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NORTHUMBERLAND TYNE & WEAR & NORTH DURHAM STP HEALTH SCRUTINY COMMITTEE

Meeting on Monday, 25 June 2018 at 2.00 pm in the Civic Centre Gateshead

Agenda

1 Appointment of Chair
In line with the terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Chair for the 2018-19 municipal year.

2 Appointment of Vice Chair
In line with the terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Vice Chair for the 2018-19 municipal year.

3 Apologies

4 Declarations of Interest

5 Minutes (Pages 5 - 18)
The minutes of the last meeting of the Joint Committee held on 19 March 2018 are attached for approval.

6 Responses to Issues Arising from the last meeting (Pages 19 - 34)
Item attached.

7 Workforce Workstream Progress Update (Pages 35 - 42)
Report attached. Lisa Crichton Jones, Director of Workforce Transformation for NE and Cumbria and Ian Renwick, SRO for Workforce Workstream will also provide the Joint Committee with a presentation on the above.

8 Integrated Care System Update
Alan Foster / Mark Adams, Leads for NE & Cumbria STP will provide the Joint Committee with a verbal update.

9 Work Programme

Meeting Date	Issue
16 July 2018 – 1.30pm (Additional Meeting)	• Progress Update Report and Presentation – Empowering Communities • Work Programme for Future Meetings

The proposed provisional work programme for the Joint Committee is set out above.

It is also proposed that representatives from Healthwatch across the patch are invited to attend the July meeting and asked to comment on the update and presentation provided.

The views of the Joint Committee are sought.

10 Dates and Times of Future Meetings

It is proposed that future meetings of the Northumberland Tyne and Wear and North Durham STP OSC are held at Gateshead Civic Centre on the following dates and times:-

- Monday 24 September 2018 at 2pm
- Monday 26 November 2018 at 2pm
- Monday 21 January 2019 at 2pm
- Monday 25 March 2019 at 2pm

Membership

Gateshead Council
Councillor L Caffrey
Councillor M Hall
Councillor P Maughan
Substitutes
Councillor M Charlton
Councillor J Wallace

Newcastle City Council
Councillor W Taylor
Councillor F Mendelson
Councillor A Schofield

North Tyneside Council
Councillor M Thirlaway
Councillor K Clark
Councillor N Craven
Substitutes
Councillor M Green
Councillor T Mulvenna
Councillor L Spillard

Northumberland County Council
Councillor E Simpson
Councillor E Armstrong
Councillor J Watson
Substitute
Councillor R Dodd

South Tyneside Council
Councillor W Flynn
Councillor A Hetherington
Councillor A Huntley

Durham
Councillor J Robinson
Councillor O Temple
Councillor J Stephenson

Sunderland CC
Councillor J Heron
Councillor D Snowdon
Councillor S Leadbitter

Contact: Angela Frisby Tel 0191 4332138 Date: 13 June 2018

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GATESHEAD METROPOLITAN BOROUGH COUNCIL

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

Monday, 19 March 2018

PRESENT: Councillor L Caffrey (Gateshead Council) (Chair)

Councillor(s): Watson and Armstrong (Northumberland CC), Charlton and Maughan (Gateshead Council), Clark (substitute – North Tyneside Council), Chequer (Sunderland CC), Flynn, Hetherington and Huntley (South Tyneside Council), Taylor, Mendelson and Schofield (Newcastle CC) and Robinson, Temple and Davinson(Durham CC)

IN ATTENDANCE: Councillor(s): M Hall (Gateshead Council) (observer)

17 APPOINTMENT OF CHAIR

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

In view of the aforementioned the Joint Committee:-

RESOLVED – That Councillor Lynne Caffrey (Gateshead Council) be appointed as Chair of the Joint Committee.

18 APOLOGIES

Councillor (s) Simpson (Northumberland and Dodd (substitute - Northumberland) Bell, Grayson and Hall (North Tyneside Council)

19 DECLARATIONS OF INTEREST

Councillor Taylor (Newcastle CC) declared an interest as a member of Newcastle Hospitals NHS FT.

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

20 MINUTES

The minutes of the last meeting held on 15 January 2018 were approved as a correct record.

Matters Arising

Prevention Workstream

The Chair advised that there had been a launch event in Gateshead relating to the all-party parliamentary report on Creative Health which highlights the use of arts in improving health and wellbeing. The Chair of the Group had attended the launch and Dr Pilkington had provided a presentation on the role of arts in promoting health and wellbeing.

The Chair advised that there was a summary version of the report and a full version which contains a number of case studies which might prove useful for colleagues. A link to the report would be circulated to the Joint Committee following the meeting.

Community Asset Based Approach Event – Durham

Councillor Schofield advised that she had attended the above event which had been held in Durham. Dr Pilkington had also provided a presentation for this event and one of the key issues which had come out was about how it was important to get the voluntary sector much more involved.

Joint STP OSC Work Programme

Councillor Mendelson noted that it was proposed that the Joint Committee received a progress update on the development of integrated care systems at its June meeting and asked that as part of this update the links to Health and Wellbeing Boards are explained.

It was agreed that Workstream leads be asked to address this issue as part of the proposed update.

The Chair also noted that an NHS consultation had been launched recently in relation to contracting arrangements and she queried whether this would have an impact on the development of integrated care systems.

The Joint Committee was advised that greater clarity was being sought from NHS England on this issue.

The Chair noted that as the Joint Committee would be receiving an update on integrated care systems at its June meeting it would be helpful to have clarification on this matter for that meeting.

21 UPDATE ON URGENT AND EMERGENCY CARE WORKSTREAM

Gary Collier outlined the structure of the Urgent and Emergency Care Network. Gary advised that the Board has complete oversight of the work undertaken and links with all A& E Delivery Boards to make sure that the strategic direction of the Board can be delivered.

Gary also highlighted the role of the Clinical Reference Group which was made up of multiple clinicians who provide advice to make sure that the work carried out is focusing on the right pathways.

The Network also incorporates two other regional groups, the delivery team and operational groups which focus on identifying challenges which will be progressed via task and finish groups such as the ambulance turn around group which is currently looking at trying to improve arrivals and discharges.

A three - year strategy had been signed off at the beginning of 2017 which had subsequently focused on the vanguard programme. However, a longer-term programme was now needed focusing on a range of areas.

Gary highlighted a range of outcomes achieved as a result of the strategy so far. These included the development of the flight deck which provides an understanding of activity in A & E and ambulance service pressures; the development of mental health training; behavioural analysis as to why patients move around the system the way that they do as part of the Great North Care Record System; the development of the NHS Health Child App which sets out the types of care children might need and provides information on where services are located and which recently won an award; the development of an emergency care programme which looks at patient flows and training for care home staff on when patients need to move into hospital settings.

Gary stated that one of the key advantages of this Network is that it has an understanding of what is happening in primary care and the demands on the system. This has meant that in Newcastle and South Tees they have been able to implement a cardiology and transport service where there is a dedicated transport service.

Gary also highlighted the work to develop a Directory of Services and stated that as part of this work they were looking to see how they could get more voluntary services included in the Directory.

The Joint Committee was also provided with a high-level overview of the income and cashable and non- cashable savings achieved by the Network so far. It was noted that not all of the work of the Network was quantifiable, for example, work around clinical assessment services, which created benefits in ensuring that patients were in the right place.

Gary stated that it was considered that the Network had made some really good progress so far and he introduced Bas Sen, Chair of the Clinical Reference Group, who would highlight some of the performance metrics.

Bas stated that he would provide the Joint Committee with information on the work of the Network and how it dovetails with the STP and would also provide an update on performance in relation to this winter.

