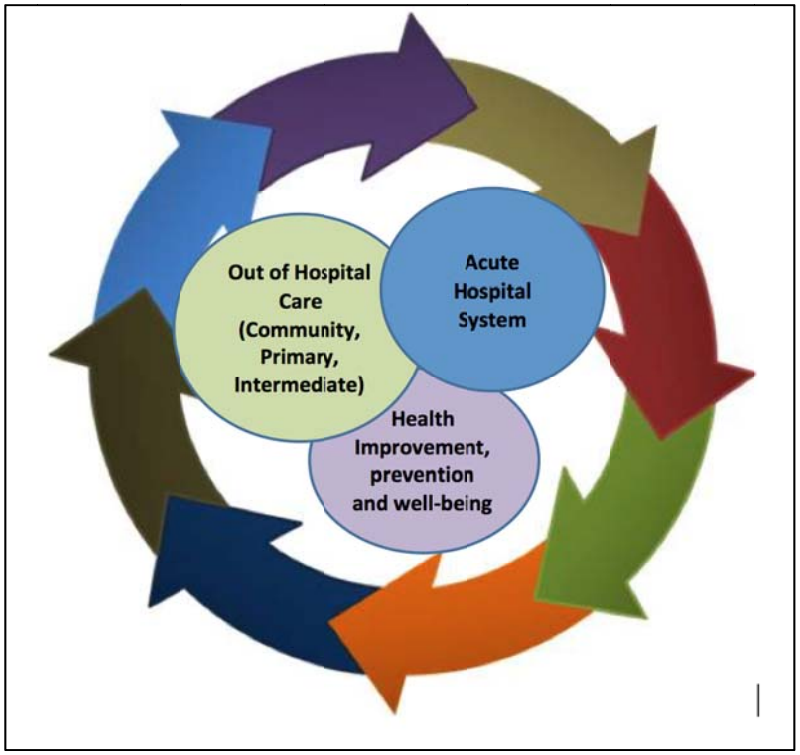


NHS Scarborough and Ryedale Clinical Commissioning Group
Summary of Planning for 2015-16

In 2015-16 NHS Scarborough and Ryedale Clinical Commissioning Group (SRCCG) will seek to consolidate the gains it made in its first two years of operation and address the significant service gaps identified from its analysis of health need. The major initiatives that will be implemented in 2015-16 include:

- Establishment of the Integrated Urgent Care Service
- Implementation of the actions described in the Better Care Fund, such as
  - Integrated Community Care teams
  - Health Prevention workers
  - Health Improvement in hospitals and care homes
  - Hospice at Home within an Integrated Palliative Care Team
- Improving access for planned care to reduce patient waiting times
- Improving access to urgent mental health care (including Crisis Response, Mental Health Liaison, and Street Triage)
- Reducing waiting times for primary care based counselling services
- Beginning delegated responsibility for the commissioning of primary care service

The actions planned in 2015-16 form part of a longer-term CCG plan that is itself part of a broader health community programme of redesign aimed to establish high-quality sustainable services on the East Coast. This programme will encapsulate three main themes across a range of partners.



NHS
Vale of York
Clinical Commissioning Group

NHS Vale of York CCG is currently involved in 2 significant national programmes which will help us move towards our vision of new models of integrated health and social care , delivered though a locally owned multi-agency organisation. These programmes are closely linked and will run in parallel as they will both help us to deliver our agreed vision; the key elements of each programme are detailed below.

New Models of Care/Pioneer

- Programme to support changes/improvements to systems and processes
- Focussing on practical solutions to deliver new care models and new pathways of care
- Leading on the development of values and outcomes based commissioning
- Network of sites across the country who share learning and solutions development
- Ring fenced external support to help access additional funding and senior system decision makers
- Helps the CCG and its partners become smarter commissioners through evaluation of models and access to international best practice

Vanguard

- National programme to identify early adopters of new provider models
- Aligned to 5 year vision for NHS and focus on development of an integrated service provider based around the Multispecialty Community Provider Model
- Running in parallel with NMOC/Pioneer work stream and despite being unsuccessful in formal Vanguard programme, we will continue to develop the vehicle to deliver the outcomes expected from NMOC
- Work is currently underway to define and agree the initial 'shadow form' to deliver the new provider organisation

Developing and exploring new financial and contracting models that link across both programmes

Selby Care Hub

- Led by York Teaching Hospitals Foundation Trust in collaboration with Primary Care and North Yorkshire County Council
- Based on Primary and Acute Care System (PACS) with emphasis on early intervention and individual support packages to facilitate care outside of hospital
- Focus on greater use of Generic Care Workers to maximise efficiencies and reduce duplication. This approach will help shape future workforce requirements building on learning from International new Models of Care Programme
- Impact of Hub being measured through Joint Delivery Group (VoY CCG led) and NYCC monitoring processes (final details to be arranged)
- Hub also links with BCF schemes developed as part of North Yorkshire submission including Urgent Care Practitioners, Street Triage and Hospice at Home
- CCG working closely with YTHFT to agree next steps for developing the hub and future investment and risk share models.
- Longer term provision of this model may be assume by the provider integration work (OTIS)

Health and Adult Services

'2020 North Yorkshire' is the vision and approach for change for North Yorkshire County Council that will result in a changed and modernised Council.

Key elements of the 2020 vision are:

- Supporting communities to take a greater role in the provision of services.
- Developing new models for delivering services by working in partnership with other councils, or providing services through staff mutual or community based social enterprises.
- Changing the way customers access and/or receive services for example accessing services online, more contacts being dealt with by our Customer Resolution Centre, and changing the way people contact us face to face.
- Looking at opportunities to increase income, particularly around people who fund their own support.
- Reviewing our need for buildings in the context of new ways of working with partners and locally based activities.
- Looking at the skills and knowledge our staff will need.

In the future, we will need to think differently, and work differently with people and our partners. How we do this will reflect the changes taking place across the Council as part of the 2020 North Yorkshire programme, which looks at how, where and when services are delivered. We will work with our partners to provide a quicker response and better results for people, including being clear about our priorities, what we are able to provide and what we want to achieve. We also want to make the most of our strengths, including our committed staff.

The Changes We Will Make By 2020:

A Distinctive Public Health Agenda for North Yorkshire

By 2020 we will have:

- Put in place new arrangements for existing public health services so that more people get the right support to manage lifestyle issues such as substance misuse, smoking or being overweight.
- Put in place actions to support communities and individuals to reduce loneliness and social isolation.
- Worked with partners to support actions so that more homes across the County have affordable heating and housing is improved where it causes a serious impact on health.
- Improved preventative services for children and young people through the Healthy Child Programme.
- Invested in local community projects across North Yorkshire that support people to live longer, healthier and more independent lives.
- Worked with the Clinical Commissioning Groups to deliver their strategic plans to reduce health inequalities through prevention, and wellbeing services.

Independence - With Support When I Need It

By 2020 we will have:

- Introduced targeted prevention, so that more people can live independently for longer in their communities, needing less, or no traditional public health or social care services.
- Provided information and advice, and opportunities for self-assessment through the County Council website, telephone, face to face and via community organisations.

- Resolved the majority of initial contacts and concerns through the County Council's Customer Resolution Centre.
- Developed integrated reablement and Intermediate Care services with the NHS.
- Changed how we undertake assessments and review people's needs and plan for their support.
- Improved social care mental health services, so that more people recover their independence.
- Improved the way we support young people with disabilities to move into adulthood.
- Worked with the Clinical Commissioning Groups to ensure integrated service- delivery for reablement, Intermediate Care and supporting people with long term care needs.

Care And Support Where I Live

By 2020 we will have:

- Expanded Extra Care Housing provision across the County.
- Explored different models of accommodation for people.
- Improved the way people can choose, buy and fit equipment and Telecare so that more people can live independently.
- Increased the availability and choice of services for people who have complex needs.
- Developed local services and activities that mean that people are safe and can live independently at home for as long as possible.
- Worked with the Clinical Commissioning Groups to ensure that people have access to appropriate care and support, and that their experience is positive.

Better Value For Money

By 2020 we will have:

- Implemented and embedded requirements of the new Care Act.
- Become more efficient in the way we work, making more use of technology to produce better results for people.
- Supported new and existing providers of public health and social care to increase the range and quality of services.
- Developed a confident, skilled and knowledgeable workforce that works flexibly with a range of partners to provide services.
- Worked jointly with partners to integrate service delivery where appropriate.
- Reviewed our approach to performance and quality management.
- Kept more vulnerable people safe by raising awareness and understanding in the social care workforce and the public about what to do if they are worried about someone who is vulnerable.
- Developed a process for sharing information appropriately with partners that means less duplication and better overall results for people.
- Invested over £800 million in health and adult social care services in North Yorkshire.
- Achieved ongoing efficiencies of £21.5 million per year by reducing costs in management and other areas of service and changing the way we work.
- Worked with our NHS partners to ensure better value for money by reducing duplication.

Service Reconfiguration for joined up, person centred care – Early outline for delivery model

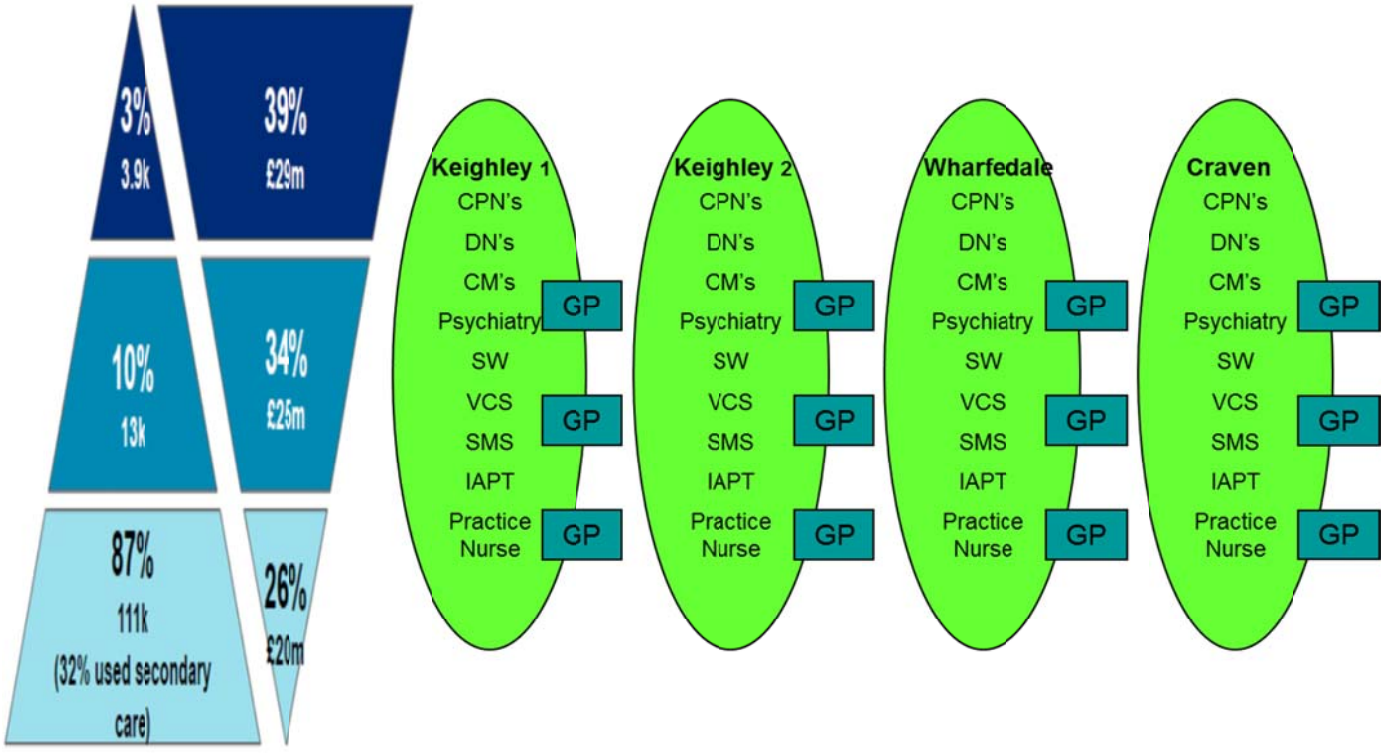
The attached diagram is a culmination of the early thoughts from BDCT regards the next steps for integration of community teams and how this links with the Oliver Wyman new models of care work and the enhancement of this from further thinking within the CCG. BDCT have also tried to embrace some of the findings from the community nursing review to enhance the provision of services for patients. This was presented in an earlier format at last weeks integrated SDG. We are going to use this diagram as a starting point for a group meeting to discuss the further integration of community teams and future service model.

