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JOINT OSC FOR THE NE & NORTH CUMBRIA ICS & NORTH & CENTRAL ICPS

Meeting on Monday, 30 January 2023 at 1.30 pm in the Council Chamber, Civic Centre, Gateshead

Agenda

1 APOLOGIES

2 DECLARATIONS OF INTEREST

3 MINUTES (Pages 3 - 12)

The minutes of the meeting of the Joint Committee held on 21 November 2022 are attached for approval.

4 NEXT STEPS FOR ICS

Dan Jackson, Director of Governance and Partnerships, NE & NC ICS, will provide the Joint OSC with an update on this matter.

5 UPDATE ON NON - SURGICAL ONCOLOGY WORKFORCE CHALLENGES IN NE & GYNAE ONCOLOGY SERVICES ACROSS NENC (Pages 13 - 16)

Attached is a briefing paper providing the Joint OSC with an update on non-surgical oncology workforce challenges in the NE.

Representatives from NHS England, who are responsible for commissioning oncology services, Newcastle Hospitals, as the provider of these services, and the Northern Cancer Alliance, alongside the newly formed Provider Collaborative, which represents all FTs in the region, will also provide the Joint OSC with a presentation on this matter to support the Joint OSC's consideration of the issues.

The Joint OSC will also be provided with a further presentation on Gynae oncology services across the NENC.

6 UPDATE ON INTEGRATED CARE STRATEGY (Pages 17 - 76)

Peter Rooney, Director of Strategy and Planning NE&NC ICB, will provide the Joint ICS OSC with a presentation on this matter. A copy of the NENC Integrated Care Strategy is also attached.

7 WORK PROGRAMME 2022-23

The Joint OSC has agreed that the below issues should be included in the 2022-23 work programme.

Meeting Date	Issue
20 March 2023	• Next Steps for ICS • Progress of the Digital Strategy • Winter Plan Evaluation and Learnings • Emergency Planning

Issue to Slot In
Children's Mental Health Provision – Update on Current Performance and Future Provision

8 DATES AND TIMES OF FUTURE MEETINGS

It was agreed that future meetings of the Joint OSC are held at Gateshead Civic Centre on the following dates and times:-

- **20 March 2023 <u>at 2.30pm</u>**

Contact: Angela Frisby Tel: 0191 4332138 Date:13 January 2023

JOINT OSC FOR THE NE & NORTH CUMBRIA ICS & NORTH & CENTRAL ICPS MEETING

Monday, 21 November 2022

PRESENT: Councillor M Hall (Chair) (Gateshead Council)

Councillor(s): J Green (substitute) and Wallace (Gateshead Council) Taylor and Pretswell (Newcastle CC) Chisnall (Sunderland CC) Ezhilchelvan and Nisbet (Northumberland CC) Jopling (Durham CC) Kilgour, Malcolm (South Tyneside Council) Mulvenna and O'Shea (North Tyneside Council)

APOLOGIES: Councillor(s): Butler (Sunderland CC), Kirwin (North Tyneside Council) and McCabe (South Tyneside Council)

171 APPOINTMENT OF CHAIR

In line with the terms of reference for the Joint Committee, the Joint Committee agreed to appoint Councillor Maria Hall of Gateshead Council as Chair for the remainder of the 2022 - 23 municipal year.

172 APOLOGIES

Apologies were received from Councillors Kirwin (North Tyneside Council), Butler (Sunderland CC) and McCabe (South Tyneside Council)

173 DECLARATIONS OF INTEREST

Councillor Hall (Gateshead Council) declared an interest as a Director of Prism Care NECIC and as a member of CNTW FT's Council of Governors

Councillor Taylor (Newcastle CC) declared an interest as an Honorary Consultant at the Freeman Cancer Centre.

174 MINUTES

The minutes of the meetings of the Joint Committee held on 4 July 2022 and 17 October 2022 respectively were approved as a correct record.

175 HEALTH INEQUALITIES UPDATE

Professor Edward Kunonga, Director of Population Health Management at NECS and Public Health Consultant at CDDFT and TEWV provided the Joint OSC with an update on the above.

Professor Kunonga provided the Joint OSC with information on the difference between health inequalities and healthcare inequalities and the causes of death that drive disparities in life expectancy by deprivation.

Professor Kunonga advised that the impact of the Covid 19 pandemic had widened the life expectancy gap. For males there was now a 10.4 year gap across the region with variations in each local authority area and for females there was now an 8.1 year gap across the region again with variations in each local authority area.

The Joint OSC learned that in males, the gap in life expectancy between the least and most deprived areas in the region was mostly due to higher mortality in circulatory disease, followed by external causes, cancer, respiratory disease* and Covid-19. In females, higher mortality in cancer in the most deprived areas contributed to the life expectancy gap most, followed by circulatory disease, respiratory disease and Covid 19.

Professor Kunonga provided the Joint OSC with information on what was contributing to the health inequalities gap and it was noted that almost 10% was as a result of Covid 19. Therefore, Professor Kunonga considered that there was still a need to encourage uptake of Covid 19 vaccinations.

Professor Kunonga also highlighted that the proportion of premature deaths by external causes in males, which includes deaths from injury, poisoning and suicide, was higher in the North East than in any other region and was affecting males in the prime of their life and really needed to be addressed. The pattern was different for females where external causes was less of a contributing factor.

Professor Kunonga stated that there was some positive news with significant progress in reducing infant mortality rates in the region being made.

The Joint OSC was advised of the national approach and the Core 20 plus programme approach. Core 20 focused on the 20% most deprived communities nationally. Professor Kunonga advised that a third of the NE&NC ICS population lives in the 20% most deprived communities and half of the population lives in the 30% most deprived communities and 70% lives in the 40% most deprived communities so the scale of the challenge in terms of reducing health inequalities was huge. The Plus element of the programme focused on giving special attention to certain disadvantaged population groups such as those with severe mental illness and homeless individuals.

Professor Kunonga stated that joint work was taking place with local authority Directors of Public Health to establish where the ICB could make a difference at a regional level to make a significant difference through economies of scale and identify what work should occur at place level.

Professor Kunonga set out the vision for the NE&NC ICB and highlighted that feedback on an outline framework for the ICP Integrated Care Strategy was due to be received at the end of the week. The aim was for the Integrated Care Strategy to be published before Christmas. Professor Kunonga stated that they were not starting from scratch in developing the Strategy and were building on a range of assets, progress which had already taken place and partnership working.

Professor Kunonga highlighted the draft key commitments in the developing Integrated Care Strategy and set out the high - level timeline and advised that the finalised strategy would be shared with the Joint OSC in due course.

Councillor O'Shea thanked Professor Kunonga for the extensive presentation and noted that the NHS has significant and ambitious plans aimed at reducing health inequalities. However, Councillor O'Shea queried whether these plans might be impacted by the Autumn Budget and austerity which will affect many classes of people and will be particularly likely to damage disadvantaged communities.

Professor Kunonga stated that they were making the case for resources to tackle health inequalities in the NE&NC ICB area as strong as they possibly could and had established a small working group to look at the national formula for resourcing and what action might be taken where it does not reflect the level of need in the region. Professor Kunonga stated that where the NHS is working more closely with local authority colleagues to progress work in this area this would provide the opportunity for the Joint OSC to examine these and offer challenge. With regard to the broader policy issue this was for others involved in policy to challenge.

Councillor Ezhilchelvan stated that some of the statistics provided were compelling for action and the data was impressive. However, Councillor Ezhilchelvan asked what information was needed so that priorities could be developed to make a difference on the ground and establish whether the causes of health inequalities were realistic. Councillor Ezhilchelvan stated that it would not be realistic to expect that if there was no austerity tomorrow that everyone would be equally well off. Councillor Ezhilchelvan stated that for example he would like to know the underlying reasons for the figures in relation to cardiovascular which were high in some areas and low in others. Councillor Ezhilchelvan considered that if this information was available then it would be possible to inform the manner in which people seek to change behaviour.

Professor Kunonga thanked Councillor Ezhilchelvan for raising a very good point and explained that this was one of the programmes that they were working on within the ICB. Professor Kunonga stated that he would be happy to come back to the Joint OSC to talk about how they were using the wealth of information to do what Councillor Ezhilchelvan had highlighted. Professor Kunonga stated that as an example they were looking at how individuals were admitted as emergencies for diabetes and linking that with data in primary care in relation to engagement with a view to then sharing information on potential actions with community leaders. Professor Kunonga stated that the presentation today was to provide the Joint OSC with the bigger picture.

