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NORTHUMBERLAND TYNE & WEAR & NORTH DURHAM STP HEALTH SCRUTINY COMMITTEE

Meeting on Monday, 19 March 2018 at 1.30 pm in the Bridges Room, Civic Centre, Gateshead

Agenda

1 Appointment of Chair

The Joint Committee has previously appointed Councillor Mary Foy (Gateshead Council) as Chair of the Joint Committee. However, due to unforeseen circumstances Councillor Foy has advised she is no longer able to continue in that position.

In view of the aforementioned, it is proposed that, subject to the approval of this Joint Committee, Councillor Lynne Caffrey (Gateshead Council) be appointed Chair of the Joint Committee in her place.

2 Apologies

3 Declarations of Interest

4 Minutes (Pages 3 - 14)

The minutes of the last meeting of the Joint Committee held on 15 January 2018 are attached for approval.

5 Update on Urgent and Emergency Care Workstream (Pages 15 - 40)

Report attached. NHS Leads for the Urgent and Emergency Care Workstream will attend and provide the Joint Committee with an update on the above.

6 Pharmacy and STP

a) Stephen Blackman, Chief Officer, North of Tyne LPC, will highlight issues on behalf of the LPC.

b) Andre Yeung, Chair of Northumberland Tyne and Wear LPN, will highlight opportunities for pharmacy to support the work being progressed via the STP.

7 Interim Update - Workforce Workstream

NHS Leads for the Workforce Workstream will provide the Joint Committee with a presentation on the above.

8 Joint STP OSC Work Programme

The proposed provisional work programme for the Joint Committee is set out below:-

Meeting Date	Issue
25 June 2018 at 2pm (tbc)	• Update on Workforce Workstream • Professor A Pollack, Director of Institute of Health and Social Care, Newcastle University – View on Accountable Care Organisations (tbc) • Development of Accountable Care System – Progress Update

Issues to be slotted into future meetings

Empowering Communities – how it is planned to engage with and involve communities in the whole STP / ACS process.

The views of the Joint Committee are sought.

9 Date and Time of Next Meeting

It is proposed that the next meeting of the Joint Committee be held on 25 June 2018 at 2pm, Civic Centre, Gateshead.

Contact: Angela Frisby Tel: 0191 4332138 Date: 7 March 2018

NORTHUMBERLAND TYNE & WEAR & NORTH DURHAM STP HEALTH SCRUTINY COMMITTEE MEETING

Monday, 15 January 2018

PRESENT: Councillor Caffrey (appointed Chair for the meeting) (Gateshead Council)

Councillor(s): Charlton (substitute – Gateshead Council) Armstrong (Northumberland CC) and Dodd(substitute - Northumberland CC) Chequer (Sunderland CC), Clark (substitute - North Tyneside Council), Davinson and Temple (Durham CC),Hetherington and Huntley (South Tyneside Council),Mendelson, Schofield (Newcastle CC) and Huddart (substitute – Newcastle CC)

10 APOLOGIES

Councillor (s); Foy and Maughan (Gateshead Council) Taylor (Newcastle CC) Bell, Grayson and Hall (North Tyneside Council), Simpson and Watson (Northumberland CC) Flynn (South Tyneside Council) Robinson (Durham CC) Heron and Leadbitter (Sunderland CC)

11 DECLARATIONS OF INTEREST

Councillor Mendelson (Newcastle CC) declared an interest as a member of NTW NHS FT Council of Governors.

Councillor K Chequer (Sunderland CC) declared an interest as an employee of NTW NHS FT.

12 MINUTES

The minutes of the last meeting held on 13 November 2017 were approved as a correct record subject to it being noted that, at item 3 Declarations of Interest, Councillor Chequer (Sunderland CC) had declared an interest as an employee of NTW NHS FT and Gateshead Health NHS FT.

13 STP PREVENTION WORKSTREAM - PROGRESS UPDATE

Dr Guy Pilkington, Chair of the regional STP Prevention Board, explained that a Board had been established to progress this area of work to demonstrate a system wide commitment to prevention work in the north east.

Dr Pilkington advised that his role was that of SRO and he was supported by

Directors of Public Health from across the patch and Terry Collins, Chief Executive Durham County Council who was acting as sponsor for the work and Alan Foster STP Lead so that assurance can be provided to the STP Board in relation to this area. Prevention is viewed as central to the success of the STP process.

Dr Pilkington noted that Prevention work was critical. Although there are financial constraints in the north east there are still good services being delivered. However, in spite of these factors there are still very poor health outcomes in the north east and there is a significant health and wellbeing gap that needs to be closed.

Dr Pilkington stated that the North East Combined Authority and local NHS organisations had established a Commission for Health and Social Integration in 2016 as part of a devolution bid and this had reported its findings in " Health and Wealth: Closing the Gap in the North East" which had provided a good steer. This work had complemented the NHS Five Year Forward View which set out the need for the NHS to support a step change increase in prevention. The Marmot Report in 2010 also supported the need for building on existing prevention activity.

As NHS budgets are fully stretched it is important to shift the focus towards prevention otherwise services will always struggle to meet demand. There has also been an increasing recognition that to progress prevention work there cannot be a reliance on local authorities alone. It is also important to shift activity and investment to support the prevention agenda in order to close the health and wellbeing gap.

As part of upscaling prevention work there is a regional ambition to address the harm caused by tobacco and the target is to reduce smoking to 5% by 2025.

Dr Pilkington advised that there is a need for system leadership to drive forward the prevention agenda and this would be the role of the Board. Dr Pilkington set out the proposed work programme for the Board.

Work focuses on action to embed prevention at all levels and in particular for the STP primary and secondary prevention.

In relation to primary prevention, this would deal with what is being done to improve the health of the population before they become ill and focus on tackling key areas such as smoking, alcohol, providing children with the best start in life and preventing / reducing obesity. Dr Pilkington stressed the importance of people being active to keep well and the fact that there is significant evidence to support intervention in this area.

In relation to secondary prevention, this would look at reducing premature mortality in areas such as Cardio Vascular Disease (CVD) Cancer, Chronic Obstructive Pulmonary Disease (COPD) and Diabetes.

The Joint Committee was advised that this winter there had been a number of pressures on the system and outbreaks of norovirus had exacerbated those pressures. In addition, a flu epidemic had affected the primary care workforce highlighting a need for extra take up of the flu immunisation amongst that workforce. An important focus for the Board's work will therefore be getting better rates of

workforce and population immunisation. Workplace health is an important area of focus within the prevention agenda. However, shifting spend to prevention is still a challenge when particular crises take up the available budgets. The Board will therefore be looking at how partners can make the shift and think differently and imaginatively about potential options.

Dr Pilkington advised that going forwards a community asset based approach would be key as part of social prescribing. Public Health England would be leading a conference on this area in the next couple of months. The methodology behind this is to make every health contact count. This means that the workforce would act as health champions and consideration will need to be given to how they are skilled and trained to provide brief advice. The aim will be to have the most skilled regional workforce who can deliver health messages at every opportunity.

The Joint Committee was advised that the Prevention Board would also be working closely with the mental health workstream in relation to people at risk and suicide prevention. The ambition is to have zero suicides. It is also planned to work with local maternity services to progress work to become smoke free.

Alice Wiseman, Director of Public Health for Gateshead, advised the Joint Committee that the initial focus for the region has been on preventing tobacco harm through implementation of a smoke free NHS. This area was addressed as a priority as it is one of those areas which will make the greatest difference to health and wellbeing of our populations. This Prevention Board has prioritised and endorsed this work to support a regional vision of having only 5% smoking prevalence by 2025 which is an ambitious target. The aim is to ensure that tobacco dependency is treated the same as other dependencies.

A dedicated Task Force has been established, chaired by Dr Eugene Milne and Tony Branson, which has representation from both NHS and local authorities with a view to ensuring that all Trusts fully implement NICE guidance PH48.

Amongst other things, this will mean that every person the Trusts come into contact with will be asked their smoking status and a conversation will be had on their admission to hospital and nicotine replacement therapy will be provided whilst an individual is in hospital. Subsequently work will continue with individuals in the community and support offered.

This approach has been endorsed at the STP oversight group and consideration is now being given to proposals for implementation.

Dr Pilkington stated that resources will be allocated to support acute trusts to become smoke free. In relation to secondary prevention work this will mean that opportunities will be provided to consider individuals' tobacco use prior to any planned procedures.

