

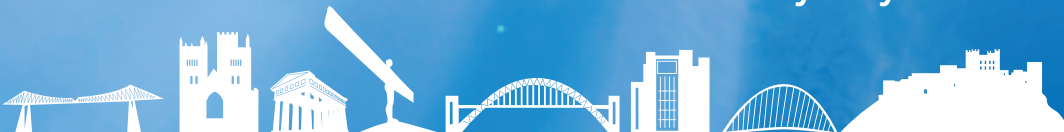
# Our vision, our future

## Our North East NHS

A strategic vision for transforming health and healthcare services within the north east of England



Summary May 2008



# Foreword

---

Our 10 year vision has been developed following a review of health and health services in the north east by the people who know best – those NHS professionals who provide care and treatment every day in our homes, surgeries, clinics and hospitals.

We have found a lot to be proud of. But, when looking at ourselves critically and talking to patients, we know that we must improve further and changes need to happen quickly.

While in recent years we have improved overall health status and reduced health inequalities, in absolute terms we remain in poor health. We observe an overdependence on treatment and yet we don't have the services to reach some of the people who need us most or to prevent them becoming ill in the first place.

Our vision sets out an agenda for putting the patient at the

heart of everything we do and, through a new sense of common purpose, describes systematically how we intend to transform services for the benefit of both patients and our 74,000 staff.

We know that some of the improvements we describe are complex and will take time. Change is always difficult and it is essential that we proceed at the right pace so that everyone affected has the chance to be involved and have their say so we get things right. This includes patients, staff and our partners.

To deliver our vision, we will start with some immediate practical steps to remove unwarranted variation in standards and outcomes for health, for mental health, in primary and community care services and in our hospitals.

In parallel we need to begin a deep dialogue with wider groups of people, patients and staff to gain support and, hence, legitimacy for our proposed approach.

To embed our vision and its practical realisation, we will deliver detailed primary care trust strategies which will be published early in 2009.

We cannot know all the technical innovations and brilliant new ideas that may transform health care in the lifetime of this vision – thinking, for example, of the advancing fields of genetics, keyhole surgery and new cancer drugs – but we have identified many things that need to be done now. We will be flexible and aim to keep the north east at the forefront of health and health care innovation.

This review would not have been possible without the outstanding commitment, time and expertise of the chairs, facilitators and members of each of the eight clinical pathway groups.

On behalf of the NHS North East community, we would like to offer our sincere thanks to everyone involved, including patients, staff and partner representatives who have attended events or otherwise contributed their insights to the review.

We will continue to reflect on and refine our findings through a programme of further engagement over the next few months. By continuing to adopt a truly inclusive approach, we can have confidence that the NHS in the north east will deliver the practical improvements that our professionals demand and patients deserve. These will ultimately define the success of our work.

Our vision is bold. It provides a real opportunity to develop, with all of our partners, a compassionate and vital health system that really is fit for the 21st century.



Ian Dalton, Chief Executive,  
North East Strategic  
Health Authority



Prof. Peter Kelly –  
Lead Clinical Chair

# Background to the north east review

---

In line with the national programme, the north east review has engaged with patients, NHS staff and members of the local public to address four key challenges:

- 1 Working with NHS staff to ensure that clinical decision-making is at the heart of the future of the NHS and the pattern of service delivery.
- 2 Improving patient care, including high-quality, joined-up services for those suffering long-term or life-threatening conditions, and ensuring patients are treated with dignity in safe, clean environments.
- 3 Delivering more accessible and more convenient care integrated across primary and secondary providers, reflecting best value for money and offering services in the most appropriate settings for patients.

- 4 In time for the 60th anniversary of the NHS, establishing a vision for the next decade of the health service which is based less on central direction and more on patient control, choice and local accountability and which ensures services are responsive to patients and local communities.

