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NORTHUMBERLAND TYNE & WEAR & NORTH DURHAM STP HEALTH SCRUTINY COMMITTEE

Meeting on Monday, 25 March 2019 at 2.00 pm in the Civic Centre, Gateshead

Agenda

1 Apologies

2 Declarations of Interest

3 Minutes (Pages 3 - 16)
The minutes of the meeting of the Joint Committee held on 21 January 2019 are attached for approval.

4 Matters Arising from the Minutes

5 Prevention - Progress Update
Dr Guy Pilkington, Vice Chair, Newcastle Gateshead CCG and SRO Prevention Board, will provide the Joint Committee with a presentation on this issue.

6 Care Closer to Home (Pages 17 - 20)
Report Attached. Janet Probert, Care Closer to Home Senior Responsible Officer, Dr Jenny Steel, Clinical Lead Care Closer to Home Network CNE and Lou Okello, Care Closer to Home Lead will also provide the Joint Committee with a presentation on this issue.

7 Digital Minor Illness Referral Service (DMIRS) -
Andre Yeung LPN Chair, North Cumbria and North East England, will provide the Joint Committee with a presentation updating the Committee on the Service.

8 Development of Work Programme 2019-20
The Joint Committee is asked to consider and give its views on the emerging issues proposed for inclusion in its provisional work programme for 2019-20 and indicate whether it has any additional issues it wishes to be considered.

Emerging Issues
Development of ICS – Progress Updates
Partnership Board Arrangements
Acute Services
Workforce
Communication and Engagement

Urgent and Emergency Care
Primary Care
Population Health Management
Digital Care

9 Proposed Dates and Times of Future Meetings

It is proposed that future meetings of the Joint Committee be held on the following dates and times at Gateshead Civic Centre:-

- 17 June 2019 at 1.30pm
- 23 Sept 2019 at 1.30pm
- 25 Nov 2019 at 1.30pm
- 20 Jan 2020 at 1.30pm
- 23 March 2020 at 1.30pm

GATESHEAD METROPOLITAN BOROUGH COUNCIL

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

Monday, 21 January 2019

PRESENT: Councillor Taylor (Newcastle CC) (Vice Chair in the Chair)

Councillor(s): Mendelson and Schofield (Newcastle CC), Hall and Beadle (Gateshead Council) Armstrong, Watson and Dodd (Substitute)(Northumberland CC),Hetherington and Huntley (South Tyneside Council), Leadbitter (Sunderland CC) Temple (Durham CC)

57 APOLOGIES

Councillor(s) Caffrey (Gateshead Council), Dungworth (Northumberland CC) Robinson (Durham CC) Snowdon (Sunderland Council) Flynn (South Tyneside Council)

58 DECLARATIONS OF INTEREST

Councillor Taylor (Newcastle CC) declared an interest as an employee of Newcastle Hospitals Foundation Trust.

Councillors Mendelson (Newcastle CC) and Huntley (South Tyneside Council) declared an interest as members of NTW NHS FT Council of Governors.

59 MINUTES

The Minutes of the last meeting of the Joint Committee held on 26 November 2019 were approved as a correct record.

60 MATTERS ARISING FROM THE MINUTES

Workforce Communications Update

Councillor Robinson had highlighted that there were major workforce issues in relation to GPs and nurses and requested further information on what was being done in relation to this. The Committee noted that further information was to be shared on this issue at this meeting as part of the update on Workforce.

KONP NE Petition

As requested by the Joint Committee, the front page of the petition submitted by KONP NE had been circulated to all local authorities represented on the Joint Committee.

61 DEVELOPMENT OF ICS - PROGRESS UPDATE

The Joint Committee was advised that there is no ICS blueprint and there are different models and approaches being progressed across the country.

In NE and North Cumbria NHS organisations are currently working towards becoming a single shadow Integrated Care System (ICS) by April 2019. The NHS Long Term Plan published in January 2019 sets out clear expectations for all Integrated Care Systems.

The NE and North Cumbria ICS aims to bring together local organisations to redesign care and improve population health, creating shared leadership and action. It is a pragmatic way of integrating primary and specialist care, physical and mental health services, and health with social care.

Through ICS, commissioners will make shared decisions with providers on how to use resources, design services and improve population health. Working in a more integrated way will make it easier to identify and act on priorities shared by all parts of the NHS and social care.

