NHS
North East and
North Cumbria

Item: 10.4

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	✓

BOARD 30 JANUARY 2024	
Report Title:	Executive Medical Director Report

Purpose of report

The purpose of the following report is to provide an update on a selection of medical directorate priority programmes, including post covid services, waiting well and the diagnostic programme.

Key points

Waiting Well

- The Waiting Well Programme is a regionwide programme that uses a population health management approach to provide targeted support to patients who are waiting for planned surgical procedures.
- All localities across the ICB now have an offer in place for their patients.
- Approximately 6500 patients have now been contacted and offered support, with 79% of those in deciles one and two.
- Patient feedback is very positive.

Winter Pathogens

- Data on flu, COVID and acute bronchiolitis outlines the peaks and troughs of winter pathogen demand placed on the local system.

Post COVID

- There is an expectation that specialist post COVID services should continue to be commissioned by ICSs and that ICBs should appoint a named lead to oversee delivery of post COVID services.
- There may be benefits in aligning pathways with other post viral, multisystem conditions that could benefit from the multidisciplinary model of care provided by post COVID services.

Diagnostic Programme

- An update on current performance and actions to address variation in performance and access.

Risks and issues

Waiting Well

- Delays in recruitment due to non-recurrent nature of funding.
- Practice and trust sign up to necessary data sharing agreements.

Post COVID

- Non -recurrent funding causes challenges in terms of staff recruitment and service sustainability.

- Managing expectations of stakeholders and public re: individual diagnosis and outcomes to be achieved.

Diagnostic Programme

- Although an improvement in performance, there is still further opportunity to improve waiting times for diagnostics.

Winter Pathogen Data

- Increase in system demand due to seasonal respiratory illness.

Assurances

Waiting Well

- The Waiting Well Programme has a governance structure in place to oversee programme delivery and manage risks and issues.

Post COVID

- Opportunity for local system to review the way in which services are commissioned and delivered to align with substantive services.

Diagnostic Programme

- Increased system capacity via additional dedicated diagnostic centres and development of flexible ways of working to streamline referral processes.

Winter Pathogen Data

- Robust scenario planning and management of demand through agreed shared protocols to manage patient flow.

Recommendation/action required

The Board is asked to receive and review the report for information.

Acronyms and abbreviations explained

H & F – Healthier and Fairer
ICB – Integrated Care Board
NENC – North East and North Cumbria
PID – Patient Identifiable Data
WW – Waiting Well
CFS – Chronic Fatigue Syndrome

Sponsor/approving executive director	Dr Neil O'Brien, Executive Medical Director
Date approved by executive director	16/01/24
Report author	Angela Farrell, Senior Reform Manager Ruth James, Diagnostic Programme Manager Anna Alderslade, Clinical Projects Manager - Respiratory / Post Covid Rachel Rooney, Strategy and Partnerships Manager

Link to ICP strategy priorities (please tick all that apply)

Longer and Healthier Lives	✓
Fairer Outcomes for All	✓
Better Health and Care Services	✓
Giving Children and Young People the Best Start in Life	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	No
Has there been/does there need to be appropriate clinical involvement?	No
Has there been/does there need to be any patient and public involvement?	No
Has there been/does there need to be partner and/or other stakeholder engagement?	No

Executive Medical Director Report

1. Waiting Well

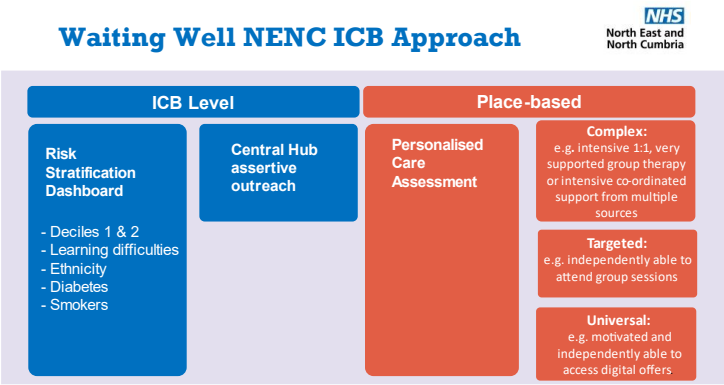
1.1. Introduction

The aim of the Waiting Well (WW) project is to support patients across North East and North Cumbria on the routine list for surgery to prepare physically and psychologically ahead of their procedure.

Innovative use of data allows us to take a population health management approach to identify and risk stratify patients, then deliver targeted support, through place-based delivery teams.

The key components of our model are:

- Data-driven identification of target cohort
- Assertive outreach to contact patients
- Holistic personalised care and assessment
- Tiered support dependent on patient need.