This diagram is intended as a starting point to focus the discussion required around the future model for integrated community teams and how this integrates further with intermediate care services. Clearly a lot of further work is required to enhance, adapt, add to this model as required to ensure this is deliverable and truly meets the needs of our population now and in the future.

1. **Integrated community teams**: This reflects the current make up of the integrated community teams that come together on a monthly basis in 8 communities and approx 11 MDTs to discuss patients with complex needs who would benefit from an MDT approach, together with the GP's from each of the practice.

   The proposal is that the monthly MDT would continue as it is, but that the current communities further integrate to become localities to ensure MDT working becomes embedded on a daily basis rather than just a monthly MDT. The 4 localities suggested are 2 Keighley, 1 Wharfedale and 1 Craven locality.

   At the side of the diagram is the triangle from the Oliver Wyman showing the need in our population and where the majority of health care funding goes (social care data is still to be added)



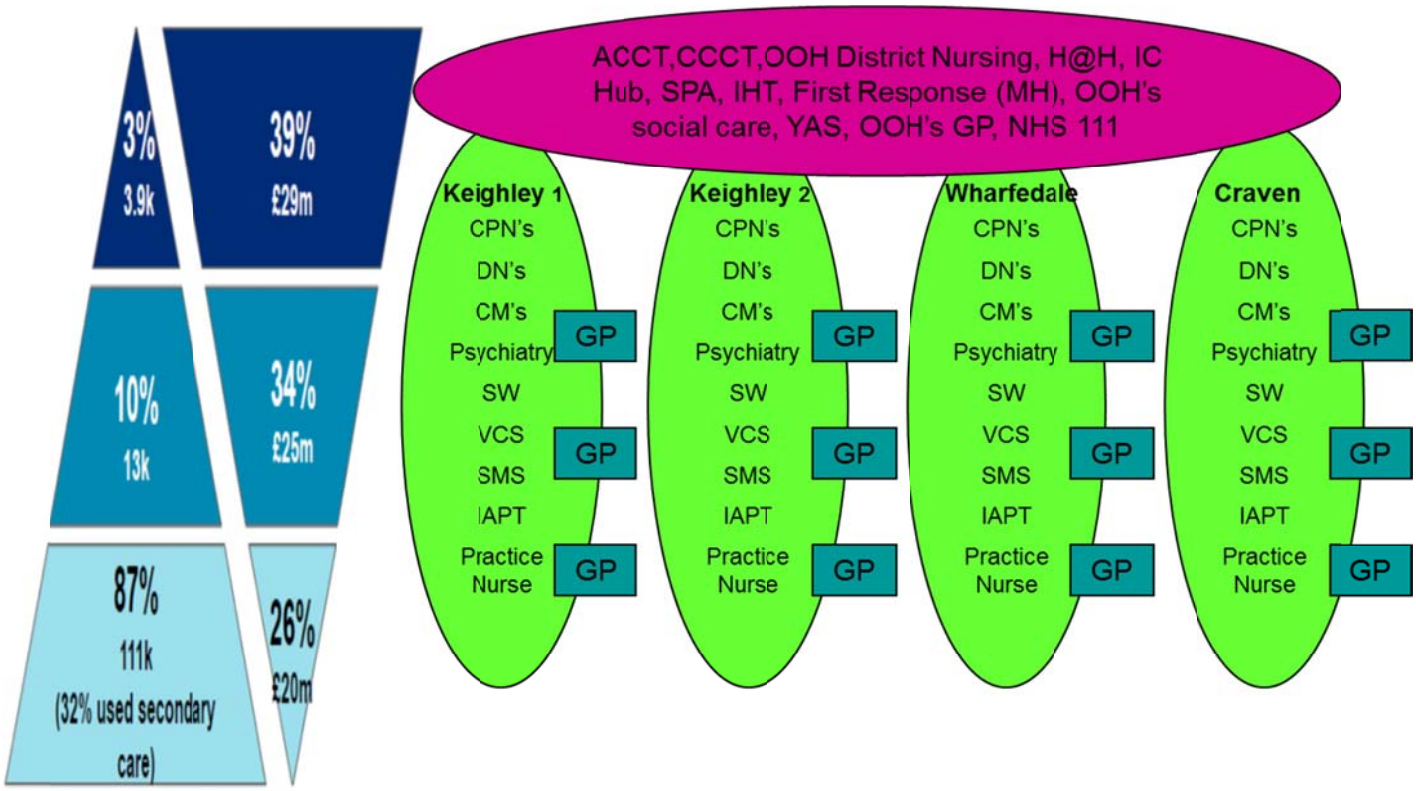
The model illustrated here suggests the need for a key link professional to ensure effective working with GP practices and across services in the locality. This link professional is envisaged to be from senior clinical staff e.g. community matron and senior mental health workers. They would act as a conduit between the GP and the wider MDT. They would have regular contact with the GP and feed into the team on a much more regular basis than happens now.

This is where further work up will be needed to consider how this might work in practice to ensure we can make a positive difference to patients and services users. For example – increasing the frequency of MDTs to weekly for the integrated team to ensure embedding of principles such as lead practitioner, a forum to air concerns and seek advice from the wider MDT and for the community matron or mental health worker to feedback from the GP etc. This would ensure that we work in a joined up way looking at more than simply health or medical needs and that wider social, therapy, nursing and lower level needs of these patients are considered. This would also need to ensure that self care is considered as part of care plans.

The operational model also needs to consider possibilities for co-location, agile working to enhance the MDT approach, how this links with the wider VCS and not just the navigators etc. The suggestion is that these services could potentially have a core team that works from 8am to 8pm and it is envisaged that this would be the layer and teams that support the enhanced primary care model.

2. Responsive services, supporting people in crisis or out of hours

The large pink oval describes the services that currently provide a more responsive service perhaps in a crisis or out of hours. A lot of these teams are currently described as intermediate care but there are other elements in this part as well.



It is envisaged that this could be the 24/7 element of services that is responsive and flexible and able to meet the needs of patients referred to enable them to stay in their own homes wherever possible and provide an increased level of support. This is the team that could become the team that wraps around the "Extensivist" model as we develop the new models of care. This team will need to work very closely with the integrated community teams and certainly the possibility needs to be considered that this in the future is organised around the localities to truly ensure seamless transition for patients.

There is also the potential that this team could take on new pathway developments to ensure we have a team that remains skilled in new competencies etc as they are doing them on a regular basis and have the capacity to respond to urgent need e.g. IV antibiotics, acute urinary retention etc. This would maintain a

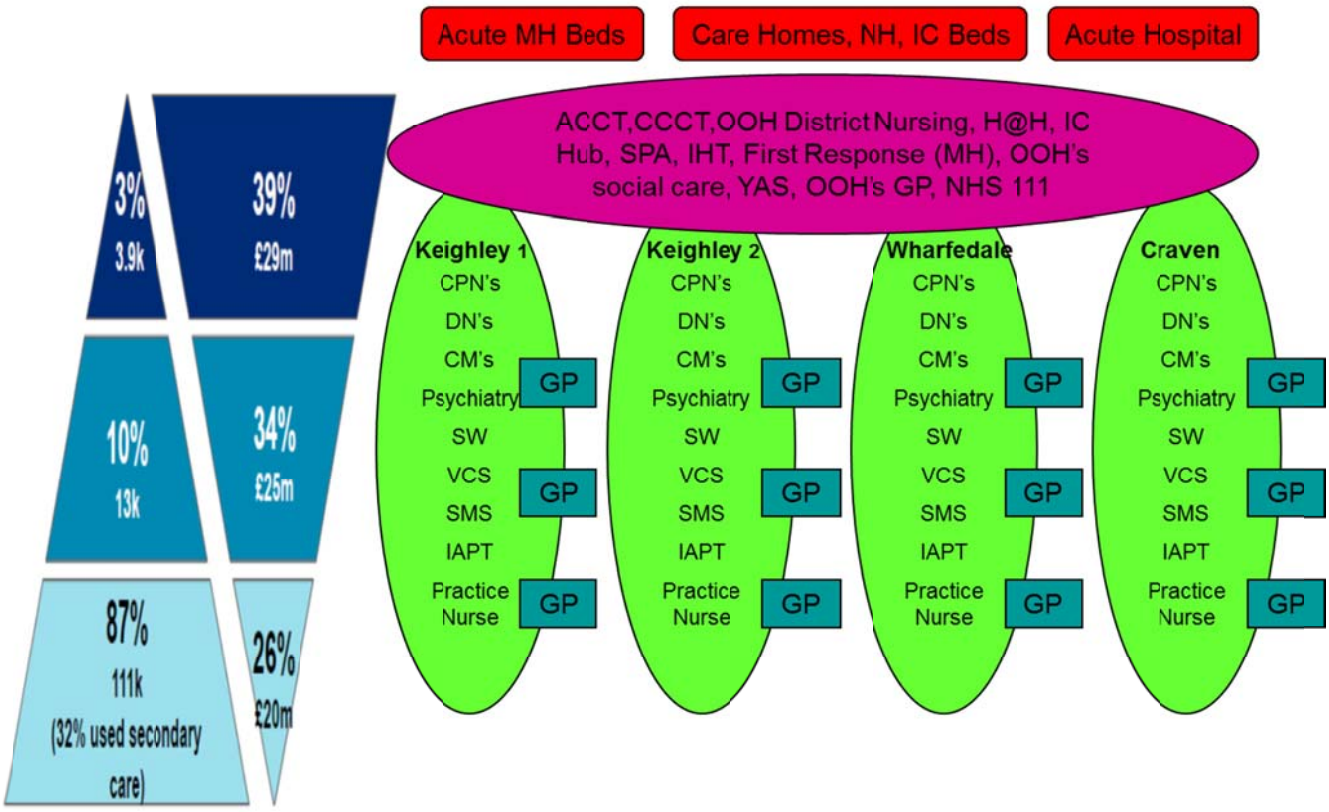
skill base to ensure there was no disparity in patients receiving the care required to help maintain them in their own home.

Consideration also needs to be given to how this element could work much more closely with YAS, NHS 111 and OOH's GP services etc. Again further work and discussion will be required around this.

The vision is that developing further this type of delivery model will enable us to merge the two delivery boards for integrated community teams and intermediate care and truly consider what is needed in the localities to meet the needs of the people in them.