Integrated Care Partnerships (ICPs) are also being established within the ICS to encourage clinical networking between neighbouring FTs.

The NE and North Cumbria ICS aims to streamline its commissioning arrangements to enable decision-making at system level where appropriate. There is an expectation that CCGs will offer strategic support to providers to partner with local government and other community organisations on population health and service redesign. All providers within the ICS will be required to contribute to ICS goals including population health with a greater emphasis on collaboration rather than competition between trusts.

The NE and North Cumbria ICS will:-

- Coordinate the common issues from the 4 Integrated Care Partnerships
- Create a single leadership, decision-making and self-governing assurance framework for work that needs to be done at scale in the North East and North Cumbria
- Establish joint financial management arrangements with aspirations to devolve control of key financial and staffing resources
- Coordinate clinical strategies that need to be regional including standards, pathways and enabling workstreams to improve quality, reduce variation and best use resources

- Arbitrate where required and hold the organisations to account for the delivery of NHS Five Year Forward View outcomes

The aspiring ICS is focused on:-

- implementing improvements to services identified as most 'vulnerable', mainly due to staffing and other pressures.
- taking shared responsibilities for managing resources for a defined population, including a joint approach to finances. Data and evidence needs to be used more widely to prevent ill health, manage demand for services and plan service structures.
- identifying how providers can collaborate across boundaries, for example doctors, nurses and other health professionals from different organisations working as a clinical network across hospital sites but also linking closely with GP and community services.

In 2018 the aspirant ICS was selected to take part in a national development programme providing support for aspiring ICSs to strengthen and accelerate progress in specific areas. Within this the aspirant ICS for NE and N Cumbria there has therefore been a focus on the following areas:-

- Population Health
- Working with Local Government
- Primary Care
- Commissioning
- Finance

The Joint Committee was advised that investment of almost £1 million funding over the next 18 months to support the NHS in expanding prevention activities and the NHS in NE and Cumbria winning a landmark legal battle against two multinational drug companies saving the tax payer millions of pounds and providing patients the option of using Avastin for wet age related mascular degeneration alongside two other current options were two regional achievements which would not have been possible if the NHS and partners had not worked together via the ICS.

In terms of governance it is proposed that the NE and North Cumbria ICS will have an independently chaired partnership board, drawn from and representing CCGs, trusts, primary care networks, and – where they wish to participate - local authorities, the voluntary sector and other partners.

A new ICS accountability and performance framework will consolidate the current amalgam of local accountability arrangements and provide a consistent set of performance measures on the effectiveness of integration

ICSs will have a key role in working with Local Authorities at 'place' level, with the flexibility to support local approaches to blending health and social care budgets where councils and CCGs agree this makes sense. At this stage further proposals for social care and health integration in the forthcoming Green Paper on adult social care are awaited.

The Joint Committee was informed that now that the NHS Long Term plan had been published this provided a better understanding of the future direction of travel. As a result, the whole NHS system would be refreshing plans and the aim would therefore be to have a refreshed ICS plan by summer / early autumn.

It was stressed however, that the ICS would be the “servant” of place and the majority of work going forwards would take place at a place based / CCG level.

Statutory decision-making will continue to sit with Clinical Commissioning Groups whose clinically-led Governing Bodies meet in public and are accountable to their local residents. The commissioning decisions of CCGs’ will continue to be shaped and scrutinised by their local Health and Wellbeing Boards, Healthwatch and Scrutiny Committees and this will not change.

The twelve CCGs in the North East and North Cumbria have also established a Joint CCG Committee to make decisions on a small number of strategic services that are planned and delivered on that footprint eg Ambulance and 111 services. This Joint Committee operates in the same way as a CCG Governing Body and holds its meetings in public.

The Joint Committee noted that a significant amount of work is already taking place with local authorities. As part of the Supporting Aspiring ICS Programme, a NHS and Local Government in Partnership workshop was held on 20th November 2018 where over 70 health and local government colleagues explored priority areas for collaboration and potential opportunities to work together in relation to population health and prevention; services for vulnerable children and adults; digital care and analytics and economic development and workplace health.

A further four clinical engagement events are to be held across the patch to seek views from a wide range of healthcare professionals, social care partners, voluntary sector and patient representatives to develop acute services to support an integrated care system and outputs from these events will form the basis of a regional ‘summary’ event bringing together system leaders and senior clinicians to agree an integrated care system strategy.