Dr Pilkington stated that one of the most significant challenges was around the amount of work involved in a single element in a process. Dr Pilkington stated that there is a need to examine whether it is feasible to shortcut some of the processes and have a governance arrangement which will drive forward a combined agenda.

Dr Pilkington highlighted an example of shared commitment where there was a need to expand the broad agenda. Peter Kelly will therefore be convening a meeting in the next couple of months. There will be a need to confirm the focus for funding and assure the system as a whole that appropriate outcomes will be delivered.

Dr Pilkington stated that the Prevention Board will continue to review its membership and its terms of reference to ensure that these are appropriate. Alice noted that as the Board was an important vehicle for delivering and implementing the recommendations of the Health and Social Care Commission, which also link to economic development, it was important to make sure that the Board was linking into the right forums to deliver on that agenda. A report had been taken to the North East Combined Authority (NECA) Overview and Scrutiny Committee where it had been agreed that there was a need to focus on those priorities.

Councillor Mendelson noted that there are an increasing number of workplaces, where employees may be on temporary contracts and there is no union involvement, where it may be difficult to drive forward the health prevention agenda. There are also a number of individuals who are on the edge of workplaces and Councillor Mendelson was concerned at how these individuals can be supported. Councillor Mendelson noted that the Joint Committee had received information about the prevention strategy and the mechanism for taking this forward but queried what the Joint Committee could expect to see in terms of a delivery plan as there appeared to be lots of disparate initiatives.

Dr Pilkington advised that given the geography of the STP a lot of activity would take place in local areas. In terms of local authority footprints there was no ambition to shoehorn localities together to form one area. The aim is to look at how individual local delivery plans can be made more effective. However, finances will need to be dealt with at a regional level.

One area of activity would focus on flu immunisation and the aim that every organisation with a cohort of the population should be in the top quartile of flu immunisation rates nationally. In addition, the aim was to have all children in primary education in the north east in the top quartile for immunisation. Having agreed this ambition processes will then need to be put in place to ensure that each local area is able to report back on its success in achieving this ambition and that there is peer to peer challenge if areas fall behind.

Dr Pilkington acknowledged that workplace terms and conditions have an impact on physical and mental health and indicated that the Prevention Board would be happy to engage with others to think about how such issues might be addressed.

Alice advised that health and workforce were key considerations for Councils and a number of recommendations had been developed and this included access to psychological therapies. The Better Health at Work Award has also been developed as a region and continues to be supported although it is recognised that one of the challenges relates to progressing the agenda with smaller employers. Alice stated that this needs to link into the Strategic Economic Plan as there is a real economic argument for employers to engage.

The Chair of NewcastleGateshead Healthwatch highlighted the importance of developing community asset based approaches and stated that if such approaches are to be developed then it is important to start conversations with communities early. The Chair of NewcastleGateshead Healthwatch also noted that due to budget issues there are now fewer staff to initiate such conversations and queried how it was planned to develop such work in light of such challenges.

Dr Pilkington stated that it was planned that work would focus on social prescribing and supporting practitioners to take a broader view of individuals' ability to stay healthy and think holistically about individuals and the fact that homes and relationships play a key part. Dr Pilkington stated that it would be important to develop a regional language around this work and collectively bid for NHS funding to put in place a more co-ordinated and easier to understand system. In times of reduced funding community assets are important and need to be supported. There is a really vibrant voluntary and community sector in the region and it will be important to tap into this. It was noted that Public Health England would be holding a conference on Community Asset Based approaches in March.

The Joint Committee noted that the Empowering Communities Model cuts across the work of all the STP workstreams and was a potential area for further consideration.

The Chair of the Joint Committee supported Dr Pilkington's view that a regional language needed to be developed.

Councillor Hetherington noted that South Tyneside OSC had carried out a Commission on Smoking last year and one of the key findings was that there are a number of reasons why people start smoking and there is not one solution. Therefore any health contacts with individuals will need to explore those reasons as, until those reasons are identified it will not matter what health benefits are articulated around not smoking and individuals will continue to smoke. It is essential that the root causes of smoking are identified and tackled and that it is recognised that smoking is an addiction and needs to be treated the same as other addictions. Councillor Hetherington noted that there are still some acute trusts which make smoking acceptable by providing places in hospital for individuals to smoke. There is a need to change attitudes.

Dr Pilkington agreed with Councillor Hetherington and stated that there is evidence which suggests that if 40% of smokers were offered brief advice and supported to stop smoking every year then it will be possible for the region to achieve the 5% target.

Dr Pilkington stated that it is not the case that the population lacks awareness that smoking is bad for individuals' health. It is important that when contacts are made with those who smoke they understand that there is no blame attached and they do not feel that they are being punished for smoking. Dr Pilkington stated that e-cigarettes are an enabler for individuals who have tried a number of other avenues.

Dr Pilkington noted that Balance had held a conference about why young people

start to drink alcohol and what the industry do to encourage people to drink alcohol. Dr Pilkington considered that this approach was needed in relation to smoking.

Councillor Huntley stated that the closing the gap ambition was fantastic but queried how robust the Board was to enable it to drive forward this ambition and how it would empower its workforce. Councillor Huntley stated that OSCs in Sunderland and South Tyneside had often received information that workforce were not involved until the later stages.

Dr Pilkington stated that the workforce will be receiving significant engagement from the Prevention Board. The Board would be rolling out training to enable the workforce to support individuals to stop smoking and look at how they can think differently about alcohol as well as being open to individuals in distress so that they can work towards a target of no suicides. Dr Pilkington stated that whilst the Prevention Board has senior management representation it does not have all the levers it needs and this is why it is taking matters to its most senior leadership.

Councillor Schofield thanked Dr Pilkington for the presentation and outlining the ambitions of the Prevention Board. However, Councillor Schofield noted that Newcastle's Overview and Scrutiny Committee had received a presentation on CAMHS and how the model would help to reduce demand on specialist services and it had been hard to see how this could be achieved with the resources available. Councillor Schofield considered that this was the case with many DOH initiatives and this inhibited the rate of change. Councillor Schofield queried where Public Health sat in all of this and whether collaboration would take place through existing mechanisms or new structures and what the legal liabilities would be and whether they would be shared if they were progressed via Partnerships.

Dr Pilkington advised that some of the points raised would be addressed in the update on Accountable Care Organisations. Dr Pilkington stated that it would be important to look at what Partnerships can achieve together that organisations can't currently do alone and how this is managed. Dr Pilkington stated that voluntary and community assets will also need to be used to the full.

The Joint Committee was informed that Public Health are involved in leading on this work jointly with the NHS around population health. The role will focus more on providing advice to the system as there is a recognition that there is only so much that can be done in terms of service delivery.

It was noted that 60% of NHS budgets have been focused on the acute sector and there is a need to shift some of that resource into secondary and tertiary prevention.

Councillor Davinson highlighted that work had been taking place in Durham to reduce smoking rates and whilst these had reduced there were still 38% of people in his area who still smoked so there was still a lot of work to be done. Councillor Davinson also highlighted the importance of exercise as a key element of prevention work as it supported both physical and mental health and if individuals joined clubs then it could also support social inclusion. However, Councillor Davinson considered that prevention initiatives would not have any impact unless they addressed the root causes of why people smoke etc and individuals had a positive view of their lives

and what they might achieve.

Dr Pilkington stated that he supported Councillor Davinson's view and considered that exercise is key to helping prevent diabetes and the mental health component of exercise was very important. Dr Pilkington highlighted that councillors can be considered to be community assets as they can be key to bringing people in communities together and creating connections between them and relevant organisations.

14 ROLE OF ACCOUNTABLE CARE ORGANISATIONS

The Joint Committee received a video presentation outlining the role of Accountable Care Organisations.

Mark Adams advised the Joint Committee that the focus in NE and Cumbria STP areas was on developing Accountable Care Systems and looking at how organisations could work together more.

The approach involved the NHS working under set budgets to improve health and working together with other services such as Social Care and Public Health to achieve this. Some of this work was taking place within the Vanguard pilots which were trialling new models of delivering community based services.

Mark highlighted that this approach would mean that whilst patients would still see their GP and access hospital care they may receive more support and treatment at home. It might also mean that individuals might have to travel further to access hospital care.