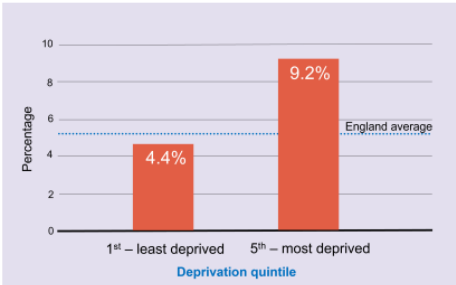


1.2. Background

North East and North Cumbria (NENC) has some of the highest levels of deprivation in the country. The Covid-19 pandemic has disproportionately affected people from our most deprived communities. This situation is reflected in those awaiting surgery, where 30% of patients on an elective waiting list are from the most deprived localities (IMD 1&2). There are also clear health inequalities for those living in the most deprived quintiles, with greater co-morbidities and risk factors associated with poorer outcomes for surgery. Interventions to support the physical and mental wellbeing of patients (prehabilitation) are effective but need to be focused and targeted to those most in need. In doing this, we have the opportunity to reduce the health inequality gap in relation to surgical outcomes and longer-term health.

Inequalities in wait times

People living in the most deprived areas of England are more than twice as likely to wait more than a year for elective care than people in the least deprived areas, August 2022 **(The Kings Fund)**



Source: Jeffries 2023

1.3. **Progress to date**

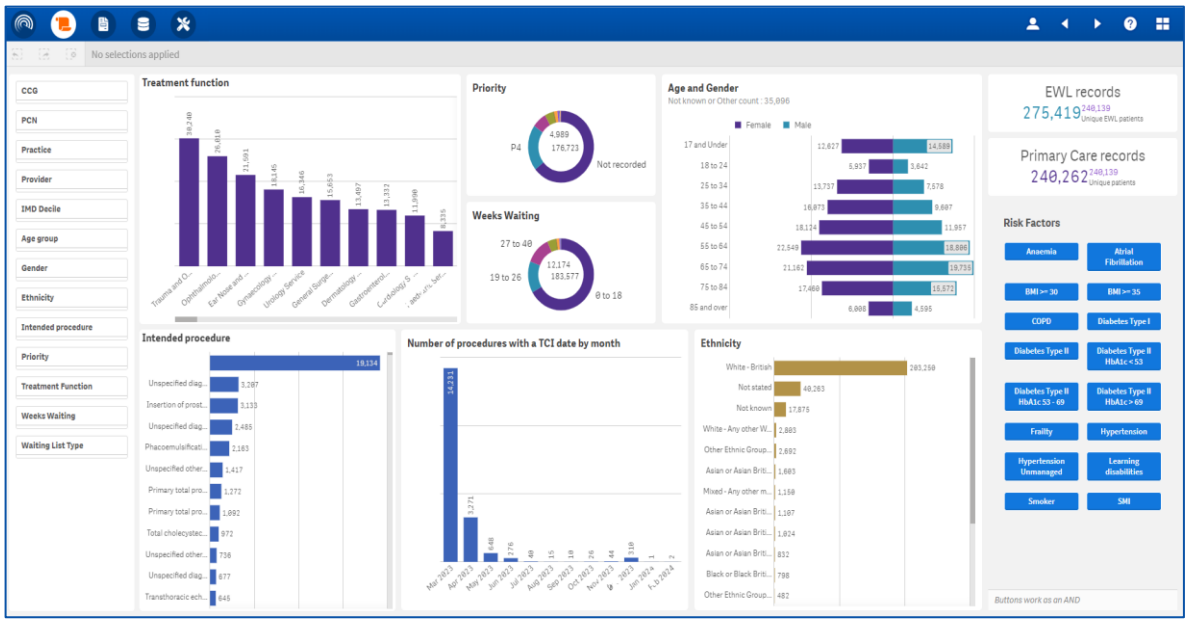
The WW Programme was initiated in August 2021. Since the update at the last H&F Board in January 2023, there has been significant progress.

1.3.1. **Waiting Well dashboard**

The Waiting Well dashboard is now live.