Councillor Ezhilchelvan thanked Professor Kunonga for the clarification and queried what he classed as “external causes”. Professor Kunonga stated that this was an ONS classification of causes of death and relates to drug related deaths, suicides and deaths the coroner is unable to make a determination on and they were trying to unpick this data further.

Councillor Jopling asked whether resources were being targeted at certain areas to get more value for money and make a difference given that budgets were tight. She also queried whether they had any plans which identified what they intended to tackle first.

Professor Kunonga stated that this was an important question and he acknowledged that tough decisions/choices would have to be made. However, Professor Kunonga advised that decisions/choices around what should be prioritised would not be made in isolation and would be agreed as a system and at place level and then collectively. The ICS ambition to improve the health of the population and reduce health inequality gaps would require tough decisions which would be made in partnership. Other joint work would involve consideration as to how assets would be utilised across the system and the important contribution of the voluntary and community sector and partnership work with local authorities to help the population understand the narrative.

Professor Kunonga stated that a recent small survey which asked whether the public would be willing to prioritise access to elective recovery had shown that the appetite for this was not high. However, Professor Kunonga stated that in order to narrow the health inequalities gap there may be a need to bring forward surgery for some groups before others and such decisions would require both public and local authority support. Professor Kunonga stated that currently they were in discussions with local authorities around whether surgery for the 2,900 patients with learning disabilities needs to be prioritised.

Councillor Taylor thanked Professor Kunonga for the excellent presentation but noted that much of what had been presented was not new and had been put forward over the last forty years. Councillor Taylor acknowledged that there had been one big success in reducing smoking but she queried how a difference could be made in other areas when the pandemic had made matters worse.

Professor Kunonga acknowledged the points made by Councillor Taylor and stated that what was new was the scale of the challenge. However, Professor Kunonga stated that there are areas where progress is being made such as in cardiovascular diseases which were being dealt with faster than the England average and this was not down to just one part of the system. Professor Kunonga stated that they wanted to learn from examples such as this to see how they could utilise these going forwards.

Professor Kunonga stated that the ICB was aware that there was potential for the cost of living crisis to wipe out the last ten years of improvements if matters were not addressed. Professor Kunonga stated that this was why the ICB wanted to work closely with local authorities to protect what has already been achieved and use this as a springboard for further improvements.

The Chair thanked Professor Kunonga for the excellent presentation but expressed concern that health inequalities for children and young people might increase as a result of the cost of living crisis particularly for those living in the most deprived communities and children with life limiting conditions from birth. The Chair noted that the Marmot Review had referenced the importance of the first 1000 days in a child's life and yet the presentation had only referred to the first 28 days and she was concerned about the depth of focus.

Professor Kunonga advised that when they started to develop the Integrated Care Strategy one of the consistent themes which came through was Children having the best start in life. Professor Kunonga noted that work had taken place around the first 1000 days of a child's life within the ICB and there was compelling evidence as to adverse childhood experiences which they were looking to address but there were no short-term fixes. Professor Kunonga stated that at the region wide Children's Health Network, which was attended by Head Teachers, Directors of Children's Services and representatives from the voluntary sector, there was overwhelming feedback that the ICB was not pushing far enough in its strategies and this would therefore be reflected in the next iteration of the Strategy. However, Professor Kunonga stated that progress in tackling health inequalities across the patch might still be affected by national policy and could still be wiped out.

The Chair noted that a major issue in terms of tackling health inequalities was the ongoing issue of resources.

176 WINTER PLANNING UPDATE

Siobhan Brown, Transformation Director System Wide, NENC Integrated Care Board, provided the Joint ICS OSC with an update on the next steps in increasing capacity & operational resilience in urgent & emergency care ahead of winter.

Siobhan advised that a key point to note was that the healthcare system is now under sustained pressure all year round not just during winter and therefore choices in relation to priority areas of work were being taken in partnership. Whilst there is a lot of focus on what the NHS was doing they were working with local authorities and local communities.

Siobhan stated that there had been a lot of modelling work in relation to disease and there had been an early peak of flu and Covid and a respiratory disease which affects children. Siobhan stated that it was expected that there would be a second peak early in the new year.

Siobhan advised that wider challenges included the cost of living crisis; energy and fuel challenges; inequalities already inherent in communities that they did not want to worsen; year round pressure on all areas of the system that outstrip capacity to deliver as well as industrial action and the interplay of human behavioural patterns and access to services.

Siobhan noted that there were 13 places within the ICS, soon to be 14, and she stated that a lot of the winter planning agenda was very local although some work

was system wide.

Siobhan advised that the ask to have a 24/7 System Control Centre linked regionally and nationally by 1 December 2022 was well on the way to being achieved and they would use what works well and build on from there.

The need had also been identified to build on the surge model and agree escalation triggers for place, area, system level interventions as required as well as being prepared for variants of Covid-19 and respiratory challenges and this had been based on the work of local resilience forums and the learning from Covid along with constant horizon scanning and a major focus on vaccinations.

In terms of flu vaccinations, in Care Homes and amongst over 65's they had achieved a take up of 73% and 75% respectively and for Covid vaccinations a take up of 80% and 83% respectively. Front line workers were also being offered Covid and Flu vaccinations and there was also constant promotion of vaccines being offered to health and care staff via a range of pharmacies and GP practices.

Siobhan stated that in relation to clinical triage, clinical advisors at call centres were doing significant work in pointing patients towards alternative pathways, such as two hour community response services at a local level, which meant that ambulances did not need to be dispatched. Siobhan stated that they had also added in extra capacity to help reduce call times for 111 and these were improving although there was still a lot to be done.

On the issue of Hospital Discharges five hundred million pounds was to go to Better Care Funds to tackle this issue and each local authority would be meeting with the Chief Nurse to determine how work on this should be progressed.

Siobhan also advised that as part of the planning process for our ICS each area had been tasked with implementing two virtual ward pathways, Acute Respiratory and Frailty. This model would support early discharge and provide alternative pathways to early discharge. The NENC Respiratory Network, working closely with Acute Trust Clinicians were leading on this work. Siobhan stated that the aim was to have 350 virtual ward beds up and running by Christmas with up to 800 by March 2023.Siobhan stated that initially the virtual beds would be focused on respiratory with the next layer focused on frailty and falls. Siobhan advised that acute respiratory hubs were also looking at having increased numbers of beds and the aim was to have 292 new beds by December.
To support the most vulnerable patients during the challenging winter months Siobhan advised that the Chief Executive of the ICB had written to Ofgem and asked that the very vulnerable should not be punished and cut off from services and had received a favourable response.

Siobhan advised that in terms of risks to the plans, the ICB was operating in a very challenging environment which felt unprecedented. A significant concern was around workforce in view of planned industrial action and the top priority was to keep patients safe. Siobhan stated that the ICB was also very conscious of capacity issues within Social Care and was looking at joint ways to tackle matters where this was possible.

In terms of measuring success, Siobhan noted that the ICB is assured by NHS England and the ICB's Board Assurance Framework sets out the progress it is making each month against key metrics.

Siobhan stated that as far as the key metrics were concerned the ICB was doing really well in relation to 111 call abandonment rates. In terms of mean 999 call answering this was still an issue for medically optimised patients but they were performing well in England in relation to category 2 response times. However, in some areas there were significant problems in relation to handover response times and next week a community practice event was being held to examine what more could be done to tackle this. Siobhan advised that bed occupancy in both care homes and the NHS was currently really high and this situation becomes really challenging when beds are occupied by those who are medically fit.

Siobhan advised that the ICB was just about to launch its winter communications campaign which would focus on supporting health and wellbeing (keeping people well), signposting people to the right service for their needs - as well as some of the key issues being faced by health and care partners such as high need and times of surge.

Siobhan advised that she was happy to update the OSC on winter planning issues as and when it wished to receive these.

Councillor Pretswell thanked Siobhan for an excellent presentation and stated that she just wanted to comment on Siobhan's point about patient safety being a priority in light of industrial action. Councillor Pretswell stated that no trade union would put patient safety at risk and they would work with the employers to ensure that was the case.

The Chair queried what the ICB was doing in terms of tackling fuel poverty for CHC funded patients and whether the ICB was looking to give more to older people who might suffer from hypothermia.

Siobhan stated that the ICB had inherited 13 systems in relation to CHC and as a result was in the process of carrying out a review and the issues raised would be part of that review.