3. Acute hospital, acute mental health beds, intermediate care and long term care

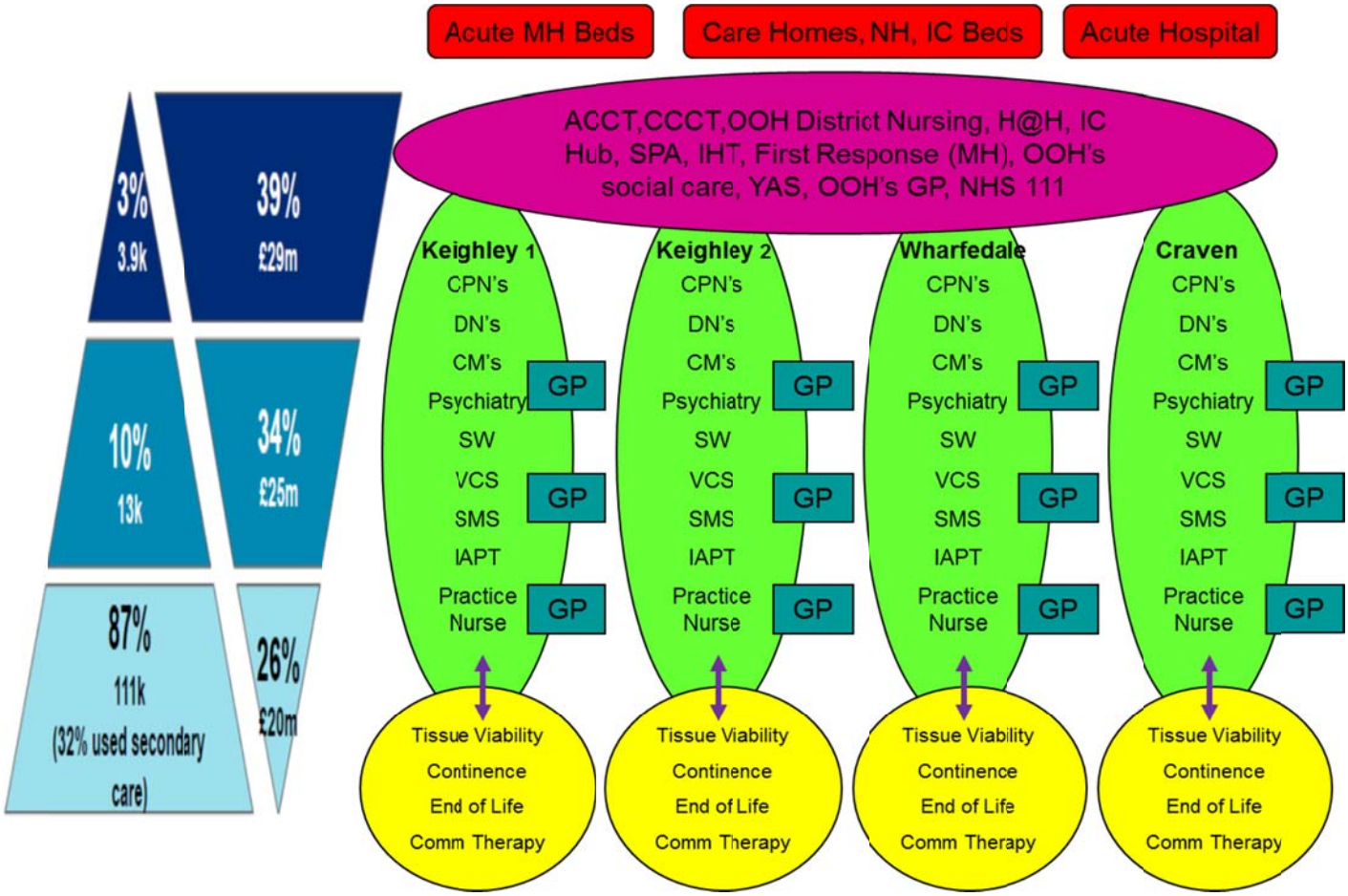
The red boxes at the top of the diagram are the acute hospital, acute mental health beds, intermediate care and long term care. These should only be required for the exceptions where it is not safe for someone to remain in their own home or there is an urgent medical need (physical or psychological) that requires specialist intervention.



Our vision must always be the patient's own home is the best place for them and we should be wrapping our services around individuals to enable them to remain there for as long as possible including ensuring they return there following any intervention required from the services in the red boxes.

4. Specialist services

In the yellow circles at the bottom of this diagram are specialist services that will in reach into the community teams as required and work closely with these teams where required.


Acute MH Beds
Care Homes, NH, IC Beds
Acute Hospital
ACCT,CCCT,OOH District Nursing, H@H, IC Hub, SPA, IHT, First Response (MH), OOH's social care, YAS, OOH's GP, NHS 111
3%
3.9k
39%
£29m
10%
13k
34%
£25m
87%
111k
(32% used secondary care)
26%
£20m
Keighley 1
Keighley 2
Wharfedale
Craven
CPN's
DN's
CM's
Psychiatry
SW
VCS
SMS
IAPT
Practice Nurse
GP
Tissue Viability
Continence
End of Life
Comm Therapy

NORTH YORKSHIRE COUNTY COUNCIL

SCRUTINY OF HEALTH COMMITTEE

12 June 2015

Developments at Scarborough Hospital

Purpose of Report

1. The purpose of this report is to provide an opportunity for the Scrutiny of Health Committee to be updated and to offer comment on developments taking place at Scarborough Hospital.

Introduction

2. Simon Cox, Chief Officer, Scarborough and Ryedale Clinical Commissioning Group and representatives from the York Teaching Hospital NHS Foundation Trust will be attending the meeting to give a verbal presentation on developments taking place at Scarborough Hospital and to respond to Members' questions.

3. Recent developments in relation to Hyper-Acute Stroke Services, Neurology Services and the Urology Diagnostic Service are covered in APPENDICES 1, 2 and 3 respectively.

Recommendations

4. That Members offer comment on the developments taking place in Scarborough Hospital.

Bryon Hunter
Scrutiny Team Leader

County Hall
Northallerton

02 June 2015

Temporary changes to hyper-acute stroke services at Scarborough Hospital

This briefing has been prepared to inform you of temporary changes to the treatment and care of acute stroke patients in the Scarborough and Bridlington area. The following organisations are involved in implementing these changes:

- York Teaching Hospital NHS Foundation Trust (the provider of stroke services)
- NHS East Riding of Yorkshire CCG
- NHS Scarborough and Ryedale CCG

What is changing?

Patients who suffer a stroke in the Scarborough and Bridlington area will now receive hyper acute stroke care (typically the first 72 hours of care) at York Hospital rather than Scarborough Hospital.

This means that all patients who suffer a stroke in the Scarborough and Bridlington area will be transported by ambulance to York Hospital to receive specialist acute care. Patients who are within an appropriate distance of Scarborough Hospital will first be taken there for assessment and, if stroke is confirmed, given clot busting drugs (thrombolysis) before being transferred to York. Patients within an appropriate distance of York Hospital will be taken there directly for thrombolysis and subsequent treatment.

Why is this change necessary?

The need to introduce this measure has arisen from challenges with recruiting replacements for stroke consultants currently working at the hospital who are due to retire in June. Despite a number of attempts to find replacements since 2013, only one consultant has recently been recruited. This means that a hyper-acute stroke service cannot be provided due to the need for seven day per week consultant cover.

It would not be clinically safe to provide acute care to stroke patients without this level of consultant cover.

When will the change take effect and how long will it remain in place?

Stroke patients will start to be diverted to York Hospital from early July. This arrangement will remain in place until we have successfully recruited the required number of stroke consultants to provide a safe service.

In the meantime, we will continue with our recruitment campaign.

How long will patients remain at York Hospital?

Hyper-acute stroke care is typically needed for around 72 hours after a stroke has been confirmed.

Once medically stable, patients will be transferred back to Scarborough Hospital to receive the appropriate level of rehabilitation.

What will happen to patients who have a stroke mimic?

A stroke mimic is when a patient is suspected of having a stroke but following assessment, is proven otherwise. Patients who are initially assessed at Scarborough Hospital and are discovered to have had a stroke mimic, will not be transferred to York Hospital.

How will these changes be monitored to ensure patients receive the care they need?

We will continually monitor the impact of these changes to ensure stroke patients receive the best possible care and treatment.

Who can we ask if we have further questions?

If you have further questions regarding these changes, please contact:

alextrewhitt@nhs.net

York Teaching Hospital NHS
NHS Foundation Trust

Stakeholder update: neurology services

The purpose of this briefing is to provide you with information regarding short to medium term changes to the neurology outpatient service for York Teaching Hospital NHS Foundation Trust. The approach has been agreed between York Teaching Hospital NHS Foundation Trust, the current provider of this service, and NHS Scarborough and Ryedale CCG and NHS East Riding of Yorkshire CCG, who are the commissioners.

What is changing?
The neurology outpatient service will be delivered from York Hospital, with a single point of access for all referrals coming in.

This affects patients from the following CCG areas:

NHS Scarborough and Ryedale CCG
NHS East Riding of Yorkshire CCG

This is a short to medium-term measure which is necessary to continue to deliver a service across the Trust's patch.

For inpatients, the neurologists would provide telephone advice to Scarborough doctors. They are able to access scans and blood results electronically and, based on the number of referrals and type of referrals seen, they are clear this would be a safe and workable solution. A rota will be introduced to enable the consultants to provide one full day session at Scarborough for inpatients every Thursday.

Why is this change necessary?
Referrals to Scarborough and York Neurology services have risen by around 10 percent every year for more than a decade. The increasing frequency of certain conditions (Parkinson's disease, spinal and other degenerative disorders and dementia) in the ageing population is having a significant impact on the demand for the service.

Neurology services have been successfully integrated across York and Scarborough Hospitals since 2012, and delivered on both sites. However, due to medical staffing constraints, in recent months at Scarborough the service has only operated for two days a week. This is having an impact on waiting times and, potentially, clinical outcomes due to delays in reviews and treatments.

Although the recruitment of consultant neurologists has been a long-standing issue both locally and nationally, the problem has been further compounded by recent developments whereby two consultants left their posts and one retired in April 2015, leaving three vacant consultant neurologist posts. The Trust advertised in September 2014 and January 2015 and had no suitable candidates to shortlist with the relevant, skills, knowledge and experience.

This is not about saving money or reducing services, as there is funding available for additional consultants, however the shortage nationally of consultants with the necessary specialist skills means that the current staff within the neurology department are being placed under significant pressure that is simply not sustainable.
Our priority is to ensure that patients who need to be seen by a highly skilled specialist can do so as quickly as possible, and the only way to do this within the current resources is to centralise the service to a single location.

When will it happen and how long will it be in place?
It is proposed that from the week commencing 6 July 2015 outpatient activity will move to York. The Trust will continue to seek to recruit to all vacant posts, with a view to returning to a locally-delivered service in Scarborough as soon as possible.

Why can't services be centralised at Scarborough Hospital rather than York?
This option was considered as part of the discussions regarding the service, however after careful consideration York Hospital was decided upon as the preferred location for several reasons.

There are already dedicated inpatient beds for neurology and an existing neurology outpatients department at York Hospital, which includes neurophysiology services, sleep services, and a gym for rehabilitation purposes. There are no dedicated neurology beds at Scarborough Hospital, and clinics are undertaken in the main outpatient department.

Creating the additional facilities at Scarborough Hospital would require the movement of other services to accommodate the beds required or capital investment to build a new facility. Furthermore, the number of patients accessing services at York (2195 a year) compared with those accessing services at Scarborough Hospital (665 per year) would mean that far greater numbers of patients overall would be travelling for appointments if the service was in Scarborough.

What are the next steps?
The Trust will continue to seek to recruit to all vacant posts and if successful would review the service again with a view to delivering a service locally in Scarborough as soon as possible.

Whilst continuing with recruitment efforts, the Trust is also exploring other ways to support the service including the use of middle-grades, Advanced Care Practitioners, and specialist nurses.

Who can I ask if I have further questions?
If you have any questions about this briefing please contact Lucy Brown, Head of Communications, York Teaching Hospital NHS Foundation Trust: lucy.brown@york.nhs.uk

Proposals for one-stop urology diagnostic service

The three Clinical Commissioning Groups (CCGs) covering Scarborough, Ryedale, York and East Riding of Yorkshire are working together with York Teaching Hospital NHS Foundation Trust to review the urology diagnostic service.

