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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.