The Chair considered that the focus appeared to be mainly on adult health and she queried the position in relation to childhood illness. The Chair stated that she was aware that nationally there were 308 critical beds for children and young people but the ICB area only has 14 and she asked what was being done in terms of step down for them. The Chair was concerned that currently some children and young people might have to be transferred to Southampton and Manchester and families would find this hard to cope financially.

Siobhan stated that the ICB would do all it could to prevent that situation occurring and would protect tertiary centres so when there was a surge they would know the number of critical care beds and take pressure from them.

The Chair queried whether numbers of critical care beds had increased as demand had.

Siobhan stated that she did not have information on the volume but the virtual wards must include children and the respiratory hubs.

Councillor Taylor thanked Siobhan for her excellent presentation. Councillor Taylor considered that the biggest challenge was workforce and she noted that one of the urgent treatment centres in Newcastle had recently closed due to staffing issues.

Councillor Taylor stated she was also pleased to see End of Life Care highlighted as she was aware of a case where an individual had been admitted to hospital instead of a hospice and this had been inappropriate.

Councillor Taylor queried how virtual wards would work. Siobhan confirmed that patients would be supported by technology in their home combined with a multi-disciplinary team who would wrap around the patient and contact the patient to see how they were doing.

Siobhan stated that in terms of workforce the ICB was working with Provider Collaboratives to encourage them to collaborate more and share staff.

The Chair queried whether there was an End of Life Plan.

Siobhan stated that this was in the emergency care space where it was identified that there should be no inappropriate or unnecessary journeys or admissions. Siobhan also advised that understanding care plans and ensuring these were communicated well and ensuring sufficient hospice provision was also identified.

Councillor Kilgour thanked Siobhan for an excellent and realistic presentation. However, Councillor Kilgour considered that whilst the ideas and aspirations outlined were the right ones the problem was resources and she did not know where the resources were coming from to progress the work that was needed.

Siobhan acknowledged that a pragmatic approach was needed in relation to resource allocation.

Councillor Ezhilchelvan stated that he was pleased to see that cost of living, fuel poverty and industrial action were part of winter planning as they may continue to be issues due to the ongoing war in Ukraine.

Councillor Ezhilchelvan also noted that he had received a letter signed by all Chief Nursing Officers in England and Scotland, in relation to Social Care, seeking agreement to a deviation from normal practice to help the current situation. Councillor Ezhilchelvan queried whether Siobhan was aware of this and what the deviations were that were referred to.

Siobhan stated she was unaware of the letter.

The Chair considered that everyone recognised that if there was a buoyant Social

Care System this would solve many of the issues which the NHS was currently facing. However, the Chair advised that she was not aware of any conversations at a regional level with providers in relation to home care provision and the way it is currently commissioned. The Chair stated the local authority commissioners' budgets are being continually squeezed and within the NHS people are remaining in hospital for longer and agency staff are costing more. The Chair stated that she believed that if some NHS funding was diverted to Social Care for care provision this would solve some of these issues but this needs those conversations to happen.

Siobhan stated that, in terms of the joint planning and investment that the ICB and system partners needed to do, conversations were starting with Directors of Adult Social Care. Siobhan also stated that she would be happy to make sure that the points raised were fed back.

Councillor Chisnall queried whether most of the calls to the NE Ambulance Service could be prevented if individuals accessed their GP.

Siobhan stated that from a 111 perspective 42% of calls required primary care to speak to the individual so she stated that the answer was yes. Siobhan stated that they were looking to build capacity in all GP practices as well as looking at overflow models.

Councillor Jopling stated that she felt that there was a bit of a disconnect between the 111 system and GP's and she queried how many GP appointments were wasted.

Siobhan stated that this was a good point and something they were looking at. Siobhan stated that 111 slots in primary care were well used but there was something about how primary care were signposting with 111 that they were looking to address with a view to improving people's experience.

Councillor Taylor asked Siobhan whether the Joint OSC would receive an update on lessons learned.

Siobhan stated that she would be happy to come back to a future meeting of the Joint OSC to provide this.

177 WORK PROGRAMME 2022-23

The Joint Committee agreed its work programme should now include an item on the Integrated Care Strategy for its January 2023 meeting and that the item on Emergency Planning should be moved to its March 2023 meeting as set out below :-

Meeting Date	**Issue to Slot In**
30 January 2023	• Next Steps for ICS • Oncology Services – Proposed Service Changes and briefing on Gynae Oncology Services • Integrated Care Strategy
20 March 2023	• Next Steps for ICS

	• Progress of the Digital Strategy • Winter Plan Evaluation and Learnings • Emergency Planning

Issue to Slot In
Children's Mental Health Provision – Update on Current Performance and Future Provision

178 DATES AND TIMES OF FUTURE MEETINGS

It was agreed that future meetings of the Joint OSC are held at Gateshead Civic Centre on the following dates and times:-

- 30 Jan 2023 at 1.30pm
- 20 March 2023 at 2.30pm

Chair……..

Update on non-surgical oncology workforce challenges in the North East

January 2023

Current challenges

Workforce challenges in oncology services are being felt across the entire NHS and nationally there is a predicted consultant oncologist workforce shortage of 28% (401 whole time equivalents) by 2025. We expect to feel the impact of this even more within the North East region in the years ahead.

The immediate workforce pressures being faced locally are within the specialties of breast, lung and colorectal (bowel) cancer and in June 2022 NHS England Specialised Commissioning advised members that over the coming months we expect a shortage of approximately six whole time equivalent (71.5 PAs) Consultant Oncologists at Newcastle Hospitals. This is due to a combination of vacant posts (compounded by an inability to recruit), planned retirements and sickness/absence. This is coupled with a growing demand and complexity in non-surgical oncology treatments with for example chemotherapy use increasing significantly.

NHS England Specialised Commissioning are currently discussing the best way to address these immediate workforce challenges to ensure the continued safe delivery of specialist oncology services. As we manage this difficult position, we want to ensure that key stakeholders are well sighted on the issues being faced and the likely temporary action that will need to be taken.

Background

Consultant oncologists from Newcastle Hospitals travel across the whole of the north of the region to deliver specialist outreach clinics at several local hospital sites.

Given the scale of the immediate challenge and gaps in the consultant oncologist workforce, it was necessary in 2022 to change the number of local outreach clinics on a temporary basis to ensure that all patients still have fast access to staging diagnostics and treatment. This is in relation to breast, lung and colorectal (bowel) cancer only.

This has involved a phased approach to establishing fewer outreach clinics, that allow the consultant oncologists in post to see as many patients as possible who are on a breast, lung or colorectal (bowel) cancer pathway. This interim approach has increased resilience within the existing workforce as it has meant there are no longer lone workers which makes recruitment to vacant consultant oncologist posts more attractive.

Without consolidating the number of outreach clinics, patients in some areas would have been disadvantaged in how quickly they could be seen by the appropriate specialist Consultant Oncologist compared to other parts of the region. This means they would have waited longer to agree their initial treatment plan and their cancer treatment would have been delayed. This was not an acceptable position and the NHS worked as swiftly as possible to ensure there was no detrimental impact on patient care as a result of these difficult workforce challenges.

Impact for patients

The vast majority of patient care has continued to happen locally with no impact on the initial diagnostic pathway, local MDTs, local surgery and chemotherapy continuing at local hospital chemotherapy units.

However, for some patients the first face to face outpatient appointment with the consultant oncologist and for any necessary face to face follow up appointments may be offered at a different site from their local hospital. The oncology service has continued to offer and maximise the use of virtual appointments where this is appropriate.

These first face to face outpatient appointments are generally followed up by multiple trips for radiotherapy and chemotherapy. We would like to stress that there has been no impact on local chemotherapy services or current radiotherapy services which continue to operate as normal.

Whilst we recognise this has caused some disruption for patients, our prime concern is to ensure every person gets the timely access they need for cancer care and that there is clear communication with patients.

