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North Tyneside Council

Health and Wellbeing Board

9 December 2020

Dear Board Member,

With reference the agenda previously circulated for the Health and Wellbeing Board to be held on Thursday, 10 December 2020, in now attach a report in relation to Item 5.

Agenda Item		Page(s)
5.	**Future Care: Place Based Transformation Plan** To receive a joint presentation from the Clinical Commissioning Group and Council on the emerging objectives contained in the Future Care: Place Based Transformation Plan to enable members of the Board to contribute to its preparation and to inform the Board's work in developing its own future work plan and priorities.	3 - 74

North Tyneside
Health & Wellbeing Board Report
Date: 10 December 2020

Title: North Tyneside Place Based Transformation Plan August 2020 – March 2022

Report from :	NHS North Tyneside CCG (on behalf of the system)
Report Author:	Dr Lesley Young-Murphy (Tel: 0191 293 1160)
Relevant Partnership Board:	North Tyneside Place Based Transformation Programme: Future Care

1. Purpose:

In conjunction with the presentation, the purpose of the report is to present members with a final draft of North Tyneside Place Based Transformation Plan August 2020 – March 2022, and to receive member feedback prior to finalising the plan.

2. Recommendation(s):

The Board is recommended to:-

- Receive the plan and provide feedback prior to it being finalised.
- Note the cohesiveness of the plan with the priorities of the health and wellbeing board.
- Agree the program areas for the Future Care Programme Board (FCPB) which is made up of partner organisations working on behalf of the Health & Wellbeing Board and residents.

3. Policy Framework

This item relates to a plethora of policy framework and strategic documents inclusive but not limited to:

- North Tyneside Children & Young People's Plan, including SEND agenda
- Primary Care Network Plans
- NHS Long Term Plan
- Carers Strategy
- VCS "Better Together" Strategy
- Safeguarding Strategy
- Ageing well strategy
- End of Life
- Mental Health

4. Information:

This plan was initially developed to describe North Tyneside's response to future service delivery to the period March 2022, recognising the impact the COVID-19 pandemic has had, and continues to have on the needs of our population. The initial response, together with the current work programme of the FCPB was developed further to reflect the health and social care aspirations across the borough for the next 2 – 5 years. The plan and the subsequent work plan has now become the North Tyneside Place Based Transformation Programme: Future Care work plan.

The Future care Programme Board will monitor and assure its delivery as well as report on outcome measures to the Health & wellbeing Board.

5. Decision options:

Not applicable**,** no decisions to be made

6. Reasons for recommended option:

Not applicable

7. Appendices:

North Tyneside Place Based Transformation Plan August 2020 – March 2022

8. Contact officers:

- *Anya Paradis, Director of Commissioning and Contracting, NHS North Tyneside CCG, 0191 2931157*
- *Gary Charlton, Deputy Director Commissioning and Corporate Development, North Tyneside CCG, 0191 2931160*
- *Scott Woodhouse Strategic Commissioning Manager Adults, North Tyneside Local Authority, 0191 643 7082*

North Tyneside Place Based Transformation Plan

August 2020 – March 2022

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INTRODUCTION

This plan has been developed to describe North Tyneside's response to future service delivery to the period March 2022, recognising the impact that the COVID-19 pandemic has had, and continues to have on the needs of our population.

It is important to say, at this point, that our thoughts are with all of our residents, especially those who have lost loved ones to the virus.

We would also like to say a special thank you to all of the care givers and our NHS staff who are working to provide care during these difficult times. Our best wishes and appreciation also go to all key workers who are working tirelessly to ensure that the essential needs of our residents and patients are met during this pandemic.

There are a number of influences on how services will or can be provided in the future, some national and some local, particularly because of the covid-19 pandemic. While there are certainly challenges to be faced and overcome, there is also an opportunity to realise and embed some positive changes that in response to the pandemic. Where applicable, we have described these positive benefits in this plan as well as outline other developments we wish to make as a system.

1.2 National Context

As all partners will be more than aware, the COVID-19 pandemic halted the normal ways of working in health and social care while staff and services have responded to the needs of the population during the pandemic.

When the covid-19 pandemic started having a significant impact, a number of changes to existing practice had to be made such as temporarily stopping most routine surgery and outpatient appointments, redeployment of staff and use of PPE.

Part of this work has been to suspend normal contracting processes between CCGs and health providers with the national team taking over those responsibilities for the financial year 2020/21. Contracts were issued on a block contract basis with, for part of the year, an additional top up for COVID-19 related expenses and activity.

Further guidance was issued Central Government on 31 July 2020 to explain how health services are expected to operate, commission and contract for the remainder of 2020/21. There are 3 priorities stated in the letter:

- Accelerating the return to near normal levels of non-Covid health services, making full use of the capacity available in the "window of opportunity" between the date of issue of the letter and winter
- Preparation for winter demand pressures, alongside continuing a vigilance in the light of further probably covid spikes locally and possibly nationally

- Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action in inequalities and prevention."

It remains the national ambition to continue to set back up those services which had been halted during the first wave of the pandemic, taking into account infection control and safety restrictions. A considerable amount of work has been ongoing to achieve this during the past few months since the national guidance was issued in July to ensure providers do meet the new national activity target, ensuring good outcomes for patients while doing so in a safe way.

1.3. Regional Context

Integrated Care Systems (ICS) were established nationally, creating partnerships across systems including local council and other organisations which have collective responsibility for managing resources, meeting NHS standards and improving the health of the population they service. It is thought that local systems would have better understanding of the needs of their population and, through collaboration, be able to tailor more services to meet needs aiming to help people to live healthier lives for longer and stay out of hospital when they do not need to be there.

North Tyneside is part of the North East & North Cumbria ICS. Due to the considerable size of the ICS, Integrated Care Partnerships (ICP) have been arranged which consist of Trusts, CCGs and Local Authorities working together within a smaller geographical patch. North Tyneside is part of the North ICP which also includes Newcastle Gateshead CCG area and Northumberland CCG area.

Improving health, wealth and wellbeing are key areas of focus across all organisations within the North ICP footprint. Tackling inequalities and unwarranted variation are common themes building up from local Health and Wellbeing / Wellbeing for Life Strategies.

Given the relative strength of the North ICP, Local Authority and NHS Chief Officers have focussed joint work across the ICP on three priority areas.

1. Climate Change & Sustainability

All of the four Local Authorities in the ICP have declared a climate change emergency as has Newcastle upon Tyne Hospitals NHS Foundation Trust. Consequently, we have committed to work together to consider in the first instance:

- What is our shared understanding of climate change and sustainability and how can we share and learn from best practice
- Subsequently, how can we influence the behaviour of our staff and communities to deliver positive climate change and sustainability action
- Given the purchasing power of our respective organisations how can we consider further and grow local supply chain to add Social Value

Poor air quality is the largest environmental risk to public health, as long-term exposure to air pollution can cause chronic conditions such as cardiovascular and respiratory diseases as well as lung cancer, leading to reduced life expectancy.

Therefore, we need to consider our collective response and actions in reducing the risk factors which contribute to poor air quality and will work together with our local authorities to share and learn from best practice.

2. Prevention

We recognise that prevention is better than cure, and that the NHS has a responsibility, alongside Local Authorities and others, as a major stakeholder at "place" level in tackling the wider determinants of health such as social, economic and environmental factors.

In discussion with the North ICP Directors of Public Health, it is their intention to consider the following areas and develop an action plan which allows us to go further and faster in relation to tobacco and alcohol and the plans in place at an ICS level:

- the challenges faced by high levels of deprivation.
- an ageing population and the demands placed on health and social care as a result of this.
- how we can collectively address health inequalities – access to services and unwarranted variation
- wider determinants of health (living wage for example)

Where there are beacons of good practice (for example, work on smoking in pregnancy in maternity services or on alcohol licensing), we will ensure that this is shared and implemented systematically across the ICP.

Action on prevention including tobacco, alcohol, obesity and the wider determinants of health underpins achievement of all elements of our clinical strategy.

3. Workforce, Employment & Skills

As detailed in the workforce section above, in the North ICP we can help to create and generate greater Social Value. Collectively, we recognise that good employment is, of itself, preventative, and by supporting our LAs employment and skills work, tackle deprivation and support specific parts of the population. Using our leverage as employers, we are able to collaborate together for better health.

Therefore, by addressing issues related to workforce, employment and skills, noting our collective position as one of the largest employers in the area we will consider:

- How we can work together to create more and better jobs contributing as 'businesses' in the area
- How we can ensure fair and equitable employment from targeted demographic groups e.g. looked after children, learning disability etc.
- How we can work together with a commitment to Good Work

The ICS was required to develop plans to demonstrate how they it will achieve the national ambitions and priorites with plans to NHS England/Improvement by 21 September 2020. As an ICP, we developed plans to inform the ICS plan. Our ICP plans are based on our local Place Based Plans, including this Plan, to ensure that plans at all levels are being informed from the grassroots upwards.

1.4 Local Context

In North Tyneside, the Future Care Programme Board, North Tyneside's transformation change Board, received a series of presentations at its meeting in May 2020 outlining, by provider, changes that had to be made to manage the pandemic. In relation to stepping services back up again, we are conscious that some service needs to be maintained as they were pre-covid while others need to evolve to manage the current situation as well as plan for the future.

Local providers are continually reviewing their processes and ways of working, on an almost daily basis, to try to increase activity or change practices where appropriate despite the various constraints that providers are facing. This is helping to provide further clarity on what else needs to change and where further work is needed as well as identify and implement alternative methods of providing services for the benefits of patients and staff.. Providers offering services to North Tyneside patients and residents are also conscious of performance targets as well as activity targets, recognising that while there is a regional and national focus on activity, good performance is very important and the national focus is likely to return to performance at some point in the near future.

There are limitations in returning to pre-COVID-19 services some of which are as a result of various challenges such as social distancing, patient transport imitations etc. However, this has provided the health and social care system with an opportunity to reconsider how some provision was accessed or provided and for new systems to be put in place.

The CCG and Trusts, both acute and mental health, are also working together to put in place new pathways and systems, or agreeing changes to existing systems, to ensure safe ways of working are put in place and patients can continue to access services appropriate to their needs.

Additionally, North Tyneside CCG (NTCCG) and the LA have entered into a COVID-19 s75 agreement to reflect the current contracting and funding arrangements for social care provision, specifically in relation to services for people being discharged from hospital. Again, this ensures that people who need social care following a period in hospital have access to services which meet their needs.

FUTURE CARE

During 2019, the CCG and its partners co-produced a vision for the future of health and care services in North Tyneside, which is called Future Care. It is a person-centred patient delivery model which builds on existing services and developmental work, to deliver person-centred sustainable care closer to home for the GP-registered population of North Tyneside (with hospital by exception). The delivery model lends itself to a model of integrated, place-based commissioning that is consistent with the goals set out in the NHS Long Term Plan. The Future Care programme is still developing in North Tyneside and we are continuing our programme of work with partners during 2020/21.

We describe Future Care as North Tyneside's transformation programme which aims to:

- Deliver population health and wellbeing
- Deliver high quality, coordinated care
- Improve quality of life and experience of services
- Support and empower staff
- Provide effective stewardship of resources

The vision is to deliver a patient-centered sustainable health and social care system with a focus on:

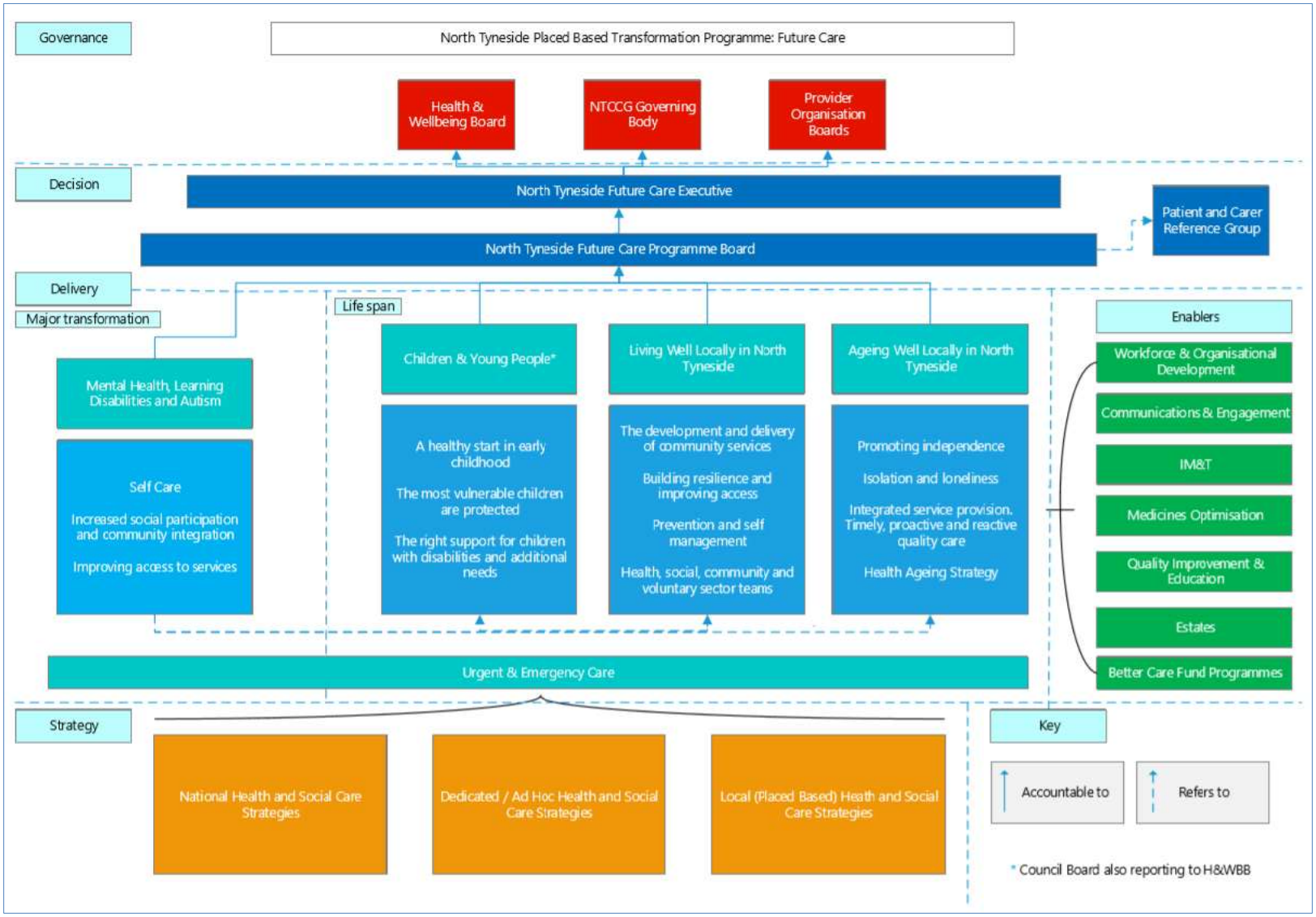
- Self-care and preventing ill health
- Resilient communities and families
- People living longer and with better quality of life
- People staying as independent and as well as they can for as long as possible
- Those at the end of life to have support and care to enable them to live in the best way they can, taking into account their wishes, beliefs and values
- People dying with dignity in their chosen place of death
- A more resilient, responsive and financially stable health and social care system.
- High quality, fully integrated services
- High levels of people and staff satisfaction with services
- Evidence based practice and care models
- Reduced reliance on acute services
- Reduction in bed based care
- Right Care, Right Place and Right Time
- North Tyneside system is seen as a preferred place to work with high levels of wellbeing, satisfaction, recruitment and retention

The North Tyneside Future Care Executive oversees the direction, development and delivery of Future Care in North Tyneside. However, it is evident that there are a number of health system changes in play which may provide an opportunity to formalise the development of place-based commissioning in North Tyneside. The Future Care Executive (extended as required) oversees the emergent place-based commissioning system in line with the NHS Long Term Plan.