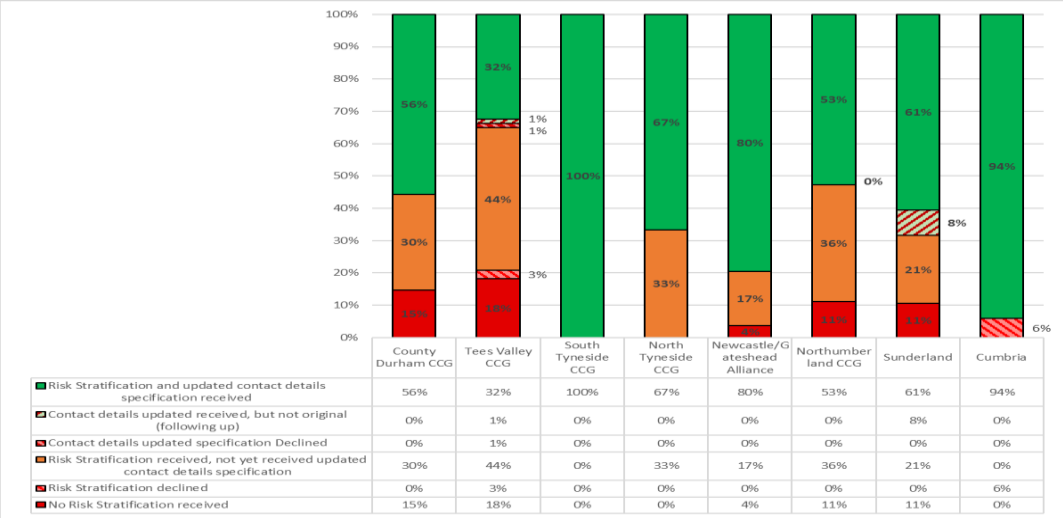
One of the challenges we faced was to establish how to effectively and accurately identify the right patients for the programme.

A digital solution, the WW dashboard, was developed to provide near real-time information relating to patients who were currently awaiting a procedure with the ambition to improve clinical outcomes. It brings together primary care data from RAIDR alongside the Elective Waiting List minimum dataset (EWL). This enables quick and effective risk stratification of individual patients on the waiting list, by decile and potential risk factors such as unmanaged health conditions. With intuitive navigational features, users of the dashboard can self-serve, drill down and extract the data with the touch of a few buttons. The team have won a Health service Journal award for this innovative development and use of data. The image below is a screenshot of the dashboard.



1.3.2. **Central hub function**

Part of the model of delivery was a central hub function to undertake the risk stratification and provide an assertive outreach approach to patients to offer support, and if taken up, book appointments with their local place-based delivery team. To enable this to happen, the central hub team needed access to Patient Identifiable Data (PID) from the WW dashboard. This necessitated data sharing and processing agreements to be put in place between NECS, the acute trusts and GP practices. The challenge in doing this should not be underestimated and has been one of the biggest issues for the programme to date. However, only two trusts are left to sign up, and these are in progress. There are also a large number of practices now signed up. The chart below shows primary care sign up as of 5th December 2023.



	County Durham CCG	Tees Valley CCG	South Tyneside CCG	North Tyneside CCG	Newcastle/Gateshead Alliance	Northumberland CCG	Sunderland	Cumbria
Risk Stratification and updated contact details specification received	56%	32%	100%	67%	80%	53%	61%	94%
Contact details updated received, but not original (following up)	0%	1%	0%	0%	0%	0%	8%	0%
Contact details updated specification Declined	0%	1%	0%	0%	0%	0%	0%	0%
Risk Stratification received, not yet received updated contact details specification	30%	44%	0%	33%	17%	36%	21%	0%
Risk Stratification declined	0%	3%	0%	0%	0%	0%	0%	6%
No Risk Stratification received	15%	18%	0%	0%	4%	11%	11%	0%

Work continues at target the outstanding practices directly.

Further progress at the central hub is the development of an end-to-end system for the programme offer. The first phase, which enabled the hub team to send letter and record contacts etc. went live in April 2023. In October 2023, the hub team contacted 691 patients to offer them support.

Phase two, which enables the place-based teams to record their interventions and capture patient outcomes has just gone live in December 2023. This a key milestone in enabling the teams to capture and report on the minimum dataset for evaluation purposes.

1.3.3. **Place based delivery**

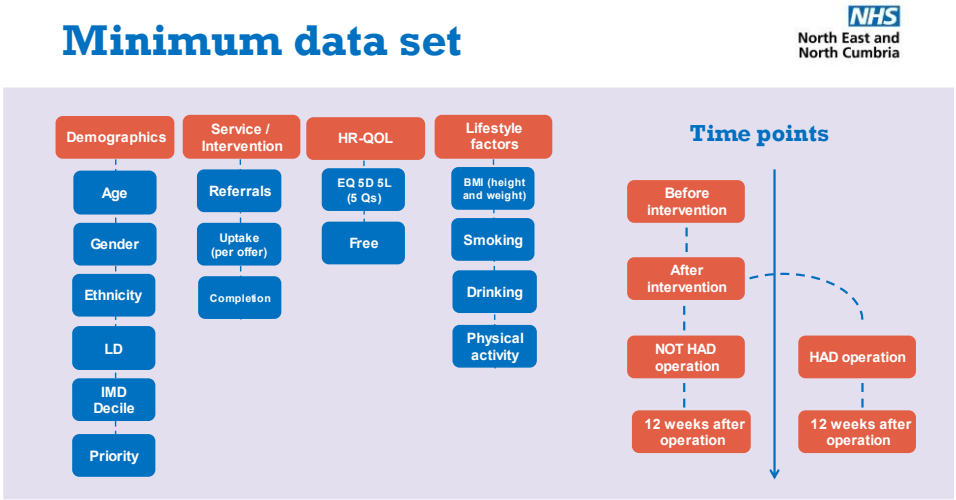
At the last update, not all areas were delivering support and numbers coming through the programme were small. This was because of recruitment difficulties faced by the localities. We are pleased to report that all areas across the ICB now have a WW offer in place. Figures to the end of October 2023 show that:

- 6575 patients have been contacted and offered support.
- 79% of those contacted were from deciles 1&2.
- 2601 accepted support (40%).
- 68% of those who accepted are from deciles 1&2.