The review has incorporated a number of distinct elements, including work undertaken by eight clinical pathway groups each looking at a major area of NHS care with input from over 300 of the north east's leading doctors, nurses and other clinical staff. These are

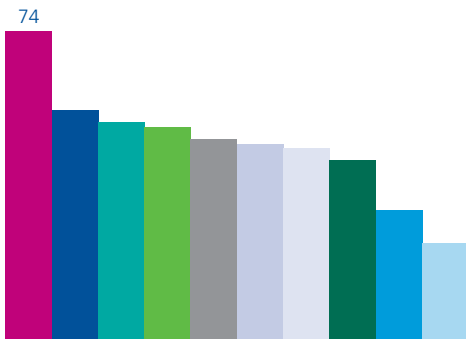
- Staying healthy
- Long-term conditions
- Mental health
- Acute care
- Planned care
- Maternity and newborn care
- Children's services
- End of life care

We have also had a number of meetings, workshops and focus groups involving staff, patients, local people and our key partners.

# The case for change and summary of our findings

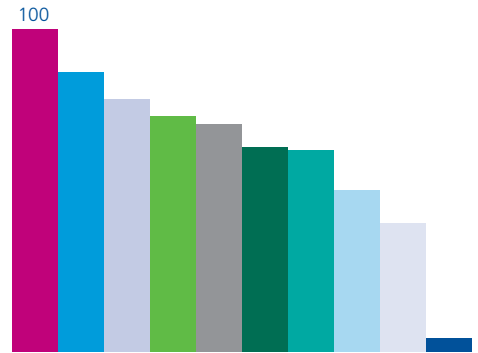
*Our NHS, Our Future* has provided the NHS North East community with a real insight and series of challenges around the future of local healthcare.

Whilst in many respects healthcare within the north east is already seen, using a range of measures, as amongst the best in the country, the population of the north east continues to suffer from high historic levels of ill-health, economic and social deprivation and premature deaths.



% of NHS organisations scoring excellent or good for Quality of Services in 2006/7  
Healthcare Commission Ratings

- North East
- London
- East Midlands
- West Midlands
- East of England
- Yorkshire and The Humber
- South Central
- North West
- South West
- South East



% of NHS trusts identified as providing best performing or better performing maternity services

- North East
- London
- East Midlands
- West Midlands
- East of England
- Yorkshire and The Humber
- South Central
- North West
- South West
- South East

Growing demand for healthcare services can deflect both focus and investment from prevention and tackling the root causes of ill-health - which can in turn contribute to further ill-health. Therefore tackling the underlying causes of ill-health must be an overwhelming priority and focus.

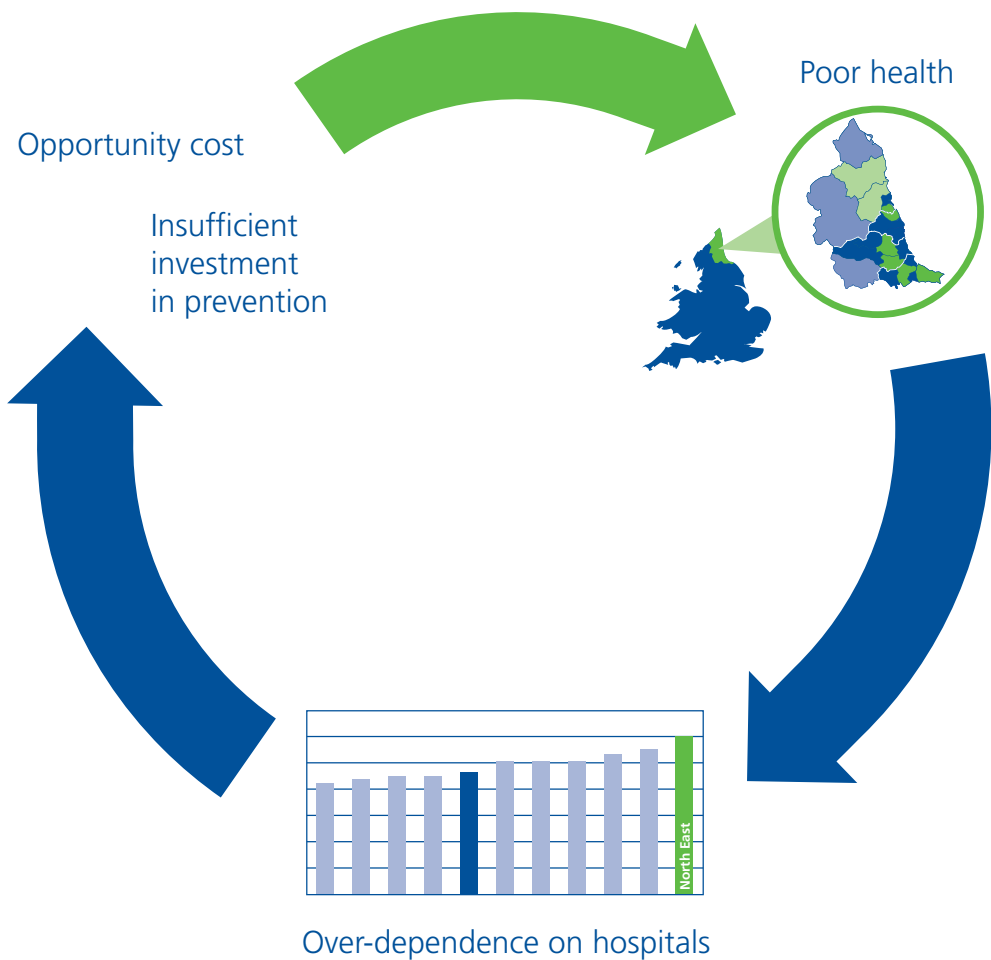
Taking a patient pathway-based approach to the review has helped to highlight that too often individual patients experience problems with their care. We have variation in access, performance and outcome.

