Durham Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Health Scrutiny Committee

Meeting on Tuesday 25 September 2018 at 2.00 pm in The Council Chamber, Redcar and Cleveland Leisure and Community Heart, Redcar, TS10 1TD

Agenda

1. **Apologies for absence**
2. **Substitute Members**
3. **To receive any Declarations of Interest by Members**
4. **Minutes (Pages 3 - 10)**

   To receive and approve the minutes of the meeting of the Durham Darlington and Teesside Hambleton Richmondshire and Whitby STP Joint Health Scrutiny Committee held on 13 June 2018 – Copy attached.

5. **Empowering Communities - Communications and Engagement for Integrated health and care (Pages 11 - 24)**

   Presentation by Mary Bewley, Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP Communications Lead.

   A copy of the narrative and communications pack published on 14 June 2018 in respect of "Integrating and optimising health care services to meet local need and maximise stability" is attached for members information.

6. **Durham Darlington and Teesside, Hambleton, Richmondshire and Whitby STP - Workstream Update by Mary Bewley, Durham Darlington and Teesside Hambleton Richmondshire and Whitby STP Communications Lead**
7. **Chairman's urgent items**
8. **Any other business**
9. **Date and time of next meeting**

   To be confirmed.

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

Membership:

DARLINGTON BC
Councillor Wendy Newall
Councillor Jan Taylor
Councillor Lorraine Tostevin

DURHAM COUNTY COUNCIL
Councillor John Robinson
Councillor Jean Chaplow
Councillor Richard Bell

HARTLEPOOL BC
Councillor Brenda Loynes
Councillor Gerard Hall
1 Vacancy

MIDDLESBROUGH BC
Councillor Eddie Dryden
Councillor Bob Brady
Councillor Alma Hellaoui

NORTH YORKSHIRE COUNTY COUNCIL
Councillor Jim Clark
Councillor John Blackie
Councillor Heather Moorhouse

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

STOCKTON BC
Councillor Lisa Grainge
Councillor Sonia Bailey
Councillor Lynn Hall

Durham Darlington Teesside Hambleton Richmondshire and Whitby STP Joint Health Scrutiny Committee

At a meeting of the **Durham Darlington Teesside Hambleton Richmondshire and Whitby STP Joint Health Scrutiny Committee** held in Council Chamber, Civic Centre, Hartlepool on **Wednesday 13 June 2018 at 2.00p.m**.

Present:

Councillors J Robinson and R Bell (Durham County Council)
Councillors J Clark and H Moorhouse (North Yorkshire County Council)
Councillors N Cooney and R Goddard (Redcar and Cleveland Borough Council)
Councillors L Grainge and L Hall,(Stockton-on-Tees Borough Council)

In Attendance

Councillor C Dickinson (North Yorkshire County Council)

Officers

Peter Mennear (Stockton-on-Tees Borough Council)
Joan Stevens (Hartlepool Borough Council)
Alison Pearson (Redcar and Cleveland Council)
Daniel Harry (North Yorkshire County Council)
Stephen Gwillym (Durham County Council)
Caroline Breheny, Edward Kunonga and Hayley Coleman (Middlesbrough Borough Council)

Trust and CCG Representatives

Alan Foster, STP Lead and Chief Executive – North Tees and Hartlepool NHS Foundation Trust
Mary Bewley, Head of Communications and Engagement, North of England Commissioning Support
Janet Probert, Chief Officer, Hambleton, Richmonshire and Whitby Clinical Commissioning Group
Stewart Findley, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Apologies

Councillors W Newall J Taylor and L Tostevin (Darlington Borough Council)
Councillor J Chaplow (Durham County Council)
Councillor B Brady and E Dryden (Middlesbrough Council)
Councillor J Blackie (North Yorkshire County Council)
Councillors M Ovens (Redcar and Cleveland Borough Council)
Councillor S Bailey (Stockton-on-Tees Borough Council)

1. **Appointment of Chair**

   Councillor John Robinson (Durham County Council) was appointed as Chair of the Committee.

2. **Appointment of Vice Chair**

   Councillor L Hall(Stockton Borough Council) was appointed as Vice Chair of the Committee.

3. **Substitute Members**

   None.

4. **To receive any Declarations of Interest by Members**

   None recorded.

5. **Minutes**

   Agreed that the minutes of the meeting held on 17 January 2018 be confirmed and signed by the Chair as a correct record subject to the inclusion of more detailed reference to the discussions that had taken place in respect of the development of a 3 centre acute hospitals model and that an associated press release on this be published jointly within a reasonable timescale.