This service is currently provided by York Teaching Hospital NHS Foundation Trust from Scarborough, Bridlington, Malton, York, Whitby and Selby Hospitals with around 3,500 patients accessing it each year. To cope with increasing demand for urological diagnostics as a result of an ageing population and successful public health campaigns encouraging patients to get symptoms checked, we are proposing to change the way this service is provided. This will ensure the service is able to manage the increasing number of patients requiring urology diagnostic tests in the future, whilst also improving patient experience by providing a one-stop-shop.

We are writing to inform you of these proposed changes along with our approach for obtaining feedback from patients who have accessed the service in the past to ensure it is fit for purpose.

Typically, patients currently accessing the service will require up to three separate appointments at one of the hospitals mentioned above. This proposal will mean that from February 2016, all patients who are referred to the urology diagnostic service will have their appointment at Malton Hospital.

The main difference, however, is that the new service will be a one-stop-shop, meaning that the majority of patients will only require one appointment and will leave the clinic with a treatment plan.

This is considered to be the ‘gold standard’ model for urology diagnostics and creates an opportunity to improve patient experience.

Although we appreciate that our proposal may result in longer travel times for some patients, overall, we hope it will be a far more convenient and efficient service due to the reduction in the total number of appointments they need to attend.

Follow-up appointments, surgery etc would continue to take place at the other sites, as they do now.

In order to fully appreciate the impact these changes will have on patients, we are sending a survey to patients who have recently accessed the service to hear about their experiences and whether they agree that our proposal is fit for purpose.

We will use this feedback to help us make a decision about whether to continue with our proposal or change it in light of any issues that are raised.

We will write to you again after this survey is complete to inform you of the outcome and the actions we plan to take. We have included a copy of the survey in appendix 1 for your information.

If you have any questions or would like to share your views on this proposal, please do not hesitate to get in touch.

Appendix 1: Urology patient survey

Dear Sir/Madam

Re: Tell us about your experience of the urology service

We are writing to you because you were recently referred to the urology service provided by York Teaching Hospital NHS Foundation Trust.

We are currently considering making some changes to the diagnostic part of this service and we would welcome your views as to whether you feel they would benefit other people accessing the service in the future.

We would be very grateful if you could take five minutes to complete the enclosed survey and return it to us using the freepost address by no later than Friday 19 June 2015.

Your feedback will help us to ensure that the care and treatment we provide to patients in the future is the very best it can be.

Thank you for your time.

Section 1 – your experience of the service

1. Where did you access the urology service?

- ☐ Scarborough Hospital
- ☐ York Hospital
- ☐ Malton Hospital
- ☐ Selby Hospital
- ☐ Whitby Hospital
- ☐ Bridlington Hospital

2. How many appointments did you have with the urology service?

- ☐ One
- ☐ Two
- ☐ Three
- ☐ More than three

3. How did you travel to your appointments? Please tick all that apply.

- ☐ Walk
- ☐ By car (driver)
- ☐ By car (passenger)
- ☐ Taxi
- ☐ Patient transport
- ☐ Public transport
- ☐ Other (please state):

4. Approximately how long did it take you to travel to your appointments?

- ☐ Less than 10 minutes
- ☐ Between 10 minutes and 30 minutes
- ☐ Between 30 minutes and one hour
- ☐ More than one hour

5. Overall, how would you rate your experience of the service?

- ☐ Excellent
- ☐ Good
- ☐ Average
- ☐ Poor

Please explain your answer:

Section 2 – your views on the proposed new service

We are proposing to provide the diagnostic element of the urology service solely from Malton Hospital. This will replace the urology diagnostic services currently provided at the other hospitals listed in question 1. The main difference is that this will be a one-stop-shop, meaning that most patients will only need to attend one appointment. Follow-up appointments, surgery etc will continue to be provided at the other hospitals.

Please answer the following questions based on this proposal.

6. Would providing the urology diagnostic service at Malton Hospital have meant an increase in how long you had to travel to access the service?

- ☐ Yes
- ☐ No
- ☐ Not sure

7. If yes, approximately how much longer would it take you?

- ☐ Less than 10 minutes
- ☐ Between 10 minutes and 30 minutes
- ☐ Between 30 minutes and one hour
- ☐ More than one hour

8. Considering that most patients will only have to visit the new service once, do you think this will be an improvement compared to the current service?

- ☐ Yes
- ☐ No
- ☐ Not sure

Please explain your answer

9. If you had to attend your appointment at Malton Hospital, would this have caused you any problems getting there?

- ☐ Yes
- ☐ No
- ☐ Not sure

Please explain your answer

10. Based on your experience of the service, is there anything else we could do to improve it?

11. Any other comments on our proposal?

Section 3 – about you

12. Which of the following best describes where you live?

- ☐ Bridlington and surrounding area
- ☐ Scarborough and surrounding area
- ☐ York and surrounding area

Other (please state):

13. Which GP Practice are you registered with?

14. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Prefer not to say

15. What is your sexuality?

- ☐ Heterosexual/straight
- ☐ Bi-sexual
- ☐ Gay/Lesbian
- ☐ Prefer not to say

16. What is your partnership status?

- ☐ Married

- Single
- Widowed or surviving civil partner
- Registered civil partnership
- Separated, divorced or civil partnership dissolved
- Cohabiting
- Prefer not to say
- Other (please state)

17. What do you consider to be your ethnic group?

- White (British)
- White (other)
- Mixed background
- Asian or Asian British
- Black or Black British
- Chinese
- Prefer not to say

18. What is your religion or belief?

- Christianity
- Buddhism
- Hinduism
- Islam
- Judaism
- Sikhism
- No religion
- Prefer not to say

19. Do you consider yourself to have a disability? If so, please indicate the type of disability or illness you have. You may tick more than one:

- No disability
- **Physical impairment** such as difficulty moving your arms or mobility issues
- Wheelchair user
- **Sensory impairment** such as being blind or having a visual impairment
- **Sensory impairment** such as being deaf or having a hearing impairment
- **Mental health condition** such as depression, dementia or schizophrenia
- **Long-standing illness or health condition** such as cancer, HIV, diabetes, chronic heart disease or epilepsy Single
- **Learning disability or difficulty** (such as Down's syndrome or dyslexia) or cognitive impairment (such as autistic spectrum disorder)
- Prefer not to say
- Other (please state)

Note *- The Equality Act 2010 considers a person to be disabled if they have a "mental or physical impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities". You do not need to be registered disabled.*

Please return your survey to following address by no later than Friday 19 June 2015:

RTJR-UYYB-BCUC, Yorkshire and Humber Commissioning Support, Health House, Great Gutter Lane, Willerby, HU10 6DT

This survey has been produced by Yorkshire and Humber Commissioning Support on behalf of:

- York Teaching Hospital NHS Foundation Trust
- NHS East Riding of Yorkshire Clinical Commissioning Group
- NHS Scarborough and Ryedale Clinical Commissioning Group
- NHS Vale of York Clinical Commissioning Group

NORTH YORKSHIRE COUNTY COUNCIL

North Yorkshire Scrutiny of Health Committee

12 June 2015

Joint Report on the Relocation of Hyper Acute Stroke Services from Airedale NHS Foundation Trust to Bradford Teaching Hospitals NHS Foundation Trust

Purpose of Report

1. This report provides an overview on the current stroke services in Airedale NHS Foundation Trust and Bradford teaching Hospitals NHS Foundation Trust and outlines the relocation of the hyper acute stroke service from Airedale NHS Foundation Trust to Bradford teaching Hospitals NHS Foundation Trust for the population of Bradford District and Craven.

Background

What is a stroke?

2. A stroke is a brain attack where the blood supply to a part of the brain is cut off. If the brain cannot receive blood then brain cells can be damaged or die. It will have different effects dependent on where it happens in the brain. All strokes are different and the effects for some may be minor. For others, however, they can be significant which is why access to prompt treatment is crucial to improve the chances of a better recovery.[1]

3. In the UK, a stroke occurs every three minutes and 27 seconds with men at higher risk than women. Age is the most important risk factor although lifestyle plays a significant part in increasing the likelihood of having a stroke. Important to note for the Bradford District and Craven is that people from the most economically deprived areas are twice as likely to have a stroke, and that people of black and South Asian origin are at a higher risk also.[2]

Where should a suspected stroke patient receive their treatment?

4. Everyone who has a suspected acute stroke should be immediately transferred to a hospital which provides acute stroke services. There – after initial triage - they will have an expert clinical assessment, and a CT and/or MRI scans. People who have had a stroke will be cared for by a specialist team who can deliver the necessary treatment - such as intravenous thrombolysis (a clot busting procedure) - throughout a 24 hour period (National Stroke Strategy 2007). This will take place in a hyper acute stroke unit (known as a HASU which provides intensive care for stroke patients) and needs to happen within a very short timescale - one hour for the scan via a CT or MRI,

[1] https://www.stroke.org.uk/what-stroke/what-stroke
[2] https://www.stroke.org.uk/sites/default/files/stroke_statistics_2015.pdf

and a maximum of four and a half hours from the onset of symptoms to thrombolysis treatment, if required.

5. Patients who have had a stroke will spend between 24 and 72 hours in a HASU, where beds are similar in nature to critical care beds, and be cared for by a skilled specialist multidisciplinary team which includes therapists, specialist nurses and stroke consultants. Following this 72 hour period, they will be transferred to an acute stroke unit where this specialist care will continue but with consultant care moving to five day per week ward rounds. Following their care on the acute stroke unit, patients will receive a period of rehabilitation either in the hospital environment or at home dependent on their level of need.

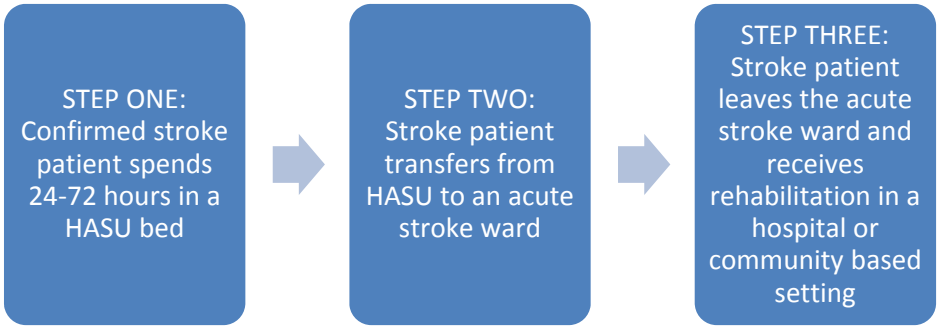


Figure 1: Current in hours services at Airedale FT & BTHFT

6. People who experience a suspected stroke in the district are currently receiving services provided by Airedale NHS Foundation Trust (Airedale FT) and Bradford teaching Hospitals NHS Foundation Trust (BTHFT).

7. In 2014/15, Airedale FT treated 480[3] suspected strokes, and BTHFT treated 951 suspected strokes.

Local stroke services in Airedale, Wharfedale, Craven and Bradford District

8. Airedale FT has had problems sustaining a 24 hours a day, 7 days per week HASU (this can also be referred to as the hyper acute stroke service) since the resignation of two of their stroke consultants, and the long term sickness of a third consultant in March 2014. Nationally, there is an acute shortage of stroke consultants, with approximately 46% of posts across the country remaining unfilled. As a result, despite several recruitment attempts, Airedale FT has not been able to secure a stable stroke consultant workforce, the service is currently being staffed by interim consultants (known as locums) who do not have permanent employment contracts and can therefore provide the minimum period of notice should they choose to resign their post. This has also meant that Airedale FT has not been able to staff its HASU out of hours (between the hours of 6pm until 8am Monday to Friday, and during weekends and bank holidays). As a result, during the out of hours period, patients in Airedale, Wharfedale and Craven have been treated in the Hyper Acute Stroke Unit at BTHFT.

[3] Note this excludes East Lancashire patients

9. Airedale FT has been fortunate in that until May 2015, the locum consultants recruited between May 2014 and January 2015 have remained in post, however two of the three consultants have now given notice with one having left already and the second will leave at the end of July. This will leave one consultant to continue to manage the service from July onwards during the hours of 8am-6pm Monday to Friday.