Various key elements of the NHS and social care system (including primary and secondary care) have actually developed and evolved quite separately from each other. The entire system has never been “designed” to work in an integrated way to ensure safe, effective and seamless care for individuals.

We have concluded that the case for change is clear:

- 1 We have the worst health in England.
- 2 Our population both requires and makes more use of hospitals than any other part of England.
- 3 Our dependence on hospitals limits the resources we have to do more in preventing poor health and we have to do more for patients who have long term problems.

*These three features we call the cycle of missed opportunities and we must change the way we do things to break this cycle.*

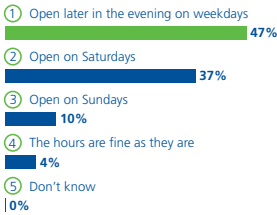


- 1 We know we are not providing uniformly good services to all our population – we have too much variation in performance.
- 2 We have waste and errors in our services and variation in outcomes for our patients.

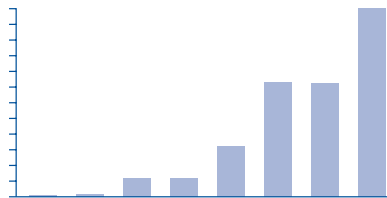
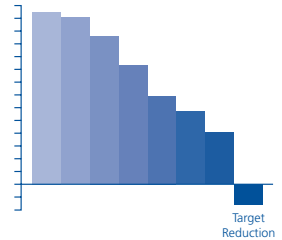
- 3 Our patients tell us that their experience of our services – whilst often good – is too often inadequate and failing to meet either our or their expectations.

*These three features we call the cycle of tolerating imperfection and we must change the way we do things to break this cycle.*

Poor patient experience, complaints, reputation damage



Not perfect



Errors, waste, variation in outcome



Our vision shows us what we must change as well as how we can start to change and sustain those changes. Each of the clinical groups has identified a long term vision for improvement and immediate actions so that we can make a start. The strategy to implement the vision has been carefully thought through and features:

### 1 Four cross-cutting themes:

- Strengthened focus on the NHS North East vision - “the seven nos” (see page 10).
- Taking forward the concept of “Team North East”.
- Development of clinical networks.
- Rebalancing the system.

### 2 Three important regional strategies:

- Primary and community care.
- Safety.
- Estates development.

### 3 Important national enablers, particularly:

- Information technology.
- Workforce development.
- Leadership development.

### 4 The North East Transformation System

### 5 Primary care trust commissioning strategies

Further details can be found in the full NHS North East document “Our Vision, Our Future” which can be accessed on the SHA website using the following link:  
<http://www.ntwha.nhs.uk/publications-and-reports/our-nhs-our-future-review>

The review has emphasised the strong sense of community and common purpose within the north east, this is referred to as “Team North East” above. Staff, patients and the public involved in the review and local events have constantly reinforced our unique identity and potential to improve in collaboration with a full range of partners.

