Better Health Programme Joint Health Scrutiny Committee

Meeting on Monday 10 July 2017 at 2.00 pm in Council Chamber, Civic Centre, Hartlepool

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Agenda

1. **Appointment of Chair**
2. **Appointment of Vice Chair**
3. **Substitute Members**
4. **To receive any Declarations of Interest by Members**
5. **Minutes (Pages 5 - 22)**

   To receive and approve the minutes of the meeting of the Better Health Programme Joint Health Scrutiny Committee held on 9 March 2017.

6. **Proposed re-designation of the Better Health Programme Joint Health Overview and Scrutiny Committee (Pages 23 - 34)**

   To consider the attached report of the Principal Overview and Scrutiny Officer, Durham County Council.

7. **Better Health Programme - Update (Pages 35 - 184)**

   To receive a joint presentation Alan Forster, Durham Darlington and Teesside, Hambleton, Richmondshire and Whitby STP lead officer which sets out:-

   - The story so far and timeline going forward;
   - Proposals for option appraisal evaluation criteria;
   - STP/Better Health Programme Engagement activity –update;
   - Potential agenda items for forthcoming meetings.

   For members information the following Phase 5 engagement reports for Maternity and Paediatrics services are attached:-

   (a) On-street survey of women by Explain market research;
   (b) Feedback on discussions with Community and Voluntary groups co-ordinated by VONNE;
   (c) Feedback report from 11 Public engagement events by Proportion Marketing Ltd.

8. **Chairman's urgent items**
9. **Any other business**

10. Date and time of next meetings

- Wednesday 13 September 2017 at 2.00 p.m. – Committee Room 2, County Hall Durham.
- Wednesday 8 November 2017 at 2.00 p.m. – Venue TBC.
- Wednesday 17 January 2017 at 2.00 p.m. – Venue TBC

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Contact Officer: Stephen Gwillym, Principal Overview and Scrutiny Officer, Durham County Council **Tel:** 03000 268 140

Membership:

DARLINGTON BC
Councillor Wendy Newall
Councillor Jan Taylor
Councillor Lorraine Tostevin

DURHAM COUNTY COUNCIL
Councillor John Robinson
Councillor Morris Nicholls
Councillor Owen Temple

HARTLEPOOL BC
Councillor Ray Martin- Wells
Councillor Rob Cook
Councillor Ged Hall

MIDDLESBROUGH BC
Councillor Eddie Dryden
Councillor Bob Brady
1 Vacancy

NORTH YORKSHIRE COUNTY COUNCIL
Councillor Jim Clark
Councillor John Blackie
1 Vacancy

REDCAR AND CLEVELAND BC
Councillor Ray Goddard
Councillor Mary Ovens
Councillor Norah Cooney

STOCKTON BC
Councillor Lisa Grainge
Councillor Allan Mitchell
Councillor Lynn Hall

Better Health Programme Joint Health Scrutiny Committee

At a meeting of **Better Health Programme Joint Health Scrutiny Committee** held in Committee Room 2, Town Hall, Darlington on **Thursday 9 March 2017 at 2.00pm.**

Present:
Cllr J Robinson (Durham County Council) Chair

Councillors –
Councillors W Newall, H Scott and J Taylor (Darlington Borough Council)
Councillor O Temple (Durham County Council)
Councillors R Cook and R Martin-Wells (Hartlepool Borough Council)
Councillor B Brady (Middlesbrough Council)
Councillor C Dickinson (North Yorkshire County Council)
Councillor R Goddard (Redcar and Cleveland Borough Council)
Councillors S Bailey and L Hall (Stockton-on-Tees Borough Council)

Officers –
Peter Mennear (Stockton-on-Tees Borough Council)
Jenny Haworth and Stephen Gwillym (Durham County Council)
Joan Stevens (Hartlepool Borough Council)
Alison Pearson (Redcar and Cleveland Council)
Daniel Harry (North Yorkshire County Council)

Better Health Programme –

Alan Foster
Edmund Lovell
Dr Stewart Findley
Nicola Bailey
Dr B Posmyk

Local Authority and CCG Representatives

Dr. Jenny Steel, Primary Healthcare Darlington Lead, Darlington CCG
Edward Kunonga, Director of Public Health, Middlesbrough Borough Council
Jane Robinson, Director of Adult and Health Services, Durham County Council
Suzanne Joyner, Director of Children and Adults Services, Darlington Borough Council
Patrick Rice, Assistant Director of Commissioning and Adults, Redcar and Cleveland Borough Council
Mike Webster, Assistant Director for Contracting, Procurement and Quality Assurance, North Yorkshire County Council
Lesley Jeavons, Director of Integration, Durham County Council/North Durham and DDES CCG
Graham Niven, Chief Finance Officer, Hartlepool and Stockton CCG
Sue Reay, Better Care Fund Transformation Team, Stockton on Tees Borough Council
Gill Collinson, Chief Nurse, Hambleton, Richmondshire and Whitby CCG

Also in attendance – Councillor L Tostevin (Darlington Borough Council)

1. Apologies

Councillors J Blakey and W Stelling (Durham County Council)
Councillors S Akers-Belcher (Hartlepool Borough Council)
Councillors E Dryden and J Walker (Middlesbrough Council)
Councillors J Blackie and J Clark (North Yorkshire County Council)
Councillors N Cooney and M Ovens
Councillor A Mitchell (Stockton-on-Tees Borough Council)

2. Substitute Members

Councillors O Temple (Durham County Council)

3. Declarations of interest

None recorded.

4. Minutes of the meeting on 19 January 2017

AGREED that the minutes of the meeting held on 19 January 2017 be confirmed and signed by the Chair as a correct record subject to the inclusion of Councillor R Martin Wells as being in attendance.

5. Better Health Programme – Local Authority Public Health and Social Care considerations

Consideration was given to the report of the Principal Overview and Scrutiny Officer, Durham County Council which referenced previous presentations made to the Better Health Programme Joint Overview and Scrutiny Committee in respect of the process of developing the Better Health Programme and the overarching Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP.

During the course of these presentations, the Committee had asked for confirmation of and details regarding the involvement of local authority public health and Social Care service providers in the development of the BHP and STP.

Members were advised that representatives from the local authorities within the BHP footprint were in attendance to provide the Committee with a series of presentations which set out the involvement of local authority public health and social care directors in drafting the Durham, Darlington and Teesside; Hambleton, Richmondshire and Whitby STP and the neighbourhoods and communities' element of the Better Health programme. The presentations also included information on the progress of addressing how health and social care services were being integrated to ensure that there is a seamless care pathway from the acute hospital to community and neighbourhood based provision.

(i) South Tees System Integration – Keeping People Healthy

Edward Kunonga, Director of Public Health, Middlesbrough Borough Council gave a presentation regarding the South Tees system Integration programme. Reference was made to the establishment of a Regional STP Prevention Group covering both STPs which sought to address health and wellbeing gaps and promoted the upscaling of ill-health prevention and health promotion across the North East. The group included key representatives from within local authority public health, Public Health England, NHS Acute Hospitals Foundation Trusts, Fire and Rescue Services and the community and voluntary sector.

The South Tees system Integration programme set out primary and secondary prevention targeted at population, organisations, community and individual levels. Edward Kunonga explained the references to primary, secondary and tertiary interventions as being before any signs of ill health (Primary); identifying those at risk of developing or in the early stages of illness (Secondary) and after an acute injury or illness (Tertiary).

The presentation set out a number of examples of such prevention projects and reference was made to the context of delivering such prevention activity against the backdrop of a range of wider determinants of health which included education, employment, environment and housing factors.

Specific reference was made to the Middlesbrough Prevention Strategy for Adults and Older People currently out for consultation and to a similar strategy proposed for Redcar and Cleveland.

Assurances were given to the Committee that similar work was being developed across the Region.

The presentation concluded with examples of the metrics identified to gauge the success of outcomes from the prevention strategies and projects together with health summary statistics for Middlesbrough and Redcar and Cleveland boroughs.

Cllr J Robinson referred to joint work that was being undertaken within County Durham by the County Council and County Durham and Darlington Fire and Rescue service in respect of initiatives such as home safety visits which were geared to making every contact count with residents to ensure that those in need of support services were identified and appropriate and timely support provided to safeguard against the need to access more acute health services.

(ii) Social Care perspective across the Better Health Programme/STP footprint

Jane Robinson, Director of Adult and Health Services, Durham County Council gave a presentation setting out key principles in respect of health and social care integration; discussions and involvement of Directors of Social Care within the production of draft STP documents and a series of reflections from the Directors of Social Care services on progress made to date and what should happen next.

She stressed that the integration of health and social care is a legislative requirement and key policy driver where the integration of services will promote the wellbeing of adults with care and support needs or of carers in its area; contribute to the prevention or delay of the development of needs of people; and improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.

The presentation acknowledged that the STP development process was NHS led and that local authorities were not initially around the table. This meant that STPs lacked insight into the wider contributions local authorities could make; the impact of proposals on council services particularly social care and public health and the gaps and challenges existing in social care. Jane Robinson indicated that this lack of initial engagement had been acknowledged nationally and locally and governance arrangements had been revised to include local authority representation on the STP Board through Social Care and public health directors.

Reference was made to the importance of health and social care integration within the neighbourhoods and communities' workstream of the BHP/STP and that a joint health/social care workshop was planned for the near future and that a report form that event could be brought back to this Committee if members wished.

Jane Robinson stressed that the role of local authority directors within the STP/BHP governance arrangements was to highlight key social care issues and not to endorse STPs. She also acknowledged the recognition of care market issues and the positive work referenced in the previous presentation on potential public health interventions at scale.

In presenting the perspectives and reflections of the Directors of Social services across the STP footprint, Jane Robinson made reference to several key messages including:-

- The clear role for local authorities in shaping services and outcomes, prevention, commissioning and scrutiny of the development of plans and associated proposals for communications, engagement and consultation;
- The engagement of local government as a key partner on issues such as transport and travel, capital opportunities and equalities/rurality proofing;
- The need for clarity on the purpose of STPs – service development and improvement vs financial savings/reductions;
- The need for investment in primary and community care if hospital services change;
- Clear messages about where the money/funding flows across and between Acute health provision to community health and integrated health and social care;
- The need for greater connectivity across STPs – given County Durham is in 2 and North Yorkshire in 3;
- Where children's services are in the NHS debate;
- The inclusion of social care in the workforce development needs identified within the BHP/STP.

Jane Robinson concluded the presentation by emphasising how important the use of local authorities' knowledge and experience in service modelling and commissioning against a backdrop of austerity can be in the development of the STP/BHP and any associated proposals for service change.

In the discussion which followed, Cllr J Robinson asked what political input had been made within the STP development process; what involvement has taken place with Local Authority Directors of Social services on the financial modelling for the STP and finally the potential impact of the anticipated reduction in Public Health grant to local authorities?

Jane Robinson, Durham County Council stated that regular presentations on both STPs covering Durham were considered by the County Council's Health and Wellbeing Board as a standing item on their agenda. Directors of Adult social care have been asked for and provided information into potential local authority social care funding gaps although no figures have been provided. This is being examined across all local authorities. Colleagues within Durham County Council's public health team are examining options for the potential modelling of health promotion and ill health prevention across a range of service disciplines.

Mike Webster, North Yorkshire County Council stated that his authority was keen to integrate resources into health and social care integration plans but not necessarily finance. He acknowledged that public health was a key issue and was committed to monitoring the strain on public health budgets.

Suzanne Joyner, Darlington Borough Council confirmed that there was political input in to the STP via the Council's Health and wellbeing Board and also that she was providing information into the BHP/STP development in respect of potential local authority social care funding gaps. Where Darlington differed was around Public Health resources. She stated that Darlington BC's MTFP proposals would see the reduction of the Public Health resource down to the statutory level required. She confirmed that the Director for Public Health in Darlington was working with peer colleagues on this issue.

Patrick Rice, Redcar and Cleveland Borough Council stated that it was difficult to see what the potential impacts are across public health and social care. He stressed that whilst the upscaling of prevention and health promotion services and projects regionally may be desirable, this could prove difficult to achieve within finite staffing resources.

Cllr Scott asked if members would get the chance to input into the neighbourhoods and communities element of the STP/BHP whilst welcoming the need to acknowledge and reflect around the connectivity across the 2 STPs. Jane Robinson reiterated her previous comments regarding the proposed neighbourhoods and communities group workshop and the opportunity to bring a progress report back to this Committee on its work.

Councillor Tostevin asked how ready the NHS Community service provision and health and social services were to support the potential impacts of STP/BHP acute hospital service reconfiguration. She sought assurances that a robust strategic plan for NHS/LA community health and social care service integration would be developed. She suggested that such a plan would undoubtedly influence the acceptability of any acute hospital reconfiguration

proposals. Jane Robinson stressed that there was lots of work being done around community hubs; teams around practices and health and social care integration across all localities and were geared towards local models.

Dr Jenny Steel, Clinical lead for the neighbourhoods and communities group stated that the group has recognised that integration of health and social care services are not a “one size fits all” but rather that the group would prefer to retain those services that work well in specific localities and also ensure that best practice and learning was shared. She put out a health warning to the extent that if acute reconfiguration happened within the next six months then locality based community services may not be geared up to cope with any potential additional demands on the service.

Dr Posmyk indicated that in respect of health and social care integration requirements, Hartlepool and Stockton CCG and the ongoing work in respect of the Hartlepool Matters project would pick up the needs for local service delivery and associated structures would be developed accordingly.

(iii) New models of Care : Integrated Community Hubs

Dr Jenny Steel, gave a presentation setting out the Integrated Community Hubs new model of care being developed in partnership by Darlington Borough Council and County Durham and Darlington NHS Foundation Trust. She advised members that Darlington BC had the lowest rates of delayed discharge in the region. She indicated that partners recognised existing and potential future workforce pressures particularly linked to the need to increase the offer in respect of community health services.

Dr Steel highlighted a number of background issues that were contributing to the pressures placed upon health and social care around:-

- How staff at services disposal are utilised and if this was done effectively;
- Management of long term conditions;
- Differing needs of the population and the loss of the “nuclear family”;
- High levels of ill-health amongst the population and the need to promote wellbeing;
- Fragmentation of services and difficulties of patient information flow through the health and social care system;
- Care Home market fragmentation;
- The under-utilisation of community assets and the Community and voluntary sector.

Reference was made to the development of functionally integrated holistic teams made up of community services, allied health professionals, local authority social care, specialist nurses and the VCS all linked to GP practices. These teams would be based around a community hub population of between 30-50,000 and provide a bespoke service with one focussed single point of access.

Dr Steel suggested that the development of these integrated Community Hubs would shift the current default position from GPs referring into acute hospital settings because of the absence of an integrated service to one where

services are wrapped around the patient in their own homes. However to achieve this, new contracting and funding arrangements would need to be developed and agreed so that where acute hospital services are reconfigured, investment into community services is made at the same time.

Dr Steel then highlighted the Healthy New Towns project in Darlington which had quickened the pace for implementing the Integrated Community hub model across Darlington. She indicated that Darlington had been selected as one of ten demonstrator sites for NHS England's Healthy Towns programme.

Reference was made to NHS England's Five Year Forward View and the commitment made therein to dramatically improve population health, and integrate health and care services, as new places are built and take shape. This commitment recognised the need to build over 200,000 more homes in England every year, and invited Expressions of Interest from developments across the country. The Healthy New Towns programme will be working alongside the ten housing developments across the country to offer challenge, inspiration and support to build healthy communities.

The project involves the development of 2500 residential units and aims to close the gaps in health, care and finances facilitating closer working across the local authority and health providers/commissioners. The project focused on three key areas:-

- **Regeneration-** Including economic well-being, healthy travel and estates regeneration (new buildings);
- **New models of care-** Including the development of a care hub, cultural change and standardisation;
- **Digital technology-** Including patient self-management modules and teleconsulting.

The project sought to deliver four outcomes for the population of Darlington:-

- **Narrowing the gap-** on things like life expectancy and social inclusion;
- **Economic growth-** in relation to job prospects and people being attracted to Darlington;
- **Digital enablement-** to support informed and engaged digital channels of information e.g. access and share information and make decisions on health and wellbeing choices;
- **Sustainable efficient and effective care services**-To increase planned care and maximise the impact of the Darlington pound (the way in which the money available for Darlington is used).

In response to a question from Councillor Cook regarding the safeguards needed for those who may be socially isolated when being discharged from acute hospital care, Dr Steel emphasised the importance of raising awareness of having robust and integrated health and social care services which included rehabilitation and re-ablement at or closer to patients' homes.

(iv) Discharge Management

Lesley Jeavons, Director of Integration gave the Committee a presentation setting out work undertaken to date to improve the discharge management function from acute health to social care. She referenced that work had been

undertaken between Durham County Council and the NHS since 1998 when the first integrated team comprising health and social care professionals had been established. This had involved the County Council, County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust but not GPs.

Further development of integrated working was supported across all partners and the Health and Wellbeing Board and had led to the development of a newer model of integrated care incorporating 13 “teams around practices”. The appointment of a Director of Integration across NHS and the County Council had resulted in decision making permissions being given to that postholder across the NHS and local authority to unblock healthcare pathways.

Reference was made to the Emergency Care Improvement Programme and to an associated peer review involving County Durham and Darlington NHS Foundation Trust looking across the whole Health and social care system. The review had identified 4 key improvement areas of leadership (via the Local A&E Delivery Board); doing today’s work now; preventing inappropriate admissions to hospital (Assess to Admit) and Discharge to Assess. An operational delivery group consisting of CCG, Foundation trust and Adult social care representatives was established to oversee the improvement programme.

Lesley Jeavons referred to National Audit Office findings which stated that two thirds of hospital bed days are occupied by people over 65 and that there had been an 18% rise in emergency admissions for older people over the last four years. In view of research which suggested that 10 days of bed rest for healthy older people can equate to 10 years of muscle ageing with attendant loss of function, this highlighted the importance of reducing inappropriate admissions and also ensuring that hospital stays were kept to a safe minimum as “Time is everything” to people with frailty.

The discharge to assess process aimed to achieve active recovery with teams of nurses, occupational therapists, physiotherapists, rehabilitation assistants and social workers working together to undertake assessments in an active setting. This was achieved by identifying funding and supporting people to leave hospital when safe and appropriate to do so, continuing their care and assessment out of hospital. In a similar vein to other integrated approaches, the DTA approach resulted in supporting people to go home being a default pathway with alternatives made available for people who cannot go straight home. All steps were taken within the process to ensure assessment is rapid, effective, safe and able to mobilise required services such as rehabilitation and re-ablement.

Lesley Jeavons reported that the early pilot of the DTA process had not been as successful as originally hoped as there had been an incorrect focus within the original process which had now switched to pulling people from hospital wards when appropriate and safe to minimise their stay. Whilst the DTA process was much more effective front of house within the hospital environment, a whole system approach to this was needed with more responsive community services essential to its further success.

Members were informed of a range of additional initiatives which complimented the DTA process including the use of discharge co-ordinators; more focussed multi agency disciplinary team meetings; the use of discharge lounges at UHND and the introduction of a senior review process which sought to escalate issues up to senior management.

Councillor Robinson referred to concerns raised at a number of County Durham Adults Wellbeing and Health Overview and Scrutiny Committee meetings regarding excessive delays in ambulance turnaround times at A&E departments and suggested that the discharge to assess process could free up much needed beds for speedier admissions. He also raised concerns around the move from Acute Hospital beds to step down intermediate care beds where these may be within different STP footprints – the example given was for Acute Stroke at UHND. In response, Stewart Findlay, DDES CCG stressed that any requirements for such step down arrangements would be made on the basis of need and appropriateness and not be restricted by STP footprint boundaries.

Councillor Newall referenced the recent closure of the discharge lounge at Darlington Memorial Hospital and what impact that would have upon any discharge to assess process within the hospital. Dr Steel indicated that the discharge lounge had not closed but was not available on a 24/7 basis. Councillor Newall asked if it was intended that the lounge would return to 24/7 operation in the future and Dr Steel confirmed that this was to be tested during County Durham and Darlington FT's "perfect week".

Councillor Taylor suggested that the hours of operation for DMH's discharge lounge were changed because of blockages being experienced in the discharge system but suggested that there was a problem within the Trust/CCG around managing messages in respect of the facility. Dr Steel indicated that discharge lounges were not suitable for all patients and work was ongoing to streamline all of the discharge processes. She indicated that the use of discharge lounges, where appropriate did free up beds on inpatient wards.

Councillor Martin Wells reiterated the importance of having appropriate staff in post to deliver health and social care services in both acute and community settings. He considered one of the key issues facing the Better Health Programme was winning over public confidence and trust in both politicians and the NHS.

Councillor Scott referred to the 2015/16 Quality Accounts for County Durham and Darlington NHS Foundation Trust which included discharge summaries and post discharge surveys as key priorities within the document. She asked when the Discharge to assess pilot would be subjected to evaluation and suggested that the results of the evaluation be considered at a future meeting of this Committee.

(v) Integrated Personalised Commissioning

Graham Niven, Chief Finance Officer, Hartlepool and Stockton CCG and Sue Reay, Better Care Fund Transformation Team, Stockton on Tees Borough Council gave a presentation in respect of integrated personalised Commissioning.

Members were informed that Integrated Personal Commissioning was a new voluntary approach to joining up health and social care for people with complex needs. It was a mechanism of utilising Personal Health Budgets and the STP has committed to increasing the use of these to enable improved choice and control of peoples' care

Developed between NHS England and the Local Government Association, the Integrated Personal Commissioning Programme was announced in July 2014 and Stockton-on-Tees was the only area in the North East of England invited to join the first wave of demonstrator sites for the programme.

The Integrated Personal Commissioning programme will offer service users with complex needs the ability to tailor their support and care in ways that are effective, beneficial and meaningful to their lives; giving the individual a say in the way their care budget is spent to achieve better health, care and independence.

Local authorities and NHS service providers are offered support to address systematic barriers to change, and the voluntary and community sector will be a key partner in designing and delivering effective, target oriented approaches to supporting individuals, encouraging cultural change and aiding their service users.

The Integrated Personal Commissioning programme facilitates a shift in power to individuals and their carers in self-determination of their health and care with the programme being aimed at individuals who have high levels of need, who often have health, social care and support needs where a personalised approach would address barriers and problems identified in the current, traditional care provision.

The Stockton on Tees IPC partnership consists of Catalyst (Stockton on Tees) a CVS Organisation; Hartlepool and Stockton-on-Tees CCG; North Tees and Hartlepool NHS Foundation Trust and Stockton-on-Tees Borough Council. The programme's cohort of patients focussed on people aged over 65 with Long Term Conditions. Phase 1 consists of people with respiratory conditions particularly COPD. The second phase focusses on people with diabetes.

Key achievements identified for the programme so far included:-

- Creation of an integrated care plan with Adult social care, Primary Care, Community Services, Acute Services and the VCSE
- Creation of IT solutions with online accessible care plans that can be shared with professionals
- 163 Integrated Personalised Care and Support plans completed with a target set of 4000 for the next 12 months
- 24 new Personal Health Budgets
- Linked dataset – the first in the country to allow health and social care data to be used together for secondary use purposes
- Developed community assets and peer support with the VCSE – a new Breath Ease group has been established in partnership with NTHFT and Age UK

Graham Niven reported that in partnership with the nations IPC and local leadership, Stockton was selected for the Nesta 100 day challenge aimed at increasing integrated personalised commissioning across the area. The Challenge was launched in January 2017 with three multi-disciplinary teams focussed on improving care and outcomes for frail people aged 65 and over.

Sue Reay then explained the Stockton wellbeing model of care which provides a multi-disciplinary service for holistic assessment to over 65s for early intervention and prevention prior to the formal assessment process for a social care package. The single point of access model involves an initial triage process prior to a programme of up to six weeks' support and services aimed at early intervention. She indicated that since the model of care had been introduced in 2015 only 5% of people had gone on to receive a social care package.

Reference was also made to the McKenzie Group practice pilot which uses a multi-disciplinary team approach to look at admission avoidance in Hartlepool pulling together district nurses, GPs, community matrons, therapy staff, social acre and primary care co-ordinators.

In the discussion which followed, Councillor Martin Wells asked how the CVS organisation would receive support to deliver the programme. Graham Niven indicated that they had access to Better Care Fund resources. In response to a question from Cllr Scott, Mr Nixon stated that at the moment it was only IT systems that were linked/shared rather than budgets although should a health and social care service need be identified as part of the project, then there were resources available across a range of funding streams to provide options/choice to patients on their preferred care plan options.

In response to a query about the need for data sharing permissions to be obtained regarding patient data, it was reported that this was due to existing data protection and information governance regulations.

(vi) Supporting the Frail Elderly

Gill Collinson, Chief Nurse, Hambleton, Richmondshire and Whitby CCG and Mike Webster, Assistant Director for Contracting, Procurement and Quality Assurance, North Yorkshire County Council gave a joint presentation to members regarding work being undertaken to support the frail elderly across North Yorkshire.

Reference was made to the "Fit 4 the future" clinical summit held on 25 November 2015 in partnership involving Hambleton, Richmondshire and Whitby CCG, South Tees Hospitals NHS Foundation Trust, HeartBeat Alliance, North Yorkshire County Council and Tees, Esk and Wear Valleys NHS Foundation Trust.

The event brought together over 200 clinical professionals including GPs, hospital consultants, nurses, therapists and social care colleagues from across Hambleton and Richmondshire to discuss, influence and help shape how health and social care can be delivered effectively and sustainably in the future.

The key objectives of the event were:

- to understand the challenges that face this health economy with a focus on Rural Care, Urgent Care, Technology in Health and Care of the Frail Elderly, from a range of perspectives,
- to bring clinicians and other professionals together to share views and experiences
- to identify the key opportunities for resolving the challenges and to start to create a shared vision of care delivery across Hambleton and Richmondshire.

Members were informed of a number of achievements which had resulted from the summit which included:-

- £2.7m in investment in primary/community care
- Trusted relationships across primary, community, secondary and social care
- Regular locality Multi-disciplinary Team meetings
- Implementation of new model of integrated locality working across 8 localities,
- New model of community step up/step down bed provision
- New adult social care model beginning in April 2017

Mike Webster indicated that there were two key elements to the changes proposed, namely that things will be done differently and that there will be efficiencies delivered to reflect the reductions in local authority budget reductions and austerity.

Reference was made to the Assessment pathway project which sought to transform the social care offer and to the principles underpinning the project. Mr Webster reported that to ensure people were safe and independent they would have greater access to re-ablement resources to reduce or delay their need for care and support, and provide them with access to appropriate equipment.

Mr Webster stated that the need for additional health services, including admissions to hospital will be prevented, reduced and delayed. He suggested that Carers will be healthy and experience wellbeing and will report improved quality of life, feeling safe and a feeling of choice and control. It was also envisaged that people will report improved quality of life and satisfaction in their level of social contact and also be able to exercise both choice and control over decisions which impact them personally.

The way in which services operate would be informed by service users and carers as partner-experts by experience with all new services being designed through co-production. These services will be commissioned on an integrated basis with the NHS and delivered at or near to home, based around identifiable communities and clusters of GP practices.

Gill Collinson then presented the new pathway supporting the frail elderly which centred on getting people back to their homes as early and safely as possible. Issues considered included the desire of patients to choose to end their life at home and what NHS/Social Care providers and commissioners

could put in place to facilitate this. Reference was made to the health/social care providers being too risk averse in acceding to such requests.

Key features of the new Frailty operating model included a single Customer Service Centre (CSC) which would be dedicated point of access for the public, an initial point of contact for professionals into adult social care in North Yorkshire and, where possible, maximising opportunities to respond to enquiries at this point, which will include Adult Social Care Professionals being based in CSC, on-line assessments for some areas, validation of assessment and resolution at CSC (e.g. simple equipment).

Independence and re-ablement provision would focus on supporting individuals to maximise their independence, including preventing unnecessary hospital admission and premature admission to long term residential care, providing early well planned safe discharge from hospital and a rapid response to urgent need. This would include a period of re-ablement for those known to services who are identified as having re-ablement potential

Planned Care and Support services would support people with long term social care and support needs as well as supporting their carers through better care co-ordination, support interventions and through commissioned services. The provision of support will include Deprivation of Liberties, Best Interest Assessments and Safeguarding Investigations (enquiries).

Members were advised that in view of the rurality of the area covered by the Frailty pathway, there were concerns about the robustness of the independent care provider sector. Therefore a more defined structure over provider services had been proposed, which includes Elderly Persons Homes, Respite Services, Day Centres, and Personal Care at Home Services linked to Extra Care schemes. The Personal Care at Home (PCAH) Service will be a defined and separate service from the Re-ablement Workers.

Members were advised that along with the other presentations given, the key to the success of the Frailty pathway was the ability of integrated health and social care teams and service provision to admit people to hospital when clinically necessary and to discharge patients back to their homes/community service provision when appropriate and safe to do so.

In response to a question from Councillor Cook, Mr Webster confirmed that the new frailty care pathway was due to commence in April 2017.

The Chairman then thanked all of the officers present for their presentations and input in to the session and then invited the Committee to consider the recommendations within the report of the Principal Overview and Scrutiny Officer. At the conclusion of the discussions its was

AGREED that**:**

1. The information in the report and presentations be received and comments made by the Committee noted;
2. A report on the outcomes from the Communities and Neighbourhoods workshop referenced in Jane Robinson’s presentation be brought back to a future meeting of this Committee;

3. The evaluation report into the Discharge to Assess pilot being undertaken within County Durham referenced in Lesley Jeavon's presentation be brought back to a future meeting of this Committee

6. Better Health Programme – Developing a communications and engagement plan to support public consultation

Consideration was given to the report of Edmund Lovell, Communications and Engagement lead for the Better Health Programme which outlined preparations for the development of a communications and engagement plan to support statutory public consultation for the Better Health Programme.

The report set out the context within which consultation in respect of the Better Health Programme would take place, including the relationship between the BHP and the Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP. The public consultation would now take place from September 2017 to avoid the summer period.

Members were reminded that the NHS Act 2006 (as amended by the Health and Social Care Act 2012) sets out duties for CCGs around involvement and consultation. As such, NHS organisations have to ensure that patients and the public are properly involved in the planning and development of health services. They must also consult with the relevant local authorities' overview and scrutiny committees over any changes which could be considered to be substantial variations in the way services are provided. Organisations must also ensure that engagement and consultation activities are in line with the Equality Act 2010.

Mr Lovell indicated that when planning any service changes NHS organisations must also undergo a comprehensive programme of assurance by NHS England, which includes complying with four tests, two of which have implications for involvement and consultation (i.e. the first and fourth tests). The four tests are:

- Strong patient and public engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support for proposals from commissioners.

Reference was made to a series of reports and presentations given to the Better Health Programme Joint Health OSC to date regarding engagement activity that had been carried out to date. Members were advised that learning from all of this engagement activity was being used to shape a communications and engagement plan for formal public consultation.

Mr Lovell indicated that the objectives of the communications and engagement plan for consultation would include:

- Ensuring that public and stakeholders have an opportunity to comment on proposals for change, so that feedback can be used to inform the decision making process
- Making sure that the consultation is inclusive and provides opportunities for involvement by a diverse range of stakeholders and the public
- Including the public and stakeholder voice in the BHP
- Ensuring a high level of awareness and understanding of why changes are being proposed
- Ensuring that all steps are taken to maintain public confidence in the process, and in the future shape of services
- Meeting statutory requirements around consultation.

He also stated that some key messages were being developed which will be included in all public information supporting the consultation. These have been subject to discussions with clinical leaders and they are now being 'road-tested' with representatives from patient and community groups, whose comments will be taken into account. Their views are also being sought on how best to present these messages (i.e. in terms of format and visuals). The aim is to ensure that these messages are easy to understand for the general public and that they are presented in a way that is helpful.

The Joint Committee was invited to consider and comment on the proposals set out within the report in respect of the methodology for consultation, communications and engagement. Mr Lovell advised that a pre-consultation business case for the STP and the Better Health Programme element of that, together with options for future service provision and the results of the engagement activity undertaken so far would be produced.

The methodology set out how consultation would be undertaken with patients, carers and the public; NHS Staff and organisations and statutory bodies, including health scrutiny committees. For patients, carers and the public, a number of methods would be used including formal consultation documents; summary leaflets/flyers/posters; short video presentations; weblinks to further supporting information; structured public engagement events utilising a range of community assets and supported by the Community and Voluntary sector; targeted drop in sessions and roadshows; local and regional media, an advertising campaign and a digital media strategy.

Councillor Martin Wells emphasised that the most important aspect of the consultation process was to clarify exactly what was being consulted upon and to manage public expectations of the process and avoid any element of confusion. The frequent and interwoven references to STPs, the Better Health Programme, Not in Hospital services, Neighbourhood and community services all needed to be clearly set out within all consultation, communications and engagement material. He also suggested getting lay peoples' views on the proposed consultation material when drafted.

Mr Lovell sought the Committee's input in ensuring that the correct messages were being put out as part of the consultation process as well as the draft documentation when finalised.

Cllr Bailey suggested that when consideration was being given to the locations for roadshows, formal consultation events and drop in sessions, local Councillors be engaged in this process.

Cllr Temple encouraged the Better Health Programme Board to ensure that there was sufficient clarity within the consultation documents and that they set out the rationale for change as there was some scepticism amongst Councillors and the general public that these changes were being driven by financial pressures. Accordingly, and given the absence of any degree of detail surrounding the cost implications for the NHS and Local Government of the STPs and Better Health programme proposals, he asked that relevant financial information was included within the consultation documentation.

Councillor Tostevin highlighted concerns about the cost of the engagement activity undertaken so far. Mr Lovell stated that the costs of this work had been budgeted at £500,000 for 2015/16 and that the actual costs of the work was under budget.

In response to a query form Councillor Cook regarding the number of people who had participated in the engagement activity so far, Mr Lovell indicated that the Programme Board were happy with these numbers although it was expected that numbers would increase once formal consultation was commenced and clarity given on potential service changes.

Agreed that

(i) the report be received;
(ii) assurances be sought from the Better Health Programme Board that the Better Health Programme Joint Health OSC will be engaged in the development of consultation, engagement and communications plans for statutory public consultation;
(iii) a further report providing details of the draft communications, engagement and consultation plans and associated documentation be brought to a meeting of this Joint Committee in June 2017.

7. Chairman's urgent items

The Chairman had no urgent items.

8. Any other business

There had been no items identified.

9. Date and time of next meeting

The Principal Overview and Scrutiny Officer, Durham County Council reported that in view of the forthcoming mayoral and Council elections and the onset of purdah, it was anticipated that the next meeting of the Committee would be held in early June 2017. He asked that constituent authorities advise him of

their appointed representation to the Joint Committee as soon as possible to enable an early meeting of the Committee to be convened.

The meeting ended at 4.45 pm.

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Better Health Programme Joint Health Scrutiny Committee

Better Health Programme Joint Health Scrutiny Committee

10 July 2017

Proposed re-designation of the Better Health Programme Joint Health Scrutiny Committee

Report of Principal Overview and Scrutiny Officer, Durham County Council

Purpose of the Report

1 This report invites members to agree to the re-designation of the Better Health Programme Joint Health Scrutiny Committee previously established under the provisions of the Health and Social Care Act 2012 to incorporate joint local authority scrutiny of the Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby Sustainability and Transformation Plan and any associated service review proposals.

Background

2 During 2016 the establishment of the Better Health Programme Joint Health Scrutiny Committee was agreed consisting of representatives from each of Darlington Borough Council, Durham County Council, North Yorkshire County Council, Hartlepool Borough Council, Middlesbrough Borough Council, Redcar and Cleveland Borough Council and Stockton-upon-Tees Borough Council.

3 To date, the Better Health Programme Joint Health Scrutiny Committee has met on 7 occasions to consider proposals being developed under the programme.

Sustainability and Transformation Plans

4 In December 2015, the NHS shared planning guidance 2016/17 – 2020/21 outlined a new approach to help ensure that health and care services were built around the needs of local populations. To do this, every health and care system in England, involving local organisations such as NHS providers, commissioners, and local authorities, were asked to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services

would evolve and become sustainable over the next five years – ultimately delivering the NHS Five Year Forward View vision of better health, better patient care and improved NHS efficiency

5 The North East is covered by two separate STPs. The Northumberland, Tyne and Wear and North Durham STP and the Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP.

6 The Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP covers the footprint of the Better Health Programme.

7 NHS system leaders met to discuss how best to create these plans, reflecting on the work that has already been developed in a number of areas across the North East and Cumbria and the STP draft documents were submitted to NHS England in October 2016.

8 The two draft STPs were published in November 2016.

Implications for the Better Health Programme of STP Development

9 During consideration of the Better Health Programme development and associated proposals by the Better Health Programme Joint Health Scrutiny Committee, a number of presentations have been given in respect of the emerging Durham Darlington and Teesside, Hambleton Richmondshire and Whitby Sustainability and Transformation Plan.

10 The Joint Committee have been advised that the work undertaken as part of the Better Health programme features within the STP as part of the "Quality of Care in our hospitals" theme as well as the "Health and care in communities and neighbourhoods" and that there will be a statutory requirement for consultation in respect of the draft STP.

11 Accordingly, the Better Health Programme Joint Health Scrutiny Committee is invited to consider the potential for the Committee's remit to be broadened to include the draft STP documents and any associated proposals for significant developments or service variations arising therefrom.

Redesignation of the former Better Health Programme Joint Health Scrutiny Committee

12 In view of the integration of the Better Health Programme and the Durham Darlington and Teesside, Hambleton, Richmondshire and Whitby STP, it is proposed that the Better Health Programme Joint Health OSC be re-designated the Durham, Darlington and Teesside Hambleton, Richmondshire and Whitby Sustainability and Transformation Plan Joint Scrutiny Committee.

13 In accordance with the regulations detailed within this report, the new Joint Committee will be the vehicle through which the respective local authorities will respond to the consultation.

14 Accordingly, it is for individual member council's designated Health Overview and Scrutiny Committee to provide information and representations in respect of any consultation as it impacts upon their residents to the Joint Health OSC via its nominated representatives.