1.3.4. **Evaluation**

Our team have developed a hybrid quantitative/qualitative evaluation plan to assess the benefits of the programme for patients, staff, and the system. Our ambition is to demonstrate reduced health inequalities, enhanced patient quality of life, and improvements in surgical capacity, through reductions in surgical cancellations and postponements as a result of improvements in patients' overall wellbeing.

The team have developed a minimum dataset (seen in the diagram below) that will be captured in the K2 system which has been developed.



Case studies and patient stories have also been collated.

Two of the many positive quotes we have received are:

Patient 1: *"Before your intervention I thought I just wanted to die, now I realise life is worth living."*
Patient 2: *"It has taken me months to leave the house, I would choose to stay at home rather than socialising with friends - although I know that socialising would be good for me, I could not bring myself to leave the house. Since being asked to take part in this incentive I have left the house three times a week even if it's to go the gym and back. I look forward to doing my exercise classes."*

Early data shows patients reported improvements in their overall quality of life, reflecting the five dimensions of mobility, self-care, usual activities, pain/discomfort, and anxiety/depression.

The team are also currently working with academic teams from Teesside University to apply for a research grant to undertake a full health economic evaluation.

A Waiting Well case study

Patricia's story

Following 12 weeks of taking part in the Waiting Well programme to improve her health ahead of her planned surgery, a Newcastle woman found her health improved so much that she no longer needed surgery.

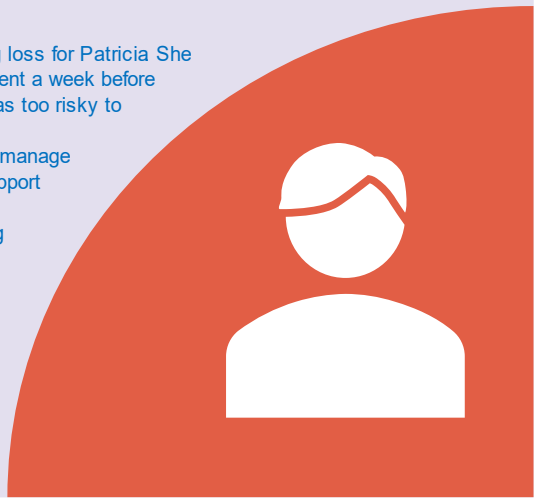
A deviated septum caused breathing issues, sinusitis, pain and hearing loss for Patricia She hoped surgery would solve her problems However, her pre op assessment a week before her surgery date showed that her diabetes was out of control and it was too risky to have a general anaesthetic for her surgery

She was referred to the waiting well programme She was given help to manage her diet to control her diabetes, along with manageable exercises to support this.

She was also referred to a respiratory nurse who showed her breathing exercises to control her breathing

After the 12 week programme, Patricia's health improved so much that she longer needed the surgery. Patricia's sugar levels were back under control, and she had dropped over a stone in weight. Her breathing also improved significantly thanks to the breathing exercises

Patricia said: "Thanks to the support from Waiting Well, I've been able to make a number of small changes which have added up to making a huge difference to my health I just needed the guidance to help me do it "



2. Winter Pathogens

2.1. Many scenarios were planned for including the scenario below which describes the pattern of this year's prevalence of winter pathogens;

- A rise in respiratory admissions through September 23
- A rise in COVID cases through Autumn with a peak in demand mid-winter
- A rise in flu in early January 24
- A peak in RSV (Respiratory syncytial virus) in November 23
- With normal levels of scarlet fever and iGAS (invasive Group A Strep).

2.2. RSV followed the usual seasonal pattern this winter and is now falling sharply. This is good news for paediatrics and hopefully next year we will have more success with the proposed vaccination programme.

2.3. The ONS data suggests the most recent COVID JN.1 wave has now peaked and has not caused undue pressure on hospitals in comparison to what was seen in previous winter waves.

2.4. Alongside this, the flu wave may have peaked and the impact in terms of hospitalisations has been much lower than seen in pre-pandemic years. We may hope that this is due to high levels of protection in the most vulnerable and a good match of flu vaccine for the circulating strains this year.