Bas stated that the Urgent and Emergency Care Network was unique in that it spans the whole region whereas others don’t. In terms of performance this year Bas noted

that the Joint Committee would be familiar with the A & E standards and that patients should be seen and treated within four hours of arrival. Bas noted that these standards had not taken into account the increasing volume of attendances year on year. Bas stated that never-the-less Cumbria and the North East was leading the country in terms of performance. Bas referred the Joint Committee to slides setting out attendances and admissions which highlighted that these had flattened and decreased which might raise the question as to why performance had not improved. Bas stated that the key reason for this was that emergency admissions had gone up by 25 %. Bas indicated that reducing emergency admissions was the key to improved performance.

Bas noted that the Joint Committee would also be familiar with delayed transfers of care which refers to patients who remain in hospital for a variety of reasons although they are medically fit to be discharged. Bas indicated that this winter delayed discharges as a result of issues relating to home care were more of a problem than last year.

Bas also highlighted performance in relation to ambulance handovers and noted that there were a number of delays and work had been ongoing to address these.

Bas also highlighted the NHS 111 system which he considered was a huge success as the number of calls had increased year on year and had gone up by 23 %. However, Bas noted that an issue with the system was that as call handlers were not medically trained they are guided by a medically driven protocol which errs on the side of caution and so they send more people to hospital and send more ambulances.

As a result, a second step had been added in to the 111 system, which is clinician involvement and this created a shift in performance of approximately 80% which has since continued.

Bas stated that in terms of how the work of the Network dovetails with the STP it is acknowledged that going into the future a radical change in the health system is necessary which may involve many steps.

Bas noted that the Joint Committee might be familiar with the system in the US and United Health and Kaiser Perminente and the way that organisations such as this look at value added steps. This involves analysing patient centred work flows and looking at value added steps and non-value added and taking out the non-value added steps eg the amount of time a patient spends in a waiting room. Bas stated that the aim of the STP was to take out the non-value added. The Network has also carried out this type of work in relation to heart attacks, paediatrics and major trauma. Bas advised that he was involved in developing the major trauma system in this region and the work undertaken had led to a decrease in mortality of between 30% to 50% since 2012. This had been achieved by taking patients to a designated centre so that whilst an accident might occur in Durham the patient would be taken to Newcastle or South Tees where the two hospitals in question were manned 24/7 by highly skilled staff and with high levels of technical equipment in areas such as radiology facilitating the scanning of patients in 3 minutes thereby cutting down on diagnostics in major trauma. Bas stated that this means that patients can be in

theatre within 30 minutes which was impossible under the old system. Bas stated that he felt that this approach was the way forward.

The Chair thanked Bas for the information provided and noted that some of the Committee could remember when Kaiser Perminente was considering coming to the UK.

The Chair asked if Ian could also highlight the triage work that the Queen Elizabeth Hospital had been taking forward in relation to emergency care.

Ian advised that he is one of the Co - Chairs of the Urgent and Emergency Care Network and the Halo system which the Chair was referring to had been adopted by most hospitals now. It involved a Hospital Ambulance Liaison Officer who was a member of NEAS becoming part of the team. It had been trialled in hospitals suffering the most challenges and it had subsequently become a vital part of the system and had made a definite difference. Ian advised that the Queen Elizabeth Hospital had been lucky in that this approach had been introduced at the time the hospital had opened its emergency care centre. The work on HALO had emerged as a result of the work of the Urgent and Emergency Care Network.

It was however noted that Newcastle did not have the HALO system and its handover times were the best in the region.

The Chair noted that they had received information that admissions had increased and she queried why this was the case.

Bas explained that this is because the system is not integrated so when a call is made to NHS 111 and a patient advises they have chest pains, even if they are young and have been relatively fit and well up to that point, they had to be taken to the emergency department in a hospital via an ambulance. Bas stated that there is a need for a virtual ward which could give care to a patient at home. However, for such a model to be in place there would need to be an integrated service where the first point of contact could be someone's carer who could then have access to a district nurse/OT/social worker / GP or other relevant specialist where needed. Bas stated that if such a system was to be in operation then he believed that this would mean that 50% of patients could stay at home and would not need to be admitted to hospital.

The Chair also noted that information had been provided on the NHS 111 pilot of making referrals direct to local pharmacies and she queried whether this was likely to be rolled out across the region.

Andre advised that he would provide the Joint Committee with information on this project later on in the meeting.

Councillor Robinson noted that the £682,000 funding for winter pressures worked out at 40 pence per head of population and he queried how the NHS had worked out that the population in that area was only worth a spend of 40 pence. Councillor Robinson also advised that he had a stroke approximately six weeks ago and if he had to go to James Cook Hospital rather than the local hospital, where he received

excellent care from the staff, he would likely not have survived.

Bas advised that he was not saying that all stroke cases should go to major centres, only complex highly specialised cases need to go to major trauma centres. Bas stated that most hospitals can deal with acute strokes and the work they are doing is not about taking good care away.

Bas advised that the £682,000 was the amount of funding allocated to the Urgent and Emergency Care Network for collective schemes. Alongside this there was also significant funding allocated to NHS providers in the region amounting to millions of pounds.

The Chair asked if the £682,000 funding allocation to the Network had been ringfenced.

Bas explained that the funding had been allocated to the Network and the Network had collectively prioritised what the funding should allocated for and it had been used in a number of ways eg to have NEAS staff in A & E Departments, provide additional IT and storage equipment for paramedics etc.

The Chair asked whether the monies allocated to providers had been allocated on a needs basis and whether this had been ringfenced.

Bas stated that the process for allocating the monies effectively meant that the monies were ring fenced. NHS England had advised that if providers could not provide adequate explanations as to how the monies were to be spent then these monies would be clawed back.

Councillor Schofield noted that many members on the Joint Committee were aware of the health care system adopted in the US and were concerned about going down that path. Councillor Schofield stated that there were millions of people in the US who were disenfranchised from the health care system because they could not afford to be part of it. Councillor Schofield stated that any valued added system developed in the patch must ensure that people are not disenfranchised.

Bas stated that there was no intention of blindly adopting the US system.

Councillor Schofield stated that it was pleasing to hear that the work of the Network would dovetail with the STP and she queried how this would work, would it have to be specifically incorporated or was it something that was built in to the STP.

Bas explained that the Network has some independence as they scrutinise clinical models and the Network would not endorse a model which was not appropriate.

Councillor Schofield queried what would happen if there were ever problems with the NHS 111 system given the high level of calls.

Gary advised that no provider operates in isolation so if there was a significant incident which affected the North East and NHS 111 provision the work would be shared with another NHS 111 provider.

It was queried how the work being progressed would affect payments to different parts of the system. Gary noted that work was often tariff driven which did not always facilitate transformation by the Network. However, work was starting to take place to look more broadly at how they could ensure that finite monies could be shared in different ways amongst providers. Providers are engaged in this work and the NHS is trialling new payment systems in vanguard areas. However, this type of work could not be implemented overnight.

Ian explained that active conversations were taking place with local commissioners who were looking to develop a local payment mechanism.

Ian stated that United Health and Kaiser Perminente had been set up for a very different type of healthcare system and this was why the approach here was different and was being focused on developing an integrated care system. Bas stated that the secret to an integrated care system was that it was not just about services but about integrated finances also.

Councillor Charlton noted that the number of abandoned calls to the NHS 111 system appeared to have increased hugely and she queried the reasons for this.

Gary explained that this was as a result of a significant increase in call volumes which could not have been predicted and which the staffing model had not been geared up for in terms of activity. As a result, changes had been made to the staffing model and performance is back on track.