15 The protocol and terms of reference for the revised Joint Health Scrutiny Committee have been drafted by health scrutiny officers across the respective local authorities setting out the updated role and function of the joint committee as well as the proposed representation required from each council. These are attached to this report (Appendix 2).

16 It is proposed that the councils' representatives appointed to the Better Health Programme Joint Health OSC would assume the positions on the re-designated Durham, Darlington, and Teesside, Hambleton Richmondshire and Whitby Sustainability and Transformation Plan Joint Health Scrutiny Committee.

Provisions for consultation and engagement of Overview and Scrutiny Committees

17 The Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 require the formation of a joint scrutiny arrangement, where an NHS body or relevant health service provider consults more than one local authority on proposals to make substantial variations or developments to services. They provide that all the local authorities whose residents receive such services must participate in the joint scrutiny arrangement for the purpose of responding to the consultation, using the method most appropriate to the areas and issues being considered.

18 A local authority can opt-out if, having considered the information provided by the NHS body or relevant health service provider proposing the service change, they determine that the proposal is not "substantial" for their residents. Where a local authority opts out in this way, they will relinquish the power to refer the proposed change to the Secretary of State for the purposes of that particular consultation.

19 Only the joint scrutiny committee may require the organisation proposing the change to provide information to them, or attend before them to answer questions. That organisation is under a duty to comply with these requirements. If a local authority has opted out of the joint arrangement, they may not request information or attendance from the NHS body or relevant health service provider proposing the change. Failure by an NHS body or relevant health service provider to provide information requested by a local authority who is not participating in the joint scrutiny process and who is therefore not entitled to that information does not constitute a failure to consult that authority and is therefore not a valid reason for a referral to be made to Secretary of State.

20 They may not participate further in the joint scrutiny arrangements, unless changes occur during the development of proposals that make the impact substantial for residents in the local authority's area. The local authority, in these cases, should not expect to revisit any matters that the joint committee has already considered.

21 In scrutinising the proposals, the joint committee should aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal. The provisions of co-option set out above apply, enabling the involvement of district councils in the scrutiny process.

22 Only the joint scrutiny arrangement can then make a report and recommendations back to the organisation proposing the change. The power to refer to Secretary of State should only be exercised once the NHS body or relevant health service provider proposing the service change has responded to the comments of the joint scrutiny committee and all forms of local resolution have been exhausted. However, it can be exercised by any of local authorities originally consulted or by the joint arrangement where the power to refer has been delegated to it.

23 This joint committee does not have the power of referral to the Secretary of State delegated to it and it is proposed that the re-designated committee will not have this power either.

Recommendations and reasons

24 The Better Health Programme Joint Overview and Scrutiny Committee is recommended to:-

(a) Receive and comment upon the information detailed within the report;

(b) Agree to the re-designation of the Better Health Programme Joint Health OSC to the Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby Joint Health Overview and Scrutiny Committee under the terms of the Health and Social Care Act 2012 as set out in this report;

(c) Agree the proposed protocol, terms of reference and membership of the re-designated Joint Health Scrutiny Committee.

Background papers

None

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer, Durham County Council Tel: 03000 268140

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – None

Procurement - None

Disability Issues - None

Legal Implications – None

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APPENDIX 2

Protocol for a Joint Health Scrutiny Committee

Durham Darlington Teesside Hambleton Richmondshire and Whitby STP

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for considering and providing a formal consultation response in relation to the Durham Darlington and Teesside Hambleton Richmondshire and Whitby Sustainability and Transformation Plan and any associated proposals for substantial development and variation to health services contained therein or resulting therefrom. The proposals affect the Durham Dales, Easington and Sedgefield CCG area of County Durham, the Tees Valley region and the Hambleton, Richmondshire and Whitby CCG area of North Yorkshire. They are being proposed by the following:

   - Darlington Clinical Commissioning Group (CCG);
   - Durham Dales, Easington and Sedgefield CCG;
   - Hartlepool and Stockton-on-Tees CCG;
   - South Tees CCG;
   - Hambleton, Richmondshire and Whitby CCG

2. The terms of reference of the Joint Health Scrutiny Committee is set out at **Appendix A**.

3. A Joint Health Scrutiny Committee ("the Joint Committee") comprising Darlington BC; Durham County Council, Hartlepool BC, Middlesbrough BC, North Yorkshire County Council, Redcar and Cleveland BC; and Stockton-on-Tees BC ("the constituent authorities") has been established in accordance with the Regulations for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraphs 1. In particular in order to be able to:-

   (a) respond to the consultation

   (b) require the relevant NHS Bodies to provide information about the proposals;

   (c) require members/employees of the relevant NHS Bodies to attend before it to answer questions in connection with the consultation.

4. The Joint Committee formed for the purpose of the consultation outlined at paragraph 1 will, following approval of this protocol and terms of reference at its first meeting, circulate copies of the same to:-

   Local Authorities

   Darlington Borough Council (BC); Durham County Council, Hartlepool BC, Middlesbrough BC, North Yorkshire County Council, Redcar and Cleveland BC and Stockton-on-Tees BC;

   Clinical Commissioning Groups
   Darlington; Durham Dales, Easington and Sedgefield; Hartlepool and Stockton-on-Tees; South Tees and Hambleton, Richmondshire and Whitby.

NHS Foundation Trusts

County Durham and Darlington NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
North East Ambulance Foundation Trust

Membership

5. The Joint Committee will consist of equal representation, with three non-executive representatives to be appointed by each of the constituent authorities.

6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority's next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the joint committee secretariat and the replacement representative shall serve for the remainder of the original representative's term of office.

7. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all the constituent authorities, those authorities operating a substitution system shall be entitled to nominate substitutes.

8. The Joint Committee may ask individuals to assist it (in a non-voting capacity) and may ask independent professionals to advise it for the purposes of the consultation process.

9. The quorum for meetings of the Joint Committee shall be a minimum of one member representative from each of the constituent authorities.

Chair and Vice-Chair

10. The Chair of the Joint Committee will be a Member representative from [XXXX] and the Vice-Chair will be a Member representative from [XXXX]. The Chair will not have a second or casting vote.

11. If the agreed Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to chair that meeting from the representatives present who are members of the same constituent Council as the Chair.

Terms of Reference

12. The Joint Committee will be the formal consultee under the Regulations and the Directions for the purposes of the consultation by the relevant NHS Bodies concerning those matters outlined at paragraphs 1. Terms of reference are set out at Appendix 1.

Administration

13. Meetings shall be held at the times, dates and places determined by the Chair in consultation with each of the constituent authorities.

14. Agendas for meetings shall be determined by the secretariat in consultation with the Chair.

15. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee at least 5 clear working days before the date of the meeting and also to the Chair of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" should be avoided where possible.

16. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

Final Report and Consultation Response

17. The relevant NHS body are required to notify the Joint Committee of the date by which its consultation response is required, and the date by which it intends to make a decision. The Guidance highlights that it is sensible for the Joint Committee to be able to consider the outcome of public consultation before its makes its consultation response.

17. The Joint Committee is independent of its constituent councils, executives and political groups and this independence should not be compromised by any member, officer or relevant NHS bodies. The Joint Committee will send copies of its final report and formal consultation response to the relevant NHS Bodies and the constituent authorities.

18. The primary objectives of the Joint Committee will be to reach consensus, but where there are any aspects of the consultation as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Following the Consultation

19. Any next steps following the initial consultation response will be taken with due reference to the 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny' (Department of Health; June 2014).

Principles for joint health scrutiny

20. In scrutinising the proposals, the joint committee will aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal.

21. The constituent authorities and the relevant NHS Bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct.

Personal and prejudicial and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

22. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.

23. Communication with the media in connection with the Joint Committee's views will be handled in conjunction with each of the constituent local authorities' press officers.

Appendix A

Joint Health Scrutiny Committee

Durham Darlington Teesside Hambleton Richmondshire and Whitby STP

Terms of Reference

1. To consider the draft Durham Darlington Teesside Hambleton Richmondshire and Whitby STP (hereafter called STP)

2. To consider proposals for substantial development and variation to health services as contained in and/ or developed from the STP and as proposed by the following:

   a) Darlington Clinical Commissioning Group (CCG);
   b) Durham Dales, Easington and Sedgefield CCG;
   c) Hartlepool and Stockton-on-Tees CCG;
   d) South Tees CCG;
   e) Hambleton Richmondshire and Whitby CCG.

3. To consider the following in advance of the formal public consultation:

   - The aims and objectives of the STP, the constituent workstreams therein including those proposals formerly developed as part of the Better Health Programme;
   - The plans and proposals for public and stakeholder consultation and engagement;
   - Any options for service change identified as part of the STP including those considerations made as part of any associated options appraisal process.

4. To consider the STP's substantive proposals during the period of formal public consultation, and produce a formal consultation response, in accordance with the protocol for the Joint Health Scrutiny Committee and the consultation timetable established by the relevant NHS Bodies.

5. In order to be able to formulate and provide views to the relevant NHS bodies on the matters outlined above, the Joint Committee may:-

   a) require the relevant NHS Bodies to provide information about the proposals the subject of the consultation with the constituent local authorities and the Joint Committee; and

   b) require an officer of the relevant NHS Bodies to attend meetings of the Joint Committee, in order to answer such questions as appear to them to be necessary for the discharge of their functions in connection with the consultation.

6. To ensure the formal consultation response of the Joint Committee includes, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

7. To oversee the implementation of any proposed service changes agreed as part of the STP/Better Health Programme process.

8. The Joint Committee does not have the power of referral to the Secretary of State.

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explain
market research

NHS Better Health Programme

Maternity services pre-consultation research

June 2017

Version 3

Executive summary

Explain was commissioned by the Better Health Programme in February 2017 to conduct a programme of independent pre-consultation research. The focus of this strand was local maternity services, which are likely to see changes as part of a reconfiguration of services across the County Durham, Tees Valley and North Yorkshire region.

The key objectives of the research were to gain an understanding of the priorities of local women in relation to maternity services, to understand feelings about travelling for delivery and specialist care, and to identify any concerns about possible changes in service provision.

An on-street interviewing methodology was adopted to engage with a mix of mothers of children aged five and under, and local women who planned to have children in the future (considered 'future mothers' for this research). Interviews were conducted across a wide range of locations and 946 mothers and future mothers were engaged in the research in total, of a mix of age and socioeconomic groups.

Results

Antenatal and postnatal care

- 27% of women interviewed ranked 'availability of staff with the right skills and experience' their number one priority, 24% considered their top priority to be 'distance to travel', while 17% overall felt it was most important to have all of your care before and after birth led by the same small team of midwives

Overall, factors relating to antenatal and postnatal care were ranked by respondents from highest to lowest priority as follows:

1. Availability of staff with the right skills and experience
2. Caring and compassionate staff
3. Having a range of different services available under one roof
4. Distance to travel
5. Having all of your care before and after giving birth led by the same small team of midwives
6. Flexible appointment times
7. Ease of access

- Suggestions for other services which could be provided in community settings included family planning (16), support for postnatal depression (12), and baby clinics (7)

Labour and delivery

- 28% of respondents considered 'availability of consultant doctors' as their highest priority during labour, while a further 28% prioritised 'distance to travel to your delivery setting'

Overall, factors relating to care during labour and delivery were ranked by respondents from highest to lowest priority as follows:

1. Availability of consultant doctors
2. Range of pain relief available
3. Having your baby delivered by the same small team of midwives who provided care during pregnancy
4. Distance to travel to your delivery setting
5. Pleasant and relaxing environment
6. Facilities for birthing partners, including somewhere to stay
7. Availability of birthing pools

Overall, respondents ranked their first preference of delivery setting as follows:

1. Alongside midwife-led unit (52%)
2. Consultant-led unit (26%)
3. Standalone midwife-led unit (13%)
4. Home birth (10%)

- Over half (59%) of respondents would expect to travel 16 to 30 minutes to a unit to give birth
- A majority (94%) of women interviewed reported that they would be willing to travel further for specialist care should this be required
- A majority (93%) of respondents did not have concerns about the possible changes to local maternity services

Conclusions

Similarities were seen in terms of the priorities of local women in relation to antenatal and postnatal care, and their labour and delivery. At all points of their pregnancy journey, the availability of staff possessing skills and experience was a key priority. A strong preference was seen for the alongside midwife-led delivery setting.

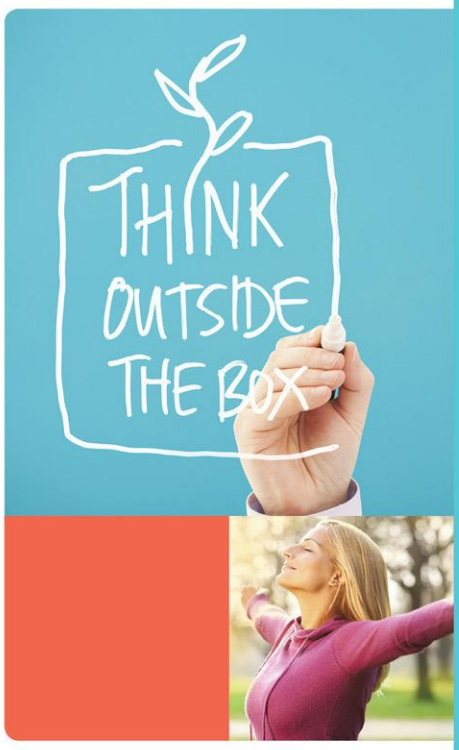
'Distance to travel' divided respondents, with this being either a very high priority or a very low priority for both antenatal and postnatal care and during labour and delivery, and was influenced by where they currently lived. Proximity to their home also played a key role for respondents when faced with a decision between two consultant-led units in two different towns.

When introduced to the possible changes in local maternity services, a majority of respondents (93%) would not have any concerns about these. For those who did have concerns, these were centred on the distance which may be required to travel to receive care, the potential for overcrowding, and some felt more broadly that services should not be taken away from local areas.

Content page

1.0 Introduction

An overview of the project background and methodology.



Project background

Explain was commissioned by the Better Health Programme in February 2017 to provide reliable independent research at the pre-consultation stage of a significant programme of service change.

Under the Better Health Programme, now part of a Sustainability and Transformation Plan (STP), NHS organisations across County Durham and Teesside have been working together to understand how care is provided across the region, to ensure local services provide the best possible care for the future.

As part of this reconfiguration of hospital services in the Tees Valley, changes are likely to be made in the way maternity services are provided. Independent research was therefore commissioned to inform the group's work in shaping these services in the future, and to build on the findings of ongoing local engagement activities.

The key objectives of the research were as follows:

- Understand the priorities of local people who might use maternity services when it comes to maternity care
- Identify any potential concerns about changes in service provision
- Understand how local people feel about travelling for specialist care and any perceived barriers this would present
- Understand likely future behaviours in relation to use of maternity care services

Methodology

Explain's in-depth experience of maternity services research provided an opportunity to build upon some of the key results and themes of past North East projects, which were used to shape the priorities of this project alongside discussion with the wider Better Health Programme team.

An on-street research methodology was adopted to provide a robust and representative evidence base. This was seen to be the most appropriate approach as it enabled engagement in a wide range of locations within the area covered by the CCGs.

Explain has utilised this on-street methodology a number of times across a range of healthcare projects as it allows us to gain access not just to patients who have had an experience, but also the wider public to understand perceptions of local services within the area. Face to face interviewing allowed us to build rapport with respondents and prompts were utilised in the form of showcards where appropriate, to supplement the questionnaire and ensure all respondents could give informed responses.

Explain's team of Market Research Society (MRS) registered interviewers conducted the surveys across a range of days of the week and times of day to ensure that a representative sample was captured, split equally between mothers of children under the age of six and future mothers.

On-street research was conducted in the following locations and volumes:

CCG	Locations	Number of surveys
NHS Durham Dales, Easington and Sedgefield CCG	Bishop Auckland	232
	Newton Aycliffe	
	Barnard Castle	
	Spennymoor	
	Seaham	
	Sedgefield	
	Crook	
	Peterlee	
NHS Darlington CCG	Darlington Borough	138
NHS Hartlepool and Stockton-on-Tees CCG	Stockton-on-Tees	234
	Hartlepool	
	Thornaby	
	Yarm	
	Eaglescliffe	
NHS South Tees CCG	Middlesbrough (Central)	219
	Skelton/Brotton/Loftus	
	Guisborough	
	Redcar	
	Eston	
NHS Hambleton, Richmondshire and Whitby CCG	Northallerton	123
	Richmond	
	Stokesley	
	Catterick	
	Leyburn	
	Bedale	
	Colburn	
TOTAL INTERVIEWS		946

Notes on analysis

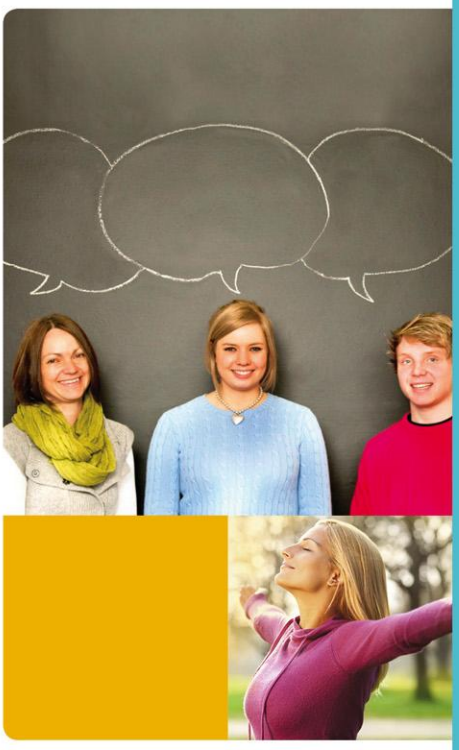
Where comparisons have been drawn between findings based on research locations, please note the fluctuation in base sizes.

'Don't know' responses and 'no replies' have been excluded from analysis. Please note percentages may not add to 100% due to rounding of figures.

Where themes in literal comments have been identified, please note that these are drawn out through analysis and are not pre-determined code frames.

2.0 Respondent profile

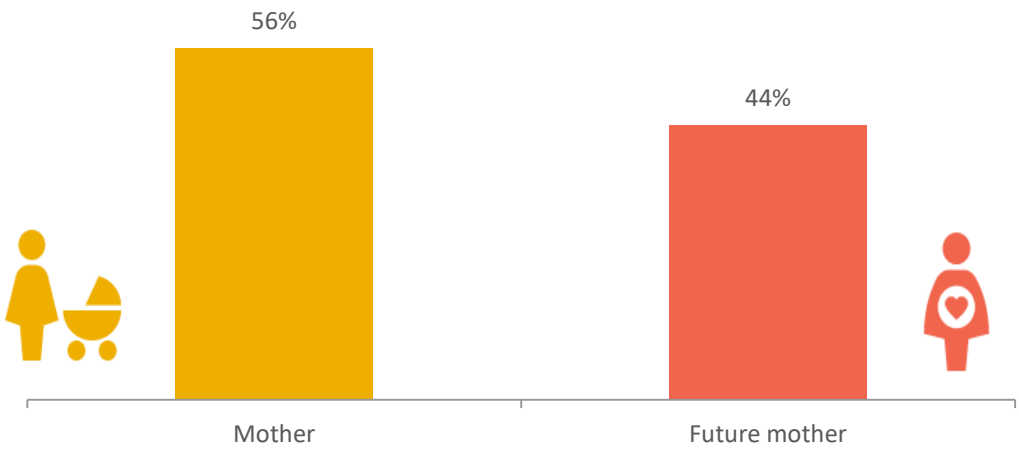
An overview of the profile of respondents who participated in the on-street survey.



Respondent profile

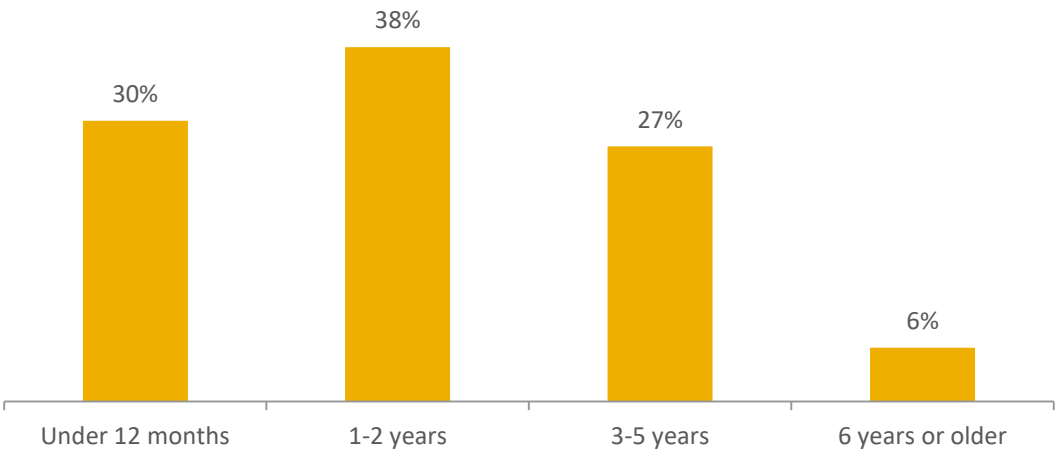
The research was designed to engage with women who were currently a mother to children between newborn and five years of age, and women who planned to have children in the future. Over half of respondents (56%) were currently mothers, while the remaining 44% of those interviewed planned to have children in the future and were therefore considered 'future mothers' for the purposes of this research.

Mother or future mother
(Base size 945)

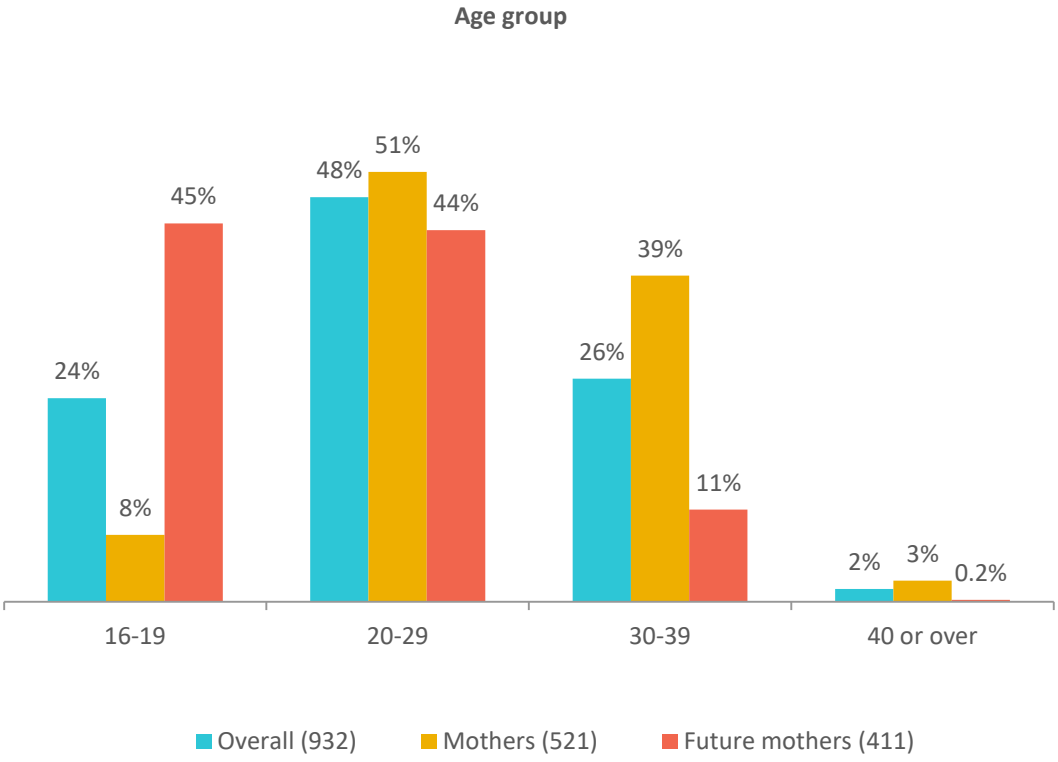


Over a third (38%) of mothers interviewed reported that their youngest child was aged 1-2 years, 30% stated they were under 12 months old, and 27% reported they were between 3 and 5 years of age.

How old is your youngest child? Mothers only
(Base size 562)

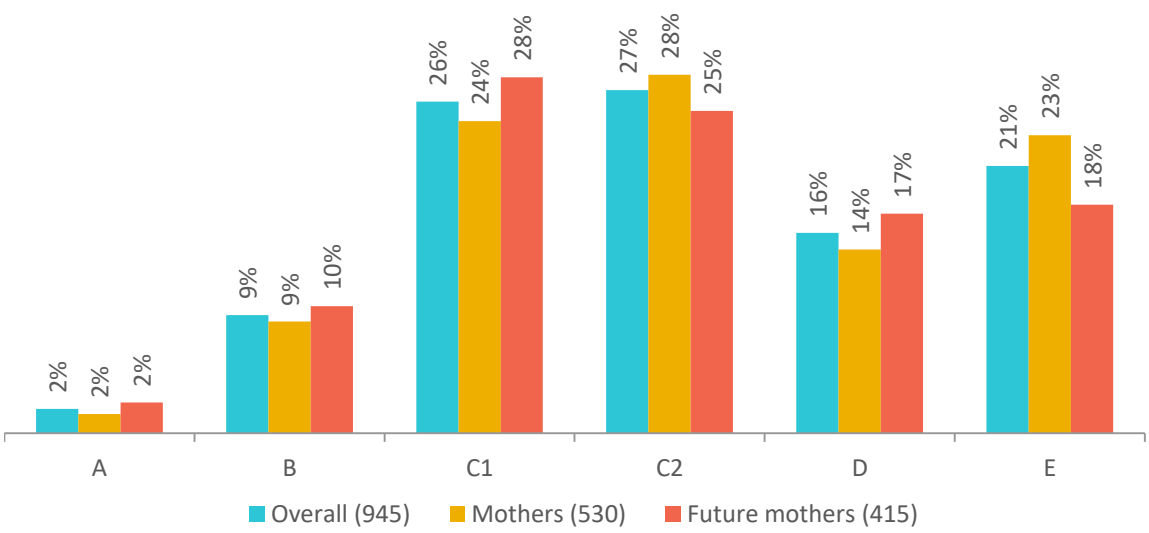


Overall, 48% of women interviewed were aged 20-29; a similar proportion was seen amongst mothers and future mothers. In the younger (16-19) and older (30-39 and 40+) age groups, however, there were significant differences. 45% of future mothers interviewed were aged 16-19, compared to 8% of mothers. 39% of mothers were aged 30-39, compared to 11% of future mothers.



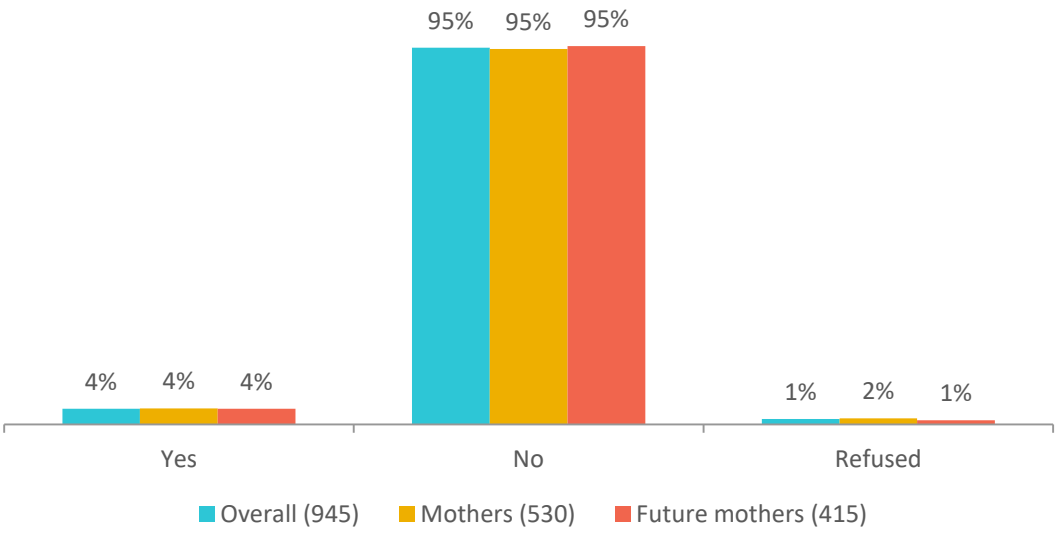
Respondents were asked to identify the occupation of the main wage earner in their household, in order to determine which socioeconomic group they belonged to. Over half of respondents overall (53%) were group C1 or C2, 21% were socioeconomic group E and a further 16% were group D. No quotas were set on socioeconomic group during on-street fieldwork, therefore these results can be considered natural fallout.

Socioeconomic group



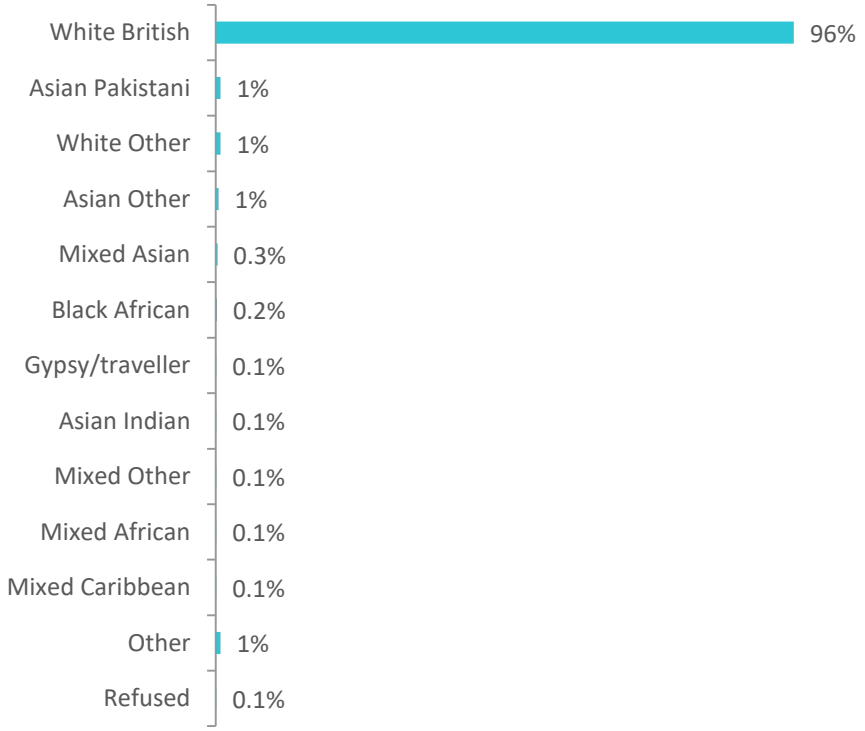
A majority (95%) of all respondents did not have a long term health condition or a disability, while 4% reported that they did.

Do you have any long term health conditions or a disability?



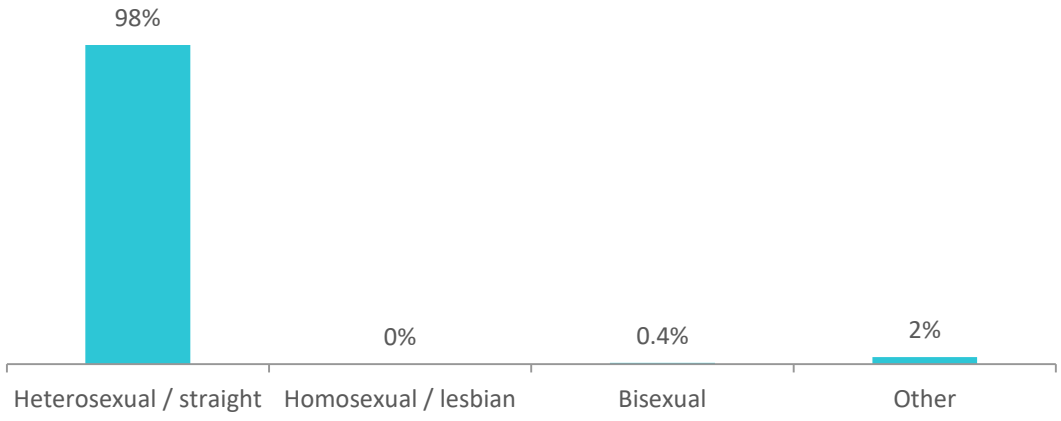
A majority (96%) of respondents described their ethnic origin as 'White British'. A small minority of women interviewed reported their ethnic origin as 'White Other' (1%), Asian Pakistani (1%), 'Asian Other' (1%) and 'Other' (1%).

Ethnic origin
(Base size 946)



A vast majority of respondents (98%) described their sexual orientation as 'heterosexual / straight'. 0.4% considered themselves 'bisexual' and there was one 'other' response provided - "*pansexual*".

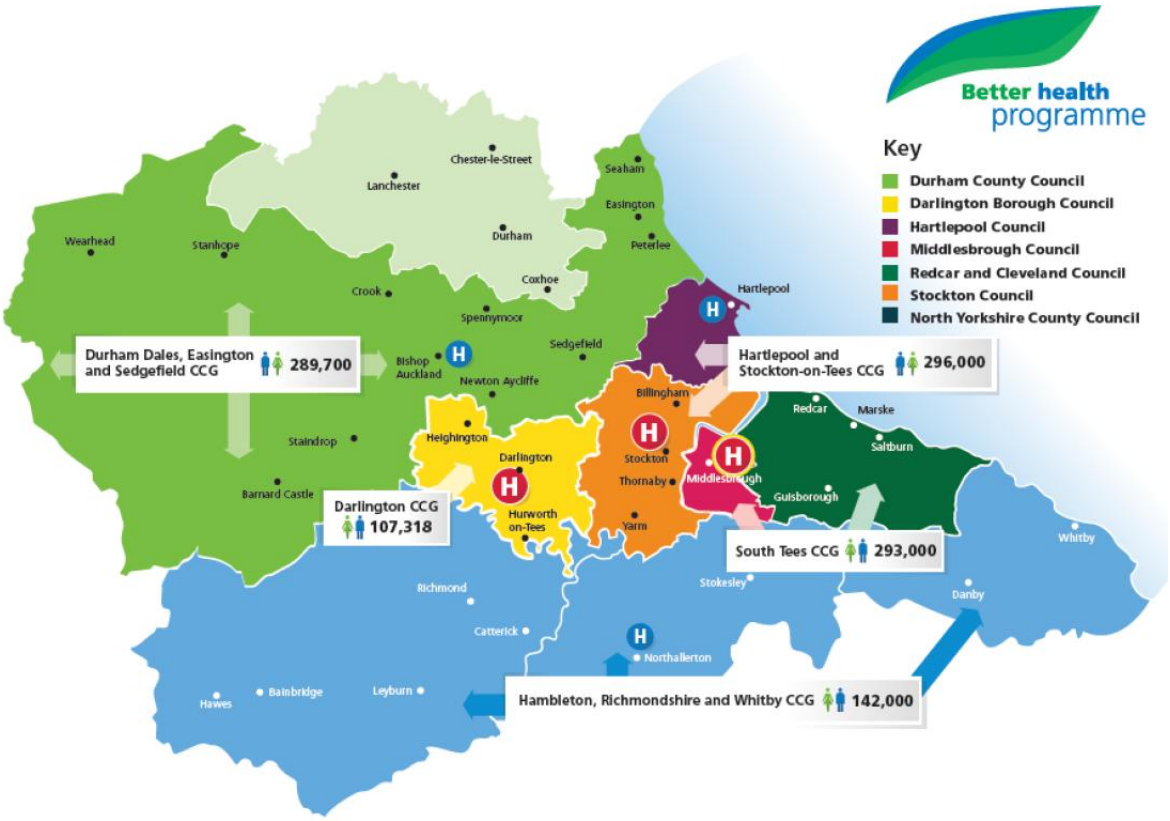
Sexual orientation
(Base size 946)



Local authority area of residence

Respondents were asked to identify the area in which they lived using a map provided on Showcard A.

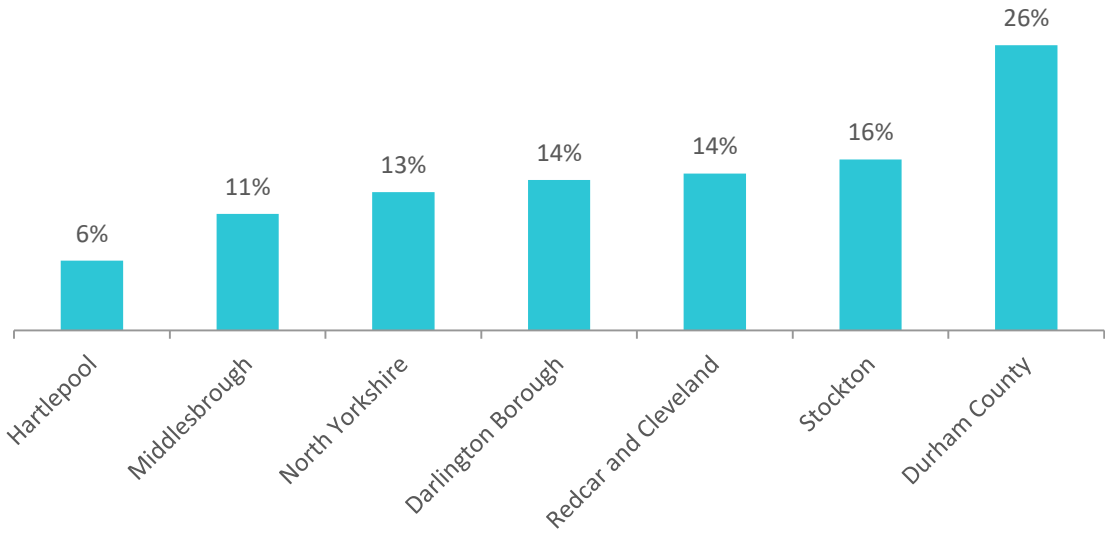
Please note, all showcards used in the on-street research can be found in Appendix Two.



The coloured areas represent the local authority areas within the Better Health Programme patch.