2.5. Hospitalisations for flu at regional level are below England levels and much lower than we saw last year or in pre-pandemic years.

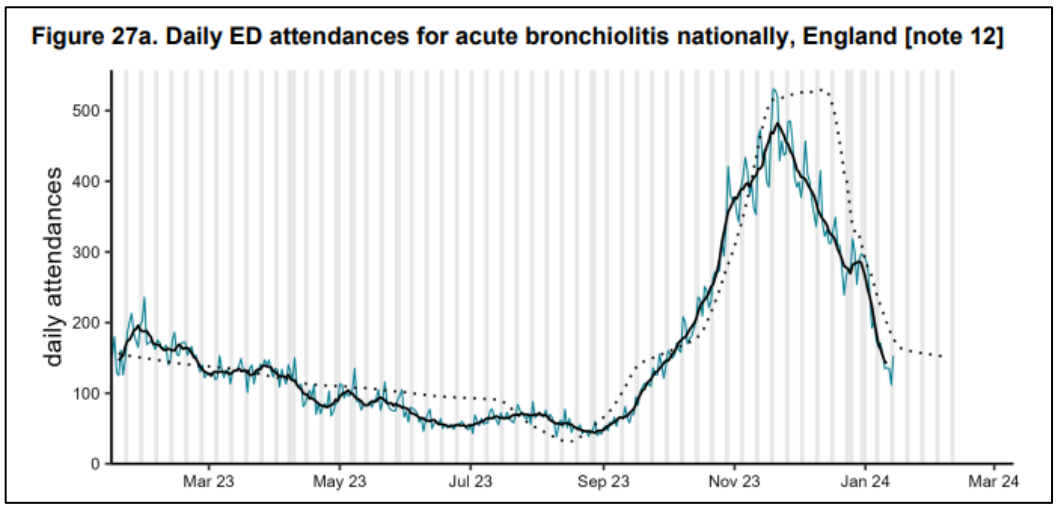
2.6. The most recent data for Emergency Department attendances shows a sharp fall over the last week back to levels which are the norm for this point in the season. This is not converting to raised admissions.

2.7. Since the testing guidance was changed we have seen much lower identification of in-patients with COVID but even in this context the most recent wave has seen a very minor rise in occupancy. Occupancy this year has been below the levels in the previous 2 years for the whole of 2023.

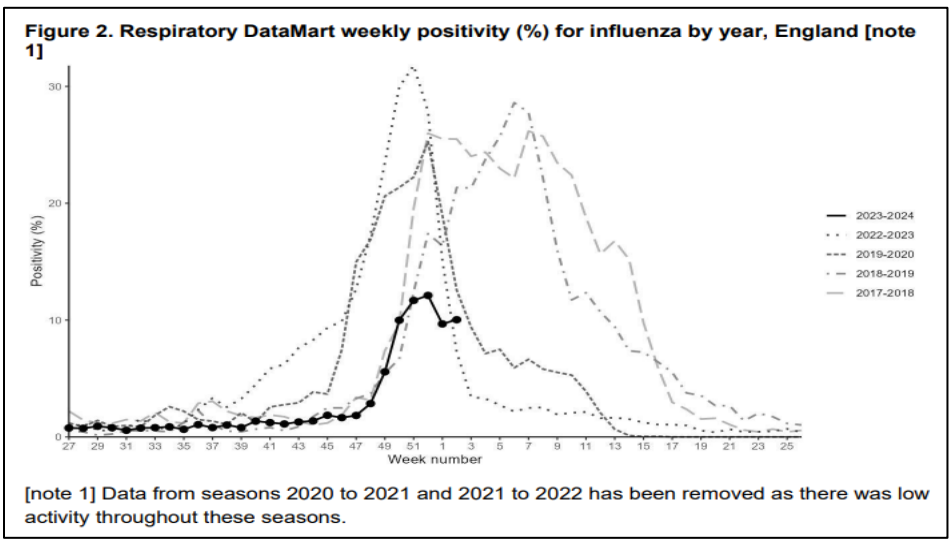
2.8. Looking just at this winter, we have seen a gradual rise in beds lost to infection (Flu, COVID and Norovirus) but in the last week there has been some improvement – mostly due to a drop in beds lost to norovirus. It is to be hoped that we will see a steady fall in beds lost over the rest of the season.