Councillor Charlton queried whether the increased number of abandoned calls had led to additional admissions. Gary stated that he would argue not as the calls to NHS 111 tend to relate to lower risk health issues unlike 999 which deal with more serious health matters. Gary advised that there was some ongoing analysis taking place to see if there was a link to A & E attendances but at this current point in time it was not believed to have had an impact.

Bas indicated that he was not certain that this was the case as he was concerned that people did not always know which number to call in all circumstances. Bas considered that sometimes people were confused as to which number to call. Bas considered that there was a natural tendency in some people not to call 999 and he considered that if calls were not effectively filtered then this might increase admissions.

Councillor Watson noted that handover delays could definitely fall under the category of non – value added. Councillor Watson also noted that this could apply to circumstances which he was aware of when family members had to wait for seven hours to be admitted to a hospital bed only to be seen and then told to go home and circumstances where people wait for six hours to receive medication from the pharmacy. Councillor Watson queried whether these were common occurances which could be sorted.

Bas indicated that this was a really important point and work was taking place to try and resolve these types of issues but it was important to remember that the Network

only started three years ago.

The Chair indicated that it would be helpful for the Joint Committee to have a further update on the progress being made by the Network at a future meeting.

22 PHARMACY AND STP

Stephen Blackman, Chief Officer, North of Tyne LPC, advised the Joint Committee that he was here to highlight the role of Pharmacy which he considered was not addressed within the STP currently.

Stephen stated that Pharmacy can support both urgent care and primary care and the key message was that Pharmacy wanted to transform and be part of the integration of services at both a national and regional level.

Stephen noted that 88% of the population is within a twenty minute walk of a local pharmacy and that there are 390 pharmacies in our area which deliver important services such as Stop Smoking. Stephen stated that the area has a long history of pharmacies delivering a range of services and in some areas pharmacies help with hospital discharges.

Stephen noted that the NHS 111 Community Referral Scheme was a great success.

Stephen stated that currently there is not a national contract for pharmacy but this is the direction that pharmacy wants to move towards.

In terms of the direction of pharmacy, as set out in the Five Year Forward View, there were three areas of focus; supporting long term conditions; acting as the first port of call for health advice and treatment and acting as a health and wellbeing hub.

Stephen stated that they had looked at the STP priorities and how it is aligned to the vision of the Forward View and it matches. They had also looked in detail at the services already being delivered and where Pharmacy can evolve and extend.

Stephen stated that currently they have a patchwork of services across the region and nationally and they would like to look strategically at a framework of services. Stephen stated that he considered that there was great potential for Pharmacy to be integrated.

In the area of long term care there are great opportunities as there is much more that can be done to support patients to manage their medicines and conditions eg asthma care. The Community Pharmacy Referral Scheme is already providing some support in this area.

In terms of transfers of care, pharmacy is also providing some help so that discharges can take place more quickly. Stephen stated that moving forwards there were opportunities to build on the foundations of the work already taking place and relieve pressure on other areas and be more integrated with primary and urgent care.

Andre Yeung, Chair of Northumberland Tyne and Wear LPN outlined further details regarding the Community Pharmacy Referral scheme and its achievements to date and opportunities for working better together.

Andre stated that he works closely with colleagues in the Durham, Darlington and Tees Valley area so that there is coverage across the whole region.

Andre explained that in August 2014 Durham University had carried out some research which suggested that community pharmacy bucked the inverse care law and deprived communities were best served by the services it provided.

At that time, less than 1% of referrals from NHS 111 were going to community pharmacy and it was considered that there was scope for integration between the two. As a result, a proposal was developed for the Community Pharmacy Referral Scheme which is regional and covers all ten CCGs across the North East and a population of 2.8 million with 618 pharmacies in that area. In order to tie in to urgent and emergency care systems the algorithms to NHS 111 were changed and it was identified that there were a potential 35,000 patients who could be referred to community pharmacy. The aim is to help increase resilience in urgent care by helping patients to self - care and by helping to deliver care closer to home. The project went live on 4 December 2017 and has been up and running for three months now. During this period Pharmacy had been seeing high levels of patients with 62.5% attending consultations with pharmacists and 30% receiving telephone consultations and 100% of patients are being supported with self -care. In terms of advice provided to patients 60% had been happy with the advice provided and this had included the sale of over the counter medicines in some circumstances. Some cases are escalated to NHS 111 for other support or to GPs. There has been 85% patient satisfaction with the service overall. The service is providing real benefits as most of the patients supported would have gone to out of hours services of their GP if they had not been able to access this support.

Andre advised that the project was committed to run until September this year when there was to be a full evalutation of the project.

Andre echoed Stephen's view that there were also other ways that Pharmacy could support the work being carried out in the STP around prevention which would save time in general practice for example in dealing with blood pressure.

Councillor Mendelson queried the position around funding and whether there might also be capacity issues if Pharmacy was to take on other areas of work.

Andre noted that time is precious for Pharmacy as with many other providers and if Pharmacy is taking significant numbers of patients out of the system and supporting them then they would require funding for this. Andre stated that the Local Pharmacy Network made a business case for this project to national colleagues and secured funding and it was hoped that if the project proves successful that this will then be rolled out to other areas.

Stephen noted that Community Pharmacy has had its budgets cut. Most regions have had 20% to 30% reductions in community pharmacy funding which has led to

some redundancies although not to closures. Funding is difficult but there is capacity amongst Pharmacy teams as there was a shift in the service model and this would make Pharmacy more sustainable.

Councillor Taylor queried whether all pharmacies were willing and able to take on additional work and whether there was anything else which could be done to support pharmacies take on the types of work outlined.

Stephen stated that what was needed was to make the services outlined part of Pharmacy's every day work when the new contract was put in place. Under the current framework pharmacies receive more money by dispensing more medicines. Stephen stated that they are suggesting that if there was a regional framework which included a number of services as part of pharmacy's daily business this would ensure that Pharmacy was involved in the integration agenda.

Stephen stated that Pharmacists are keen to become independent prescribers but can't issue medications and so they would like services to become a larger part of what Pharmacy does.

Stephen stated that Community Pharmacy is not the same as general practice. Much of the service provision is opportunistic as it relies on people coming through the door. This means that when they are designing services there is a need to understand what is to be achieved to ensure the right structures are in place and patients are targeted appropriately eg blood pressure.

Councillor Charlton noted that some of the facilities at Pharmacies did not provide much privacy for consultations and queried whether this was likely to prove off putting for patients.

Stephen acknowledged that there is some variability in facilities although some now have three consulting rooms and a second Pharmacist. Stephen considered that facilities would develop.

The Chair asked Mark whether he had any comments on the issues highlighted in relation to future contracts and commissioning arrangements.

Mark stated that the points in the presentation had been well made and the pilots referenced and Andre's role as part of NHS England were pivotal in taking matters forward via various processes. One of the starting points for this work was through the Urgent and Emergency Care Network where they are working to bring Pharmacy in.

Caroline stated that, within the Urgent and Emergency Care Network, Pharmacy is a cornerstone in the Behaviour and Child Illness App which identifies local pharmacies as a route for support services. Caroline acknowledged that there was a need to raise public awareness further that Pharmacy is the place to go in a range of circumstances.

Councillor Robinson highlighted the position of rural communities and noted that the Durham dales had lost a number of rural pharmacies due to the GP contract.

The Chair considered that it was surprising that Pharmacy was not yet integrated into the STP. The Chair hoped that consideration was being given as to how to change that position with a view to further progress being provided to the Joint Committee going forwards.

23 INTERIM UPDATE - WORKFORCE WORKSTREAM

Ian Renwick advised that he was Co-Chair of the Workforce Workstream, alongside Amanda Hulme.