10. In addition to providing services for people suspected of stroke in Bradford, BTHFT's team of four permanent stroke consultants has provided an out-of-hours, weekend and bank holiday service to Airedale FT's suspected stroke patients.

11. Due to the shortage of consultants, performance of the HASU at Airedale FT has been decreasing over a number of months. HASUs are measured on their performance by a self-assessment against a series of proxy measures which are accepted standards nationally to measure patient outcomes. Key to this are the number of stroke consultants and specialist nurses who can support the HASU to ensure patients are receiving optimum care. This data is referred to as Sentinel Stroke National Audit Programme (SSNAP) data and, during 2014 and early 2015, Airedale FT shows significant poor performance compared to both national and West Yorkshire providers in those indicators relating to the first 48 hours of stroke care – please refer to the table below for further information.

Standard	**SSNAP target %**	**WY average %**	**ANHSFT %**	**BTHFT %**
Proportion of patients scanned within 1 hour	50	30.2	18.3	46.0
Proportion of patients scanned within 12 hours	90	79.4	69.7	82.3
Proportion of patients directly admitted to a stroke unit within 4 hours	N/A	53.8	34	61.3
Proportion of all stroke patients given thrombolysis	N/A	11.5	2	17.3
Proportion of eligible patients given thrombolysis	N/A	72.7	27.7	94.3
Proportion of applicable patients directly admitted to a stroke unit within 4 hours AND who either receive thrombolysis or are not suitable for thrombolysis	N/A	51.2	32.7	61.3
Proportion of patients assessed by a stroke specialist consultant physician within 24 hours	N/A	79.7	58.3	82.0
Proportion of patients who were assessed by a nurse trained in stroke management within 24 hours	N/A	82.3	62.7	87.3
Proportion of applicable patients who were given a swallow screen within 4 hours	N/A	63.4	51	68.0
Proportion of applicable patients who were given a formal swallow assessment within 72 hours	N/A	69.3	77	72.7

Compliance against the occupational therapy target	N/A	63.2	45.7	76.3
Compliance against the physiotherapy target	N/A	56.9	48.3	64.3
Compliance against the Speech and Language Therapy target	N/A	23.4	27.3	68.7
Proportion of applicable patients receiving a joint health and social care plan on discharge	N/A	86.0	100	98.0
Proportion of patients treated by a stroke skilled early supported discharge (ESD) team	N/A	28.3	6	51.0
Proportion of applicable patients in Atrial Fibrillation on discharge who are discharged on Anti-coagulants or with a plan to start anti-coagulation (that is, with an irregular or abnormally fast heart rate) who, are discharged on anticoagulants (medicines that reduce the ability of the blood to clot, helping to prevent further stroke) or with a plan to start anti-coagulation	N/A	96.3	100	100

Table One: SSNAP Indicators - extract

What is the regional and national picture?

12. There is a national shortage of trained stroke consultants, and the incidence of stroke is increasing. The British Association of Stroke Physicians, (BASP), calculates that there is a national shortfall of 163 stroke consultants posts across the whole of the UK, or a 46% shortfall in what is required to deliver stroke services.

13. Internationally, stroke is not recognised as a specialism and therefore training programmes do not exist in other countries for the UK to recruit these individuals in order to backfill the UK shortage.

14. For a HASU to operate efficiently and provide the most effective care, it is recommended that:

- the unit must admit a minimum of 600 confirmed strokes per year, and
- that six British Association of Stroke Physicians (BASP) trained in thrombolysis are required to staff a 24/7 rota for an acute hospital that receives 600 or more suspected strokes per year.

15. Across the country a number of hospitals – including North West London, Birmingham and Manchester have already established centralised specialist units and located HASU services hyper acute stroke services on one or two sites. On a more local setting, Northern Lincolnshire and Goole NHS Foundation Trust centralised to the Scunthorpe site in November 2013, and their outcomes for patients have improved as a result.

16. The HASU service is similar to the long established acute myocardial infarction (heart attack) service. Patients in Airedale, Wharfedale and Craven who have a myocardial infarction which shows on an ECG heart tracing are transferred directly to Leeds General Infirmary to undergo immediate investigation and treatment of blocked arteries if indicated. After the intervention patients are then discharged or transferred back to Airedale FT.

17. Bearing in mind the national shortage of stroke consultants – and the recommendations about the patient numbers required for safety, clinical effectiveness and outcomes – it is unrealistic to plan for a service that requires both Airedale FT and BTHFT to have six BASP consultants.

Intended changes to ensure safe, resilient, high quality acute stroke services for the population

18. The over-riding priority is to ensure the provision of high quality, safe and effective care to local residents across Bradford District and Craven, and therefore the three Clinical Commissioning Groups, Airedale FT, and BTHFT - supported by the Strategic Clinical Network for Stroke and NHS England - have been working through potential solutions to address the gaps in service provision in Airedale FT. The Medical Director for NHS England, Yorkshire & the Humber has stipulated that in his opinion maintaining a HASU at Airedale Hospital is not an option to provide safe, high quality acute stroke care.

19. Discussions are ongoing at a regional level to address the future gap in stroke service provision but this will not be addressed in the short- to medium- term and will therefore not provide a timely solution for patients living in Airedale, Wharfedale and Craven.

20. Therefore a decision has been taken to relocate the two hyper acute stroke beds from Airedale FT to BTHFT. This will provide six HASU beds at BTHFT which is in line with the national recommendations for the number of beds required for 900 confirmed strokes set against the 950 confirmed strokes treated across Bradford and Airedale, Wharfedale and Craven in 2014/15.

21. Acute stroke services and rehabilitation will continue at both acute hospitals.

22. This will result in the pathway in figure 2:

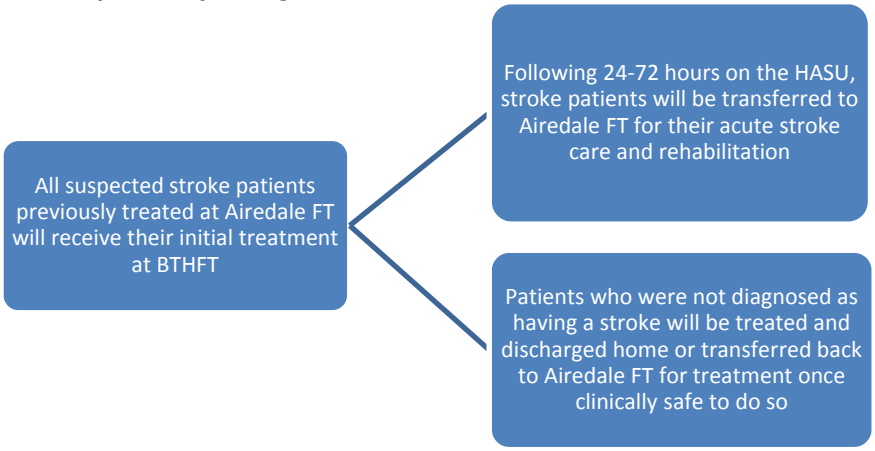


Figure 2 - Future provision of HASU

Impact of the relocation of hyper acute stroke beds

23. Airedale FT currently treats 566 suspected stroke patients, 480 of these are from AWC and bordering Bradford District localities (such as Bingley). Not everyone who is taken to hospital with suspected stroke actually has the condition (approximately 160 of the 480 cases, annually). This is because there are other conditions that might at first appear stroke-like (known as stroke mimics).

24. In the proposed model of care, anyone suspected of having had a stroke will be taken directly to the A&E department at BTHFT (where this is the nearest hospital with a HASU) and be seen by a team that includes a stroke consultant. All patients will have a brain scan (CT or MRI) within one hour of arrival which confirms whether or not they have had a stroke and, if so, whether it was caused by a blood clot or a bleed on the brain.

25. Patients **who have had a stroke** as a result of a blood clot may be assessed as suitable for treatment with a potentially life-changing drug, known as thrombolysis. This must commence within four and half hours of the onset of symptoms and, because of its complexity, can only be performed by a suitably qualified and experienced stroke consultant.

26. These thrombolysed patients, and all other patients who have had a stroke, will remain at BTHFT for their HASU care, following which they will be transferred to Airedale FT for their acute stroke care and rehabilitation.

27. Half of the **patients who have not had a stroke** will, within a matter of hours, be discharged from A&E following treatment whilst the remainder will require a longer stay in hospital for treatment and will be transferred to Airedale FT for their care.

28. As a result of the proposed changes, 85% of suspected strokes will go to BTHFT for their immediate care. The remaining 15% - who live nearer to a hospital with HASU facilities in East Lancashire, Harrogate and Leeds – will be transported directly there by the ambulance service. Yorkshire Ambulance Service is working with us to determine any impact on response times.

What will this mean for patients?

29. Patients previously treated at Airedale FT for their acute stroke episode will receive high quality, timely, hyper acute stroke care in a fully staffed 24/7 unit at BTHFT from October 2015. Their period of care at BTHFT will last no longer than 72 hours when they will be transferred to a bed on the acute stroke unit at Airedale FT. Patients who receive prompt care in a HASU have better clinical outcomes and improved mortality.

30. Locating all hyper acute stroke care at BTHFT means that there are 6 consultants available on a rota basis 24 hours a day 7 days per week to provide critical diagnosis and treatment to stroke patients to ensure the best possible outcomes can be delivered.

31. It is recognised that patients will have to travel further for their initial treatment, and then return to Airedale FT or home, and that relatives and carers will have further to travel to visit for those initial 24-72 hours. Through engagement we will explore, among other things, how any associated difficulties for patients and carers can be addressed.

What will this mean for staff?

32. Airedale FT will continue to provide acute stroke services and will therefore continue to have a multi-disciplinary team, including stroke consultants, on site. Airedale FT will continue to have stroke consultants on site Monday to Friday and these consultants will also work in BTHFT to ensure their skill set is maintained. Nursing staff who want the opportunity to continue providing hyper acute care will have the option to work across both hospital sites.

33. Future consultant and other staff recruitment for the service will include details of these plans, making the prospect of working locally more attractive for consultants and other specialist staff wishing to maintain and improve their practice. A single HASU enables an extensive and resilient workforce who can maintain and develop their necessary specialist skills by treating a greater number of patients on a continual basis.

What are the next steps?

34. As noted earlier, Airedale FT has very recently received the resignation of two consultants – who leave in July 2015 – meaning that it is now extremely urgent to resolve the current situation for the wellbeing of all stroke patients. The resignations - along with directions from NHS England about the viability of the future service and accepted best practice for stroke services - have impacted significantly on the CCGs' ability to consult meaningfully on a choice of options as there is no viable alternative that could establish and maintain a safe clinical service, and improved outcomes in the long-term, for the local population.

35. As a result, we propose not to conduct a formal 12 week consultation on the changes to stroke services, but rather to engage meaningfully on the support needed by patients, carers and the general public to enable them to access the new services.

36. We recognise that our plans will have a direct impact on patients who will need to travel a further distance to receive their HASU care and, potentially, on those already receiving or likely to receive care at BHTFT. Therefore the clinical commissioning groups, in partnership with Airedale FT and BTHFT, will conduct extensive engagement for a period of nine weeks from July through to September.

37. During the engagement period we will explain in plain English why the service has to change and what impact this will have on patients and their families. Their views will enable us to understand what is important to people when accessing stroke services and how the changes will impact on their lives, and

to identify any issues we have not considered and potential service improvements that should be discussed. All the information we receive will be collated and a report will be written and published explaining how we will respond, through the new service, to people's concerns and comments.

38. The outcome of the engagement exercise will be presented to CCG and Trust Boards, published on CCG and Trust websites, and will be shared with the Health and Social Care Overview and Scrutiny Committees in Bradford and North Yorkshire.

Recommendations

39. The Health Overview and Scrutiny Committee are asked to:

1. Note the content of the report on the relocation of hyper acute stroke services;
2. Support the intended 9 week engagement period;
3. Support discussions with their local communities to explain the changes to the hyper acute stroke service.