The Future Care Executive:

- provides oversight of the delivery of Future Care Programmes
- receives reports from the Future Care Programme Board and monitor progress in implementing key milestones
- acts as a strategic system enabler
- influences the development of sustainable system delivery model in the form of the ICP

This Place Based Plan is the North Tyneside Future Care System Transformation Plan. Overleaf is a schematic which depicts the Transformation Plan.


Governance
North Tyneside Placed Based Transformation Programme: Future Care
Health & Wellbeing Board
NTCCG Governing Body
Provider Organisation Boards
Decision
North Tyneside Future Care Executive
Patient and Carer Reference Group
North Tyneside Future Care Programme Board
Delivery
Major transformation
Life span
Enablers
Mental Health, Learning Disabilities and Autism
Children & Young People*
Living Well Locally in North Tyneside
Ageing Well Locally in North Tyneside
Workforce & Organisational Development
Communications & Engagement
IM&T
Medicines Optimisation
Quality Improvement & Education
Estates
Better Care Fund Programmes
Self Care
Increased social participation and community integration
Improving access to services
A healthy start in early childhood
The most vulnerable children are protected
The right support for children with disabilities and additional needs
The development and delivery of community services
Building resilience and improving access
Prevention and self management
Health, social, community and voluntary sector teams
Promoting independence
Isolation and loneliness
Integrated service provision. Timely, proactive and reactive quality care
Health Ageing Strategy
Urgent & Emergency Care
Strategy
National Health and Social Care Strategies
Dedicated / Ad Hoc Health and Social Care Strategies
Local (Placed Based) Heath and Social Care Strategies
Key
Accountable to
Refers to
* Council Board also reporting to H&WBB

CROSS CUTTING THEMES

During discussions at the Future Care Board meeting, several themes have been identified where it is thought that joint working across the system would prove particularly beneficial.

Covid -19 Pandemic Management & Impact

It cannot be understated how much impact the covid-19 pandemic has had on all levels of people's lives. Specifically in relation to health and care sector, hospitals, social care services, care homes and all sectors of provision have all been affected and have had to find different ways and systems to offer services safely whilst still meeting people's health and social care needs.

As a system, all partners have pulled together to respond to meet the pressures of the pandemic. Examples include how across the North-East of England, patients could still be referred for urgent care needs and cancer referrals continued during the first wave of the pandemic. Elective care was put on hold but processes were put in place between primary and secondary care, through Advice & Guidance, to provide support for patients. GPs offered alternative and innovative ways to see patients. Local Authorities and CCG work hand in hand to offer appropriate care and support for people leaving hospital. The role of the community and voluntary sector was, and continues to be, invaluable to support individuals and families in the community.

Much of this work is continuing and lessons learned from the first wave of the pandemic are now being embedded as good practice going forward. However, this has not been without significant challenges which are still being felt across the system such as health services trying to reach pre-covid activity levels in line with national requirements, whilst still managing the pandemic itself. Rigorous and meticulous attention has to be given to offering services in a covid-safe way applying the infection control methods to prevent spread of the virus.

Specifically in relation to healthcare management of individual people, we are becoming more aware of the longer term impact of the covid-19 virus on people's physical health. Equally, we are aware that the impact of both the virus and the impact of national lockdowns and social restrictions is having a significant impact on people's mental health.

As more about the virus is becoming known, ways to treat and manage people's physical health is evolving. The introduction of pulse oximetry at home is a way for people who are covid-19 positive to self-monitor their oxygen levels at home which could detect hypoxia at an earlier stage and thereby reduce mortality and morbidity. This, like many new initiatives, involves partnership and system working to be effective.

Long term covid rehabilitation services are also being implemented. Clinics are expected to offer physical, cognitive and psychological assessment to provide post-covid services for all who need them and help people manage their post-covid symptoms.

In relation to mental health provision, a considerable amount of modelling has been undertaken at ICP level to gain insight into the potential level of demand for a range of mental health provision. People are reporting being more anxious and depressed, while others are reporting symptoms consistent with post-traumatic stress syndrome. It has been thought that the mental health impact would manifest around early to mid-2021. However, anecdotal information from mental health services in North Tyneside indicates that people are presenting with increased mental health needs, as well as increased acuity of need, as early as August and September 2020 and numbers continue to grow.

Work is currently underway to plan roll out of covid-19 vaccines to ensure that the national expectations are met within the given timeframes.

In relation to this Plan, actions which are being undertaken or processes implemented to continue to manage the covid-19 pandemic are described in each section, where appropriate. However, it is important to stress that partnership working and system working will continue to be key moving forward through the pandemic.

Partnership Working

The NHS Long Term Plan was published in January 2019 and sets out a 10 year programme of expected improvements to NHS services, to be delivered over a 10 year period.

It describes how system plans will be developed, some of which will be on a wider footprint but the majority of which will be in response to local need. The supporting documentation describes how, at an ICS level, systems are expected to bring together member organisations and wider partnerships to develop and adopt "a common set of principles and leadership behaviours as they develop and deliver plans" (p4 NHS Long Term Plan Implementation Framework June 2019).

We have described above how partnership working will continue to be key to managing the covid-19 pandemic. It would therefore seem appropriate to identify and agree principles and behaviours as suggested by the Long Term Plan to Future Care. Future Care requires all of the partners in the health and social care system in North Tyneside to come together to make the identified changes.

The following set of principles for partnership working have therefore been suggested to ensure delivery of the North Tyneside Future Care Programme:

- The Future Care programme will provide a forum in which NHS organisations and their partners can make shared decisions on how to use resources, design services and improve population health (other than for a limited number of decisions that commissioners will need to continue to make independently, e.g.

procurement and contract award)

- A shared set of goals, including on issues such as economic development, environment, housing, health and social care issues, and collective agreement on how those goals should be met
- Share progress on individual and collective work to identify best practice, opportunities, challenges, issues for resolution and provide collective accountability
- Enabling shared planning and use of resources including finance, workforce, estates and IT
- Arrangements will be based on openness and transparency, enabling all stakeholders to make a full contribution
- Effective decision making in the Future Care Board with all members being confident that decisions taken by the Board will be implemented within their respective organisations

Inequalities

As we move forward and learn more from the first wave of the pandemic, we are increasingly conscious of inequalities experienced during and highlighted by the pandemic.

Tackling health inequalities requires actions to be embedded across the system and at all levels. It requires greater collaboration and actions to address underlying root causes. This relies on collaboration with local government and the voluntary, community and social enterprise sector.

Health inequalities need to be tackled and addressed at all levels

As part of the NHS response to Covid, eight domains have been set out intending to systematically tackle health inequalities. At an Integrated Care System (ICS) level, the approach to tackling health inequalities will build on work and priorities in the following key programmes:

- North East & North Yorkshire (NENC) ICS 5year Strategic plan
- NENC ICS workstream priorities and plans
- Recommendations from the Due North: Report of the Inquiry on Health Equity for the North
- Recommendations from the Health and Wealth: Closing the Gap in the North East Report
- Locally the Health and Wellbeing strategies
- Director Public Health (DPH) reports and the Joint Strategic Needs Assessments (JSNAs)

The ICS submission on Inequalities continues to state that Population Health Management approaches will be used which combine medical with social vulnerability to identify and shield people at the greatest risk from direct and indirect impacts of COVID-19. This will include supporting localities and GP practices to implement the national risk stratification tool and integrating this with other health and social care data to segment and risk stratify patients to identify vulnerability.

We will also identify elderly and frail patients who require additional support, those with physical and learning disabilities, and BAME patients from the practice list who might

benefit from specific interventions to reduce their risk of COVID-19 related mortality.

We are already working closely with the Primary Care Networks to use data to look at how we can deliver improvements in health and wellbeing, making the best use of our collective resources. This is enhanced by the links with public health colleagues including those based in foundation trusts, the business intelligence support from NECS and national, regional and local intelligence and feedback.

The ICS is developing an evidence based community engagement framework (building on the family of community centred approaches) that can be applied to a healthcare setting. It intends to build on existing regional and local structures (such as North East Homeless Forum) to understand and respond to the health needs of specific groups. This will support work to gain insight into our communities and understand different types of risk and vulnerabilities.

Work is underway across health services to develop a community engagement framework to identify, understand and provide support for groups of patients with unequal access to services. A protocol to support co-production of patient pathways will be developed. Performance management arrangements across the system are being developed to include monitoring and reporting on inequalities in access, service use outcomes across emergency, outpatient and elective care, including cancer referrals and waiting time activity.

As a result of COVID-19, we have seen a significant rise in the use of virtual patient appointments. This has dramatically reduced the number of people needing to come into our hospitals, reducing the risk of infection of COVID-19 and allowing patients to access a range of services from the comfort of their own home.

We also know that for many patients, their expectations regarding how they interact with services has changed, but many are reporting very positive experiences of digital solutions. We will co-ordinate the evaluations of key programmes to ensure they do not widen health inequalities and that good practice is identified and disseminated. We are aware that Healthwatch North Tyneside is already engaged with gaining patient and public feedback and we will continue to learn from peoples experiences.

In order to identify and act on health inequalities, it is important to have complete data sets with the information on vulnerability and protected characteristics complete and accurately recorded on the systems. All of our NHS organisations will carry out a baseline assessment of the quality and accuracy of their data on patient ethnicity and other protected characteristics and have plans in place to ensure these are recorded for all patients by 31 December 2020.

In North Tyneside, we will continue to improve on uptake of annual health checks for people with learning disabilities and people with serious mental illness, in line with the national ambition.

North Tyneside also already has in place Partnership meetings in two of the most deprived areas of the Borough, led by Public Health, aiming to put in placed localised prevention programmes. We can build upon these to consider existing programmes but also those which may have been exacerbated by the pandemic e.g. domestic violence, substance misuse, self-harm and suicidal behaviour, mental health etc.

PCNs are working with analytical teams and wider system partners, including social care and voluntary sector organisations, to maximise the opportunities and capacity released through the modified QOF requirements for 2020/2. This includes social prescribing and plans to develop priority lists for preventative support and long-term condition management, such as for obesity management and hypertension.

Mental ill-health is a significant contributor to long-term health inequalities, and the immediate and longer-term social and economic impacts of COVID-19 have the potential to contribute to or exacerbate mental health problems. An ambitious plan is being developed, in line with the national programme to transform community mental health provision. More detail will be provided in the Mental Health section of this Plan but, in summary, it will provide an opportunity to pay particular attention to advancing equalities in access, experience and outcomes for groups facing inequalities across different mental health pathways.

We will build on the ambition in the NHS People Plan for ensuring that organisation's workforce reflects at every level the diverse communities we serve.

Involvement & Communication

Providers and commissioners want to listen to our patients and local communities and to hear views about healthcare services so that we can take these into account in our commissioning decisions. We recognise this is underpinned by our legal obligation to offer opportunities to be involved at different stages of the commissioning process. Each organisation will have Communications and Engagement Strategy and will have developed a range of methods to ensure involvement and engagement. However, we would acknowledge that communication continues to be of key importance for patients and the public.

We have a variety of organisations to whom feedback from patient and the public can be provided, such as North Tyneside Healthwatch. Launchpad which is involved in the design, delivery and evaluation of mental health services and works to ensure the voices of service users and survivors are heard by those who make decisions about mental health services in North Tyneside. The 'Working With' group – a council and voluntary sector collaboration which considers health and social care issues – provides opportunities to debate key documents and suggest improvements. These opportunities should be maximized as part of the cross-system communication strategy.

A cross system communication strategy will be developed, incorporating the key messages and help to keep people informed. Throughout this document, overviews of communication needs are described and these can be used to help inform the cross system communication strategy and vice versa.

A key element will be provision of information in accessible formats and offering assistance for those who require communications or other support to enable them to engage. This may include translation into other languages, cover transport costs to engagement events to providing an independent external facilitator to capture their story.

Information can also be shared through a variety of methods such as videos to help share

information with patients and the community in an exciting and accessible way, for example playing videos with key messages in locations such as General Practice waiting rooms, to help reach a wide audience. Encouraging people to get involved through access appropriate sections on websites can be useful.

As we move forward with our programmes of work and projects, involvement, engagement, inclusivity and co-production will be a theme. We will continue to build upon the co-production and involvement work that has taken place to date. We need to continue to listen to patients, service users, the public and involve them in designing, planning and delivering services. Healthwatch North Tyneside, Community Health Care Forum and the CCG's vibrant Patient Forum will all have a role to play in developing these work areas, as will other organisations representing patient and carer views.

Hear My Voice is a new project launched by the CCG to help patients, family members, carers and staff to describe their experience of receiving and delivering health care. The CCG has supported the project by purchasing a license to use SenseMaker, an online survey tool that collects quantitative and qualitative data, combining them to produce uniquely insightful information. The project is one of the ways in which we can strengthen a culture of partnership and collaborative working, by integrating the feedback we receive into shaping and delivering services for the future. Community and voluntary sector groups and patient Forum members have helped to shape, test and pilot Hear My Voice and test the website.

Workforce

The ICS workforce programme board has recently been reconfigured (in August 2020) in line with the national and regional Peoples Planning Board. This has resulted in the development of an ICP Workforce Board which will consist of FT, CCG, LA and PCN as well as system partners. This Board will work with health education England to inform and develop an ICP workforce plan which will underpin future service plans and developments.

We will support the development of the ICS local People Plan and providers and commissioners across the ICP are already reviewing and implementing the immediate actions outlined and incorporating into strategy.

One of the key tenets of our North ICP Plan is to create and generate greater Social Value. Collectively, we recognise that good employment is, of itself, preventative, and by supporting our Local Authority's employment and skills work, tackle deprivation and support specific parts of the population. Using our leverage as employers, we are able to collaborate together for better health.

Therefore, by addressing issues related to workforce, employment and skills, noting that, collectively, our health and social care system is one of the largest employers in the area, we have an opportunity to consider what we can do to influence and support a wider agenda over and above our current joint work in respect of social care and health issues.

- How we can work together to create more and better jobs contributing as 'businesses' in the area
- How we can ensure fair and equitable employment from targeted demographic groups e.g. looked after children, learning disability etc.

- How we can work together with a commitment to Good Work

Building on rapid changes driven by the covid-19 pandemic, workforce redesign is a theme across the ICP and locally in North Tyneside, and the expectation to "lock in" those benefits seen during the pandemic. Going forward, all employers will be reviewing recruitment and promotion approaches to ensure we improve the diversity of our workforce reflective of our local population.

WDES & WRES action plans are in place supported by a dashboard of workforce metrics relating to EDI to monitor and support progress with the widening access requirements of the People Plan.