Information provided by Newcastle Hospitals NHS Foundation Trust (January 2023)

Based on information provided by Newcastle Hospitals, indicative figures show that this temporary change introduced in July 2022 impacted on patient movements 'out of area' over a six-month period as per the table below:

Locality	Impact
Northumberland to North Tyneside	99
North Tyneside to Northumberland	124
South Tyneside to Sunderland and Gateshead	74 (SRH) 0 (Gateshead)
Gateshead to South Tyneside and Durham	202 (Durham) 73 (South Tyneside)
Sunderland to Gateshead and South Tyneside	166 (South Tyneside) 0 (Gateshead)
Durham to Gateshead	0

Next steps

While these temporary changes were requested by Newcastle Hospitals NHS Foundation Trust they were supported in principle by regional NHS England Specialised Commissioners, The Northern Cancer Alliance, the Integrated Care System leadership team for North East and Cumbria and the wider hospital network that are part of this system. The regional Provider Collaborative and the Cancer Board have also been briefed regarding the challenging workforce position in non-surgical oncology services and the likely need to consolidate the number of outreach clinics as a temporary measure.

We are at a point when patient feedback to the temporary services is being carefully reviewed and used to inform considerations for the future model of service delivery.

Given the current workforce challenges we have already described, and which will continue beyond the temporary solution now in place, planning for the future model of service delivery across the whole of the ICS is continuing at pace.

Alison Featherstone – Cancer Alliance Managing Director

Julie Turner – Head of Specialised Commissioning

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Better health and wellbeing for all

a strategy for the
North East and North Cumbria

16 December 2022

Contents

Foreword by Professor Sir Liam Donaldson

Over the past year I've seen first-hand the passion and commitment of people across our health and care organisations who are all focused on doing the very best for our communities.

We have much to be proud of thanks to the strong partnerships and collaborative working which have been built on over many years.

In recent years, we have made some improvements to health with the number of people dying from cancer or heart disease decreasing and fewer people smoking.

The quality of our health and care services are rated amongst some of the best in England. But despite all of this we still have some of the poorest health outcomes in the country. Something which our communities have endured for far too long.

Facts and figures about the health of people in the region, and their lived experience, make for uncomfortable reading.

For instance, we know men living in our region spend almost a quarter of their lives in ill health.

We have the second highest rates of heart disease and liver disease in the country and our rates of respiratory disease are 42% higher than the national average.

In nine of our 13 local authority areas there is a healthy life expectancy of less than 60 years. In the south of England there are only four areas out of 67 that are this low.

I am always conscious of the fact that behind these statistics are individuals and communities. People who could be enjoying a longer and healthier life. A child who could be thriving - not just surviving, and getting the very best start in life, which we know is so important for our future generations.

So, if you were to ask me what this document is about - it is about building a new momentum which sets out our shared ambition and desire to change this and make a real difference for the people in our region.

This Integrated Care Strategy is a joint plan between our local authorities, the NHS and our partners including the community, voluntary and social enterprise sector. It starts to set out our goals to address the many challenges we have been grappling with for some time.

It describes out how we will reduce the gap between how long people live in the North East and North Cumbria compared to the rest of England, so that our communities live longer, healthier and happier lives.

Our plans describe how we will ensure fairer health outcomes for people as we know not everyone has the same opportunities to be healthy because of the environments where they are born, grow up, live, work, and their age too.

Alongside this, we want to ensure our health and care services are not only high-quality but the same quality - no-matter where you live and who you are. That they are also joined-up and that people have the same access to the right care.

We know that our ambitions cannot be achieved without supporting our committed workforce who are crucial to our success – this includes looking after their physical and mental wellbeing and building a health and care workforce for the future.

This strategy document has been developed in partnership with many people and organisations. I would like to thank everyone who has contributed to and shared their views which have helped us to shape and develop this document.

We have more to do to discuss, involve and engage with our communities about their lived experiences and how we improve their health and experience of health and care services. But the discussions we have had, and the comments we have received, have all been invaluable and we have reflected this within this document.

We recognise we are publishing this plan at a challenging time for everyone including the NHS and social care. We know that we are yet to understand the full impact of the pandemic, services are still in recovery, and rising energy costs and the cost-of-living crisis is of grave concern for all and impacting significantly on the quality of life for our citizens.

As a result, it is fair to say there have been some debates as to whether we are we being too ambitious, given these challenges.

I would argue this is exactly why we need to be ambitious and clear about what it is we want to change, together. Because we can't keep doing the same thing if we want different results.

So, this really is just the start – we will continue to engage and involve our communities in the months and years ahead. I have no doubt that this plan will continue to evolve.

We have set a vision and ambitions which we hope will mean that, in time, all our communities can live healthier and happier lives.

Bringing this plan to life, making it happen - is what we all want to see. I have no doubt we can do that, together.

Professor Sir Liam Donaldson

Chair of the North East and North Cumbria Integrated Care Board

1 Introduction

1.1 Our Integrated Care Partnership

The North East and North Cumbria Integrated Care Partnership (ICP) is a statutory committee of the thirteen local authorities (fourteen from April 2023 as two new unitary authorities begin in Cumbria) and the NHS Integrated Care Board (ICB).

The ICP is responsible for setting and developing our strategy for health and care in the region. It is an equal partnership between local government and the NHS, with a key purpose to align the ambition and strategies of partners across the area to improve the health of our communities.

The ICP is made up of our four partnerships based around our main centres of population.

These are:

• North Cumbria
• Central (County Durham, Darlington, Sunderland and South Tyneside)
• North (Gateshead, Newcastle, North Tyneside, Northumberland)
• Tees Valley (Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees)

We have committed to working together through a single overarching ICP alongside four local ICP arrangements. These local ICPs will develop a strategic picture of health and care needs from their constituent local authority places working with partners including existing health and wellbeing boards.

We will continue to focus on the importance of working at local authority place to:

- Build on our existing arrangements
- Ensure co-production between partners at local authority place
- Ensure a principle of subsidiarity, and that form to follows function, respecting the responsibilities of individual partner organisations
- Remain focussed on making improvements for the population.

Our ICP covers the largest resident population in England at just under three million people (2021 census) and a large and diverse geography - from cities and towns to rural and coastal communities.

1.2 Our partnership working

The ICP is part of what we call our **Integrated Care System (ICS) -** a new way of working across the North East and North Cumbria which aims to bring organisations together to combine their collective resources and expertise to plan, deliver and join-up health and care so our communities can live happier and healthier lives.

The Integrated Care Board for the North East and North Cumbria (ICB) is also part of this system. It is a new statutory NHS organisation which formed on 1 July 2022 and took over the responsibilities of the eight clinical commissioning groups (CCGs) in our region. The ICB will receive further responsibilities, over the coming years ahead, for the specialised commissioning of dentistry, optometry and pharmacy.

The ICB is responsible for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. As well as its strategic functions, the ICB works locally with health and wellbeing boards in each of our 13 local authority areas. The ICB's place-based teams also work alongside our 64 primary care networks (PCNs) which are groups of local GP practices, social care teams and other community-based care providers.

1.3 Our Integrated Care Strategy

The purpose of the Integrated Care Strategy is to provide a strategic direction and agreed key commitments to improve the health and care of people in the North East and North Cumbria. This is based on the understanding of health and care needs across the region and at the 13 local authority places.

The strategy is focussed much more on what we want to achieve, rather than how we will meet our ambitions. Over time we will develop more detailed delivery plans to achieve the ambitions outlined in the Integrated Care Strategy. In this way it sets out an overarching framework which leaves room for local flexibility and delivery.

The strategy is written to support the broader work of partnership arrangements, especially at local level. Local authorities and the NHS are required to give full attention to the strategy in how they plan, commission and deliver services.

1.4 Developing our strategy

In late July 2022, the Department for Health and Social Care published guidance for the development of integrated care strategies. We have worked to develop the strategy in line with that guidance. During the summer of 2022 we established a steering group to oversee the development the strategy, jointly chaired by a local

authority and ICB representative. The steering group was supported by task and finish groups, including a data and intelligence group.

In late July, the steering group issued a ‘call for evidence’ requesting key documents including joint strategic needs assessments (JSNAs) from a wide range of partners.

In total more than 300 documents were received. The call for evidence has strongly informed the content of the draft strategy, alongside the population health data, which can be viewed through the link: Picture of Health - ICS edition 2022.

In October 2022, we began to draft the strategy. On 26 October we published the first draft of the strategy and a survey to enable members of the public and stakeholders to give feedback. Nearly 400 survey responses were received and analysed, as well as further detailed responses from individuals, partnerships including health and wellbeing boards, and organisations. We also took the opportunity, wherever practically possible, to speak with key stakeholders for example through health and wellbeing board meetings.

The feedback to the first draft has been invaluable in developing the final version of the strategy.