# The NHS North East vision – seven aims for transformation

---

Over the past two years, the NHS across the north east has developed the “seven nos” - a list of overarching aims which will underpin the way that we work together in the future.

These are:

- No barriers to health and well being
- No avoidable deaths, injury or illness
- No avoidable suffering or pain
- No helplessness
- No unnecessary waiting or delays
- No waste
- No inequality

These long-term and ambitious aims must guide everyone, including all staff, patients and the public, in making decisions about health and health care.

We understand that these aims are highly aspirational and will not be achieved in the short-term. Nonetheless, there is a strong consensus from the clinicians involved in the review that we need to adopt an increasingly “zero tolerance” approach to anything falling short of these dimensions. In other words, aiming for ideal care and faultless patient experience, delivered 100% of the time is the only way we can achieve the excellence we all strive for.

# The north east strategy for public health – *Better Health, Fairer Health*

---

The north east's recently published strategy for 21st century health and well-being *Better Health, Fairer Health* provides an essential backdrop. This will significantly strengthen plans to refocus the region's NHS on delivering "good health" as well as "good healthcare". In other words, creating an increasing emphasis on prevention of illness in addition to providing high quality services to care for those who are already ill.

Full details can be found in the *Better Health, Fairer Health* report which can be accessed using the following link: [http://www.gos.gov.uk/nestore/docs/health/better\\_health\\_large.pdf](http://www.gos.gov.uk/nestore/docs/health/better_health_large.pdf)

# Vision and immediate actions emerging from the work of the eight clinical pathway groups

## Staying healthy

### Vision

- The *Better Health, Fairer Health* strategy will be fully implemented (see previous page).
- The current range of evidence based interventions to reduce the risk of illness will be dramatically increased to an industrial scale.
- Every potentially at-risk person in the population has a right to effective lifestyle interventions.
- Personal health and well-being plans will identify areas where a small change would make a big difference.
- Everybody will have a range of choices to support them in making these changes.
- GPs will hold the personal plans and be responsible for ensuring that they are monitored and reviewed.

## Immediate actions by January 2009

### Staying healthy

- We will commence the early implementation of the regional public health strategy *Better Health, Fairer Health* including establishment of regional advisory groups covering the strategy's ten themes.
- We will work with commissioners to ensure that commissioning plans demonstrate a major shift in the current range and scale of interventions.
- We will start a training and development programme in basic public health education which will progressively roll out to all our NHS workforce. This will aim to support health improvement in every contact with people and patients.

## Long-term conditions (LTCs)

### Vision

- All services will maximise the ability of individuals to care for themselves in their preferred home and achieve their desired outcomes. A wide range of support models, including assistive technology and remote monitoring will be utilised to achieve this.
- There will be a single underlying pathway for LTCs across health and social care. Specialist interventions for specific LTCs will be built around this pathway. Databases will be developed to support effective multi-agency support.
- Everyone will know what their pathway and agreed services and outcomes are.
- No one will be admitted to hospital because services have failed to provide appropriate, flexible support at home.
- Holistic case management will be available for all with a LTC who want it with the majority of this case management being provided by GPs.
- Resources will be built around individual need and desired outcomes with personal budgets

and other empowerment models being widely used.

- There will be clear and common metrics that measure the effectiveness of services from the viewpoint of the outcomes achieved by the individual.
- Crisis in-patient admissions must be seen as a failure to provide effective, flexible care.

### Immediate actions by January 2009

#### Long-term conditions

- We will undertake further work with the LTCs pathway group to identify the top three conditions which are associated with high levels of morbidity and service demand. We will then conduct a detailed work programme in the following areas:
  - Review resources currently used including for avoidable admissions.
  - Identify costed pathways to maintain individuals in the community.
  - Create a set of common metrics for future development.