Next steps will be to:-

- Identify opportunities for collaboration between the NHS and local authorities
- Explore with local authorities how they may wish to participate in the leadership and governance of our emerging ICS
- Further refine our proposed operating model with our partners ahead of a formal submission to NHS England in March.

Councillor Spillard noted that reference had been made to the twelve CCG’s continuing to make decisions and queried about the potential for this to change as it was her understanding that the government was looking to appoint integrated care providers.

Amanda advised that within the NE and North Cumbria ICS there were no plans to appoint integrated care providers. Amanda stated that there are different

opportunities that working as an ICS can develop and appointing integrated care providers is not an option this ICS is pursuing. Amanda referred to the regional achievements that they had highlighted earlier and stated that this ICS had managed to achieve some of the best performance in the country in relation to areas such as A&E and urgent care as a result of collective working.

Mark highlighted that the NHS in this area has a long history of joint working with local government and the work taken forward under the umbrella of the ICS will continue to build on this. Amanda stated that the vehicle of the ICS was being used going forwards as sufficient inroads were not being made in health outcomes for the population and this was a means by which further progress could be made.

Councillor Mendelson noted that reference had been made to streamlining commissioning arrangements where appropriate and she was aware of commissioning guidelines around going to market and that the voluntary and community sector could be affected. Councillor Mendelson expressed concerned at how transparent the decision making would be in the circumstances. Councillor Mendelson indicated that there was sense in achieving economies of scale in some areas however she was concerned as to where accountability would sit.

The Joint Committee was advised that discussions on arrangements would always start at a place - based level and consideration would be given as to whether any proposals under consideration would be relevant for a wider geography/ consideration at a higher level. This would involve the NHS taking views from local authorities and coming through local overview and scrutiny committees and this Joint Committee where appropriate to ensure robust and informed decision making. The Joint Committee was advised that unless there was a compelling reason to do a piece of work at the broader ICS level it would be progressed at a place based local level.

Councillor Hetherington noted that assurances had been provided that the default position would be that work was progressed at a place-based level. However, Public Health is the responsibility of local authorities and budgets are being reduced. Councillor Hetherington queried whether budgets would follow and whether they would be weighted to take account of differing levels of deprivation in different areas and how this would be assessed.

The Joint Committee was informed that CCG budgets had recently been published and there was a greater recognition in the levels weighted for deprivation within the national funding formula and some improvements in the allocation. The Joint Committee was advised that what needed to be recognised was that whatever the funding allocation it was about working together at place - based level to make the best use of those resources to achieve the biggest difference for local people. The Joint Committee was advised that these conversations are starting to happen and then if collectively it is possible to identify additional funding then decisions will be made collectively as to where to allocate that funding.
Through the analysis of population health needs it is possible to identify where funding will make the biggest difference. Councillor Hetherington stated that she considered the issue of “need” to be key.

Councillor Schofield stated that she was nervous about the term “aspirant ICS” as she considered that there was a lack of transparency regarding the ICS system.

Councillor Schofield also hoped that the work being progressed would address the issue of how to bring together health and social care. Councillor Schofield queried who was responsible for bringing the two together and how it was proposed to achieve this. Councillor Schofield also queried how the huge problem of insufficient GP practices to serve local communities was being addressed and how this issue fit with the work of the ICS.

Mark acknowledged that in terms of transparency as the NHS is made up of lots of organisations there can be a lack of clarity and it can look fragmented. Mark considered that CCGs will provide a local focus, however, the aim is that through the ICS areas will gain more control over what they are able to do locally and when which will then provide more clarity on who is responsible for what. The Joint Committee was advised that one of the priority areas of focus for “aspirant” ICS relates to primary care and primary care networks. In terms of trying to achieve sustainability the focus is on achieving sustainability by getting practices to work together. There has been one workshop on how to support primary care networks looking at what is needed to build sustainability of workforce capacity/partnership working with others so that we can grow strong stable GP practices. The Joint Committee was advised that the NHS Long Term Plan includes a focus on building and sustaining primary care and targeted funding was being provided to enhance and grow the workforce although there were no specific examples of this in this patch yet.

Councillor Huntley queried what the position would be if a local authority disagreed with the proposals put forward by the ICS and the ICS decided to progress these.