Mark stated that the Joint Committee would be able to see from the video presentation that as far as STPs are concerned there has been a lot of discussion around how individual organisations come together and work in different ways. Mark highlighted that one of the key areas in our STP is the emphasis on Prevention which as the video highlighted has not always been seen in other areas. Mark stated that within this STP the key focus will be on looking at what other areas can do and working with other organisations, not just local authorities to see how the best use of resources can be achieved. Mark advised that it will be really important to make sure that the organisations that come together are rooted in local work.

Mark stated that the discussion around Prevention highlight the general understanding of what we want to do collectively and what works well and less well and how it is planned to make changes.

Alan advised that the aim was to have systems working together rather than implementing organisational change. Alan stated that where it makes sense to work at scale there are a lot of things that can be done to try and provide an equitable approach. However, Alan advised that what can be achieved locally is also important. Alan stated that an accountable care systems approach means working together in the North East to agree how we deliver care and how we want to collaborate more with partners such as local authorities and the voluntary sector to

create local systems which will meet needs and improve services for local people. Alan stated that he believed there were real opportunities in progressing such an approach and in ensuring a real interface for patients at a local level.

Alan highlighted that some hospital services in the patch were vulnerable due to staff shortages in areas such as radiology and other areas are also under pressure so this may mean that patients have to travel further.

The Chair stated that on the issue of further privatisation of the NHS this was not in the interests of most people and the recent collapse of Carillion and the need for government to bail out contracts highlighted this. The Chair stated that Gateshead and Newcastle were quite far down the line in discussions on health and social care integration. However, it would be important for public accountability that whatever systems etc are set up that they are accountable to Health and Wellbeing Boards.

The Chair also noted that it will be important to look at how we commission using the Social Value Act. The Chair advised that Gateshead is now looking to ask those who contract with the Council to sign up to a Corporate Responsibility Pledge around wages/ workforce and health and wellbeing.

The Chair considered that integration would help to better deliver services and avoid duplication of effort and she considered that this approach was similar to the approach being outlined by Mark and Alan. The Chair also highlighted that it would be important for the North East to continue to attract resources from central government.

Councillor Hetherington supported the comments Alan and Mark had made about greater joint work across systems as a way forward. Councillor Hetherington considered that all local authorities support this ambition. However, Councillor Hetherington noted that STPs had come in on the back of a great deal of suspicion about the motivation for implementing them and without a great deal of input from the public and local authorities. In addition, Councillor Hetherington noted that Accountable Care Organisations were unfortunately linked to the US healthcare system which is linked to private medical care.

Councillor Hetherington also noted that this approach appeared to be in direct conflict with the Health and Social Care Act which supports competition. Councillor Hetherington queried whether there was any danger of fragmenting services if they were put out to smaller organisations.

Mark stated that Councillor Hetherington was right to say that the structure of the NHS was based on competition. However, Mark stated that as a result of the direction of travel under austerity, STPs were focusing on improving health and the quality of services and as a result of this had learnt that working collaboratively together achieves more and helps to keep funding here.

Councillor Hetherington supported the approach being adopted by Mark and Alan but expressed concern that government may try to override this approach. Dr Pilkington acknowledged that there was a risk but there would be the potential for everyone to challenge such a stance. Dr Pilkington stated that the inequalities

agenda had not been tackled successfully using the NHS focus on competition.

Councillor Clark stated that it was good to hear that a more collaborative approach was planned but expressed concern that this might not be supported nationally.

Mark stated that the Joint Committee's comments were really helpful. Whilst the methodology of Accountable Care Organisations was based on the US model the focus in this STP was on an accountable care systems approach and on how organisations work together. Mark stated that he considered that there was scope to influence government in relation to local approaches to STP delivery.

Councillor Clarke queried whether there was a clear vision as to what accountable care systems look like in the North East.

Mark advised that there is not a clear vision at the minute. It would be necessary to work together to create such a vision and understand what works best at a local level. Mark stated that there is the potential to consider other models and see what this might mean for this STP area.

Councillor Clarke considered that it would be good to have more information on this issue at a future meeting of this Joint Committee.

Councillor Temple noted that there were a lot of tensions in the system, in relation to private and public health, the spread of models and integration work and he queried how much of a challenge this represented in terms of the STP's capacity to achieve its goals.

Councillor Temple also noted that he could not see any evidence of voluntary sector representation or social care providers on the Prevention Board and he queried what was planned in relation to this.

Alan stated that there is a need to get the governance right and get the right people involved with the right approach and this is still work in progress.

Dr Pilkington advised that there were challenges within the system. Within commissioning there is currently a lot of focus on split funding and health responsibilities. However, Dr Pilkington considered that there were still potentially better ways to deliver services through efficiencies and by taking collective responsibility. Dr Pilkington advised that he would be speaking to the ADASS Board about appropriate representation for the Prevention Board. Dr Pilkington stated that by working towards an Accountable Care System the aim was to take a whole population approach and encourage commissioners and providers to be part of a collective solution.

Councillor Schofield expressed concern that a top down approach was being progressed and she was keen to understand how the voice of the community was going to be taken into account. Councillor Schofield also considered that it would be helpful to have a clear definition of an Accountable Care System to avoid confusion and misunderstandings. Councillor Schofield also noted that the issue of transport did not appear to have been covered in any of the discussion and she felt that was

an important area to take into account.

Councillor Mendelson considered that it is beneficial for everyone to work together and there is also a need to campaign for better funding. Councillor Mendelson queried how scrutiny would be built in to the development of the proposed Accountable Care System. Councillor Mendelson considered that this Joint Committee should scrutinise what was happening at various stages of development of the proposed system prior to decisions being made.

Mark acknowledged that at present there is not a collective vision/model as this is still in development. However, Mark assured the Joint Committee that whatever proposals are developed these would not cut across statutory duties to involve and consult the Joint Committee and patients. Mark considered that the views of the Joint Committee would be particularly helpful in providing a strategic steer.

Caroline confirmed that any significant service changes would be brought to the Joint Committee.

Councillor Mendelson stressed that it was important that matters were brought to the Joint Committee before decisions were made.

The Chair invited questions from members of the public.

Carole Reed from Keep Our NHS Public (Durham) highlighted that the talk about ACOs appeared to be very vague and it was unclear as to what was being proposed and who would be accountable. Carole also queried when the final version of the STP would be shared.

Alan stated that finalised STP would be shared once it was fully developed.

Carole also considered that if any reconfiguration proposals arising from the STP had taken place before the winter crisis the system would not have had the capacity to deal with this. Carole also considered that the main focus of the STP was saving money and that ACOs were the same.

The Chair noted that these points had been raised and considered at the last meeting. Carole stated that this was being raised again as there were concerns that ACOs would not be subject to public scrutiny.

Mark assured the Joint Committee that when a vision had been developed for the Accountable Care System both the Joint Committee and the public would be consulted.

A member of the public, who is a carer in Gateshead, expressed concern that when the issue of workforce was raised there appeared to be no mention of the “ invisible” workforce which was carers and their contribution to the prevention agenda. The member of the public highlighted the potential negative impact on carers’ mental health as a result of their caring role and highlighted the need for carers to be supported to deal with the pressures placed on them.

Alan acknowledged that there would need to be a to link with carers / explore support for carers going forwards and how this fits with working families as more services became more community focused.

The member of the public noted that it had been mentioned that the aim was to keep services as local as possible. However, the member of the public considered that there had been a 50% increase in out of borough services for mental health which had a big impact on his family. The member of the public expressed disappointment that CCGs whose funding had been increased to deliver mental health services had reduced the percentage of funding allocated to those services.

Alan advised the Joint Committee that investment in Northumberland Tyne and Wear NHS FT had reduced a little but mental health spend had grown overall.

15 JOINT STP OSC WORK PROGRAMME

The Joint Committee considered and agreed its provisional work programme as follows:-

Meeting Date	Issue
19 March 2018	• Urgent Care Workstream – Progress Update • Workforce Workstream – Interim Position
June 2018 (date tbc)	• Workforce Workstream – Progress Update • Accountable Care System – Progress Update

It was agreed that progress updates on the development of the Accountable Care System be provided to the Joint Committee on a regular basis and that information on how it is proposed to engage and involve communities in the whole STP/ACS process be brought to the Joint Committee at a future meeting.

The Joint Committee also indicated that it would be helpful to be provided with information on how the unions are being involved in the Workforce Workstream and have information as to how work in relation to the social care workforce was linking with the STP workforce workstream at a future meeting.