Collectively commissioners and providers can learn from each other's approaches so that recruitment opportunities are targeted at under-represented groups including BAME and disadvantaged communities and close partnership work with a broad range of key stakeholders and local community partners including Prince's Trust, Project Choice and Job Centre Plus to ensure employment opportunities are accessible to the whole local populations.

Specific recruitment plans :
NuTH
- Expanding the provider's volunteer workforce using the '#IWill' campaign
- Apprenticeship recruitment as an attractive route into employment for a large proportion of job seekers at entry and other levels.

NEAS
- intensified recruitment for clinicians to work with the Emergency Operations Centre is ongoing within a challenging marketplace in a number of shortage occupations i.e. nurses
- recruitment plans have also been developed to support the "Talk Before You Walk" programme.

Northumbria
- completing the employment of additional trust based junior doctors to meet the rota requirements of the restricted weekend working in the 2016 contract,
- recruiting qualified nurses and HCA
- a range of apprenticeships
- approving increasing our numbers of Nurse Practitioners.

CCGs are working to increase the number of clinicians with enhanced clinical skills across a range of providers, including social care. Sixteen additional nurse practitioner posts have been commissioned by North Tyneside CCG to work in Northumbria Healthcare Trust community frailty system. CCGs are also working with social care, nursing homes and HEE to recruit to advanced care practitioners.

Commissioned services support recruitment and retention as they offer retention in line with the clinicians expanding autonomy as identified in Benners Novice to Expert Continuum.

The need for accelerated adaptation to service delivery, including education and training, has proved to be a great 'unblocker' of some of the historical and traditional approaches to delivery of services. One obvious example is the much greater use of available technologies to support meetings and teaching.

A range of new roles have been utilised and will be evaluated for example:

- Aspirant Nurses and FiY1 Doctors gaining significant hands on clinical experience.
- Specialist nurses retrained for deployment in ICU and other key roles
- Technical staff to enable the rapid adoption of Robotic Processing Automation (RPA)to support covid related activity, workforce information including real time data to inform staffing decisions and deployment
- Reorganisation of community nursing teams
- Shift to least specialist level of care for long-term conditions
- Consider Nurse & Junior Doctor led discharge as future pathway
- GP Home Visiting Service in collaboration with Rapid Response
- Remodelling clinical cover to 7-days to support discharge
- Integrated discharge lounges
- Recruitment of nurse practitioners into primary and community services
- New roles in nursing homes with direct employed advanced practitioners

We are working across the system to understand the impact of the PCN DES and the associated new roles with our existing services. The newly formed ICP workforce group will inform system changes in order to maximise the existing workforce, avoid duplication, prevent instability and deliver better patient outcomes for the population.

In order to continue to attract graduates into GP Practice nursing and nursing homes, we are working to maximise placements for undergraduate students in all setting, working with local universities to do this. It is incumbent on us all to increase the number of undergraduate placements in order to realise the ambitions in the Nursing Expansion Manifesto.

There are a number of new initiatives across the system as well as the emerging PCN workforce imperative associated with the DES. At present, the impact of these initiatives on service delivery and flows are yet to be realised and therefore the emerging evidence on workforce needs to be quantified in due course as the schemes develop. Although it is anticipated that a number of schemes, for example, Talk Before You Walk project and Advice & Guidance will have a positive impact on patient flow and acute activity, they may have unintended consequences on activity in primary care. This is being monitored closely by the system and the LMC.

Digital

There are two elements to our digital related work. One is in relation to digital transformation and the other on digital inclusion and access.

North Tyneside benefits from a very strong digital transformation programme. A number of digital initiatives have been developed or are in the process of being developed. This work is gaining region-wide and national recognition. A summary of some of these initiatives is listed below:

- Digitisation of GP records
- Additional GP remote appointments through LIVI Provision of AccuRX in GP Practices to facilitate remote consultations
- Care home technology – RITA (*Reminiscence Interactive Therapy/ Activities)* and *Whzan (*multi-patient Telehealth kits)
- Rolling out NHS.net in care homes

- SMS development and deployment for GP practices (iplato)
- Shared Palliative Care Summary record(SPCSr) training for GP practices
- Black Pear software for GP practices to assist with End of Life Care
- GP Leadership Programme
- Time out sessions being delivered remotely for more than 300 GP Practice participants
- CQI toolkit training and re-modelling
- Deployment of 210 laptops deployed to GP practices to enable remote working
- Implementation of STRATA, a capacity and demand digital system facilitating integrated care
- Lift and shift digital telephone system being deployed for integrated care
- Refurbishment work, and telephony for hot and cold Covid 19 hubs
- Roll out of Total Triage
- N365 Participation Agreement
- Deployment and training of Microsoft Teams
- Implementation of Sensemaker, a Patient story system
- Patient forum digital meetings deployed
- Continuing Healthcare (CHC) IT system being deployed
- Integrated care IT system being deployed
- Tablets deployed to all nursing and care homes
- GNCR HIE Social Care Data Flows for GP practices

We are committed to continually seeking new, innovative digital transformation opportunities, seeking to build on the excellent work that has already started, much of which was also accelerated in response to the covid pandemic. We have systems in place to monitor the efficacy and effectiveness of these systems.

An example of the practical use of digital transformation and its impact on system working relates to the new "Talk Before You Walk" publicity campaign. The campaign advises patients to contact GP or 111 online rather than call 111 before accessing urgent care services.

Also, the implementation of total triage has enabled GP practices to maintain the changes adopted during the COVID pandemic and patients who choose to are routinely able to interact with the practice through online and video consultation. Digital tools are being explored which allow remote monitoring of patients with stable long-term conditions such as asthma, COPD and hypertension. This could avoid unnecessary footfall into practice and preserve the face to face care for those who need it. We will also monitor the impact of health inequalities on digitally enabled mental health and virtual outpatients services.

However, some of these key digital innovations will only be effective if patients also have access to digital technology. In North Tyneside, we are clear that commitment is needed to address digital inclusion which includes:

- access to kit,
- access to data,
- support for people to make use of the kit they have,
- understand the efficacy of delivering patient access digitally
- commitment to review "traditional" methods of access alongside digital ways to access services so that people who cannot use digital do not get left behind.

We are aware that, at ICP level, evaluation is currently underway to gain feedback from

staff and patients about this significant shift to digital pathways of care. This will help improve the way they are delivered in the future and help us understand how people feel virtual appointment systems are working and what further improvements are needed and whether people have encountered any challenges or barriers in accessing virtual consultations. Data collection will include protected characteristics to allow detailed analysis by different population groups, ensure no detrimental impact on health inequalities, and, where appropriate, out mitigating actions in place.

We are aware that some of our most vulnerable communities are living in situations of very low income, which means a choice often has to be made between purchasing data instead of other essentials. Digital skills for those with poor literacy or ability/knowledge to enable access has been an issue for certain groups including people with a learning disability, those with a learning difficulty and some minority population groups. We will seek opportunities to negate the potential risk of digital exclusion and enhance the availability of digital options for our citizens through the work already started by VODA and the VCS.

PROGRAMMES OF WORK

POPULATION HEALTH MANAGEMENT AND PREVENTION IN NORTH TYNESIDE

AIMS

Our aims for population health management and prevention in North Tyneside are:

To deliver improvements in health outcomes, healthy life expectancy and patient experience which will contribute to the reduction in health inequalities.

By 2025 we will have reduced adult smoking prevalence from 14.9% (2018) to 5% or below.

By 2029 we will raise the average healthy life expectancy for men and women from 62.5 years to 63 years.

By 2029 we will halve the gap in average healthy life expectancy for both men and women in North Tyneside from 14.7 years for men and 14.4 years for women to a gap of 7 years (or less) between our least and most deprived areas.

OBJECTIVES

- Reduced health inequalities and unwarranted variation in health outcomes through stronger action by all NHS partners at a local level (Foundation Trusts, primary care, Primary Care Networks (PCNs), CCGs) to deliver actions contained within Joint Health and Wellbeing Strategies and Health and Wellbeing Boards.
- Collective action at a local and ICP area, working with a range of partners across all Integrated Care System (ICS) workstreams (e.g. ARC – Applied Research Collaboration via Fuse, The Centre for Translational Research in Public Health), to make evidence-based interventions to improve healthy life expectancy.
- Building upon existing partnerships, continue to develop a whole systems approach for tobacco, alcohol, substance misuse, obesity and sexual health.
- For the NHS to play its part in tackling the wider determinants of health, for example through action on air pollution, its contribution to the local economy, improved access to employment for those from highest areas of deprivation, and promotion of green spaces to increase physical activity.
- Build the capacity of our population to self-care including embedding social prescribing across the system.
- Increase public health capacity and skills (including Making Every Contact Count (MECC) and brief interventions) within the NHS in order to support the move from reactive care towards a model of NHS services that embodies population health.
- Make full use of the excellent data resource available to identify, inform and deliver at scale, the most effective evidence-based systematic interventions to improve population health in line with our ambition and priorities – this is our population health management approach.

CHALLENGES

- COVID-19 is creating profound and deep shock (social and economic) that will not be straightforward to recover from.
- New role for the state (national and local) to frame recovery/systems leadership.
- Economically the crisis will shift patterns of investment, activity and consumption - cannot assume we will be able to or want to revert to 'previous'.
- Economic impact is huge – regionally over 95% of businesses are affected; 28% of UK workforce are furloughed; predicted reduction in GDP of 5-10% BUT also opportunities re innovation, technology.
- Social impact is also great - health/social inequalities impact; impact on poverty levels; changing demand for social care.
- Health impact well beyond the virus including mental health and well-being.

OPPORTUNITIES

In North Tyneside we are proud of our high quality and frequently high performing public health, health and care services, yet our population is ageing, living longer in ill health and stubborn health inequalities persist.

Healthy life expectancy for both males and females across the North East is the worst of all English regions. For the sustainability of health and care services, the NHS must increase efforts to increase healthy life expectancy and prevent ill health instead of waiting to treat it. In addition, the NHS Long Term Plan requires local health services to set out how they will contribute to the reduction in health inequalities.

Our local ICS plan will build on existing good practice and actions at a local level to identify areas of work that can be delivered at scale. We have a wealth of data within the NHS and beyond; we need to ensure this is used to maximum effect to inform the most appropriate use of our resources, combining this with system leadership to improve population health across North Tyneside and the wider ICS footprint.

WHAT ARE WE DOING ABOUT IT – TASKS & TIMEFRAMES

Our Overarching Priorities

- Protect Vulnerable People
- Protect Colleagues
- Deliver Essential Services

There are 2 aspects to Public Health work described in this document. The first section relates to covid-19 management while the second focuses on the work that Public Health aim to do in relation to service specific areas.

COVID-19 Response

- Sexual health – the One to One Centres continue to offer a full range of contraceptive and STI testing services via telephone, online and face to face as a very last resort.
- Drug and alcohol services - a full range of service is offered, but this is predominantly via the telephone and technology.
- NHS Health checks in primary care this service is suspended as per the national directive.
- Stop smoking services continue to be offered by pharmacy. Quit4COVID campaign was promoted widely.
- 0-19 children's public health service continue to provide a range of services.

Planning Assumptions 1

- COVID-19 will continue to be highly contagious and in the community for the foreseeable future – we need to be able to adapt so we can live with the virus.
- The spread of infection will be able to be slowed through 'Test, Track and Trace' in place from the start of June 2020 (enabling more gradual relaxation of lockdown by Government).
- Isolation will continue to be required for those who are confirmed cases and also their contacts (until they have been tested).
- People in the medically critically vulnerable group will continue to be shielded.
- A second wave of infections may coincide with flu season in October or November 2020. This wave is not likely to be as significant as the first but could result in further lockdown measures.
- Those with significant health conditions and older people will continue to be especially vulnerable until we have a vaccine in use.

Planning Assumptions 2

- Continued focus on care homes will be required in order to prevent and manage any outbreaks among our most vulnerable residents.
- Social distancing together with good hand and respiratory hygiene will continue to play key roles in reducing the spread of the virus.
- Frequent cleaning and disinfection of high-touch surfaces will also be needed throughout this period.
- PPE for those providing direct care to individuals and care to those who are confirmed or suspected will continue to be required to protect both care staff and the recipients of care.
- Our staff will continue to work from home unless it is deemed essential that they are required to come into the workplace – at least to the end of July 2020 (gradual return will be based on success in slowing the spread and being able to control outbreaks via 'Test, Track and Trace')
- Being out in the community will look very different e.g. face coverings advised on public transport and in shops.
- Any easements to lockdown and restart of business/services set by Government will be very gradual and on a phased basis.

Future Public Health Priorities for North Tyneside

- Continued focus on infection prevention and control at a population level.
- Test and trace programme.
- Development of Local Outbreak Management plan and governance arrangements.
- Work with Joint Biosecurity Centre.
- Continued focus on care homes to protect residents and prevent spread until vaccine is available.
- Support for schools for phased reopening.
- Continued support for the vulnerable.
- Understanding impact of COVID-19 on inequalities.
- Health and wellbeing priorities.