6. **Durham Darlington and Teesside Hambleton Richmondshire and Whitby STP – Update**

   Councillor Robinson referenced a recent press article in the Northern Echo which detailed discussions that had taken place at a meeting of North Yorkshire County Council regarding the future of health service provision at James Cook University Hospital, Middlesbrough; University Hospital North Tees, Stockton and Darlington Memorial Hospital. He stated the article suggested that key services would be retained at Darlington Memorial Hospital and this had raised issues with the DDTHRW STP Joint OSC members given their previous request for appropriate communications to be issued by the STP lead/Commissioners in respect of the development of the three acute hospitals model that had been discussed at the Committee's meeting in January 2018.

   In response, Mr Foster indicated that he had been disappointed in the press coverage on this issue and suggested that this may have been inaccurate. He stated that the press statement asked for by the Committee in January had not been issued because of difficulties that had occurred in getting all representatives to sign up to any press release. He introduced Mary Bewley, Head of Communications and Engagement, North of England Commissioning Support to members and indicated that an updated position statement in respect of the development of the STP/Better Health Programme and Integrated Care

System would be published on 14 June 2018. This will be circulated to Local Authority Chief Executives; Directors of Adult and Children's services and Directors of Public Health along with Health Scrutiny members and Health and Wellbeing Board representatives.

Mr Foster then gave a presentation to members which set out proposals for the development of an Integrated Care System for the North East and Cumbria which included associated leadership structures and governance proposals.

Mr Foster reported upon the context for the NHS within the North East and Cumbria, referencing the fact that the NHS Cycle is driven by poorer population health as a starting point leading to an overdependence on hospitals. NHS Funding is drawn away from prevention and preventative services which stops the causes of poor health from being addressed. Ill health within the region also contributes to worklessness, poor productivity and lower economic growth. The associated opportunity cost is poorer health outcomes in areas such as life expectancy at birth; smoking related deaths; under 75 mortality from cardiovascular disease and cancer.

In setting out the case for change, Mr Foster stated that the NE and Cumbria had a long established geography with highly interdependent clinical services. The vast majority of patient flows stay within the area and there is a history of joint working and a unanimous commitment from NHS organisations to establish an Integrated Care System across the North Eats and Cumbria. However, he stressed that the 2012 Health and Social Care Act had led to fragmentation across the health system making system wide decision making difficult. This coupled with significant financial gaps, service sustainability issues and poor health outcomes had led to further challenges.

The proposed changes would see the replacement of three STPs across the North East and Cumbria with a single Integrated Care system which would provide a single leadership, decision making and self-governing assurance framework for the area. Joint financial management arrangements would be established with an aspiration to devolve control of key financial and staffing resources. The ICS would set the overarching clinical strategy, standards, pathways and workstreams to reduce variation across services and would also hold Integrated Care Partnerships to account for the delivery of NHS England's Five Year Forward View outcomes.

4 Integrated Care Partnerships (ICPs) would sit underneath the ICS and will be commissioned to deliver integrated primary, community and acute care in accordance with the agreed ICS strategy as well as ensuring that a critical mass of service workload would sustain vulnerable acute services within their geography.

Mr Foster stated that the clear goal was to keep NHS finance and jobs in the North East in the face of existing staffing challenges. He referenced the recently announced commitment nationally to recruit 5000 additional GPs and the importance of being able to recruit and retain staff from abroad in the face of current visa restrictions and the impact of Brexit.

In discussing the 4 Integrated Care Partnerships across the North East and Cumbria, members noted that there would be a Joint CCG Committee covering the whole of the ICS and a CCG Committee in Common for each of the ICPs. At this point in time, it was reported that the exact footprint for each of the ICPs was not yet known.

Mr Foster stated that sitting below the ICPs would be placed based commissioning arrangements including health and social care integration at a locality level which would involve CCG and Local Authority joint working and commissioning.

Members were informed that the options for service planning and delivery that had been considered thus far included:-

<u>ICS – Across Cumbria and the North East</u>

Strategic Commissioning

- Population Health Management
- Commissioning of specialised acute services
- 111 and Ambulance Services
- Shared policies, service standards and pathway redesign

System Wide Co-ordination

- Transformation programmes
- Urgent and Emergency Care
- Joint Financial Planning
- Strategic Communications and key public health messages
- ICT, Data Management and Digital Care
- Workforce planning including recruitment and harmonised training

<u>ICP – Sub Regional Arrangements</u>

- Commissioning, contracting and performance management of acute hospital services
- Acute services reconfiguration, improvement and clinical networks

<u>Place based Integration – At CCG Local Authority level</u>

- Public & political engagement and consultation
    - Health and Wellbeing Boards
    - Overview and Scrutiny committees
    - GP representative bodies
- Relationships with local public and third sector
- Commissioning of
    - GP services
    - Community Services
    - Health and Social Care integration
    - Local pharmacy services
- Local workforce development

- Safeguarding children and adults

In considering the associated governance process, members sought assurances that Overview and Scrutiny arrangements across the ICS/ICP structures were robust and appropriate. Mr Foster indicated that any proposals for service change under the new structure would be subject to statutory scrutiny arrangements as required under the Health and Social Care Act 2012.