16 DATE AND TIME OF NEXT MEETING

AGREED That the next meeting of the Joint Committee be held on 19 March 2018 at 1.30pm at Gateshead Civic Centre.

Chair……..

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North East and North Cumbria
Urgent and Emergency Care Network

North East & North Cumbria Urgent and Emergency Care Network - Update for the Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside, Sunderland and Durham Joint Overview and Health Scrutiny Committee

March 2018

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Strategic context for Urgent & Emergency Care (UEC) Networks

NHS England set out that UEC Networks should be "the vehicle through which new ideas are reviewed, discussed, prioritised and ultimately implemented. Through this the ***boundaries of urgent and emergency care will be pushed and extended***.

Significant input is expected from the organisations that comprise the Network in terms of ***organisational leadership, expert knowledge and time***. These are supported by a ***governance*** structure that is focused on ensuring ***safe, effective delivery***. The injection of vanguard (new models of care) funding was used to deliver projects that could not be wholly funded from within existing budgets and also to provide faster implementation of all projects. Programmes of work were built around five vanguard activity areas and three high impact schemes in particular offer the opportunity for ***whole system change that is nationally transferable at pace***."

North East & North Cumbria Urgent and Emergency Care Network

Vision

To reduce unwarranted variation and improve the quality, safety and equity of urgent and emergency care provision by bringing together stakeholders to radically transform the system at a scale and pace which could not be delivered by a single organisation.

Objectives

- High quality, safe, urgent and emergency care services available seven days of the week, addressing our population health needs, balanced against requirements of personalisation
- Simple to access integrated care pathways, delivered as close to home as possible, provided across a full range of care settings, enabling good choices by patients and clinicians
- Improved patient experience and clinical outcomes delivered through care in the right place, at the right time, provided by those with the right skills

Principles

- The needs of the patient are above those of individual organisations
- As a system we can provide a higher standard of care than as individual organisations
- Patients and staff will be involved in the development and delivery of our programme
- Costs will be reduced by coordinated care focused on improving health
- We will work together to develop and meet our shared vision for urgent and emergency care
- We will involve partners in social care

Network governance

The network is accountable to CCG Governing Bodies, Provider Boards, NHS England and NHS Improvement. It is established to ensure that patients with more serious or life threatening emergencies receive treatment in centres with the right facilities and expertise, whilst also ensuring that individuals can have their urgent care needs met locally by services as close to home as possible.

The Network comprises over 30 organisations serving a population of over 3 million, spread across diverse geographies and incorporating large pockets of both densely populated and diverse populations.

Through these member organisations, the Network provides support to Local A&E Delivery Boards (LADBs) where they identify requirements beyond the local LADB footprint, and where there is advantage in delivering uniformity in the provision of a standard of care across the region.

Membership of the Network is drawn from Executive Directors and Senior Clinical Leaders from member organisations and partners across the area, patient groups from throughout the region are also represented.

The strategic board is accountable for delivering the strategy and holding partners accountable for delivering within our strategy, with support from an operational group and a clinical reference group.

A visual guide to the network's governance is included an appendix 1

Network membership

NHS Clinical Commissioning Groups

- Northumberland
- North Tyneside
- Newcastle Gateshead
- South Tyneside
- Sunderland
- North Durham
- Durham Dales Easington and Sedgefield
- Darlington
- Hartlepool and Stockton-on-Tees
- South Tees
- North Cumbria
- Hambleton, Richmond and Whitby

NHS Provider Trusts

- Newcastle Hospitals
- South Tyneside
- City Hospitals Sunderland
- County Durham and Darlington
- North Tees and Hartlepool
- South Tees Hospitals
- Gateshead Health
- Northumbria Healthcare
- North Cumbria University Hospitals
- North East Ambulance Service
- Yorkshire Ambulance Service
- North West Ambulance Service

NHS Mental Health Foundation Trusts

- Northumberland Tyne & Wear (NTW)
- Tees, Esk and Wear Valley (TEWV)
- Cumbria Partnership (CPFT)

Other partners

- Regional out-of-hours providers
- North East local authorities
- Royal College of Psychiatry
- Academic Health Service Network
- Health Education North East
- Clinical Health Information Network
- North of England Commissioning Support (NECS)
- Local A&E delivery boards
- Cumbria Partnership Trust
- NHS Improvement
- Strategic Clinical Network
- Vocare
- GATDOC
- NHS England
- Local Medical Committees
- Healthwatch

Defining 'Urgent and Emergency' Care

The definition of urgent and emergency care has been aligned with that of the Department of Health (2011), who define urgent and emergency care as:

"Urgent and emergency care is a range of health services available to people who need medical advice, diagnosis and / or treatment quickly and unexpectedly.

People and their carers using this range of services should expect to be able to access essential, high quality, consistent advice, review and treatment 24 hours a day, seven days a week – 24/7. This urgent and emergency care system should be:

- patient / user focused
- delivering good clinical outcomes
- delivering good patient experience
- timely
- right the first time
- available 24/7 at a consistent standard"

This definition of urgent and emergency care applies equally to paediatrics and adult, physical and mental health services alike, as such our Vision, Objectives and Principles apply equally to Physical and Mental Health Paediatric and Adult Services.

Wherever possible we will apply a consistent approach to the transformation of services, however we recognise that in some circumstances we will need to make changes to our approach in relation to Paediatric and/or Old Age services.

Key Principles for Good Services

In developing a strategy for evidence based, effective and efficient services, consideration has been given to what "good services" should look like. The RCGP Centre for Commissioning (2011) has identified the following key principles of a good urgent and emergency care service:

- No confusion relating to what to do, who to call or where to go
- A joined up and coordinated system
- Safe, responsive and a high quality service
- Self-care, prevention, anticipatory care and patient empowerment
- Patient and public involvement
- Monitoring of urgent and emergency care services
- Knowledge to influence spend on services
- Integrated mental and physical health care for all.

Strategic Objectives

The network has four key objectives to meet the vision:

- Focus on prevention through collaboration with local authorities, voluntary sector and other partners to build resilient communities.
- Sustainable high quality, safe, urgent and emergency care services available seven days of the week, addressing our population health needs, balanced against requirements of personalisation.
- Simple to access integrated care pathways, delivered as close to home as possible, provided across a full range of care settings, enabling good choices by patients and clinicians.
- Improved patient experience and clinical outcomes delivered through care in the right place, at the right time, provided by those with the right skills.

Links to sustainability and transformation partnerships

We recognise that Sustainability and Transformation Parnterships will generate significant change across the system with particular emphasis on out of hospital services. The Network will support the system to generate efficiencies by identifying opportunities to deliver change at scale and develop standardised pathways ensuing equitable services for patients.

We will, wherever possible, adopt the principle of doing things once.

Appendix 3 demonstrates our system wide approach to the transformation of urgent care services and how we will contribute to a number of the common work streams across our STP partners.

National context

Professor Keith Willet has previously summarised the position as follows:
"The fundamental principles upon which the NHS is founded - the provision of a comprehensive service, with access based on clinical need not ability to pay - are at their most precious when we or someone we care about needs urgent or emergency care. Every year, the NHS responds to hundreds of millions of contacts from members of the public with such needs. At one end of the spectrum these contacts relate to people seeking help and advice around options for self-care. At the other end, they relate to people needing life-saving treatment for the most serious conditions such as major trauma and heart attacks.

The demands being placed on our urgent and emergency care services have been growing very significantly over the past decade. Over the last three years alone, attendances at all types of urgent and emergency care facilities (officially termed type 1, 2 and 3 A&E departments) have risen by one million. NHS organisations and staff are continuing to work very hard to ensure that performance against key standards (such as the percentage of A&E patients discharged, admitted or transferred within 4 hours) are maintained, but it is clear that the service is at the limit of its capacity.

Every winter this pressure increases further and the signs are most visibly seen in our A&E departments, where last year's cold snap resulted in very considerable strain. The Government has announced a significant two year investment in A&E departments to help them with the further pressures that are anticipated during the forthcoming winter. This will be beneficial but it is not the sustainable long-term solution. It is also important to recognise that the pressures facing our urgent and emergency care services are not simply a phenomenon of winter. They are present all year round and require a systemic not just a seasonal response, although preparations have started earlier than ever before this year.

