

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

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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 them 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.

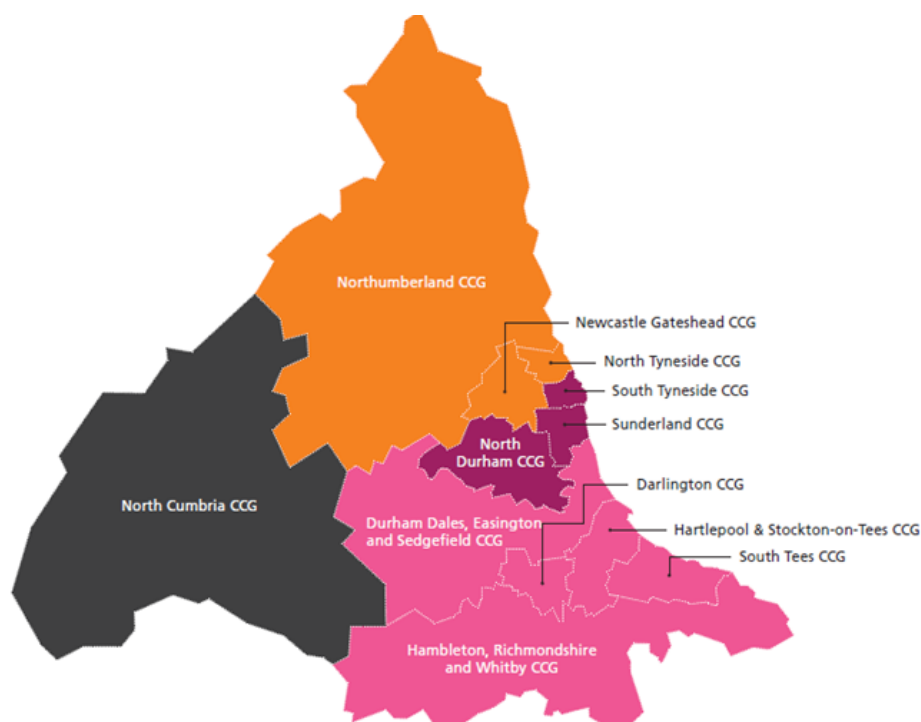
Integrated care means working together, focused on the same outcomes for patients, and often involves NHS organisations, councils and the voluntary or charity

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 Sedgfield
- 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 Sedgfield; 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 each other, 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Tangible progress towards delivering the <i>Five Year Forward View</i> 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 animation 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>