The Committee then considered the headline clinical strategy produced by NHS England. He indicated that this was driven by extensive clinical engagement and informed by insights from population health management. It proposed a shift of emphasis of care to prevention and early intervention in the community. Key strands within the strategy included:-

- Collaboration and networking of acute services around four centres of population;
- Service consolidation and organisational change only where necessary;
- CNE-wide solutions for Pathology and Radiology;
- Building on CNE-wide coordination arrangements: UEC Vanguard & Cancer Alliance;
- Developing new models of primary care to meet the needs of an ageing population;
- Industrialising our approach to prevention focused on screening for atrial fibrillation and osteoporosis;
- Delivery of an ambitious 'No Health without Mental Health' programme

Members then considered those acute hospital services across Cumbria and the North East which are considered to be "vulnerable". These included specialised services (Neonatology; Vascular; Breast symptomatic and screening; Hyper acute stroke; Interventional radiology and Neurosciences); core services (General Radiology; Pathology; Obstetrics; Emergency, general and paediatric surgery; Emergency Departments and Acute Gastroenterology and planned endoscopy) and more localised service pressures (Ophthalmology; Rheumatology; Dermatology; Clinical Haematology; Urology and Anaesthetics).

Reference was made to the discussion earlier in the meeting regarding the pressures facing County Durham and Darlington FT; North Tees and Hartlepool NHS FT and South Tees Hospitals NHS FT in respect of their ability to deliver 24/7 acute services across multiple hospital sites and the development of a 3 acute hospital site model in the DDTHRW footprint which was formerly part of the Better Health Programme and had been discussed at the Committee's meeting in January. Mr Foster suggested that the ability to deliver such an option was dependent upon a commitment to networking of clinicians across the three trusts and that to date no concensus across the Trusts had been reached on how this might be achieved.

Concern was also expressed regarding the potential impact of any proposed changes to acute services at the Friarage hospital, Northallerton. This was being compounded by the absence of any firm service proposals for Darlington Memorial Hospital. Janet Probert, indicated that whilst options for service improvements at the Friarage were being developed, there were some obvious

areas of interdependency between the Friarage and Darlington Memorial Hospitals which at the moment cannot be progressed. Mary Bewley suggested that CCG Accountable officers needed to liaise with one another across the footprint to ensure that information can be brought back to members on what is being developed.

During the discussion which followed Councillors expressed further concern at the apparent lack of progress in respect of the development of the 3 acute hospital site model discussed in January and also the press article published by the Northern Echo which had suggested that previously reported plans to set up 2 specialist emergency hospitals within the STP footprint had been dropped. Members suggested that the Committee was no further forward in this respect. Mr Foster again reiterated that there had been no concensus reached by clinicians across the three FTs on the development on the model which explained the lack of progress. Janet Probert also stressed that the issue was not only about an individual set of specialty services being discussed but also the inter-dependencies between them that was proving difficult to resolve.

In response to Councillor Hall, Mr Foster stated that the impact of the delay in developing the 3 centre model on the existing STP workstreams varied from one to another. For example such a delay would not compromise the ongoing work of the digitisation workstream but would have an enormous impact on the transport workstream. He assured members that Hospitals would not close but suggested that they may be used differently in the future.

Stewart Findlay, Chief Clinical Officer, DDES CCG reiterated that commissioners were frustrated that a position where an acceptable acute services model for consultation had not yet been reached and expressed further concerns at the potential impact of such a delay on the future viability of existing services across the DDTHRW footprint. He also stressed that less than 10% of NHS activity occurs in acute hospitals.

Councillor Bell referenced ongoing concerns that have been expressed regarding the availability of key staff to deliver acute services and the finance required for this. He asked if an increase in funding would alleviate the problem and was advised that his was not the case. Cllr Clark also referred to the recently announced Health Care professional “fast track” programme by the Secretary of State for Health and Social Care and asked if the STP programme was included in this initiative. Mr Foster indicated that he was unsure of the progress of this initiative.