## Mental health

### Vision

- The “recovery” approach will govern the model of care for mental health conditions, prioritising early detection and intervention and emphasising treatment optimism aiming for a return to normal or maximal function.
- The improvement and development of dementia services will be an absolute priority. These services are generally underdeveloped and will not meet the growing needs of our ageing population.
- Enhanced access to mental health care will be actively promoted across the entire spectrum of health and social care settings, using evidence-based approaches of collaborative care and the long-term conditions model.
- The potential of our unique regional commissioning arrangements will be maximised to meet needs and deliver rapid standardisation in models of care, with services available 24/7 and a specific emphasis on reducing waiting times.
- Avoidable deaths will be prevented through rigorous risk assessment and management, sharing lessons learned across organisations.
- The effective use of information systems will ensure access to key data on individuals and populations and to support service provision, research and development.
- The use of similar care models for old age, learning disability and child and adolescent mental health services will be explored.

## Immediate actions by January 2009

### Mental health

- We will map 24/7 inter-agency pathways for mental health across the system as a first step to developing an improved system of 24/7 care.
- We will develop a new performance framework to enable waiting times for mental health services to be managed with the same rigour and focus as occurs within acute hospitals.
- We will ask the mental health pathway group to conduct an immediate review of dementia services and produce specific recommendations as their first priority for further work.

## Acute care

### Vision

- There will be a new single telephone number for access to acute care.
- Key services will be available 24/7 and be supported by appropriately senior clinicians who have the knowledge and experience to make immediate decisions about care.
- Diagnostic investigations will be available throughout the patient pathway, where clinically and economically viable.
- Integrated health and social care teams will facilitate safe and timely hospital discharge of frail older people and prevent unnecessary admission to institutional care.
- An acute care network will be established that will explore the opportunities for more integrated working of acute care services and be responsible for future acute care service standards.

### Immediate actions by January 2009

#### Acute care

- We will seek four patch-based pilots, one from each commissioning cluster, to take forward locality integration of out of hospital acute services.
- We will develop a strategic outline case for a north east pilot of a single access telephone number for urgent care.
- We will develop service models for the provision of specialist services (including acute stroke and surgical emergencies) in conjunction with the relevant specialist networks wherever this will save lives and improve quality.

## Planned care

### Vision

- Barriers between services, organisations and sectors will be systematically dismantled to ensure that patients are consistently at the centre of more streamlined, seamless care based on their need. This will reduce unnecessary delays and waste often experienced at the interface between services, which has the potential to create problems such as delayed discharges.
- A wide range of services will be provided closer to home, combining enhanced community services with appropriate outreach and vertical integration from secondary care teams.
- Planned care services will be increasingly integrated and aligned across primary and secondary care, with a specific focus on minimising variation and inconsistency.
- Information systems will be available, accurate and accessible when needed to ensure the consistent use of current evidence-based practice and information to support choice.

## Immediate actions by January 2009

### Planned care

- We will ask the planned care pathway group as an immediate next priority to map a basket of ten marker conditions for significant variation in referral and admission rates to inform commissioning plans for 2009/10 and beyond.
- We will commission a public campaign to promote choice.
- We will ask commissioners to undertake a review of incentives and rewards for services to default to day surgery for a defined basket of procedures.

## Maternity and newborn care

### Vision

- Health inequalities will be addressed as a first priority to address key factors such as obesity, smoking, teenage pregnancy, breastfeeding and substance misuse, which impact on good outcomes for women and their babies.
- A standardised maternity care pathway and standards for services will be in place across the north east. This will ensure genuine choice for women.
- More proactive identification of high risk women before or during early pregnancy, thereby optimising pregnancy outcomes.
- Transparent information for women about their choices in individual units.
- Greater use of maternity support workers improving attendance among vulnerable groups, improve communication and links with other services.
- More personalisation of the full spectrum of maternity care from pre-pregnancy care to sign-off from a midwife.
- Consultant cover that meets Royal College guidelines.

### Immediate actions by January 2009

#### Maternity and newborn care

- We will identify standards that will apply across the whole region to improve the health of mothers in each of the following priority areas:
  - Teen pregnancy.
  - Smoking.
  - Obesity.
  - Alcohol and substance misuse.
  - Breastfeeding.
- We will review maternity service provision to understand the impact of moving towards 1:1 midwifery care in labour and 98 hour constant cover.
- We will ask the maternity and newborn care pathway group to define a pathway that specifically enables better and earlier identification of high risk women.