We know that if we do not provide an adequate or responsive service to those with less serious, but nevertheless urgent, care needs we risk allowing such problems to become worse. We also know that a failure to meet people's needs outside of hospital results in them seeking help from those services that are highly responsive - particularly A&E departments and 999 ambulances - but are intended to help those with the most serious, complex and life threatening needs. The reality is that the pressure our A&E departments and ambulance services are experiencing is absolutely not a sign of failing services, but that these services have become victims of their own success. The unsustainable demands being placed upon them have been fuelled by their own responsiveness but also the difficultly patients experience in navigating and securing help for their urgent care needs elsewhere.

We must recognise that we cannot rely on spending increasing amounts of money on a system that needs to be improved, and which is already approaching its limits. We have to be more radical than this if we are to deliver lasting solutions."

(Professor Keith Willet, 2013)

More recently, the Next Steps on the Five Year Forward View, March 2017 validates the original statement above, documenting that:

"Each year the NHS provides around 110 million urgent same-day patient contacts. Around 85 million of these are urgent GP appointments, and the rest are A&E or minor injuries-type visits. **Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system**. They turn to A&E because it seems like the best or only option. The rising pressures on A&E services also stem from continued growth in levels of emergency admissions and from delayed transfers of care when patients are fit to leave hospital.

Frontline staff have pulled out all the stops, but over this past winter there have been real difficulties. In providing nine out of ten patients with A&E care within four hours over the past year, the UK offers our patients the fastest national A&E treatment of any major industrialised country. However, in recent years the proportion of patients looked after within 4 hours has been falling – caused by rising demand in A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; the need to adopt good practice in hospitals consistently; and difficulties in discharging inpatients when they are ready to go home. So we need to take action to improve services for patients and reduce pressure on our staff."

(NHS England, 2017)

Our current service provision

Our Network urgent and emergency care system is complex and contains a vast number of different services, which operate at different times. We recognise that this needs to be simplified to ensure that users can make an informed choice regarding the best services for them or their families. A key component of our strategy is to help ensure that this is delivered.

There is a wide variety and number of services available across our Network geography. This can be summarised as detailed below, however this will quickly change as services and requirements continue to develop:

• **Ambulance Services:**	**3**
• **General Practices:**	**479**
• **Pharmacies:**	**684**
• **Dentists**	**419**
• **Urgent Care Centres:**	**38**
• **Out of Hours Providers:**	**4**
• **NHS 111:**	**3**
• **Emergency Departments/A&E:**	**11**
• **Emergency Centres Specialist services:**	**2**
• **Mental Health Providers**	**3**

Service	Delivering
Ambulance Services	
999	Care for people with serious, life-threatening injury or illness at the place of illness or injury. Telephone assessment and advice 'Hear and Treat', treatment of patients in the community 'See and Treat' without the need to transport and where required, urgent transportation to hospital ED and other departments.
Patient Transport Service	Although not an urgent or emergency service, Patient Transport Services support the delivery of UEC services through the transport of non-emergency patients and their escorts who meet the eligibility criteria and supporting more urgent transport services as required. The non urgent/emergency element of this provides patients with journeys between their place of residence and healthcare facilities, and between hospitals. PTS is only available for patients with a clear and genuine medical need.
Primary Care Based Services	
GP Practices Pharmacies Dentists	Primary health care provides the first point of contact in the health care system. In the NHS, the main source of primary health care is general practice. The aim is to provide an easily accessible route to care, whatever the patient's problem. Primary health care is based on caring for people rather than specific diseases. GP Services are available 24 hours per day, 7 days a week delivered through a combination of Out of Hours and GP Practice provision accessed through both NHS111 and directly.
Urgent Treatment Centres	Open at least 12 hours per day, staffed by doctors and nurses with the ability to give prescriptions, undertake blood tests and access to X-Ray facilities they provide treatment for a range of illnesses and injuries..
NHS 111	NHS 111 is a telephone triage, signposting and assessment service that makes it easier for the public to access local NHS healthcare services for medical help where it is not a 999 emergency. NHS 111 is available 24 hours a day, 365 day a year.
Community Based Services	
Community Care Nursing	A variety of community nursing teams providing nursing care to patients in the community, and support for carers. Community nurses work closely with GPs, social services, hospitals and other healthcare staff to provide a service tailored to meet indicidual needs. The services help patients cope with ill health and disability, allowing patients to have the best possible quality of life while maintaining dignity and respect.
Hospital Based Services	
Emergency Department / Accident & Emergency	Assess and treat people requiring immediate medical attention for serious illness or injury, supported by appropriate diagnostic and therapy services.
Psychiatric Liaison	Provides:

	i) psychiatric assessment within ED to those with an urgent primary or co-morbid mental health need and ii) consultation and treatment support for patients admitted to acute medical/surgical units across the who need treatment for physical health conditions or injuries but who also have a mental health need. Available 24/7 generally but may be subject to local variance.
Assessment Units	The assessment unit is the first point of entry for patients attending hospital as an emergency. In some cases this maybe as a result of a referral by their GP and more consistently those requiring admission from the Emergency Department.
Ambulatory Care Units	Ambulatory emergency care services usually provided conjunction with A&E / ED, allowing rapid assessment treatment and discharge for patients not requiring admission.
Short Stay Paediatric Assessment Units	An SSPAU is a facility within which children with acute illnesses, injuries or other urgent referrals (from GPs, Community Nursing teams, Walk-in Centres (WICs), NHS 111 A&E / EDs) can be assessed, investigated, observed and treated without recourse to inpatient areas.
Mental Health Services	
Street triage	Joint work with local police providing assessment and support for people police have concerns about their mental health, particularly in situations where Section 136 detention might be considered. Street Triage services are locally responsive and so operate at different times and in different ways according to local need.
Crisis resolution and home based treatment	Providing 24/7 urgent triage (telephone and face to face), community assessment and intensive home treatment as an alternative to acute mental health admission.
Inpatient facilities	Providing treatment and support in situations where this cannot be safely or viably in a community setting. Patients may be admitted voluntarily or under the provisions of the Mental Health Act.
Community teams	Support patients typically experiencing significant and enduring mental health problems over a medium to longer term. They provide biopsychosocial treatment and support, develop relapse prevention plans and wider recovery focussed work in collaboration with patients and families/carers.

The volume and variety of services above, validates the following challenges as identified through the Urgent and Emergency Care Review:

- Multiple and often confusing access points in an urgent or emergency situation
- Potential for multiple transfers and ineffective use of some key community facilities
- Poor integration in some areas across, primary, community and acute services, particularly during times of care transition
- Little focus on prevention and self-care alternatives
- Lack of consistent clinical accountability for care on transfer between organisations
- The need for improved pathways of care, not more services

Delivering our Vision

The Urgent and Emergency Care Review proposes that five key changes need to take place to deliver an improved system of urgent and emergency services. These are:

- Providing better support for people and their families to self-care or care for their dependants.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

These suggested changes form the foundations of our strategy, which we have aligned to the Urgent and Emergency Care Route Map, detailed within Appendix 5.

Our priorities

Due to the size and complexity of our ambition, we recognise that we will not succeed in delivering all of our goals in one year; as such we will undertake an annual review of priorities to ensure our continued focus on emerging areas of good practice and evaluation of impact on each initiative as we progress.

The Network has already made a great deal of progress in relation to our work plan and vision through the successful Vanguard programme in 2016/17. Particular areas of good practice from which we are already implementing learning and wider spread of good practice include, although not limited to:

- Behavioural analysis, understanding our population behaviour and the development of mosaic segmentation in relation to health service usage.
- Development of an innovative full system public campaign informed by behavioural analysis.
- RESPOND – mental health crisis care training.
- Clinical Hub Pilot – utilising multi-disciplinary team to support 111 in appropriate referral.
- GP Direct Booking – delivering direct booking from 111 into our GP Practice services.
- MIG – the region wide sharing of patient information to support clinical decision making.
- DOS – the profiling of our services ensuring maximised usage of alternative to A&E.
- Child Health App – designed for the parents of children under 5 to support improved decision making in relation to services used, shortlisted for a national award.

As a Network, we will continue to improve on the successes above. The combination of national policy, local context and service utilisation and our desire to improve services for patients provide evidence and opportunities to drive forward the delivery of our strategy.

We will also further maximise the successes of our other North East Vanguard partners through regional sharing and rapid implementation of their successful transformation programmes.