The Committee considered the options available to seek progress on the issues discussed, not least the 3 acute hospital site model, and it was suggested that the Chairman write to the Chief Executives of County Durham and Darlington FT; North Tees and Hartlepool NHS FT and South Tees Hospitals NHS FT asking them to attend a future meeting of the Committee to discuss this issue further and seek clarity on the progress being made in this respect.

Agreed that the report and presentation be noted and the Chairman of the DDTHRW Joint OSC write to the Chief Executives of County Durham and Darlington FT; North Tees and Hartlepool NHS FT and South Tees Hospitals

NHS FT asking them to attend a future meeting of the Committee to discuss this issue further and seek clarity on the progress being made in this respect.

7. Chairman's Urgent Items

None.

8. Any other business

None

9. Date and Time of next meeting

To be confirmed

The meeting ended at 3.45 pm.

This page is intentionally left blank

NARRATIVE AND COMMUNICATIONS PACK FOR NHS ORGANISATIONS IN NORTH CUMBRIA AND THE NORTH EAST

Integrating and optimising healthcare services to meet local need and maximise stability

Content

Members of the communications and engagement work stream (which includes health provider, CCG and NHS England representatives) for our aspiring ICS have developed the attached pack to support a collaborative and consistent dialogue regarding our emerging picture across North Cumbria and the North East.

A case for change

Since its creation in 1948, the NHS has evolved and adapted to meet changing needs and expectations.

Patients now have access to a wider range of treatment, using new technology, techniques and medicines, and provided by a changing workforce who have new skills and expertise. Positive outcomes have increased, with more people living longer and healthier lives, often as a result of tailored support for long-term conditions and more successful treatment for serious illness or injury.

The nature of how and where care is provided - whether that's in hospitals, community clinics, GP surgeries or at home - continues to change. For example,

many operations and treatments that would previously have needed long recovery in bed are now routine, done in a day, and carried out in local hospitals, or even clinics and GP surgeries.

Spending less time in hospital is better for patients' recovery and we know most people prefer to be cared for at home if possible. New technologies and ways of working allow this to happen more easily, which also means a greater need for social care and community health services to be coordinated, and new approaches to prevention and wellbeing, patient centred care and integration of health services across settings.

The NHS needs to continue evolving because everyone deserves access to high quality treatment and care, provided by experienced teams. Sometimes this will be in the home or community settings and sometimes in hospital. For some conditions and illnesses this will be close to where patients live and sometimes it will be in 'centres of excellence', with a larger catchment area.

In many situations, particularly emergencies such as stroke and heart attack, treatment in the right place from an experienced specialist team can mean the difference between death or life long disability and getting a good outcome and resuming a normal life.

The wider context

As well as the changes above, a number of national and local priorities are influencing how, when and where health care is provided, particularly in relation to services becoming more integrated and coordinated.

It is inevitable that some care will need to be provided in a different way, to ensure the best clinical standards are met, that services are fit for future purpose, safe and sustainable.

The NHS is complex and patients can experience a number of different organisations, processes and systems during their journey.

The majority of people – around 80 per cent - receive most care via their local GP surgery. GP practices are increasingly offering longer opening hours and more appointment slots, and a wider range of treatment can be provided at local surgeries or into patients' homes. Over the last few years, the range and availability of care provided in the community has increased and this is linked with changes to how services are provided in hospital too.

The range of care in hospitals depends on how services have grown over the years and the expertise and experience of staff working there. Medical advances, technology, the needs of local populations and staff skills, combined with national and local priorities, are shaping how services need to be planned and delivered in the future.

In future, more care currently provided in hospital could move to the community but still be delivered and funded by health, and some hospital services may need to be organised in a different way to meet the best clinical standards and changing expertise of NHS staff.

Wherever services are provided, the priority will always be to improve quality and outcomes for patients and make best use of staff skills and expertise.

Digital health approaches, through programmes such as the Great North Care Records (GNCR), is developing systems to enable patient records to be shared with appropriate health and care providers, with appropriate controls and consent. In addition, where possible, this will provide patients and citizens with secure access to their own health care records electronically, to enable then to participate and contribute to their own health and care management.