Information in the draft strategy has been calculated taking data published at local authority geographies and applying a population weighted method to generate estimates as actual data is not available for the ICP geographic area. The estimates have been provided by Office for Health Improvement and Disparities (OHID).

Source data at local authority level is taken from Office for Health Improvement and Disparities (OHID) Fingertips platform and Life Expectancy Segment tool.

2 Our case for change

2.1 The current position

It is important to be realistic about the current position. Across the North East and North Cumbria many people are struggling in their daily lives and are having to make difficult choices about how they spend their money. This can have a very real detrimental impact on health and wellbeing, especially in communities that already have higher levels of deprivation and poorer health outcomes.

Across the North East and North Cumbria many people have sadly experienced a bereavement, or a long-lasting worsening of their own physical or mental health, either directly or indirectly due to the Covid-19 pandemic.

During the heights of the pandemic people and communities showed incredible resilience, support and solidarity. But we know that the pandemic led to higher levels of anxiety and social isolation, and caused a major disruption to education, employment and home life. For example, there is clear evidence that domestic violence and broader adult and children safeguarding issues increased during the pandemic.

Health and care organisations have struggled to sustain vital services. Demand is at a very high level, with some services still working to recover and to address increased levels of unmet demand. The impact on the whole social care sector, for adults and children, has been enormous, and the NHS is now working to reduce its highest ever backlog of care, as measured by waiting lists and waiting times.

The health and care workforce has worked incredibly hard, with great ingenuity and flexibility during the heights of the pandemic. Many staff members are tired and are living with the emotional impact of the pandemic, having been through an extremely challenging time.

This sets a very difficult context for the Integrated Care Strategy. Most measures of health and wellbeing, population health, health inequalities and performance measures for health and care services, have worsened over the last three years.

We would not choose to start from here.

Despite this being a challenging starting point we have a once in a generation opportunity through our partnership to convene the widest, deepest and strongest coalition of public and community bodies ever seen in the region. With a shared ambition to deliver a programme of health and care improvement for the people of the North East and North Cumbria that reverses these negative trends and delivers the healthier and fairer lives they deserve.

2.2 Health and wellbeing outcomes

2.2.1 Measuring health and wellbeing

The World Health Organisation (WHO) defines health as '*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.* This definition moves beyond bio-medical models of health, but the definition can feel unrealistic as very few of us will ever feel truly healthy against this definition. There are a wide number of definitions of wellbeing. Some are subjective, for example feeling well, being able to function successfully and having positive thoughts and relationships. Others are objective measures such as having access to good housing, education, food and safety.

It is difficult to give a single definition of health and wellbeing, and even more difficult to properly measure health and wellbeing. We have selected two key measures for population level health outcomes as a source of focus for this strategy. We recognise the short comings in this, and over time will seek to build more inclusive and satisfactory measures.

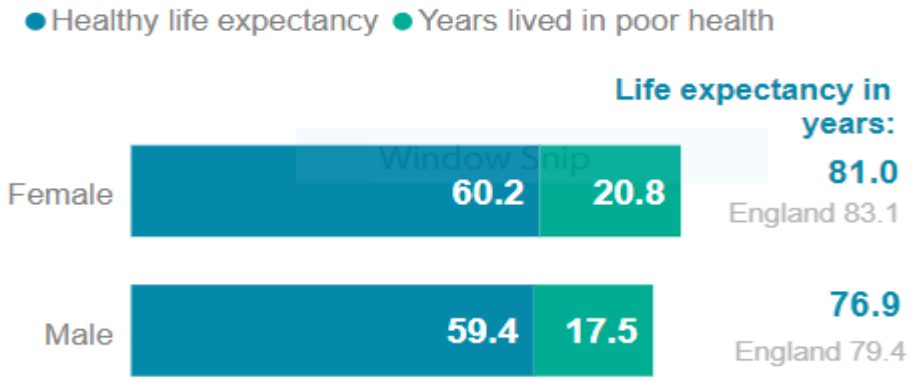
Our key measures are:

- Life expectancy at birth: this is the average number of years that would be lived by babies born in a given time period if mortality levels at each age remain constant.
- Healthy life expectancy at birth: this is an estimate of the average number of years babies born this year would live in a state of 'good' general health if mortality levels at each age, and the level of good health at each age, remain constant in the future. The healthy life expectancy measure adds a 'quality of life' dimension to estimates of life expectancy by dividing it into time spent in different states of health.

We recognise that these are not the only measures of health outcomes, and that they have the potential to focus on physical health, or to miss the very real issues for people living with a long-term condition or disability (across physical and mental health). They have been chosen as good overall indicators, which are widely and routinely measured, meaning we can track progress and make comparisons.

2.2.2 Life expectancy and healthy life expectancy at birth

Life expectancy at birth in our ICP has been persistently lower than the England average for a long time. The most recent measurement is for 2018-20 as shown below.



Source: Population weighted estimates (experimental) for NENC via Picture of Health - ICS edition 2022 based on data available from OHID Public Health Profiles 2022.

Population weighted estimates for healthy life expectancy at birth are also lower than the England average for 2018-20:

- For women this was 60.2 years in our ICP compared to 63.5 for England
- For men this was 59.4 years in our ICP compared to 63.1 for England.

Using these measures, our ICP has some of the worse health outcomes in England.

On average, people in the North East and North Cumbria are expected to die at a younger age than people in most other parts of England and have a longer period of ill health before they die. This needs to change.

2.3 Health inequalities

2.3.1 Inequality in health outcomes

Health inequalities are socially produced, unjust and avoidable systematic differences in health between groups of people. Health inequalities arise because of variations in the conditions in which we are born, grow, live, work and age. We do not all have the same opportunities to be healthy. Inequalities are driven by structural factors beyond individual control.

One key measure of health inequalities are inequalities in life expectancy, the difference in how long groups of people in they live average. The graphic below shows the difference in life expectancy at birth between the most deprived 20% and least deprived 20% areas within our ICP in 2020/21.

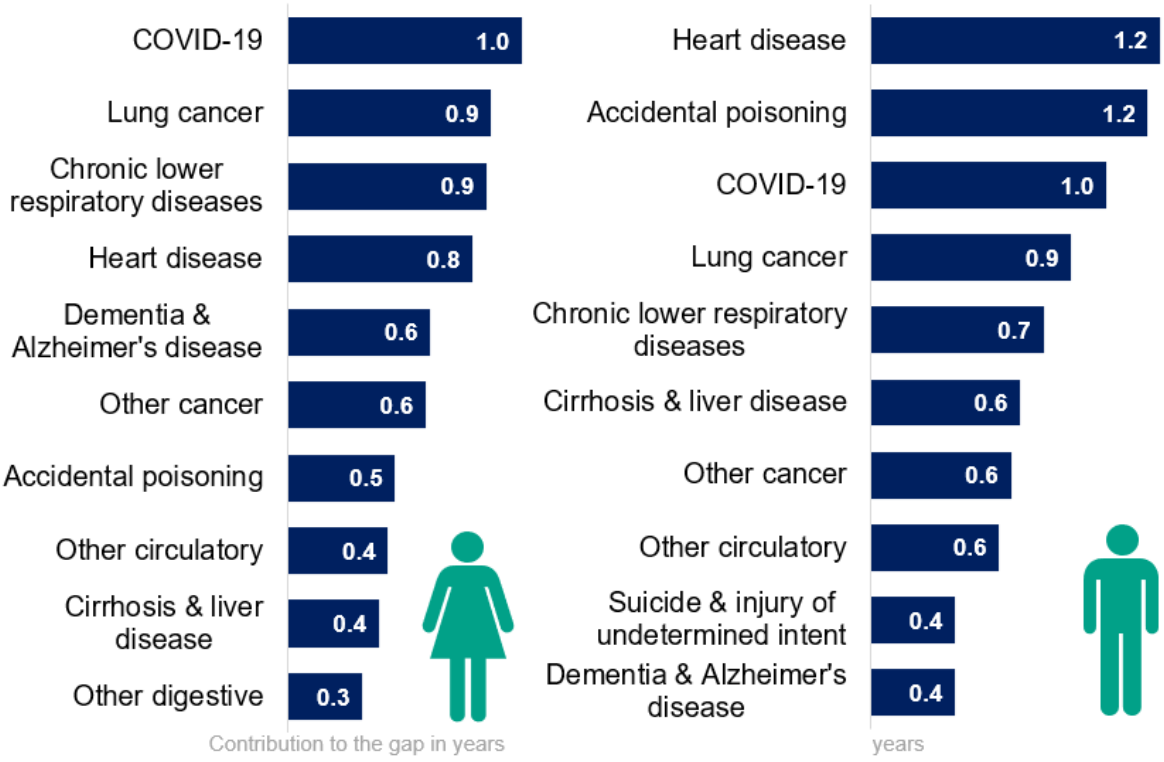
The difference was approximately 8.1 years for women and 10.4 years for men. This difference is much larger than the comparable inequality gap for England.