Services

1 Tobacco/Smokefree NHS

1.1 All of our local NHS Trusts implement Smokefree NHS NICE Guidance (PH48) by Q1 2020/21

1.2 Develop and implement a strategy to treat tobacco dependency in primary care

1.3 Establish NHS maternal smoking cessation services for expectant mothers and their partners with a new smoke-free pregnancy pathway including focused sessions and treatments (to be led by the Local Maternity System (LMS), working closely with Local Authorities)

1.4 Establish an integrated tobacco treatment offer to all smokers admitted to hospital

1.5 Develop a new universal smoking cessation offer as part of specialist mental health services for long-term patients and in learning disability services
1.6 Drive forward action on COPD for smokers through the newly formed respiratory network
1.7 Ensure the NHS understands the breadth of tobacco harm and is supportive of evidence-based population levels to drive down prevalence

2 Alcohol & Substance Misuse

2.1 Identify clinical champions and agree a local programme of work with partners from NHS, Local Authorities, voluntary and community sector, patients and their families to reduce the harm caused by alcohol
2.2 Ensure the NHS understands the full breadth of harm that alcohol causes by the development of a primary prevention plan which enhances social marketing activity and advocates for action on price, promotions and availability and ensures every child has a future free from alcohol related harm
2.3 Ensure the NHS continues to embed alcohol screening and brief interventions, and that our Acute Trusts have Alcohol Care Teams (ACT) which are part of the integrated treatment pathway within the community
2.4 Work across the ICP to understand the incidence of substance misuse in pregnant women and, if necessary, agree and implement systems to prevent this

3 Social Prescribing

3.1 Support local system leaders to develop and deliver shared local social prescribing plans
3.2 Support the embedding of social prescribing link workers into Primary Care Networks in North Tyneside

4 Obesity

4.1 Develop and contribute to the North Tyneside Healthy Weight and Physical Activity Action Plan.
4.2 Support the role of local physical activity clinical champions to promote the new Chief Medical Officer (CMO) guidance on physical activity amongst staff and patients
4.3 Contribute to the NHS Diabetes Prevention Programme (NDPP) rate by establishing a target number of referrals for each PCN area in North Tyneside
4.4 Share the progress from the 1b CQUIN (17-19) and support the implementation of new hospital food standards (published in 2019) to ensure patients, staff and carers have access to healthy food
4.5 Ensure all front-line staff feel equipped to talk to patients about nutrition and achieving a healthy weight in an informed and sensitive way

5 Air Pollution

5.1 Ensure at least 90% of the NHS fleet will use low-emission engines (including 25% Ultra Low Emissions) by 2028
5.2 Ensure primary heating from coal and oil fuel in NHS sites is fully phased out

6 Antimicrobial resistance

6.1 Continue to support implementation and delivery of the government's new five-year action plan on Antimicrobial Resistance

7 Sexual health

7.1 Co-commission sexual health services in partnership with NHSE and the LA

OUTCOMES

1. **Tobacco/Smokefree NHS**

- Adult smoking prevalence to reach 5% by 2025
- Smoking in pregnancy rates lower than 6% by 2022
- Reduced inequality gap in smoking prevalence rates between those in routine and manual occupations and the general population by 2022
- Number of NHS FTs implementing Smokefree NHS NICE Guidance (PH48)
- Increased number of patients accessing stop smoking support from community pharmacies, primary care and acute trusts

2. **Alcohol**

- Increased number of patients identified as alcohol dependent within acute trusts
- Increased number of patients receiving treatment for alcohol dependency
- Number of frontline staff trained in alcohol brief interventions
- Number of patients receiving alcohol brief intervention
- Reduce number of pregnant women with substance misuse

3. **Social Prescribing**

- Increased number of patients referred to and accessing social prescribing programmes
- Improved health and wellbeing – as evidenced in validated pre and post measures

4. **Obesity**

- Number of physical activity clinical champions trained
- Reduction in BMI for those accessing the NDPP and tier 2 and 3 weight management programmes
- Increased number of patients identified as having nondiabetic hyperglycaemia in primary care
- Increased number of patients attending the NDPP

5. **Air Pollution**

- North Tyneside meets the UK National Air Quality Objectives

6. **Antimicrobial resistance**

- 50% reduction in the use of healthcare associated with gram-negative bloodstream infections by 2025
- 10% reduction in the number of specific drug-resistant infections by 2025
- 15% reduction in antimicrobial use in patients by 2024

7. **Sexual Health**

- Increased number of individuals accessing sexual health and contraceptive services
- Achieving national standards for cervical screening coverage and reduced local variation between GP practices
- Lower number of termination of pregnancies
- Improved earlier detection and diagnosis of STIs

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

- Contribute to an ICS programme of engagement with staff and the public around prevention, looking at changing the narrative from illness and treatment, to health and wellbeing including developing a set of recommendations for training, communications and further engagement

WORKFORCE

- Continue to scale up activity and embed a model of Making Every Contact Count (MECC) across the health and social care workforce in North Tyneside
- Increase NHS and Local Authority participation in the evidence-based and nationally-recognised Better Health at Work Award (BHAWA)

INFORMATICS

- Contribute to a system-wide, consistent understanding and interpretation of Population Health Management (PHM)
- Contribute to the ICS proof of concept work on PHM for specific work areas of tobacco addiction as part of an NHS smoke-free model, reducing alcohol-related harm, and the ABC of cardiovascular disease. Exploring within each area the impact of deprivation and all work examined though the lens of reducing the inequality in healthy life expectancy
- At a local place-based and PCN level; assess local population by risk of unwarranted health outcomes and working with the relevant components of the system to make support available to people where it is most needed

VOLUNTARY AND COMMUNITY SECTOR IN NORTH TYNESIDE (BETTER TOGETHER)

AIMS

Our aims for working with the Voluntary and Community Sector (VCS) in North Tyneside are:

To develop new ways of working with the voluntary and community sector that make vest use of our collective assets to support peole's health and wellbeing

Build strong and sustainable partnerhsips based on shared values and priorites, to support healthy and resilient communities

Encourage a high level of user and community invovlement particularly with vulnerable and underrepresented groups many of whom are less likely to access ehalth services

Improve current ines of engagement with the VCS in relation to service developments and commissioning intentions.

OBJECTIVES

- To work with members of the voluntary and community sector to identify and pursue shared priorities that reflect the changing health and wellbeing needs of our local communities, based on our collective data and intelligence.
- To value and invest in preventative work delivered by the voluntary and community sector that tackles the wider determinants of health
- To work with the voluntary and community sector to ensure all residents have easy access to up to date information about local services
- Work with the voluntary and community sector to increase our collective ability to reach people who are not currently accessing services

CHALLENGES

- The voluntary and community sector is made up of 500+ different groups and charities which can present challenges around engagement.
- The statutory sector and the voluntary and community sector do not always use the same language and see issues through different lenses.
- Impact of covid-19 on voluntary sector funding
- Impact of covid-19 pandemic on ability to offer services as commissioned due to lockdown, social distancing etc

OPPORTUNITIES

- North Tyneside has a strong and well established voluntary sector infrastructure body that can help develop partnership working
- The covid-19 pandemic has created an opportunity and energy to explore new ways of working together to help address the changing need of local people
- The voluntary and community sector has access to data and intelligence which can inform work, reflecting the needs of local communities
- Existing voluntary and community sector neighbourhood networks ambassadors and champions can help with reach into communities
- We can build on existing work such as the work to create an online community platform to provide access to clear trusted information and advice
- CCG grant funded organisations adapted services to meet needs in alternative ways.

WHAT ARE WE DOING ABOUT IT – TASKS & TIMEFRAMES

- Members of the Voluntary and Community Sector will have a key role at a range of strategic meetings and events with an opportunity to actively influence decisions at the Future Care Board and the Living Well Locally Board as well as other initiatives and programmes as they arise. Voluntary and community sector organisations will be encouraged to share data and intelligence around key health and wellbeing themes to help influence our future work.
- In June 2019 North Tyneside Clinical Commissioning Group launched a new grant scheme in recognition of the important role that voluntary and community sector organisations play in improving health and wellbeing outcomes for local people. Following a thorough evaluation process 9 local VCS organisations were identified and awarded a grant. Once the COVID pandemic is over, it is the CCGs intention to review the VCS grant scheme with the hope that we can invest further in voluntary and community services.
- Ongoing support will be given to the development of a new online community platform to replace the existing SIGN directory.
- Regular and timely information updates will be provided to members of the Voluntary and Community Sector in order that they can get key messages and support to some of our most vulnerable residents.

OUTCOMES

- Increased partnership working with the voluntary and community sector organisations to meet the health and wellbeing needs in North Tyneside
- Resilient communities more actively involved in supporting people to manage their own health and wellbeing
- VCS organisations playing a strong, meaningful role in strategic development with the emphasis on co-production and collaboration between different groups to support community cohesion

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

Partners will continue to work with the VCS through a number of existing channels, both geographic and thematic, depending on need and opportunities.

CARERS IN NORTH TYNESIDE

AIMS

Our aims for Carers in North Tyneside are:

Improve timely *access* to information and support by increasing oppotunities for carers to find out whats available

Improve identification and support for unpaid carers in primary care

Improve the support to carers during hospital admission and the discharge of the person they care for

Develop mechanisms that allows and encorages the carer voice and carer experience to influence system change

Increase focus on physical and emotional support for carers

Develop a system wide approach to supporting carers through workfore development

Help us to understand the impact of the Covid 19 pandemic on carers and respond to issues raised

Develop a system wide approach to identifing and supporting young carers

OBJECTIVES

- Develop a programme to support Primary Care to identify all carers
- Ensure the carers voice is heard and that their needs are identified, and their wishes are taken into account during hospital admission and discharge
- Carers views are considered and used to influence developments in any strategic decisions
- Service reviews and development ensure physical and emotional support for carers is included
- Carers can access timely high-quality information in a format that works for them
- Ensure frontline workforce in health and social care have the skills and confidence to identify carers and deliver a consistent message
- Providers and commissioners respond to issues and gaps raised by carers to improve services and pathways
- Young carers are better identified and supported by all partners

CHALLENGES

- Ensuring a whole system approach to consistently identifying and supporting carers

- Ensuring consistency of national and local priorities for partners that impact on the support for carers.
- Training for staff on carers awareness is not consistent across organisations and is not mandatory in the statutory sector
- Individual residents are often not aware that they are carers and have rights
- Impact of covid-19 on carers both in relation to their own needs as well as having to manage the needs of the person/people they are caring for. This is relevant to both physical health care needs and carers mental health and wellbeing.
- Increased isolation and reduced access to support networks, both formal and informal, due to pandemic restrictions
- Inequalities have become more apparent in certain sectors of carer, for example, young carers who have had an increased caring role while schools have closed and who may, consequently, be struggling to return to school
- Identification and management of older carers own physical and mental health and wellbeing needs while they are also undertaking a caring role.
- Increase in the number of people in North Tyneside who are caring for more than 20 hours: the point at which caring starts to significantly impact on a carer's health and wellbeing and their ability to have a life alongside caring.

OPPORTUNITIES

- To develop a robust mechanism for two-way information flow between the Carers Partnership Board and system review groups and boards
- To build on the multi-organisational work of North Tyneside Carers Partnership Board
- Continued focus on carers as described in the NHS Long Term Plan
- Embedding listening to, understanding and responding to the needs of carers in the commissioning and development of services
- To influence national, regional and local policy, initiatives and developments -"Think carer"

WHAT ARE WE DOING ABOUT IT – TASKS & TIMEFRAMES

By March 2022:

- Agree robust mechanisms for two-way information flow between the Carers Partnership Board and system review groups and boards
- Consider development of a Carer Friendly Award Scheme for Primary Care
- Pilot a Carers Passport scheme within a hospital setting, to improve the identification, recognition and support for carers
- Pilot the role of a carers support worker within hospital settings
- Develop mechanisms that allows and encourages the carer voice and carer experience to influence system change
- Carers Partnership Board members promote discussion of carers support within service reviews
- Minimum standard of information for carers agreed for all providers agreed to include:
    - Link to carers centre
    - Link to relevant support for carers and information about carers' rights
- Work with health and care providers to improve identification, recognition and support for carers of all ages

- Healthwatch North Tyneside and North Tyneside Carers Centre to undertake research to understand carers experiences and issues. Feedback and recommended actions are shared with providers and commissioners
- Young carers:
    - Develop a young carers needs assessment pathway. Ensure pathway is implemented system wide
    - Implement learning from relevant serious case reviews
    - Develop a transition approach between children and adult services
    - All schools in North Tyneside to identify a young carers lead
    - Using school and GP data, create baseline data of the number of young carers
- Develop a Whole Family approach to address caring responsibilities the across wider family

OUTCOMES

- 5% of practice population to be registered as carers
- Carers Passports rolled out in secondary care following completion of pilot and review. Possibility of roll out of passports to other healthcare settings
- Clear evidence that carers have influenced work undertaken by the Carers' Partnership Board and that carers' needs are included in care pathways.
- Identification and support for carers is embedded within all health and care pathways
- Improved information and support will result in:
    - Increase in referrals to Carers' Centre year on year
    - Increase in numbers of people accessing information (evidenced in analytics)
    - Carers feedback indicates that they have had the information needed to support them – findings in ASCOF & GP survey
- Recognising that these outcomes below are aspirational, workforce development activities will aim to result in:
    - An increase in number of good quality completed carer assessments ; and referrals for support to NorthTyneside Carers' Centre
    - All frontline staff in primary care completing RCGP training in 'supporting carers'
    - Development and implementation of a local policy in relation to statutory and mandatory carers training
- Support for all carers is improved as the pandemic develops
- For young carers:
    - Increased number of young carers identified and supported within schools
    - Increased number of completied Young Carers Needs Assessments
    - Improved quality of Young Carers Needs Assessments
    - Improved feedback from young carers on how they feel they have been supported

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

- Commitment of system leaders, strategic boards and working groups to embed carers identification and support within pathways and services.

CHILDREN & YOUNG PEOPLES SERVICES IN NORTH TYNESIDE

AIMS

Our aims for Children & Young Peoples Services in North Tyneside are:

To improve mangement of long term conditions in child health

To reduce childhood obesity

To improve maternity services

To improve vaccination rates

To develop more services for 0-25 age range

To ensure children access the right services at the right time, including intervening early

OBJECTIVES

In North Tyneside, the overarching objective is that we believe that all children and young people should be given the opportunity to flourish and reach their potential and be advantaged by organisations working together.

We also wish to:

- Create a fully inclusive system where children and young people with Special Educational Needs and Disabilities (SEND) will have all their identified needs met
- Reduce the numbers of children and young people who attend A&E inappropriately
- Through partnership working with maternity and neonatal services, reduce the number of stillbirths, maternal and neonatal mortality and serious brain injury

CHALLENGES

- Ensure services meet national requirements in relation to maternity and neonatal care, recognising the important of very early years care- the first 1001 critical days of a child's life
- Ensuring seamless pathways from social care to health care and vice versa.
- Managing pregnancy, birth and post-natal care during the covid-19 pandemic from both a clinical perspective and in relation to patients and families experience.

OPPORTUNITIES

- NHS Long Term Plan expectations to improve services on specified areas
- Refresh of the North Tyneside's Children and Young People's Plan, providing focus for children and young people's services for the period 2020 to 2024
- Potential to accelerate on improvements already started e.g. reduction in stillbirths and neonatal death

WHAT ARE WE DOING ABOUT IT – TASKS & TIMESCALES

- We will review the newly introduced perinatal pathways, access and activity to accord to the Long Term Plan ambition to increase usage and to have care available, including perinatal support to new fathers and provision of maternity outreach services, from preconception to 24 months after birth.
- We will use fair shares funding for 2020/21 to begin roll-out of a range of national initiatives between 2020/21 – 2023/24 for local maternity services to include:
  - implementation of the Better Births expectations
  - roll-out of the Saving Babies Lives Care Bundle in maternity units
  - work with partners to improve the safety and effectiveness of neonatal critical care services, expand the workforce and provide care coordinators who will work with families
  - provision of postnatal physiotherapy and multidisciplinary pelvic health clinics
- We will develop maternity services to ensure we meet the Continuity of Carer during pregnancy, birth and post-natal requirements by March 2021 as laid out in the Long Term Plan, focussing on women in deprived areas of North Tyneside.
- We will continue work with partners to integrate and improve services to increase capacity to treat obese children and the severe complications related to their obesity.
- We will apply to the NHS Hospice Grant programme to try to access funding opportunities to invest in children's palliative and end of life care.
- We will begin work over the next few years to meet the Long Term Plan requirements for children with cancer, including increasing the number of children taking part in clinical trials by 50% by 2025 and will work with hospitals so that children can access more advanced technologies and treatments.
- We will begin to plan a service model for young people which offers person centred and age appropriate care for both mental health and physical health needs, which is based on need, not age.
- We will review the pathways for paediatric short stay services to ensure that children and young people are receiving the appropriate level of care in the right place.
- Partner organisations, including the CCG and Local Authority to ensure that children and young people with Special Educational Needs and Disabilities have their identified needs met.
- Partner organisations, including the CCG and Local Authority to continue to work closely to ensure that Children in Care have their identified needs met and are well-supported.
- To review the outcomes from the Healthwatch North Tyneside maternity experience feedback due later in 2020/21.
- To understand the outcomes of the Alcohol Admissions Task & Finish group, specifically around alcohol and drug use in pregnancy and consider next steps

OUTCOMES

Outcomes will be tailored according to each individual task. We will have regard to Operating Framework requirements, and we will develop and agree other local measures as appropriate.