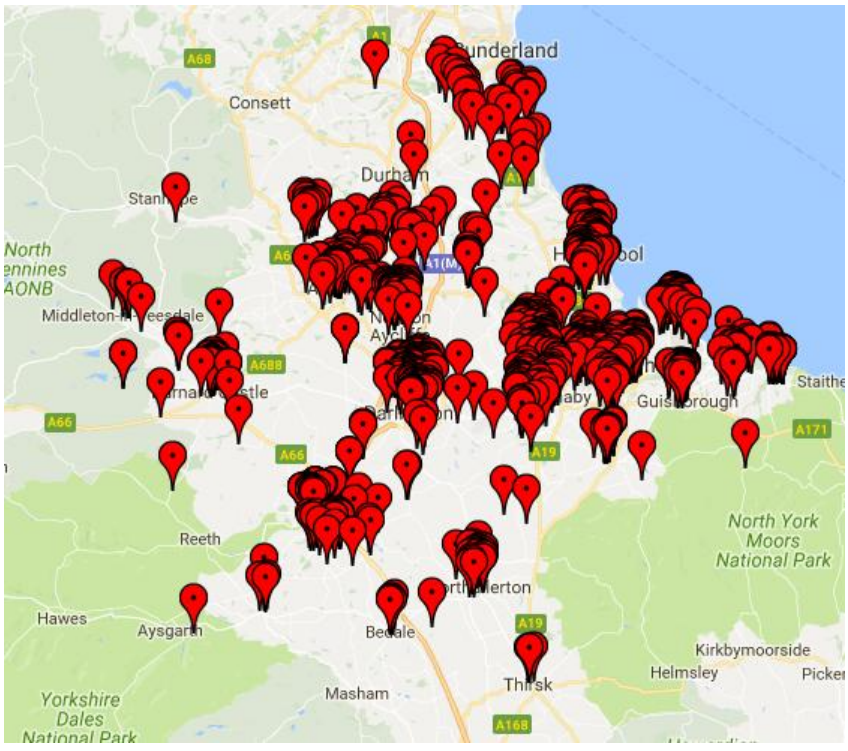
Over a quarter (26%) of those interviewed reported that they lived within Durham County, while 16% lived in the Stockton locality.

Local authority area of residence
(Base size 942)



Geographical spread

Respondents' home postcodes were collected and the map below demonstrates the geographical spread.



3.0 Results

This section details the results from the on-street research.

Antenatal and postnatal care

Before answering the main survey questions, each respondent was read a short script of background information, designed to inform the respondent and set the scene for the research.

> The health needs of the population are changing both locally and nationally, and specialisation in healthcare is resulting in better, safer care. With this in mind, local clinical professionals believe there is a need to change how care is provided near you.
>
> Local healthcare organisations are looking at how more care can be provided outside hospital in communities, particularly for uncomplicated pregnancies. For the many mums with uncomplicated pregnancies, care during labour can be managed by a midwife at home or in a midwife-led unit. Women whose pregnancies are considered more complicated may need support from specialist doctors (obstetricians, anaesthetists and paediatricians).

Priority factors

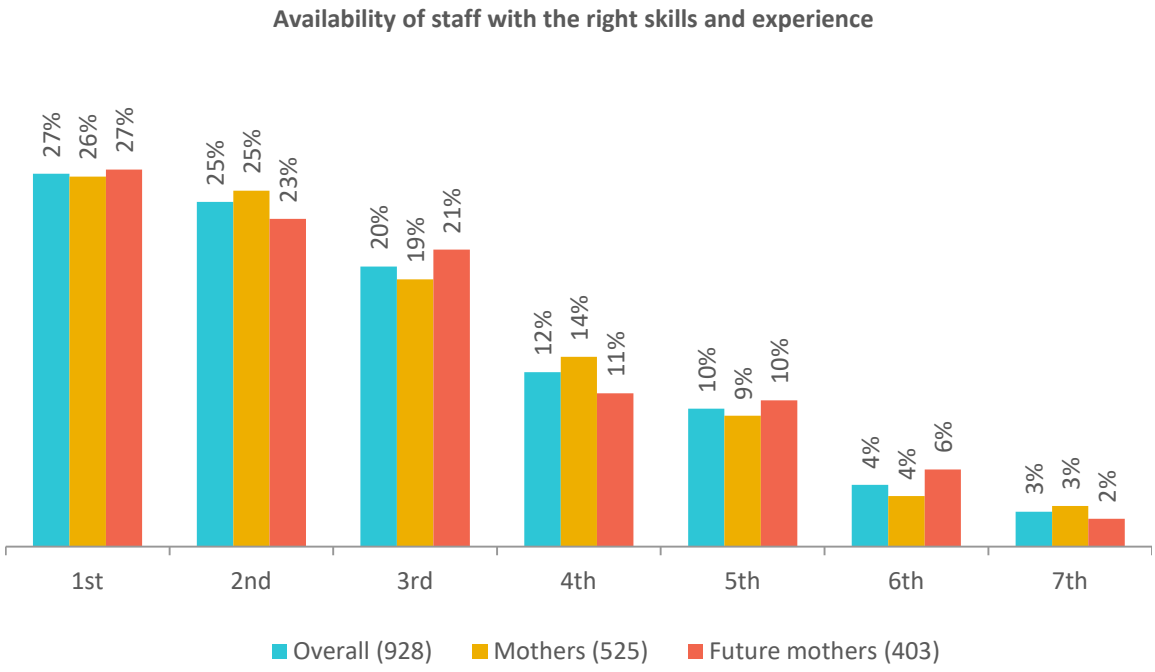
We were keen to understand what was important to women during and after pregnancy.
Respondents were given a grid of factors relating to antenatal and postnatal services and were asked the following:

"Thinking about antenatal and postnatal care, please could you rank the following factors in order of your priorities in relation to these services, from 1st to 7th, where 1st is equal to your highest priority and 7th is equal to your lowest priority?"

Rankings were provided and the graphs overleaf demonstrate how respondents ranked each factor on their priority scale. Respondents were also asked to explain their ranking choices and themes in literal response were identified.

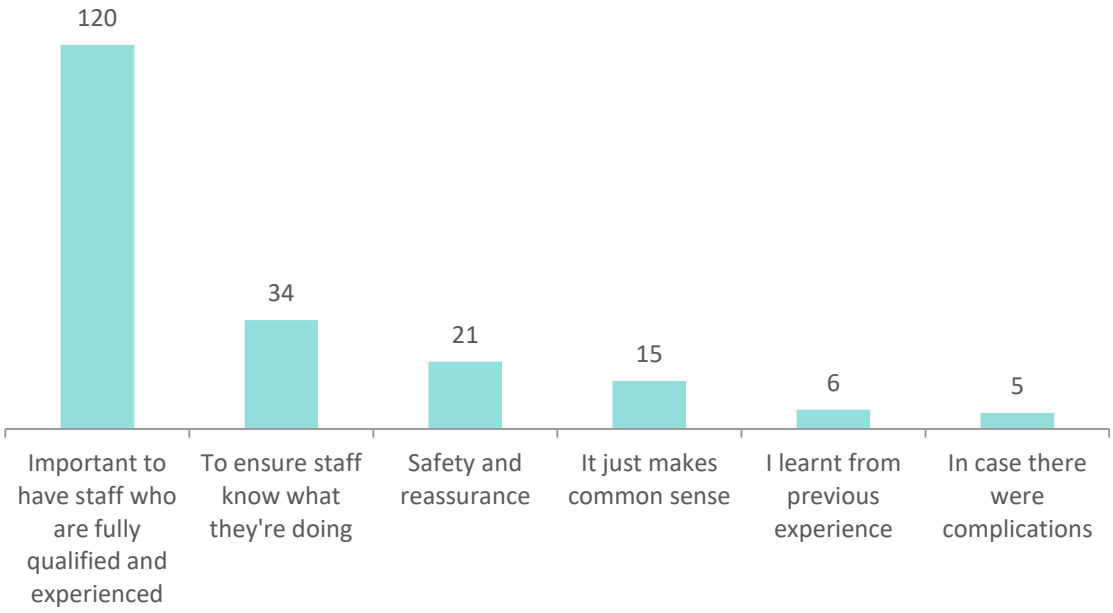
Availability of staff with the right skills and experience

'Availability of staff with the right skills and experience' was considered a top priority overall, with 27% of women ranking this first priority, 25% ranking it second, and a further fifth (20%) ranking it third priority. There was a downward trend across the rankings, and this trend was consistent between mothers and future mothers.



The skills and experience of staff were a particular priority amongst respondents in Sedgefield (47% ranked it their highest priority), Eaglescliffe (42% ranked it first), and Thornaby (39%). Over a third (37%) of women who lived in the Middlesbrough Council region considered this their number one priority.

When explaining their ranking choices, the key themes in literal responses from those who ranked this service area their top priority, as identified in analysis, included:



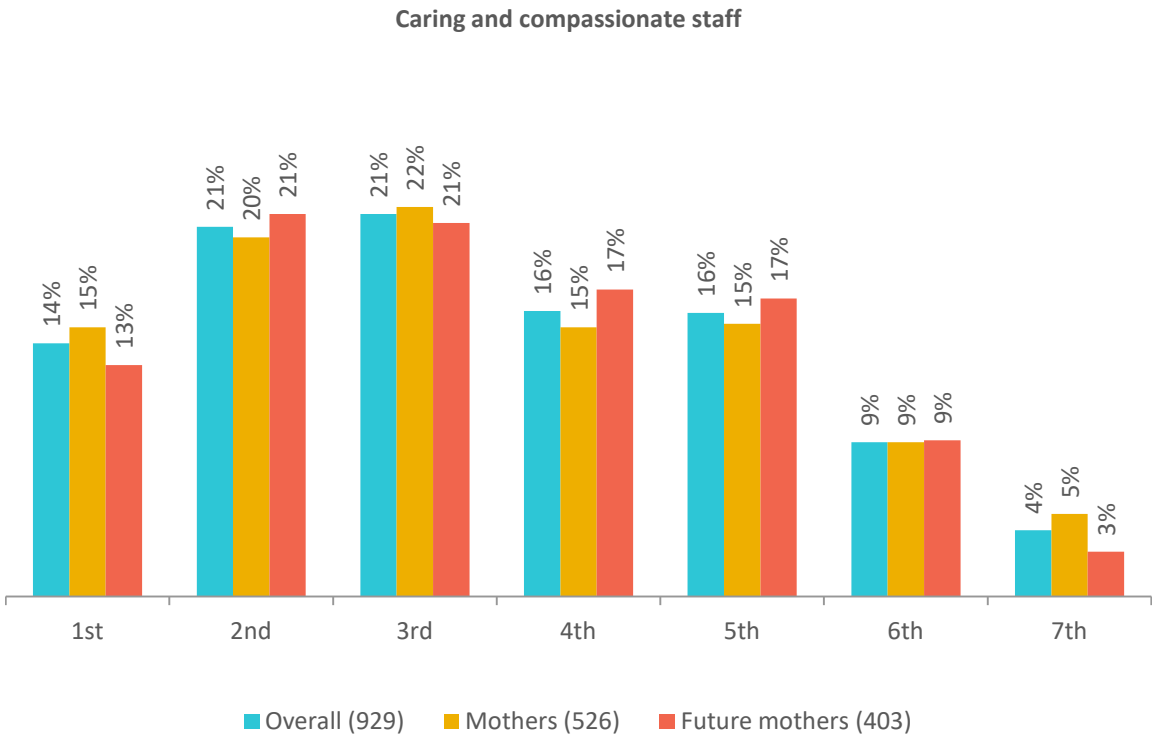
Please note, figures indicate the number of comments relating to each theme.

Literal comments included:

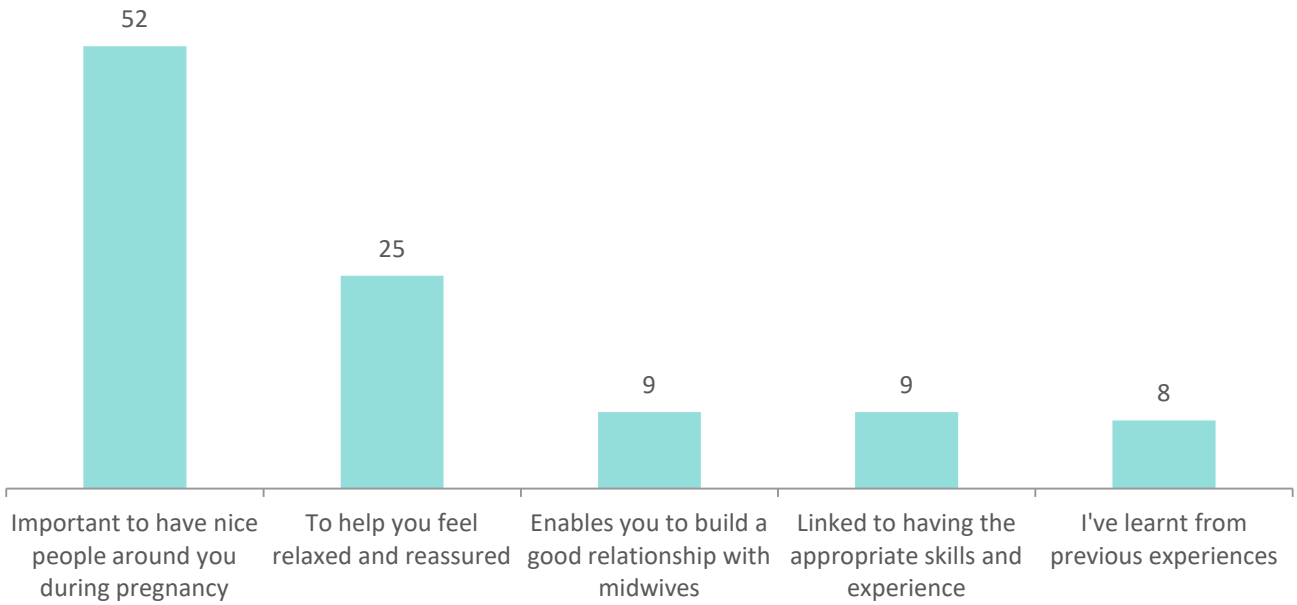
- *"You want to have experienced staff in your field to look after you through all of the pregnancy and to have the confidence that you trust them"*
- *"I would not want to be seen by someone who is not fully qualified, like an auxiliary or student, in case I was given the wrong information"*
- *"You always want to think you are in the most capable hands"*
- *"It is the reassurance especially with it being my first. I would want someone there with the best skills and knowledge"*
- *"I would feel at ease with trained staff"*

Caring and compassionate staff

Having 'caring and compassionate staff' was also important to both mothers and future mothers during their antenatal and postnatal care. Overall, 21% rated this third priority, 21% rated this their second, and 16% rated it their fourth priority out of seven. Looking at differences in results between age groups, 18% of 20-29 year olds considered 'caring and compassionate staff' to be their number one priority, compared to 7% of 16-19 year olds. A third (33%) of respondents in Thornaby ranked this their top priority.

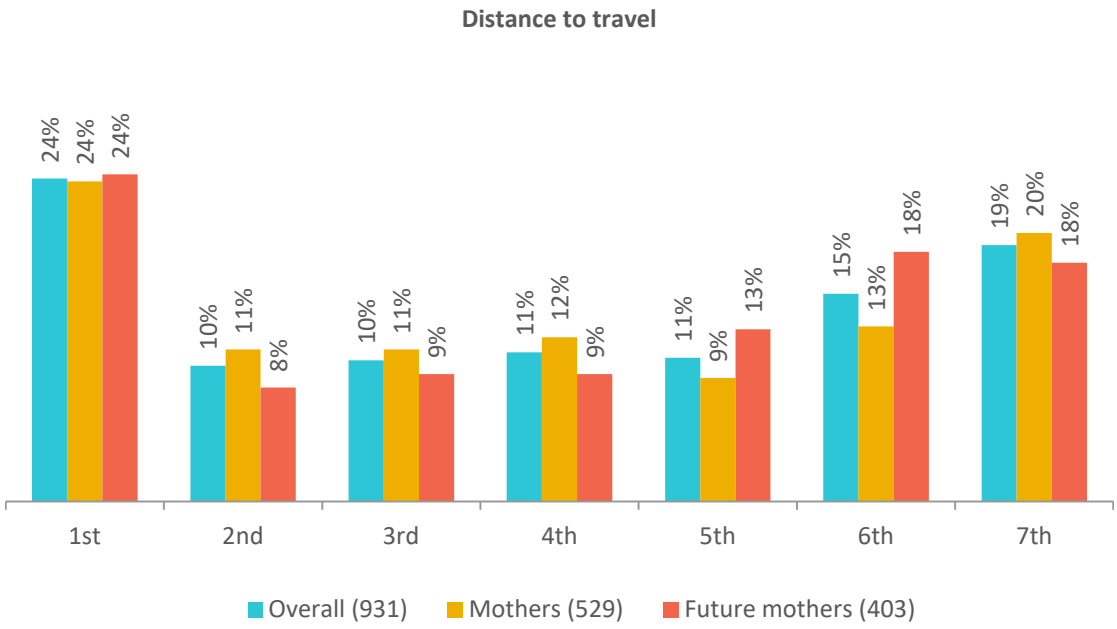


The reasons why women ranked 'caring and compassionate staff' as a top priority included:



Distance to travel

When considering 'distance to travel' for care, this was seen as a high priority for nearly a quarter of respondents overall (24%). However, it was also considered the lowest priority for 19% of women interviewed. Looking at the differences in opinion between mothers and future mothers, distance to travel was typically less important for future mothers, with higher proportions of this group ranking this factor fifth or sixth out of seven.

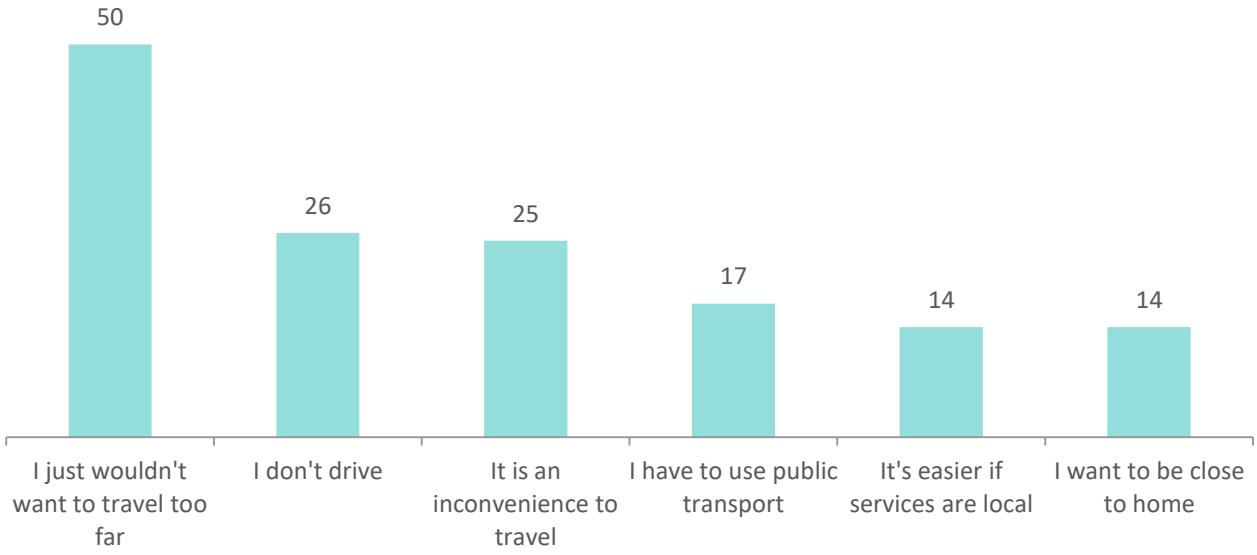


Differences in the relative importance of travel distance between research locations were identified and full results can be found overleaf.

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Crook	Spennymoor	Sedgefield	Seaham/Peterlee	Darlington Borough	Hartlepool	Stockton-On-Tees	Eaglescliffe	Thornaby	Yarm	Middlesbrough (Central)	Eston	Guisborough	Skelton/Brotton/Loftus	Redcar	Northallerton	Richmond	Leyburn	Stokesley	Bedale	Catterick	Colburn	Other
Base	40	61	39	15	22	15	20	136	79	99	12	18	21	64	33	39	42	35	28	53	6	14	6	15	1	20
1st	13%	**39%**	21%	**40%**	18%	27%	30%	18%	28%	18%		11%	10%	13%	9%	21%	**43%**	**46%**	14%	**45%**	**50%**	21%		**47%**		15%
2nd	10%	15%	10%	33%	5%	7%	20%	8%	20%	3%			10%	9%	12%	10%	17%	9%		9%		7%	17%	7%		5%
3rd	5%	2%	13%	13%	5%	20%	15%	14%	8%	12%		6%	24%	3%	12%	15%	26%	9%	4%	6%	17%		17%	13%	100%	10%
4th	8%	7%	15%		5%	13%	10%	11%	19%	14%	8%	6%	14%	19%	24%	3%	7%	3%	11%	8%			17%	7%		10%
5th	15%	12%	13%		9%	20%	10%	16%	3%	15%	17%	6%	19%	14%	3%	3%	2%	11%	14%	9%		14%		7%		
6th	15%	15%	10%	13%	41%	13%	10%	15%	10%	22%	33%	28%	5%	25%	3%	21%	2%	11%	11%	4%	33%	14%		13%		35%
7th	35%	12%	18%		18%		5%	18%	13%	15%	42%	44%	19%	17%	36%	28%	2%	11%	46%	19%		43%	50%	7%		25%
Mean	**4.9**	**3.3**	**3.9**	**2.3**	**4.8**	**3.3**	**3.0**	**4.2**	**3.3**	**4.3**	**6.1**	**5.6**	**4.1**	**4.6**	**4.6**	**4.3**	**2.3**	**3.1**	**5.3**	**3.1**	**3.0**	**4.9**	**5.0**	**2.9**	**3.0**	**4.8**

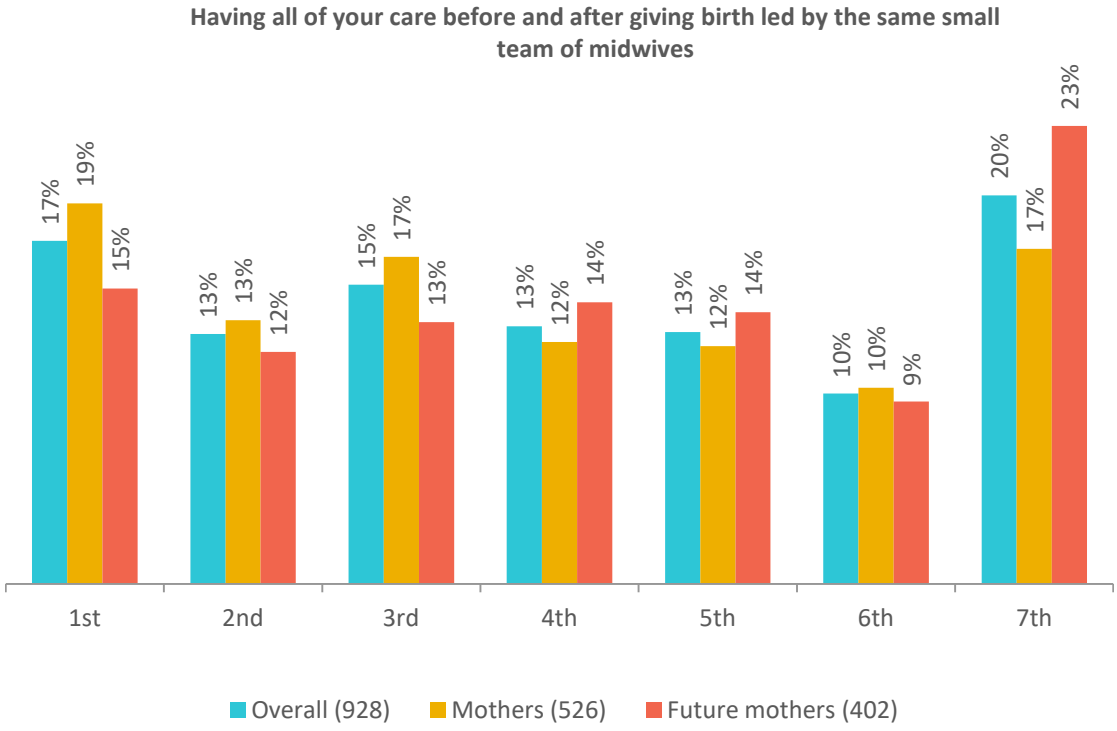
Distance to travel for antenatal and postnatal care was considered a higher priority amongst respondents in Leyburn (50% ranked it highest), Catterick (47% ranked this their highest priority), Redcar (46%) and Skelton/Brotton/Loftus (43%). In contrast, half (50%) of respondents in Bedale ranked this seventh, as well as 46% of respondents Northallerton. Please note fluctuating base sizes and remember that the lower the mean score, the higher the average priority ranking in that area.

Key themes in literal responses from those who ranked 'distance to travel' their highest priority were identified as:



Having all of your care before and after giving birth led by the same small team of midwives

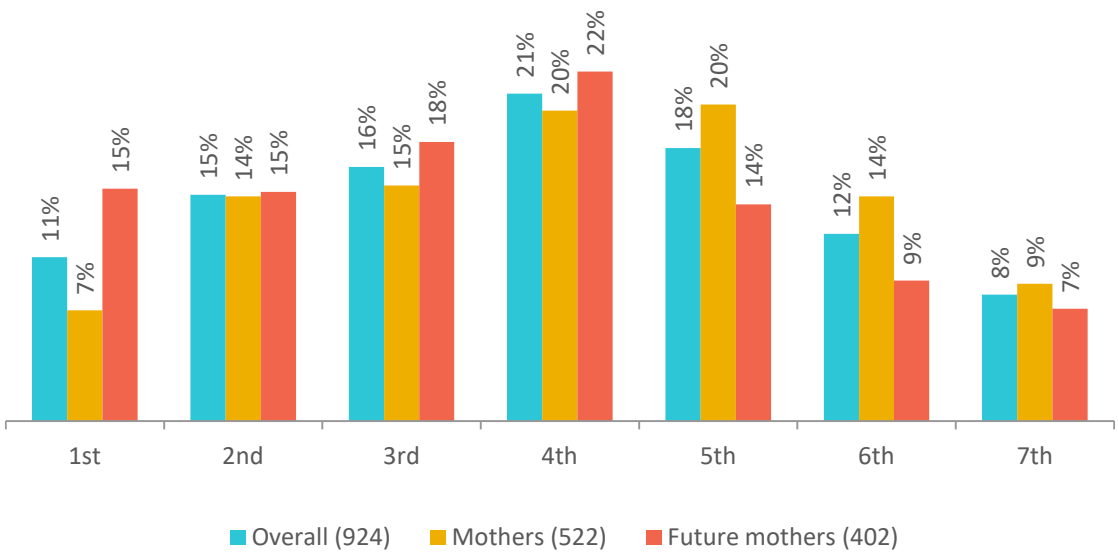
Responses were mixed when thinking about 'having all of your care before and after giving birth led by the same small team of midwives'. Overall, a fifth (20%) of respondents ranked this their lowest priority factor of service. However, 17% ranked this their top priority – a score driven by the 19% of mothers who saw this as an important factor in antenatal and postnatal care, compared to 15% of future mothers.



Having a range of different services available under one roof, e.g. breastfeeding support, stop smoking advice, ultrasound tests

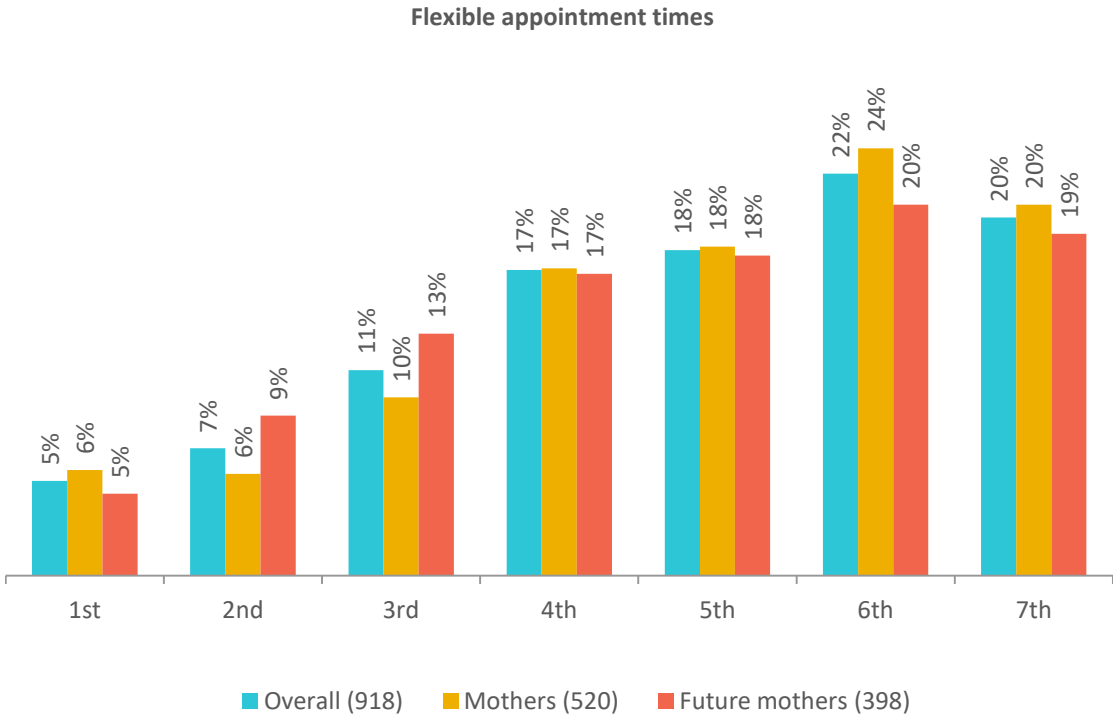
The importance of 'having a range of different services available under one roof' was considered middling by respondents; 21% ranked this fourth out of seven, 18% ranked it fifth, and a further 16% ranked it their third priority. A higher proportion of future mothers than mothers considered it their highest priority (15% and 7% respectively).

Having a range of different services available under one roof (e.g. breastfeeding support, stop smoking advice, ultrasound tests)



Flexible appointment times

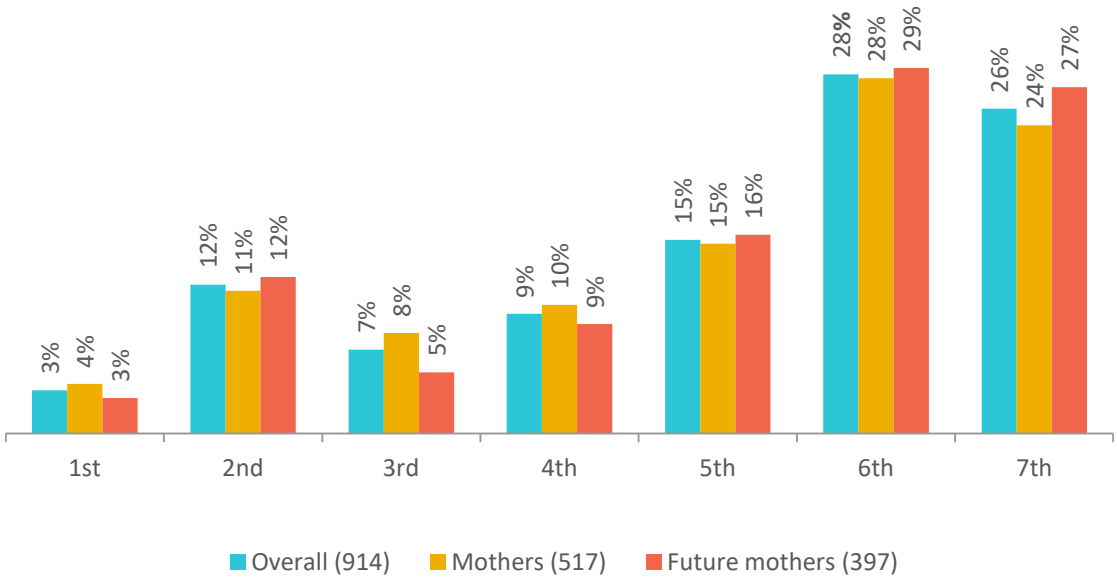
'Flexible appointment times' were seen to have middling to low levels of importance for respondents – overall 77% ranked this factor between fourth and seventh out of seven. 5% of women interviewed ranked 'flexible appointment times' their highest priority when considering their antenatal and postnatal care. Slightly higher proportions of future mothers ranked this factor second and third (9% and 13% respectively) compared to those who were already mothers (6% and 10% respectively).



Ease of access, e.g. public transport, parking

The results relating to ease of access suggested that this was a low priority for both mothers and future mothers when it came to antenatal and postnatal services. Overall, 28% of respondents ranked 'ease of access' sixth, and a further quarter (26%) ranked it seventh out of seven. 3% of women interviewed felt this was their highest priority.

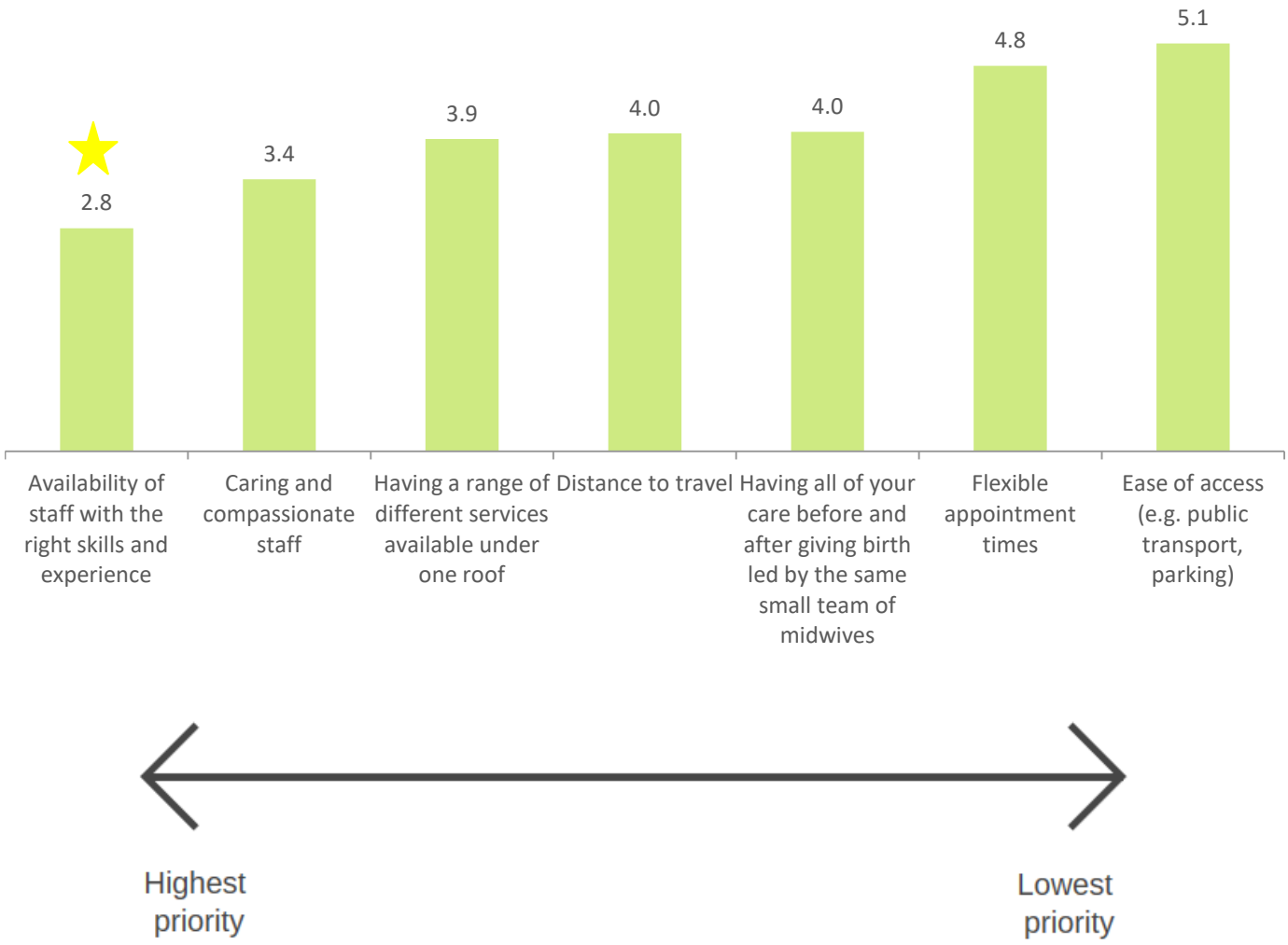
Ease of access (e.g. public transport, parking)



SUMMARY

Mean scores were created for each service factor based on respondents' rankings and are summarised in the graph below. The mean scores demonstrate the overall ranking of factors relating to antenatal and postnatal care. Please note, the lower the mean score, the higher the priority ranking.