Our Vanguard partners are:

- Gateshead Care Home Vanguard
- Sunderland Multispecialty community provider vanguard
- Northumberland Integrated primary and acute care systems vanguard; and
- Northumbria Acute Care Collaboration vanguard

System Leadership

The system is undergoing a period of major transformation with the emergence of Accountable Care Organisations. This will bring huge opportunities as well as significant challenge. **The Network will support system leaders to deliver transformational change at pace** building upon existing foundations for region and sub-regional working.

- Through **strong system architecture and clinical leadership we will ensure appropriate clinical standardised evidence based pathways are in place**, thus improving clinical outcomes.
- Through **reforming payment systems** we will ensure the quality and sustainability of urgent care services across our region.
- The **development of a regional workforce plan** will support the sustainability, resilience and flexibility of our services.

Access to the UEC system

We will deliver the eight key elements of Integrated Urgent Care:

- **Multi-disciplinary clinical hub, strengthened support to Care Home, enhanced DOS and integration of 111/OOH** will ensure patients are directed to the right care first time, thereby having a positive impact on clinical outcomes through reduced occurrences of multiple appointments and earlier treatment by the right professional.
- A **single point of access to the Urgent Care System through 111 or appropriate clinical streaming** improves the patient experience through improved access, direct booking and informed decision making resulting in improved patient experience.
- **Improved pathways developed as a result of system wide integration** will enhance safety and quality through reduced risk of error and improved equity in provision for service users.

Out of hospital

Our strategy, aligned to the Out of Hospital programmes within our three STPs footprints, will ensure that we will **deliver services in the community where clinically appropriate**.

- A **standardised offer in each of our regional community based services** reduces patient confusion and reduces pressure on more specialist services.
- **Paramedics empowered and supported to make decisions and onward referrals** reduce demand on our most pressured services.
- Patient experience will be improved through **standardising practice and improving access** resulting in reduced waiting times and fewer appointments.

Hospital services

Whilst our intention is to ensure more care is provided out of hospital, we must ensure that the **right services are there for those who need them most**.

- By implementing **7 Day Services across 10 specialties** and the **standardisation of services regionally** we will ensure positive experiences for all patients.
- **Hospital Transfer Pathway (Red Bag) initiative** will enable reductions in ambulance transfer times, A&E assessment times and reduced avoidable hospital admissions.
- **Reducing Delayed Transfers of Care** improves hospital flow thus reducing pressure on Emergency Departments.
- **Specialist hospital services with consistent care pathways** ensure that patients are treated in the right networked facilities.

Mental Health

Mental Health services will be developed equally with our physical health services.

- **More responsive community services** reduce chances of people requiring assistance from emergency departments, involvement of police, breakdown of care packages and admission to hospital.
- **Improved collaborative working** leads to integrated approaches across providers, reduced repetition and reassessment and increased engagement of family and carers in care.
- Through the implementation of the **new national access and waiting time standards for Urgent and Emergency community and acute care** we aim to deliver more responsive services that increase opportunities for earlier diagnosis and reduce the risk of deterioration and reduce the risk of harm; particularly suicides.
- Implementing the **Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults** will result in swift and compassionate assessment of mental health needs, reduce inappropriate hospital admissions and improved discharge planning resulting in shorter lengths of stay for those requiring admission.

Self-care and self-management

To ensure the long term sustainability of our services, we must **build resilience in our communities and reduce the ever increasing demand on our services**.

- **Develop Self Care resources** to support patients in self-management and leading healthy lifestyles reducing the risk of ill health.
- Whole population primary prevention through **community level campaigns** to improve health behaviours.

- **Person centred care and support plans** for those most at risk of needing emergency care support patient's wishes and clinical decision making.
- Better and easily accessible information about **self-treatment options** through NHS 111 on a digital platform.

Enhanced health in care homes

We will **learn from the national care home vanguards and implement new ways of working** to improve the health of our care home residents.

- **Enhanced Primary Care Support** providing access to consistent, named GP and wider primary care services provides continuity of care for residents and access to expert advice for those with complex needs.
- **Reablement and rehabilitation** to reduce the chance of readmission and promote independence at home.
- **High quality end-of-life care and dementia care** ensures patients die in their place of choosing with dignity and comfort and that those with dementia have equal access to the services and support they require.

Primary care

Primary care services deal with the largest levels of activity in any urgent care system. We must **ensure that services are accessed appropriately and increase access** into alternative services such as Pharmacy and Dental.

- **Increased access to evening and weekend appointments** increases the opportunity for people to be treat in the most appropriate place regardless of their employment situation.
- The implementation of **Think Pharmacy First and NHS Urgent Medicine Supply Advance Service Pilot (NUMSAS**) schemes, **development of self-care applications** and the **direct booking of 111 calls into GP Practices and other urgent care services** will improve clinical outcomes by providing the right care at the right time by the right practitioner within a fully integrated out of hospital care model.
- Patient safety and quality will be improved through **standardised approach**, reducing the incidents of late or mis-diagnosis. It will reduce patient queues and provide one-stop services. It will prevent unnecessary attendance at GP practices, urgent care centres and acute services.

Digital / Technology

Working in partnership regionally to support the **delivery of the 'Great North Care Record'** and with our STP Partners in relation to Digital Road Maps, deliver our urgent and emergency care priorities through:

- Introducing **robust information governance processes, enhanced connectivity and information sharing** allowing increased **clinician access to end of life plans, medication, allergies and Long Term Condition information** will result in improved clinical decision making.
- Ensuring care planning and access to patient information at point of delivery will improve patient experience by ensuring care is delivered in accordance with patients wishes in the most appropriate place and will facilitate personalised care.

- Expanding the use and functionality of our available tools such as the **Flightdeck** (real time capacity and performance information) and ensuring **key patient information is available at the point of care** will result in collaborative system wide capacity management, reduced admissions and duplication and help identify vulnerable patients.

Financial Sustainability

The Network must implement changes that have a **positive financial impact on our whole health system**. The current activity projections and associated spend are not sustainable and we must think differently in our approach.

We will **explore alternative contracting methods** that encourage the system to work collectively with a focus on incentivise that demonstrate improvements in patient outcomes.

Our focus on these priorities will benefit all of our Network members, but we also recognise that there is more that we need to achieve within specific areas and to ensure sustainability.

Ambulance Service Commissioning and Transformation

Whilst we have included specific activities within our work plan and vision that encompass our ambulance services, we believe that as a regional service, the development of our commissioning and transformation of such services is fundamental to our success.

Our ambition is to commission highly effective, patient focused transformation of the ambulance service including NHS 111 through flexible and collaborative commissioning models.

Ambulance commissioning is acknowledged to be complex and mirrors many of the key tasks and roles associated with Specialist Commissioning, including complex relationship management and the use of expert knowledge to support the transformation of services. The delivery of our strategy relies on our ability to manage such relationships through our collaborative approach and expert knowledge, transforming the system through:

- A refocus on commissioning and provider systems that support non-conveyance and provision of the right care closer to home as its principal aim for most patients, while continuing to provide immediate transport and treatment solutions for those emergency patients who need a fast response.
- Supporting a shift away from time-based targets for the majority of responses, to ones focused around patient and clinician experience and patient outcomes and support the ambulance service to develop into a mobile health provider working in multidisciplinary teams.
- Linked with our Integrated Urgent Care priority we will focus on an improved triage that will be consistent, systematic and focused on the right response for the patient (based on patient outcomes and appropriate speed of response).
- Implement a workforce and training plan developed with commissioners that supports the shift to new models of care which are realistic in terms of timescales for implementation and address geographical differences.

- Increase communication and engagement with the public to provide more clarity around expectations, and how we can shift to providing the 'right' response for them as a mobile treatment service and not simply a speed of response service.

The vision for the future is of a system that is safe, sustainable and capable of delivering care closer to home, helping to avoid journeys to hospital unless clinically appropriate. The impact on the ambulance provider in the development of new models of care is paramount and must be considered at the earliest opportunity. As detailed throughout our strategy this cannot be delivered by a single organisation alone. Our priorities set out how as a system, our urgent care strategy will address our ambulance services objectives:

  - Ambulance staff competent and with the range of skills, tools and empowered to support decision-making to enable patients to be treated appropriately out of hospital or to make referrals in a flexible way.
  - Services available to support ambulance staff to step down patients to community based services and responsive access to GPs.
  - Ambulance providers and local commissioners working together to ensure there is access to up-to-date information regarding how to access alternative services and that those alternative services are commissioned to respond within an appropriate timescale.
  - A system built around patients and care closer to home, which is a sea change from the systems being based around the 'acute' trust model.