Measures will include:

- An agreed % reduction in the number of women smoking in pregnancy
- An agreed % reduction in the number of stillbirths
- Increase in the numbers of pregnant women receiving the flu vaccination
- Improved number of school aged children receiving the flu vaccination
- Improved numbers of children receiving second MMR vaccination

LIVING WELL LOCALLY IN NORTH TYNESIDE

AIMS

Our aims for Living Well Locally in North Tyneside are:

Services should enable people to take more responsibility for their health and wellbeing

Patients should be supported to stay in their own home and connect with community assets

When patients need more complex care it should be delivered in the community and in hospital by exception

Patients should only have to tell their story once

Care is personalised and coordinated

OBJECTIVES

We want to create a health and social care system, underpinned by holistic community service provision, more closely aligned to the needs of local people, which supports self-care, proactively provides early interventions and minimises the need for patients to be admitted to hospital or a permanent care setting.

CHALLENGES

- Reduced capacity within practices due to workforce/estates constraints.
- Increased need for GP services following COVID-19 due to delays in diagnosis, exacerbation of conditions, impact of reduced social/economic environment.
- Capacity in partner organisations across the system for referrals, diagnostics etc. and shift of work from acute trusts to practices e.g. re-referral/ reassessment of patients, picking up actions/prescribing where remote outpatient contact.
- The impact on capacity of appropriate infection prevention and control measures be available for all settings delivering care.
- Understanding the full extent of unmet need across the system
- Reluctance of the public accessing NHS and social care services whilst in the midst of the covid-19 pandemic
- A strategic approach to looking after and growing the workforce.
- Understanding the impact of COVID-19 have on local care homes in the medium-to-long term and the consequences of this for the wider health and social care system in North Tyneside.
- IT systems that facilitate sharing of relevant information across health and social care.
- Assistive technology and internet/N3 connectivity to support remote working (particular relevant for nursing/residential home).
- Capacity to flex services to meet increase demand with usual expected winter pressures/flu.
- Ageing workforce and ensuring we have the right people with the right skills in the right place.
- Limited estates across community and primary care to facilitate hub and spoke working (new model of integrated frailty).

OPPORTUNITIES

The current patchwork of primary care and community services has evolved over a number of years in response to the developing needs of local people and fluctuations in NHS resources. Whilst individual services produce excellent outcomes in their own right, the system as a whole often operates in silos, meaning that there are gaps in provision in some parts of the pathway and duplication in others.

Patients also tell us that the care they receive should be coordinated, ensuring that they only have to tell their stories once and can reasonably expect for this information to follow them throughout their episode of care.

During 2020/21 we aim to initiate several major programmes of change aimed at dissolving traditional organisational / sectoral boundaries between providers of care and facilitate the development of services that are more reflective of local and individual needs.

WHAT ARE WE DOING ABOUT IT – TASKS & TIMEFRAMES

By the end of July 2020:

- Understand estates issues for practices to function in safe way in line with national guidance and infection control advice.
- Continue financial support to practices to support resilience and response to COVID-19.

Between August 2020 and March 2021:

- Deliver enhanced care in care homes, structured medication reviews and early cancer diagnosis elements of PCN DES.
- Support PCNs to make best use of additional roles funding.
- Implement LIVI pilot to increase capacity and extended digital offer to local patients.
- Review 'total triage' model and support practices that wish to further develop their process.
- Cross over services – these services are centrally coordinated but delivered in the localities (hub and spoke approach).
- Work with Primary Care Networks to support the development of community MDTs.
- Enact our contingency plans to commission additional community beds as part of an OPEL 4/major incident response to winter pressures/further covid-19 infection spikes.
- Review current community service provision and begin planning for community and primary care integration, working with current community service providers, Primary Care Networks and the community and voluntary sector
- System review of how service provision in the community and voluntary sector links in with community service provision being delivered by primary and community health services, considering gaps and opportunities.

From March 2021 onwards:

- Deliver further PCN DES specs.
- Re-provision extended access through PCNs.
- Revise current contract arrangements relating to community services
- Deliver primary and community services integration programme

OUTCOMES

- % reduction in hospital admissions.
- % reduction in conveyances to A&E.
- % reduction in admissions to permanent care settings.
- % reduction in average length of stay in hospital and intermediate care settings.
- % reduction in delayed transfers of care.
- % reduction in waits for repatriation.
- Increase in patient, carer and staff satisfaction
- Reduction in prescribing rate of medicines that can cause dependency, antimicrobial medication and medicines of low value.
- Increase in social prescribing referrals.
- Increase in the proportion of cancers and long term conditions diagnosed at early stage

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

A joint communications strategy is being developed in conjunction with Northumbria Healthcare NHSFT, North Tyneside Council and TyneHealth Ltd (GP Federation).

WORKFORCE

- General Practice Workforce strategy developed.
- Staff will be invited to help us coproduce new pathways of care.
- Work with providers and local HEE training hub to develop pipeline of roles needed to deliver the above actions.
- Trainee nurse associates both in general practice and provider organisations.

INFORMATICS

- Continued commissioning of online consultation software for practices.
- Delivery of GP IT Futures requirements.
- Informatics will be key to the integration of existing services and the coordination of care. An IT task and finish group has been established to lead this work across the system.

ESTATES

- Production of an estates strategy for Primary Care.
- The CCG is part of the Primary Care Data Gathering Programme pilot which aims to get a baseline of consistent data collected for every NHS-reimbursed GP practice across England.
- An estates review will be undertaken as part of the integrated community frailty service review.

MENTAL HEALTH PROVISION IN NORTH TYNESIDE

AIMS

Our aims for mental health provision in North Tyneside are:

Promoting resilience, prevention and early intervention

Improving access to effective support

Caring for the most vulnerable

Ensuring accountability and transparency

Developing the workforce

OBJECTIVES

- To achieve parity of esteem between mental health and physical health
- To meet the requirements of the Mental Health 5 Year Forward View and the NHS Long Term Plan
- To reduce health inequalities, providing equal access to mental health interventions
- To increase and enhance prevention and early intervention, reducing pressure on higher level services
- To ensure that higher level services are accessible, robust and sustainable

CHALLENGES

- Anticipated surge in referrals for range of needs including anxiety, PTSD, Domestic Violence, alcohol dependency, bereavement following the covid-19 pandemic, including a greater acuity of presentation.
- Inequalities are starker post-COVID-19.
- Uncertainty over funding and planning requirements.
- Access to services is perceived as difficult in some cases
- Gaps in service provision

OPPORTUNITIES

- Whole system and partnership working to tackle issues collaboratively.
- New services have been introduced which should have a longer positive impact
- Closer collaboration between services and providers.
- Review some pathways and ways of working and evidence impact of new ways of working evidence.

WHAT ARE WE DOING ABOUT IT – TASKS & TIMEFRAMES

July – August 2020:

- CAMHS and Early Help provision working collaboratively to prevent bounce back to referrers and improve access for children & young people.
- More use of digital technologies to improve productivity e.g. Talking Therapies.
- Enhanced Mental Health urgent and emergency care services at NSECH, ward 9.
- Consider development of primary care mental health workers.
- Offer postvention support to people bereaved by suicide.

From August 2020 – March 2021:

- Develop the Strategic Alliance with Barnardo's to improve children and young people's emotional health and wellbeing, focussing on early intervention and prevention. A range of schemes have been agreed and are in the process of being implemented as follows:
  - Continue the collaboration between CAMHS and Early Help through creation of an Early Help post sited in CAMHS and employ 4 children's wellbeing practitioners. Training of wellbeing practitioners to begin in January 2021
  - Following the sleep conditions needs assessment undertaken by Public Health, implement a stepped intervention model of provision with training for staff to begin in Q4 2020/21 and be fully commissioned in 2021/22
  - Implement the Whole School Approach focussing on Mental Health First Aid being provided via the Education Department of the Local Authority into schools.
  - Implement the Recovery Bridge programme for children with a social worker i.e. provide an opportunity to assess needs, develop a support plan and provide a safe space for children and young people to help them address emotional needs and develop coping skills with a counsellor.
- Roll out the New Forest parenting training programme across social care and health provision.
- Evaluate the Department for Education initiative to trial a more in-depth Mental Health Assessment of Children in Care
- Develop a Positive Behavioural Support approach for schools to prevent challenging behaviour more effectively through de-escalation and distraction techniques prior to crisis management.
- Work with schools to implement improvements identified in the Schools Link Programme workshops.

- Restructuring service delivery, focussing on the national requirement to transform mental health community provision and also development of alternatives to crisis provision.
- Work with ICS and Mental Health Network to review the psychological pathway across the system including health psychology, Community Treatment Teams and specialist psychological therapies to evidence impact, identify gaps and possible duplication.
- The Talking Therapies service and secondary services work on strengthening relationships and ensuring access to range of people, including older people.

- The CCG will commission research from CNTW Trust into mental health trauma in North Tyneside to evidence anecdotal feedback which will, in turn help inform future commissioning.
- Invest in mental health services ensuring that the requirements of the Mental Health Investment Standard are met.

- Ensure that the physical health needs of people with a serious mental illness are met, to reduce mortality in people with serious mental illness.

- Develop a joint action plan for mental health services for older people aligned to development of the Mental Wellbeing in Later Life Strategy 2018-2023.
- Implement new pathways for older people who are experiencing a mental health crisis.
- Consider what psychological support needs patients with cancer and other long term conditions and their carers may have post-COVID-19.

From March 2021 onwards:

- Explore options to develop mental health support teams for children and young people.
- Begin implementation of system plan to transform community mental health services and alternatives to crisis provision
- Refocus on delivery of the Mental Health Long Term Plan.
- Work with relevant organisations to review inequalities in access to Mental Health services.
- Assess the impact of additional funding for expansion of the North Tyneside Talking Therapies service for people with Long Term Conditions and improve waiting times for access to Step 3 therapy. Review pathways for the service.
- Review the recently re-established North Tyneside Recovery College, with the aim of extending the range of courses and workshops offered related to mental health and wellbeing.
- Review new North Tyneside Admiral Nurse Service providing post diagnostic support for people with dementia and their carers.
- Develop a single model of mental health care for older people across North Tyneside.

KEY PERFORMANCE INDICATORS

General

There are a range of Key Performance Indicators (KPIs) which already operate for particular mental health services and, nationally, this continues to be reviewed with the intention of adding further measures. In addition to the national indicators, we have developed local indicators for some specific services.

Children & Young People

A review of the Key Performance Indicators for the CAMHS service has been undertaken. These KPIs will continue to be closely monitored.

Kooth Online is provided by XenZone and service specific KPIs are incorporated into that contract. This is monitored jointly by the CCG and local authority (LA) on a quarterly basis.

The new services provided via the Youth Offending Team (YOT) are subject to KPIs which have been determined by NHS England as the funders of these initiatives. Quarterly submissions are made by the North Tyneside YOT to NHSE.

KPIs will be developed for the Barnardos Strategic Alliance workstreams.

Working Age Adults

Within the Future Care Performance Framework, one KPI has been identified which relates to people with mental health needs. This KPI focuses on the percentage of people in employment with the expectation that North Tyneside will match the England average percentage.

The social prescribing service, which has been commissioned by the LA, is subject to a contract which has quantitative and qualitative reporting requirements included in it.

We have an agreed dataset with Northumbria Healthcare NHS Foundation Trust, the provider of the North Tyneside Talking Therapies service, which is submitted monthly. This provides detail of both the nationally mandated KPIs as well as agreed local KPIs and relates to both the core service as well as the expansion into provision of services for people with Long Term Conditions.

We have a number of services which are either to be established or are new services in North Tyneside. For those new services, KPIs will be agreed or, if they have been established, KPIs are included in the individual service specifications. This will also be applicable to new services or newly formatted services as a result of the community mental health transformation work and the alternatives to mental health crisis work.

Work is underway across the CCGs which receive mental health services from Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust to review the performance information received about those services. This will ensure that commissioners can be assured of the quality of services being provided and will inform future commissioning of those mental health services.

Older People

The CCG is monitored as to the number of people with dementia who receive an annual health check and receives a rating accordingly. For 2018/19, the CCG was rated as outstanding for dementia care.

There is a specification for the current Admiral Nurse Service with KPIs but this will be reviewed along with the current service, ensuring integration with other, appropriate older people's mental health services in North Tyneside. The same process will be followed for the new mental health carers post.

We recognise that the uptake of Talking Therapies for the older population is low. As we develop methods to encourage more older people to access the service, we will develop relevant KPIs to monitor access and uptake.

We will take the opportunity to review existing KPIs and identify new KPIs as we progress with developing a single service model for older people's mental health across North Tyneside.

OUTCOMES

- Progress towards delivery of mental health provision for the people of North Tyneside in line with the Mental Health Five Year Forward View and the NHS Long Term Plan
- Development of sustainable, gold standard quality services to meet the full range of mental health needs for the people of North Tyneside

- Improved accessibility to services with waiting lists and waiting times minimised to meet or fall below national standards and in line with clinical best practice
- Achievement of national and local standards and maintenance of the "outstanding" rating for mental health provision in North Tyneside
- Increased social participation and community integration of service users
- Improved service user choice and experience of services
- Highly efficient use of resources and capacity

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

- Development of individual engagement strategies where appropriate for individual service developments to involve patients and carers in the coproduction of new services and strategies
- Consideration of innovative methods of gaining input and feedback including the Hear My Voice service with the Community Health Care Forum and co-review work with Healthwatch North Tyneside

WORKFORCE

- Embedding system wide workforce development across professional groups to enhance understanding, capability and embed evidence-based practice to support mental health effectively across the system
- Recognition that there is a shortage of personnel with relevant qualifications, skills and experience. Anecdotally, it appears that the situation in the North East is converse to the rest of the country in that there is a shortage of mental health consultant posts in the North East while recruitment to mental health nursing posts is not as much of an issue

INFORMATICS

- Ensuring that all services have access to and use an appropriate IT system(s) for case management
- Develop IT systems for organisations to safely and securely share patient information, where appropriate, to ensure that the best quality care can be provided to individual patients

ESTATES

- Ensure that premises are fit for purpose, meet relevant regulations and standards and are accessible to patients
- Identify maintenance and/or capital requirements and ensure inclusion in the North ICP and the ICS Estates Strategy

LEARNING DISABILITIES & NEURODEVELOPMENTAL PROVISION IN NORTH TYNESIDE

AIMS

Our aims for learning disabilities and neurodevelopmental provision in North Tyneside are:

Developing community focused service provision with timely access to specialist input when needed

Improving access to effective and safe support

Caring for the most vulnerable

Ensuring accountability and transparency

Developing the workforce

OBJECTIVES

- To reduce inequalities and improve life expectancy for those with learning disabilities or neurodevelopmental diagnoses
- To reduce the number of inappropriate admissions to inpatient facilities
- To improve access to appropriate services and reduce waiting times and waiting lists

WHY IS CHANGE NEEDED

- National expectation to meet the requirements of the Transforming Care agenda, reducing inpatient beds and increasing, and improving, community-based provision
- Some services are experiencing increased waiting lists and waiting times for access to their services
- Lack of appropriate community-based provision is leading to inappropriate admissions into inpatient facilities

CHALLENGES

- Being cognisant of people's needs and impact of lockdown on their condition, recognising that for some people lockdown may have had a positive impact on some people with autism or neurodevelopmental needs while for others it may have had a detrimental impact.
- Helping people to understand and manage social isolation measures.
- Ensuring the needs of carers are met.