Amanda advised that whatever is agreed for the ICS has to go through local place-based mechanisms first.

Councillor Huntley noted that as the NE and Cumbria has a mix of urban and rural components there are bound to be disagreements. Amanda stated that if a decision needed to be made which was nuanced to the needs of a particular population then it would need to be made at a place- based level. Only decisions which would not have a differential effect across the patch would be made at an ICS level eg the campaign to promote Cumbria and NE as a place to live and work (recognising that this needed to be nuanced to reflect different geographies and populations). Amanda advised that the ICS was about providing a framework. Mark also advised it was not a case of all or nothing. If there was a piece of work which a couple of local authorities within the ICS did not want to participate in then the work could be carried out across the rest of the ICS but not those two.

Councillor Huntley asked if there was a scenario where a local area could be forced to take forward proposals it did not wish to progress. Amanda stated that she could not envisage such a scenario without legislative changes having been made. Currently the CCG Joint Committee requires any decisions to be unanimous. Mark stated that the ICS could not cut across the sovereignty of other organisations so if a CCG does not want to progress an issue then that is in their gift as they have the

statutory responsibilities and decision - making powers.

Councillor Huntley queried what work was taking place with local authorities and what are the next steps.

Amanda noted that Mary had already shared some of the engagement work which had been taking place. An ongoing dialogue was being developed with partners and there had been a local authority workshop. Engagement was also taking place at a local level on a frequent basis via existing mechanisms eg Health and Wellbeing Boards and meetings with local authority Chief Executives, Directors of Adult Social Care and Cabinet members. Engagement was also taking place through meetings such as this and meetings with the STP OSC in the south of the region and via individual conversations with smaller groupings.

Mark stated that as work progressed regarding the ICS planning process with the aim of putting in place a plan by the end of summer / beginning of autumn engagement would take place with groups such as this.

Councillor Beadle noted that the report made reference to an independently chaired Partnership Board and he queried when the Board would be established and what the timeline was for this. Councillor Beadle also queried how the constitution would relate to the new NE Mayor as this won't be established.

Amanda noted that the NHS Long Term Plan refers to the establishment of the Board and work is already taking place on how to establish the Board. In terms of timescales Amanda advised that there was no specific timeframe as they wanted consultation to be meaningful and take the necessary time to get the right constitution/ membership and memorandum of understanding. The process would therefore take as long as necessary in order that all partners were signed up and work had already begun with views being sought from Leaders and Chief Executives.

Councillor Beadle asked about the position in relation to next steps as he noted that a submission needed to be made to NHS England regarding the aspirant ICS and therefore he presumed that there was a timeline.

The Joint Committee was advised that there was an indicative timeframe but work would take as long as necessary in order to accommodate partners. In terms of linking with the new NE Mayor, the Joint Committee was advised that whatever structures were put in place they would need to be sufficiently flexible to take this into account.

Councillor Dodds highlighted that in terms of the work around promoting NE and Cumbria via the ICS there needed to be a talking up of the area, particularly if our NHS performance is higher than elsewhere, to tackle the problem of losing skills to other areas. Amanda agreed and considered that everyone was supportive of such an approach and there was collective energy, resource and commitment to achieve that.

Councillor Spillard stated that she understood that when the idea of the ICS was first

introduced it was the case that each member of the population would have a fixed amount of funding attached to them and she queried whether this was still the case. Mark stated that there was still a financial formula based on capitation/population. Councillor Spillard queried whether this funding still went to CCGs. Mark stated that there had not been any change in primary legislation so the funding still went to CCGs. However, place - based working provides opportunities to look at the public sector pound and have discussions about how partners may make decisions around funding allocations together.

Councillor Spillard queried in terms of mobility of workforce across CCGs and Hospital Trusts who makes decisions in relation to areas such as cardiology etc. Mark stated that this would be covered in the update on workforce.

Councillor Taylor stated that she considered that the proposed independent Partnership Board should have representation on it from Public Health in local authorities and the Joint Committee would wish to be kept updated around this point. Councillor Taylor also stated that she hoped all the Board meetings would be open to the public to provide appropriate transparency.

Amanda advised that these were the sorts of issues they would like to seek views on and they would be coming back to this Joint Committee at a future date to seek these views.

62 UPDATE ON WORKFORCE

Lisa Crichton-Jones provided the Joint Committee with an update on workforce.