## Child health

### Vision (for care of the sick and injured child)

- The care pathways and standards of care for the sick and injured child will be consistent, safe, equitable and sustainable across the whole north east and take account of national best practice, the north east vision and patient expectations.
- There will be clear access and referral procedures for parents of a sick or injured child. This will reduce parental uncertainty, inappropriate use of care, delays in treatment and distress to families.
- Staff across the whole care pathway will be trained and competent to recognise and initiate the management of an acutely sick or injured child (24/7).

### Immediate actions by January 2009

#### Child health

- We will establish standards and a common pathway for the acutely sick and injured child.
- We will conduct a review of services to fully understand the reasons behind current variation and implications for issues such as safety, effectiveness and the appropriateness of clinical support.
- We will review the potential impact of moving towards the common pathway. This will include strengthened front-end local services including primary care and hospital paediatric assessment units and co-ordinating plans for in-patient medical and surgical paediatric services. Priority will be given to acute surgical services.

## End of life care

### Vision

#### *Identification of all people approaching end of life*

- Proactive approach to care.
- Placement of names on palliative care registers.
- Use of evidenced based techniques to identify individuals.
- Access to specialist assessment of needs of patients and carers.
- Identification of an individual key worker who will co-ordinate care.
- Sensitive discussion about care preferences.
- Advise commissioners to ensure that appropriate services are available.
- Holding of regular multi-disciplinary team meetings to proactively plan and manage care.

#### *Identification of last days of life*

- Ongoing assessment of needs.
- Addressing spiritual and psychological needs.
- Reviewing the advance care plan and advising commissioners and services of significant changes.
- Establishing the place the person would prefer to die.
- Rationalisation of medications and discontinuation of inappropriate interventions.

#### *Death*

- Verification of expected death.
- Support for carers (including staff).
- Clear details on who to contact.

#### *Care after death*

- Awareness of care after death procedures, including cultural issues.
- Advise on practical issues (e.g. contacting undertaker).
- Sensitive and dignified handling of possessions.
- Sharing information with key professionals.

- Information given about the grieving process and who to contact.
- Bereavement risk assessment and ongoing bereavement follow up.

All this must be underpinned by public health and social marketing work to help address society's perceptions and fear of death and help people recognise it as a normal part of the life cycle.

## Immediate actions by January 2009

### End of life care

- We will complete the initial draft of a regional charter for end of life care for consultation.
- We will ask commissioners to identify the current resources utilised to support individuals at the end of their life and explore more flexible and individually focussed alternatives.
- We will map out variation in current standards of end of life care as a first step towards providing consistency across the region.

N.B. further details and a full list of recommendations can be found in the individual pathway group reports which can be accessed on the North East SHA website using the following link: <http://www.ntwha.nhs.uk/publications-and-reports>

## Other immediate actions by January 2009

---

### Clinical themes – future work

- Agree the right arrangements for continuing the work of clinical pathway groups. In some cases, the groups may be complemented or replaced by local clinical advisory groups and networks. To support this, we will create a major development programme for clinical leaders identified through the review.
- Creating ongoing links and clinical advice to local commissioning and planning processes.
- Extending the clinical pathway group (CPG) model to potentially incorporate other themes e.g. the elderly, condition specific groups.
- Agreeing processes that will enable the pathway groups to have oversight across NHS North East regarding progress.
- Engage with members of CPGs in instigating a process for the planned development of clinical leaders and innovators.
  - Agreeing implementation programmes and priorities.
  - Taking forward initial action plans.
  - Linking in with national workstreams around issues for which the scope may be partly outside the remit of the region.
- Clarify the role and function of the potential new networks and fully establish them by January 2009.

## Communication and engagement

- Continue an extensive process of challenging, refining and building up a wide consensus about the outcomes of the review through planned engagement of clinicians and other staff, patients, the public, NHS partner organisations and stakeholders.
  - Cascading process through all organisations to ensure all staff are personally engaged.
  - Cascading public/patient engagement through local forums.
  - Developing members of clinical pathway groups and others as ambassadors for change.
- Progress the deep conversation with all NHS NE chief executives about the future implications of the review and to agree what needs to be done at a regional or local level. Clarify priorities and components of the change programme.
  - With primary care trust (PCT) chief executives, continue to engage with key partners, particularly local authorities and directors of adult social care and children's services.
    - Event to be organised with PCT chief executives and directors of adult and children's social services in summer 2008 to discuss implications and next steps.
    - Further local discussions to be arranged including events for non-NHS staff to challenge, refine and build up a wider consensus about the vision.