2.9. **Winter pathogen data**

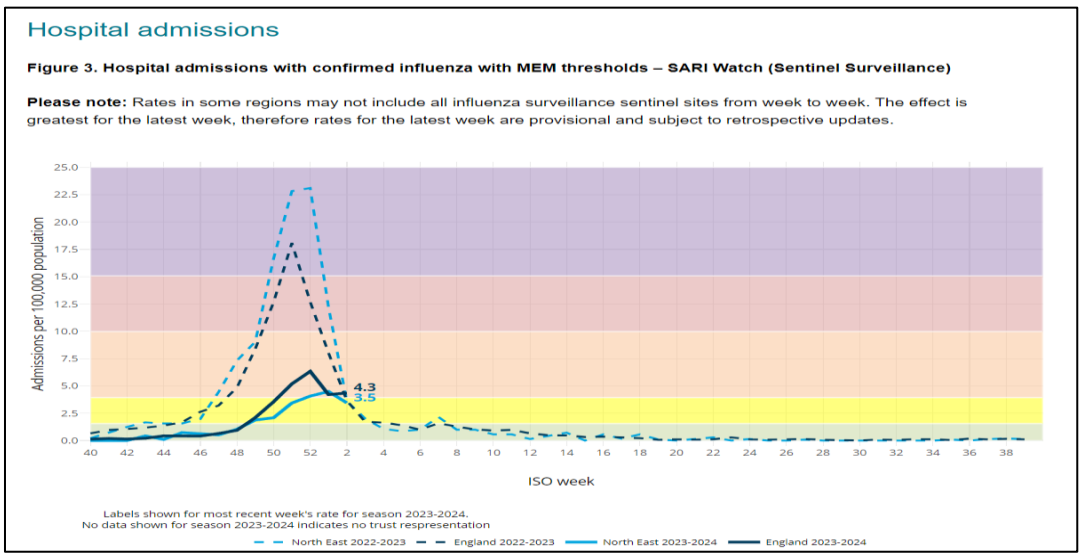
2.9.1. Acute bronchiolitis attendances (RSV infection)