How we're working together

Senior leaders and doctors from NHS organisations across Cumbria and the north east are working together regionally and locally to:

- Plan and develop services to meet the needs of local populations from North Yorkshire to the Scottish Borders now and in the future – taking into account how services are currently provided and where they need to change or develop. In particular, where new models of care might need to be introduced to integrate what is provided and ensure patients are seen in the right place, by the right person to meet their needs.
- Use information held by each organisation to ensure planning and development of services is based on patient and population need and available skills and resources.
- Consider how the current and predicted NHS workforce affects the provision of services.
- Look at services such as tests, scans, x-rays and other diagnostics, and how they could be provided in a more accessible and efficient way.

Initial thinking and priorities for this were outlined in sustainability and transformation plans published in the autumn of 2016. The partnership working that has evolved since then is focused on bringing about change in a number of areas. The rationale and context for making the changes is not dependent on organisational form however, a number of developments are taking place to ensure organisations are best aligned to support the changes, which are often needed across organisational boundaries.

Our partnership working involves a focus on number of areas of work (workstreams), all of which have interdependencies that we need to understand. These include:

Main themes

- Acute care including specialised and core services which are vulnerable due to staffing shortages, e.g. Pathology; Paediatrics; Radiology etc.
- Care closer to your home/ Primary Care

Pathways

- Urgent and emergency care
- Cancer
- Mental health
- Digital
- Learning disabilities
- Prevention
- Continuing healthcare

Supporting workstreams

- Workforce – staff engagement is key to this
- Communications and engagement
- System development / knowledge sharing
- Demand management
- Estates
- Transport

A cross-cutting work stream newsletter is planned for stakeholders and NHS organisations to keep all partners updated on developments.

Integrated care system and partnerships

There has been a lot of discussion about how NHS organisations can work together to deliver required change.

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.

As a result we have been thinking about how we could deliver the positive changes we need for our patients, and how planning for those changes would benefit from taking place across the whole North Cumbria and North East footprint, working for people from North Yorkshire to the Scottish Borders.

Integrated care means working together, focused on the same outcomes for patients, and often involves NHS organisations, councils and the voluntary or charity

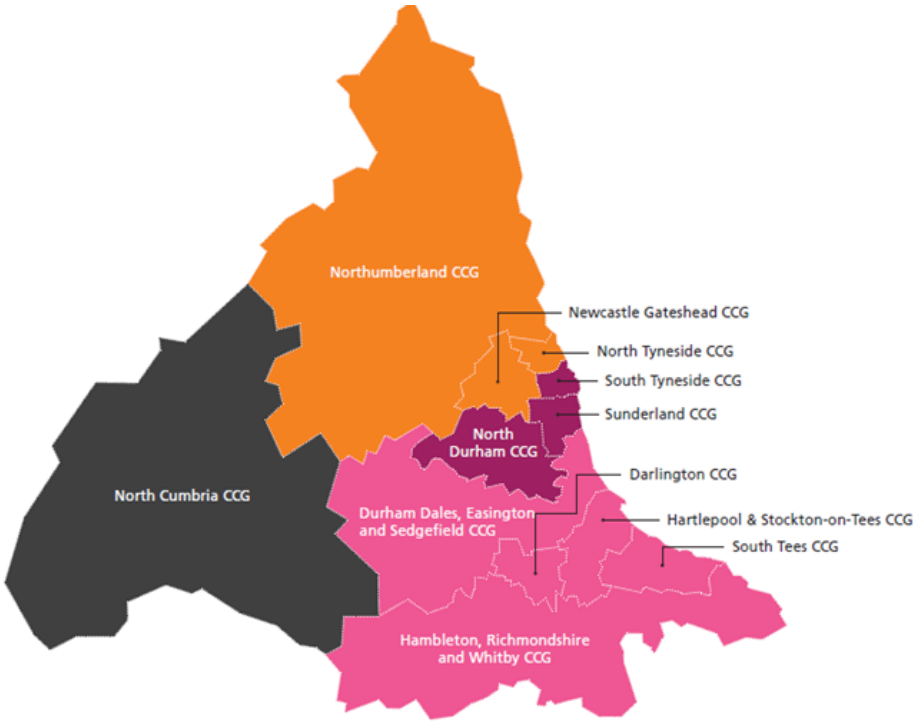
sector, in particular when providing care closer to home and tackling the causes of ill health.

- **Integrated care systems (ICSs)** are evolving and will lead and plan care for their specific population and provide coordinated leadership across NHS organisations. This involves where appropriate taking a 'do once' approach to joint priorities and pieces of work that are common to all organisations in the area.