Antenatal and postnatal priorities



Other services in community settings

Respondents were introduced to the suggestion of more antenatal and postnatal care being provided out of hospitals, with the following text read aloud by researchers:

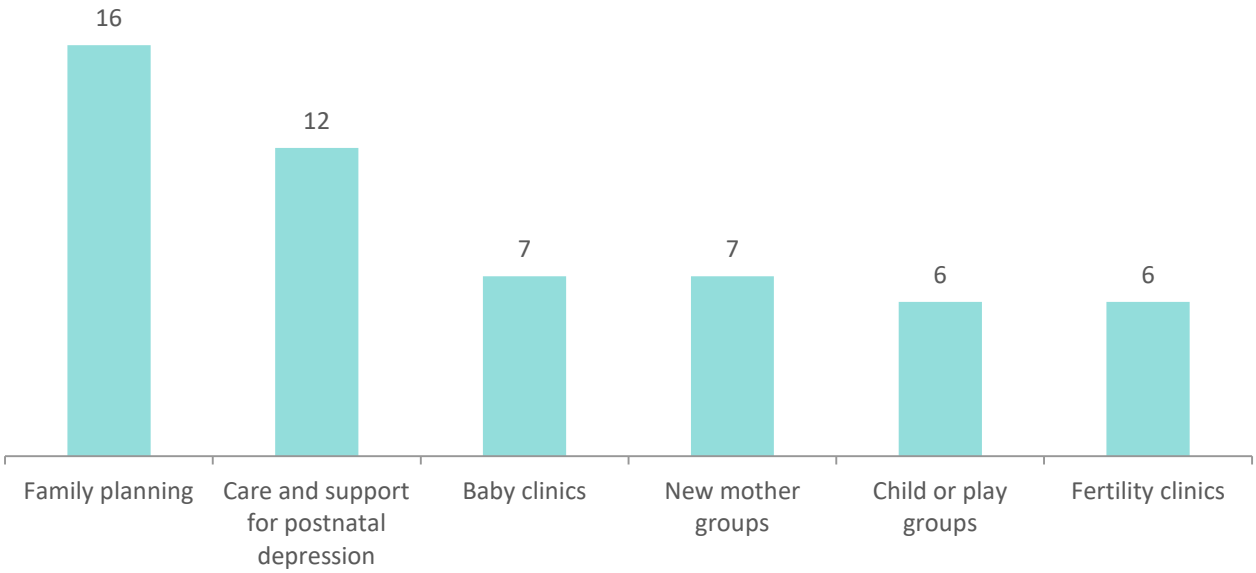
> Local NHS organisations would like to provide more antenatal and postnatal care out of hospital with much of the care being provided in the community and available under one roof.
>
> Services available at these places might include:
>
> – Antenatal and postnatal clinics all in one place
> – Ultrasound tests
> – Breastfeeding support
> – Baby care / education
> – Stop smoking advice
> – Healthy eating advice

Respondents were then asked:

"Are there any other services or support which you would find helpful to have available in these community settings?"

Suggestions can be found overleaf.

Key themes in suggestions included the following:



Family planning (16)

- *"Maybe somebody to do a talk about family planning, a nice person"*
- *"Fertility services, family planning and breast screening"*
- *"Maybe a family planning clinic"*

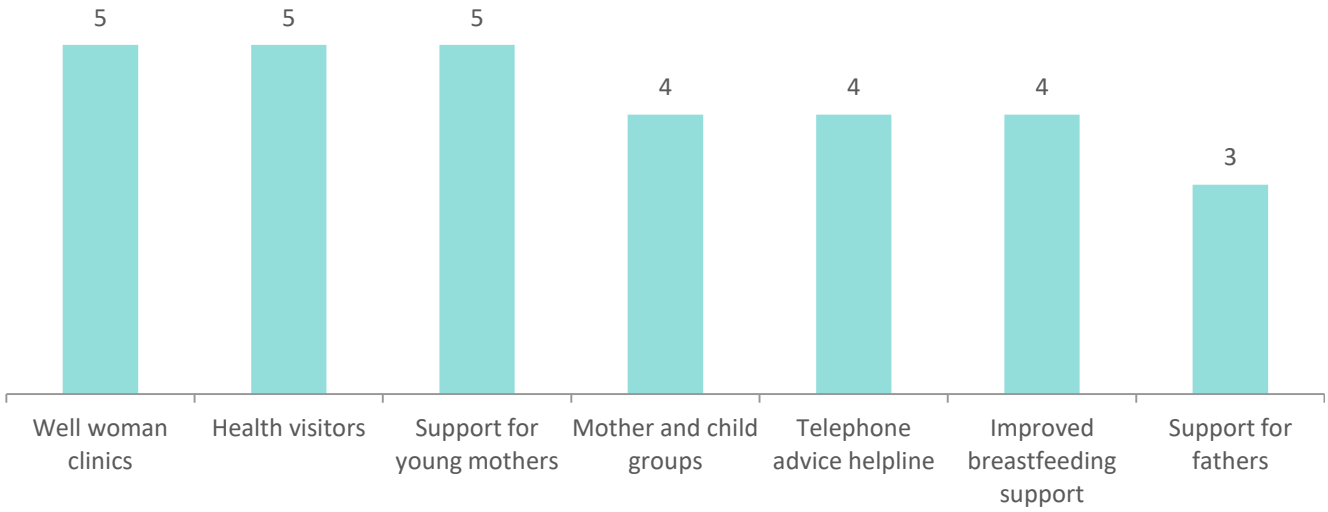
Care and support for postnatal depression (12)

- *"Mental health support for after birth as some people suffer and it is never talked about much"*
- *"Postnatal care and something in regards to mental health after birth"*
- *"Therapy and recognition of postnatal depression"*
- *"Antenatal and postnatal depression talks and help"*

Baby clinics (7)

- *"A baby clinic and a new mums group"*
- *"Baby clinic, family planning and sexual health"*
- *"Having a baby clinic there as well"*

Other suggestions for services or support which respondents would find helpful in community settings included:



Labour and delivery

Priority factors

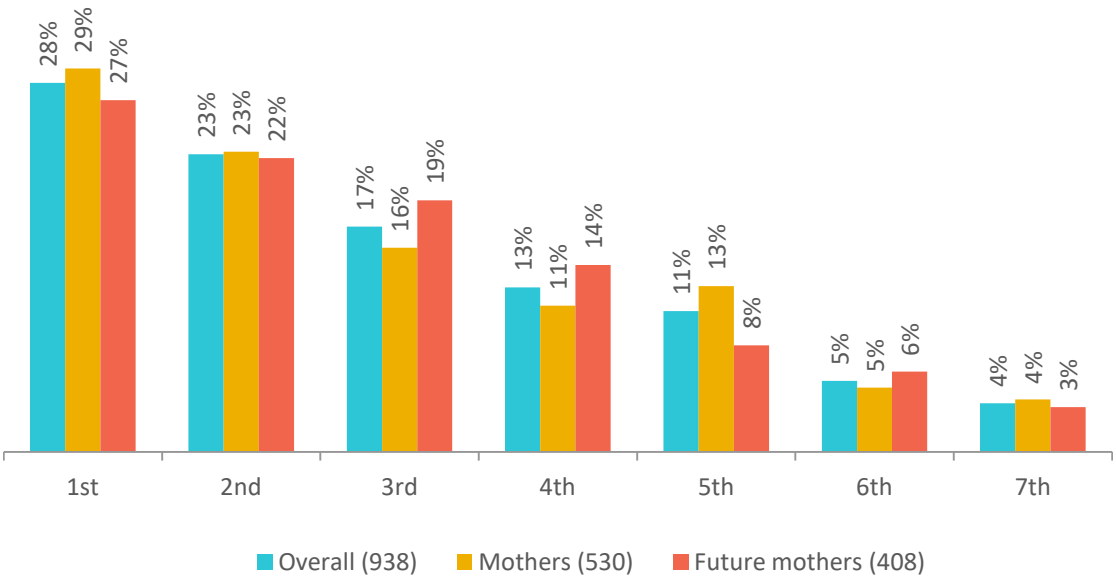
To understand respondents' priorities during labour and delivery, they were provided a grid of factors and were asked:

"Thinking about care during labour and delivery and assuming an uncomplicated pregnancy, please could you rank the following factors in order of your priorities in relation to this care, from 1st to 7th, where 1st is equal to your highest priority and 7th is equal to your lowest priority?"

Availability of consultant doctors

The availability of consultant doctors was considered the highest priority during delivery for 28% of respondents overall, and a further 23% considered it a second priority. As seen with the 'availability of staff with the right skills and experience' in relation to antenatal and postnatal care, there is a downward trend in results across the priority scale.

Availability of consultant doctors (obstetricians, anaesthetists, paediatricians)



A majority of respondents in Yarm (86%) ranked the availability of consultant doctors their number one priority during labour, with 69% of respondents in Eaglescliffe and 46% of respondents in Eston feeling the same.

Results broken down by the research locations broadly representing the A689 corridor were as follows:

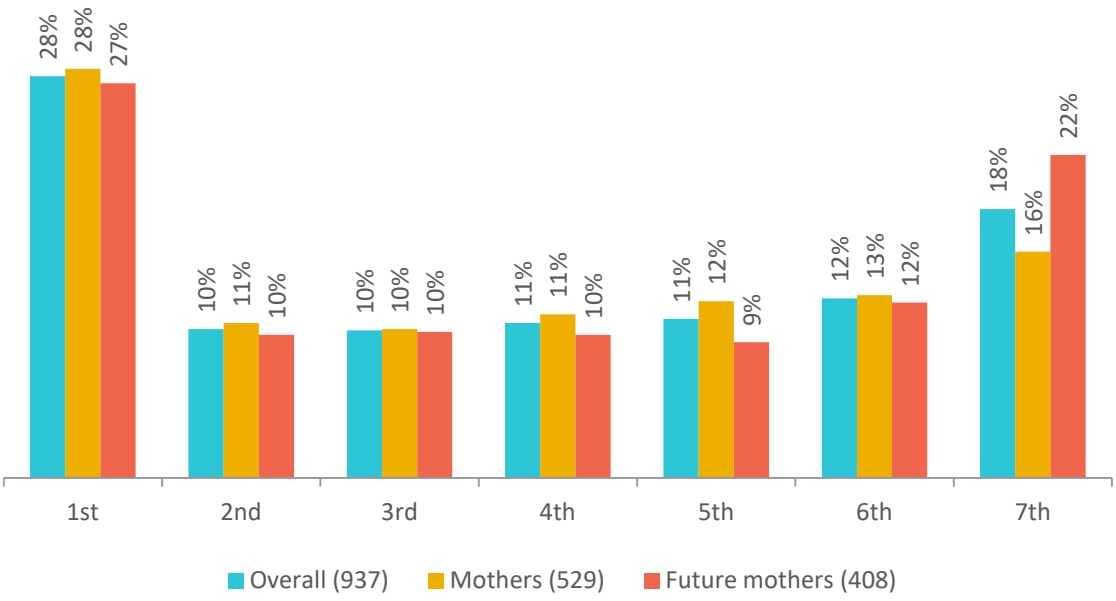
	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	40	61	39	22	15	79
1st	20%	15%	15%	**27%**	**20%**	**30%**
2nd	**25%**	**26%**	15%	14%	**20%**	22%
3rd	18%	21%	**26%**	18%	13%	13%
4th	13%	12%	15%	14%	13%	9%
5th	13%	21%	18%	14%	7%	11%
6th	13%	3%	10%	5%	13%	9%
7th		2%		9%	13%	6%
Mean	**3.1**	**3.2**	**3.4**	**3.2**	**3.6**	**3.0**

'Availability of consultant doctors' was a higher priority amongst respondents in Hartlepool and Spennymoor, with 30% and 27% rating this factor their highest priority respectively. A quarter (26%) of respondents in Bishop Auckland ranked this their second priority, as did 25% of respondents in Newton Aycliffe. In Barnard Castle, 26% of respondents ranked availability of consultants third out of the seven factors.

Distance to travel to your delivery setting

As seen for 'distance to travel' for antenatal and postnatal care, this factor divided respondents – 28% of women interviewed saw this as their top priority, while 18% considered it their lowest priority of the seven factors. The result for the seventh ranking position is driven by the responses of future mothers – 22% of future mothers ranked 'distance to travel to your delivery setting' seventh compared to 16% of mothers.

Distance to travel to your delivery setting



Distance to travel was also a greater priority for those who had a long term health condition or disability, with 35% of those with a health condition ranking distance as their top priority, compared to 27% of those who did not suffer from a long term health condition.

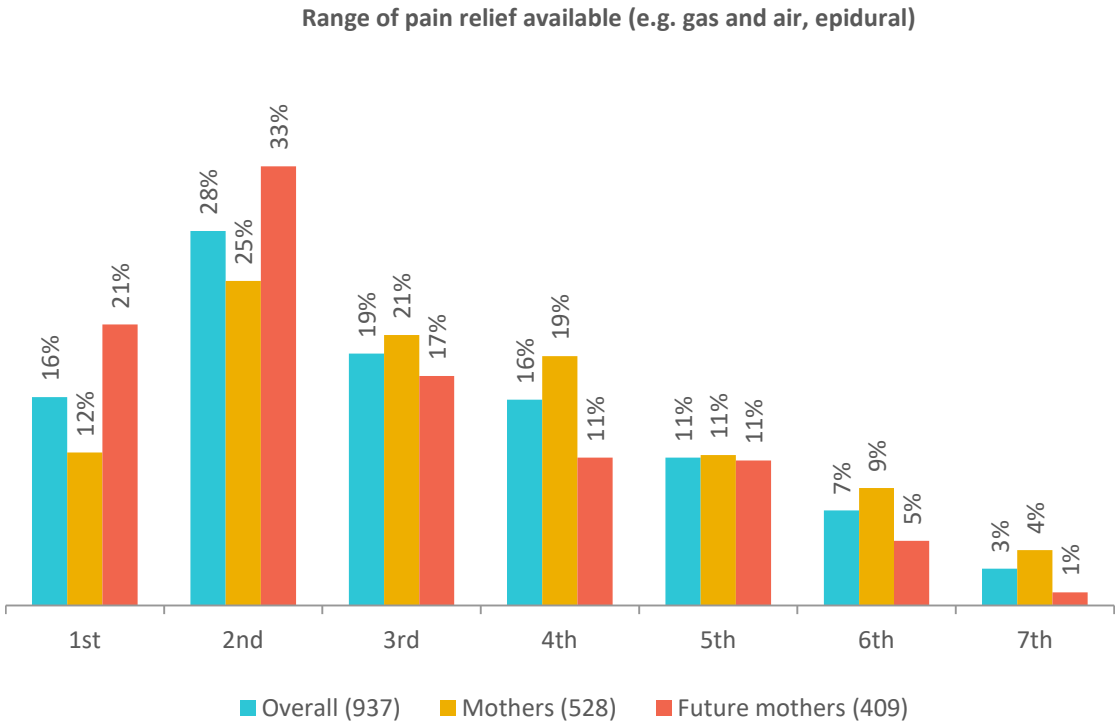
Full results comparing the relative importance of travel distance between research locations can be found in the table overleaf.

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Crook	Spennymoor	Sedgefield	Seaham/Peterlee	Darlington Borough	Hartlepool	Stockton-On-Tees	Eaglescliffe	Thornaby	Yarm	Middlesbrough (Central)	Eston	Guisborough	Skelton/Brotton/Loftus	Redcar	Northallerton	Richmond	Leyburn	Stokesley	Bedale	Catterick	Colburn	Other
Base	40	61	39	15	22	15	20	138	79	99	13	18	21	66	33	39	42	36	28	53	6	14	6	15	1	20
1st	18%	**54%**	15%	**40%**	18%	33%	35%	20%	35%	23%	8%	6%	10%	12%	9%	31%	**45%**	**44%**	25%	**43%**	**50%**	**43%**	17%	**53%**		15%
2nd	18%	5%	23%	47%	18%	7%	10%	15%	10%	4%		6%	10%	11%	9%	3%	7%	6%	4%	15%		7%		7%		5%
3rd	10%	5%	15%	7%	9%	13%	10%	7%	10%	16%		11%	43%	9%	9%	10%	24%	3%		6%		7%	17%	7%		
4th	8%	10%	13%	7%	5%	7%	10%	11%	14%	9%		22%	29%	12%	24%	3%	10%	14%	4%	9%			17%	7%	100%	
5th	10%	3%	10%		5%	13%	15%	20%	9%	6%	31%	28%	10%	18%	12%	10%	7%	6%	7%	6%	17%			20%		5%
6th	25%	8%	8%		5%	7%	10%	16%	9%	11%	8%	22%		21%	9%	21%	2%	8%	18%	6%	33%	7%	17%			35%
7th	13%	15%	15%		41%	20%	10%	12%	13%	30%	54%	6%		17%	27%	23%	5%	19%	43%	15%		36%	33%	7%		40%
Mean	**4.0**	**2.9**	**3.6**	**1.8**	**4.4**	**3.6**	**3.3**	**3.9**	**3.3**	**4.3**	**5.9**	**4.5**	**3.2**	**4.4**	**4.6**	**4.1**	**2.5**	**3.3**	**4.9**	**3.0**	**3.3**	**3.7**	**4.7**	**2.6**	**4.0**	**5.4**

'Distance to travel to your delivery setting' was considered a higher priority amongst respondents in Bishop Auckland (54% ranked this their highest priority), Catterick (53%), Leyburn (50%) and Skelton/Brotton/Loftus (45%). In contrast, 54% of respondents in Eaglescliffe and 43% of respondents in Northallerton considered distance to travel their lowest priority of the seven factors. The findings in relation to 'distance to travel to your delivery setting' are largely consistent with those for distance to travel for antenatal and postnatal care. Please note fluctuating base sizes and remember that the lower the mean score, the higher the average priority ranking in that area.

Range of pain relief available (e.g. gas and air, epidural)

The 'range of pain relief available' is seen to be a notably higher priority for future mothers compared to current mothers, with 21% of future mothers highlighting this factor as their number one priority, compared to 12% of mothers. Overall, two thirds (63%) of women interviewed ranked pain relief in their top three considerations during labour and delivery.

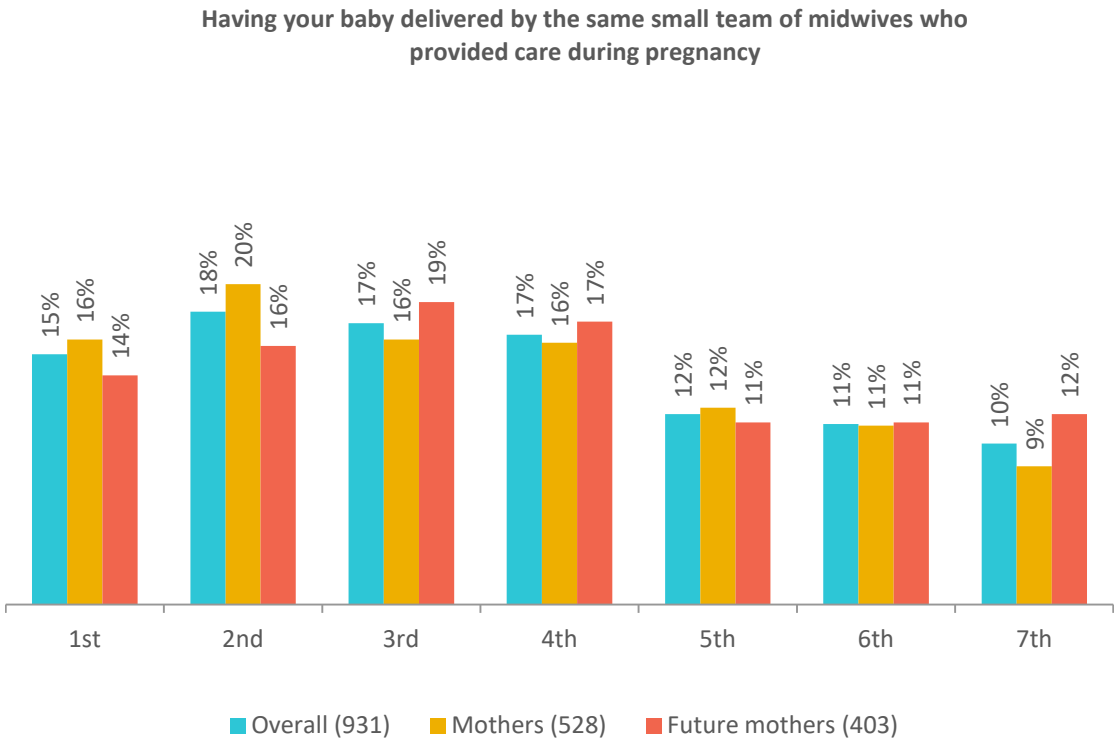


	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	40	61	39	22	15	79
1st	18%	15%	**28%**	18%	7%	13%
2nd	15%	**30%**	**28%**	18%	20%	20%
3rd	15%	16%	18%	**23%**	20%	**23%**
4th	15%	21%	13%	5%	**33%**	20%
5th	**25%**	13%	8%	9%	13%	10%
6th	8%	3%	3%	18%	7%	8%
7th	5%	2%	3%	9%		6%
Mean	**3.6**	**3.1**	**2.6**	**3.6**	**3.5**	**3.4**

The 'range of pain relief available' was a higher priority amongst respondents in Barnard Castle, where 28% of respondents ranked this their first priority, compared to Sedgefield, where 33% ranked this fourth of seven, and Newton Aycliffe, where it was ranked fifth of seven factors by 25% of respondents.

Having your baby delivered by the same small team of midwives who provided care during pregnancy

This factor was met with mixed levels of priority amongst the women interviewed, though a majority of respondents ranked it within their top considerations. Overall, 18% of respondents ranked this factor second out of seven, 17% ranked it third, and a further 17% ranked it fourth.



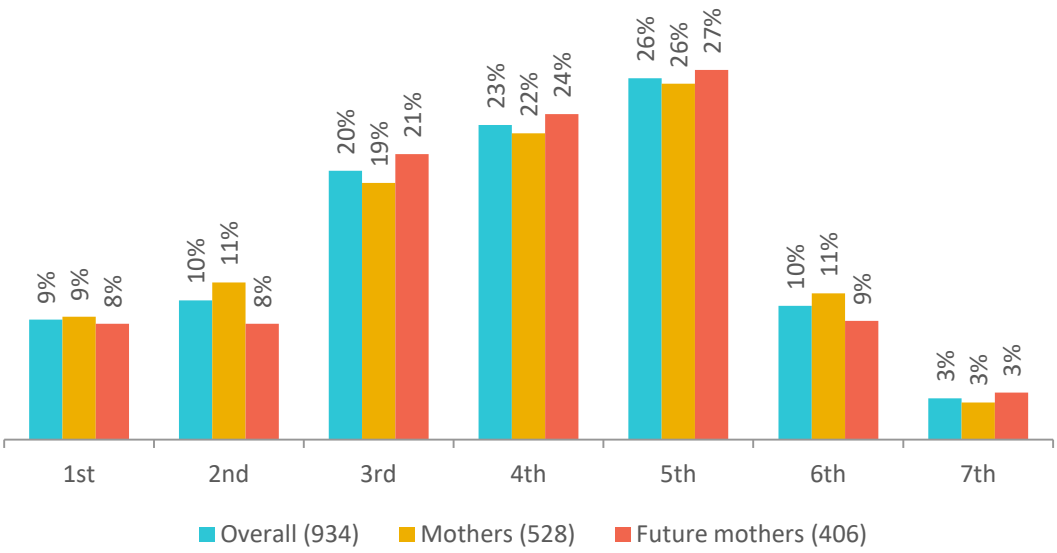
'Having your baby delivered by the same small team of midwives' was a higher priority amongst women in Hartlepool, where 29% of respondents ranked this their second priority, than in Barnard Castle, where it was ranked seventh of seven by a third (31%) of respondents.

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	40	61	39	22	15	79
1st	20%	10%	8%	18%	13%	11%
2nd	**23%**	13%	13%	18%	13%	**29%**
3rd	**23%**	18%	3%	5%	13%	25%
4th	15%	**31%**	8%	**27%**		18%
5th		16%	10%	14%	**40%**	8%
6th	15%	12%	28%	14%	13%	4%
7th	5%		**31%**	5%	7%	5%
Mean	**3.2**	**3.7**	**5.1**	**3.6**	**4.1**	**3.1**

Pleasant and relaxing environment

Overall, a quarter (26%) of respondents ranked 'pleasant and relaxing environment' their fifth priority out of seven; a further 23% ranked it fourth and 20% ranked it third priority. One in ten (9%) of all respondents ranked their environment during labour and delivery their top priority.

Pleasant and relaxing environment



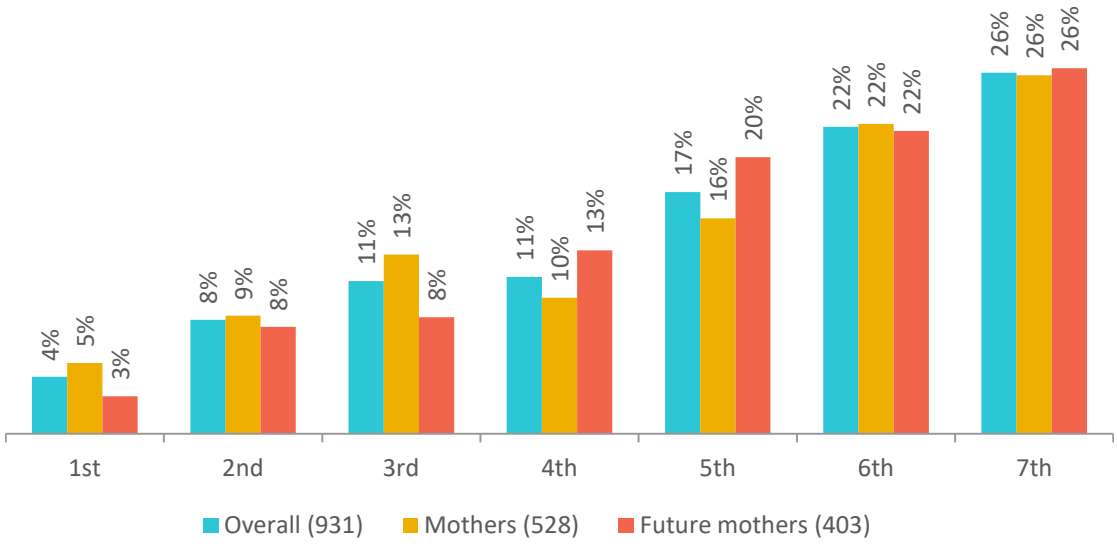
Having a 'pleasant and relaxing environment' was ranked first priority by 23% of respondents in Barnard Castle. In contrast, a third (33%) of respondents in Hartlepool ranked this fifth of seven.

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	40	60	39	22	15	79
1st	15%	3%	**23%**	14%		4%
2nd		10%	10%	14%	27%	8%
3rd	20%	15%	**23%**	**27%**	7%	18%
4th	**30%**	10%	18%	18%	7%	24%
5th	25%	**28%**	18%	23%	20%	**32%**
6th	5%	25%	5%		**33%**	13%
7th	5%	8%	3%	5%	7%	3%
Mean	**3.9**	**4.6**	**3.2**	**3.4**	**4.5**	**4.2**

Facilities for birthing partners, including somewhere to stay

Overall, 48% of women interviewed ranked 'facilities for birthing partners' either sixth or seventh out of seven in terms of priority during labour. The importance of facilities for partners was slightly higher amongst mothers than future mothers, for example with 13% of mothers ranking this factor third out of seven, compared to 8% of future mothers.

Facilities for birthing partners, including somewhere to stay



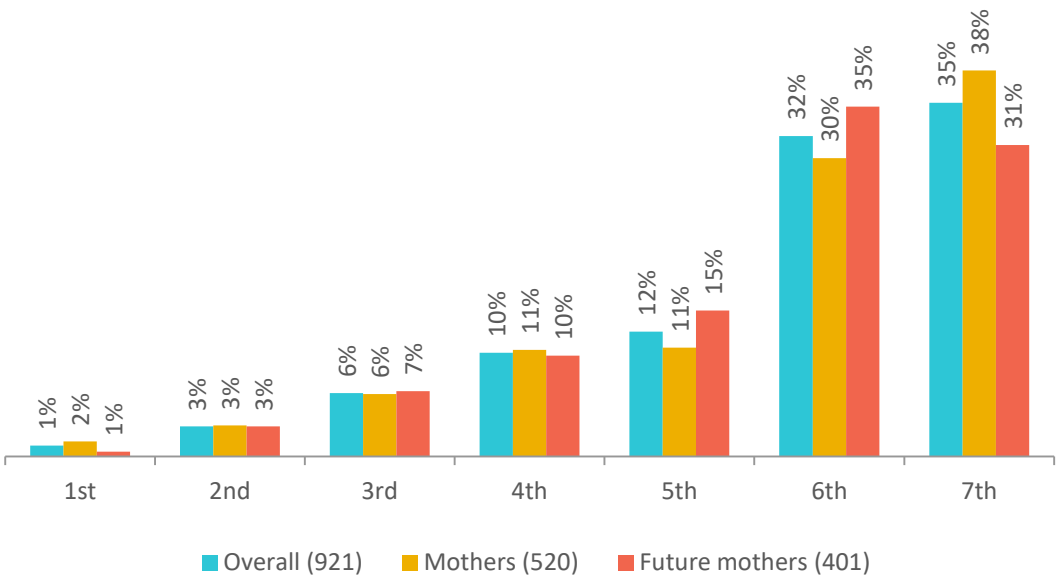
Facilities for birthing partners were considered a high priority amongst Sedgefield respondents, with 27% of respondents ranking this top priority.

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	40	60	39	22	15	79
1st	10%	2%	8%		**27%**	6%
2nd	13%	15%	8%	18%	7%	8%
3rd	13%	22%	15%	5%	20%	10%
4th	15%	8%	18%	18%	27%	8%
5th	**25%**	10%	**26%**	5%	7%	14%
6th	20%	13%	13%	**27%**	7%	**33%**
7th	5%	**30%**	13%	**27%**	7%	22%
Mean	**4.1**	**4.7**	**4.4**	**5.0**	**3.3**	**5.0**

Availability of birthing pools

'Availability of birthing pools' was considered lowest priority during labour and delivery, with over a third (35%) of respondents ranking this seventh out of seven, and a further 32% ranking it sixth. 1% of respondents reported that birthing pools were their highest priority, and this included respondents in Bishop Auckland, Barnard Castle, Spennymoor, Darlington Borough, Stockton-on-Tees and Middlesbrough (Central).

Availability of birthing pools



On the whole, it was considered a low priority across the research locations, though 10% of respondents in Darlington Borough ranked this second out of seven.

Looking at the results for the A689 corridor locations, 'availability of birthing pools' was a higher priority amongst respondents in Spennymoor, where a third (33%) of respondents ranked this fifth priority, compared to Newton Aycliffe, where two thirds (67%) of respondents ranked it seventh of seven.

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	39	61	39	21	15	78
1st		2%	3%	5%		
2nd	8%	2%	3%		7%	5%
3rd	3%	7%		14%	13%	1%
4th	5%	5%	18%	14%	13%	8%
5th	3%	10%	8%	**33%**		17%
6th	15%	**34%**	33%	29%	20%	24%
7th	**67%**	41%	**36%**	5%	**47%**	**45%**
Mean	**6.2**	**5.9**	**5.7**	**4.8**	**5.5**	**5.9**

SUMMARY

Mean scores were created for each service factor based on respondents' rankings and are summarised in the graph below. The mean scores demonstrate the overall ranking of factors relating to care during labour and delivery. Please note, the lower the mean score, the higher the priority ranking.

Place of delivery

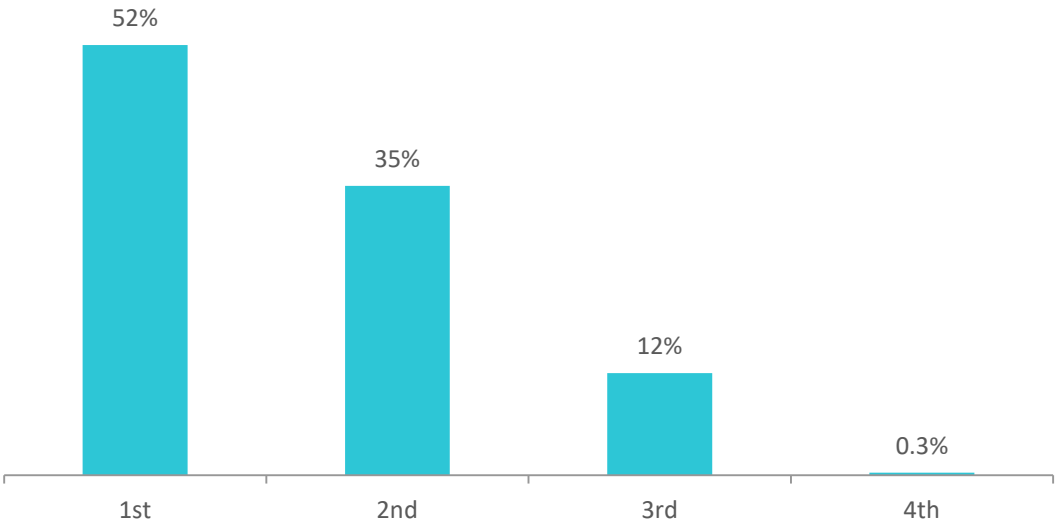
Respondents were asked to rank four settings in order of place of delivery they would prefer, again assuming an uncomplicated pregnancy. Showcards B were used here to demonstrate what would be available at each setting, to ensure all respondents could give informed responses.

Respondents were then asked, unprompted, to explain what it was that particularly attracted them to that delivery setting. Respondents' preferences and themes in comments can be found in the following pages.

Alongside midwife-led unit

Overall, the alongside midwife-led unit was found to be the most preferred, with over half (52%) of respondents stating this setting was their first choice, and a further third (35%) chose it as their second preference. Over half of women interviewed who did not have a long term health condition (53%) felt this setting would be their first choice, compared to 35% of women who did suffer from a long term condition.

Alongside midwife-led unit, next to or in the same hospital as a consultant-led unit
(Base size 929)

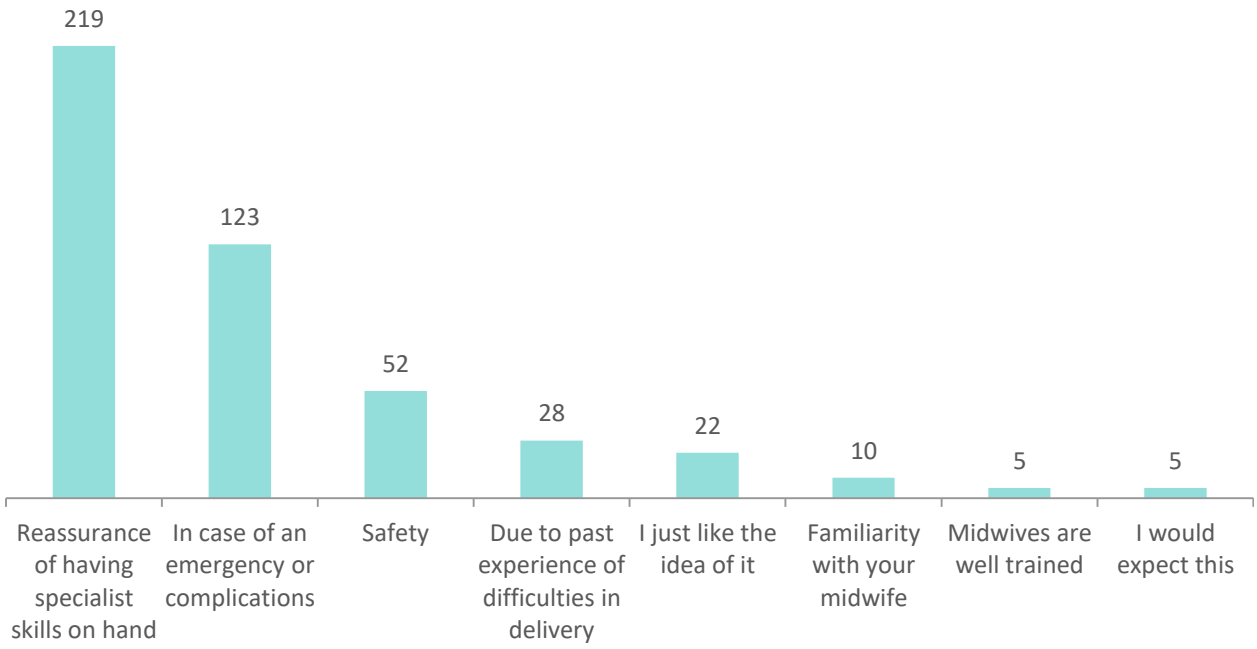


The alongside midwife-led setting was considered the first choice for 85% of respondents in Yarm (base size of 20) and 80% of women interviewed in Crook (base size of 15).

Comparing the results for each of the A689 corridor locations, a majority of respondents in each ranked the 'alongside' unit as their second choice, though a high proportion of respondents in Barnard Castle, Bishop Auckland and Hartlepool ranked this setting their first preference (46%, 39% and 39% respectively).

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	39	61	39	22	15	78
1st	33%	39%	46%	14%	13%	39%
2nd	**56%**	**41%**	**49%**	**64%**	**73%**	**45%**
3rd	10%	20%	5%	23%	7%	17%
4th					7%	

In terms of what particularly attracted women to the alongside midwife-led units overall, themes in literal responses included:



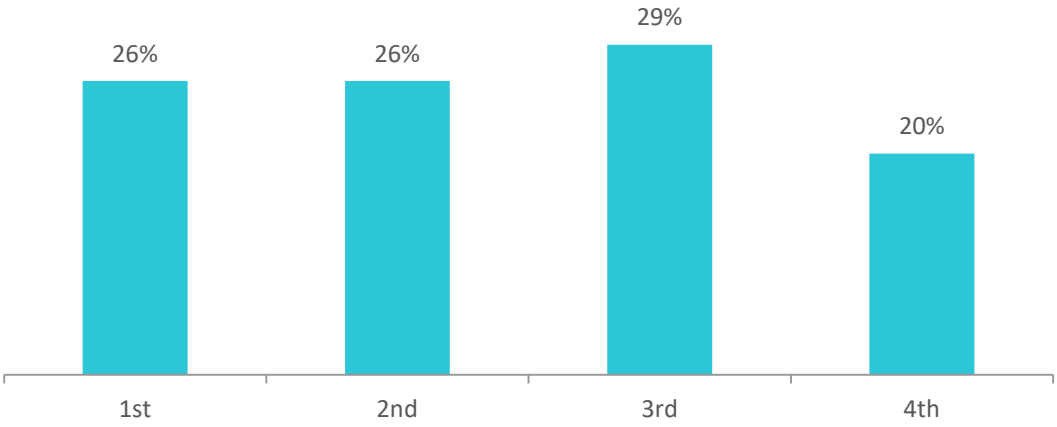
Literal comments included;

- *"Anything can go wrong and it could be a life or death situation so I need everybody there. It's not necessary to have them in the room but nearby"*
- *"Doctors do not have to be in the room but it is nice to know that they are around in case of complications, like if the heart rate drops suddenly or you might need a caesarean"*
- *"The alongside has the benefit of being next door or within a hospital so you would be okay if you need intervention"*
- *"Having a relaxed atmosphere with just a midwife but with doctors on hand if you need them"*
- *"I want the midwives as I want a comfortable birth, and the consultants are there if they are needed"*

Consultant-led unit

Responses were mixed in relation to the consultant-led unit, with similar proportions seen for first (26%), second (26%) and third (29%) preferences. It was a higher priority for women with a long term health condition or disability, with 41% of this respondent group choosing a consultant-led unit as their preferred delivery setting compared to 25% of respondents who did not have ongoing health concerns.