Ian advised that he would be attending the Joint Committee meeting in June to provide a full update in relation to the workstream. However, at this stage Ian was able to advise that the workstream was one of three key planks in the STP. This is due to recognition that there are a number of challenges in areas such as recruitment where there are difficulties in relation to recruitment and retention of GP's and in areas of hospital based care.

Ian stated that these challenges are borne out by recent statistics which highlighted that nationally and locally this is the first year where many more nurses have left the NHS than joined. Within the NHS there are also issues in relation to the employment of locums and agency staff. There are also huge pressures on adult social care as a result of a number of years of austerity which means that for ADASS workforce is also a key area of focus and where the challenges are similar. As a result, ADASS are developing a three year workforce strategy. The aim is to dovetail both areas of work.

Ian advised that together the NHS and ADASS are actively engaging their key workforces.

Ian advised that the Social Partnership Forum brings together NHS employers and Unions and is the route for employers to share information. Going forwards the Forum will be a mechanism for consultation on key service pathways. Ian advised that at the last meeting of the Social Partnership, representatives from local authorities also attended.

A workforce summit was also held on 24 February and the key issues challenges and opportunities highlighted were as follows:-

- Innovation and quality improvement are subordinate to daily fire fighting and crisis management
- Demand, specialisation, reducing numbers of trainees, staff retirement and the intensity of modern working practice
- A reliance on expensive locum and agency staff is making the existing configuration of services unsustainable
- The workforce is fragmented in silos and divided by organisational and professional boundaries
- Social care shares similar challenges and is under significant pressure due to Local Authority budget cuts
- There is huge untapped potential in the community and voluntary sectors – but this too requires investment and development

Group discussions were held in the context of a Cumbria / North East approach and work was carried out to identify potential quick wins. For example it was noted that a lot of back office functions are similar across sectors. Work also focused on potential new ways of working with the NHS and local government. Consideration is also being given to the greater portability of skills and how these might influence integration. In terms of recruitment and retention work is also focusing on sustainable ways of working. An example of this can be seen in the work relating to trainee GPs. Northumbria Healthcare has led on a project called Find Your Place which was a collaborative marketing campaign aimed at newly qualified doctors coming out of medical school with a view to attracting them to positions in the North East. All Trusts in the North East came together as part of a partnership Health Education North East and contributed 10k each to showcase the strengths of the North East and that it meets 15 out of the 17 GMO survey. The campaign has led to a 9% increase in trainees coming to the North East and will lead to fewer locums needing to be used. The return on investment for the campaign is estimated at three quarters of a million pounds and the campaign is being refreshed for 2018-19 with the commitment of all trusts.

Councillor Taylor queried whether there was any information on the impact of Brexit on the numbers of EU nationals who have left the NHS since the referendum or reductions in applications for posts in the NHS.

Ian advised that he did not have that information today but would look to bring some information on this to the next meeting.

Councillor Taylor noted that training for staff was crucial and needed to be appropriately funded going forwards. Ian agreed and also noted that they would be looking to assess the impact of the withdrawal of bursaries for nurses.

Councillor Schofield stated that she was unclear as to what was meant by the phrase the “whole workforce” and asked that a definition be provided. Councillor Schofield also considered that there should be opportunities for shared training across the health and social care workforce which would be a real culture shift. Ian agreed and stated that this should also include Continual Professional Development (CPD). Ian agreed to provide a clearer definition in relation to the workforce at the next meeting.

Ian advised that they would soon be appointing a Strategic Lead for Workforce. Ian considered that there was likely to be even more momentum in relation to the Workstream following this appointment.

Councillor Mendelson noted that the Joint Committee was keen to see that the Trade Unions are being engage and involved in the Workforce Workstream and queried whether this was happening.

Ian confirmed that engagement with the trade unions was taking place via the Social Partnership Forum and that trade union representatives had attended the Workforce Summit in February.

24 JOINT STP OSC WORK PROGRAMME

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

Meeting Date	Issue
25 June 2018	• Workforce Workstream – Progress Update • Integrated Care System
Additional Meeting (date tbc)	• Empowering Communities

The Joint Committee agreed that in relation to the Workforce Workstream update in June, trade union representatives should again be invited to the meeting considering this issue.

The Joint Committee also agreed that Professor Pollack should be invited to address councillors on the Joint Committee regarding her perspective on Accountable Care Organisations at a separate session, following on from a Joint Committee meeting. It was considered that this would facilitate a fuller discussion of the issues given the time constraints at meetings of the Joint Committee.

The Joint Committee also agreed to hold an additional meeting (date to be confirmed) to consider an update on how it is planned to engage with and involve communities in the whole Integrated Care System process.

The Chair also advised that, given the full agenda at today's meeting, councillors and external parties attending the meeting could email any outstanding written questions and a response would be provided in due course.

25 DATE AND TIME OF NEXT MEETING

AGREED That the next meeting of the Joint Committee be held on 25 June 2018 at 2pm at Gateshead Civic Centre.

Chair……..

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Update for matters arising Northumberland, Tyne and Wear and Durham

May 2018

Questions about:

1. NHS 111 procurement
2. Queries from Keep our NHS Public – response letters from Mr Bas Sen and Mr Alan Foster
3. Concerns raised by Health Watch organisations – response letter from Mr Mark Adams

NHS 111 service for the North East

In relation to enquires from Cllr F Mendleson about the North East NHS 111 Service. The procurement was carried out by the region's clinical commissioning groups and was concluded in March 2018.

The media release below sets out that North East Ambulance Service were the successful bidders.

Successful NHS 111 service will continue to improve under new contract

The successful NHS 111 telephone helpline in the region will continue to improve, as commissioners agree a new contract for the service.

Current providers the North East Ambulance Service NHS Foundation Trust will operate the new service under a five-year contract to start in October 2018.

The service operates 24 hours a day, seven days a week, helping patients who need medical help fast but do not need to call 999 – as well as anyone who is unsure which service to use.

Dr Neil O'Brien, Chair of the Northern Clinical Commissioning Groups Forum, said: "NHS 111 is a vital part of the urgent and emergency care system in the North East, and helps over 800,000 patients every year to get the care they need.

"The new service builds on this success, including a clinical assessment service meaning patients can conclude their call with advice, a prescription or an appointment for further assessment or treatment.

"With quick and easy access to a service that is fully integrated with other NHS services, patients can have real confidence in the care they will receive."
A recent Ipsos Mori survey showed 88% of patients using NHS 111 saying they would be likely or extremely likely to recommend the service.
The new service is designed to ensure that most patients' problems are dealt with on their first call, including a consultation with a clinician where that is needed. Staff will have access to a range of real-time information, including a summary of GP-held patient records, and details of local services such as GP extended hours schemes and community pharmacies.

Staff will also be able to book appointments with local GPs, send prescriptions directly to a convenient pharmacy or dispatch an ambulance where that is necessary.

Clinicians supporting the service – such as dental nurses, mental health nurses and palliative care nurses – will also be available to help professional colleagues working with patients in the community.

Gerardine Hope, Service Manager for the North East Ambulance Service, said: “We have a fantastic record of success and continue to deliver a safe, effective, caring and compassionate service – evidenced by the low number of serious incidents and high number of positive comments from our patients.
“None of this would be possible without our outstanding team who want to do the best for the patients of the North East. We are incredibly proud to have been awarded this contract and to know that the people of the North East can continue to rely on us for at least the next five years.”

Last year NEAS handled 858,224 calls to NHS 111, including 95,142 in December alone. NEAS currently handles an average of 64,000 calls every month, and is leading the way nationally in providing directly bookable appointments with local GPs.

Referrals to ambulances from NHS 111 decreased throughout 2017 to around 9%, and referrals to emergency departments to around 2.5%.