Source: Population weighted experimental estimates based on [OHID Segment tool]

Mortality rates from Covid-19 have been considerably higher in the more deprived areas, deepening health inequalities. By April 2022, the cumulative death rates since the start of the pandemic in people aged under 75 were 3.5 times higher in the most deprived areas compared to the least deprived across the North East and North Cumbria.

2.3.2 Main causes of in inequality by disease groups

The graphic below shows the main causes of inequality in health outcomes between our ICP and England by disease groups for 2020 – 21.

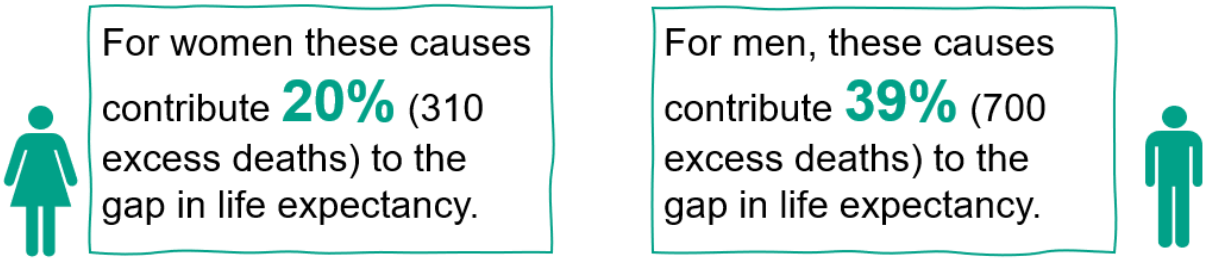


Source: Population weighted experimental estimates based on [OHID Segment tool]

Most of the gap in outcomes is attributable to avoidable mortality. For our region, inequalities in life expectancy are heavily associated with:

- Covid-19: As there is much higher Covid-19 mortality in more deprived communities
- Smoking: This causes respiratory disease and lung cancer
- Alcohol: This can cause cirrhosis and liver disease
- Smoking, alcohol, and healthy weight: Which causes heart disease, circulatory disease and cancers
- Substance misuse: Accidental poisonings are most frequently drug related deaths. The North East (not including North Cumbria) had the highest rate of drug related deaths in England in each of the past nine years.
- Emotional and mental wellbeing: which is a significant factor in all causes of mortality, including suicide.

Accidental poisoning, suicide and injury of undetermined intent, and cirrhosis and liver disease contribute considerably to the gap in life expectancy between our ICP and England, as highlighted below:



Source: Population weighted experimental estimates based on OHID Segment tool

2.4 Social determinants of health and wellbeing

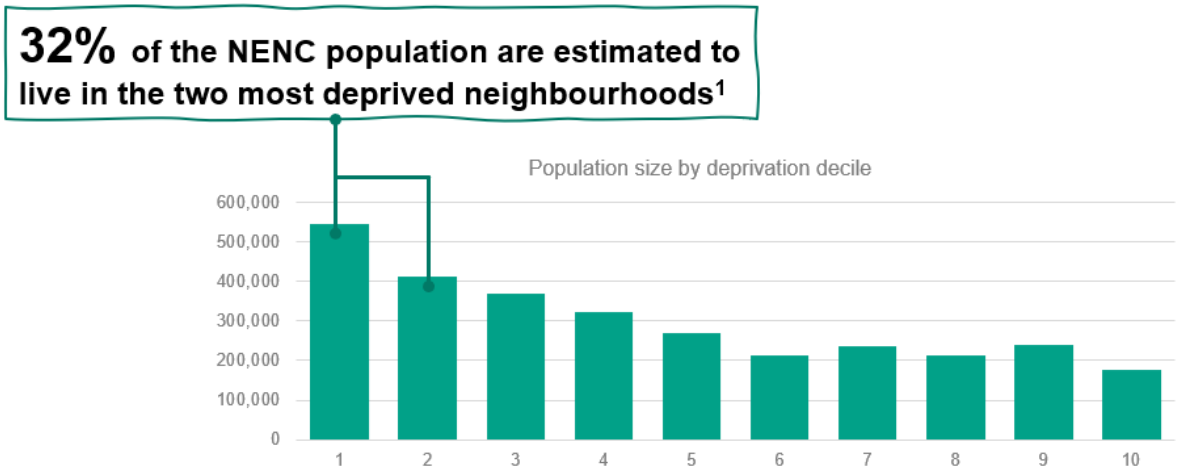
2.4.1 Socio-economic deprivation

Poor social and economic circumstances affect health throughout life. People living in poverty and multiple dis-advantage have greater risks of serious illness and premature death. They face increasing health inequalities and spend a greater proportion of their shorter lives living with long term conditions and disabilities.

People living with this disadvantage also begin to use health services at an earlier age, increasing the demand for health and social care for a longer period. Although the root causes of health inequalities are driven by factors outside of the NHS and social care, these services deal with the often-preventable consequences and should therefore play an active role in supporting local communities.

In the North East and North Cumbria this is a major challenge. Our population overall has much lower levels of wealth, and a much higher percentage of our population

live in the twenty percent (two deciles) most deprived neighbourhoods for England as shown below.



Source: ONS mid 2020 population estimates and index of multiple deprivation

In total 32% of people in the North East and North Cumbria live in neighbourhoods which are in the 20% most deprived in England. This is even starker for children and young people, where the figure rises to 40% of infants aged 0 – 4, much higher than the England average of 25%.

This is set to worsen in the context of the current cost of living crisis. Average pay growth is well below the current rate of inflation and in 2022/23 and 2023/24 we are anticipating the largest fall in real incomes since records began. This will have a disproportionate impact on people living in more deprived neighbourhoods.

2.5 Health and care services

Across a range of metrics the quality of health and care services in the North East and North Cumbria is consistently rated amongst some of the best in England. However, people do not always experience services as excellent. There are real challenges in:

- The unwarranted variation in the quality of services, and inequalities in access, experience and outcomes
- The experience of using services, including access, navigating different systems, waiting times, geographical distance and culturally appropriate services
- The safety of services, including for some people experiencing harm from their contact with services
- The outcomes delivered.

There are now more services across all sectors with a 'Requires Improvement' or 'Inadequate' Care Quality Commission (CQC) rating and worsened indicators of performance than pre-pandemic. In the short term at least, without very concerted action, this is only likely to continue to worsen. We also know that the way health and care services are delivered and experienced can be very inequitable. This also needs to change.

3 Strengths to build on

In the North East and North Cumbria we have much to be proud of. We have outstanding strengths that provide a credible source of hope and collectively we can make real improvements with confidence and realistic optimism.

We have strong communities, with hundreds of thousands of people providing unpaid care to support their loved ones, or freely giving their time and skills through volunteering. Our voluntary, community and social enterprise (VCSE) sector makes a huge contribution to the health and wellbeing of our region and our communities.

We are home to areas of outstanding natural beauty and habitats of international importance. Millions of people visit our area every year to enjoy our environment and cultural assets. We have vibrant industries in all sectors, providing employment and infrastructure of national value.

We also have some of the best research and development programmes of any health system, developing the next generation of treatments, and procedures and cures (including world leading genetic research programmes) alongside dedicated research capacity through our Academic Health Science Network (ASHN) and Applied Research Collaborative (ARC).

Our medical training is rated as among the best in the UK. We are home to one of the UK's top ten medical schools at Newcastle, and an innovative new medical school in Sunderland, dedicated to widening access to ensure the profession reflects the communities it serves. By taking the lead in apprenticeships and training we have offered a way into highly skilled and rewarding professions for thousands of young people and our future generations.

We have a very strong foundation of partnership and collaborative working, across the ICP and at local authority place level. These and our many other strengths and assets provide a fantastic foundation for us to make a real and lasting difference to the health and wellbeing of or population.

4 Our vision, goals and ambition

4.1 Introduction and overview

From our case for change, and feedback on our initial draft strategy, we have developed a basic framework to show our vision, goals and enabling actions.