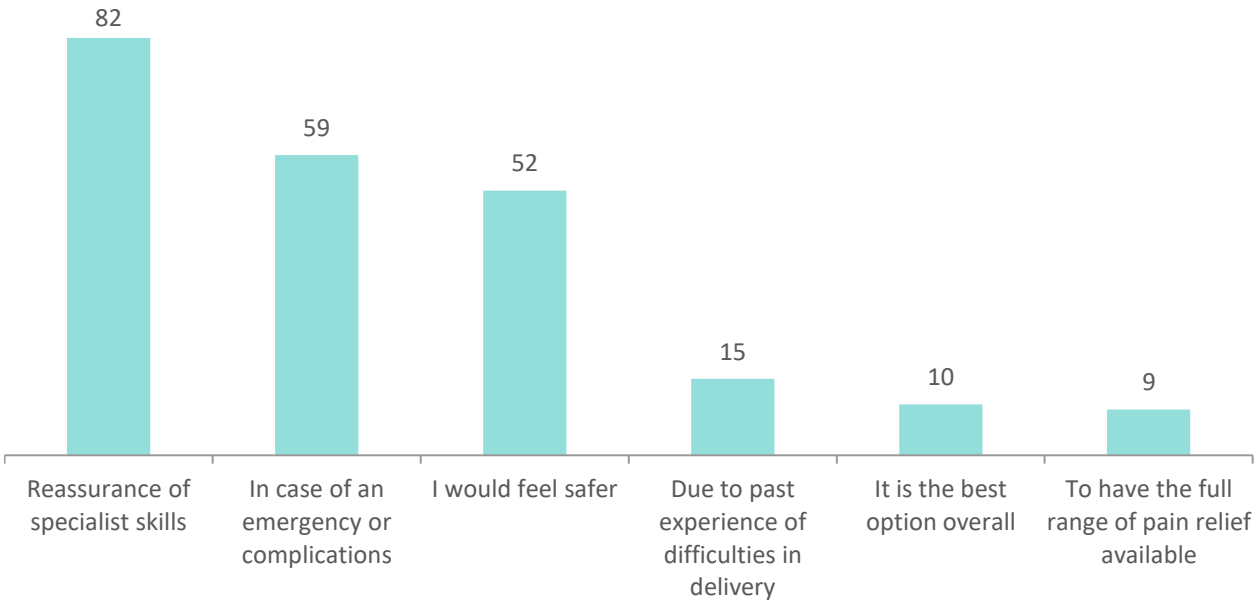
Consultant-led unit
(Base size 925)



Preference for this setting was highest amongst respondents in Eaglescliffe (64%, base size of 11), Sedgefield (60%, base size of 15), Spennymoor (59%, base size of 22) and Newton Aycliffe (59%, base size of 39). In contrast, 33% of respondents in Darlington Borough (base size of 137) reported that the consultant-led unit would be their least preferred delivery setting.

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	39	61	39	22	15	78
1st	**59%**	**30%**	26%	**59%**	**60%**	**37%**
2nd	26%	28%	18%	14%	13%	24%
3rd	5%	16%	**31%**		13%	17%
4th	10%	26%	26%	27%	13%	22%

In terms of what particularly attracted women to the consultant-led units, themes in literal responses were similar to those for the alongside midwife-led unit and included:



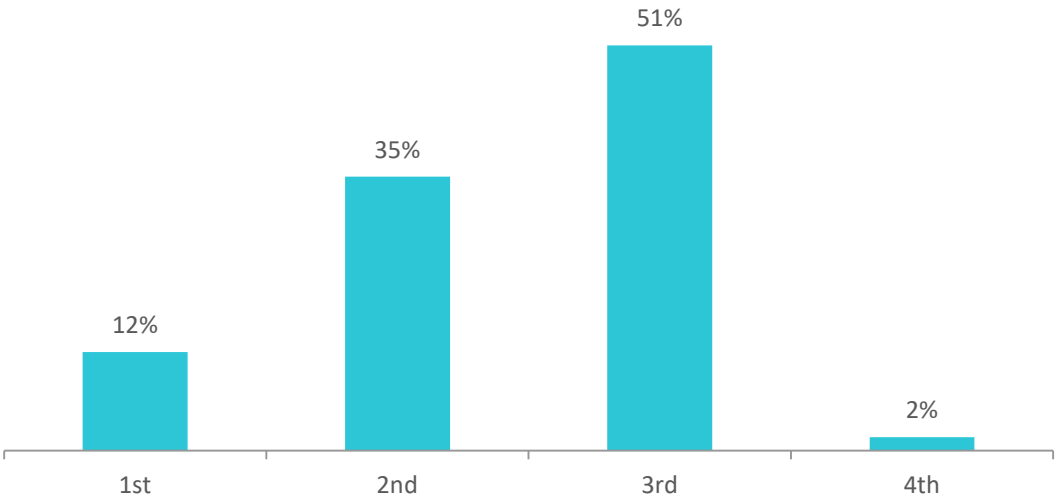
Literal comments included;

- *"Anything can happen during labour, I think a doctor should deliver in case of any complications"*
- *"Unexpected things can go wrong. I would feel happier if a doctor was in charge"*
- *"Safety first, I would want to be reassured that I was in safe hands"*
- *"It's important that you feel in safe hands. It's a stressful time anyway, going through labour and delivery"*
- *"From past experience, it is best to be prepared for an emergency"*

Standalone midwife-led unit, where there are no consultant doctors available

Over half of women interviewed (51%) stated that a standalone midwife-led unit would be their third preference of delivery setting, while a further 35% chose it as their second preference.

Standalone midwife-led unit, where there are no consultant doctors available (Base size 919)

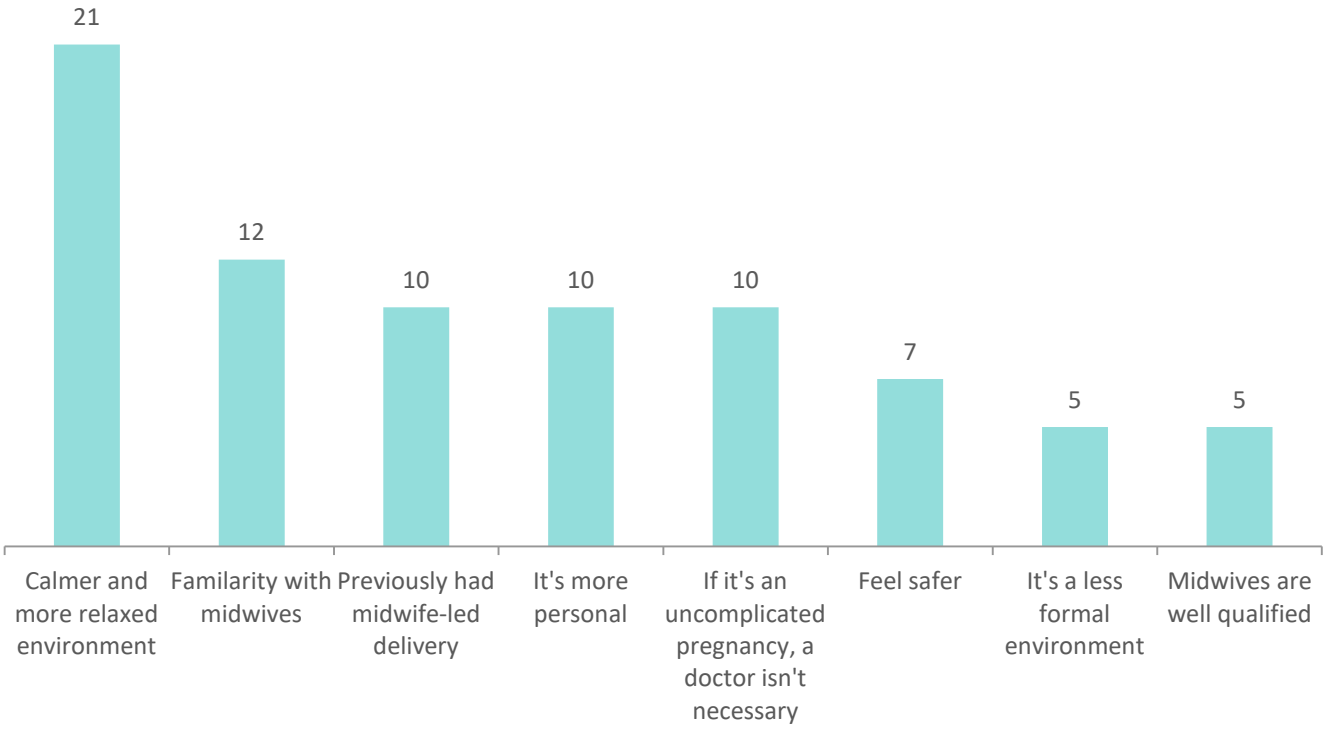


The overall results were consistent amongst women who had long term health conditions or a disability and those who didn't, though showed slightly more popularity amongst mothers (14% ranked first) compared to future mothers (11%).

The standalone midwife-led setting had the highest levels of popularity amongst respondents in Northallerton (36% ranked it their first choice, base size of 28), Bedale (33%, base size of 6), Darlington Borough (23%, base size of 137), Seaham/Peterlee (20%, base size of 20) and Barnard Castle (21%, base size of 38). Please note fluctuating base sizes. Results for each of the A689 locations can be found overleaf.

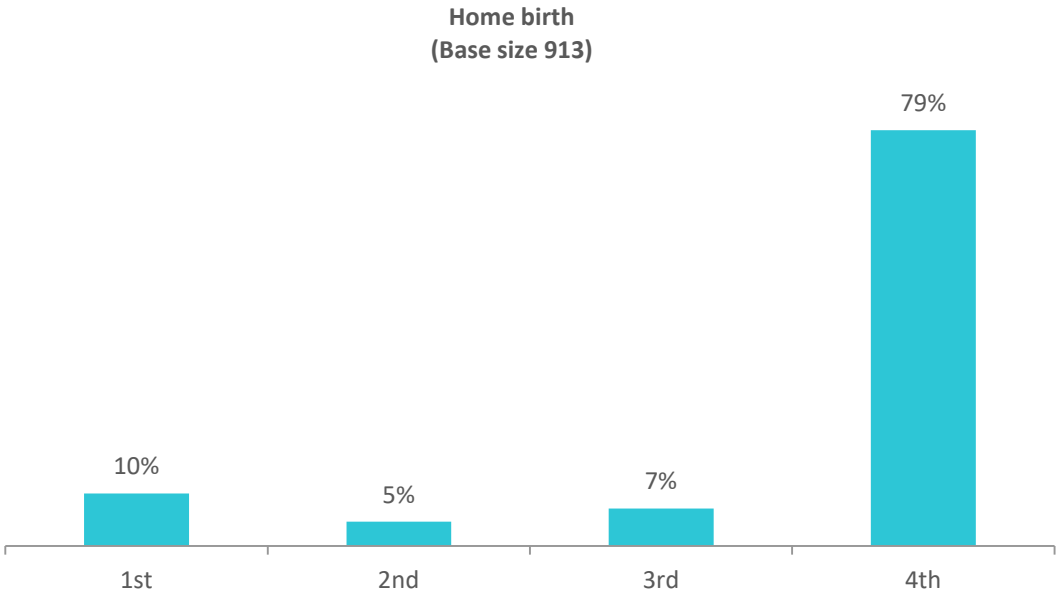
	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	38	61	38	22	15	78
1st	3%	8%	21%	9%	20%	12%
2nd	13%	25%	34%	18%	13%	24%
3rd	**82%**	**64%**	**42%**	**73%**	**67%**	**64%**
4th	3%	3%	3%			

When asked what particularly attracted them to the standalone midwife-led units, themes in literal responses from the women interviewed included:



Home birth

Preference for a home birth was low and a majority (79%) of respondents chose a home setting as their fourth and least preferred choice out of four.



There was a greater preference for a home birth setting amongst respondents in Seaham/Peterlee (35% ranked it their first choice, base size of 20), Bishop Auckland (25%, base size of 61), Spennymoor (19%, base size of 21) and Darlington Borough (17%, base size of 137). However, it was the least preferred setting across all research locations. Results per the A689 corridor locations were as follows:

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	39	61	38	21	15	78
1st	5%	25%	8%	19%	7%	13%
2nd	5%	5%		5%		6%
3rd	5%		21%	5%	7%	3%
4th	**85%**	**71%**	**71%**	**71%**	**87%**	**78%**

Those who were particularly attracted to a home birth setting typically felt that it would be more comfortable and relaxed, and some highlighted a desire to have their family around them during delivery. A minority of respondents had previously given birth at home, while others put their preference down to not needing to travel to a hospital setting.

Literal responses included:

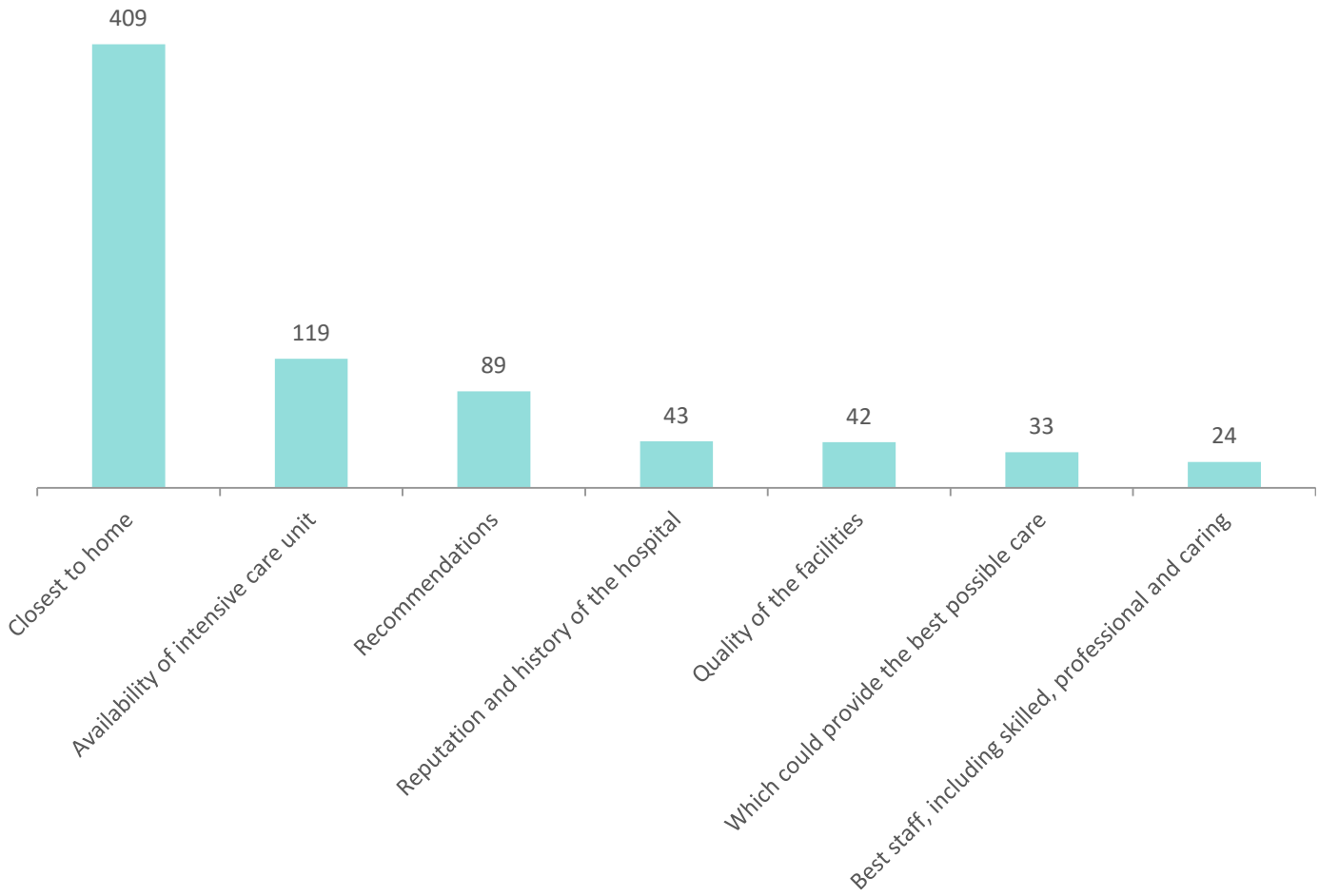
- *"It is less scary and not so clinical"*
- *"I had my little boy at home and it was the most relaxing and easy time"*
- *"I would love a home birth as I think it is more personal to have your family near"*
- *"I would prefer my home comforts where I can choose who is around me"*

Factors leading to choosing a unit

To gain a greater understanding of the drivers behind future behaviours, respondents were asked:

"If you had a choice between two consultant-led units (in two different towns), what factors would lead you to choose one unit over the other?"

Key themes identified through analysis of literal comments included:



Literal comments included;

Closest to home

- *"Distance from home so it's not too far to travel. If they are both the same you want the closest to home"*
- *"I have no transport so I would have to go to the closest hospital"*
- *"I would choose James Cook as it is near to me"*
- *"Friends who have had a baby tell me to choose the one nearest to home"*

Availability of an intensive care unit

- *"Having an intensive care unit for my baby in case of any complications"*
- *"An intensive unit for babies would make me choose"*
- *"The intensive care unit is my priority"*

Recommendations

- *"I would choose Durham due to word of mouth because I think it is a better hospital that has all of the facilities you need"*
- *"Recommendations from family and friends are important. If you hear nasty things from previous births you wouldn't want to go there and have it happen to you"*
- *"Recommendations - you would always go with somewhere that has a good reputation"*
- *"Family tell me the best care around is James Cook hospital"*

Quality of the facilities at the site

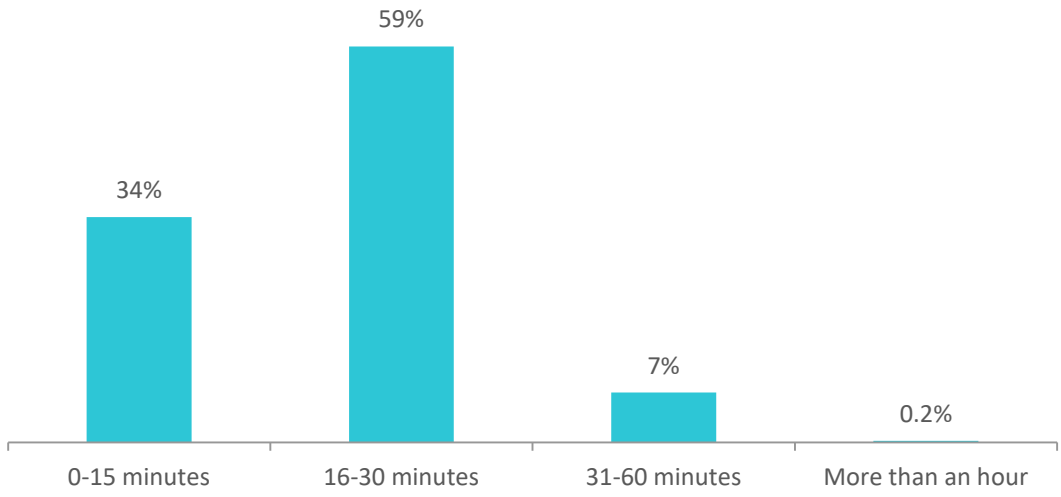
- *"The bigger hospital of the two. It would have all of the facilities"*
- *"The environment of the place and the facilities that are the best"*
- *"The one which had the most up to date facilities"*

Themes in literal comments made by respondents in the A689 corridor locations have been identified and this analysis can be found in Appendix Three.

Travel to give birth

Respondents were asked how long they would expect to travel to a unit to give birth. Over half (59%) of all women interviewed reported that they would expect to travel for between 16 and 30 minutes, while a third (34%) expected a shorter travel time of 0 to 15 minutes.

How long would you expect to travel to a unit to give birth?
(Base size 936)



Respondents interviewed in Stockton-on-Tees, Middlesbrough (Central) and Darlington Borough reported expectations of shorter travel times, with 66%, 55% and 49% of women respectively who expected to travel 0-15 minutes to give birth.

Full results by local authority area can be found in the table overleaf.

	Overall	Durham	Hartlepool	Darlington Borough	Stockton	Middlesbrough	Redcar and Cleveland	North Yorkshire
	936	244	59	130	146	100	134	120
0-15 minutes	34%	18%	39%	48%	**55%**	**51%**	31%	11%
16-30 minutes	**59%**	**70%**	**54%**	**49%**	45%	44%	**65%**	**72%**
31-60 minutes	7%	12%	5%	2%	1%	5%	5%	18%
More than an hour	0.2%	0.4%	2%					

Respondents who lived in Stockton and Middlesbrough Council areas typically expected to travel shorter lengths of time to a unit to give birth, with 55% and 51% of respondents respectively stating they would expect to travel for between 0 and 15 minutes. Respondents in North Yorkshire and Durham County Council areas demonstrated an expectation for longer travel time, with 18% of respondents in North Yorkshire expecting travel time of between half an hour and an hour; 12% of respondents in Durham also expected to travel for 31-60 minutes.

Respondents in Hartlepool typically expected to travel for a shorter length of time compared to respondents in Newton Aycliffe and Barnard Castle:

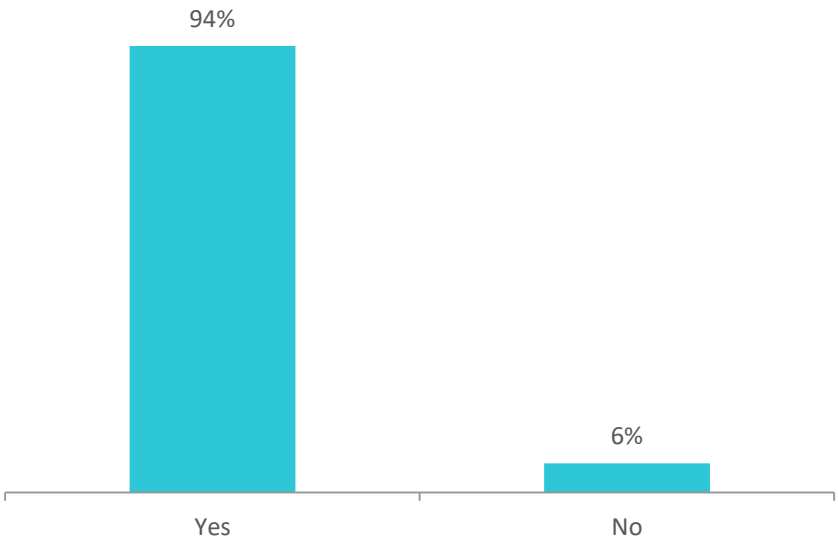
	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	40	59	39	22	14	77
0-15 minutes	8%	20%	13%	18%	21%	35%
16-30 minutes	**80%**	**70%**	**77%**	**68%**	**71%**	**57%**
31-60 minutes	13%	9%	10%	14%	7%	7%
More than an hour		2%				1%

Respondents were asked if they would be prepared to travel further for specialist care if it was needed, after being read the following preamble:

> Some women with more complicated pregnancies require care from a specialist doctor or specialist midwife, for example women who develop conditions during their pregnancy such as very high blood pressure or diabetes. Specialist clinics are also now held for women expecting twins and for women with conditions such as cystic fibrosis, severe asthma and epilepsy.

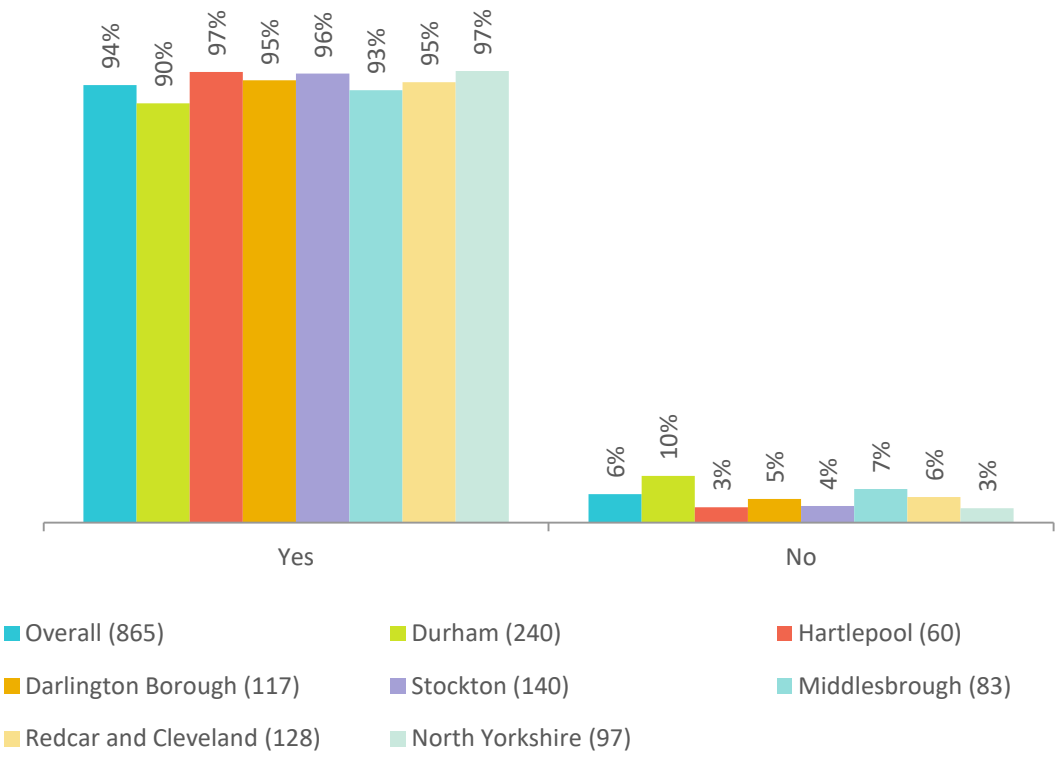
A majority (94%) of all women interviewed stated that they would be prepared to travel for specialist care.

Would you be prepared to travel further for this type of specialist care if it was needed?
(Base size 868)



These findings were consistent between women who had long term health conditions or a disability (92%) and those who didn't (94%).

Would you be prepared to travel further for this type of specialist care if it was needed? By local authority area



A majority of women in all local authority areas reported that they would be prepared to travel further for specialist care. This figure was highest amongst women in the North Yorkshire County Council and Hartlepool regions, where 97% of respondents respectively said they would be prepared to travel further. In contrast, 90% of respondents in the Durham County Council patch reported that they would travel further; one in ten respondents in this area would not be prepared to travel further.

A higher proportion of respondents in Barnard Castle and Hartlepool were prepared to travel for specialist care compared to respondents in Newton Aycliffe:

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	39	61	37	22	15	79
Yes	**85%**	**92%**	**95%**	**91%**	**93%**	**95%**
No	15%	8%	5%	9%	7%	5%

The minority (6% overall) of respondents who reported that they would not be prepared to travel for specialist care were asked why that was the case. Key themes in literal responses were:

I wouldn't want to travel / it would be difficult to travel (13)

- *"I have no transport, it would be difficult to have to go to another area"*
- *"Because I don't drive it would need to be close"*
- *"It takes an age to get there and if you need care it can be so inconvenient seeing consultants in other areas"*

All hospitals should have specialist facilities (12)

- *"It should be available nearby. You shouldn't have to travel to get the care"*
- *"This specialist care should be available in every maternity department"*
- *"I don't think that it should be too far away, every hospital should have a unit for this"*

Possible changes to maternity services

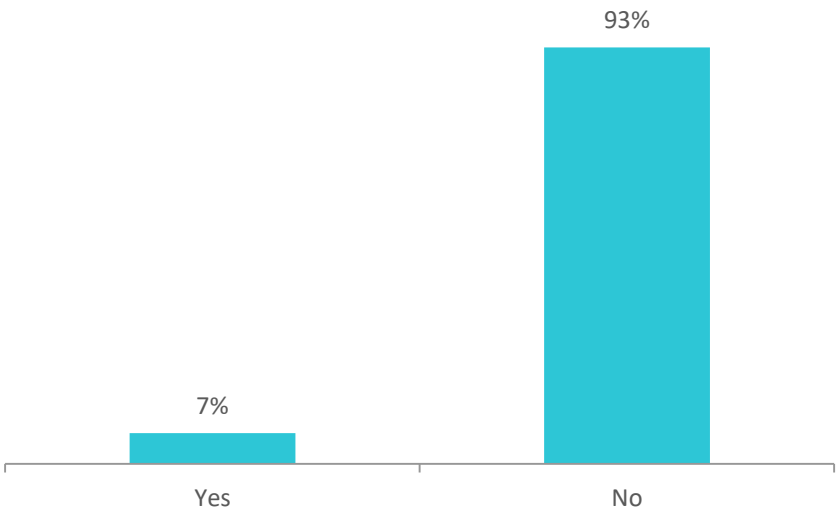
As part of a Sustainability and Transformation Plan (STP), the Better Health Programme may look to make changes to maternity services in the future. With this in mind, our research sought to understand if local women would have concerns about service change.

All respondents were read the following information:

> Local doctors and nurses believe that we may need to change the way that we provide maternity services. A possible change to maternity services could involve centralising consultant-led maternity care at one or two hospitals, one of which would include intensive care for very premature babies.

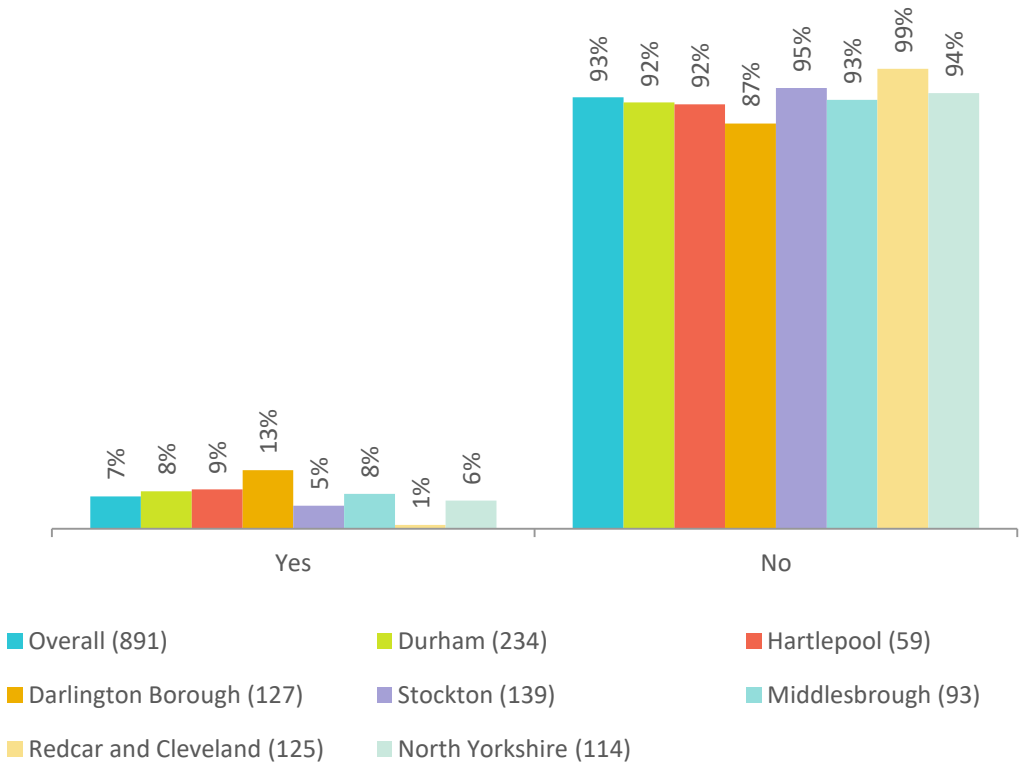
A majority of respondents (93%) reported that they would not have any concerns about the possible centralisation of consultant-led maternity care, while the remaining 7% would have concerns. This figure was slightly higher amongst women with long term health conditions, 8% of whom reported that they would have concerns about the possible changes.

Would you have any concerns about these possible changes?
(Base size 895)



Levels of concern were notably higher than the overall figures in Crook, where 43% of women interviewed (base size of 14) said they would have concerns about the possible changes. A further 17% in Richmond (base size of 53), 16% in Newton Aycliffe (base size of 31) and 12% in Middlesbrough (base size of 59) felt the same way.

Would you have any concerns about these possible changes? By local authority area

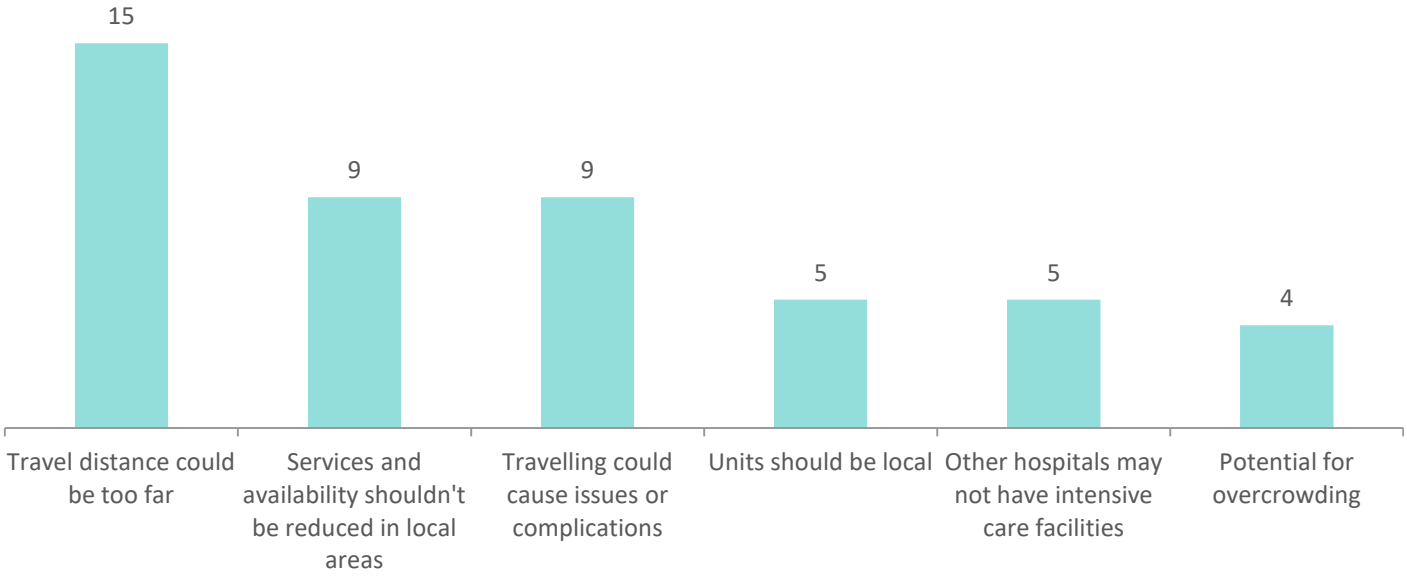


Looking at differences in results between local authority areas, the highest levels of concern about the possible changes were seen in the Darlington (13%) and Hartlepool (9%) council areas. In contrast, 99% of respondents in Redcar and Cleveland reported that they would not have any concerns about the possible changes.

A higher proportion of respondents in Newton Aycliffe reported that they would have concerns (16%) compared to respondents in Spennymoor and Sedgefield (0% in both locations).

	Newton Aycliffe	Bishop Auckland	Barnard Castle	Spennymoor	Sedgefield	Hartlepool
	31	61	37	21	14	78
Yes	16%	2%	3%	0%	0%	8%
No	**84%**	**98%**	**97%**	**100%**	**100%**	**92%**

The 7% of women overall who did have concerns were asked what their concerns would be. Key themes identified in analysis of literal comments included:



Literal comments included:

Travel distance

- *"It depends where it's centralised to as you may have to travel further depending on where you live which could damage the pregnancy"*
- *"Because it is too far, they should have one in each town as things can change so quickly"*
- *"If my baby was in danger then I would want the service at the nearest hospital"*

Services and availability shouldn't be reduced in local areas

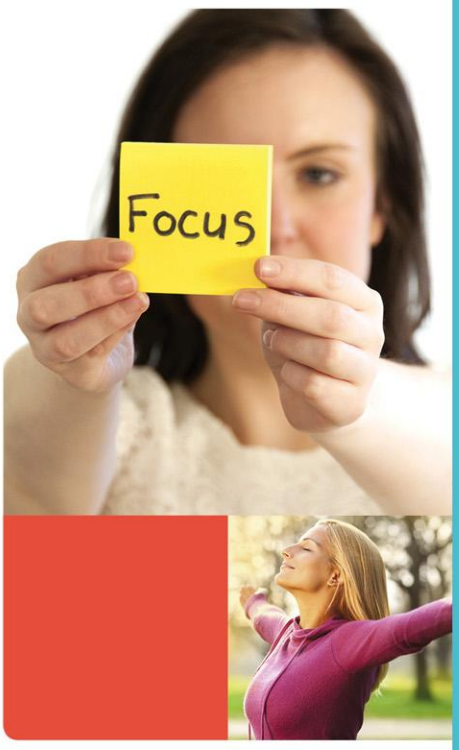
- *"It's ridiculous that they're reducing the service and choice availability in the local area"*
- *"All hospitals should provide all services, you should not have to go out of the area"*
- *"Not having many available would worry me"*

Potential for overcrowding

- *"If it is only going to be in one or two hospitals, there is going to be some overcrowding in the one that has the specialist care"*
- *"Imagine all the travel up and if there wasn't a bed for me because it was too overcrowded in my area"*
- *"If it was too far and if there were too many people in the same place"*

4.0 Conclusions

Conclusions based on results as detailed.