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Presenter of Report: Dr Phil Pue, Chief Clinical Officer

01/06/2015

Appendix: Proposal for Bradford and AWC Stroke Service

Airedale NHS
NHS Foundation Trust

Bradford Teaching Hospitals NHS
NHS Foundation Trust

Proposal for the Development of a Sustainable Stroke Service Across Bradford and Airedale

Authors

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Isabel Greenwood, Finance Manager (BTHFT)
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Laura Wood, Finance Manager, (ANHSFT)

Date

19th May 2015

1. Background

All patients with suspected onset of stroke within previous 24 hours stroke should be immediately transferred to a receiving hospital providing acute stroke services, with a stroke triage system, able to provide expert clinical assessment, timely imaging and able to deliver intravenous thrombolysis throughout a 24 hour period, (National Stroke Strategy 2007). Minimum requirements at the receiving hospital are an appropriately staffed Acute Stroke Unit and the ability to provide specialist brain imaging 24/7. Specialist stroke consultants must be available 24/7.

The resilience of acute stroke care has been identified by the CCG Collaborative (10CC) in Yorkshire as a priority area for focus. This is in part because there is a recognition that the quality and outcome of current services is variable and in some places at risk in terms of the ability to sustain the specialist workforce needed. Plans for the local and regional stroke management must be developed to meet the demands and performance indicators identified within the Sentinel Stroke National Audit Programme (SSNAP) as best practice for managing acute stroke. This best practice has been defined by the Royal College of Physicians (see www.rcplondon.ac.uk/projects/sentinel-stroke-national-audit-programme)

Nationally, there is a view, which is supported by evidence from London that clinical outcomes improve when patients are treated in acute stroke services which admit more than 600 strokes per year. This has resulted in the reconfiguration of stroke services in a number of parts of the country. In support of this, 10CC have commissioned a review of Hyper-acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) services. This will enable sustainability and achieved improved outcomes for the stroke patients across West Yorkshire.

The 10CC workstream to review the resilience of local HASU was brought forward after ANHSFT encountered staffing problems amongst its consultant workforce

2. The stroke Pathway and HASU/ASU Requirements

People with suspected acute stroke must be conveyed immediately to a hospital that can provide the following:

a) Immediate specialist assessment
b) Rapid scanning
c) Thrombolysis if appropriate
d) Direct admission to HASU
e) 7 day stroke specialist consultant delivered ward rounds and 24/7 availability

For strokes caused by a blood clot, Alteplase can be used to try to disperse the clot. For most patients thrombolysis should be given within the first 4 hours after the onset of the stroke; however there are some cases where benefits from thrombolysis can be achieved up to 6 hours. There are some clinical exceptions to thrombolysis and only 15% of patients will be eligible for treatment.

The HASU will be geographically distinct from an acute stroke unit and brings experts and equipment under one roof to provide world-class treatment 24 hours a day, reducing death rates and long-term disability.

- Physiological Monitoring
- 4 hourly general Monitoring – NEWS
- Neurological Monitoring (GCS NIHSS) with protocols to manage abnormal results
- Continuous monitoring for unstable patients.

HASU will have access to a 24/7 stroke consultant and level 2 (see appendix 1 for definition) standards of nurse staffing. Stroke patients would normally spend an average of 48 hours on HASU before being discharged or transferred to ASU.

Up until April 2014 stroke patients had access to HASU on both hospital sites. In order to safely run a sustainable HASU and to give quality care to critically ill stroke patients the following are required:

- A viable and sustainable stroke consultant rota to deliver 24/7 care to critically ill stroke patients in the first 48 hours following a stroke. Stroke consultants have to be on-site to deliver this care and due to the nature of the critically ill stroke patient it is not widely accepted by stroke physicians that this care can be delivered off-site using telemedicine. Stroke Networks, British Association of Stroke Physicians (BASP) and Royal Colleges accept that a minimum number of stroke consultants for this rota to be sustainable is 6.
- A viable and sustainable consultant rota to deliver 24/7 thrombolysis to those stroke patients who are eligible for thrombolysis treatment. There are different models of delivery for 24/7 thrombolysis. Throughout some of West Yorkshire, in-hours thrombolysis decisions are made by each of the hospitals established stroke consultant, however, un- like the provision of 24/7 critical care to stroke patients in HASU, decisions as to whether to undertake thrombolysis with a patient or not can be made via telemedicine and out-of hours thrombolysis decisions are made by a network of stroke consultants via telemedicine.
- HASU beds that are distinct from other stroke beds and have continuous physiological monitoring
- Minimum workforce numbers for HASU and ASU as defined by the Healthy Ambitions Program and monitored via the Regional Stroke Assurance Framework
  These are as follows:

Role	Whole Time Equivalent
Consultant	1 Lead Clinician per Unit
Nursing - HASU	3.5 WTE per bed
Nursing - Acute/Rehab	1.5 WTE per bed
Physiotherapy	1 WTE per 5 beds
Occupational Therapy	1 WTE per 5 beds
Speech & Language Therapy	1 WTE per 10 beds
Clinical Psychology	0.92 WTE per 10 beds
Dieticians	0.3 WTE per 10 beds
Dietician support worker	0.3 WTE per 10 beds

3. Current Service Provision and the Issues

BTHFT is currently accredited to provide a Level 2 Acute Stroke and Thrombolysis Service and commissioned by Bradford District CCG and Bradford City CCG to provide a service to the population of Bradford. BTHFT currently manages approximately 600-650 definite strokes and approximately 310 stroke mimics. The BTHFT Stroke Service currently comprises of:

Ward 9 – Bradford Royal Infirmary
3 HASU Beds
19 Ward Beds Combined Stroke (14 beds) and Neurology (5 beds)
Rapid Access TIA Clinic

Ward F6 – St Luke's Hospital, Bradford
19 Ward Beds Combined Stroke (8 beds) and Neurology Rehabilitation (11 beds)

Community Services
Community Stroke Nurse Service
Community Stroke Information Service (Newly Commissioned)
Stroke Early Supported Discharge Team

The average length of stay is for stroke patients is 15.4 days

ANHSFT is currently accredited to provide a Level 2 Acute Stroke and Thrombolysis Service and commissioned by Airedale, Wharfedale and Craven CCG. The service currently admits approximately 350 confirmed strokes and 189 stroke mimics per annum. The ANHSFT Stroke Service currently comprises of:

Ward 5 – Airedale General Hospital
2 HASU Beds (stroke)
19 Ward Beds (Acute Stroke and Stroke Rehabilitation)
6 Ward Beds (Neuro-rehabilitation – non-stroke)
Rapid Access TIA Clinic

The average LOS for stroke patients is currently 12 days

Activity Data (2014/15 SSNAP)

Bradford (2014/15 Data)	**Airedale (2014/15 Data – YAS Excludes East Lancs work)**
951 calls suspected stroke	480 calls suspected stroke
631 confirmed strokes	320 confirmed strokes
73 thrombolysed	30 thrombolysed
68 (deceased)	25 (deceased)
320 stroke mimic (admission to AMU or discharged home)	160 stroke mimic (admission/discharged home) on average 50/50

Consultant Stroke Workforce Shortage and Clinical Outcomes

Evidence from Royal College of Physicians National Clinical Guidelines for Stroke (2012) indicate poorer clinical outcomes for those stroke patients who do not receive optimum care in the first 48 hours of onset of a stroke and some of the key recommendations are; immediate access to brain imaging; immediate assessment for thrombolysis; direct admission to a specialist stroke unit; immediate access to a stroke physician.

Since April 2014 Airedale NHS Foundation Trust (ANHSFT) have not been able to provide a 24/7 Stroke service or a viable Hyper Acute Stroke Unit (HASU) following the resignation of 2 of their 3 Stroke Consultants and long term sickness of the third member of the Consultant team. This has meant that some of the clinical outcomes that are important for stroke patients have deteriorated (SSNAP data accessed at: www.rcplondon.ac.uk/projects/sentinel-stroke-national-audit-programme). SSNAP data from Airedale during 2014 and early 2015 show significant poor performance compared to both National and West Yorkshire providers, in those indicators relating to the first 48 hours of stroke care, (see table 1). These are the standards directly relating to the services delivering the 24/7 critical care of stroke patients, namely 24/7 availability of a stroke consultant, access to rapid diagnostics, decisions on thrombolysis treatment and the care provided by HASU in the first 48 hours of stroke onset.

Significantly for Airedale, SSNAP indicators relating to acute stroke care and rehabilitation of stroke patients, traditionally compare favourably against other providers. This indicates that care provided to stroke patients after the first 48 hours of onset of a stroke is good. This care often does not directly depend on 24/7 access to a stroke consultant and is more an indicator of how well an acute stroke and rehabilitation unit functions, rather than how HASU functions.

Table 1 - SSNAP data (Oct-Dec 2014) 16 key indicators (HASU resilience review)

Standard	**SSNAP target %**	**WY average %**	**ANHSFT %**	**BTHFT %**
Proportion of patients scanned within 1 hour	50	30.2	18.3	46.0
Proportion of patients scanned within 12 hours	90	79.4	69.7	82.3
Proportion of patients directly admitted to a stroke unit within 4 hours	N/A	53.8	34	61.3
Proportion of all stroke patients given thrombolysis	N/A	11.5	2	17.3
Proportion of eligible patients given thrombolysis	N/A	72.7	27.7	94.3
Proportion of applicable patients directly admitted to a stroke unit within 4h AND who either receive thrombolysis or have exclusions to thrombolysis	N/A	51.2	32.7	61.3
Proportion of patients assessed by a stroke specialist consultant physician within 24h	N/A	79.7	58.3	82.0
Proportion of patients who were assessed by a nurse trained in stroke management within 24h	N/A	82.3	62.7	87.3
Proportion of applicable patients who were given a swallow screen within 4h	N/A	63.4	51	68.0
Proportion of applicable patients who were given a formal swallow assessment within 72h	N/A	69.3	77	72.7
Compliance against the occupational therapy target	N/A	63.2	45.7	76.3
Compliance against the physiotherapy target	N/A	56.9	48.3	64.3
Compliance against the SALT target	N/A	23.4	27.3	68.7
Proportion of applicable patients receiving a joint H&SC plan on discharge	N/A	86.0	100	98.0
Proportion of patients treated by a stroke skilled early supported discharge ESD team	N/A	28.3	6	51.0
Proportion of applicable patients in AF on discharge who are discharged on ACs or with a plan to start AC	N/A	96.3	100	100

This table indicates that ANHSFT clinical outcomes fall short of expectations in the majority of indicators, but especially those indicators relating to the first 48 hours of stroke care.

Despite several recruitment attempts, Airedale has not been able to secure a stable stroke consultant workforce and since April 2014, Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) has supported Airedale's Stroke service with the out of hours provision of thrombolysis where indicated and advice for some complex patients.

It is well recognised that there is a national shortage of trained stroke consultants. The British Association of Stroke Physicians, (BASP), calculate that there is a national shortfall of 163 stroke consultants posts across the whole of the UK, or a 46% shortfall in what is required to deliver stroke services. At the time of publication of this report, 40 Stroke Medicine trainees are registered for completion of specialist training by 2014; however it is important to note that this will not automatically convert to 40 whole-time-equivalent stroke physicians as most stroke physicians will share their time with another specialty. BASP strongly recommends that, as a continuation of the 2008 English Department of Health initiative, an extra 30 Stroke Medicine trainee places should be created per year in the UK for the next 4 years. This will address the current shortfall by providing an additional 120 Stroke Specialists. The distribution of these trainee posts should be determined on a population basis with sensitivity to the existing specialist resource. A forward view looking at the availability trainees and the number of graduates taking medicine suggests that this is unlikely to be delivered.