- Unrestricted referral rights to community and primary care services any time of the day, either through urgent care centres, mental health crisis teams, facilities for geriatric assessment, respite care, paediatric assessment, maternity and end-of-life care.
- Implementing enhanced GP Triage pathways applicable to all ambulance clinicians regardless of title, enabling contact directly with the patient's GP in hours for consultation and joint clinical decision making on the most suitable pathway of care for their patient. This could include the following outcomes:

  - GP call back
  - GP home visit
  - Appointment
  - Convey to general practice

These objectives support delivery of increased levels of Hear and Treat, Hear, Treat and Refer and See and Treat as set out in the national guidance "Clinical Models for Ambulance Services". As a system, these increases to Hear and Treat and See and Treat provide potential opportunities for greater system savings which we will monitor through system-wide clinical indicators that look at re-contact following discharge via telephone and re-contact following discharge at scene.

Such transformation will require changes to our approach to commissioning of ambulance services, acknowledging that there is a need to support ambulance services and workforce to diversify into providing multidisciplinary responses in situ as well as mobile units. The Network will therefore:

- Strengthen commissioning of our ambulance service provision via collaborative lead commissioner arrangements.

- Shift our focus to the commissioning of outcomes rather than the requirements of current contract for services.
- Explore opportunities for National specialised commissioning of specialist ambulance services such as HART and MERIT to ensure expertise in commissioning is not diluted and capability is assured.

In summary, the Network will seek to ensure:

- Enhanced skills within our paramedic workforce and improved access and links to out of hospital services which reduce the need to convey patients to hospital, providing care closer or at home, resulting in reduced unnecessary hospital visits and maintained independence for patients.
- Patient experience improved through higher levels of clinician intervention at the initial point of contact ensuring patients are assessed and treated in the most appropriate place first time.
- Reduced demand as a result of higher levels of clinician input ensuring our ambulance services are able to reach our most vulnerable or urgent cases more quickly.

Workforce

We know that the numbers of people living to older age, and with multiple and complex needs are increasing and will continue to do so. Future generations will be increasingly more actively engaged with their own healthcare, with treatment and care delivered through integrated models, and more provided outside hospitals. The role and participation of carers and the voluntary sector, both formal and informal will be an increasing feature of the future workforce and service delivery models.

As a result, the need to have a workforce that can work responsively, in a range of settings, and across organisational and professional boundaries, supporting people and carers to manage their own care more effectively is a cornerstone to achieving this change. We aim to build on our success of being leading providers of medical and non-medical education, attracting and retaining the right people, with the right knowledge and skills, underpinned with values and behaviours that reflect the NHS Constitution. We want to drive forward on-going workforce development and transformation in order that we meet our local populations' health needs.

We will help to deliver and develop a workforce which will be able to work across boundaries and different settings, supporting the delivery of care closer to home, seven day working, self-managed care and integrated working across health and social care. We will support this goal through commissioning development activity which will assist staff to work in different settings. Underpinning our workforce skills strategy is the patient experience in terms of supporting staff to deliver safe, high quality compassionate patient care in changing settings and with an ageing population with more complex and long term conditions.

We aim to support our workforce to be passionate about prevention, promoting parity of esteem and health and well-being through ensuring that they have the skills, knowledge and confidence to support individuals and families in addressing health needs, and those which are most prevalent in the North East. We will do this through embedding health promotion within our education and developing staff so that they

are enabled to support the whole person needs, (physical and mental health). This will include development of specialist knowledge and skills.

Our strategy for developing the urgent and emergency care workforce will be multi-functional in design encompassing staff working in emergency departments, but also those working in other settings (primary and community) where patient activity could \ should be seen. This will include providing appropriate development of the workforce which impacts on the whole urgent and emergency care journey. We will do this in a number of ways, including skills developments for staff at all levels and points of service delivery. We will develop the workforce to ensure that we not only deliver an appropriate service within urgent and emergency departments, but also that where patients access treatment out with these services then staff will be sufficiently skilled to deliver an appropriate intervention. This will be funded by a variety of routes including HEE NE and employer funding (including that accessed via the apprenticeship levy).

Our particular actions will include the following, although this is by no means and exhaustive list, and will develop as we further refine out training and development plan for the urgent and emergency care workforce:

- Train sufficient medical trainees to reflect the future consultant workforce demand levels. In addition we will seek to maximise the retention of trainees by identifying suitable employment opportunities, post CCT.
- Ensure appropriate development for consultants and non-consultant career grade doctors. This will include local developments by the appropriate employers, but also in partnership with and led by (where appropriate) HEE (North East).
- Provide appropriate education for the nursing, allied health professional workforce working in urgent and emergency care. This will include ensuring that suitable modules of education are key elements of the provision of high quality healthcare thus ensuring staff keep their skill set and education relevant and as up to date as possible. As such we will ensure that our continuing workforce development (CWD) programmes and portfolios are relevant to service needs, now and in the future. This will ensure that the University post registration portfolio reflect the needs of staff working in acute, MH, community and primary care services.
- Development of pharmacists with additional and enhanced skills, including Independent prescribing, working in both primary and secondary care thus enabling pharmacists to provide an enhanced service both in an acute and primary care setting.
- Working with CCGs, GP Federations and Community Education Provider Networks to ensure we develop the whole primary care workforce (GPs, practice nurses, AHPs, support staff) to identify and develop the skills needed to support the care of patients in the primary care setting and in the place of residence.
- Work with care homes, care alliances and carer representatives \ organisations to ensure we support staff working in the care sector to be able to identify and develop the skills needed to support care of the patients.
- Work with ambulance paramedics, and all ambulance service staff, to identify and develop the skills needed to support the care of patients, including increasing the number of cases in respect of ‘see and treat’.

Patients and Public Engagement

A key element of our Network programme is the recognition of the importance of using robust market research techniques and the incorporation of behavioural analysis.

We know that the choices we all make as patients have a major impact on NHS services. The behavioural analysis study has given us a clearer insight into what drives these decisions and provided a strong evidence base to design service improvements, social marketing campaigns and influence patient behaviour - and help to reduce the pressure on services in the future.

Using innovative research methods with both patients and clinical groups, we have created key mosaic segmentation groups which aid our understanding to support channel shift. We have also distilled eight key themes from the behavioural analysis which are helping to inform further practical actions to drive forward our ambitions for urgent and emergency care services in the North East.

These are (full report available):

- Data sharing and tracking
- Fairness and justice
- Too much choice, too many names
- Education through communication
- Quick advice
- Missing specialist skills
- More community focus
- Acceptance of risk

The behavioural analysis informed the development of a major new regional campaign using a family of 'plasticine people' who help to share hard-hitting messages in an engaging and friendly way. The campaign was based on the behavioural analysis findings, and so far has supported surge management, antibiotics messages and primary care services over Christmas. It was also had an important role in the NHS cyber attack communications response.

The campaign is designed to be flexible and responsive, so that the plasticine people become mouthpieces for factual, topical and timely information that influences public choice about use of care services, in line with local peaks and dips of A&E use and using a surge modelling algorithm to influence some of the key messages that are being used. The campaign creative of a family of character gives future flexibility around different set of key messages.

The North East and North Cumbria NHS Communications and Engagement Network has formed a sub group to support the on-going development of the campaign and co-ordination of activity. This group of professionals also link to each local A&E delivery board, to ensure consistent advice is provided based on evidence and insight.
Key members are also STP communications and engagement leads, and also provide system oversight communications for transformational change.

This supports our on-going engagement with patients and the public, and will ensure that there is continued input from patients in the on-going development of urgent and emergency care services through the successful communication and engagement methods which are already in place to support existing transformation plans in each of our local health economy areas. We will seek to maximise these existing mechanisms, but recognise that urgent and emergency care as a specialised area of service provision will also benefit from:

- Ensuring that our successful behavioural insights research and the learning that we have gained is fundamental in the on-going development and transformation of all our services.
- Where necessary we will develop specific urgent and emergency care engagement approaches to support our projects.

Resources

We recognise that in order to deliver the challenging agenda we face we will need to make the most effective use of our resources. We will adopt a 'do once and spread approach' ensuring we implement solutions that are standardised where appropriate but tailored to meet the needs of the local population.
Organisations across the health economy will be asked to support delivery by providing people or funding.