Conclusions

Thinking about the priorities of local women in terms of maternity services, similarities were seen between priorities in relation to antenatal and postnatal care, and labour and delivery. At all times during their pregnancy journey, the availability of staff possessing skills and experience is a key priority for women. This was seen when considering antenatal and postnatal services, with over a quarter (27%) of all respondents ranking 'availability of staff with the right skills and experience' their number one priority, while 'availability of consultant doctors' was the top priority for 28% of women during labour and delivery.

Distance to travel appeared to divide respondents, with this either being a very high priority or a very low priority for both antenatal and postnatal care, and during labour and delivery. Looking at the differences in priority between research locations, distance to travel was a greater consideration at all stages of the pregnancy journey for women in Catterick, Bishop Auckland, Richmond, and Skelton/Brotton/Loftus.

Over half (59%) of respondents would expect to travel 16 to 30 minutes to a unit to give birth, and a majority (94%) of women interviewed reported that they would be willing to travel further for specialist care should this be required. Of those who stated that they would not be prepared to travel further for this type of care, this was typically because they felt it would be difficult to travel due to personal circumstances or that the specialist care should be available at all maternity sites.

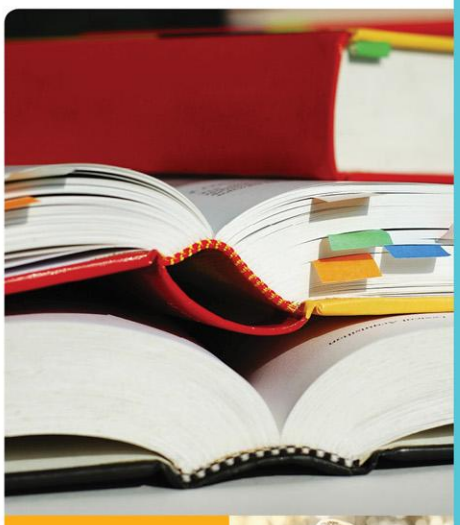
A strong preference was seen for the alongside midwife-led delivery setting, with over half (52%) of respondents considering this their first choice. Over a quarter (26%) of respondents preferred the consultant-led unit, 12% preferred a standalone midwife-led setting, and the remaining 10% reported that they would choose a home birth.

Proximity to their home played a key role for respondents when faced with a decision between two consultant-led units in two different towns. Availability of intensive care facilities was important, as were recommendations and the reputation of the unit.

When introduced to the possible changes in local maternity services, a majority of respondents (93%) would not have any concerns about these. For those who did have concerns, these were centred on the distance which may be required to travel to receive care, the potential for overcrowding, and some felt more broadly that services should not be taken away from local areas.

5.0 Appendices

Resources including the questionnaire and showcards used in the research can be found here.



Appendix 1 – On-street survey

NHS Better Health Programme

Good morning/afternoon. My name is X from Explain, an independent research agency. I am working on behalf of the NHS Better Health Programme - a group of local NHS organisations - who are considering what changes might be needed to health services. As such, they are keen to understand what is important to you about the care you and your family receives from local maternity services and how they can make it better. Your comments will help to inform proposals about how these services could be provided in the future.

Would you be able to spare around ten minutes to answer some questions to contribute to the research?

The interview will be conducted in line with the Market Research Society code of conduct and any information you give us will be treated in the utmost confidence.

Quota information

Q1 Are you a mother?

- ◯ Yes
- ◯ No (Go to Q3)

Q2 How old is your youngest child?

- ◯ Under 12 months
- ◯ 1-2 years
- ◯ 3-5 years
- ◯ 6 years or older (Go to Q3)

Q3 Do you plan to have children in the future? [Only ask non mothers or those whose youngest child is 6 years or older]

- ◯ Yes (class as future mothers)
- ◯ No (**thank and close**)

Q4 In which town do you live? (For analysis purposes)

Q5 In which area on our map is this? [**SEE SHOWCARD A**]

- ◯ Light green
- ◯ Purple
- ◯ Yellow
- ◯ Orange
- ◯ Pink
- ◯ Dark green
- ◯ Blue
- ◯ Other (**thank and close**)

Q6 Can I take your full postcode please? (For analysis purposes)

Q7 How old are you?

- ◯ 16-19
- ◯ 20-29
- ◯ 30-39
- ◯ 40+
- ◯ Refused

READ OUT IN FULL: The health needs of the population are changing both locally and nationally, and specialisation in healthcare is resulting in better, safer care. With this in mind, local clinical professionals believe there is a need to change how care is provided near you.

Local healthcare organisations are looking at how more care can be provided outside hospital in communities, particularly for uncomplicated pregnancies. For the many mums with uncomplicated pregnancies, care during labour can be managed by a midwife at home or in a midwife-led unit. Women whose pregnancies are considered more complicated may need support from specialist doctors (obstetricians, anaesthetists and paediatricians).

Thinking first about antenatal and postnatal care...

Q8 Thinking about antenatal and postnatal care, please could you rank the following factors in order of your priorities in relation to these services, from 1st to 7th, where 1st is equal to your highest priority and 7th is equal to your lowest priority:
[Please select only one of each ranking]

	1st	2nd	3rd	4th	5th	6th	7th	Don't know
Distance to travel	○	○	○	○	○	○	○	○
Ease of access (e.g. public transport, parking)	○	○	○	○	○	○	○	○
Availability of staff with the right skills and experience	○	○	○	○	○	○	○	○
Having a range of different services available under one roof (e.g. breastfeeding support, stop smoking advice, ultrasound tests)	○	○	○	○	○	○	○	○
Caring and compassionate staff	○	○	○	○	○	○	○	○
Flexible appointment times	○	○	○	○	○	○	○	○
Having all of your care before and after giving birth led by the same small team of midwives	○	○	○	○	○	○	○	○

Q9 Please can you explain your ranking? [Unprompted]

READ OUT IN FULL: Local NHS organisations would like to provide more antenatal and postnatal care out of hospital with much of the care being provided in the community and available under one roof.

Services available at these places might include:
- Antenatal and postnatal clinics all in one place
- Ultrasound tests
- Breastfeeding support
- Baby care / education
- Stop smoking advice
- Healthy eating advice

Q10 Are there any other services or support which you would find helpful to have available in these community settings? [Unprompted]

Thinking now about labour and delivery...

Q11 Thinking about care during labour and delivery and assuming an uncomplicated pregnancy, please could you rank the following factors in order of your priorities in relation to this care, from 1st to 7th, where 1st is equal to your highest priority and 7th is equal to your lowest priority:
[Please select only one of each ranking]

	1st	2nd	3rd	4th	5th	6th	7th	Don't know
Distance to travel to your delivery setting	○	○	○	○	○	○	○	○
Range of pain relief available (e.g. gas and air, epidural)	○	○	○	○	○	○	○	○
Availability of consultant doctors (obstetricians, anaesthetists, paediatricians)	○	○	○	○	○	○	○	○
Having your baby delivered by the same small team of midwives who provided care during pregnancy	○	○	○	○	○	○	○	○
Pleasant and relaxing environment	○	○	○	○	○	○	○	○
Availability of birthing pools	○	○	○	○	○	○	○	○
Facilities for birthing partners, including somewhere to stay	○	○	○	○	○	○	○	○

Q12 [SEE SHOWCARD B] Thinking about your place of delivery and again assuming an uncomplicated pregnancy, please could you rank the following four choices from 1st to 4th, where 1st is equal to the place of delivery you would most prefer and 4th is equal to the place of delivery you would least prefer:
[Please select only one of each ranking]

	1st	2nd	3rd	4th	Don't know
Home birth	○	○	○	○	○
Standalone midwife-led unit (where there are no consultant doctors available)	○	○	○	○	○
Alongside midwife-led unit (next to or in the same hospital as a consultant-led unit)	○	○	○	○	○
Consultant-led unit	○	○	○	○	○

Q13 Please can you explain what particularly attracts you to this delivery setting? [Unprompted, then probe]

Q14 If you had a choice between two consultant-led units (in two different towns), what factors would lead you to choose one unit over the other? [Unprompted, then e.g. distance from home, intensive care unit for babies, recommendations from friends/family, accommodation for partners etc.]

Q15 How long would you expect to travel to a unit to give birth?

- ◯ 0-15 minutes
- ◯ 16-30 minutes
- ◯ 31-60 minutes
- ◯ More than an hour
- ◯ Don't know

Q16 Some women with more complicated pregnancies require care from a specialist doctor or specialist midwife, for example women who develop conditions during their pregnancy such as very high blood pressure or diabetes. Specialist clinics are also now held for women expecting twins and for women with conditions such as cystic fibrosis, severe asthma and epilepsy.
Would you be prepared to travel further for this type of specialist care if it was needed?

- ◯ Yes
- ◯ No (Go to Q17)
- ◯ Don't know

Q17 If no, why is that? [Unprompted, then probe]

READ OUT IN FULL: Local doctors and nurses believe that we may need to change the way that we provide maternity services. A possible change to maternity services could involve centralising consultant-led maternity care at one or two hospitals, one of which would include intensive care for very premature babies.

Q18 Would you have any concerns about these possible changes?

- ◯ Yes (Go to Q19)
- ◯ No
- ◯ Don't know

Q19 If yes, what would these concerns be? [Unprompted]

Respondent Information

Q20 What is the occupation of the main wage earner in your household (or what was the occupation of the main wage earner before retirement)?

Q21 **RESEARCHER TO CODE:** SEG

- ○ A
- ○ B
- ○ C1
- ○ C2
- ○ D
- ○ E

Q22 Do you have any long term health conditions or a disability?

- ○ Yes
- ○ No
- ○ Refused

Q23 What is your ethnic origin?

- ○ White British
- ○ White Irish
- ○ White Other
- ○ Mixed Caribbean
- ○ Mixed African
- ○ Mixed Asian
- ○ Mixed Other
- ○ Asian Indian
- ○ Asian Pakistani
- ○ Bangladeshi
- ○ Asian Other
- ○ Black Caribbean
- ○ Black African
- ○ Black other
- ○ Chinese
- ○ Gypsy/Traveller
- ○ Refused
- ○ Unknown
- ○ Other (please state below)

Other

Q24 Which of the following best describes your sexual orientation?

- ○ Heterosexual / straight
- ○ Homosexual / lesbian
- ○ Bisexual
- ○ Other (Please state below)
- ○ Refused

Other

Q25 Name (REQUIRED FOR VERIFICATION)

Q26 Address (REQUIRED FOR VERIFICATION)

Q27 Telephone number (REQUIRED FOR VERIFICATION)

Q28 Would you be happy for NHS Better Health Programme to use your contact details in future to get in touch about further research regarding healthcare services?

- ◯ Yes (Go to Q29)
- ◯ No

Q29 If yes, please can I take your email address?

Thank you for your time today. Take care.

Q30 Date of interview:

Q31 Time of interview:

Q32 Name of researcher:

- ◯ Beverley Jackson
- ◯ Catherine Scrivener
- ◯ Julie Kleinee
- ◯ Margaret Vickers
- ◯ Maureen Plunkett
- ◯ Rosalyn Gray
- ◯ Sandra Grant
- ◯ Val McNally
- ◯ Other (Please state below)

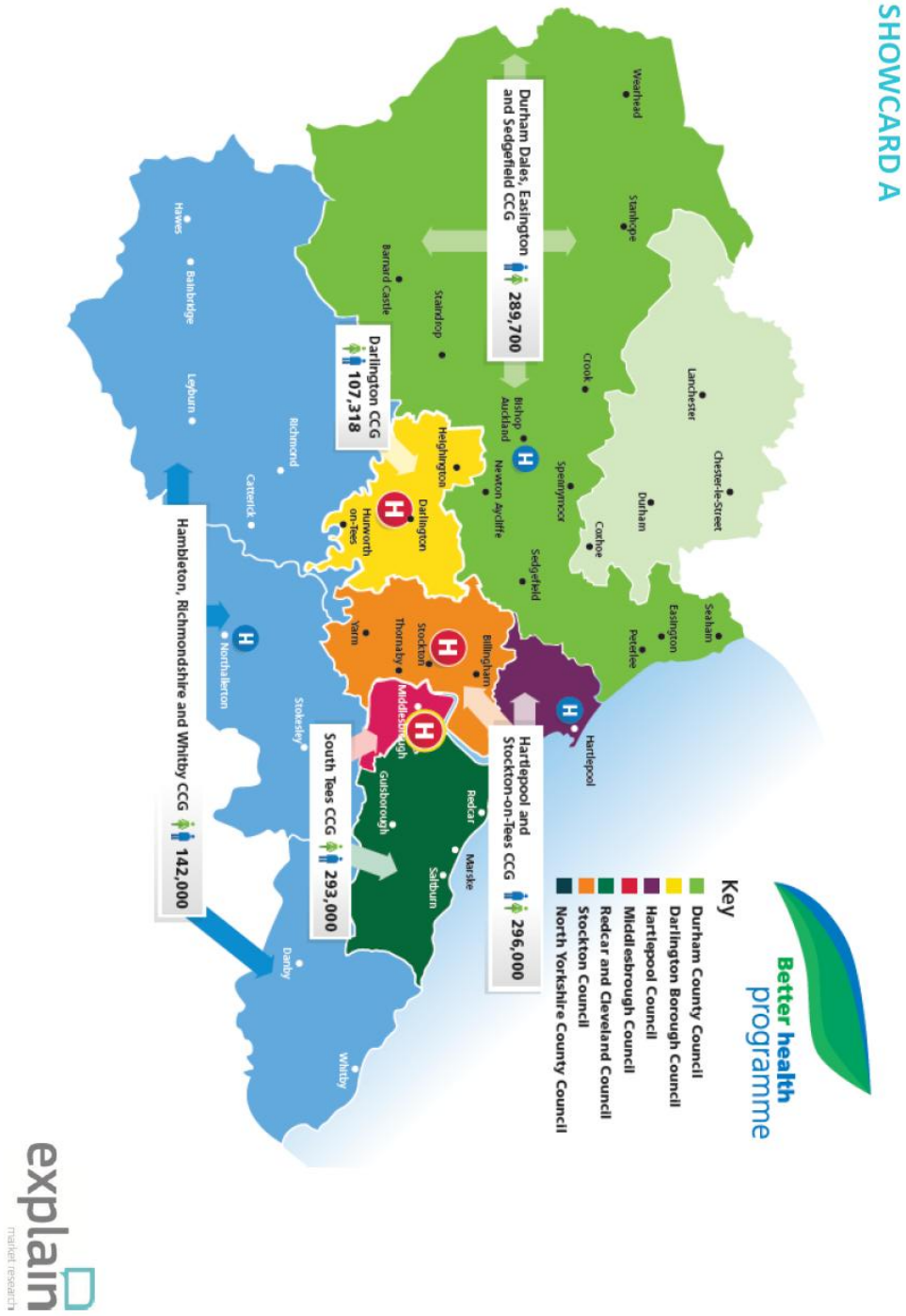
Other

Q33 Research location:

- ◯ Newton Aycliffe
- ◯ Bishop Auckland
- ◯ Barnard Castle
- ◯ Peterlee
- ◯ Crook
- ◯ Spennymoor
- ◯ Sedgefield
- ◯ Seaham
- ◯ Darlington Borough
- ◯ Hartlepool
- ◯ Stockton-On-Tees
- ◯ Eaglescliffe
- ◯ Thornaby
- ◯ Billingham
- ◯ Yarm
- ◯ Middlesbrough (Central)
- ◯ Eston
- ◯ Guisborough
- ◯ Skelton/Brotton/ Loftus
- ◯ Redcar
- ◯ Northallerton
- ◯ Richmond
- ◯ Leyburn
- ◯ Stokesley
- ◯ Thirsk
- ◯ Bedale
- ◯ Other (Please state below)

Other

Appendix 2 – On-street showcards



SHOWCARD B

Home birth

- Midwifery-led care
- Can hire birthing pool
- Limited pain relief available, e.g. gas and air
- Transferred by ambulance to consultant-led unit if your midwife has concerns about you or your baby

Standalone midwife-led unit

- Midwifery-led care
- Some have a birthing pool
- Limited pain relief available, e.g. gas and air
- No doctors available on site
- Transferred by ambulance to consultant-led unit if your midwife has concerns about you or your baby

SHOWCARD B

Alongside midwife-led unit

- Midwifery-led care
- Some have a birthing pool
- Limited pain relief available, e.g. gas and air
- Situated next to or on the same hospital site as a consultant-led unit
- Transferred to consultant-led unit on site if your midwife has concerns about you or your baby

Consultant-led unit

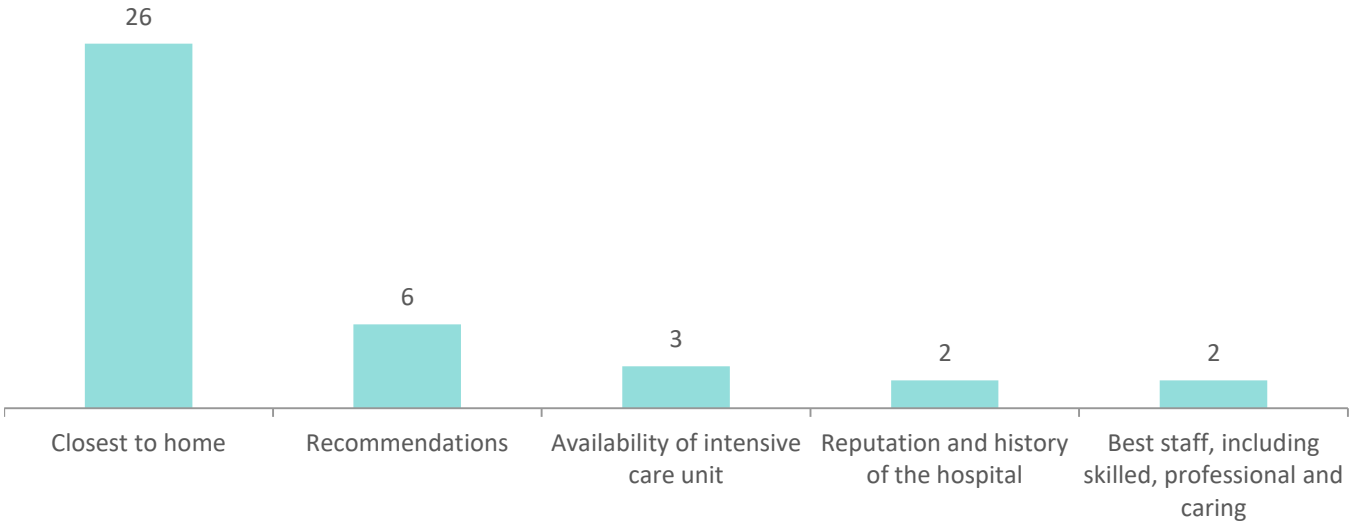
- Midwifery-led care with consultants also available
- Birthing pool available
- Full range of pain relief available, e.g. epidural
- Specialist doctors (obstetricians, anaesthetists and paediatricians) on hand in the same building should complication occur, e.g. emergency caesarean section, baby needs special care

Appendix 3 – Additional literal analysis

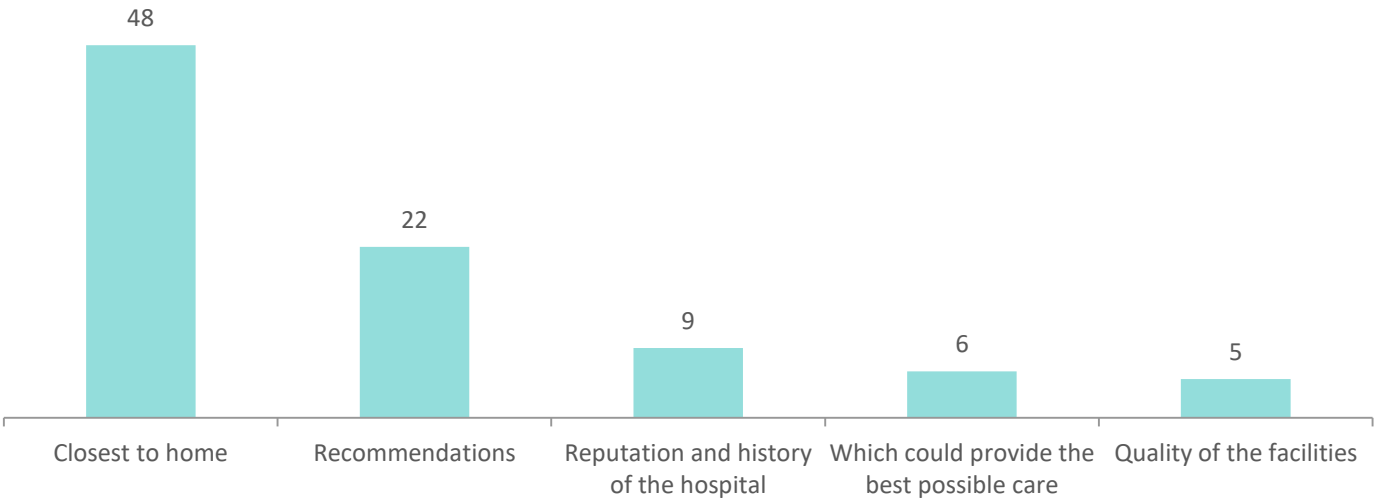
'Factors leading to choosing a consultant-led unit' - key themes for A689 locations

Please note there are fluctuating base sizes between locations.

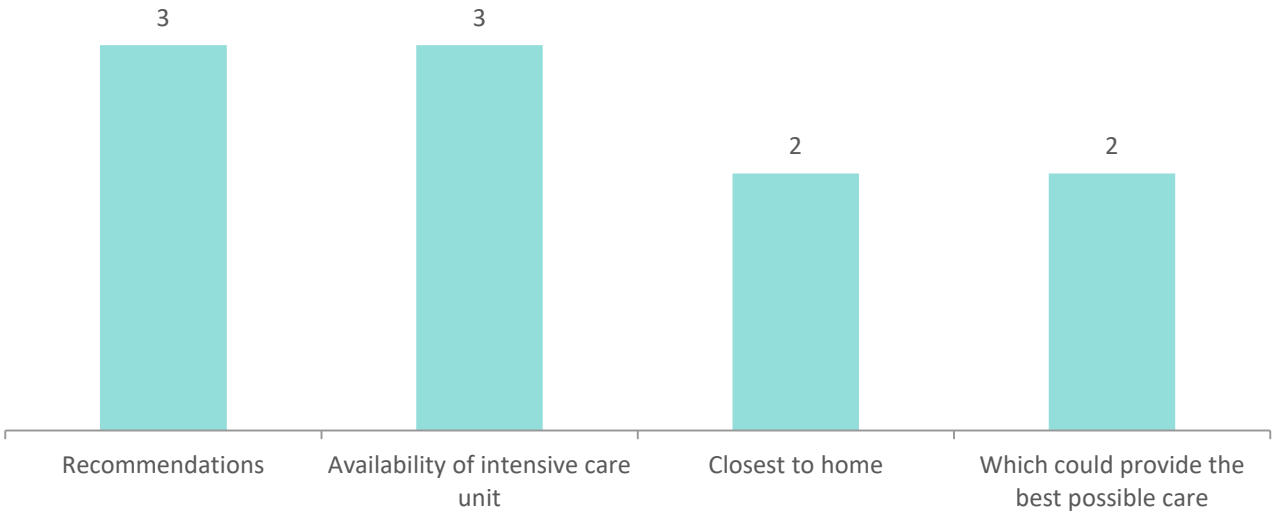
Newton Aycliffe



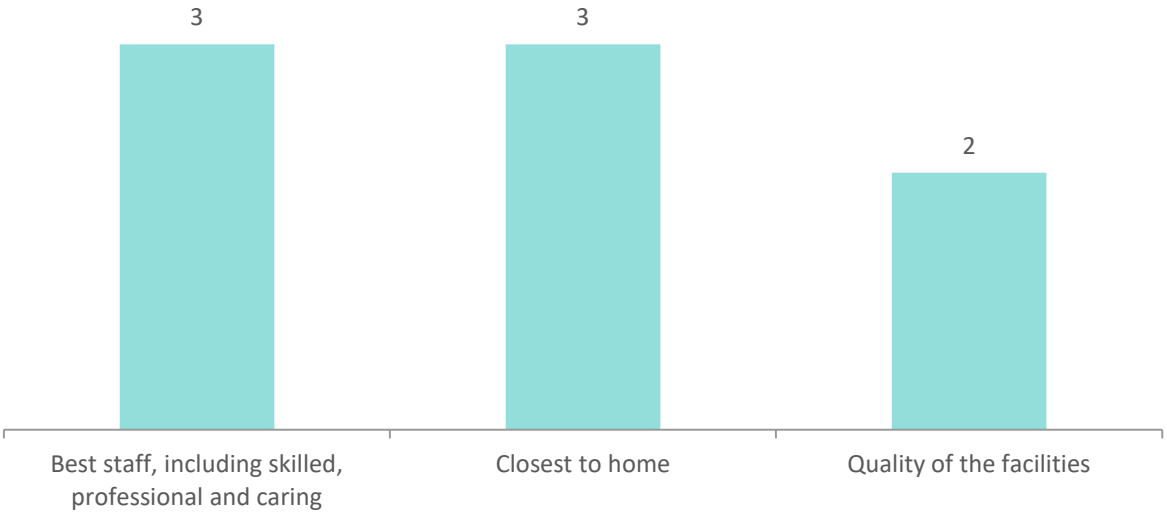
Bishop Auckland



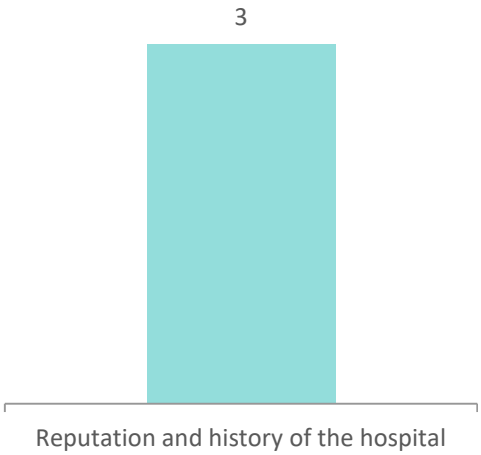
Barnard Castle



Spennymoor

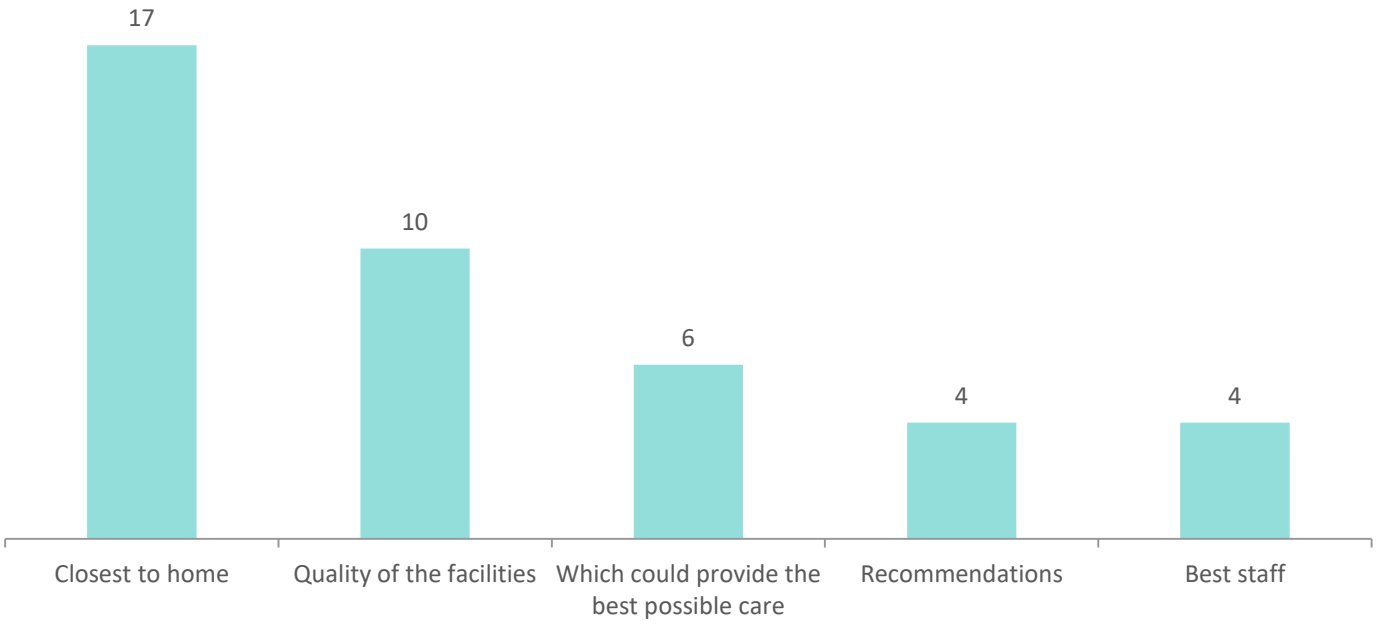


Sedgefield



Please note, other comments were given by respondents in Sedgefield, however themes were not identified due to very small base sizes.

Hartlepool



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The NHS in Darlington, Durham and Tees

NHS Better Health Programme

Maternity & Paediatric Services

Voluntary and Community Group Conversations Feedback Report

ACE's Internet Café Mother and Toddler Group

April 2017

NHS Better Health Programme

Engagement with Voluntary and Community Sector Groups

1. Background:

The NHS Better Health Programme (BHP) committed to having conversations with over 100 voluntary and community sector groups and organisations across County Durham, Darlington and Tees Valley.

NHS Better Health Programme particularly wanted to encourage smaller community-based groups and organisations to engage in conversations about the NHS Better Health Programme representing the following: .

- Groups whose members identified themselves as having 'protected characteristics,' as defined in current equalities legislation (sex, disability, race, age, religion & belief, sexual orientation, gender reassignment, pregnancy & maternity)
- Groups that may meet regularly but do not normally choose, or have the opportunity, to engage in discussions around this type of health issue.

VONNE as a regional infrastructure organisation representing and supporting the voluntary sector with significant reach over the BHP area acted as the lead body working with other CVS/ LDA (Local development agencies), Healthwatch and key special interest group organisations to support delivery of the 100 conversations across County Durham and Tees Valley between August and December 2016 as part of the BHP Engagement plan. This work enabled NHS Better Health Programme to build a full picture of the needs of all parts of the community, particularly groups that experience health and wellbeing inequalities and enable members of those groups and communities to influence the health services they use.

Following these conversations North East Commissioning Support Unit (NECS) commissioned VONNE to lead on co-ordinating delivery of a further 50 conversations with smaller voluntary groups around their views on maternity and paediatric services

2. The structure for voluntary and community sector engagement

. The delivery partners for the maternity and paediatric conversations were as follows:

	Partner Organisation	Area delivered	Interest group
1.	Redcar & Cleveland Voluntary Development Agency (RCVDA)	Redcar & Cleveland	Mixed
2.	Catalyst Stockton	Stockton & Hartlepool	Mixed
3.	Playgroup Network	Tees Valley	Parents of Young children
4.	East Durham Trust	East Durham	Mixed
5.	Healthwatch Darlington	Darlington	Mixed
6.	Middleborough Voluntary Development Agency (MVDA)	Middlesbrough	Mixed
7.	Durham Community Action (DCA)	Co. Durham	Mixed
8.	Darlington Association on Disability (DAD)	Darlington	Disabled children and young people

Each delivery partner identified smaller community and voluntary sector groups within the target communities and approached those groups about having a discussion with their members/participants. The final list of groups was agreed with VONNE and the NHS North of England Commissioning Support Communications and Engagement Team. (See full list at Appendix A).

Groups participating in a discussion were offered a ‘supported’ conversation facilitated by the local delivery partner organisation.

A facilitators engagement pack including information about the NHS Better Health Programme, advice on how to facilitate the discussion and information on how to feedback the responses from the discussion group was developed with input from VONNE and key representatives of delivery partners. Information was produced in other languages as requested. Standard feedback templates were agreed to ensure the format of feedback was standard across all partners.

The facilitated discussions with groups took place during March and April 2017 and each delivery partner organisation provided VONNE with numbers of the people who were involved in the discussion and the key feedback from the discussion on the feedback template provided by NECS.

46 group conversations had taken place by mid April 2017 with 421 participants providing their feedback.

Gender Specific (Women) **6%** Disabled People **7%** General Public **13%** Parent Carers **7 %** Parents **19%**
Parents of Babies **8%** Parents of Young Children **36%** People of a particular ethnic/racial origin **11%** Young People **9%**

NB. Some groups came under two beneficiary categories therefore have been accounted for twice.

VONNE has managed the collation of the conversation feedback notes via delivery partners and produced this feedback report summarising and analysing the feedback from the conversations so far. Appendix A sets out the full list and profile of groups engaged and Appendix B contains each individual feedback from for each group.

3. NHS Better Health Programme – Maternity & Paediatric Conversations Overview of questions

a) The National Maternity Review (Cumberlege Report) recommendations were highlighted to the groups which recommends that every woman:

> "…should develop a personalised care plan, with their midwife and other health professionals, which sets out her decision about her care reflecting her wider health needs"
>
> "…should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally"
>
> "Community hubs should enable women and families to access care close to home, in the community from their midwife and from a range of other services, particularly for antenatal and postnatal care."

b) Current and forthcoming issues for maternity, paediatrics and neonatal were highlighted:

Increasing specialisation leading to better care for:

- More mothers to be with risk factors
- More premature babies, born earlier needing care for longer
- Children with long term conditions
- Specialisation and staffing pressures means we need to change how we provide care

c) A video with clinicians setting out the current challenges in maternity & paediatrics was shown where facilities allowed

d) The different options for maternity care were explained as follows:

Choice in maternity	
Home Birth	Midwife led care Can hire birthing pool Limited pain relief available, e.g. gas and air Transferred by ambulance to consultant-led unit if your midwife has concerns about you or your baby.

Standalone midwifery–led unit	Midwife leads care Some have a birthing pool Limited pain relief available, e.g. gas and air No doctors available on site Transferred by ambulance to consultant-led unit if your midwife has concerns about you or your baby.
Alongside midwifery–led unit	Midwife leads care Some have a birthing pool Limited pain relief available, e.g. gas and air Situated next to or on the same hospital site as a consultant –led unit Transferred to consultant-led unit on site if your midwife has concerns about you or your baby.
Consultant-led unit	Midwife leads care with consultants also available Birthing pool available Full range of pain relief available, e.g. epidural Doctors and specialist consultant on-hand in the same building should complication occur, e.g. emergency caesarean, baby needs special care
Community hub	Ante and post-natal clinics Ultrasound tests Smoking cessation Voluntary sector support Quick referral to the right expert

e) Paediatric Services - The different types of paediatric care were explained as follows:

What children's health services have your family used?	
Outpatient clinics	Appointment or series of appointments with a doctor or nurse
Paediatric A&E	Children only area of an A&E department
Day assessment units	An assessment and observation ward for children with less severe episodes of illness

Inpatient ward	For children who are seriously unwell, sometimes as a result of a long term condition
Regional centres at Newcastle and Leeds (No changes to Regional Centres are being considered as part of this process)	The most specialised care – this will not change

f) Questions put to the groups:

Maternity

1. What is important to you about the maternity care you and your family receives?

2. What influences your choice about where you would have your baby? e.g. (prompts) Midwife led care? Consultant presence? Pain relief? Safety? Distance to travel? Car parking? Facilities, e.g. birthing pool? Homely surroundings? Continuity of care (same team of midwives)? Other?

3. Which would you choose:
    a. Home birth – midwife-led (low risk only)
    b. Standalone midwife–led unit (low risk only)
    c. Alongside midwife–led unit (low risk only)
    d. Consultant led unit (low and high risk)

4. How we can make it better?

Paediatrics

1. What children's health services have your family used?
2. What is important to you about paediatric care?
3. How can we make it better?

4. Executive Summary Feedback:

Maternity Conversations – Key Summary Issues

Question 1

What is important to you about the maternity care you and your family receives?

Travel/Access:

‘Ease of access to services throughout pregnancy’

Access particularly from rural areas for women in labour, especially those with higher risk and pregnant women attending appointments who do not have access to a car. Cost and availability of transport was an issue. Women needing to get back to attend to other children after appointments so not having to travel long distances

Access for family/carers visiting by public transport was also a key issue.

Sufficient ambulances available to transfer to hospitals.

‘Most important factors for maternity care were locality’.

Specialist/consultant/midwifery care all being centralised and available close to home

‘Pregnancy plans can change quickly from a low risk home birth to a high risk C-section, so proximity to a consultant led unit or accident & emergency department is crucial’

Neo Natal: Until the model is rolled out not sure about distance and cost especially if it is neo-natal unit where you want to visit daily. Juggling other commitments/children/work. Cost of parking.

Quality of Care

Experienced, knowledgeable staff, professionalism and staff attitude were important to many in addition to having sufficient staffing at right level.

A significant number of participants felt continuity of care from midwives, doctors and health visitors and having the same midwife throughout labour was important.

‘One to one relationship with designated midwife or midwifery teams.’

‘Seeing the same person all the way through pregnancy, a person who knows me.’

Having a plan, well talked through with the midwife was also felt to be valuable.

Midwife led care within specialist centres was felt to be ideal by many in addition to having midwives in the community, going out to the pregnant women at home.

Specialist care availability / Specialist care there when needed ‘Consultant presence brings re-assurance’

Regular check ups & scans through pregnancy. Having plenty of support while pregnant and after baby is born.

More support with breast feeding.

Hospital:

The neo-natal care at North Tees is 'fantastic'

Hartlepool General is on 'its last legs.'

Excellent service at Sunderland (5 comments)

Reputation is very important and lots of mums have heard horror stories about James Cook

Equality & Diversity

Understanding of cultural backgrounds: ‘when told baby’s gender midwife stereotyped me thinking I must want a boy as I am Muslim’.