With the knowledge of the national shortage of stroke consultants in mind, it is unrealistic to plan for a service that requires both hospitals to have 6 Consultants, (the number required in order to sustain viable 24/7 consultant cover). It is clear from this that there is no viable short- medium term fixes to address this shortage and in turn no realistic prospect of doubling the current numbers of Stroke Consultants across Bradford and AWC.

The 10CC resilience model has also indicated that the majority of single site HASU's within West Yorkshire will find it difficult to sustain services beyond 5 years. Working models provided by 10CC indicate that over the next 5 years providers would require a material uplift in Consultant Stroke Physicians, Specialist Nursing and Therapy staff to deliver this model. Coupled with the workforce issues highlighted above this may not be affordable within the current tariff for Stroke services.

Interim arrangements

Currently ANHSFT provide HASU and thrombolysis for patients presenting with stroke during Mon-Fri 8am-6pm. Outside of these hours and at weekends, confirmed stroke patients are transferred by emergency ambulance to BTHFT for thrombolysis (if appropriate). This arrangement is seen as temporary in nature and is not a sustainable solution because:

- It carries with it a high risk rating for quality and safety (see quality & safety impact below) which is being managed currently and is on the AHFT corporate risk register
- It does not improve clinical outcomes significantly
- It does not meet national HASU resilience model
- It does not meet the increase in stroke admissions
- It is not a sustainable model
- It does not have the approval of each of the provider Trust Boards
- It does not have the approval of the NHSE Medical Director
- It has been approved by the Strategic Stroke Network only as a temporary measure

4. Proposed future model - One-site HASU with collaborative working and 2 Acute Stroke Units

This model will deliver the minimum for patients within Bradford and Airedale:

- 24/7 Hyperacute stroke and thrombolysis.
- 7 day acute stroke
- 7 day TIA service
- Monday-Friday therapy and rehabilitation provision

All patients from Airedale, Wharfedale and Craven presenting with a suspected stroke (ie FAST positive) will be conveyed directly to BTHFT where they will receive appropriate diagnostics, treatment and care within the Emergency Department. Patients with confirmed stroke will then be transferred directly to HASU on the main hospital site and remain there to receive a period of critical care. For the majority of patients this will be for the first 24-72 hours of their care.

ANHSFT would continue to provide an Acute Stroke Unit (ASU) and Rehabilitative Stroke Unit and patients would be repatriated to this unit from Bradford as soon as appropriate after their initial care in the HASU . The ANHSFT Stroke Service would be configured to continue to provide acute stroke care for patients whom no longer require daily review (post HASU) and stroke rehabilitation.

If HASU is not required an appropriate plan of care will be implemented by a medical consultant and repatriation to an appropriate service at ANHSFT will be organised and accepted at the earliest opportunity.

Working on HASU average length of stay of 48 hours, it is estimated that to accommodate the anticipated number of admissions to Bradford Stroke Service will require an additional 2 HASU beds and 1 ASU bed. This will require some minor building work on the current stroke unit.

The timeline for the completion of this work can be found later in the paper.

The Consultant workforce would be amalgamated to provide a 1:6 or 7 rota and provide 7 day ward rounds. This will provide the standard for meeting consultant delivered 24/7 HASU stroke care, thrombolysis, 7 day HASU and ASU ward rounds (the latter with the aid of telemedicine). It will also

provide the additional resilience required to deliver HASU. BASP and Regional Stroke Networks indicate that in order for HASU's to be resilient in their consultant cover, they require a minimum of 6 stroke consultants contributing to a 24/7 rota.

The stroke services across the 2 sites will become one integrated service, with one overall clinical lead, one set of local clinical governance arrangements and one integrated clinical pathway. Stroke patients that are repatriated to ANHSFT will be under a named on-site stroke consultant.

It is important to point out that in the proposed model, BTHFT will be admitting over 900 confirmed stroke case per year and the developments below to support the stroke pathway will be essential to ensuring a service of this size delivers the best possible clinical outcomes 24/7.

a) Development of the Stroke Responder Team

A nurse led Stroke Responder Team within the Emergency Department. A team of nurses with the specialist training in the early identify, treatment and care of strokes would improving the service provided within the Emergency Department and therefore improve experience, care and overall patient outcomes.

b) Development of a 7 day Therapy service.

Currently both sites have staff for a 5 day therapy service to their stroke units as described in the National Clinical Guidelines for Stroke (Fourth Edition). However this falls short of the 7 day service mandated by SSNAP and the Regional Stroke Assurance Framework and is recommended for those services with over 900 stroke admissions per annum.

c) Neuro-Rehabilitation Services

In support of this reconfiguration of the stroke services across Bradford and Airedale, there is an opportunity to change the configuration of Neuro-rehabilitation services, particularly for those patients with specialist rehabilitation needs such as patients with a brain injury and some specialist long term neurological patients.

Neurology is an associated service currently co-located with stroke on Ward 9, there may be options to look at the location of inpatient Neurology between Bradford and Airedale to enhance this service and make optimal use of inpatient capacity across the two Trusts.

Utilising capacity in ANHSFT and the specialist skills that are available there will not only increase HASU capacity at BTHFT but also provide an improved service for this group of patients with complex needs.

Ensure there is minimal impact on critical care beds at BTHFT by ensuring appropriate HASU (level 2) capacity is commissioned.

d) Community Stroke Nursing and Information Service

BTHFT has, for several years, had a Community Stroke Nursing Team in place which as a service provides advice, information and support post discharge to patients. The Trust has also recently been commissioned by Bradford CCG's in order to deliver a Community Stroke information service to the population of Bradford.

It is understood that there is currently no dedicated community nursing provision for stroke patients in the Airedale, Wharfedale and Craven CCG footprint and this needs to be resolved to ensure patients at this end of the patch have access to early supported discharge.

YAS will need to provide assurance of timely transfer of patients being repatriated and confirm costs

Infrastructure (Bed) Requirements (BTHFT)

The following additional beds will be required:

Type of Bed	Number Required
HASU	2
ASU	1

Staffing Requirements (BTHFT)

Staff Group	Current	Proposed	Add WTE Required (Above Current)
Nursing (HASU)	10.5	17.5	7.00
Nursing (Acute)	10.87	11.95	1.09
Nursing (Rehab)	18.99	18.99	-
Physiotherapy	3.20	3.54	0.34
Occupational Therapy	2.40	2.66	0.26
SALT			-
Dietician	0.40	0.44	0.04

In the event that BTHFT are not able to recruit sufficient skilled nurses in time, it is likely that ANHSFT will support the HASU and ASU across both sites until such time that sufficient nurse numbers can be recruited to.

PEST Analysis

Political	Economical
West Yorkshire HASU review Supports the national model **Measured Clinical outcomes (SSNAP)** Potential for improving data but collection may be difficult. However across the 2 sites SSNAP data will improve with improved clinical outcomes (see options appraisal below) **Strategic Stroke Network** **Future workforce implications based on known pressures in the system** Integrated clinical model which will provide more resilience. Less impact on future medical and nursing across patch. Therapy future workforce planning still required **Sustainability of model** Medium term sustainability (5-10 years).	**Overall impact on local health economy** TBD **Affordability** TBD **Timescales for delivery** September-October 2016
Social	**Technological**
Patient experience Medium impact. Patients will have their stroke care across 2 sites but patients will experience improved and more consistent care for hyper acute and thrombolysis. **Demographic health changes** Resilient to increases in stroke admissions **Access to services** Improved access to thrombolysis and hyper-acute stroke units and high risk TIA service	**Potential for use of telemedicine and remote consultation** High – cross-site working for hyper-acute and acute decision making and use of TM **Impact on YAS** High. This will have a bigger impact on YAS logistics

SWOT Analysis

Strengths	**Weaknesses**
Improved resilience Improved clinical outcomes (data from London and other models) Improved SSNAP data Meets expectations of HASU review and national models] Can be delivered in 2016	Patient and carer groups may not see benefits Care across 2 organisations may lead to inequality Door to needle time may increase for those patients travelling from North Yorkshire to BTHFT. However, in London a larger service volume and improved access to key services offset the extra transport times.
Opportunities	**Threats**
Improved cross provider working and an integrated clinical model Use of technology and TM Benefits for staff to work collaboratively	Recruitment to increased nursing numbers on BTHFT site may be rate limiting (lack of nurses available) YAS and logistics unknown Stroke mimics will place pressure on HASU provider Self-presenters to ANHSFT ED will need transferring indirectly. Tariff share will require review

5. Appraisal of proposal model and current interim arrangements against clinical outcomes

Scored against how likely it would improve clinical outcome across the patch for both Airedale and Bradford patients. Clinical outcomes are based on a basket of 16 SSNAP indicators as defined by the 10CC HASU resilience work.

0 = worse
1 = no improvement
2 = slight improvement
3 = significant improvement

Standard	Interim arrangement	Proposed model
Proportion of patients scanned within 1 hour	1	3
Proportion of patients scanned within 12 hours	1	3
Proportion of patients directly admitted to a stroke unit within 4 hours of attending ED	1	3
Proportion of all stroke patients given thrombolysis	1	3
Proportion of eligible patients given thrombolysis	1	3
Proportion of applicable patients directly admitted to a stroke unit within 4h AND who either receive thrombolysis	1	3
Proportion of patients assessed by a stroke specialist consultant physician within 24h	1	3
Proportion of patients who were assessed by a nurse trained in stroke management within 24h	1	2
Proportion of applicable patients who were given a swallow screen within 4h	1	3
Proportion of applicable patients who were given a formal swallow assessment within 72h	1	2
Compliance against the occupational therapy target	1	1
Compliance against the physiotherapy target	1	1
Compliance against the SALT target	1	1
Proportion of applicable patients receiving a joint H&SC plan on discharge	1	1
Proportion of patients treated by a stroke skilled ESD team	1	2
Proportion of applicable patients in AF on discharge who are discharged on ACs or with a plan to start AC	1	1
Total score	16	35

Comparison of proposed model and interim arrangements against key indicators

	Interim arrangement	Proposed model
Improves clinical outcomes (SSNAP see table above) (Score out of 10)	1	8
Will meet local support from patients and families (score out of 10)	8	6
Has Clinical and Trust Board agreement from both Trusts (score out of 5)	1	5
Provides solution for Sustainable services across both sites (score out of 10)	2	8
Meets agreed national and local HASU resilience model (score out of 10)	4	10
Impact on YAS and patient transfers (score out of 5; 1= high impact)	3	1
Impact on costs for both sites (score out of 5; 1 = high impact)	3	2
Ease of implementation (score out of 5)	5	4
Total	27	44

Airedale NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust

Quality and Safety Impact Assessment

Interim arrangement	Strengths	Weaknesses	Risk Rating:
Quality	1. Fast access during working hours 2. Local service for the population of Airedale during the Hyper Acute phase of stroke care	1. Not 24/7 service 2. Patients will receive one of two care locations dependent upon the times they present	Likely (4) Moderate (3) RR = 12
Safety	1. Patients living locally to Airedale will benefit from faster 'time of onset to needle' times for those presenting OOH and at weekends 2. HASU weekend ward rounds	1. Virtually impossible to run HASU ward rounds on both sites due to the numbers on the rota and the highly unlikely possibility of recruiting to the numbers required to safely function such a rota 2. Low numbers of thrombolysis will decrease the efficiency of the system due to the infrequent throughput 3. The critical 4 hour window for thrombolysis will be missed for some Airedale patients dependent upon the time they present	Likely (4) Major (4) RR = 16

Proposed	Strengths	Weaknesses	Risk Rating:
Quality	1. LoS for Hyper Acute patients will decrease 2. Increase in skilled staff due to consistency and higher numbers of patients requiring thrombolysis	1. Increased distance for patients and families for those during the hyper acute phase 2. Some staff at AGH will lose skills for managing hyper acute stroke patients, although there will be the option of working across the two hospital sites	Possible (3) Moderate (3) RR = 9
Safety	1. Increased thrombolysis rate 2. Improved 'door to needle' times 3. Improved resilience for the HASU service 4. Improved access to diagnostics out of hours	1. Unlikely that in-patients at Airedale who have a stroke will get access to a skilled hyper acute service 2. Time of onset to needle times will be increased for a proportion of Airedale patients dependent on their geographical location	Unlikely (2) Major (4) RR = 8

Appendix 1

British Association of Stroke Physicians
Service Development and Quality Committee, 2005

Stroke Service Specification

This specification describes the characteristics of a stroke service that would satisfy the basic minimum requirements of the National Service Framework for Older People (NSF; Stroke chapter) in England (Level 1), but also describes those characteristics considered to indicate a service level beyond that minimum specification and thus eligible for accredit-ation as a Stroke Centre (Level 2 or Level 3). In assessing the quality of any stroke service, this specification should be considered with the results from national audit (National Sentinel Audit of Stroke or Scottish Stroke Care Audit).