Yvonne Ormston, Chief Executive of the North East Ambulance Service, said: “Our service is perfectly placed at the heart of the region’s urgent and emergency care network and our clinical assessment service already supports the region’s patients, ensuring patients can access quickly the healthcare service that best meets their needs.

“The commitment and dedication of the team who deliver the service – from management to call handlers and everyone in between – and the developments they have brought in have made the service the success it is. This new service builds upon the work they have already started and we look forward to further developing the service with support from colleagues across the region.”

Queries from Keep our NHS Public
Please find attached to this update letters of response from Mr Bas Sen and Mr Alan Foster in relation to questions received.

Concerns from Health Watch organisations
Please also find attached a response letter from Mr Mark Adams in relation to concerns raised by healthwatch organisations regarding developing sustainability and transformation partnerships for the North East and North Cumbria.
Also to note, the intention to appoint a lead healthwatch organisation to support the development of engagement for the region.

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Great North Trauma & Emergency Centre
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10th April 2017

Answer to Q1

Whereas we accept the argument regarding accessibility to local A&E departments the following facts need to be taken into account;

(i) Workforce: A&E departments are struggling to maintain appropriate staffing, medical, nursing and ancillary. This is evident in the number of times the departments are diverting to other FTs which is a regular occurrence and increases in winter. This of course is not a reflection of just the A&E departments but of the overall hospital capacity. This means we are left with little choice but to look at how we better organise existing services, because there is a direct relationship between staff resource and capacity and patient care. Staffing issues are across the whole country.
Whereas in cases this may maintain some services as status quo there is no doubt that other services which are vulnerable will need to be considered. Any substantial changes to how services are organised will be subject to public engagement, case for change development and subsequent public consultation as required. The objective would be to have better arranged services that would be sustainable and would directly result in improved quality or care which means better outcomes for patients.

(ii) FT capacity: there are services within the hospital trusts that are vulnerable – what we mean by vulnerable is concerns about staffing capacity which could result in an emergency (unplanned) closure to a service on safety grounds (because the service becomes unsafe directly due to staffing expertise or availability).
Reorganisation of such services will result in patients going to the correct place first time and be seen by the appropriate staff, who deliver the best safe care. This then directly impacts on the outcome patients have. We recognise that people are concerned about having to travel a bit further, but any loss in travel time is more than compensated by the gain in reduced hospital LoS. This has been demonstrated by published work in conditions such as major Trauma, Stroke services, Heart attacks and Children's services. Again, any proposed changes would be subject to public consultation, and the issue of travel and transport discussed and considered particularly with wider partners.

(iii) Advances in treatment and providing a world class service: The establishment of trauma centres been driven by evidence based medicine higher survival and lower morbidity rates. For e.g. 25-50% of the major trauma patients are surviving compared to 5-10 years ago. It is important to realise that this involved the most complex and multiple injured trauma patients. The straightforward injuries continue to attend local EDs. This is possible because

the management is based on a network model of emergency care in which all hospitals across the region work together with common goals. I appreciate the question that was put to me regarding one of the councillors individual condition however as advances in medicine continue to progress to provide the high quality services (NHS hallmark of a world class service) the services will to continue to work together change and adapt so that centres are available to provide it. For e.g. some of you may be aware that the treatment of stroke is changing from the existing clot busting treatment to a treatment called thrombectomy. By its very nature this change can only be provided in centres that have stroke specialist staff along with neuro radiologists (of which there is a national shortage). By doing so we can significant improve the outcomes people have from stroke, helping them to get back to normal as possible and minimising life-long disability or death.

This is similar to the treatment change in heart attacks which are now treated by primary coronary angiography and stenting (PPCI). However to provide this the heart attack service had to be changed. We are now one of the leading regions for heart attack treatment for ST elevation myocardial infarction (STEMI) from this reorganisation – again saving people's lives. The FTs in London have undergone major changes with great patient benefit – this means saving lives when previously patients would have died.

As a region, and as clinical leaders we need to look at what more we can do to better organise specialist care across different disciplines in order to save more lives, and get better long term outcomes for our patients.

(iv) Quality vs privatisation: At the meeting I felt there was some confusion regarding quality v privatisation. It is important we continue to improve quality of patient care by embracing evidence based medicine and Key performance Indicators (KPIs). Evidence based medicine is the science behind clinical practice and hence the importance of senior clinical leaders within the UECN, however the KPIs may be process driven which may have been proven within the private sector which can be transferable to processes in the NHS. We always look at good examples of how other hospitals and health systems nationally and internationally are making such improvements and share best practice hence my example of Virginia Mason.

For example, this is where we identify a process or pathway, review it for non-value added activities, re-think the process or path way to drive out waste and freeing up much needed funding/time/resource for quality improvements. We firmly believe that there is scope for further quality improvement which then have a direct impact on the care we give patients and the clinical outcomes they gain.

It's important to note that just because we look at examples of how health systems in the USA are making improvements to evidence based medicine, this does not mean we wish to become an insurance based or US style private system.

We apply the improvement processes we learn to our own NHS, funded by tax payers, with rights and standards set out in the NHS constitution, Health and Social Care Act (2012) including free at the point of use.

Answer to Q2

It was unfortunate that given the short presentation time we could not cover the important headings of;

(i) Urgent Care Centres: NHS England have published their national specification for such services which clearly sets out what we need to do at a local level. This forms an important strand in our work to standardise services offered by such centre, ensuring that they are an integral part of the UECN and will along with 111 form a point of access to the wider health care system. The current UCCs are undergoing review and it is expected that there will be a revised, standardised provision by December 2019.

(ii) GPOOH forms an important and essential part of the service. We are acutely aware of the fact that some of these providers are private organisations. These providers have been appointed after a procurement process that is governed by legislation and UK procurement policy set nationally.

NHS England has worked to develop a new national service specification for the provision of an integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call-handling and former GP out-of-hours services. This new specification is just the starting point to revolutionise the way in which urgent care services are provided and accessed and will lead to regional changes in the historical current service provision by the OOH providers. You may be aware that North East Ambulance Service have just been announced as successful for the new NHS 111 contract from October 2018. This is as a result of a procurement process.

(iii) Vocare was selected following a full procurement exercise to determine how we could most cost-effectively deliver the high-quality outcomes our communities need. We are confident that the relationship continues to deliver on all KPIs. Also, it is worth remembering that the NHS itself is required to generate a surplus on its operations, which is exactly the same concept as profit. Vocare earns an appropriate profit while delivering the services we need at the price we specified. It is an example of how private providers can work seamlessly with the NHS to deliver the services our communities need. As a society, we are comfortable with the GP model, which sees private medical practitioners, who run GP practices which are in effect small businesses employing staff and make profit from the GP contract, work at the frontline of the NHS and we believe that this is a model that can work very well.

In regards to the CQC inspections, the quality of the services provided are monitored through regular contract monitoring and we are comfortable with the quality being provided in local contracts. We are aware with challenges Vocare is having with other contracts, but also that all of the metrics on those contracts are continuing to improve under its new ownership by Totally Plc.

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April 2018

Dear Mr Whalley,

Thank you for your emails and enquiries.

I am sorry that we have not got back to you sooner. I thought it would be helpful if you and your other campaign group colleagues meet with myself and other NHS leaders in the Northumberland, Tyne and Wear area so that we could discuss your group's concerns face to face.

I understand that you do not wish to take that offer up at the moment, but I am happy to arrange a meeting if you change your mind in the future. These are complex and emergent issues, which as I hope you will see after reading my responses, have changed since the original announcement of sustainability and transformation plans.

The NHS in the North East and North Cumbria is one of the best performing regions in the country, but we still have significant challenges around our future sustainability, and over the last 18 months there have been discussions among NHS leaders and clinicians across all the NHS organisations in the region about what could be the best ways to do this.