## Responding to the needs of our rural population

- Establish a Commission for North East Rural Healthcare to identify and tackle inequality of access to services.
  - This is based on what local people are telling us about issues such as ambulance response times, journey times to hospitals and variable access to other service, although there is also evidence of some excellent rural services that we will need to build on.

## Commissioning strategies and plans

- Work closely with commissioners to define and manage a work programme designed to translate high level design principles developed by the clinical pathway groups into detailed and locally appropriate three year commissioning strategies by January 2009.
- Building on a series of initial meetings with PCT chief executives, to establish a specific work programme to manage the transition from CPG recommendations to local commissioning plans.
- As part of this, utilise the CPGs as a focal point for developing robust clinical input and advice.

# Timelines

---

Completion of urgent reviews of mental health and acute services pathways. Completion of initial communication/engagement programme. Completion of priority implementation programmes for eight pathway groups. Completion of PCT three year commissioning strategies.

Jan  
2009

Fully established clinical networks starting to significantly improve quality.

July  
2009

Priority recommendations from clinical pathway groups fully implemented. Completion of review.

2010

Mid-point of a programme to progressively move services close to home. North east vision and focus on four dimensions fully embedded. Workforce is changing to reflect changes. Fully integrated health and social care services developed.

2012

New service models continuing to emerge. Networks have now matured and care is fully managed clinically around defined, evidence based pathways. Prevention models have resulted in less demand for treatment.

2014

The north east is acknowledged as a world class health system, with significant competition from clinical staff to work here. Prevention rather than treatment has become the main focus, and both the culture and adverse behaviours within the population have changed significantly. Systematic user feedback is now approaching 100% complete satisfaction and health outcomes are the best in the country.

2018

For more information visit  
[http://www.northeast.nhs.uk/  
publications-and-reports/](http://www.northeast.nhs.uk/publications-and-reports/)

# This document can be made available in large print and on audio tape.

Arrangements for translation can also be made for anyone whose first language is not English.

For further information contact:

Communications Team, North East Strategic Health Authority, Riverside House, Goldcrest Way, Newburn Riverside, Newcastle upon Tyne, NE15 8NY  
Telephone 0191 210 6422  
May 2008

আপনি অনুরোধ করলে এই খবরটা অন্য ভাষাতেও জোগানো যাবে। এই নম্বরে টেলিফোন করুন - 0191 210 6422

निवेदन किए जाने पर यह जानकारी दूसरी भाषाओं में मिल सकती है। कृपया 0191 210 6422 पर टेलिफोन करें।

"این اطلاعات میتواند بنا به درخواست به زبانهای دیگر در دسترس قرار گیرد. لطفاً به شماره ۰۱۹۱ ۲۱۰ ۶۴۲۲ تلفن نمائید."

Na życzenie informacje udostępniamy również w innych językach. Tel. 0191 210 6422.

“ਇਹ ਜਾਣਕਾਰੀ ਦੂਜੀਆਂ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਬੋਲੀ ‘ਤੇ ਉਪਲਬਧ ਹੋ ਸਕਦੀ ਹੈ। ਕਿਰਪਾ ਕਰ ਕੇ ਇਸ ਨੰਬਰ 0191 210 6422 ‘ਤੇ ਟੈਲਿਫੋਨ ਕਰੋ।

本資料文件可以按要求製作成其他語文版本，以供索取。請電 0191 210 6422

提出有關要求。

本信息文件可应你的要求提供其它语言版本。如欲索取请致电 0191 210 6422。

من الممكن توفير هذه المعلومات بلغات أخرى حسب الطلب. الرجاء الاتصال بالهاتف رقم: 0191 210 6422.

یہ معلومات درخواست کرنے پر دوسری زبانوں میں بھی فراہم کی جاسکتی ہیں۔ براہ کرم 0191 210 6422 پر ٹیلی فون کریں۔