Language barriers – access to interpreters- must be able to communicate.

Transport to maternity services is very important as the members of the group are visually impaired and did not have access to other transport options

Dignity & Choice

A number of participants felt they wanted to be listened to and respected by medical professionals. Want to feel in control of birth of baby and birth plans being followed where possible. One woman said that she would never have another baby as she felt that none of her views were taken on board.

The attitude of staff was important, being treated with care and compassion and not being patronised by professionals. There was some particular negative experiences around staff attitude fed back by a teenage mother and a single parent.

Mental Health training for staff in maternity units and neonatal units. ‘If someone is visibly upset following a loss, it is not good for them or for other worried parents, very worrying to observe’.

Privacy when in labour, not pressured to have trainee doctors present. Privacy when feeding baby.

Having your partner with you as much as you can throughout my stay

Understanding and sensitivity - Separate space for miscarriage scans as sitting alongside pregnant women for scan is insensitive.

Confidentiality was important – ‘don’t base ante-natal clinics in open access places like Sure Start centres especially if only just pregnant’

Options for home delivery & water birth to be readily available

Communication & Information

Communication between professionals and parents or parents to be, felt to be of prime importance- explaining what tests were for, what was happening and what to expect.

Getting good advice as a new mum. ‘More advice about how to look after a new baby, felt a bit lost going home on my own’.

Knowing where to go and who to contact in an emergency and being given correct information or signposting.

More information about the choices pregnant women have regarding their baby's birth.

Advice about diet, routines and feeding.

Question 2:

What influences your choice about where you would have your baby?

Key factors influencing choice:

Midwife led care/consultant presence

The level of care available was an important factor for many participants ‘Level of care would be important to me not so bothered about the travel’

Proximity of specialist services was important for many.

A number of participants said access to consultant led care ‘Having a consultant present should anything go wrong as I needed the support quickly when I went from low risk to high risk because of complications’

‘Women who have had babies already seem to prefer midwife or consultant led care as they are fearful of being too far away from very pressured units’

A number of participants wanted midwife led care and to have the most natural birth possible

Staff with expertise in dealing with downs syndrome

Quality

The quality of service - checked out reviews of service

Pain relief

Some participants mentioned pain relief availability

Safety

Safety was identified by a number of participants and was often associated with consultant presence

Distance to travel

Distance to travel was an important consideration for some particularly as a number of participants did not have access to a car and ease of visiting for family members was a consideration.

‘First time mothers are concerned about "long waits" and travelling time if there is an emergency during pregnancy/birth’.

Continuity of care (same team of midwives)

A number of people wanted to have continuity of care particularly if possible the same midwife.

‘Preferences for births - especially second pregnancies - is for home delivery. There is a recognition that this may not be possible for a number of reasons, but continuity of having the same midwife all through the pregnancy is on mother’s wish lists’.

Professional or Family/friends Advice

Recommendations from friends, family and other mothers

Many identified advice from healthcare professionals/ Midwife

Pre-existing conditions.

Existing conditions, preeclampsia etc. dictate where is appropriate

Proximity of specialist support ‘I have had a heart condition since birth, mine is a high-risk pregnancy’.

Family Needs

A number of participants identified the needs of the family at home as being a priority for them in considering options

‘Closer the better- other children to think about’

Other

Own research, on line (mums net) & reading (multiple).

Own previous experience of maternity care for subsequent pregnancies

Question 3. What would make it better?

Key summary factors:

Access

Need to consider the needs of rural areas and ease of accessibility

Need to increase the amount of support in the community if there are going to be reductions to services in some hospitals

Anti-natal services including scans to be in GP or community centres so that they are local.

Free parking for pregnant mums, especially in later pregnancy as hard to walk.

Cheaper or free parking especially if baby is in special care

Provide transport for classes for those who do not have any

Put in better transport provision that compliments visiting times

More car parking spaces

Better signage - road and hospital.

Midwives & Community Support

A significant number of participants identified a need for more midwives & health visitors and consistent midwifery contact:

> ‘Mothers benefit from contact with same individual midwife but often promises can’t be kept due to staff shortages or workload’.
>
> ‘All would like a first contact midwife service available 24/7 via the phone.’
>
> ‘Increased numbers of health visitors - many of the group had not seen a Health Visitor after a few weeks. There provide a great support especially for those who do not have family support’.
>
> ‘More staff - as they must be under pressure as well, one midwife was working a ten hour shift due to lack of capacity which will affect their demeanour’
>
> ‘All would like the same midwife throughout pregnancy during delivery and after care – all feel this is very important to them. ‘

Promotion of home births as an option especially for 2nd or 3rd babies

Aftercare needs to be improved: ‘Better after care for first time mothers as I never really felt I got very much support’

Have a consultant on call to attend Midwife led units as and when required - mums to be would be more confident to have babies in the unit.

More help with breast feeding especially for first time mothers: ‘Breast feeding support – some were encouraged some were not, with little or no after care’

More education to allow for better self-care, better use of voluntary sector as support mechanism

Milk/nappies/sanitary protection etc. being provided in first 24 hours

Quality of Care

High quality care, friendly approachable staff.

Consistency of care across all hospitals and GP surgeries - as group talked about their experiences it was clear that they had not all had the same level of care

Discharge was a bit quick, you made to feel as if you need to move out right away

There was a concern expressed that there should be sufficient numbers of beds on Consultant led units as delays in admittance will lead to birth complications.

Information & Communication

Improved communication- better explanations of what is happening by medical professionals to pregnant woman and new parents was identified by a number of participants including better education/information especially for first time parents. 'There needs to be better communication about what is happening during labour'

Have a person based at GP surgery or community centre who could provide advice and support to new parents. Not everyone has family they can ask.

'Would like to be given more information about what to expect in pregnancy and once the baby is first born. For first time mums it can be a scary time and it is not always possible to speak to family, having the opportunity to attend groups and classes along with having discussions with the midwife helps'

Provide information and communications in different languages or if not even a diagram, for those who cannot read written English.

Improve communication between hospitals and midwives especially if the baby is born out of area.

Dignity & Choice

A number of participants had not had a have birth plan in place and felt this was important.

Want to visit the maternity facilities in order to choose the right option for them

There is a need for a more flexible approach to engagement and interaction for those with additional barriers e.g. mental ill health, poor parental health, caring responsibilities etc.

Midwives need to listen and communicate better - parents didn't feel they were important; 'Listening to me and talking to me would have been good as opposed to talking to my mum' and they should be less judgemental - 'one mother felt she was stigmatised because she was in a women's refuge. She was not given any information on classes or support available'

Comments were made about not stigmatising mothers who do not want to breast feed or find it hard to do so. Help and support needs to be given regardless of what feeding method is used.

Somewhere for partner or family member to stay with you, even if it is after hours

Chairs for visitors (People should be comfortable, especially partners who are there for hours)

More birthing pools

Equality & Diversity

These are examples from women from Bangladeshi communities -

DO NOT MAKE ASSUMPTIONS - e.g.:

- Assume women want to be fully covered (They might be extremely hot and this just makes them even more uncomfortable)

- Not letting partner in

- Assume you MUST see a female health professional, which sometimes means you wait longer for appointment.

The women would like to be ASKED and not have these assumptions made.

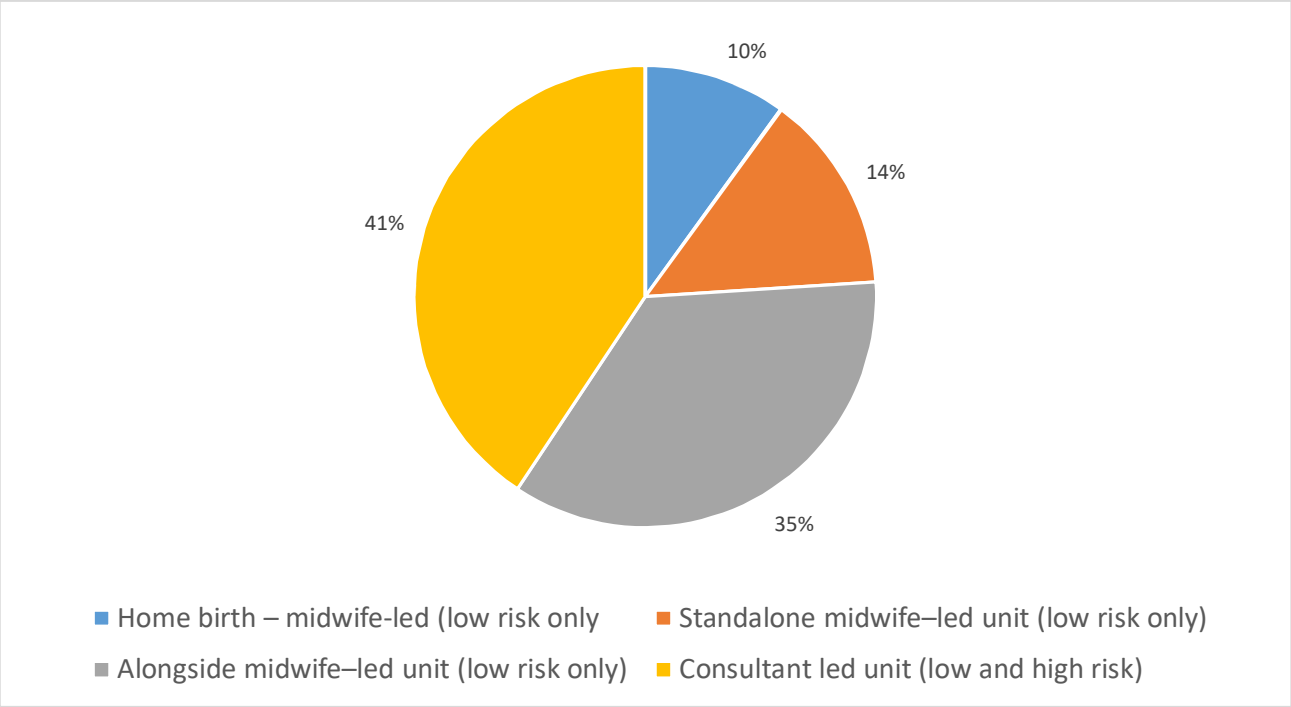
Ethnic communities only receive 1-2 visits, post birth/discharge - used to be more. Need more help with first baby - often Mothers do not have the family support they would have in their old country - pushed to do things for themselves, but may not even know what temperature the babies' bath should be.

'Babies born to women with little English speaking ability who may have been subject to domestic violence should not just be discharged with no support'.

'Refugees need to be thought about, they have come from war torn countries and don't know how to use household goods, let alone navigate the NHS service. They must be given lots of help when they need it, they are not used to getting medical help'.

'If you have to use a machine in reception to book in for appointments, it needs to be voice activated as well for those who have a visual impairment.'

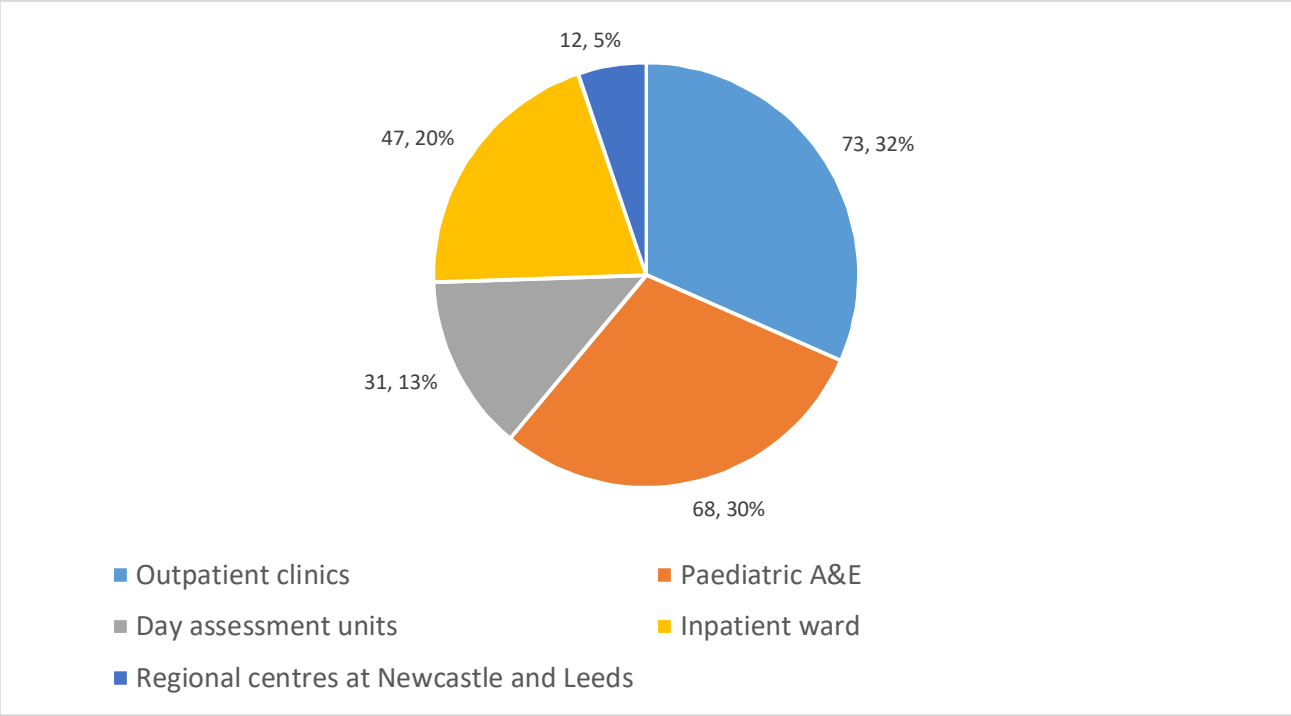
Question 4: Which would you choose?



Paediatrics: Key Summary issues

1. **What children's health services have your family used?**

N.B Not all participants responded to this question as not all had used paediatric services



2. What is important to you about paediatric care?

Quality Care

The quality of care in terms of experienced paediatric nurses and doctors/consultants was important but staff being helpful, reassuring, supportive and caring in their approach to the child was of significant importance to the majority of participants and 'staff who appear to really care about the child'.

The quality of care was important but also continuity of care.

Parents and children being kept informed was also a key priority for many.

Making children feel safe and taking the child's feelings into account was also important to many.

Environment was felt to be very important and the need for **c**omfortable homely surroundings, somewhere for parents to stay when children are kept in hospital for prolonged periods.

Clean & tidy surroundings, friendly welcoming, non-judgemental staff.

'Ability to stay with your child - not just a chair - Shower, food/drink etc.'

Play facilities, toys and games, internet access – age appropriate activities. Access to kitchen facilities, refreshments etc.

Access to separate A & E area for children was also highlighted by a number of groups

Communication

Being kept informed was felt to be of key importance to many and explaining things in plain English. Understanding the need for reassurance and regular feedback. There was also feedback about the need to recognise the needs of people whose first language was not English.

Responsiveness

Speed of response to children was felt to eb important as children can detonate quickly.

Reductions in waiting times and time waiting between testing and results was felt to be important

Location was important particularly as speed of response was felt to be important and access from rural areas was a concern.

Some feedback was about closeness to home because of demands of rest of family/ other children in school etc.

a. What would make it Better?

Location
Better access from rural areas and support for transport cost for families on low income and/or without access to a car.
'Specialist centres good if they improve results but need to be balanced with need to keep services as local as possible'.
Local Hubs /clinics felt to be a good idea by many and more health delivery from Sure Start/Children's centres was suggested.

Environment
Access to separate A & E area for children was also highlighted by a number of groups
Access to a separate quiet room for children with particular needs i.e. children on Autistic spectrum.

Better facilities for parents/carers to be able to stay with their child overnight. Access to shower, refreshments and bed.

Clean, tidy & homely environments (non clinical) with friendly welcoming staff.

Play facilities, toys and games, internet access – age appropriate activities.

Need more privacy (comment from a 16yr old)

Appointments
Reductions in waiting times for speech and therapy - referrals are very slow
Not having to wait long for appointments as this causes anxiety
Reminders about appointments - especially when they are booked 6 months in advance
If appointments need to be cancelled they should be rearrange in a timely manner.

Quality of care
A significant number of participants felt there should be more trained staff, particularly nursing staff and better staffing levels on overnight shifts .Also that there was a need for GP's to have great knowledge of paediatrics.
Improved continuity of care was felt to be important and a need for more respect and compassion from staff.

Communication
Communication was identified as a key area for improvement with many identifying the need for better and more communication between staff, parents and children/young people.

'Medics need to treat the parents and children as individuals because each case is different'
The need for more sensitivity and to be aware of parents emotional needs when given bad news about their child.
'Would be good to have someone that parents could talk to when they first receive the diagnosis of their child condition.'
The need for professionals to respect and communicate more effectively with children/young people with learning disabilities was also highlighted: 'Give me more time to talk' 'Talk to me as well as my parents'
'Use more simple language and pictures to help me understand written information'
'More information in Easy Read so that we are able to read our own letters and information without having someone needing to explain.'
Challenges for people in need of interpreters were raised and that this can cause delays.
Improved communication between departments and health and care services was also highlighted as in need of improvement by many:
'There should be co-ordination between departments to ensure that parents do not have to repeat giving the information.'
'Information sharing with other services should be encouraged to be improved'

5. Feedback from conversations:

Below is a selection of the majority of the feedback from the conversations including a selection of representative quotes. The full feedback can be found at Appendix B (click on relevant question links at bottom of excel spreadsheet to access all responses to a particular question).

Maternity Conversations

Question 1

What is important to you about the maternity care you and your family receives?

Travel:

Regional specialist centres ok but consideration needs to be taken of the time required to travel rather than the distance, 50 miles up the A1 isn't the same as 50 miles starting in rural East Cleveland.

Practicalities: 6.5 hr round trip to and from Middlesbrough by bus from Middleton in Teesdale which takes 3 buses.

Rural location - some people have got to get to Middleton in Teesdale - may be totally car dependant and no car available.

Having to go any further than Darlington could cause many problems. (Upper Teesdale)

Lack of discharge support due to distance from hospital, no mobile connection.

Limit to what GP can provide, not as many choice in rural area.

Local - scared about getting to hospital on time

Distance/Transport issues of visiting/picking up other children from school etc.

I don't want to be travelling back and forth for hours for clinic appointments that last 10 minutes.

Ambulances available to transfer from hospitals.

Upper dales (all rural areas) are at risk, if there's a 'risky' birth.

That it is accessible by public transport.

Travel/distance

Travel /transport

Women cannot drive in labour

Travel issues and costs

A woman with experience of a premature baby said that the baby had stopped in hospital until the gestation date (40 weeks) and if she had had to travel distances this would've made it much harder to cope.

Travel is a huge issue. I could not travel far as do not drive, have no family here and husband works long hours. Rely on friends for support. It would be a massive worry if had to travel far. It would cost money.

Close - nearby - hard to travel if you are from another country, especially if your husband isn't home. Hard to get other children looked after. - Sometimes you might need to go back 2-3 times a night - difficult to do if further away. Some people may decide not to go and end up in a much worse state

Getting there quickly - Really good signage - road on route and in Hospital itself. No signs on roads until you get close to Hospital.

Local as possible, transport an issue for visitors (time, cost, public transport)

North Tees is difficult for travel and transport from Hartlepool but Consultant was at North Tees

Closer to home would be preferable and would feel scared if they had to travel further than Durham

High risk - more appointments - cost, travel time etc. if have to see them 2-3 times a week

Family members also have to travel - sometimes 3 - 4 times per day.

What about if low risk becomes high risk - suddenly needs C section etc.

Parents will travel to the best place for treatment of their children and feel that services are excellent at present.

Being moved in an ambulance when you're having contractions is awful - being strapped down when you want to move, can't get comfortable

Ambulance staff will need extra training - it will be extra pressure on them

'Three-quarters of people would rather go to James Cook than North Tees. Hartlepool is closer, it's a big town but the hospital is practically non-existent. Hartlepool General is only out patients, it does not have the services, not just lacking maternity.

Costs incurred due to centralised services (travel, parking etc.), people in this position should not even think about parking

The cost of car parking at James Cook was highlighted.

You can NOT rely on ambulance transfers or that they will even get to you within a given time slot. Xxx is a paramedic and is afraid it will take a pregnant mother or baby to die before this is re-evaluated.

Access

Closing any units down is completely wrong, some of the units are already some distance away, travelling and having to leave babies in units is distressing and impacts on the whole family.

Ease of access to services throughout pregnancy

Shutting North Tees would be detrimental to the whole Teesside area.

Need to have easy access to GP and midwives and longer opening times

High risk pregnancies and complicated births need appropriate services available

Difficult situations - wouldn't want to be far away from home if you had lost a baby - again, other children to be looked after

Home birth classed as high risk due to rural nature and not allowed.

Most important factors for maternity care were locality. Previously women were transported back to their local hospitals from James Cook Hospital once their babies were born, but this will not occur with these proposals.

That the services are local so do not have to take too much time out from work for appointments and easy to get to if you have a toddler in tow

The visiting hours at North Tees are restricted and don't coincide with public transport

Flexible approach to appointment times.

No waiting, if they need help/care they should get it.

Access to health visitors.

Specialist/consultant/midwifery care all being centralised and available close to home

Having support in my local community, I don't like driving.

Neo Natal: Until the model is rolled out not sure about distance and cost especially if it is neo-natal unit where you want to visit daily. Juggling other commitments/children/work. Cost of parking. Was offered to stay over- night at James Cook on a put up bed as there was only 1 member of staff per 3 babies

Experiences of intensive baby care units was that they were cramped for space and full. Often parents have to watch upsetting things happening to their own child or other people's babies.

Pregnancy plans can change quickly from a low risk home birth to a high risk C-section, so proximity to a consultant led unit or accident and emergency department is crucial

Quality of Care

Highest quality available

Appropriately qualified people to deal with individual needs.

When appropriate to be midwife led.

Good, friendly midwives

More midwives. Midwife led care within specialist centres the ideal. Bring in the high tech when it is required not before.

5/17 in the group had the same midwife throughout.

Want to see the same midwife throughout whole pregnancy and when you have had your baby to build up rapport and confidence.

Same midwife and consultant throughout with involvement from family GP

Continuity-many of the group did not see the same midwife during the whole of their pregnancy. This can be a problem in not being able to build up trust and confidence

I had a plan which was very well talked through by my midwife but then we needed the consultant

Same person all the way through pregnancy and labour.

Same midwife all through, not going at end of shift and new one not knowing how the labour has been.

Prefer to see same midwife

Seeing the same person all the way through pregnancy, a person who knows me.

Having midwives available 24/7.

Having the same midwife all the way through pregnancy and labour.

Midwives who know what to do if things go wrong, 14 hour labour then another 6 hours before emergency surgery.

Having midwives in the community, going out to the pregnant mums home.

Regular check-ups all the way through pregnancy.

Regular scans to give reassurance everything is ok.

Having plenty of support while pregnant and after baby is born, especially 2nd baby as didn't get much support 2nd time around.

Check-ups to see if baby and mum are healthy.

Improved support from GP around health of mother during pregnancy, optimum health should be the ideal not lack of illness.

More support with breast feeding.

One to one relationship with designated midwife or midwifery teams.

Older ladies being supported

Obese and diabetic pregnancies being supported

Continuity of care

Continuity of care, same health professional.

Continuity of care from midwives, health visitors and doctors.

Pain relief

Being prepared for complications because of previous risks making second pregnancy high risk

Having high risk care available as there isn’t any at Hartlepool

The best care for you and your baby - consultant led

Specialist care availability / Specialist care there when needed

Quality of care - the right levels of staffing

Staffing - have the right staff available

Want to know that there are enough staff who are competent and equipped to deal with any problems

Comforting staff - scary times

Experienced, knowledgeable staff

Want the best care so wouldn't bother me if I had to travel, you do it for your child

Having everything in place ready for delivery especially if a premature baby labour

Consultant presence brings re-assurance

See same midwife and doctor so as not to have to explain things over and over again and are able to build confidence

Consistent approach to care and feeling safe

Continuity-many of the group did not see the same midwife during the whole of their pregnancy. This can be a problem in being to be able to build up

Complicated pregnancies and pleased that expertise was on hand to deal with situations

Managing pain during labour.

Staff Training

Professionalism and staff attitude

Want to feel confident that staff have the expertise to deal with all and any problems that might occur

To have enough staff on duty. One mother was left with just a student midwife who she felt did not know what she was doing

Hospital:

The neo-natal care at North Tees is 'fantastic'

Hartlepool General is on 'its last legs.'

Excellent service at Sunderland (5 comments)

Breast feeding team were very understanding at Sunderland - didn't feel pressured at all or made to feel as if I was doing something wrong

Regular check-ups and support was well rounded at Sunderland

Reputation is very important and lots of mums have heard horror stories about James Cook

Equality & Diversity

Understanding of cultural backgrounds, when told baby's gender midwife stereotyped me thinking I must want a boy as I am Muslim.

No language barrier - must be able to communicate

Cultural issues - Elders tell women to, 'sit it out' as they do not want to make 2 trips - sometimes women get into trouble for not waiting long enough before going to hospital, if they are sent home in early labour. Health visitors need to have more training to spot issues in the home. - A lot of women who know the area/service, know they can get there by foot or by ordering a local taxi, if it is out of town, they may not have any idea how to get there. Need one single point of contact.

Must make use of BME Health Connectors in Darlington - involve them in the transition process, use them to help with communication and putting people at ease, sharing information, give them peace of mind. Help to reduce extra appointments by ensuring they understand what's happening.

Polish speaking midwife/ doctor

Someone to translate for us if we had to ring for an emergency.

Transport to maternity services is very important as the members of the group are visually impaired and did not have access to other transport options

Dignity & Choice

Being treated like an individual

Being listened to as mother's instinct is usually correct and consultants believe that they are always right

Being treated well, older mums get treated differently

Attitude of staff, my midwives were very condescending and patronising particularly as I was only 16

I didn't like being patronised because I was a young single mum - midwife was very judgemental and asked very personal questions

NEED somebody Mental Health trained at maternity units and neonatal units. If someone is visibly upset following a loss, it is not good for them or for other worried parents, very worrying to observe. It is a massive state of distress.

Not being patronised and treated like I'm useless

Privacy when in labour, not pressured to have trainee doctors present.

Want to feel in control of birth of baby. One woman said that she would never have another baby as she felt that none of her views were taken on board.

Having your partner with you as much as you can throughout my stay

Care and compassion.

To feel that health staff care

Midwifes and consultants to be open to different options such as Daisy Class which is about natural active labour.

Understanding and sensitivity

Confidentiality - don't base ante-natal clinics in open access places like Sure Start centres especially if only just pregnant.

Separate space for miscarriage scans as sitting alongside pregnant women for scan is insensitive.

Privacy when feeding baby.

Knowing about different options in time to make choice**.**

Birthing plan being followed

Right for us, not just what is available

Option for home delivery

Be listened to - felt not listened to

Water birth availability

Being able to have more scans if worried.

Communication & Information

Information sharing between trusts

Trusting the staff that are looking after you, one consultant had me worried the whole time, running all sorts of tests but not explaining what was happening.

Communication is also important especially in early stages

Getting good advice as a new mum.

Knowing where to go and who to contact in an emergency.

Being given correct information.

Good signposting and information/knowledge/training

Knowing the options about where and how to deliver your baby.

More information about the choices mums have regarding their baby's birth.

Info on different types of birth and where could have baby.

More information about the choices mums have regarding their baby's birth.

More advice about how to look after a new baby, felt a bit lost going home on my own.

Health promotion leaflets are useful.

Advice about diet, routines and feeding.

Question 2:

What influences your choice about where you would have your baby?

Midwife led care/Consultant presence

Proximity of specialist services.

Consultant led care (multiple)

For birth I wanted a consultant as you don't know what's going to happen, particularly if you're constantly in pain

Knowing there was somebody there, a consultant needed to be there. For my daughter's first two children no consultant was available when she went into distress

Level of care but what is really worrying is if there are specialist units and there is no more expertise in the local area - we need to make sure that things are picked up correctly so we can access the specialist support

Level of care and attitude

Level of care would be important to me not so bothered about the travel

Having a consultant present should anything go wrong as I needed the support quickly when I went from low risk to high risk because of complications

Midwife led care.

Want to be where specialist care is

Women who have had babies already seem to prefer midwife or consultant led care as they are fearful of being too far away from very pressured units.

Wanted midwife led care to have the most natural birth possible

All the parents had wanted to have midwife led care but when problems developed in their pregnancy they were transferred to consultant led care.

The majority of the group wanted consultant led care as they have the expertise and parents felt safer

Staff to have expertise in dealing with downs syndrome

Quality

The quality of service - checked out reviews of service

Pain relief

Pain relief availability

Pain relief - epidural.

Wanted full range of pain relief

Safety

Safety

Safest place if anything went wrong

Survival rates for babies.

Consultant presence – safety x 3

Want to feel secure that they can deal with any problem

Distance to travel

Close by as possible - no-one wants to give birth in the car

Distance x 3, ease of visiting.

Most people drive but those who don’t may have issues getting to places that are further away

Travel would be a major issue for those who don't drive

Travel still affects those who have no car

First time mothers are concerned about "long waits" and travelling time if there is an emergency during pregnancy/birth.

The distance to the hospital is important as some of the group do not have cars

Family can't drive so need to be close to hospital

Car parking

Bigger parking area

Facilities

Availability of modern equipment

Continuity of care (same team of midwives)

Continuity of care (multiple)

Preferences for births - especially second pregnancies - is for home delivery. There is a recognition that this may not be possible for a number of reasons, but continuity of having the same midwife all through the pregnancy is on mother's wish lists.

Professional or Family/friends Advice

Ease of visiting, recommendations from friends, advice from health care professionals.

Recommendations from mothers at school (new to area)

Advice from healthcare professionals/ Midwife (multiple)

Advice from my mother

Talking to other Mams

Pre-existing conditions.

Existing conditions, preeclampsia etc. dictate where is appropriate

Proximity of specialist support, I have had a heart condition since birth, mine is a high-risk pregnancy.

Family Needs

Need to support family.

The needs of the rest of my family.

Friends and family feedback (multiple).

What is available locally.

Requirements of the rest of the family and work commitments.

Closer the better- other children to think about

.

Other

Own research, on line (mums net) & reading (multiple).

Own previous experience of maternity care for subsequent pregnancies

How well you have been during pregnancy.

Previous experiences

Question 3. What would make it better?

Access

Need to consider the needs of rural areas and ease of accessibility

Need to increase the amount of support in the community if there are going to be reductions to services in some hospitals

Anti-natal services including scans to be in GP or community centres so that they are local.

Do ultra sounds at GP surgeries

There is a lack of health visitors - many of the group had not seen a Health Visitor after a few weeks. There provide a great support especially for those who do not have family support.

Accessibility is key. Members of the group felt that decision makers do not recognise the significant differences between the needs of rural and urban areas. There needs to be more services in the rural areas not less because of the lack of transport. Services should be based on local need.

Within reasonable travelling distance.

Bring more maternity services back to Hartlepool

Bring Bishop Auckland Hospital maternity unit back!

Free parking for those in the labour wards

Free parking for pregnant mums, especially in later pregnancy as hard to walk.

More car parking spaces

Better signage - road and hospital.

Cheaper or free parking especially if baby is in special care

Provide transport for classes for those who do not have any

Put in better transport provision that compliments visiting times

Midwives & Community Support

More midwives & health visitors (multiple comments)

'Mothers benefit from contact with same individual midwife but often promises can't be kept due to staff shortages or workload'.

Better use of and an increase in the number of, Midwives and community services.

During pregnancy mums -to - be would like to see their midwife more often and not feel that the visits are rushed.

Would prefer to see the SAME midwife throughout - some see a different one every week

Keep the same midwife throughout pregnancy.

Promote home births as an option especially for 2nd or 3rd babies

Consistent midwifery team

All would like a first contact midwife service available 24/7 via the phone.

Usually can get a GP appointment but when baby has additional needs would be good if they could see same doctor

Better after care for first time mothers as I never really felt I got very much support

More help with breast feeding for first time mothers

Breast feeding team have lost funding twice in the last couple of years and now don't even have the time to visit nurseries or healthy start sessions to give advice/talks

Breast feeding support – some were encouraged some were not, with little or no after care

Breast feeding support is disgraceful - told that funding has been cut so can't access the breast feeding cafes which were great as they helped act as a support network as well

Help with keeping pregnant mother healthy, not just stop smoking advice but help with healthy eating, weight control.

More education to allow for better self-care, better use of voluntary sector as support mechanism

Milk/nappies etc. being provided in first 24 hours

Free baby milk/nappies/sanitary protection for the first few hours

Care

High quality care, friendly approachable staff.

More staff - as they must be under pressure as well one midwife was working a ten hour shift due to lack of capacity which will affect their demeanour

Best available care, budgets ought to be irrelevant when discussing the health of a child

After care – all would like the same midwife throughout pregnancy during delivery and after care – all feel this is very important to them. A different midwife every time is ‘dreadful…terrible’

Have more suites like the 'Martin Suite' at James Cook

Aftercare needs to be improved

There should be some consistency as I had 4 different consultants and they all conflicting opinions

Consistency of care across all hospitals and GP surgeries - as group talked about their experiences it was clear that they had not all had the same level of care

Have a consultant on call to attend Midwife led units as and when required - mums to be would be more confident to have babies in the unit.

Discharge was a bit quick, you made to feel as if you need to move out right away

There was a concern expressed that there should be sufficient numbers of beds on Consultant led units as delays in admittance will lead to birth complications.

Information & Communication

Better education/information for first time parents.

Have a person based at GP surgery or community centre who could provide advice and support to new parents. Not everyone has family they can ask.

Young mothers really need to be told about what will happen when you go in to hospital - especially about having food before hand

There needs to be better communication about what is happening during labour - one of the women said her hospital experience had put her off having any more children.

Would like to be given more information about what to expect in pregnancy and once the baby is first born. For first time mums it can be a scary time and it is not always possible to speak to family, having the opportunity to attend groups and classes along with having discussions with the midwife helps

Provide information and communications in different languages or if not even a diagram, for those who cannot read written English.

Improve communication between hospitals and midwives especially if the baby is born out of area.

Feel that things were being done to the baby without explaining what or why. For example baby tested for diabetes without explain what was happening to the baby. Again communication in this area needs to be improved.

Utilise new technologies to support the care of expectant mothers

Dignity & Choice

Want to have birth plan in place - the majority of the group did not have one. A member of the group is due to have baby in a week's time but still does not have a plan and does not feel sufficiently informed to put one in place.

Want to visit the maternity facilities in order to choose the right option for them

More flexible approach to engagement and interaction for those with additional barriers, mental health, poor parental health, caring responsibilities etc.

Less judgemental - mother felt she was stigmatised because she was in a women's refuge. She was not given any information on classes or support available.

Midwives need to listen and communicate better - parents didn't feel they were important.

Listening to me and talking to me would have been good as opposed to talking to my mum

Listen to mums, they usually know best and know their body.

Do not stigmatise mothers who do not want to breast feed or find it hard to do so. Help and support needs to be given regardless of what feeding method is used.

Somewhere for partner or family member to stay with you, even if it is after hours

Take care of new mothers who may be distressed - had a baby who is taken away for treatment, partner sent home, all alone with no baby, no partner

Enable partners or other family members to stay over to help out new mums during the night especially if they have had a C section

More private rooms

Chairs for visitors (People should be comfortable, especially partners who are there for hours)

More birthing pools

Equality & Diversity

DO NOT MAKE ASSUMPTIONS - E.g. of assumptions made currently:

- Assume women want to be fully covered (They might be extremely hot and this just makes them even more uncomfortable)

- Not letting partner in

- Assume you MUST see a female health professional, which sometimes means you wait longer for appointment.

These are examples of what women from Bangladeshi communities have given - they would like to be ASKED and not have these assumptions made.

Ethnic communities only receive 1-2 visits, post birth/discharge - used to be more. Need more help with first baby - often Mothers do not have the family support they would have in their old country - pushed to do things for themselves, but may not even know what temperature the babies' bath should be.

Babies born to women with little English speaking ability who may have been subject to domestic violence should not just be discharged with no support.

Refugees need to be thought about, they have come from war torn countries and don't know how to use household goods, let alone navigate the NHS service. They must be given lots of help when they need it, they are not used to getting medical help.

If you have to use a machine in reception to book in for appointments, it needs to be voice activated as well for those who have a visual impairment.

Paediatric Services

1. What is important to you about paediatric care?

Environment

Friendly, welcoming service - personalised, knowing the children's name, making the child feel special

Clean & tidy surroundings, friendly welcoming, non-judgemental staff.

Comfortable surroundings, somewhere for parents to stay when small children are kept in for prolonged periods.

Separate A&E area

Side waiting area for children at A&E

Children only area for A&E (waiting area away from drunks etc.)

Easy visiting regime.

Modern equipment

Secure - need to know children are safe

Nice environment.

Clean environment

Games and toys for older kids - something for people of different ages

Play room - toys, can wheel a bed in - ability to transport child - change of scenery

Child needs to be able to sleep in hospital, too many checks and interruptions during the night.

Facilities for family members to stay - offered refreshments, can cost a fortune to stay and have to pay £1 for every drink, food etc. - £10 for TV etc.

Facilities for parents to stay with children.

Facilities to stay over with children when in hospital.

Made to feel at home - given use of kitchen facilities, showers, play room for children

Ability to stay with your child - not just a chair - Shower, food/drink etc. (Provision for carers - staying overnight for under 5's)

Specialist equipment meaning you could move child around. E.g. Spica cast buggy

Keep specialist paediatric units as small as possible, parents and children need to bond, impossible in a huge unit miles from home.

Offer parents respite - they need to wash and go to the loo, eat etc.

Quality Care

For specialisms, it is important to have centres of excellence.

Care - comfortable, clean, check on temp etc., turning child etc. Always there, a comforting presence, keep families up to date

Helpful reassuring supportive staff

Staff who appear to really care about the child

Child is happy and doesn't feel patronised.

Making children feel safe.

Taking child's feelings into account.