As you are aware, NHS organisations locally implement nationally set NHS policy which is decided by the elected UK government.

Sustainability and transformation plans were designed to build on collaborative work under the NHS Shared Planning Guidance for 2016/17 – 2020/21, to support implementation of the Five Year Forward View which is the key national NHS policy.

Originally these were described as 'plans' in the national planning guidance, and subsequently updated as 'partnerships'.

From our perspective, we are working together as a region in different partnerships to transform health and care in the communities we serve. In the past, organisations have each had their own plans, and they will continue to do so – but STPs are the first time *shared* planning has been developed across a geographical footprint. These are not new plans, but planning and partnerships, in some cases brought together for the first time, to tackle shared issues.

STP footprints are not new, statutory organisations but they are decision making forum, and a way to bring people and organisations together to develop a shared ways for better health and care for our local areas.

Draft planning for Northumberland, Tyne, Wear and North Durham were shared during winter 2016/17, and the feedback was published in summer 2017.

The feedback highlights eight key topics including:

- Vision – people were supportive of the vision and many suggested it should be even more ambitious, having local communities with better health outcomes than the rest of the country
- Finance – concerns were raised about the ability to make improvements within current resources
- Tackling health inequalities – people said this was an important area to improve but stressed that it could not be done quickly
- Workforce – concerns were raised about having enough staff with the right skills in the right place at the right time to improve the health of local people
- Access to services – many people in rural parts of Northumberland and North Durham were worried about accessing the help they needed if current services change

This feedback was very valuable and it has influenced how we are developing our partnerships.

What is clear from the discussions we have had with staff, partners and the public that there is broad agreement that, in order to create a better future for the NHS, we need to adapt the way we do things.

That doesn't mean doing less for patients or reducing the quality of care, or changing services without involving people. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently.

The Five Year Forward View brings this together agreement in an overall vision for the NHS. It highlights three areas where there are growing gaps between where we are now, and where we need to be in 2020/21. These gaps are:

- Health and wellbeing of the population
- Quality of care that is provided
- Finance and efficiency of NHS services.

Closing these three gaps and the Five Year Forward View vision will be achieved by everyone who has a stake in health and care adapting what they do, how they think, and how they act – at both local, regional and national levels.

One of the most powerful ways to achieve change is through local organisations and services working together in new, better ways and think differently about how close the gaps and truly meet the needs of patients in each area. While we already have a strong track record of partnership working, it's clear we need to do more.

As a group of NHS leaders, we need to create the best conditions that allow those relationships and partnerships to flourish, so people can build connections in order to generate ideas and create new and better ways to improve health and care by 2020/21.

I want to emphasise that being part of a Sustainability and Transformation Partnership does not mean that any organisations in the partnership will lose their own autonomy or identity.

It does mean we will have agreed collective working in order to develop plans which needs to address how we collectively improve health, care and finance for our local populations by 2021.

What has become clearer in the 18 months since the three STPs in the North East and North Cumbria were first discussed with local people, is the unique nature of the NHS across our region, in particular in relation to patient flows (how and where patients use services) and clinical networks (how we share clinical expertise) and taking into account the strong partnerships that have been in place for many years, puts our region in a different position when thinking about how sustainability and transformation partnerships could deliver the positive changes we need for our patients.

Towards the end of 2017, discussions between the STP leads in the North East and North Cumbria have been looking towards bringing the three STP footprints of NTW, North Cumbria and Durham, Darlington, Tees, Hambleton, Richmond and Whitby together under a single governance arrangement. Again, this would be around working together, not about creating new organisations.

These discussions have recognised that close partnership working is the only way we can ensure the transformation and sustainability of NHS services in order to improve health and wellbeing, improve the quality of care and ensure local services are efficient.

At the present time, we continue to have discussions with our regulatory bodies about how we can work more closely together across the NHS as a region, and once we have more clarity we intend to engage further with our stakeholders, partners and public.

It is our intention to share our thinking, key issues and documents as they emerge.

We want to tackle shared problems together, reduce duplications of effort and stream line administration processes and in particular address the staffing shortages we all face which create vulnerable services which has a direct impact on the care patients receive.

I want to reassure you that if there is a requirement for significant NHS service changes, proposals will be subject to requirements set out in the Health and Social Care Act (2012) and English case law for public consultation.

I am aware that there is an incorrect perception that somehow sustainability and transformation partnerships will mean that changes to NHS services can be made without proper process, or that there are secret plans somewhere.

As our thinking is clarified we will share this with stakeholders, partners and the public, and carry out service change planning including public consultation as

required that is set out in the Health and Social Care Act (2012), the NHS constitution and English case law.

We will continue to attend local and regional overview and scrutiny committees which are held in public and update elected members as health and care partnership working continues to strengthen.

I hope this provides you with information and assurance on the issues you are concerned about, and that it explains that we have had a moving situation to ensure that as a group of NHS leaders, we are looking to find the best ways of working in order to provide the best circumstances to tackle the shared challenges we have.

I would be pleased to have a face to face to discussion with yourself and your fellow campaigners, these are complex issues we are trying to tackle, and we all remain committed to doing the very best we can for the patients and communities we serve.

Yours sincerely,

Alan Foster
STP/ICS Lead for Cumbria and the North East

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30 April 2018

Mr I Kitt & Ms S Morgan
Joint Interim Chairs Healthwatch North Tyneside
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Dear Ian and Sokhjinder,

Thank you for your letter dated April 2018 where you express deep concerns about a story you have read in the Health Service Journal and what this might mean for our ambitions for the region's NHS to deliver the NHS Five Year Forward View.

I hope this response will address the concerns you have and clear any misconceptions there are about the issues your letter highlights. However, if it does not I am more than happy to talk to you about them.

You will recall when Alan Foster, Alison Slater and I met with North East Health Watch leaders on 29th November 2017 in Hartlepool, we discussed how as a region, NHS organisations were looking to bring the three sustainability and transformation partnerships (STPs), for the North East and North Cumbria together, and work towards becoming an integrated care system.

We discussed that what had become clearer in the 18 months since the three STPs in the North East and North Cumbria were first discussed with local people, was the unique nature of the NHS across our region and that this was leading us to think about bringing the three STPs together.

This is particularly so in relation to patient flows (how and where patients use services), clinical networks (how we share clinical expertise), and in relation to the strong partnerships that have been in place for many years across the region.

This put us in a different position when thinking about how STPs could deliver the positive changes we need for our patients and how planning for those changes would benefit from taking place across the three existing STP footprints.

At that meeting we shared with you the strategic direction we hoped to take, and that we were sharing it with you well in advance of more formal discussions.

We agreed we would ensure that we would communicate any key developments to health watch partners prior to any announcement. This remains our intention and it is included in our communications and engagement planning.

Notwithstanding the advance discussions that we had with you and other partners, in order for the region's NHS statutory organisations to support the idea of working towards the three STPs coming together, and the notion of an integrated care system, we must first ask each NHS governing body and board to consider the issues and agree their support for this way of working.

This is a critical part of our governance process, which must be carried out before we can progress and before we can then formally communicate that with external partners. The process to gain that board agreement continues and has been going on now for a number of months.

Noting that position, the HSJ article that you have read was not the result of any formal announcement that we have proactively made, but was as a direct result of the HSJ gaining a copy of a NHS board paper.

To be clear, in response to your perception that we have made a formal proactive announcement and not communicated it to Health Watch first, as we promised in November, this is simply not the case.

The situation we discussed with you in November has not changed, however I am sorry that you feel we have not kept you up to date with our plan to take the issues to Board and Governing Body meetings.