Our vision is better, fairer, health and wellbeing for everyone. This is intended to be an inclusive vision, capturing the need to improve health and broader wellbeing for everyone across the North East and North Cumbria.

The pandemic has further reduced the life expectancy at birth of our population and there is need for focused work to ensure we recover from this position

Our goals are overarching commitments, supported by measurable improvements. Our enablers are cross cutting themes that will enable the delivery of our goals.

This framework provides the structure for the remaining sections of the strategy.

4.2 Longer and heathier lives for all

Our first goal is to achieve to longer, healthier lives for everyone. Our key measurable commitment is to:

Goal 1: Reduce the gap between our ICP and the England average in life expectancy and healthy life expectancy at birth, by at least 10% by 2030.

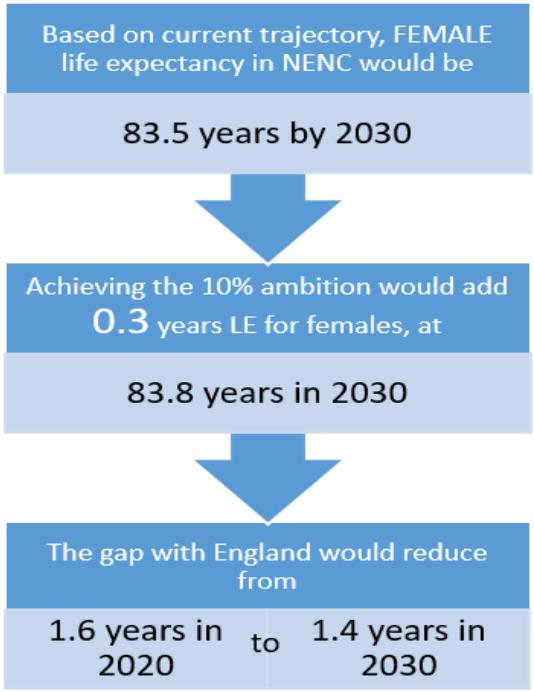
As set out in our case for change, we have lower life expectancy and healthy life expectancy at birth than the England average. In the longer term our ambition is to eliminate this inequality. The people of the North East and North Cumbria deserve at least the same level of health outcomes as people in the rest of the country. But this will take time, this inequality is longstanding and worsened during the Covid-19 pandemic.

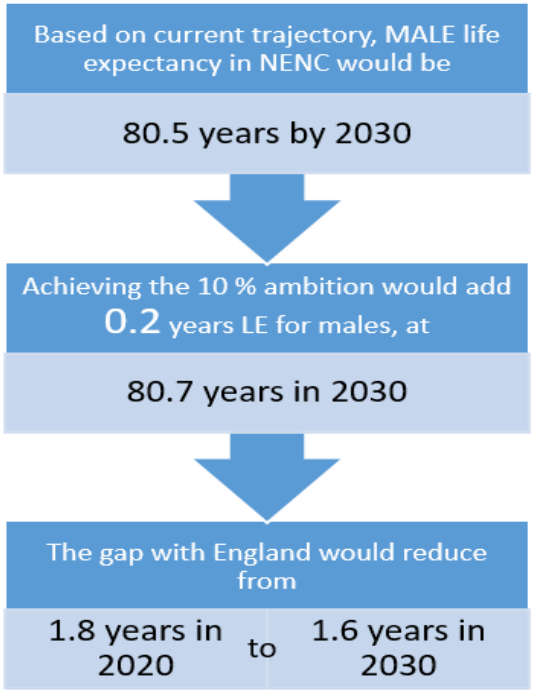
Our first collective task is to reverse the current trajectory, to recover our pre-pandemic position, and to begin to set a real momentum towards a longer-term transformation in health outcomes.

The wording of this goal can be confusing. We cannot know in advance what the England average for life expectancy and healthy life expectancy at birth will be in 2030. We can model the current position, and the current trajectory – meaning the 'if we did nothing different' scenario.

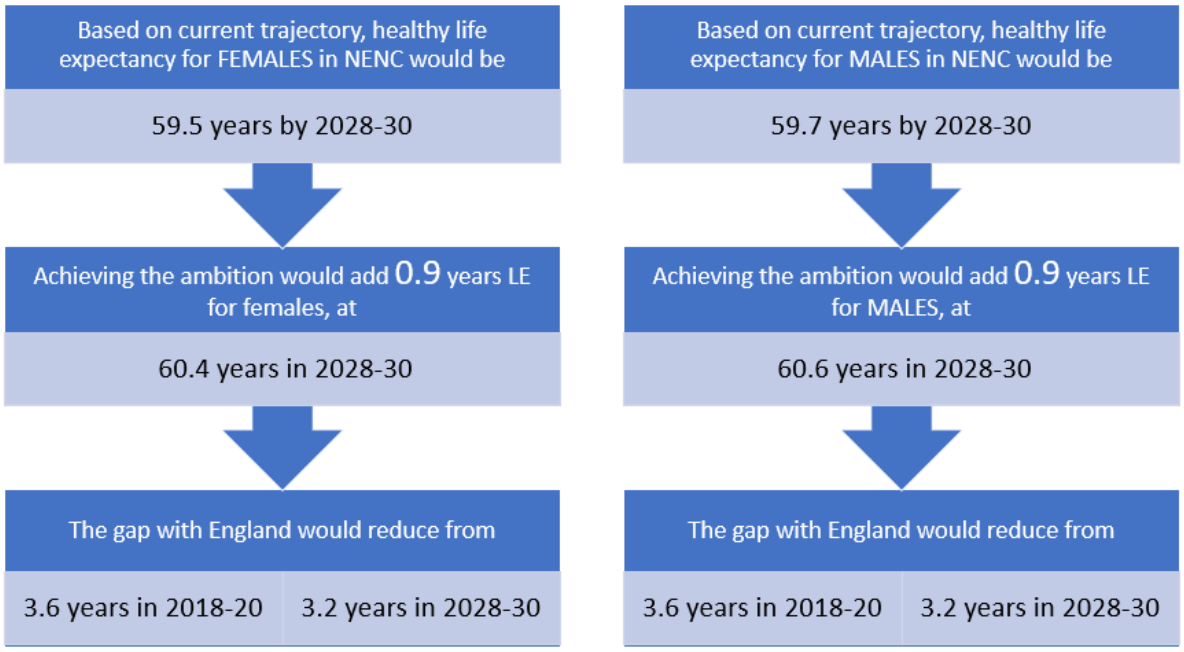
The charts below show the modelling.

Life expectancy at birth





Healthy life expectancy at birth



4.3 Fairer health outcomes for all

Our second goal relates to delivering fairer outcomes. Our key measurable commitment is to:

Goal 2: Reduce the inequality in life expectancy and healthy life expectancy at birth between people living in the most deprived 20% of neighbourhoods and the least deprived 20% - by at least 10% by 2030.

This is a measure of reducing health inequalities in the quality of life at population level. This means preventing ill health, delaying the onset of long-term conditions and reducing the gap in health outcomes all along the social gradient. We are committed to improving health outcomes for everyone, but to make the biggest difference for the people and communities who currently experience the poorest health outcomes.

As described in our case for change, the current level of inequalities in health outcomes is large and deeply entrenched. Over time we will work to deliver a much bigger change, but in recognition of the current position we are seeking to set a challenging yet realistic ambition.

4.4 Best start in life for our children and young people

Our third goal is a specific focus on children and young people. Our experiences during infancy, childhood and as young people deeply shape our long term, and often lifelong ability to reach full potential as well as enjoy good health and wellbeing. Children and young people in our region often experience significant inequalities. We want to enable children and young people to have the best possible start in life, as a worthwhile commitment in its own right, but also because this will have a lasting positive effect on health outcomes and fairer outcomes.

Early in 2023, we will work with children and young people, and across partner organisations, to agree the most appropriate overall measurable commitment in relation to this goal. Provisionally, we have set a goal to:

Goal 3: Increase the percentage of children with good school readiness at reception, especially for children from disadvantaged groups.

This recognises the multiple issues that impact on to a young child's life as they enter school, including family support, good nutrition, healthy lifestyle – activity, play, sleep, socialisation, language development, physical development and growing in a truly healthy environment.

4.5 Improving health and care services

Our fourth goal relates to improving health and care services. Our key measurable commitment is:

Goal 4: To ensure that our Integrated Care System is rated as good or outstanding by the Care Quality Commission (CQC).