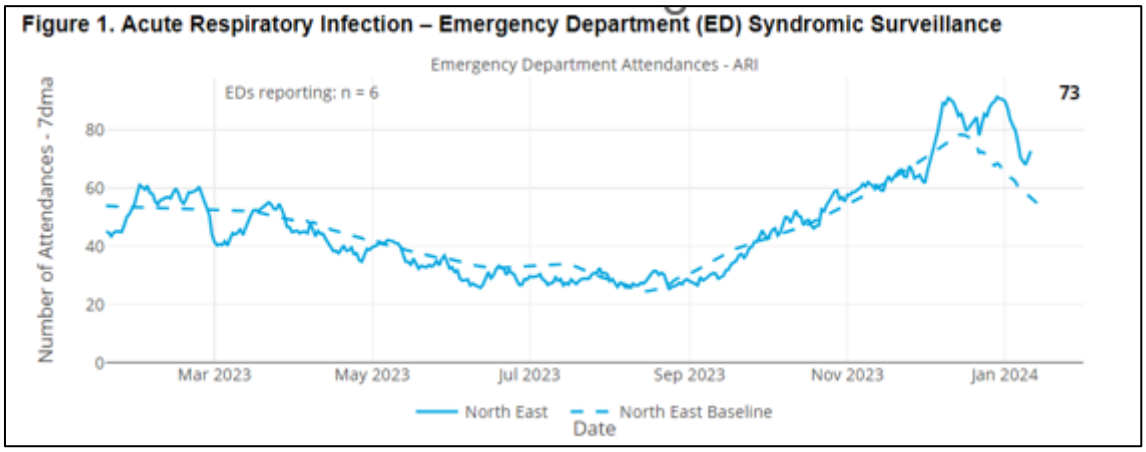
2.9.2. Influenza rates



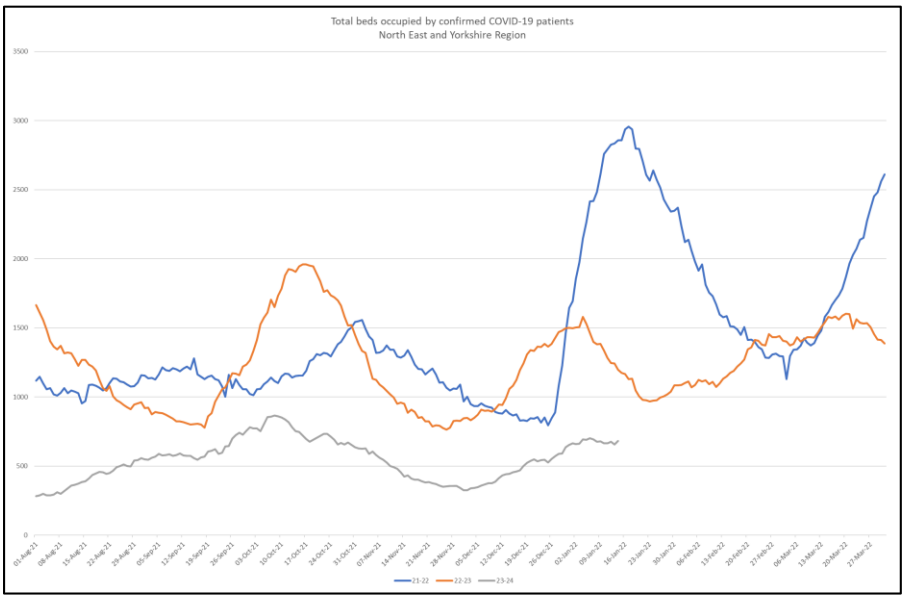
2.9.3. Influenza admissions



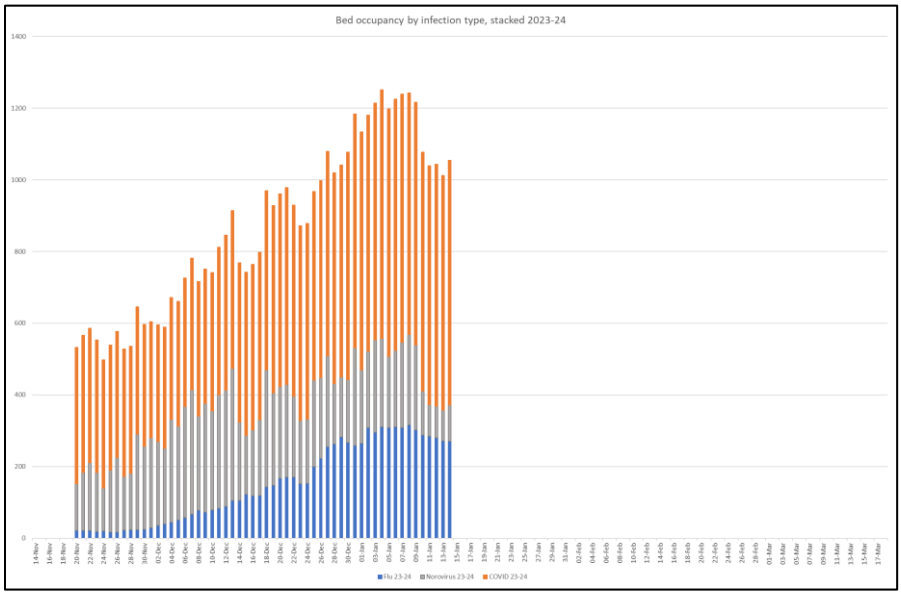
2.9.4. ARI (Acute Respiratory Infections) attendances



2.9.5. Bed occupancy for COVID patients



2.9.6. Bed occupancy by infection type



3. Post COVID services

3.1. National guidance

3.1.1. Commissioning for post COVID services transitions to the ICS from April 2024, the updated guidance is intended to be used as a blueprint for best practice in supporting people with long COVID and is designed to be adapted to local needs.

3.1.2. The updated guidance sets out the expectation that specialist post COVID services should continue to be commissioned by ICSs and that ICBs should appoint a named lead to oversee delivery of post COVID services.

3.1.3. It also sets out the expectation of an NHS regional assurance function to ensure consistent provision of post COVID services within regions.

3.1.4. There are no significant changes proposed to the model of care provided by post COVID services and the expectation is that patient experience and access to services should not be impacted by the transition of commissioning responsibility from national to ICS level.

3.1.5. The guidance acknowledges that there may be benefits to align pathways with other post viral, multisystem conditions that could benefit from the multidisciplinary model of care provided by post COVID services, however systems need to ensure that this is done in accordance with funding available for additional conditions.

3.1.6. It emphasises that a positive COVID test is not required for referral to a post COVID services and re-access to services after discharge should be available to patients should their condition deteriorate.

3.2. **Latest adult data**

3.2.1. To note, all services started as assessment only before being expanded to provide treatment in Q2 2022. The funding was distributed later at the end of Q3. As teams have expanded and developed expertise, this is reflected in the numbers travelling through the clinics.

3.2.2. Services have commented although referrals into services have increased, there is a feeling services are less busy, contrasting with the data that suggests otherwise.

3.2.3. **Adult referrals**

Date Range	National	NEY	NENC
1st Apr 21 - 31 March 22	3,782	1,177	154
1st April 22 – 31st March 2023	6,992	1,264	296
1st April 2023 – 30th November 2023	12,880	1,755	684

3.2.4. **Initial assessments**

1st April 2023 – 30th November 2023

National: 16,179

NEY: 2,608

NENC: 932

3.2.5. **Follow up assessments**

1st April 2023 – 30th November 2023

National: 90,135

NEY: 24,655

NENC: 7,765

3.3. **Key improvements/future plans**

3.3.1. South Tyneside and Sunderland (ST&SFT) are currently piloting a new 'ABC' approach which changes the focus of the clinic to assessment of breathless patients.