Since we met with Health Watch colleagues, we have also discussed bringing the STPs together at the Northumberland, North Tyneside, Newcastle, Gateshead, Sunderland, South Tyneside and Durham Joint Health Overview and Scrutiny Committee (JHOSC), to which I understand Health Watch representatives have been in attendance.

If it is helpful I will ensure any papers we sent to the JHOSC are also sent to you in case you have missed them.

As you rightly point out, we are extremely mindful of our responsibilities in regards to public engagement around developing an integrated care system, and across the region NHS organisations are agreed that there will be opportunities put in place for this to happen.

From a Northumberland, Tyne, Wear and North Durham (NTWND) perspective over the last year I am conscious that it had been our intention to carry out more engagement with the public around sustainability and transformation partnerships.

Taking on board the feedback from the engagement carried out over winter 2016 with the then emerging consideration that the right direction for the NHS was in developing a regional

approach, on balance we felt unable to develop localised NTWND engagement work further until we had clarity over the future arrangements.

This position though, has not either stopped or affected all the place based public engagement that continues in local CCG areas.

On the subject of statutory responsibilities to engage and consult, I would like to emphasise that the NHS duties around any potential future service changes remain, including the development of cases for change, and where required formal public consultation.

When significant service change issues emerge through the regional work, the NHS will fully meet the both the letter and spirit of our statutory, legal and policy obligations to engage and consult the public.

The list of expectations you include in your letter are helpful to know, and I will ask our strategic communications and engagement lead to include these in our planning.

I will also ask that a meeting is put in place with Health Watch officers to start to look at a regional approach to engagement on service change, in anticipation of what I hope will be positive developments for the region's NHS working in the best interests of patients and the communities we serve.

In summary, the situation remains the same as when we discussed it in November, and I would like to reassure you that you have not missed out on any opportunity to be involved, although I understand why you feel that you have, but I hope this letter sets out our intention for the future.

I am aware that you have included a copy of your letter on the agenda of the two Newcastle and Gateshead health and wellbeing boards. In line with the Cabinet Office pre-election guidance (known as purdah) I will wait until after the local elections to forward this letter to the chairs for inclusion in a future agenda and to provide a public response to the concerns you raise.

In the meantime I wanted to respond to your letter, given the nature of your concerns, but I would ask you not to share this response at this time publicly for the reasons stated above.

I hope this response goes some way towards providing you with assurances about the issues you raise. Please do not hesitate to contact me if you wish to discuss these or any other issues both now and in the future.

Yours sincerely

Mark Adams
Chief Officer

CC to original copy list

Norma Redfern, Mayor, North Tyneside Council
Councillor Karen Clarke
Cllr Margaret Hall
Alan Foster, Chief Executive of North Tees and Hartlepool NHS Foundation Trust
Richard Barker, Regional Director (North), NHS England

North East & North Cumbria Workforce Programme - Update for the Northumberland, Tyne and Wear and North Durham Joint Overview and Health Scrutiny Committee – 25 June 2018

Introduction

This paper follows an earlier update to the Committee in March 2018 and provides information with regards to the current and emergent work of the North East and North Cumbria Workforce Programme.

The programme is establishing as one of the STP / emergent ICS enabling programmes and on 1 June 2018, Lisa Crichton-Jones commenced in post as the Director of Workforce Transformation for the region. She will be working with partners to firmly establish the Programme, incorporating a number of strategic workforce themes of work to help realise the ambition *to deliver seamless and cost effective health and care through innovative partnership working, achieving the 'best' health outcomes for the people of the North East and North Cumbria.*

Executive Summary

This paper provides an overview of the following information.

- Context, opportunity and challenges.
- Work to date
- Priority actions
- Next steps and recommendation

It reminds the Committee of the context, opportunities and challenges relating to the health and social care workforce including recruitment and retention challenges, skills shortages and the need to further improve workforce planning as well as the overall employment experience across health and care pathways.

A regional workforce summit was held in February 2018 with over 100 attendees from across health and social care and a wider range of partners. A number of suggested actions arose from the summit and these are set out within the paper.

A number of priority actions are underway including the creation of a Strategic Workforce Board which will oversee the development and implementation of a regional workforce strategy with emerging themes of work on recruitment and retention, preparing people for change and supporting the workforce, workforce development and innovation, education and training, leadership development, development of the primary care workforce and employment experience.

A Workforce Programme Board will also be established to maintain oversight on all areas of work, reporting progress and risks to the Strategic Workforce Board.

As the approach to this work is finalised and formally agreed, the information set out within this paper may be subject to some change.

A further update on workforce communications will be given in September 2018 and a full programme update in December 2018.

Context, opportunities and challenges

A lot has been written and debated as to the current context in which we all work and the opportunities and challenges faced.

By way of reminder, we know current service delivery models are struggling to meet the demographic challenge of people living longer often with complex co-morbidities, and the increasing demands on the health and care system.

It is also recognised that we are experiencing a multi-factorial workforce crisis, caused by challenges in recruitment, retention, and lack of specialist skills, affordability, and a preference for shorter work time commitments.

Across the North East and North Cumbria partners including Arm's Length bodies (for example Health Education England (North East), Foundation Trusts, CCGs and Local Authorities / social care are already working hard to tackle these issues but much of our current workforce planning could be better coordinated and move from being based around professional silos.

Further, workforce development funding has reduced significantly with central funding allocated non-recurrently and to various agencies, resulting in what can sometimes be an uncoordinated and patchwork approach to investment.

As set out in March, we need to move from the position of innovation and quality improvement being subordinate to a future where there is far less daily firefighting and crisis management. Demand, specialisation, reducing numbers of trainees, staff retirement and the intensity of modern working practice all contribute to complex and often difficult work environments. There is a reliance on expensive locum and agency staff contributing to making the existing configuration of services unsustainable. The workforce is fragmented in silos and divided by organisational and professional boundaries

Social care shares similar challenges and is under significant pressure due to Local Authority budget cuts and we know there is huge untapped potential in the community and voluntary sector – but this too requires investment and development.

We now have an opportunity through our STP / emergent ICS arrangements to develop a coordinated regional workforce strategy, across health and care, to meet these challenges, ensuring that we plan our future workforce on a whole systems basis, allowing for greater innovation and new models of care.

We should also be cognisant of the recent draft national workforce strategy for health and care. 'Facing the facts, shaping the future' and await publication of the final strategy in July 2018, following consultation in the spring time.

Work to date

Whilst the regional Workforce Programme is currently being formally established and more so becomes fully operational, there have been a number of early successes to date and these include;

- A large scale Workforce Summit event, held in February 2018.
- Briefings to Health HR Directors and regional Trade Union colleagues at the North East Social Partnership Forum.
- Beginning to establish links with Directors of Adult and Children's Social Care and Local Authority Heads of HR.
- Scoping the opportunity to build on the many examples of good work, already underway within the region.
- A regular meeting of colleagues from across the system to drive this work forwards; the *Workforce Scoping Group,* whose membership comprises colleagues from health, local authority, CCGs, Health Education England and a regional trade union representative in their role as Joint Chair of the North East Social Partnership Forum.

Workforce Summit event - February 2018

The Workforce Summit was a well-attended event with attendees from CCGs, Health Education England, hospital trusts, public health, NECS, trade unions, NHS Employers, NHS England, primary care organisations, local authorities, NHSI, the voluntary sector, skills for care and the ambulance trust.

The 100+ attendees actively participated in the half day session to make significant contributions to a SWOT analysis, mapping out current challenges and discussing what were referred to as 'wicked issues'. Examples of which included;

- What does the integrated workforce look and feel like – what are we wanting to achieve?
- How to we truly engage with the workforce?
- How do we balance current workforce pressures and long term planning?
- How do we as a region influence national policy to make health and social care the career of choice?
- What will make it different this time?