- **Integrated care partnerships (ICPs)** are alliances of providers and commissioners who are collaborating to deliver care. In North Cumbria and the North East, the proposal is for four ICPs to be in place, to run alongside a Cumbria and North East ICS, which will take responsibility for overall coordination in the whole geographical area, by April 2019. Health providers include hospitals, community services, mental health services, GPs, and independent and third sector providers. The ICPs will focus initially on bringing together enough critical mass to sustain vulnerable acute services within their geography, and the commissioning of non-specialist acute care. CCGs within these ICP geographies will continue to develop place-based arrangements for the planning and provision of primary and community care and health and social care integration, aligned to the overall ICS strategy.

We aim to build strong collaborative relationships with patient groups, local HealthWatch and VCSE organisations operating across the region, including organisations and groups working with some of the most excluded and hard to reach communities.

Proposals for North Cumbria and the North East



North Cumbria ICP – proposed footprint

- Population 327k
- North Cumbria CCG
- North Cumbria University Hospitals Trust
- Cumbria Partnership NHS Foundation Trust
- Cumbria County Council

'North' ICP – proposed footprint

- Population 1.025 million
- 3 CCGs: Northumberland; North Tyneside; Newcastle Gateshead
- 3 Foundation Trusts: Northumbria, Newcastle, Gateshead
- 4 Councils: Northumberland, North Tyneside, Newcastle, Gateshead

'Central' ICP – proposed footprint

- Population 675k
- 4 CCGs: South Tyneside; Sunderland; North Durham; Durham Dales Easington and Sedgefield
- 3 Foundation Trusts: Sunderland-South Tyneside, CDDFT
- 3 Councils: South Tyneside, Sunderland, County Durham

'South' ICP – proposed footprint

- Population 1.1 million
- 6 CCGs: Durham Dales Easington and Sedgefield; North Durham; Hartlepool and Stockton; Darlington; South Tees; Hambleton, Richmondshire and Whitby
- 3 Foundation Trusts: North Tees, South Tees, CDDFT
- 7 Councils: County Durham, Darlington Hartlepool, Stockton, Middlesbrough, Redcar & Cleveland, North Yorkshire

We envisage the two mental health trusts, working in ongoing collaboration with eachother, the North East Ambulance Service NHS Foundation Trust (FT) and neighbouring foundation trusts (such as the Yorkshire Ambulance Service NHS FT and North West Ambulance Service NHS FT) will continue to play into ICPs at the appropriate level, given their size and geographies.

The status of integrated care systems

ICSs are not statutory bodies or organisations. Although they need clear leadership, decision-making and governance structures, they are essentially about individual organisations joining together to improve health and care. ICSs are expected to:

- Have a formal agreement with NHS England and NHS Improvement to implement faster improvements in care, to agreed shared targets.
- Manage resources for a defined population by taking shared responsibility, including a joint agreement and approach to finances.
- Have effective collective decision-making and governance structures aligned with the statutory accountabilities of each constituent organisation.
- Show how providers will collaborate across boundaries, for example doctors and nurses from different organisations working as a clinical network ‘horizontally’ across hospital sites but also integrating ‘vertically’ with GP and community services.
- Use data and evidence to improve the prevention of ill health, manage avoidable demand and reduce variation.
- Ensure people have the information they need to make an informed choice about where they are treated.

Within an integrated care system, constituent organisations will have:

- Delegated decision making for commissioning primary care and primary care, community services and acute care.
- A streamlined relationship with NHS England and NHS Improvement and the opportunity to access resources, including relevant staff and funding from the two organisations in support of ICS work.

To achieve integrated care system status, organisations must demonstrate the following:

Criteria	Key measures
Effective leadership and relationships, capacity and capability	• Strong leadership, with mature relationships including local government. • Clear shared vision and credible strategy. • Effective collective decision-making. • Effective ways of involving clinicians and staff, service users/public and community partners. • Ability and capability to carry out decisions that are made.
Track record of delivery	• Tangible progress towards delivering the *Five Year Forward View* priorities (redesigned urgent and emergency care services, better access to primary care, improved mental health and cancer services). • Progress in improving performance (relative to rest of country) against NHS Constitution standards (or sustaining performance where those standards are being met).
Strong financial management	• Strong financial management, with a collective commitment from CCGs and trusts to system planning and shared financial risk management, supported by system control total and system operating plan.
Focused on care redesign	• Compelling plans to integrate primary care, mental health, social care and hospital services, and collaborate horizontally (between hospitals). • Starting to use population health approaches to redesign care around people at risk of becoming acutely unwell. • Starting to develop primary care networks.
Coherent and defined population	• A meaningful geographic footprint that respects patient flows. • Contiguous with local authority boundaries, or – where not practicable – clear arrangements for working across local authority boundaries.