WHAT ARE WE DOING ABOUT IT – TASKS & TIMEFRAMES

- Continue to implement and review joint processes between the local authority (LA) and CCG to enhance and/or integrate services that underpin living well in the community.

- Work as part of the regional Transformational Board to develop system-wide out of hospital care and allow people with complex learning disabilities to be appropriately and safely supported closer to home.
- Work with partners and regional colleagues to develop a complex case framework to ensure community-based pathways are of high quality, are robust and fit for purpose with clear step up and step down processes for people with challenging and complex behaviours.
- Develop a robust clinical pathway for the review of psychotropic mediation prescribed to people with learning disabilities in line with the STOMP good practice guidelines.
- Embed governance process through the local learning disability Integration board, including a standard operating procedure and assurance framework for C(E)TR's
- Develop an assurance framework for physical health screening and explore how this offer can be extended to people with a diagnosis of autism without learning disability.
- Continue to carry out Mortality Reviews for people who are known to services as having a learning disability and who have died.
- Monitor impact of the newly commissioned and implemented forensic and crisis pathways
- Undertake a pathway mapping exercise in relation to community service provision (which incorporates New Care Models) ensuring that the enhanced community model offer is inclusive of a wrap-around service, including crisis and forensic provision.
- Develop robust transition pathways in line with national guidance which ensure preparation for adult and access to appropriate services.
- Review the model of delivery for specialist assessment and community provision for ongoing management of people diagnosed with ADHD/Autism, aiming to reduce waiting lists and times for both services.
- Develop of a system-wide neuro-diverse strategy North Tyneside, including an analysis of potential areas for development, informed by the autism Self-Assessment Framework which will include consideration of behavioural support needs.
- Consider development of carer passports

KEY PERFORMANCE INDICATORS

- National standard: Reliance on inpatient care for people with a learning disability and/or autism
- National standard: Proportion of people with a learning disability on the GP register receiving an annual health check
- National standard: Completeness of the GP Learning Disability Register
- Production of strategies which meet their stated outcomes
- People are cared for in a safe environment and are protected from avoidable harm: the number of serious incidents and number of never events are within nationally prescribed limits for individual provider Trusts
- Production of conclusions from the community pathway mapping exercise

OUTCOMES

- Progress towards delivery of the national Transforming Care agenda and the requirements of the NHS Long Term Plan.
- Development of sustainable, gold standard quality services to meet the full range of learning disability and neurodevelopmental needs for the people of North Tyneside

- Improved accessibility to services with waiting lists and waiting times minimised to meet or fall below national standards and in line with clinical best practice
- Increased social participation and community integration of service users
- Achievement of national and local standards for learning disabilities and neurodevelopmental provision in North Tyneside
- Improved patient experience of services
- Highly efficient use of resources and capacity
- Improved transition pathway for people with a neurodevelopmental diagnosis, eradicating delays and waits in the system
- Improved adult ADHD and autism services, based in the community
- Provision of specialist assessment hub for people with a neurodevelopmental diagnosis with community input for ongoing support and management

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

- Development of individual engagement strategies where appropriate for individual service developments to involve patients and carers in the coproduction of new services and strategies
- Consideration of innovative methods of gaining input and feedback including the Hear My Voice service with the Community Health Care Forum and co-review work with Healthwatch North Tyneside

WORKFORCE

- Embedding system wide workforce development across professional groups to enhance understanding, capability and embed evidence based practice to support patients effectively across the system
- Recognition that there is a shortage of personnel with relevant qualifications, skills and experience
- Ensure close links with the ICP Workforce Group

INFORMATICS

- Ensuring that all services have access to and use an appropriate IT system(s) for case management
- Develop IT systems for organisations to safely and securely share patient information, where appropriate, to ensure that the best quality care can be provided to individual patients

ESTATES

- Ensure that premises are fit for purpose, meet relevant regulations and standards and are accessible to patients
- Identify maintenance and/or capital requirements and ensure inclusion in the North ICP and the ICS Estates Strategy

PLANNED CARE SERVICES IN NORTH TYNESIDE

AIMS

Our aims for Planned Care in North Tyneside are:

To work with providers to seek to achieve national waiting list and time targets, acknowledging the difficulties caused by covid-19

To improve shared care arrangements for immune-modifying drugs

To rollout equipment to GP practices to enable high-quality images to be submitted with dermatology referrals

To implement new pathways and alterantive ways to safely access planned care services where appropriate

OBJECTIVES

- To work with providers to seek to achieve the 92% 18 weeks referral to treatment (RTT) target, acknowledging the difficulties caused by COVID-19.
- To work with providers to reduce the waiting list size from January 2020 to January 2021, acknowledging the difficulties caused by COVID-19.
- To work with providers to reduce the numbers of patients waiting over 52 weeks, acknowledging the difficulties caused by COVID-19 and to work towards achieving no 52 week waits when possible.
- To implement a new system to make shared care arrangements for immune modifying-drugs safer.
- To implement non-medical prescribing for continence products, stoma products and oral nutritional support.
- To improve dermatology referrals by providing practices with equipment to take high-quality images of skin lesions.

CHALLENGES

- Ability to meet Referral to Treatment time targets whilst maintaining infection control and safety measures due to the covid-19
- Rise in number of 52 week waits and long waits as a result of planned care being suspended due to covid-19
- Workforce, ability of staff to turn focus from COVID-19 to recovery process and have sufficient reserves of energy.
- Public confidence to attend appointments and acceptance of required behaviours
- Supply chain technology, ensuring digital services have sufficient resources to deliver required improvements.
- Regulatory over-reach, slowing down recovery process.
- Impact of ongoing social distancing guidelines on meeting national targets for elective care.
- Accessibility of Patient Transport currently reduced to comply to social distancing measures when conveying patients.

- MSK First Contact Practitioners are not in place across all 4 North Tyneside Primary Care Networks.

OPPORTUNITIES

- Increase in number of virtual clinics reducing the need to travel for patients and providing a covid-safe way of providing care.
- Telephone pre-assessment for endoscopy.
- Maximising use of the independent sector.
- Sharing and learning of ways of working between Trusts.
- Increase in Advice & Guidance for GPs to discuss potential referral with hospital consultants before a referral is made, reducing unnecessary referrals

WHAT ARE WE DOING ABOUT IT – TASKS & TIMELINE

July – August 2020:

- Continue to commission more Advice & Guidance services, with an aim of having comprehensive coverage across all specialties.
- Work closely with acute Trusts to understand impact of COVID-19 on activity.
- Review pathways in particular specialities.
- Review use of independent sector provision.
- A Future Care Medicines Optimisation Strategy Group to enhance the delivery of objectives by system working has been established and is meeting quarterly.
- An Antimicrobial Stewardship (AMS) Group has been established to support the delivery of the 2019-24 National Action Plan and to evaluate and implement recommendations from the local decision-making infrastructure (Area Prescribing Committee and its subcommittees and groups).
- We have also established meetings between PCN lead pharmacists and Medicines Optimisation colleagues to ensure that the wide range of pharmacist roles in North Tyneside are supported and coordinated.
- All four North Tyneside Primary Care Networks have recruited MSK First Contact Practitioners

August 2020 – March 2021

- We are continuing to work with Northumbria Healthcare Trust as part of their outpatient project to reduce follow-ups, explore digital solutions and review capacity & demand.
- We are exploring how best to manage the growing number of fibromyalgia patients, potentially by developing a persistent physical symptoms service.
- We are working with Northumbria Healthcare Trust to develop non-medical prescribing capacity.
- We will strengthen the roll of commissioned Medicines Optimisation services to support targeted medication reviews. Funding has been provided to the Medicines Optimisation team in NECS for additional staff to support patient's reviews. The posts have been filled with staff being inducted in September 2020.
- Continue with the national discharge to assess work, ensuring that patients needs post hospital discharge are met in a safe and timely manner

March 2021 onwards

- Work closely with acute Trusts to improve RTT performance and waiting list size targets.
- We will consider commissioning alternatives to secondary care referral to reduce demand where possible.
- We will work with providers and other commissioners across the ICP to review the requirements of the Long Term Plan and determine how they can be implemented, taking into account the impact of covid-19 pandemic on planned care services.

OUTCOMES

National Measures

- 18 weeks RTT, 52 weeks and waiting list size are already measured.

Other/Local Measures

- FCPs data collection as part of PCN programme.

Other measures will be identified in line with national guidance.

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

- Communication with GPs will be key to success if changes are made to referral systems, when more Advice & Guidance services are available, and when changes to the outpatient model are made as part of the Northumbria outpatient project.
- Communication with patients will also be very important. Patients are reporting to organisations such as Healthwatch North Tyneside that when they are experiencing delays in their treatment they have not been kept informed of the delay or the reasons for the delay.

WORKFORCE

- Availability of additional consultant capacity to reduce waiting lists and waiting times.

INFORMATICS

- Digital solutions are being explored as part of the outpatient project.

ESTATES

- Maximise the use of clinical estate including outpatient facilities and operating theatres to ensure that lack of physical capacity is not a block to reducing waiting times and waiting lists

LIVING WELL WITH LONG TERM CONDITIONS IN NORTH TYNESIDE

AIMS

Our overarching aims for people in North Tyneside living with multiple long term conditions are:

To improve the use of telecare at a distance and implement a wide range of technological solutions that reflect on the growing number of patients with multiple long term conditions and in doing so, move away from managing conditions in silo towards a multi-factorial model based on year of care

To bring together and widen multidisciplinary teams to include carer champions, care navigators and local integrated services such as the frailty service to deliver joined up coordinated care

To ensure the housebound population living with multiple long term conditions receive holistic care with continuity so that patients know who to contact and how to get the necessary help and support with more chronic complex issues

OBJECTIVES

- Reduce health inequalities and improve health outcomes through the delivery of targeted interventions with a focus on prevention, self-management and personalised care for people living with multiple long term conditions
- Make best use of technology and strengthen pathway interfaces towards more seamless care with focus on self care
- Maximise the opportunities Primary Care Networks bring in the delivery of personalised care
- Improve the quality of care for the housebound population

CHALLENGES

- Assuring patients reluctant to access services that returning to hospital is safe.
- Impact of second/third wave of COVID-19 infections.
- Access to timely diagnostic services.
- Workforce, ability of staff to turn focus from COVID-19 to recovery process and have sufficient reserves of energy.
- Reducing prevalence and severity of disease in more deprived groups
- Respiratory disease is a major factor in 'winter pressures' with twice as many admissions occurring in December compared to August.
- There is variation in the care people receive for diabetic care
- Opportunities for patients with diabetes to be supported to manage their own condition aren't widely available
- Current gap in provision for diabetes structured education courses for those with learning disabilities (LD)
- High reliance on hospital based care to manage diabetes

- Long Term Conditions or Chronic Disease are usually defined as conditions for which there is currently no cure, often managed with drugs and other treatments.

OPPORTUNITIES

A key priority is to further explore opportunities to improve the quality of care for the housebound population who are often isolated from emotional and social support, and vulnerable to risk factors for decreased quality of life and increased medical complications.

Areas of focus will be based on identifying more programmatic structured approaches for the housebound population who at present often receive more fragmented care particularly across multiple chronic conditions.

The NHS Long Term Plan sets out the intent to focus on universal personalised care. Primary Care Networks present an opportunity to refocus on delivering and supporting the care of people with multiple chronic conditions by making best use of electronic records that help in bringing about person-centred care through an individualised management plan.

Recognition of the role of district nurses and specialist nursing in community settings and what they can bring to management of long term conditions.

WHAT ARE WE DOING ABOUT IT/TASKS

Overarching

- Adopt the House of Care Model for the future commissioning of services for people with long term conditions and in doing so, embed the year of care approach for people with multiple conditions
- Work with primary care and community services to identify and implement strategies for improving the quality of care for the housebound population that bring about behavioural change, reduced anxiety and better adherence to treatment regimes. Strategies may include improved transportation for housebound patients to access their GP, better use of telecare, etc.
- Continue to focus on specific conditions where transformational changes in how and where the services will be delivered in the future can be made - e.g. Diabetes, Respiratory and CVD
- Develop a user-friendly electronic chronic disease management template that enables all relevant information from all services to be entered correctly into practice systems

Cardiovascular Disease

AF Optimisation and Detection Programme

- Follow on from NHS England project in GP practices to ensure ongoing identification, risk assessment, education and prescribing of optimal medication.
- Work with Tyne & Wear Fire & Rescue Service to promote detection in community settings and as part of Safe & Well Checks in patients' homes.

CVD Prevention programme

- In partnership with Public Health, commission services to link with workplaces to deliver blood pressure monitoring and AF checks using AliveCor devices.
- Link with Better Health at Work Awards and deliver training for workplace champions.

- CVDPREVENT audit will also be rolled out

Cardiac Rehabilitation services

- Review of services to ensure they are the best they can be.

Heart Failure

- In partnership with Northumbria Healthcare NHS Foundation Trust, review the heart failure pathway and review options for rehabilitation for heart failure patients.

Familial Hypercholesterolaemia

- Undertake a review of pathway to ensure patients are detected and are referred into a specialist Lipids clinic if found to have a cholesterol of 7.5mmol or more. These patients will be risk assessed and cascade testing offered to ensure this is prevented in future generations.

Hypercholesterolaemia

- Pilot of lipid optimisation in high risk CVD patients not optimised on oral therapy with a view to introduction of PCSK9 inhibitors as per NICE guidance.

Breathlessness pathway

- Develop a breathlessness pathway to improve investigation of those with breathlessness and reduce time to patient receiving the most appropriate treatment.

Diabetes

- Increase uptake of the NHS Diabetes Prevention Programme by working with general practices in North Tyneside and NHS England to promote uptake of the digital education offer for the programme when it is introduced
- Review of structured education provision for those with type 1 diabetes (DAFNE) and re-procure structured education for type 2 diabetes (currently EMPOWER) and continue to work closely with providers to increase uptake of structured education, including exploring digital offers
- Improve access to specialist diabetes care in community settings and reduce variation within primary care
- Pilot the development of structured education programmes for patients with type 2 diabetes and LD
- Evaluate North Tyneside Diabetes Remission Service pilot to inform future commissioning intentions

Respiratory

- Implementation of long covid rehabilitation services to manage the long term effects of covid-19 on peoples physical health
- Introduction and roll-out of pulse oximetry at home services to help detect silent hypoxia, aiming to reduce mortality and morbidity as a result of contracting the covid-19 virus
- Reduce smoking prevalence through partnership working to develop a cohesive North Tyneside integrated smoking pathway in conjunction with Public Health, community pharmacy and primary and secondary care that offers a broad range of interventions based on individual patient needs.
- Achieve Earlier Diagnosis of COPD and Asthma by designing and commissioning community provision which will provide the opportunity to move spirometry out of secondary care, reduce variation and improve accuracy.
- Reduce unnecessary hospital admission and reduce the variation in primary care; ensuring patients receive the correct diagnosis.
- Promote self-management through improved compliance of treatment and correct inhaler use equitable to the individual's needs.