A **Level 1 Stroke Service** comprises the basic minimum level of provision in any acute Trust providing care to patients with stroke, and includes all of the following components:

Acute Stroke Service
Medical cover for in-patients 24 hours a day
CT available on site 24 hours a day, with >75% of stroke patients scanned within 48 hours of onset
MRI available during working hours
Stroke consultant physician opinion available on site
Carotid ultrasound available at same or other site
Local availability of routine investigations e.g. cardiac echo
Emergency access to neurosurgery and interventional neuroradiology
Access to vascular surgeons
Stroke Unit
Adequate staffing levels incl. Medicine[1]
Multidisciplinary team includes nursing, physiotherapy, occupational therapy, speech and language therapy and social work

Access to clinical psychology, dietetics, pharmacist
Specialist nursing expertise e.g. tissue viability, continence
Weekly multidisciplinary rehabilitation meetings
Provision for gastrostomy insertion within one week of referral if required
Sufficient sessional commitment from Stroke Physician[2]
All patients on the Stroke Unit under the care of a Stroke Physician
Stroke unit admission rate of at least 50% (for primary diagnosis of stroke)[3]
Structured training and supervision available for all disciplines of staff
Neurovascular Clinic
Stroke/Neurovascular Clinic (in which patients are assessed by a Consultant Physician with specialist interest in Stroke) with a waiting time of <4 weeks, all investigations complete within 8 weeks
Access to the full range of relevant out-patient investigations
CT brain scanning available for outpatients presenting within 14 days
MRI scanning available for outpatients presenting beyond 14 days
Stroke Rehabilitation
Multidisciplinary domiciliary rehabilitation or Day Hospital
Rehabilitation provision for stroke patients of working age within same or adjacent hospital/Trust[4]
Managerial/Audit
Existence of NSF Implementation Plan[5]
Participation in National Audit
Presence within the trust of a nominated Lead Clinician for Stroke
Consultant Post
Adequate sessional commitments devoted to stroke[2]

Sufficient medical junior staff support for the in- and outpatient workload

A **Level 2 Stroke Centre** provides all the components of a Level 1 Stroke Service, plus all the additional features in at least four out of the five following categories:

Acute Stroke Service
Carotid ultrasound available at same site
Access to specialised investigations e.g. TOE, cerebral angiography
Stroke Unit
Stroke unit admission rate of at least 70% (for primary diagnosis of stroke)[3]
At least 75% of stroke unit admissions arrive on the unit within 24 hours of admission to hospital
Protocols for the prevention and management of venous thrombosis, fever, hyperglycaemia, nutrition and feeding
Neurovascular Clinic
Weekly Stroke/Neurovascular Clinic (in which patients are assessed by a Consultant Physician with specialist interest in Stroke) with a waiting time of <2 weeks, all investigations complete within 4 weeks
Referral protocol for Neurovascular Clinic available to all local GPs
Guidelines for secondary vascular prevention widely available[6]
Referral protocol for carotid endarterectomy agreed with local vascular surgeons
Stroke Rehabilitation
Specialist stroke community rehabilitation[7]
Capacity for follow-up of all stroke patients
Capacity for follow-up of all patients treated with gastrostomy
Established liaison with voluntary sector organisations

Managerial/Audit
Evidence of change in response to National Audit findings
Evidence of local audit, and practice change in response to the findings

A **Level 3 Stroke Centre** meets the criteria for a Level 2 Stroke Centre, plus provides at least four of the following additional features:

Stroke Unit
Stroke unit admission rate of at least 90% (for primary diagnosis of stroke)[3]
Facility for direct referral and admission to Stroke Unit from home or Emergency Department
Thrombolysis protocol for ischaemic stroke presenting within 3 hours, with SITS-MOST participation
Neurovascular Clinic
Stroke/Neurovascular Clinic (in which patients are assessed by a Consultant Physician with specialist interest in Stroke) with a waiting time of <1 week, all investigations complete within 2 weeks
Consultant Post
Other specialist non-medical expertise available locally e.g. Stroke Specialist Nurse, Stroke Nurse Consultant
24-hour access to Consultant Stroke Physician advice
Research/Audit
Routine outcome measurement in all stroke in- and out-patients
Involvement in stroke-related research

Notes

1. The minimum staffing levels on the Stroke Unit should be: 8.0 trained or untrained nurses/10 beds; 1.0 junior doctors/10 beds for an acute unit; 0.9 sessions of physiotherapy/bed; 0.7 sessions of occupational therapy/bed; 0.35 sessions of SALT/bed.

2. The minimum timetabled commitment to Stroke in the consultant job plan should be: 1.0 sessions/10 beds for the in-patient Stroke service, 1.5 sessions/week for the out-patient Neurovascular Clinic.

3. The most objective and reliable measure of the level of Stroke Unit provision comes from the expression of the total number of bed days spent by patients with a primary diagnosis of stroke on a Stroke Unit as a proportion of the total number of bed days spent in the hospital as a whole by patients with a primary diagnosis of stroke. This proportion should reach the thresholds of 50%, 70% and 90% corresponding with the successive levels of Stroke Service.

4. This would include at the least the capacity to refer to a Consultant in Neurological Rehabilitation and access to a local young disabled rehabilitation facility, unless the Consultant Stroke Physician had themselves received accredited training in the specialty.

5. In Scotland, involvement with a Stroke Managed Clinical Network.

6. The NSF in England also specifies the use in primary care of registers for the *primary* prevention of stroke in those at risk. Requirements for this standard are beyond the scope of this specification.

7. The definition of specialist stroke rehabilitation is not made clear in the Stroke section of the NSF in England, but at a minimum this should represent a multidisciplinary team for whom stroke patients make up at least one third of the caseload.

NORTH YORKSHIRE COUNTY COUNCIL

SCRUTINY OF HEALTH COMMITTEE

12 June 2015

Remit of the Committee and Main Areas of Work

Purpose of Report

1. The purpose of this report is to highlight the role of the Scrutiny of Health Committee (SoHC) and to review the work programme taking into account current areas of involvement and decisions taken in respect of earlier agenda items.

Introduction

2. The role of the SoHC is to review any matter relating to the planning, provision and operation of health services in the County.

3. Broadly speaking the bulk of the Committee's work falls into the following categories:

   a) being consulted on the reconfiguration of healthcare and public health services locally;

   b) contributing to the Department of Health's Quality Accounts initiative and the Care Quality Commission's process of registering NHS trusts;

   c) carrying out detailed examination into a particular healthcare/public health service;

4. The Committee's powers include:

   - reviewing and scrutinising any matter relating to the planning, provision and operation of health services in the local authority's area;
   - requiring NHS bodies to provide information within 28 days to and attend (through officers) before meetings of the committee to answer questions necessary for the discharge of health scrutiny functions;
   - making reports and recommendations to local NHS bodies and to the local authority on any health matters that they scrutinise;
   - requiring NHS bodies to respond within a fixed timescale to the health scrutiny reports or recommendations;
   - requiring NHS bodies to consult health scrutiny on proposals for substantial developments or variations to the local health service;
   - referring contested proposals to the Secretary of State for Health.

Scheduled Committee Dates

5. The Committee meetings up to May 2016 are:

- 4 September
- 6 November

2016

- 22 January
- 22 April

6. All of the above meetings start at 10.00am. Venues are yet to be confirmed.

Areas of Involvement and Work Programme

7. The Committee's on-going and emerging areas of work involvement are summarised in APPENDIX 1.

8. Key issues which Members are invited to note include:

- Child and Adolescent Mental Health Services (CAMHS)

  The Committee has a long standing interest in CAMHS. The Department of Health have published Future in mind - Promoting, protecting and improving our children and young people's mental health and wellbeing: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

  Locally developments are being taken forward under the umbrella of the **Children and Young People's Emotional and Mental Health Strategy 2014-17** which in turn will contribute to an overarching Mental Health and Wellbeing Strategy a draft of which was considered by the Health and Wellbeing Board on Wednesday 3 June 2015.

  On behalf of the Clinical Commissioning Groups and the North Yorkshire Children's Trust the North Yorkshire Partnership Commissioning Unit (PCU) is planning to hold a series of engagement events with young people and parents/guardians. Arrangements are in being made for Members from this Committee to being involved in these events. Opportunities for the Committee to carry out its own research in conjunction with Healthwatch which could support the work being undertaken by the PCU are also being explored.

- All Age Autism Strategy

  The Committee's interest in Autism dates back to late 2013 when it came to light there were long delays in autism diagnosis across the County. Since that date the Committee has been monitoring the situation closely. The latest information indicates the situation is improving, for instance, the number of

first appointments offered each month has steadily improved over the last year.

The consultation on the Strategy went live on Friday 22nd May 2015: http://www.northyorks.gov.uk/autismstrategy

Five events are planned in July which will be open to service users, carers and stakeholders to attend. These dates will be made available to members of this committee in the near future.

The results of the consultation and the delivery plan will be considered by the Committee later this year.

Recommendation

9. That Members review the Committee's work programme, taking into account issues highlighted in this report, the outcome of discussions on previous agenda items and any other healthcare developments taking place across the County.

Bryon Hunter
Scrutiny Team Leader

County Hall
NORTHALLERTON

01 June 2015
Background Documents: None

NORTH YORKSHIRE COUNTY COUNCIL

Scrutiny of Health Committee – Work Programme/Areas of Involvement - 2015 (as at January 2015)

(Note: Shading denotes period of involvement; ✓ = Confirmed agenda item)

	2015		*2016*	
Scheduled Committee Meetings	**4 Sept**	**6 Nov**	**22 Jan**	**22 April**
Overview/On-Going Monitoring				
1. Hambleton, Richmondshire & Whitby CCG: Whitby - “Fit 4 the Future”				
2. Hambleton, Richmondshire & Whitby CCG: Hambleton and Richmondshire - "Fit 4 the Future"				
3. Primary Care Commissioning				
Local Service Delivery Issues				
4. Short Stay Paediatric Assessment Unit, Friarage Hospital				
5. Mental Health services in the Craven area	Timescale to be determined.			
Performance				
6. Yorkshire Ambulance Service – Outcome of Care Quality Commission Inspection (Including planned service developments and improvements to response times)	✓			
7. South Tees Hospitals NHS Foundation Trust – Outcome of CQC Inspection, financial situation and Impact on Services	Timescale to be determined.			
8. York Teaching Hospitals NHS Foundation Trust - Outcome of CQC Inspection	Timescale to be determined.			
9. Tees, Esk and Wear NHS Foundation Trust - Outcome of CQC Inspection	Timescale to be determined.			

	2015		*2016*	
Scheduled Committee Meetings	**4 Sept**	**6 Nov**	**22 Jan**	**22 April**
Strategic Service Developments				
10. The role of Pharmacy in primary care	✓			
11. Child and Adolescent Mental Health Services (CAMHS)				
12. All Age Autism Strategy				
13. Winter measures				
14. Hydraulic fracturing (Fracking)	Timescale to be determined.			
15. National Review of Congenital Heart Surgery (Adults and Children)				