Lisa recapped on earlier updates provided to the Joint Committee and the work carried out to date set out below

- Workforce Summit – February
- Appointment of Director of Workforce Transformation
- Establishing key relationships
  Health, Social Care, Partners
- Starting to capture the good work underway, building on Health Education England NE work
- Preparing the ground work for the workforce programme + resources
- Half day with Health Strategy Group – October
- Day with Health HRDs – November
- Regional and national work with partners and ALBs
- Workforce Transformation and Strategy Board established and meeting
- Vision, mission and priority areas emerging

Lisa stated that she was pleased to share that the new NE and NC Workforce Transformation and Strategy Board had its first meeting and a second meeting was now pending and priority areas of work were now emerging.

Adaptability of the workforce was a key theme and there was a recognition that whilst 25% of work needed to focus on business as usual the focus for the remainder of work should be on transformation. There was also recognition that developing the workforce across health and social care would take us to a stronger position.

Lisa advised that the framework for the programme centred on the three pillars of work set out below:-

Workforce Development – responding to demand – clinical strategy

- Increase supply (inc international recruitment)
- The primary care workforce
- Widening participation
- Workers across health and care

A key area of focus was ensuring flexible / multi-skilled workers

HR Community – standards, consistency, equity, flexibility

- Flexibility and easier movement
- Better use apprentice levy
- Improving the employment experience – retention focus

System Development – ICS / ICP/ Place

- Prevention focus
- Preparing the workforce for technological developments / Appreciative Enquiring on current offer to support and develop staff

A further major area of focus was staff retention. It was noted that there was much work to be done in this area and work was only just beginning.

Lisa shared information on Health Education England's current/planned activity for the NE and North Cumbria and advised of the development of a Health Education England workforce transformation hub. Lisa advised that the development of the virtual faculty would support the development of new roles.

Work was now taking place to ensure the workforce programme aligns with the national priorities for the NHS set out in the long - term plan and the workforce implementation plan will be published later in the year.

The aim was to reduce the nursing vacancy rate to 5% by 2028 by increasing clinical placements; providing job guarantees; online nursing degrees; new "earn and learn" opportunities for mental health and learning disability nursing students and a further expansion of 7,500 nurse associates starting in 2019 as well as increased action to improve nurse retention. There would also be a refreshed focus on international recruitment whilst recognising the current challenges as well as work to support

leadership development / talent management.

In terms of next steps there was a need to map clear work plans and develop the Workforce Hub as well as focus on wider engagement and an event with Regional Trade Union Representatives was scheduled for early February and an event with local authority Heads of HR was scheduled for the end of February. There would also be events with digital and housing colleagues.

Dr Groen provided the Joint Committee with information on local NHS employed workforce and the potential impact of Brexit on workforce.

Dr Groen advised that overall the proportion of EU individuals working for the NHS in the North East and North Cumbria had risen between Sept 2012 and 2018 it had gone from under 1.7% to 2.7% of the overall workforce which equated to just over 1635 members of staff. Dr Groen clarified that this information only referred to those individuals who had indicated on the NHS Electronic Staff Record (ESR) that they held an EU nationality.

Dr Groen provided figures for specific areas of the workforce. Dr Groen advised that the risk of Brexit was multifactorial in nature, with much based on the assumption that the EU nationals referred to would make an active decision to leave the UK, which was not necessarily the case and it was therefore important not to overstate the risks. Dr Groen acknowledged, however, that there were some areas of the workforce where further closer scrutiny and risk management strategies ought to be in place.

Dr Groen offered to work with individual local authorities at a local level to help understand the local position if there was interest.

Councillor Hall queried how the figures would be affected if they were overlaid with the numbers of NHS staff due to retire. Dr Groen stated that it would be possible to look at that and see what could be done to moderate, where appropriate. Dr Groen stated that the local workforce supply looks relatively ok, particularly in the area of nursing and AHPs.

Lisa highlighted that retention of older staff with caring responsibilities appeared to be a particular area to explore as part of the work plan.

Councillor Hetherington queried the position in relation to nursing staff. Councillor Hetherington stated that she understood that the fact that nursing bursaries are no longer provided had led to a significant reduction in the number of nurses coming into the system. She had heard that there was a 40% reduction in nursing students and she queried whether the significant impact highlighted could be used to look at the position again if it is the case that ICS / CCG's are responsible for their own budgets / making decisions for local areas and populations.