Need to feel safe, no bullies (Disability group –children/young people)

Nurses tell me what is going to happen (Disability group –children/young people)

Consistent and informed services

Expertise in their field

Friendly caring staff.

Personalised care

Staff - numbers, caring, gentle, experienced

Staff - Who is looking after them - named nurses, child knows and is comfortable with them, consistency/continuity of care

Consistent care from all the staff dealing with child and parent.

Continuity of care so that you do not have to continually repeat everything.

Having a doctor that knows the family/child history on hand is very important

Having doctors who specialise in paediatrics.

Paediatric consultants are necessary.

To have paediatric trained nurses is very important.

Getting the best possible care including going to a specialist hospital if needed.

Learning Disability and Disabilities need quality local provision.

It needs to be high quality. That they can cope with challenging patients (autistic son)

High quality care, friendly approachable staff.

Best available care, budgets ought to be irrelevant when discussing the health of a child

Child gets the best possible start in life or most timely interventions to improve chances.

High quality, well explained interventions.

Responsiveness

Speedy response.

Be seen quickly

Speed - quick as possible, reduce waiting times. - Reduce time waiting between testing and results. - Reduce waiting times between appointments

Quick access to care - children tend to get sick during out of hours and this can be very stressful

Communication

Being kept informed

Good communication - appointment letters and information and regular feedback

Explain things in simple English

Level of care but being kept informed and better communication

Medical staff being as honest as possible in a caring way.

Reassurance - scary time, keep informed of what is happening, give explanations

Mental health issues need understanding (parents/carers) sometimes challenge due to lack of understanding or fear of unknown

Location

Closer to home for routine interventions, visiting important for mothers and young children. More care at home an excellent idea but do we have the necessary staff trained and available to cover East Cleveland?

Within reasonable travelling distance.

Closeness to hospital

Need services close by as children can be accident prone

Timing - having to get back for the other children in time

Reliable ambulance service

Again Accessibility from rural West Durham.

2. What would make it Better?

Location
Better coverage for rural areas. Keep waiting times low. More support for carers. Hub idea good, will we see one in East Cleveland or are we travelling to Guisborough or Redcar. Keep Guisborough Hospital open if you believe in local care.
More support for transport - how are low income families to get to appointments out of town, daily
Specialist centres good if they improve results but need to be balanced with need to keep services as local as possible; public transport provision poor in East Cleveland, not everyone has access to a car.
Within reasonable travelling distance.
Local clinics, can we have more health delivery from Sure Start Centres?
More care at home an excellent idea, no one wants to go to hospital if they can avoid it.
Care closer to home an excellent idea.
Support services in the community

Environment
Having a smaller room for child or parent with special need, better if can be away from others, children on Autistic spectrum.
Comfortable surroundings, somewhere for parents to stay when small children are kept in for prolonged periods.
Having toys for children to play with when they are in hospital, if quarantined can't leave room to go to play area.
Make environment homely.
Special areas just for children.
Places for parents to stay - put up beds.
Area for parent/carer to stay

Need more privacy (comment from a 16yr old)
The waiting rooms are dull and too small and crowded. This is not good for disabled people - they should have a quiet space for those who can't cope with noises / crowds.
Internet access

Appointments
Long waiting times for speech and therapy - referrals are very slow
Making sure follow up appointments are made.
Not having to wait long for appointments as cause's anxiety
Quicker appointments
Less waiting times
Reminders about appointments - especially when they are booked 6 months in advance
If appointments need to be cancelled they should be rearrange in a timely manner. It takes a lot of energy for parents to keep track and chase appointments.

Staff
Bring back school nurses and district nursing staff, they know their patients.
More trained staff, better training for GP's.
We need better local GP knowledge of paediatrics.
Train more staff
More trained staff and staff to stay in post.
Trainees to do lower level stuff - clean, paperwork, bloods etc.
Continuity of care.
High quality care, friendly approachable staff.
Improve staffing levels (multiple)
Health visitors available out of hours.
Better staffing levels on overnight shifts
Best available care, budgets ought to be irrelevant when discussing the health of a child
Health Visitor should be one to one service – privacy is needed and separation of sick/ill children during this service.
There should be more respect/compassion and support not increased 'target' levels.
Very Low staff moral

Communication

More communication between staff and parents
‘Give me more time to talk’ (disabled young person)
‘Talk to me as well as my parents’ (disabled young person)
‘Use more simple language and pictures to help me understand written information’ (disabled young person)
‘More information in Easy Read so that we are able to read our own letters and information without having someone needing to explain’
‘More time to read information’ (disabled young person)
There needs to be training on interpersonal skills for all medics on Downs Syndrome and how to talk to parents
Medics need to treat the parents and children as individuals because each case is different
Be aware of parent’s emotional needs when given bad news about their child.
Would be good to have someone that parents could talk to when they first receive the diagnosis of their child condition.
Allowing other health care professionals to speak to patients instead of only consultants especially at outpatients appointments.
It is already excellent if you understand the system, more help for those who don’t. Advocates.
Please do not be judgemental: One Doctor has allegedly made a comment stating "You're an overprotective parent. ALL Bangladeshi communities do this"
Sometimes patients are waiting at the back of the queue for an interpreter to arrive. Families and partners can be used or even a telephone service to confirm with the patient that they are happy for the other person to translate on their behalf.
Been told more about process so we understand what’s going to happen. (BME group)
Giving parents results of tests by email, phone or post if they do not need to attend an appointment.
Having a way to get back into the system when a problem reoccurs rather than starting a new referral.
Improve communication between departments
There should be co-ordination between departments to ensure that parents do not have to repeat giving the information.
Improve communication between patient and consultant
A & E Communication is rubbish, people are just left guessing what is going on as staff have to prioritise and may have had to go elsewhere, but being informed would be helpful. Perhaps they do not explain to avoid conflict.
Doctors and nurses should talk to us as well as our parents, they should explain to us what is going on and what will happen
Communications between services must be improved. E.g. NHS, GP's, schools, Urgent Care etc.
Information sharing with other services should be encouraged to be improved
Share information

Prevention
Better support, education and training for parents to allow them to play a bigger role in caring for children.
Better prevention information

Other:
Child gets the best possible start in life or most timely interventions to improve chances.
Planned discharge - not waiting until 10pm for meds etc.
Where is Young Peoples Mental health in the proposals? Current service appears to be crisis only, we need better. CAHMS poor, waiting times unacceptable.
Don't forget the needs of carers.
More resources to be put in including staff and equipment

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Independent Analysis of the PHASE 5 Public Engagement Events (February to March 2017) for the Better Health Programme

Proportion Marketing April 2017

Contents

1.0 Introduction

This BHP Phase 5 feedback analysis has drawn on the scribe notes from 11 public engagement events (held between the 1st February and 8th March 2017 - total attendance 270) and direct emails to the BHP team.

Attendees were asked to evaluate the event.

- 94% of attendees found the events informative
- 93% said the presentation was informative
- 90% said the video was informative
- 96% said the workshop was helpful

Attendees were asked the following questions around two main areas, Maternity and Paediatrics:

1. Maternity

What is Important to you about maternity care?
How can we make it better?
What influences your choice about where you would have your baby?
If DMH or NT was the 2nd consultant-led and co-located midwifery-led birth centre.
What would make this more/less attractive?

2. Paediatrics

What is Important to you about paediatric care?
How can we make it better?

Attendees were also asked for any other comments that they wanted to make to ensure every opportunity to contribute to the event was offered.

Any other comments?

Feedback was recorded by scribes at each table and has been independently analysed by Proportion Marketing Limited for this report.

As they are scribe notes and not comments/positions assigned to individual attendees it is not possible to quantify support or opposition to ideas, but counting comments and grouping them into themes does provide a sense of the main issues raised by the attendees that should inform BHP decision-making.

2.0 Executive summary

The Phase 5 engagement events proved successful in highlighting a number of issues that the Better Health Programme should feed into its processes.

Information Analysed

11 events
1,671 comments analysed
941 (56%) Maternity / 730 (44%) Paediatrics

Main phase 5 themes (Maternity only)

1. Transport (22% of all comments)
2. Safety/Quality of Care (13%)
3. Communication (10%)
4. Needs of the Individual (10%)
5. People/Staff/Skills (9%)

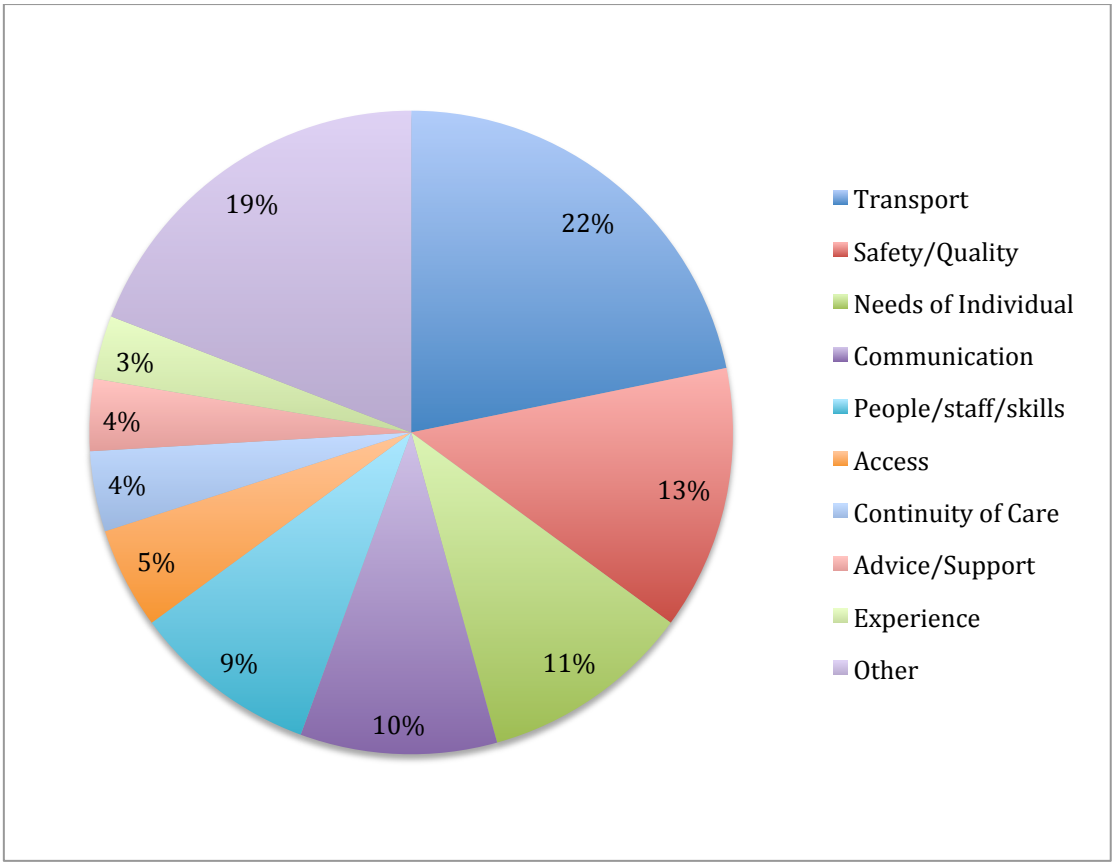
Main phase 5 themes (Paediatrics only)

1. Communication (17% of all comments)
2. Access (17%)
3. Transport (13%)
4. Safety/Quality of Care (11%)
5. People/Staff/Skills (8%)

Main phase 5 themes (Maternity and Paediatrics combined)

1. Transport (18% of all comments)
2. Communication (13%)
3. Safety/Quality of Care (12%)
4. Access (10%)
5. People/Staff/Skills (9%)

MATERNITY THEMES BY NUMBER OF COMMENTS (TOTAL 941 COMMENTS)



Transport dominated the maternity services feedback - travel distance and travel times, ambulance availability and car parking.

Safety/quality of care included if low risk births change to high risk and how capacity would be affected.

The **needs of the individual** included homebirths, pain relief and sibling support.

Attendees sought improved **communications** - about the services and choices available to women.

Concerns about the availability of **people, staff and skills** included specialists and midwives.

Ease of **Access** to services - before, during and after birth was considered important, particularly in an emergency and community based services.

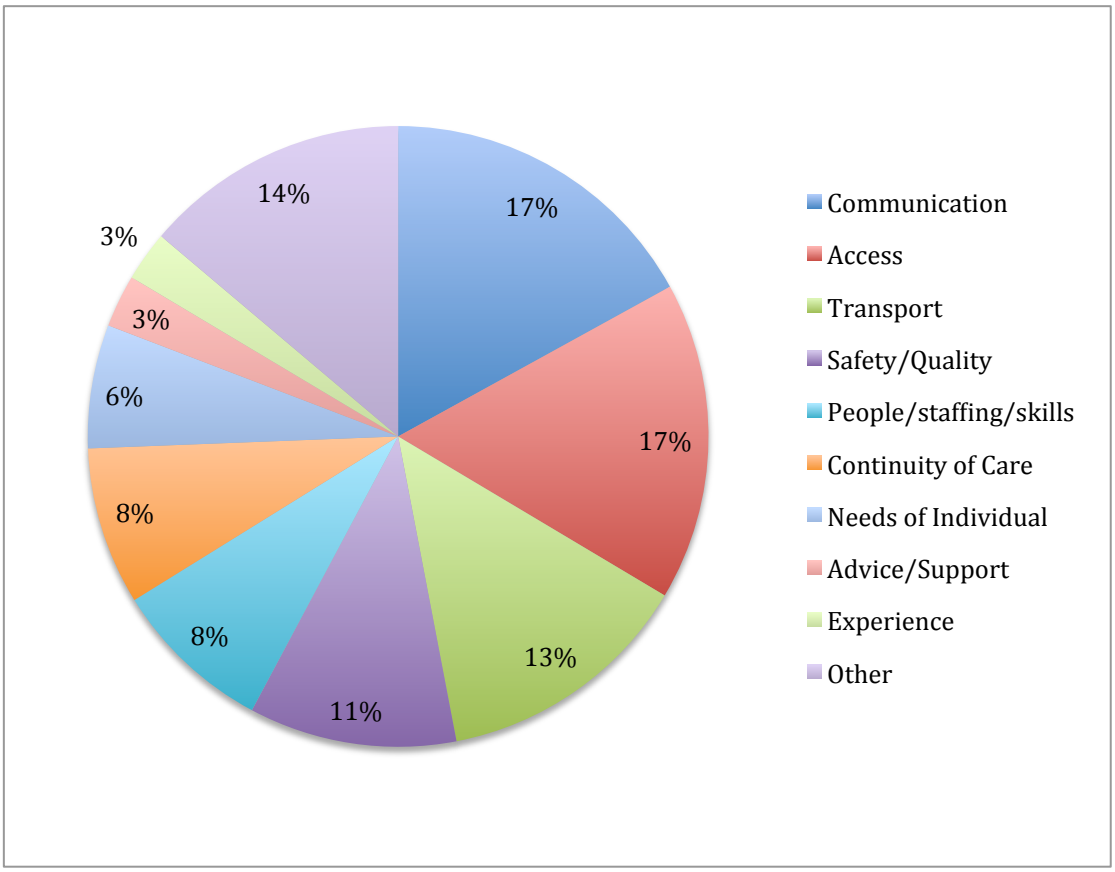
Continuity of care - included seeing the same midwife, familiar surroundings, planned pathways and a personal service.

The pre and post-natal availability of **advice and support** - included voluntary services, GP contributions and focus on new mothers.

Previous **experience** included the impact on choice of venue, homebirth, and the knowledge to access the right services.

Other themes included finance, mental health needs, links to other services and returning lost services.

PAEDIATRIC THEMES BY NUMBER OF COMMENTS (TOTAL 730 COMMENTS)



Both **Communication** and **Access** to services dominated the paediatric services feedback.

Communication included keeping parents informed about where paediatric care is available, when to use a GP, parental and child reassurance and patient information.

Access was about speed, community-base and 24/7 - the concerns of parents of a sick child.

Transport included travel distance and travel times, ambulance availability and car parking.

Safety/quality of care included integrated paediatric capacity, the availability of right equipment and, in some cases, the willingness to travel further for specialist care.

People, staff and skills to ensure the correct diagnoses first time and better training deal with children appropriately.

Continuity of care included transitioning from children's to adult services and multi-disciplinary team setting.

The **needs of the individual** included specific areas for children, consideration of family/sibling needs, the success of assessment units and dealing with chronic or specific conditions.

Advice and support included child-centric thinking, support for parents and carers as well as children and lamenting the loss of Sure Start as a valuable source of support.

Experience included positive and negative comments where children were seen by specialists and personal accounts of treatment by existing service providers.

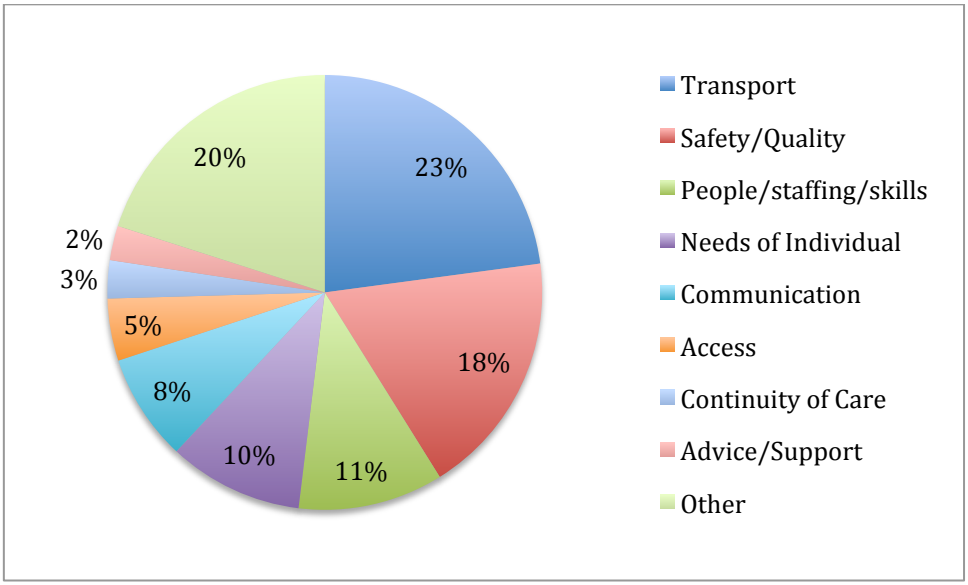
Other included mental health concerns, use of technology and issues around finance.

3.0 Main Findings

MATERNITY

3.1 Feedback prompted by the following questions

What is Important to you about maternity care? (389 comments)



23% of comments were around **transport** - travel distance and travel times - not just transport for expectant mothers but for family and visitors too.

"Concerns around distance via roads when in e.g. East Cleveland"

"A bit of a concern – 3 hospitals becoming 1 and things keeps getting further and further away from Hartlepool. This is people's feelings"

18% of comments were around **safety and the quality of care** – having specialists available and if the circumstances of a low risk birth change quickly.

"Safety of mum and baby - things can change very quickly"

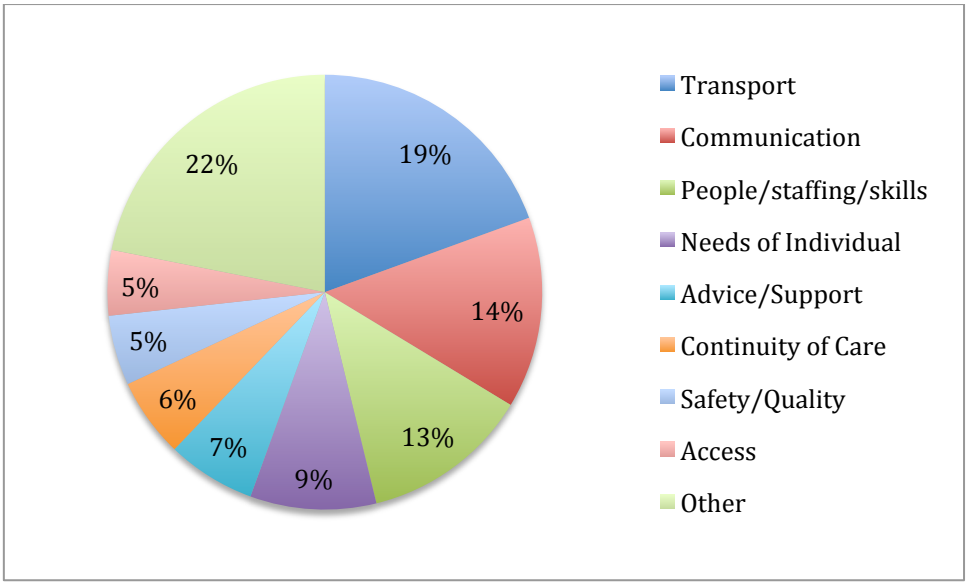
"How do we know if somebody is high risk? What the pathway will be – if problem suddenly arise, how will mum and baby be looked after – thinking about the transfer to specialist care"

11% of comments were around **people, staffing and skills** - shortages of midwives, availability for homebirths and overall capacity.

"Homebirth – more midwives needed – spread further over the patch"

"Difficult to recruit – they try really hard to recruit"

How can we make it [maternity] better? (288 comments)



19% of comments were around **transport** - travel distance and travel times – availability of ambulances and transport support.

"Need to ask people in the rural areas how they would prefer births – rural areas needs experts community care"

"Expand James Cook car park – massive issue – enough capacity to manage the patients"

14% of comments suggested that attendees sought improved **communications** – about the services and choices available to women.

"Being well informed at each stage"

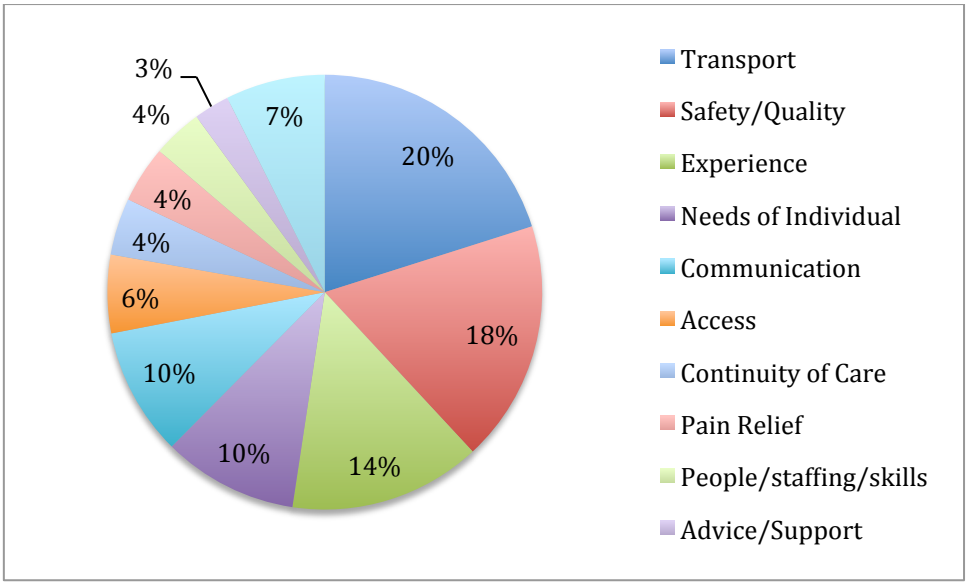
"Education – not just for the mothers but for the whole family, the support networks (expectant dads most especially) how best they can cope with the situation"

9% of comments were around addressing the **needs of the individual** – their choices and preference for homebirths.

"The system needs to change to reflect the evolving needs of the society"

"Mums who are in constant crisis – accessing other services needs earlier, proactive, community based support – ask mums what they want"

What influences your choice about where you would have your baby? (189 comments)



20% of comments suggested **transport** would influence choice.

"Immediate access/distance to travel"

"As close to home as possible"

18% of comments suggested **safety/quality of care** would influence choice.

"Expertise first"

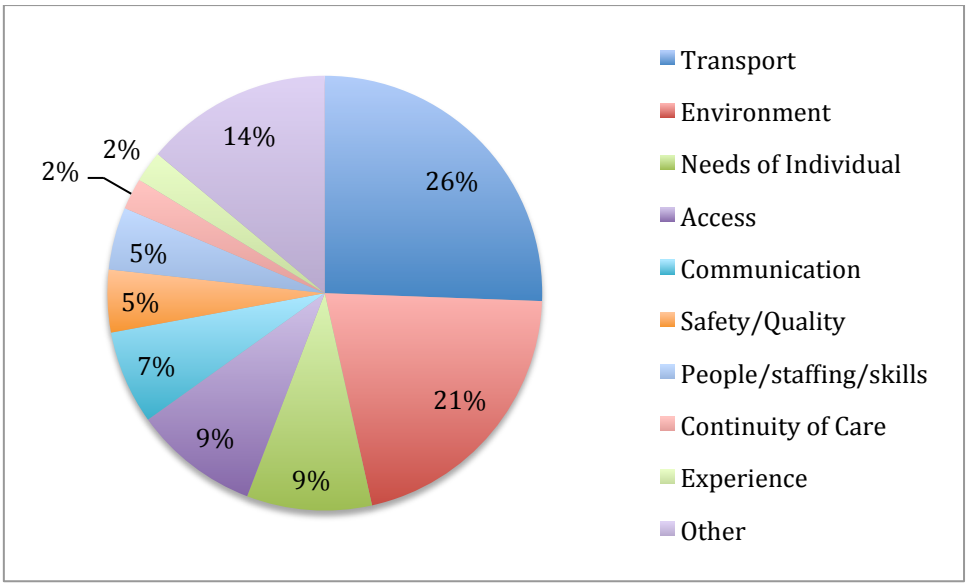
"Confidence in service"

14% of comments suggested previous **experience** would influence choice.

"First and second child are different. First time mums are more sceptical. Second child more confident, more research"

"The reputation of a hospital/unit would heavily influence mums to be. Word of mouth and hearing other people's experiences, can be very powerful and influential"

If DMH or NT was the 2nd consultant-led and co-located midwifery-led birth centre. What would make this *more* attractive? (43 comments)



26% of comments suggested **transport** would positively influence choice.

"Darlington is the only option, with distance and ease of access"

"Good access/parking"

21% of comments suggested **environment** would positively influence choice.

"Less intervention – next best thing to being at home – less mess. Not as clinical. More homely"

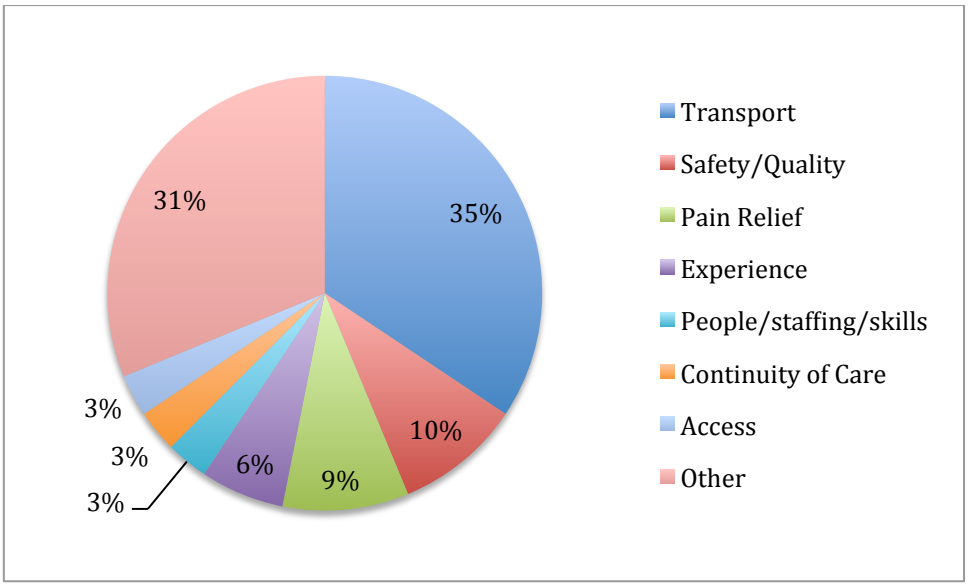
"Calm. Cleanliness. Personable"

9% of comments suggested **needs of the individual** would positively influence choice.

"Being able to visit in advance"

"Accommodation for families overnight"

If DMH or NT was the 2nd consultant-led and co-located midwifery-led birth centre. What would make this *less* attractive? (32 comments)



35% of comments suggested **transport issues** would negatively influence choice.

"Distance to nearest hospital - 20 – 30 mins to Friarage"

"Ambulance is an issue"

10% of comments suggested **safety/quality of care issues** would negatively influence choice.

"Safety level of professional"

"Confidence – unit might be closed - hectic on a ward"

9% of comments suggested **pain relief issues** would negatively influence choice.

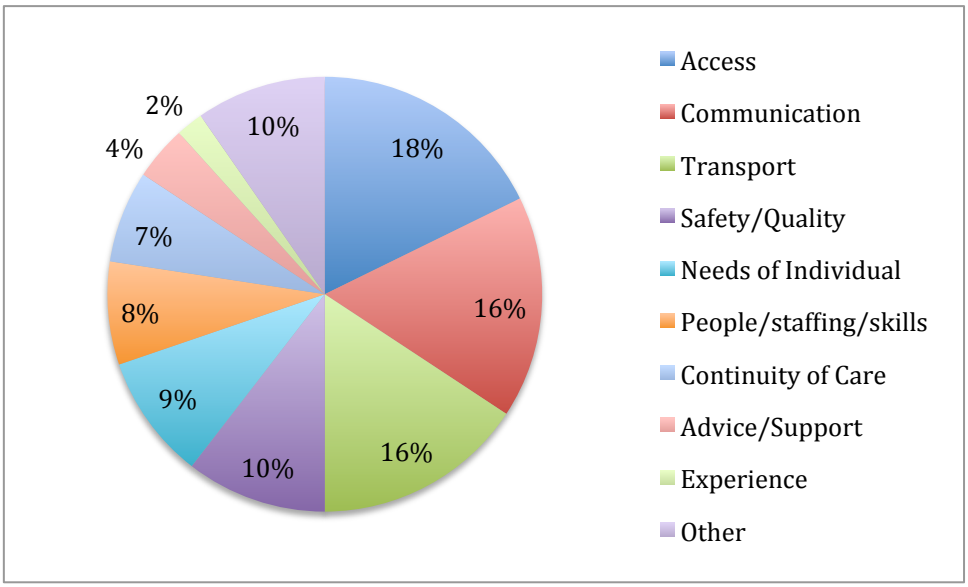
"Epidural Consultant"

"No pain relief"

PAEDIATRICS

3.2 Feedback prompted by the following questions

What is Important to you about paediatric care? (248 comments)



18% of comments were around **access** – appointment times, rapid response and reassurance.

"Timely appointments for children"

"Accessibility – people want to know they are in the safest hands"

16% of comments suggested that attendees sought improved **communications** – knowing who and were to go to when their children are unwell.

"Keeping parents well informed"

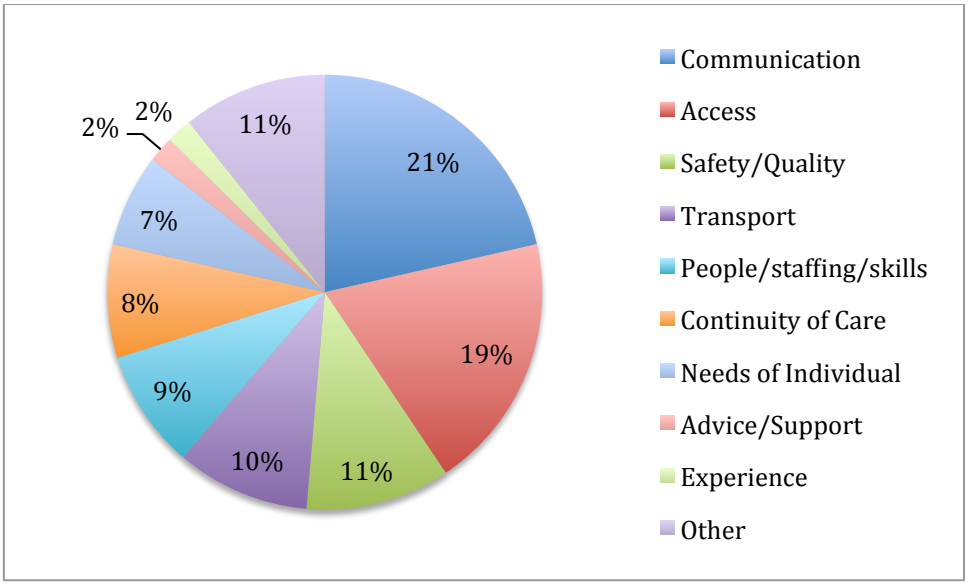
"Make it clear – understanding what is where – best care and simple"

16% of comments were around **transport** – travel distances and difficulties faced.

"To be able to access the best care but if not available locally can impact significantly on the whole family"

"Acceptance that people will travel if they need to access specialist care"

How can we make it [paediatrics] better? (261 comments)



21% of comments suggested that attendees sought improved **communications** – sharing knowledge and clearer signposting of services.

"Communicating with children in own right not parents. Experts in own condition. Empowering children – will cope better"

"Education and communication – parents needs to know where to go – sign posting – right place at the right time"

19% of comments were around **access** – appointment times, rapid response and integrated services.

"Access to other health professional like dietician, health visitor, physio"

"Access outside school times – massive impact on schools - can they be more fully involved in the process? E.g. record attendance later due to appointments with services to avoid marking absence"

11% of comments were around **safety and the quality of care** – having the right specialists available and child-friendly equipment.

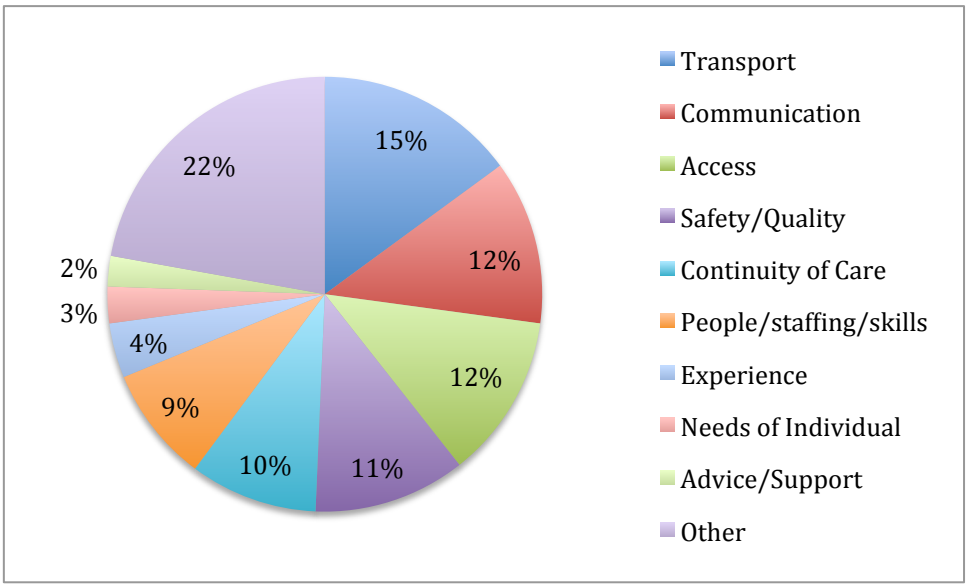
"Safeguarding – anyone providing care to children – ensuring the right qualification quality assurance – making sure the staff are properly trained in handling situations appropriately"

"Better specialist care available across the network"

ANY OTHER COMMENTS

3.3 Feedback prompted by the following questions

Any other comments? (221 comments)



15% of other comments were around **transport** – reinforcing earlier comments.

"Seriously ill children – parents may not have capacity to travel, but most will"

"Travel time from Hartlepool to North Tees with parents looking after other children is very hard and challenging enough"

12% of comments were around **access** – reinforcing earlier comments.

"Paediatric day units PDU – can these be done in schools alongside health visitors?"

"We need more local clinics to be run in Hartlepool (closer to home and where accessibility, especially with maternity and paediatrics)"

11% of comments were around **safety / quality of care** – reinforcing earlier comments.

"Two populations and one unit – the strain – will it have the capacity?"

"Huge concerns about rural GP closing – solutions are supposed to be looked at more nationally?"

22% of **other** comments included reach issues, use of technology and issues around finance.

"Challenges in engagement with seldom heard groups – barriers and stigma?"

"In case of technology – if you live in a more rural area, how do you benefit from the services and innovation?"

"How much is this reconfiguration going to cost with the clinical impact?"

4.0 Conclusion

Phase 5 asked attendees to discuss what factors were most important around Maternity and Paediatric services.

The most common comments for maternity services were around transport (particularly emergency/ambulance transport) and the options available if a low risk birth becomes a high risk birth. Those with further to travel were concerned with the needs of expectant mothers, families and siblings.

The importance of safety and quality of care, access to adequate numbers of skilled specialists, the capacity of the scenarios to cope and the need for clear pre and post-natal communication were all matters represented by attendees. The need for reassurance and meeting individual needs (particularly for new mums) were also concerns.

Previous experience and word of mouth were felt to be important factors in informing expectant mothers, as were staff considering individual needs such as home births and pain relief. After close proximity, improving the environment, listening to expectant mothers, familiarising them with the surroundings/process and keeping them informed would all contribute to where an expectant mother would choose to go. Attendees added continuity of care in community based settings would also improve current maternity services.

The most common comments for paediatric services were around access (appointment times, rapid response and reassurance), communications (knowing where to go to when children are unwell) and transport and travel times.

Suggested improvements from attendees around paediatric services included improving communications – sharing knowledge and clearer signposting of services, improving access and improving safety and the quality of care – having the right specialists available and child-friendly equipment.

Specialisation, improved services and improved communication linked with the potential need for patients to travel further for better outcomes continues to gain conditional support amongst attendees in face-to-face events. The benefits of the BHP programme need to be clearly communicated to gain public support and allay public concerns around travel and transport in particular.

The comments in phase 5 refine the key themes identified earlier in this engagement process and offers further evidence of the public's views and priorities with which the BHP team can use in its communication and consultation stages.