Hospital services in North Cumbria and the North East – priorities for change

Since Autumn 2017, around 70 senior clinical staff, doctors and nurses from across North Cumbria and the North East have been discussing how to work together to provide the best possible services for patients.

Discussions have confirmed pressures relating to the sustainable delivery of some services, particularly due to challenges around workforce, quality and optimum levels

of safety. They have highlighted that some services need to be provided in a different way to ensure they meet the best possible clinical quality standards.

Safe and high quality services need to be provided by the correct medical professional, with access to the best diagnostics and treatment to give patients the strongest possible chance of recovery. The discussions have shown that some services don't currently operate like this, meaning not all patients are provided with the best possible chance of recovery.

Often, these services are the ones facing the most severe workforce and quality challenges, driven predominantly by a shortage of medical staff. This situation results in risks to service provision and quality, and additional financial pressures. It is likely that a failure to bring improvement to such 'vulnerable' services could lead to emergency suspension or closure, putting patient safety at risk, i.e. increasing the possibility of harm or a life-long health condition or disability.

The most vulnerable hospital services across North Cumbria and the North East have now been agreed, including the underlying reasons for changes that need to take place. This clinically-led list identifies priorities to provide more patients with access to high quality and safe services in the most appropriate place. By definition, this will not always be local to all patients.

The need for change to these services does not pre-determine decisions on potential future structure and location of services. The priorities for change have been discussed by boards and governing bodies of hospital trusts and clinical commissioning groups. With the ongoing input of the wider group of senior doctors, the urgent steps to improve the safety and sustainability of these vulnerable services will be defined over the coming months and link with the development of the integrated care partnerships and system outlined above.

The responsibility to engage with staff, stakeholders, patients and the public – as well as to formally consult on future service arrangements – remains essential. Engagement with local authorities, Health and Wellbeing Boards and key stakeholders will take place during 2018 and beyond, led by clinical commissioning groups.

A collaborative communications approach

There is a need for a coordinated system-wide approach to communications, engagement and, where necessary, consultation activity to create a wider understanding and support for the system and service change outlined above.

Organisations in Cumbria and the north east (CNE) are asked to sign up to the joint communications approach and narrative in this document to help create a better understanding amongst patients, staff and other stakeholders about what is happening.

This will be the basis of a communications and engagement strategy which we are now developing to deliver the objectives below.

Collaborative leadership communications objectives

- Keep public confidence in the system through a co-ordinated approach.
- Manage a safe and robust process for all system change.
- Ensure the voice of patients and our communities is heard at all levels of the system and at every step of change and improvement.
- Ensure consistent language and terminology supports a wider understanding of the rationale and evidence for change - a key principle of this strategy will be the use of transparent language with the public and stakeholders, avoiding technical terms, jargon and acronyms where at all possible.
- Provide a leadership role in delivering joint communications strategies and activities, i.e. using agreed key messages and resources to support internal and external communications and engagement, with coordinated and consistent timings (where possible) including: staff briefings, stakeholder briefings/letters, board/governing body papers, media statements.
- Commit organisational resource to a joint communications approach.
- Endorse and support the delivery of communications work through the NCNE communications network and regional communications and engagement workstream, including resources as required.

CNE-wide or ‘do once’ communications, engagement and, where necessary, consultation strategies will be developed by the nominated leads for NHS England, provider organisations and CCGs/NECS, via their strategic communications group meeting. This will happen when joint objectives and business needs are identified.

In terms of delivering this activity, the work stream for communications and engagement will consider resource requirements and identify how the work will be delivered. In most cases, delivery will be a shared responsibility between provider organisations and CCGs, in partnership with NHS England. Teams will ensure communications and engagement activities are implemented across system partners and through their ‘owned’ channels, including internal and external.

Regional and national approvals from NHS England and NHS Improvement will still be required for certain elements of communications and engagement work. This will be managed in partnership with the regional communications teams for NHSE and NHSI.