A number of next steps were suggested and summarised as follows

- Developing a vision for the future workforce
- Developing some principles and priorities to underpin out future ways of working
- Establishing a governance framework
- Establishing baseline data and the 'as is' 'starting point' position
- Establishing links with the Communications and Engagement Work stream, given the importance of ongoing communication and engagement, linked to this work.

Feedback was given to all attendees during early May and this work is being taken forward and integrated into the wider Programme as it gains momentum.

Priority Actions

With the Director of Workforce Transformation now in post the following areas of work are commencing;

Establishment of a Strategic Workforce Board

The current Cumbria and North East Local Workforce Action Board (LWAB) is being reviewed to ensure that the health and care workforce ambitions for North East and Cumbria are shaped and then overseen by a Strategic Workforce Board. This new Board, reporting to the Health Strategy Group, will be chaired by one of the Senior Responsible Officers for Workforce. Members of the new Board will have sufficient seniority to engage with, represent and where possible, make decisions in the best interest of the system.

Whilst terms of reference are yet to be formally agreed, it is envisaged some of the responsibilities of the Board will be to;

- Champion the vision for the future workforce across health and social care, seeking out the best workforce innovation, be that nationally or internationally.
- Champion and influence workforce development and innovation across health and social care at a regional and national level.
- Oversee the development and implementation of a regional workforce strategy for health and care workforce.
- Establish and oversee a number of strategic, regional workforce priorities and delivery programmes to ensure the supply, education, leadership development and innovative ways of working for the future workforce.
- Oversee the provision of advice, guidance and support to the ICS delivery programmes to shape future workforce needs across pathways.

Whilst yet to be formally ratified, a number of strategic themes of work need to be established or realigned into the programme from existing pieces of work; each with clearly assigned lead officers. These areas of work will likely take the form of delivery groups and will report to the Strategic Workforce Board, through a Programme Board, where oversight can be maintained and progress against plan monitored.

Once formalised each delivery group will need to scope their delivery plan and updates on both plans and lead officers will be given at a future committee meeting.

Early thoughts on strategic workforce themes include;

Recruitment and retention;

How do we attract the future workforce to the North East and North Cumbria and once here, how do we retain them?

How do we build on the work of the Find Your Place campaign, (shared with the Committee in March 18).

How do we nurture a vibrant employment environment and promote an employment offer and brand?

How do we work with the unemployed within the region to support them back into employment, supporting the public health agenda?

How might we retain an ageing workforce and create opportunities which meet both their needs and those of health and care pathways?

How do we create greater efficiency across all recruitment processes within health and care, building on the North East NHS regional Streamlining work?

Preparing people for change and supporting the workforce;

How do we ensure the workforce are ready for change? To work across organisational and professional boundaries, in different settings, with different teams and with new skills, maximising use of technology?

How do we support our future workforce to be passionate about prevention? To promote parity of esteem and health and well-being within the early stages of education programmes?

How do we align the workforce programme with the communication and engagement programme, recognising the interdependencies and with a workforce of nearly 200,000 people across health and care, to see our workforce and their families as a significant part of our local population?

Workforce Development and Innovation

How do we seek national and international best practice on workforce development, pushing boundaries and moving away from traditional thinking, traditional education and traditional ways of working?

How do we design new innovative roles that work across pathways and deliver excellent care and support to the local population, whatever their health and care needs?

How do we widen access to roles within health and care, developing career entry opportunities and progression into and across a range of new and existing roles?

Education and Training

Based on the above, how do we design and commission new and innovative education programmes?

How do we build on the work of the Excellence Centre, working with Skills for Care and Skills for Heath, to maximise use of the apprenticeship levy, implementing a new apprentice standard for roles where individuals work across health and care?

How do we create greater efficiency through standardising and sharing records across a number of core standard training subjects, building on the North East NHS regional Streamlining work?

Leadership development

How can we work together to design and deliver leadership development programmes for the health and care workforce, working to ensure that their leadership needs are met, increasing personal resilience and readiness for change.

How can we work together on talent management and be influential partners in the developing Northern Regional Talent Boards?

Development of the primary care workforce

How do we build on the work of the Community Education Provider Networks and address the workforce challenges arising from the GP Five Year Forward View. We know the primary care workforce is under increasing pressure with an ageing population and work being transferred from secondary care contributing to an average annual 4-5% increase in workload since 2010, with similar increases anticipated over the next 10-15 years. The current workforce is increasingly mature with ~20% of GPs and ~ 30% of practice nurses within 5 years of average retirement age.

How do we transform the recruitment of doctors to GP training programmes where levels have been below capacity for the past 4 years – with Cumbria and the North East being the region with the lowest fill rate [75% for each of the past 2 years].

As a consequence there are insufficient numbers of newly qualified GPs to replace those leaving, and there will also be many of the nursing workforce retiring soon.

Employment Experience

How do we collectively work towards the employment experiences, for employees within the health and care sectors in the North East and North Cumbria, being the best it can be with strong employee engagement and low levels of bullying and harassment?

How we become better employers for those colleagues in protected characteristic groups, notably colleagues from BAME backgrounds?

How do we ensure excellence in work place health and wellbeing, supporting the strategic theme of prevention and improved public health?

Wider Programme Governance and Infrastructure

In addition to the emergent high level strategic workforce themes, the Workforce Programme needs to be able to influence, support and respond to the workforce needs arising from the wider delivery programmes within the region, for example, from the Urgent and Emergency Care network, the Mental Health or Cancer Network programmes.

Work is currently underway to map the ‘as is’ position with regards to each programme and a Workforce Programme Board, when established, will oversee all of the ongoing work, map themes and interdependencies and determine key programme milestones, objectives and review risks, monitoring delivery against plan.

In addition, the workforce programme will need to take account of any ‘place based’ approaches to health and care integration and where this may include place based people strategies, establish links and any interdependencies with the wider regional approach. The wider regional approach will continue to support person-centred care and local population health needs.

Workforce Transformation Hub

Consideration is also being given to what a 'Workforce Transformation Hub' for the emerging ICS could look like, building on some of the emerging models elsewhere such as the Workforce Transformation Hub being created for the South Yorkshire shadow ICS. The principle of a Workforce Transformation Hub is to bring together system-wide stakeholders as appropriate, in order to ensure effective use of collective data, intelligence and resources to deliver on agreed local workforce priorities across the ICS footprint. As a coordinated approach, a Hub would have direct links to any Strategic Workforce Board and ICS governance, as well as local links to stakeholders to ensure delivery remains appropriate for the local needs of the population.

Communication and engagement

The importance of communications to the Workforce Programme is not underestimated and alignment of this work to the Communications and Engagement Work Stream is essential. A Communications Director has been aligned to work with the programme and early work will include a full stakeholder analysis, development of an identity / branding for the programme (building on ‘Join our Journey’) and the design and planning for regular communications, for example, a programme newsletter.

We recognise the early stage of a lot of this work and that further stakeholder links are yet to be made, but give a commitment to develop this work and embed a partnership approach at the heart of the programme.

Next steps

- Strategic Workforce Board to be established by August 2018.
- Workforce Programme Board to be established by August 2018.
- Initial workforce delivery work streams and lead officers to be agreed by September 2018.
- Draft regional workforce strategy (high level) to be drafted by October 2018.
- Each workforce delivery work stream to develop high level objectives by October 2018.
- Further updates to be given to the Committee;

- Workforce communications in September 2018.
- Workforce Programme update in December 2018.

Recommendation

The Committee is asked to receive this update report for information, advise of any further information required and note the further scheduled updates in September and December 2018.

Lisa Crichton-Jones

Director of Workforce Transformation

North East and North Cumbria

June 2018

Ian Renwick

SRO Workforce