Dr Groen stated that at an ICS level looking jointly at a bursary scheme might make sense. However, Dr Groen advised that the figures Councillor Hetherington had referred to related to the national position whereas the supply line in the North East has improved and is looking healthier than the national equivalent issue.

Councillor Hetherington stated that this was the type of information that needed to be brought to this Joint Committee.

Lisa advised that this information could be brought to a future meeting as well as figures relating to student nurses.

Councillor Beadle noted that reference had been made to 75 % transformation and 25% business as usual and he has what that meant in reality. Lisa referred to an earlier slide where she had addressed this issue and said it was about fundamentally changing the way a workforce worked. This could include what they did, where they did it, who they work with, the tools they have to do the job etc.

Councillor Watson noted that the information they had considered related to the EU proportion of the NHS workforce and queried if the Joint Committee could be provided with figures on the proportion of other foreign nationals who formed part of the NHS workforce. Dr Groen stated that this information could be provided for a future meeting. However, Dr Groen stated that the general trend was that the proportion of other foreign nationals coming to work in the NHS was significantly down and it was not known why at this stage.

Councillor Watson stated that he was aware of a Canadian nurse who had advised that it was more difficult to work in the UK due to extra hoops in the process.

Councillor Schofield advised that she was disappointed in the update provided to the Joint Committee as she had expected more information on actions being progressed, whereas what the Committee had been updated on was a framework. Councillor Schofield also advised that there was nothing in the update to reassure her that the workforce would not be provided by private companies. In addition, Councillor Schofield stated that she did not get any sense of the workforce going across health and social care and she noted that in terms of existing training the trade unions were doing fantastic work. Councillor Schofield stated that for the next update on workforce to the Joint Committee she would like more information on these areas.

Lisa advised that early work had focused on establishing relationships and this had been important. However, it would be possible to bring more detail underpinning the high - level work to a future meeting.

Steph Downey, Director of Adult Social Care, Gateshead, advised that Lisa and a colleague had attended the ADASS Heads of Service meeting from across the twelve local authorities. Steph advised that work was taking place in Newcastle and Gateshead, in relation to health and social care apprenticeships and there was a big drive to ensure that they were bringing the right people in and building career pathways, although this was still in its early days. Other parts of the region were developing academies. Whilst this was place based work there was an overview from the region.

Councillor Mendelson stated that she would like to see more of this type of work. Councillor Mendelson stated that she also felt that involvement of the unions was an

afterthought and she wanted to see evidence of the unions being involved all the way through the process both at a regional and a local level.

Councillor Taylor stated that she would also like to see more detailed information on what is being done to retain NHS staff in the next workforce update.

Councillor Temple also noted that he understood that national policies were impacting on changes to the pension cap and making it uneconomic for GPs to continue and he stated that he would like to have further information on this and the potential impact on retaining GPs.

63 NEAS - INTEGRATING THE AMBULANCE SERVICE IN THE STP

Mark Cotton, Assistant Director, Communications and Engagement, NEAS provided an update to the Joint Committee on integrating the ambulance service in the STP.

Mark advised that work had focused in the following three areas:-

- Transforming from transport to treatment service
- Integrating care and transport
- Implementing ambulance response standards

Mark explained that historically the service had focused on responding to 999 calls as well as despatching ambulances to transport individuals to scheduled care in hospital. However, since 2013 the service had also been responding to NHS 111 calls.

However, as patients are now living longer and presenting with a number of different conditions this has been placing a strain on A & E and hospitals. As a result, the Ambulance Service has been changing how it operates within the framework of the ICS to support patients and provide the best care as close to home. This work has involved dual training two thirds of staff in the ambulance control room on the process for clinically assessing patient needs in relation to both 999 and 111 calls so that when demand goes up in one area staff can be moved across to meet that demand. The assessment service involves paramedics, nurses, GPs and A & E consultants and it can also access and increasing range of other clinical specialities so that it can appropriately identify patient needs and where they need to go for help in a timely way.

Mark stated that the service has integrated care and the transport system together and provided staff with the clinical training / skills necessary to meet patient needs and so that the workforce can be used more adaptively and flexibly. Mark highlighted the role of Advanced Practitioners who can manage urgent care and prescribe medication.