- Support Primary Care through the provision of structured education opportunities designed to equip practitioners with the relevant information guides and specialist facilitative support to embed improved standards and practices.

OUTCOMES

- Rationalised approaches to personalised care using personalised delivery models such as Year of Care
- Reduction in emergency admissions from the housebound population
- More services delivered out of hospital and closer to home

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

We will work with Primary Care Networks, community services, the Patient Forum and the Voluntary and Community Sectors including social prescribing in co-design of a multi- factorial chronic disease management template.

WORKFORCE

The development of Primary Care Networks will provide opportunities for new ways of working and address some of the fundamental challenges that currently exist in relation to health inequalities. Additionally, the CCG will continue to build capacity within the voluntary and community sector to support the prevention agenda and to provide a platform that engages people in education and self-management of their own health.

INFORMATICS

Improving management of long term conditions will require the reduction and removal of multi-layered systems and documents that often lead to duplication and inefficiencies in how care is delivered particularly for patients with multiple co-morbidities who may experience numerous health professionals and therefore multiple entries onto a range of clinical systems. We will work with information system providers and service providers to rationalise how data is inputted and recorded.

ESTATES

Where services are expected to undertake transition away from traditional hospital settings and towards community settings such as in respiratory, we will work with Primary Care Networks to ensure services are delivered in safe, fit for purpose settings close to people's home.

LIVING WELL WITH CANCER IN NORTH TYNESIDE

AIMS

Our aims for Living Well With Cancer in North Tyneside are:

Embed a whole system response to prevention and addressing the causes of cancer, including tobacco addiction, alcohol, obesity and poor diet

Achieve earlier diagnosis and improve patient pathways with the aim of consistently achieving standards in the national screening programmes, improving diagnostic waiting times and delivering NHS constitutional standards in referral to treatment

Ensure that patient experience for cancer is high across secondary and primary care

Transform our approach to personalised care for people living with and beyond cancer by replacing traditional hospital follow up with patient-supported self-management

Ensure commissioning, provision and accountability processes are fit for purpose and aligned to the ICS reconfiguration plans for diagnostic services and delivery of optimal care pathways

Proactively work with specialist teams, primary care, social care and the voluntary sector to develop services that improves access to high quality psychological and emotional support for people affected by cancer.

OBJECTIVES

- Enable more smokers to quit with support from an integrated stop smoking pathway into smoking cessation services
- Increase the proportion of people diagnosed with cancer at stage 1 and 2 from 50% to 75% by 2028
- Improve management of patients who are experiencing psychological symptoms secondary to diagnosis, treatment or palliative care for cancer
- Improve mortality rate with more people surviving and living well with cancer at least 5 years or more following diagnosis
- Deliver 28 day referral to first treatment standard by 2020/21
- Improve patient experience and introduce co-production involving all communities on par with clinical effectiveness and patient safety
- Embed GP cancer reviews, incorporating needs assessment and signposting for support-advice as required

CHALLENGES

- Fewer beds are available now due to social distancing measures.
- Assuring patients reluctant to access services that returning to hospital is safe.
- Impact of second/third wave of COVID-19 infections.
- Access to timely diagnostic services.
- Workforce, ability of staff to turn focus from COVID-19 to recovery process and have sufficient reserves of energy.
- Supply chain technology, ensuring digital services have sufficient resources to deliver required improvements.

- Public confidence to attend appointments and acceptance of required behaviours
- Managing the annual increase in number of people diagnosed with cancer and living well longer after diagnosis
- Increasing awareness of symptoms of cancer and reducing the number of preventable cancers before they appear
- Provision of a range of psychological support for cancer patients and carers at diagnosis, during treatment and post-treatment
- Address the inequality gap that exists for deprived communities

OPPORTUNITIES

- To lead regional efforts to improve the rates of early diagnosis and treatment for lung cancer.
- To improve access to screening and diagnosis, thus ensuring that cancer is detected and treated at the earliest possible opportunity.
- To facilitate the delivery of holistic, personalised, care which reflects the needs of the individual.
- To make the best possible use of the resources that are available by encouraging providers to work together across organisational boundaries.

WHAT ARE WE DOING ABOUT IT – TASKS & TIMEFRAMES

To March 2021:

- Commissioning changes to current pathways in line with NICE guidelines and rolling out and embedding Optimal care pathways in Lung, Breast, Oesophageal and Gastric, Gynaecological and Prostate cancers.
- Developing a raising awareness programme across Primary Care Networks on Human Papillomavirus (HPV) screening for cervical cancer.
- Increasing vaccination rates in North Tyneside and rolling out HPV vaccination to boys.
- Promoting, developing and delivering whole system approaches with all partners in health including the Voluntary and Community Sector (VCS) and social care to improve the quality of 2 week referrals with the aim of improving the patient experience and reducing variation.
- Work with acute providers to develop a full Recovery Package as a full transitional approach to achieving personalised care.
- Pilot a lung cancer screening service which aims to increase the detection rate of lung cancer amongst high-risk patient groups.

From March 2021 onwards:

- Support North Tyneside's Primary Care Networks to achieve the requirement to improve the quality of referrals and cancer care planning in primary care.
- Continue to work closely with Newcastle Hospitals and Northumbria Healthcare to overcome the barriers to improved performance against the national targets for waiting times from referral to treatment.
- Continue to support the North East Cancer Alliance and our provider organisations to implement Rapid Diagnostic Centres that will improve access to cancer testing for our residents.
- Support the implementation of stratified pathways of follow-up for cancer patients wherever possible, recognising that many patients will benefit from being support to access care closer to home.

- Work with our partners across the North ICP to determine whether it is possible to develop mutual aid protocols to support the collective delivery of acute oncology, diagnostic radiography and endoscopy services.
- Map existing support provision for families and carers of people with cancer, identify gaps in provision and plan how those gaps may be filled, recognising the potential role of the voluntary and community sector could have in providing support.

OUTCOMES

- National aspiration to reduce smoking prevalence for the North Tyneside population by 12% by 2022
- Increased survival rates for people living with cancer
- Majority of patients completing 28 day pathway
- Improved uptake in screening programmes with improved uptake in bowel screening to 75%
- Increase in early detection rates for Lung cancer
- Every person diagnosed with cancer to have access to personalised care, a GP cancer review and supported by cancer key workers across all settings by 2021
- By 2023, safety-netted stratified pathways will be in place for all appropriate cancers
- Primary Care Networks working together with public health, social prescribing and the VCS in reducing health inequalities, improving overall cancer outcomes and delivering the best possible patient experience

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

A Cancer Patient and Public Engagement Strategy will be developed and processes established to identify survivors and their carers who can actively support the Cancer Locality Group around co-design and enable meaningful engagement for and on behalf of cancer patients and those who care for them.

Continue to build on existing engagement work on cancer developments and ensure that patient experience is incorporated into service redesign.

WORKFORCE

Nationally, the NHS cancer workforce is facing significant challenges in meeting the requirements set out in the NHS Long Term Plan. With the push to diagnose people with cancer earlier and with more people living longer with often more complex conditions, the role of specialist cancer teams, the skills gap in radiology, the increasing demand for psychological support and the increasing role of primary care in supporting personalised care mean a clear strategy for workforce planning, training and access to high quality education is needed across the ICS. The North East and Cumbria Cancer Alliance and partnership working at ICS level will continue to ensure the workforce requirements at local level continue to be sustainable, and patients have the highest standard of coordinated care and support during and after treatment.

AGEING WELL IN NORTH TYNESIDE

AIMS

The strategic aim for Ageing Well in North Tyneside is:

Support North Tyneside residents to age well and remain healthy and independent for as long as possible, delivered through three key workstreams aiming to keep older people healthy, active and connected

OBJECTIVES

Key Workstream 1 - HEALTHY

Optimal long term conditions management for all people in North Tyneside

- People are involved in streamlined year of care planning to maximise health and minimise the impact of long term conditions.
- Equity of service for all including, housebound patient, those with learning disability and minority groups.

Care for older people is fully integrated

- The patient is able to tell their story once, their voice is central to care decisions
- Care is delivered in the right place at the right time by the right individual with the relevant information
- MDTs work together to ensure that all patient care needs are met
- Transitions between working age, older peoples and palliative services are smooth.

Mental health

- Parity of esteem with physical health
- Truly holistic care is offered to all older people with attention paid to mental and physical health alongside social wellbeing.
- Mental health services are integrated and accessible to all residents across North Tyneside.

Key Workstream 2 - ACTIVE

Physical

- Physical activity for older people is normalised with a range of options to suit preferences and abilities.
- Older people in North Tyneside are supported to be active, eat well, stop smoking, reduce alcohol intake and live well.

Mentally

- Older people are supported to remain mentally active and active participants in their age friendly communities
- The skills and knowledge of older people are recognised and utilised to build, healthy active and cohesive communities.

Training and development programme

- Structured training programme in place across health, social and third sector organisations, centrally coordinated to ensure 'core' learning
- Staff are satisfied in the work place, there are opportunities for development and staff retention is good

Environment

- Safe and well maintained outdoor spaces conducive to physical activity

Key Workstream 3 - CONNECTED

People and environment

- Older people are supported to connect to their communities physically and digitally.
- Carers are recognised and supported in their roles
- Housing that is digitally enabled, adaptable, accessible, affordable and facilitates people to live independently in their own homes.

Data

- Used effectively to identify vulnerable individuals and offer proactive care

Technology

- Technology is utilised to connect communities and reduce the impact of social isolation.
- Digital care options are first line and open to all

Workforce

- Integrated and flexible workforce equipped to response to pressure points within the service
- Stable domiciliary care workforce able to meet demand
- Stable care home workforce able to meet local demand

CHALLENGES

- Reduced capacity within practices due to workforce/estates constraints.
- Increased need for GP services following COVID-19 due to delays in diagnosis, exacerbation of conditions, impact of reduced social/economic environment.
- Capacity in partner organisations across the system for referrals, diagnostics etc. and shift of work from acute trusts to practices e.g. re-referral/ reassessment of patients, picking up actions/prescribing where remote outpatient contact.
- The impact on capacity of appropriate infection prevention and control measures be available for all settings delivering care.
- Understanding the full extent of unmet need across the system
- Reluctance of the public accessing NHS and social care services whilst in the midst of the covid-19 pandemic
- A strategic approach to looking after and growing the workforce.
- Understanding the impact of COVID-19 have on local care homes in the medium-to-long term and the consequences of this for the wider health and social care system in North Tyneside.

- IT systems that facilitate sharing of relevant information across health and social care.
- Assistive technology and internet/N3 connectivity to support remote working (particular relevant for nursing/residential home).
- Capacity to flex services to meet increase demand with usual expected winter pressures/flu.
- Ageing workforce and ensuring we have the right people with the right skills in the right place.
- Limited estates across community and primary care to facilitate hub and spoke working (new model of integrated frailty).

OPPORTUNITIES

The current patchwork of primary care and community services has evolved over a number of years in response to the developing needs of local people and fluctuations in NHS resources. Whilst individual services produce excellent outcomes in their own right, the system as a whole often operates in silos, meaning that there are gaps in provision in some parts of the pathway and duplication in others.

Patients also tell us that the care they receive should be coordinated, ensuring that they only have to tell their stories once and can reasonably expect for this information to follow them throughout their episode of care.

During 2020/21 we aim to initiate several major programmes of change aimed at dissolving traditional organisational / sectoral boundaries between providers of care and facilitate the development of services that are more reflective of local and individual needs.

WHAT ARE WE DOING ABOUT IT – TASKS & TIMEFRAMES

Work stream	Success looks like	Key milestones		
		0-12 months	12-36 months	36-60 months
Healthy	Optimal long term conditions management for all people in North Tyneside • People are involved in streamlined year of care planning to maximise health and minimise the impact of long term conditions. • Equity of service for all including, housebound patient, those with learning disability and minority groups.	• Enhancement of Care Point • Development of Primary care Networks and wider community services	• Training programme for community nurses delivering LTC management • Enhanced links with community matrons and integrated frailty service. • Engage practices/ PCNs with year of care LTC management • Look to develop resources to facilitate self-care • Enhance links with LD teams to ensure vulnerable groups are not excluded from gold standard LTC management • Enhance links for escalation of care to PCN/ NT LTC experts	• Review data at a borough wide and local (PCN/ practice) level and refine implemented programmes • Look towards a tiered system for LTC support and management

	Care for older people is fully integrated
	• The patient is able to tell their story once, their voice is central to care decisions
	• Care is delivered in the right place at the right time by the right individual with the relevant information
	• MDTs work together to ensure that all patient care needs are met
	• Transitions between working
		• STRATA role out
		• Procurement – intermediate care beds
		• Single patient record/ clinical system
		• Patient passport/ EHCP development
		• Joint service specification for Integrated Frailty
		• Work with PCNs to ensure that centrally delivered and
			• Launch of integrated frailty unit to include
			  ○ JDH
			  ○ Care Point
			  ○ Care point enhancement
			• Implementation of single patient record for use in frailty services
			• Joint referrals process/ SPA
			• Implementation of STRATA capacity and demand system
			• Link frailty services with specialist services (e.g. respiratory, cardio, Stroke)
			• Link frailty services and palliative care
				• Implementation of single patient record across primary and secondary care for older people
				• MDTs linked to individuals – seamless links between primary and secondary care

	age, older peoples and palliative services are smooth.	network delivered services work in an integrated fashion to deliver the enhanced health in care home agenda.	services • Integration of falls services into the Single point of access/ frailty service.	
	Mental health • Parity of esteem with physical health • Truly holistic care is offered to all older people with attention paid to mental and physical health alongside social wellbeing. • Mental health services are integrated and accessible to all residents across North Tyneside.	• Development of older peoples crisis services • Recruit mental health workers into Integrated Frailty • Review of memory services for older people – to include dementia and delirium services	• Mental health workers established within frailty services • Work with mental health providers to streamline services and pathways across North Tyneside • Mental health is considered in every assessment of an older person.	• Review and refinement
Active	Physical • Physical activity for older people is normalised with a range of options to suit preferences and abilities. • Older people in North Tyneside are supported to be active, eat well, stop smoking, reduce alcohol intake and live well.	HOWfit • Leaflet drop • Website • Goal seeker app • Age UK support • Links to universal via voluntary and third sector	• Volunteers to support exercise and activity in care homes	
	Mentally • Older people are supported to remain mentally active and active participants in their age friendly	• Develop a clear pathway linking the voluntary sector with commissioned older peoples mental health services	• Clear directory of social prescribing options available. • Care coordinator role clearly defined and established • Early links between health, social care and the voluntary sector established	• Mature links and joint understanding of activity in health, social care and the voluntary sector

	communities • The skills and knowledge of older people are recognised and utilised to build, healthy active and cohesive communities.			
	Training and development programme • Structured training programme in place across health, social and third sector organisations, centrally coordinated to ensure 'core' learning • Staff are satisfied in the work place, there are opportunities for development and staff retention is good		• Develop/ source resources for a range of audiences • Communication strategy • Workforce plans across organisations	
	Environment • Safe and well maintained outdoor spaces conducive to physical activity		• Accessibility to universal services	
Connected	People and environment • Older people are supported to connect to their communities physically and digitally. • Carers are recognised and supported in their roles • Housing that is digitally enabled, adaptable, accessible, affordable and	• SIGN Plus	• Support digital technology	

	facilitates people to live independently in their own homes.			
	Data • Used effectively to identify vulnerable individuals and offer proactive care		• Develop a strategy for use effective use of data currently available from multiple sources. • Data sharing agreements in place	• Implementation of strategy
	Technology • Technology is utilised to connect communities and reduce the impact of social isolation. • Digital care options are first line and open to all		• Partnership working with VODA, Age UK and others to reduce digital poverty • Increase access to services via digital, remote and agile working across organisations	
	Workforce • Integrated and flexible workforce equipped to response to pressure points within the service • Stable domiciliary care workforce able to meet demand • Stable care home workforce able to meet local demand		• Sustainable workforce including different skill mix • Community Care Practitioners across Integrated Frailty service • Advanced care Practitioners in Care Homes	

OUTCOMES

- % reduction in hospital admissions.
- % reduction in conveyances to A&E.
- % reduction in admissions to permanent care settings.
- % reduction in average length of stay in hospital and intermediate care settings.
- % reduction in delayed transfers of care.
- % reduction in waits for repatriation.
- Increase referrals to community frailty teams.
- Increase in patient, carer and staff satisfaction
- Increase number of North Tyneside residents completing programmes to improve their strength and balance.
- Increase proportion of patients receiving a Comprehensive Geriatric Assessment.
- Increase number of people dying in their place of choice.
- Reduction in prescribing rate of medicines that can cause dependency, antimicrobial medication and medicines of low value.
- Increase in social prescribing referrals.
- Increase in proportion of cancers diagnosed at early stage (1 & 2).