Appendix A - Communications objectives and actions

Objective	Action	Who	When	Status
Agree overarching narrative and clear messages setting out the rationale and evidence for service change	Produce narrative and core messages to form context/rationale for trust, CCG and NHSE internal and external communications materials	NHSE to draft. ICS lead and communications and engagement workstream SRO to agree	May 18	Complete
Map key stakeholders and information/engagement needs – including staff, unions/staff representatives, overview and scrutiny committees, elected members, MPs, campaign groups and third sector/partner organisations - and map the methods/channels available in each organisation to reach these groups and individuals.	Stakeholder and influencer mapping exercise to identify priorities. Identify 'owned' and 'earned' communications channels to reach and engage with identified individuals and groups	NECS and providers	Ongoing	
Identify and produce a core set of communications and engagement materials (linked with above stakeholder mapping) to support all organisations with their internal and external communications and engagement activities	Map what's already available and identify gaps. Produce materials and information to use with key individuals and groups (above), including briefing documents, papers, videos, internal communications, digital and other content.	All – work to be allocated and progressed in discussion with communication and engagement work stream SROs	April onwards	

Agree communications and engagement approach, including content and timings, with NCNE leaders.	ICS lead to circulate agreed communications pack and narrative, inviting leaders to use in their communications with key stakeholders.	ICS lead	May 18	
Set a best-practice framework for communications, engagement and formal consultation activities, so organisations across the health system can demonstrably meet statutory requirements and stakeholder needs.	Produce summary overview and checklists to ensure statutory obligations are understood and met. Provide evidence of 'what works' based on previous activities and evaluations.	NECS and provider reps	June 2018	
Work with and through NHS communications network in Cumbria and the north east to deliver the joint communications and engagement requirements of emerging integrated care system.	Establish new terms of reference and reframe NHS communications network and agree a programme of work to deliver the joint communications and engagement requirements and, potentially, integrated care systems across the area.	New ToRs agreed. Development and implementation of work programme ongoing.	March 18 onwards	
Agree a systematic approach to communications and engagement activity about ICS developments across	Agree content and approach for consistent and timely stakeholder	All	Various - ongoing	LA leader and communications lead meetings

CNE health economy.	engagement, including: - briefings and meetings with LA chief executives, directors of social services, directors of public health and key elected members. - staff engagement			taking place or arranged. OSC meetings to be mapped and paper tabled. Staff briefing to be produced.
Agree consistent protocols for: handling joint 'regional' work, including: media enquiries, production of materials and formal briefings e.g. for health overview and scrutiny committees, parliamentary activity, attendance at (J)OSCs etc.	NHSE, CCG and provider representatives to draft and agree protocols and share with communications network.	NHSE and NECS	July 2018	

Communications materials – priorities

Material	**Status**
Generic video animation explaining the case for change.	Two versions available for use and comment
Grid of agreed core messages for use with mapped stakeholders. Narrative above document provides backdrop and context but themed messages by service / work stream are required, i.e. to explain context and proposed service change, as well as a geographical overview of local priorities	NECS to draft by geographical area.
Timetable and core content for 'regional' LA engagement regarding ICP/ICS.	To be agreed with ICS lead and CCG AOs
Timetable and core content for local LA and MP engagement regarding ICP/ICS	To be finalised by trusts and NECS and cross referenced to above.
Programme and content for wider staff engagement regarding ICS progress (not specific engagement regarding service change).	To be finalised by all – June

NB. Individual organisations retain statutory responsibility for engagement and consultation regarding service change involving and affecting their organisation. This joint approach relates to wider communications and engagement about ICS and the rationale and requirement for change.

Appendix B - Key facts

- *Over the course of a year in North Cumbria and the North East, NHS organisations provide 14 million appointments, including 680,000 emergency appointments and 3 million out-patient appointments.*
- *In a 12 month period, over 78 million prescriptions are written across the region.*
- *While the number of patients treated continues to increase, medical advances and a shift towards treatment and care outside of hospital, means the number who have long-term stays in hospital has reduced.*
- *In 1974, about 7% of procedures were carried out as day cases. By 2013 this had increased 35% (an increase from 417,000 to 6.3 million!)*
- *Ten years ago the average time spent in hospital after a hip operation was about nine days, it's now about two and a half days. The average time spent in hospital after a knee operation has also reduced by about six days in the last ten years.*
- *One week of bed rest equates to 10% loss in strength, which can be the difference between dependence and independence, and meaning it is very beneficial to help patients be as mobile as possible and support them to return home.*
- *It costs the NHS approximately £820million a year for older people to stay in hospital beds when, in many cases, they could be successfully cared for at home or in the community.*
- *Patients and their families repeatedly tell us they want to be treated at home or as close to home as possible.*

Appendix C - Animation

We have produced an amination for public / staff facing use which summarises the case for change. There is a shorter version for social media platforms.

https://www.dropbox.com/s/u0zwumw1c2gns0x/NHS%20Journey%20SOCIAL%20EDIT%20CCG.mp4?dl=0

https://www.dropbox.com/s/kv9v8ag8txevre0/NHS%20Journey%20CCG%20social%20edit%20further%20cuts.mp4?dl=0