Mark explained that this way of working has now seen an increase in the

numbers of patients discharged and fewer individuals calling 111 going to A & E. Mark stated that partnership work had been key to this collaborative way of working.

However, Mark advised that the biggest change in relation to ambulance performance had occurred nearly two years ago with the introduction of new ambulance response standards. Mark outlined the changes to the standards which applied national response targets to every single 999 patient for the first time leading to faster treatment for those needing it and improved care for patients suffering from stroke and heart attacks and an end to “hidden waits”.

Mark advised that in terms of ambulance service performance as at January 2019 the service was performing well and meeting its targets in categories 1 and 4 but was not meeting its targets in categories 2 and 3. However, comparing performance against the standards for the period Dec 2017 and December 2018 the services response times had improved in all categories and where previously there had been long delays in categories 2 and 3 significant improvements had been made in response times.

Mark advised that in order to achieve the new ambulance standards the service carried out a review to determine the underlying capacity needed to achieve the new ambulance response programme targets. The review took account of demand predictions to 2021 and modelled performance to 2021 with current resourcing. It also identified potential efficiencies and modelled the performance impact of each potential efficiency and modelled resource needs to bridge any performance shortfall. At that time, the Review identified that an additional 272 paramedics were needed in order to meet the new response standards. However, the modelling did not take account of the additional 42 paramedics funded through additional investment in 2017-18 in staffing calculations. It is planned that a further 22 paramedic posts are to be delivered through reducing average turn around to 30 minutes and a further 95 paramedics through reducing abstractions with 13 to be delivered through an 8 hour shift re -roster. The Joint Committee was informed that this will reduce the gap in paramedic establishment to 100.

Mark explained that the ambulance service contribution to delivering these efficiencies will save almost £9.4million with additional funding totalling £10.4million from commissioners for the additional 100 paramedics identified. Mark also explained that as a result of the modelling all areas across the region will have an improved ambulance service in the future and he outlined proposals for future ambulance resourcing.

Councillor Watson stated that he felt the programme outlined was ambitious however, he was not convinced that the number of abstractions would be achieved or the reductions in turnaround time.

Mark advised that the modelling had been based on the number of staff already in place. Mark acknowledge that the service currently has high sickness levels which need to be tackled. However, Mark advised that in terms of retention, whilst the service had a high turnover rate approximately 4 to 5 years ago this

has been turned around due to a significant amount of work building career paths for staff and wrap around support.

Councillor Mendelson queried what staff feedback had been like in relation to the proposals outlined. Mark advised that on the whole feedback had been positive as staff were being involved in developing new rotas and were very much a part of making the programme work. Mark also advised that feedback over the winter had been that whilst workload was similar to last year this had been easier to manage due to the increased number of paramedics.

Mark also highlighted that significant work had been carried out with hospital trusts in Northumberland and Durham who had experienced issues with delays in ambulance turnarounds. Work has taken place to change how those hospitals take in ambulances and this has made a big difference. It was acknowledged that there was still more work to be done but work so far had been positive.

The Chair thanked Mark for the information provided.

64 WORK PROGRAMME

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

Meeting Date	Issue
25 March 2019	• Prevention – Progress Update • Care Closer to Home • Digital Minor Illness Referral Scheme(DMIRS) – previously known as the Community Pharmacy Referral Service

Issues to Slot In
Acute Services

65 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting was scheduled for 25 March 2019 at 2pm at Gateshead Civic Centre

Chair……..

The Care Closer to Home (CCH) and Frailty iCare Programme – progress update

Author: Lou Okello – CCH Programme Lead

On behalf of Janet Probert – CCH SRO

Joint Scrutiny Committee for the North of the ICS Patch

Monday 25th March 2019

The Care Closer to Home Frailty iCare Programme

Purpose:

The purpose of this report is to provide the Joint Scrutiny Committee with a progress update on the work of the Care Closer to Home programme of the North East & North Cumbria (NENC) Integrated Care System (ICS).

Introduction

The over-arching scope of the CCH programme of work is to support the local delivery of outcomes which look to ensure the provision of an improved range of Out of Hospital Services (including statutory, independent and voluntary sectors) with consistently high standards and improved patient satisfaction, that provide earlier intervention, better coordinated care, support independence and reduce the length of hospital stays.

The CCH work-stream has prioritised 'frailty' as an area of focus and has developed a 'Frailty Toolkit' for preventing frailty and supporting older people, families and communities living with frailty.