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

A joint communications strategy is being developed in conjunction with Northumbria Healthcare NHSFT, North Tyneside Council and TyneHealth Ltd (GP Federation).

WORKFORCE

- Continuation of Nurse and GP career start programmes.
- Primary Care Practitioners (PCPs) programme funded for 16 nurses.
- Support work development within the care home sector.
- Support primary care and care homes to develop a learning environment for students.

INFORMATICS

- Continued commissioning of online consultation software for practices.
- Delivery of GP IT Futures requirements.
- Informatics will be key to the integration of existing services and the coordination of care. An IT task and finish group has been established to lead this work across the system.

ESTATES

- Production of an estates strategy for Primary Care.
- The CCG is part of the Primary Care Data Gathering Programme pilot which aims to get a baseline of consistent data collected for every NHS-reimbursed GP practice across England.
- An estates review will be undertaken as part of the integrated community frailty service review.

CONTINUING HEALTHCARE SERVICES IN NORTH TYNESIDE

AIMS

Our aims for Continuing Healthcare (CHC) Services in North Tyneside are:

Commissioned packages of care will respond to assessed needs, taking patient preferences into consideration in line with CCG policy. Transparency and equality in relation to care packages will be achieved as well as quality and value for money

Ensure appeals are responded to within agreed timeframes and outcomes are communicated to appellants

OBJECTIVES

- Implement the revised Continuing Healthcare framework
- Meet the national timeframe of 28 days from checklist to decision making
- Meet the national ambition to provide the opportunity for Personal Health Budgets (PHBs)
- Respond to appeals within nationally agreed timeframes

CHALLENGES

- Meet expectations of the national discharge to assess requirements
- Address the backlog of CHC assessments in a timely manner in partnership with the Local Authority
- Support the Local Authority to address the backlog in financial assessments for patients discharged from hospital between 19 March 2020 and 31 August 2020 to ensure that those patients will either be moved to core NHS, social care or self-funding arrangements

WHAT ARE WE DOING ABOUT IT – TASKS & TIMESCALES

- Assessing, monitoring and reviewing fast track packages of care in an appropriate time frame and ensuring support is proportionate to needs
- Ensuring all reviews are up to date, prioritising high cost cases
- Review of all shared care cases and support packages
- Joint monitoring and quality reviews in nursing homes in partnership with the Local Authority
- Commissioning domiciliary services from the joint provider framework
- Further developing the Broadcare IT system to ensure accurate reporting
- Ensuring all CHC patients living in their own homes are offered Personal Health Budgets
- Offering Personal Health Budgets to wheelchair users
- Developing procedures to ensure appeals are reviewed and responded to in a timely manner

OUTCOMES

In relation to quality of service provision, the initiatives will:

- Provide ongoing assurance in relation to CHC assessment toolkit recommendations in order to promote equity
- Ensure providers meet the quality Key Performance Indicators and that packages of care meet assessed needs
- Ensure commitment to working with the Local Authority in an integrated way so that the care needs of people in North Tyneside are met and transition into CHC is a seamless process
- Ensure existing commissioned providers understand their contribution to care packages
- Ensure that activity data is accurate and accessible
- Ensure that PHBs will offer patients flexible opportunities to meet their care needs
- Ensure that appeals will be resolved within 6 months

URGENT & EMERGENCY CARE PROVISION IN NORTH TYNESIDE

AIMS

Our aims for urgent & emergency care provision in North Tyneside are:

Simple and convenient access to uniformly, high standard urgent and emergency care services, in a way that is primarily determined by clinical need and not by patient demand

Patients are assessed and treated by the right professional with access to the right interventions, at the right time, in the right place

Quality and safe services are provided which are evidence based, effective and consistent for patients

Ensure the system is less complex and easier to understand and navigate for patients and staff, with effective patient flows between staff and services

Services proactively target and support people with chronic, long term conditions and the rapidly increasing frail, elderly population through improved, comprehensive and standardised care planning as the vast majority of emergency admissions result from acute exacerbations of one or more long-term conditions or are frailty-related

Ensure out of hospital services are enhanced and available so that there are alternatives to admission and where patients are admitted - acknowledging that some patients do need to be admitted to hospital - they can be transferred from an inpatient environment to a community setting with no delays and are able to continue their rehabilitation at home (or normal place of residence) with the same intensity and expertise that they would receive in hospital

OBJECTIVES

- Develop a sustainable, long lasting model of care which supports self-care, helps people with urgent care needs to get the right advice or treatment in the right place, first time, and provides a highly responsive, effective, personalised service as close to peoples' homes as possible.
- Minimise delays in the emergency and urgent care pathway through the delivery of a comprehensive model of same day emergency care in both medical and surgical specialities without the need for admission to hospital.
- Improve patient flow, experience and performance through the implementation of robust analysis and data quality systems that inform the level of effectiveness on patient flow in the context of accelerating improvement.
- Reduce unwarranted variation across the region, standardising services and delivery.

CHALLENGES

- Impact of second/third wave of COVID-19 infections on hospital admissions, including Emergency Departments.

- The ability of staff to turn focus from COVID-19 to recovery process and have sufficient reserves of energy.
- Supply chain technology, ensuring digital services have sufficient resources to deliver required improvements.
- Regulatory over-reach, slowing down recovery process.
- Public confidence to access urgent & emergency care when they need it and in a timely manner, particularly during the covid-19 pandemic
- Impact of ongoing social distancing guidelines on facilities
- Increasing demand for urgent and emergency care services
- Staffing issues in some sectors of urgent & emergency care

WHAT ARE WE DOING ABOUT IT/TASKS

By the end of July 2020 we:

- Established a single North ICP Local Accident & Emergency Delivery Board.
- Developed the 'Talk Before You Walk' implementation and communication plans across the North ICP, including North Tyneside, as an early adopter before roll-out across the ICS.
- Rolled out local communications to primary care to ensure tele-triage and phone consultations continue.
- Urgent Treatment Centres implemented more effective triage systems emphasising appropriate use of booked appointments via 111.

Between August 2020 and March 2021

- Begin implementation of 'Talk Before You Walk' across the North ICP, including North Tyneside
- Develop and agree system-wide 2020/21 Winter Plan.
- Reduce demand by proactive management within ambulatory care and community services.
- Redesign the 'Think Pharmacy First' offer.
- Roll-out the flu vaccines in line with national expectations and timeframes
- Review the impact of the Urgent Treatment Centre, including review of the outcomes of patient feedback and North Tyneside Healthwatch reports into Urgent and Emergency Care Services in North Tyneside, and develop options for future service development.
- Integrate Community Pharmacy into the urgent care pathway and improve uptake of and access to the Community Minor Ailment Scheme (including referrals from the NHS 111 Service).
- Maximise the use of technologies and media to facilitate better access to information and advice about conditions, treatment and services.

From March 2021 onwards

- Develop multi-disciplinary mechanisms for identifying high impact users in both Emergency and Urgent Care Services including the introduction of case management where appropriate.
- Review the impact of A&E based psychiatry liaison services on urgent and emergency waiting times for mental health support.
- Ensure that the changes to the capacity and responsiveness of community and intermediate care services aimed at preventing unnecessary admission to hospitals and residential care, as well as ensure timely transfer from hospital to community are linked to urgent care to avoid or minimise unnecessary stays.

OUTCOMES

- An urgent and emergency care system that is able to meet the needs of people in North Tyneside, where all parts of the system are integrated with the wider health and social care economy and make best use of existing resources to deliver improved quality and patient experience.
- Improved public and patient satisfaction
- Patients have more certainty about when and where they will be seen through increase of booked appointments
- Patients attend the right place at the right time and are treated by the right professional to meet their needs
- Improved working between GPs and community pharmacists that facilitates the management of self-limiting illnesses to shift to pharmacists.
- More patients are supported by community services (health and care) rather than hospital care, reducing pressure on urgent and emergency care provision

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

Seek to ensure patients are aware of the most appropriate service to access depending on their need.

WORKFORCE

Close working with all stakeholders including Health Education England to ensure that the correct workforce structure is in place to support future changes, as well as ensuring innovative service delivery models do not impact on core service delivery.

Maximise best utilisation of skill mix within community based multi-disciplinary teams including nurse practitioners, allied health professionals, community and district nursing and social care.

INFORMATICS

All urgent and emergency care services should be able to access the patient's full primary care record wherever a patient presents. At the end of the consultation or episode of care, appropriate transfer of care documents should also be immediately relayed to the patient's GP and other relevant services, such as community nursing teams to ensure continuity of care.

ESTATES

Make the most effective use of current estate but recognise that, to achieve a comprehensive shift in provision from hospitals, community based facilities need to be developed and reconfigured to meet the vast majority of patients' needs.

PALLIATIVE AND END OF LIFE CARE IN NORTH TYNESIDE

AIMS

Our aims for Palliative and End of Life Care in North Tyneside are:

For everybody approaching the end of their life to be offered the chance to create a personalised care plan

That Personalised Care Plans, including Emergency Health Care Plans and the Care of the Dying documents are shared electronically with the consent of the person and their family and all those who may be involved in their care

To involve, support and care for those important to the dying person including families, friends and carers

To improve standards in the delivery of palliative and end of life care over and above specialist palliative teams through the delivery of high quality education to other clinical and non clinical staff groups

To reduce health inequalities for those hard to reach/socially excluded and disadvantaged patients who are approaching end of life

OBJECTIVES

- To improve the advance care planning process and develop an engagement plan for everyone involved in the patient's care including the patient
- Develop new ways of working that enable a better system wide response using the full range of coordinated services deployed in the community
- Use evidence based approaches including local data, population profiling and service evaluations to determine future direction of travel
- Develop with partners a system wide solution for the sharing of records that enable palliative and end of life care staff to mobilise and deliver care in a timely way
- Ensure that our specialist palliative and end of life care services provide the highest possible care for people approaching end of life and support their families and carers.
- To achieve equity in access, provision and responsiveness for those populations where inequalities in access to palliative and end of life care currently exist e.g. black, Asian and minority ethnic (BAME) communities; lesbian, gay, bisexual, transgender and questioning (LGBTQ) communities; areas of social deprivation; learning disabilities; dementia and the prison population.

CHALLENGES

- Potential exacerbation on inequities to the right levels of support due to the covid-19 pandemic

OPPORTUNITIES

- Build upon the positive work that is already happening in North Tyneside with the number of people less likely to die in hospital than in most parts of the country and with deaths occurring at the usual place of residence being higher than the national average
- Creation of the End of Life Specialist Team for residents of care homes
- To create a co-designed personalised care plan to follow the patient journey across the whole pathway

WHAT ARE WE DOING ABOUT IT – TASKS & TIMESCALES

Death and dying are inevitable and the quality and accessibility of care will affect all of us at all ages - the living, dying and bereaved. Nationally, more than half a million people die each year, and many live with a life expectancy of less than a year at any one time and this is projected to rise by 20% over the next twenty years. We also expect more people to die at an older age and have more complex needs. The Office of National Statistics reported that out of the registered deaths in 2017, 78% were aged 70 years or above, and 22% were aged 90 or above.

The story of Palliative and End of Life Care in North Tyneside is generally positive, with people in North Tyneside less likely to die in hospital than in most parts of the country (39% compared to 47% nationally) and with deaths occurring at usual place of residence at 61% which is higher than the national average. Additionally the development of an End of Life Specialist Team for residents of care homes in 2015 has resulted in a significant increase of patients on the end of life pathway living in care homes dying in the place of residence. Since 2015, the rate of care home deaths has risen from 58% to 90% in 2019.

Partners in North Tyneside recognise that further work is needed to improve the interoperability of information flows for patients on the end of life pathway to allow for data sharing across the whole pathway that allows for a co-designed personalised care plan to follow the patient journey.

- Improve interoperability of information flows for patients on the end of life pathway to allow data sharing and production of co-designed personalised care plan
- Encourage the initiation of Care of the Dying documents in primary care and secondary care
- Provision of ongoing education and training for professionals involved in palliative and end of life care including for those staff groups who care for patients with debilitating and life limiting conditions such as COPD and heart failure
- Address inequities in access to the right level of support for those individuals who may be disadvantaged as a result of their personal situation such as limited mental capacity or due to social exclusion
- Instigate a programme of evaluation of existing commissioned palliative and end of life care services

- Explore opportunities to integrate palliative care services and collaborate on joint initiatives with partners including foundation trusts, social care, local hospice providers and the Voluntary and Community Sector on new ways of working
- Roll out and embed the Electronic Palliative Care Coordination System across the system to enable advance care planning and improved communication at end of life
- Roll out the Care of the Dying Document across GP Practices
- Increase the percentage of patients at the End of Life stage on the Primary Care Palliative Care Register
- Improve access to bereavement support by sharing and embedding a joined up bereavement policy that is as inclusive as possible with good access to information about the range of support services available
- Take forward the findings of the recent North Tyneside Public Health Needs Assessment on socially-excluded groups

OUTCOMES

- Improve the experience and the quality of care received
- Enable and increase the number people who are on the End of Life pathway to die in the place of their choice
- Reduce the number of inappropriate interventions
- Reduce unplanned hospital admissions as well as length of stay
- More people at the End of Life who have a Care of the Dying Document in Place and an Advanced Care Plan that works to the principles of personalisation

SUPPORTING ACTIONS

COMMUNICATION & ENGAGEMENT

In 2013, North Tyneside CCG established a Patient Forum End of Life sub-group. The group continues to play a valuable contribution to setting the End of Life agenda. As we look to further develop its End of Life Strategy, the Patient Forum subgroup will be proactive in the designing of information materials, providing feedback on Care of the Dying Patient audits and supporting improvement access to bereavement support.

INFORMATICS

Maximise data sharing opportunities across health and social care and the voluntary sector to help inform service delivery and future developments.

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