External Evaluation

In 2017 an external evaluation of the UEC was carried out by a unique collaboration between Cordis Bright, Cobic and PPL. This evaluation found that:

1. *Stakeholders identified the following as positive elements of the programme's governance, management and procurement processes:*
    - *facilitating networking and sharing of good practice;*
    - *project management support; and,*
    - *clinical input.*

2. *Stakeholders reported positive evidence regarding the impact of the Vanguard programme and the Clinical Hub, in particular, on patients' ability to access services. The Clinical Hub, the Enhanced Directory of Services (DoS) and the GP Direct Booking project were highlighted as having a particularly positive impact in this area.*

3. *Secondary Uses Service (SUS) data analysed showed that fewer patients with less severe conditions attended emergency departments in the region in January 2017, when the Hub was operational, than in January 2016, prior to the*

implementation of the Hub. This data may suggest that the Clinical Hub was effectively re-routing these patients to alternative services.

4. *Stakeholders interviewed did report that in the initial stages of the Vanguard programme's implementation, there were difficulties in engaging with Foundation Trusts. However, it was suggested that due to the effectiveness of the PMO, these partners were engaged with the Network and it has since had a strong and clear membership.*

5. *The fact that the number of A&E attendances for major ailments has continued to grow in line with the national trend is telling. Unless, for reasons unknown, the overall ratio of major to minor incidents in the North East has changed over the past year, it is reasonable to assume that, under a 'do nothing' scenario, the number of A&E attendances for minor ailments would have increased in line with the number of A&E attendances for major ailments. The drop in frequency of A&E attendances for minor ailments therefore strongly implies that the approaches to A&E demand management implemented in the North East are proving to be effective. Not only has a 5% real terms reduction in minor A&E attendances been observed, the reduction against the projected baseline (5% year-on-year growth) appears to be closer to 10%.*

Appendix 1 appended
Network governance arrangements

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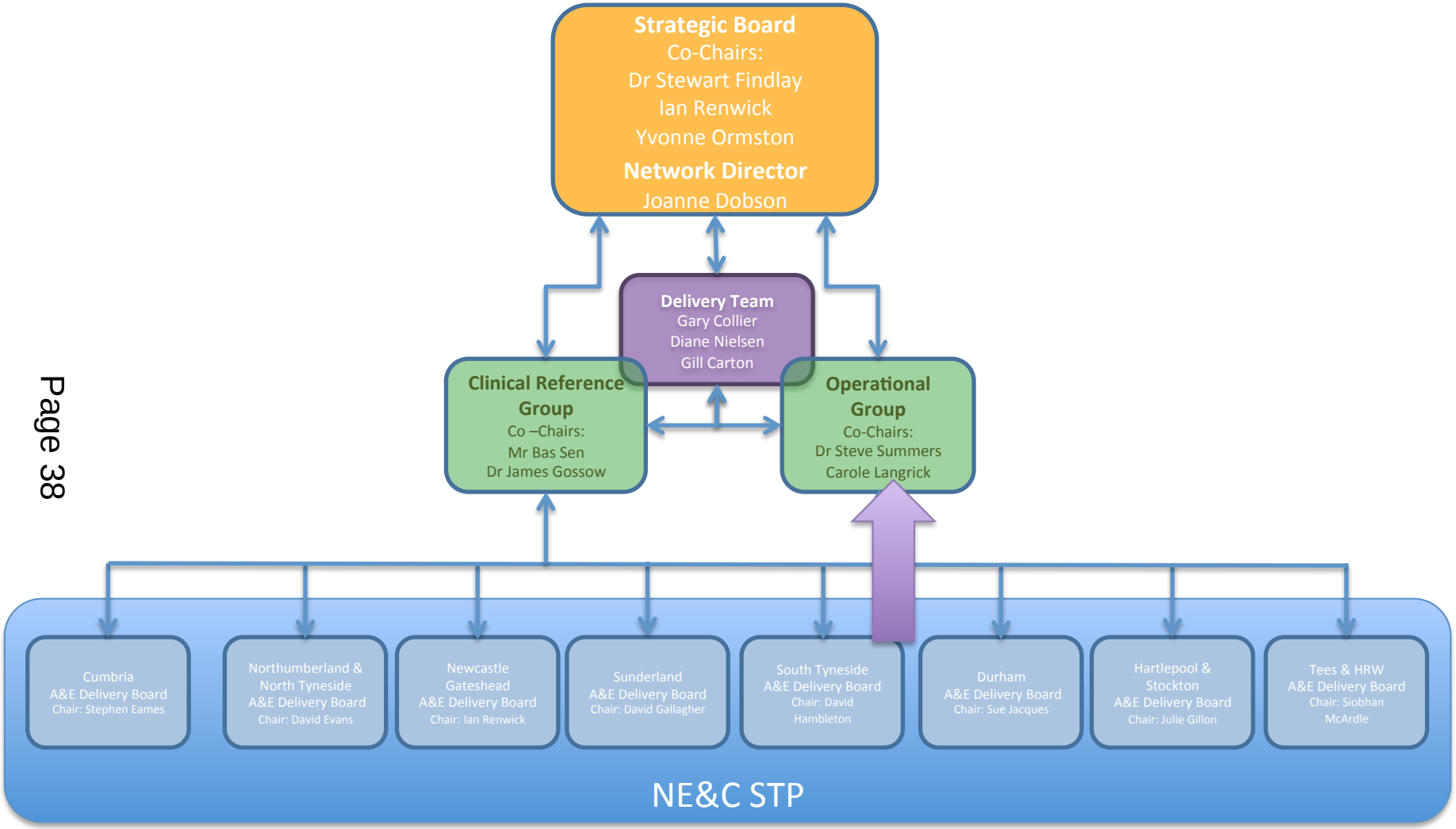
Leadership and governance


Strategic Board
Co-Chairs:
Dr Stewart Findlay
Ian Renwick
Yvonne Ormston
Network Director
Joanne Dobson
Delivery Team
Gary Collier
Diane Nielsen
Gill Carton
Clinical Reference Group
Co –Chairs:
Mr Bas Sen
Dr James Gossow
Operational Group
Co-Chairs:
Dr Steve Summers
Carole Langrick
Cumbria A&E Delivery Board
Chair: Stephen Eames
Northumberland & North Tyneside A&E Delivery Board
Chair: David Evans
Newcastle Gateshead A&E Delivery Board
Chair: Ian Renwick
Sunderland A&E Delivery Board
Chair: David Gallagher
South Tyneside A&E Delivery Board
Chair: David Hambleton
Durham A&E Delivery Board
Chair: Sue Jacques
Hartlepool & Stockton A&E Delivery Board
Chair: Julie Gillon
Tees & HRW A&E Delivery Board
Chair: Siobhan McArdle
NE&C STP

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NHS Foundation Trust

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FAO of NTWND STP Joint Overview and Scrutiny meeting

Date 02/03/2018

To whom it may concern,

Re: North East Ambulance Service **(**NEAS) engagement in the STP Urgent and Emergency Care Work stream

NEAS is the only regional NHS provider across the whole North East region and is uniquely placed to input to discussions in both STP footprints to the North and South.

With our perspective of the North East, we are actively involved with every NHS trust in the footprint on a regular basis. We are active participants in the regional Urgent and Emergency Care Network with Yvonne Ormston, our CEO, as Co-Chair. We have been involved in strategy and finance discussions, including engagement with North Cumbria on potential collaboration, including close working with North West Ambulance Trust.

Aligned to the STP, we have been involved in the South Tyneside/ Sunderland reconfiguration discussions and in a number of service changes which have been considered across the area.

We have been consulted on the STP plans and subsequently engaged in initial discussions on the formulation of an Integrated Care System, albeit this is at a very early stage. We recognise the challenges of finance and staffing facing NHS trusts and have invested in the development of an in-house modelling tool to identify the impact of changes on NEAS. With this tool, we are then able to identify the mitigation required to support service changes at the consultation stage and then to track these changes through mobilisation and implementation.

Our Medical Director has been a regularly attending the NTWND Clinical group

Members of the JOSC can be assured that our mission of safe, effective and responsive care for all underpins our approach to considering service changes and we have a robust process for discussing these with commissioners and engaging patients in this dialogue.

Yours faithfully,

Mark Cotton
Assistant Director of Communications & Engagement
North East Ambulance Service NHS Foundation Trust

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