The ambition is to work more collaboratively across the wider health and care system to improve the quality of life for our aging population, whilst exploring the significant economic case for change.

The Impact of Frailty/the Case for Change

The presence of frailty, and its severity, correlates with poor outcomes, such as poor quality of life, institutionalisation, mortality and increasing cost to health and care systems.

Looking after the frail elderly is one of the biggest challenges facing primary care: GPs, dentists and community pharmacists.

Caring for the frail elderly also presents huge challenges to social care, housing and residential care providers and the whole spectrum of third sector services.

There is a spectrum of frailty from mild to moderate through to severe, ultimately leading to end of life.

Frailty is common amongst older adults, with the overall prevalence of frailty in people aged over 60 estimated to be around 14%. In England, there are 1.8 million people aged over 60 and 0.8 million people aged over 80 living with frailty. The prevalence of frailty increases with age, resulting in 5% of people aged 60-69 living with frailty and up to 65% of people aged over 90 living with frailty. Frailty is also considered more common in women (16% versus 12%).

The CCH approach

It is understood that local health and care systems will have, or will be developing, their own plans but the common vision for these plans should be to:

'Enable people and communities to look after themselves and remain well, independent and healthy but, when needed, offer care and support at or close to their homes, in a way that identifies issues early, resolves them quickly and prevents people going into hospital unnecessarily or supports them through transfers of care when needed'.

The CCH Frailty Project is seeking to facilitate efficiency through the sharing of knowledge, learning and evidence-based Good Practice and by providing support to local commissioners and providers. This is being delivered in several ways as summarised below:

- A regional frailty Toolkit is being developed (incorporating evidence-based approaches to care across the frailty journey, key resources and local examples of good practice).
- The Toolkit is underpinned by a dashboard of key outcome metrics.
- Local health and care economies will be able to benchmark existing care provision and metrics against others in the region, identify their priorities and then draw on the Toolkit to introduce new initiatives and improve the care and support they offer.
- A regional frailty 'Community of Practice' (CoP) has been established to drive the work forward, bringing together a wide range of professionals from across the regional health and care system, who understand frailty and older people's services.
- A Workforce competency framework has been developed for registered and non-registered staff working anywhere in the care system and plans are afoot for testing it in a variety of settings in the coming months. A longer term vision is for the development of an apprenticeship. A workforce lead 'CoPper' has been identified, supported by clinical leads and linked to the regional ICS workforce programme.
- The programme is also collaborating with local Universities as part of an ARC bid where Frailty has been chosen to be one of the key themes supported by 'evaluation CoPpers.
- Academics and librarians have agreed to support the evaluative methodology surrounding the toolkit and strengthen the presentation of supporting evidence.

- A simple web-based digital platform for the Frailty Toolkit has been set up.
- Working in partnership with Newcastle Hospitals Trust, we have been successful in securing funding from Health System Led Investment in Provider Digitisation over the next 3 years to support digitisation of the Frailty ICARE work. Three digital projects are underway which look to support our regional CoP, the Frailty ICARE website and a patient-facing pathway.
- We are also working to support the regional digital access portal.

Next steps:

- To continue to develop the Frailty Toolkit to offer a region-wide common understanding of frailty and establish a supportive way for learning and sharing best practice to support local health and care system planning.
- To continue to facilitate and support a region-wide CoP, where initiatives are shared, learning and recommendations agreed, plans made for wider sharing through local forums and the Toolkit kept iterative.
- To take advantage of digital solutions to further enhance the technological platform for the Frailty Toolkit and frailty CoP to better facilitate access through the implementation of the DCJS-funded Projects.
- To support the reduction in financial costs, time spent and resource utilisation across the health and care system by: improving current practice, streamlining and aligning services to avoid duplication, thereby working more efficiently and cost effectively whilst improving patient experience.
- To work across the whole health and care system: to support carers and family members taking a ‘whole family’ approach and to support people with daily living tasks, promoting independence and the ability to live at home for as long as possible.
- To explore potential integration of services and shared pathways of care.

Conclusion:

The work of the CCH programme and the focus on frailty is generating a huge amount of interest and enthusiasm both locally and nationally. The approach to this work and specifically the Frailty Toolkit and Community of Practice has real potential to support and facilitate both local and ‘at scale’ transformation.