- ABC1= Asthmatics with ongoing symptoms
- ABC2 = Cor pulmonale patients
- ABC3= patients attending ED with breathlessness >2 in 6 months

3.3.2. Northumbria have used a robust triage system and currently redirect most referrals to other services as appropriate (typically respiratory/sleep service/chronic fatigue). They are now looking at refreshing their

Persistent Physical Symptoms Service to incorporate Post Covid patients.

3.3.3. Tees Valley as a whole are planning to merge Post Covid with CFS/ME services to create a general fatigue service.

3.3.4. All services demonstrated improvements in outcome measures at the start of 2023, with new data to be presented 8th January 2024 for previous 6 months.

3.3.5. Newcastle Upon Tyne Hospitals revised their clinic structure in 2022, making significant reductions to their waiting list.

3.3.6. The NENC network are developing a standardised set of principles and outcome measures which providers will deliver against.

3.3.7. In addition, the number of centres currently offering services across the region is being reviewed to ensure suitability and sustainability.

3.4. **Key challenges**

3.4.1. No testing available to ascertain positive covid test and current symptoms often not distinct to other causes of post viral fatigue.

3.4.2. Some areas do not have existing Chronic Fatigue Services and do not have the workforce to combine post covid/CFS/ME services.

3.4.3. Investment will be required to support the development of combined services despite funding availability for continuation of Post Covid assessment and treatment from national team. There will be no national team from April 2024 and light touch assurance/governance will be transferred to the regional teams.

3.5. **Children and young people**

3.5.1. Nationally, this cohort is very small in number compared to adult but waiting times are increasing, local providers currently report more CFS/ME/neurodiversity referrals rather than Post Covid and many have not had prior covid testing.

3.5.2. Focus on symptom-based rehabilitation with broader illness and rehab context strongly support by the 5 NEY hubs.

3.6. **Key challenges**

3.6.1. Lack of data for CFS rehab/ issues with outcome measures, questionnaires and treatment options differ for CFS compared to Post Covid.

3.6.2. Post Viral cases are only a small percentage of cases in CFS, and key outcomes markers more often considered to be return to full time school attendance.

3.6.3. Patchy provision and lack of established services mean post code lottery for access.

3.6.4. Issues have been those who cannot attend clinics, and where/which service should assess and treat these patients.

3.7. Finance

3.7.1. NHSE post covid national team have verbally confirmed that the national 2024/2025 funding allocation will be the same as 2023/2024 which was £90 million, for the continuation of post covid assessment and treatment services.

3.7.2. The NHSE national team will not be in place after 2024/25 and it expected whilst regional teams will continue to provide light touch assurance, funding will be distributed to ICBs using a non-weighted population basis although this approach has yet to be confirmed formally.

3.7.3. Formal confirmation is expected within the planning guidance for 2024/25.

4. Diagnostics Programme

4.1. Performance

4.1.1. The November performance data show that in NENC ICS we have a steadily improving position with 14.8% of patients waiting more than 6 weeks for their diagnostic tests (compared to the NEY position of 17.5% and the national position of 23.3%),

4.1.2. There is variation in performance between the providers in NENC with a range of 1.7% to 23.9% patients waiting more than 6 weeks.

4.1.3. There is also variation between wait times for different diagnostic modalities with the largest number of long waiting patients waiting for an MRI test.

4.2. Improvement Plan

4.2.1. In the short term the actions we are taking are to look at opportunities for providers to give mutual aid to trusts with longer waiting lists, we are also expanding our diagnostic capacity though the development of community diagnostic centres and additional diagnostic equipment.

4.2.2. In the medium term there will be three new community diagnostic centres opening during 24/25 and we have a number of digital diagnostic projects underway which will support better visibility of available capacity and waiting times and will enable new ways of working through sharing of digital images across providers.

4.3. Access

4.3.1. We have undertaken a review of the compliance with NICE guidance regarding GPs having direct access to request diagnostic tests for suspected cancers (particularly imaging tests).

4.3.2. Most of our providers are compliant with this and in the few cases where this is not currently available (although alternative referral pathways are in place) we are working with the primary and secondary care clinicians to agree a solution.

4.3.3. There is new national guidance regarding further direct access to additional diagnostic tests in respiratory and cardiac services and we are in the process of reviewing what our position is in relation to this.

4.3.4. The new digital diagnostic projects will help to facilitate more flexible use of capacity by streamlining and simplifying the referral process onto a common platform and provide an opportunity to review referral pathways.

5. Recommendations

The Board is asked to:

- Receive and review the report for information.

Name of Author: **Angela Farrell, Senior Reform Manager**
Ruth James, Diagnostic Programme Manager
Anna Alderslade, Clinical Projects Manager - Respiratory / Post Covid
Rachel Rooney, Strategy and Partnerships Manager

Name of Sponsoring Director: **Dr Neil O'Brien, Executive Medical Director**

Date: 16/01/24