We accept that there are limitations to how we can measure the quality of our health and care services. This measure has been selected as the CQC will in the future, and for the first time, undertake inspections of whole system from a broader partnership perspective.

4.6 Supporting goals

Alongside our measurable goal, we have also set some supporting goals which are critical in our ambition to achieve the overall goals described in the above section. These are important in their own right and in combination also contribute to the achievement of our measurable goals. The combination of goals will form our performance framework for assessing how well we are meeting our strategy commitments.

By 2030, we aim to:

1. Reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below.

2. Reduce alcohol related admissions to hospital by 20%.

3. Halve the difference in the suicide rate between our ICP and England in 2019/2021 (three year rolling average) by 2029/31.

4. Reduce drug related deaths by at least 15% by 2030.

5. Increase the percentage of people diagnosed at the early stages of cancer (stage 1 and 2) to the national target of 75% by 2028.

6. Increase the percentage of regulated services, across each of social care, primary care, and secondary care, that are rated as good or outstanding by the Care Quality Commission.

During 2023 we will additionally seek to set stretching yet realistic supporting commitments in relation to:

7. Increase the number of people children, young people and adults with a healthy weight.

8. Reduce social isolation, especially for older and vulnerable people.

9. Reduce the gap in life expectancy for people in the most excluded groups (see section 6.3, inclusion health).

5 Longer and healthier life expectancy

5.1 Supporting economic and social development

We recognise that health and care services only play a small but important part in determining overall health and wellbeing outcomes. Health and care services cannot resolve the broader social and economic structures that give rise to poorer health outcomes and health inequalities. However, there are active steps that we can take to make improvement.

We will ensure there is clarity in our leadership, collaborative and advocacy actions to address the underlying causes of poor population health outcomes and inequalities.

We will be an active partner in advocating for economic and social development in the North East and North Cumbria and support and develop strong links with leading organisations and partnerships - for example Local Economic Partnerships.

5.2 Health and wellbeing related services

A broad range of services can have a positive impact on health and wellbeing. We will work with partners across a broad range of sectors to integrate approaches to health and wellbeing.

Housing plays a very important role. Living in a house with poor energy insulation, damp or living in overcrowded housing can all have a major detrimental impact on wellbeing. We will work in partnership with local authorities, and through them partner with registered social landlords and the independent/private sector to find support approaches to improve housing.

Services which support people to access benefits, legal advice and other advice services are also deeply important. For example, there is clear evidence that people supported by the Citizens Advice Bureau and community led advice and support services feel a health and wellbeing gain.

Leisure services have an obvious health and wellbeing positive impact, as do other approaches to encouraging or enabling physically active lives.

Education and employment services have a major impact on health and wellbeing. Educational attainment is the strongest correlative factor in health outcomes, and employment, particularly in better paid roles, is a protective factor for health and wellbeing.

Particularly working at local authority place level, we will seek to work in partnership with a broad coalition of services that have a positive impact on health, not just

health and care services. Such services need to be included in our approach to integrated neighbourhood teams to support broader wellbeing.

5.3 Community centred and asset-based approaches

Asset-based approaches emphasise the need to redress the balance between meeting needs and nurturing the strengths and resources of people and communities. We will use asset-based approaches to address health inequalities in access, experience and outcomes building on the knowledge, skills, experience, resilience, and expertise that lie within the communities we serve. We will build on the learning from the Covid-19 pandemic in which community centred approaches across the region played a key role in a number of the key strands for the pandemic response.

5.4 Community wealth and anchor institutions

Local authorities, working with place partners, have a leading role in building community wealth.

Large partner organisations, rooted in their local communities, can make a big difference to social determinants by acting as 'anchor institutions'. The term anchor institutions refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and can help improve the health and wellbeing of communities by:

- Purchasing more locally for social benefit
- Using buildings and spaces to support communities
- Widening access to quality employment
- Working with local partners, spreading good ideas for civic responsibility
- Reducing environmental impact

5.5 Prevention and health promotion

5.5.1 Healthier and Fairer Committee of our ICP

We will continue to implement evidence-based programmes of preventive interventions, recognising the key leadership role of local authorities in public health, but including all partner organisations.

Health and wellbeing boards and local authority place-based partnerships are already actively delivering a wide range of prevention and health promotion approaches.

To support their work we have established a Healthier and Fairer Committee of our ICP, jointly led by the ICB medical director and the chair of the North East Directors of Public Health network. The healthier and fairer committee will provide leadership across the ICP, and give support to local authority places, focussed on:

Prevention, including:

- Reducing the harms from alcohol, substance misuse and smoking
- Promoting healthy weight and active lives
- Supporting people to prepare well when waiting for planned operations.

Core20Plus5 (this is explained in sections 6.2 and 7.4)

- For both children and young people and adults
- Deep End Network (a network of general practices based in deprived communities)

Broader economic and social benefits, including:

- Acting as anchor institutions
- Digital inclusion
- Promoting health literacy
- Responding to the cost of living
- Poverty proofing services – working with people on low incomes to identify and overcome the barriers that might prevent access to services.

5.5.2 Improving nutrition and supporting active lives

Health weight is a key factor in health outcomes. We do not want to stigmatise anyone, but we do want to find improved ways to support children, young people and adults to have good nutrition and to live active lives. This is a complex issue and national support will be needed to make healthier food more accessible to everyone in addition to health promoting interventions. We will work to include programmes promoting healthy weight, good nutrition and active lifestyles in our partnerships at neighbourhood, local authority place and regional level. This will include social prescribing programmes.

5.5.2 Smoking and alcohol programmes

Fresh and Balance are the ICP tobacco and alcohol programmes. Their purpose is to work with partners and the public to help drive a societal shift around two of our biggest preventable causes of ill health in our region.

The programme works at population level and is a valuable resource to assist both NHS and local authority partners as they support people to stop smoking or reduce drinking. Equally important is a focus on shifting the norms around both tobacco and alcohol use, coupled with enforcement of legislation and a call for action to prioritise both issues at national level.

The Fresh Balance programme supports local action to highlight the impact of alcohol and tobacco on families, communities, public services and the wider economy. It encourages healthier behaviours through award winning media campaigns and advocates on behalf of the region for evidence-based policy through collaboration with the Smokefree Action Coalition and Alcohol Health Alliance.

The Fresh and Balance approach recognises the role of all partners across the system partners including the Association of Directors of Public Health North East, the Office of Health Improvement and the ICP Healthier and Fairer Committee

The North East and North Cumbria has made significant progress in reducing overall adult smoking rates through a multi-strand approach led by Fresh. Tobacco remains a key driver of health inequalities and smoking rates are significantly higher in some groups. There is a commitment to achieve less than 5% smoking rates across all groups. This will be achieved through action from national to local level.

The region has made some progress around alcohol with the ground-breaking campaigns led by Balance resulting in significantly more people knowing the fact that alcohol causes cancer compared to the national average. Evaluation has shown that almost half of the people who saw the most recent campaign took steps to cut down their alcohol consumption as a result. However, nearly one million adults are still drinking above the Chief Medical Officer's low risk guidelines and putting their health at risk. The 20 year high in alcohol related deaths in England signifies that there is an urgent need for national action to support work within the region.

5.5.3 Social isolation

High-quality social connections are essential to our mental and physical health and our well-being. Social isolation and loneliness are important, yet neglected, social determinants of the health of older people. A large body of research shows that social isolation and loneliness have a serious impact on older people’s physical and mental health, quality of life, and their longevity. The effect of social isolation and loneliness on mortality are comparable to that of other well-established risk factors such as smoking, obesity, and physical inactivity.

Health and care organisations need to work in support of local organisations, particularly voluntary, community social enterprise and faith-based organisations at neighbourhood level to reduce social isolation.

5.5.4 Health literacy

Health literacy is about people’s ability to understand and act upon information relating to their health. The World Health Organisation (WHO) recognises that improving health literacy provides a foundation for people to be active in their own care and improve their health. It also highlights that improving health literacy has the potential to reduce health inequalities. We will support the skills of people to be active in their own health, and of how services communicate with people.

6 Fairer health outcomes

6.1 Health inequalities

We are committed to delivering fairer health outcomes by reducing health inequalities across our entire population. Health and wellbeing inequalities are the unfair, unjust, systemic and avoidable differences in the health and well-being of our communities. The conditions in which people are born, grow, develop and age are the underlying causes of health inequalities – the key drivers are social, economic and environmental conditions.

Inequalities:

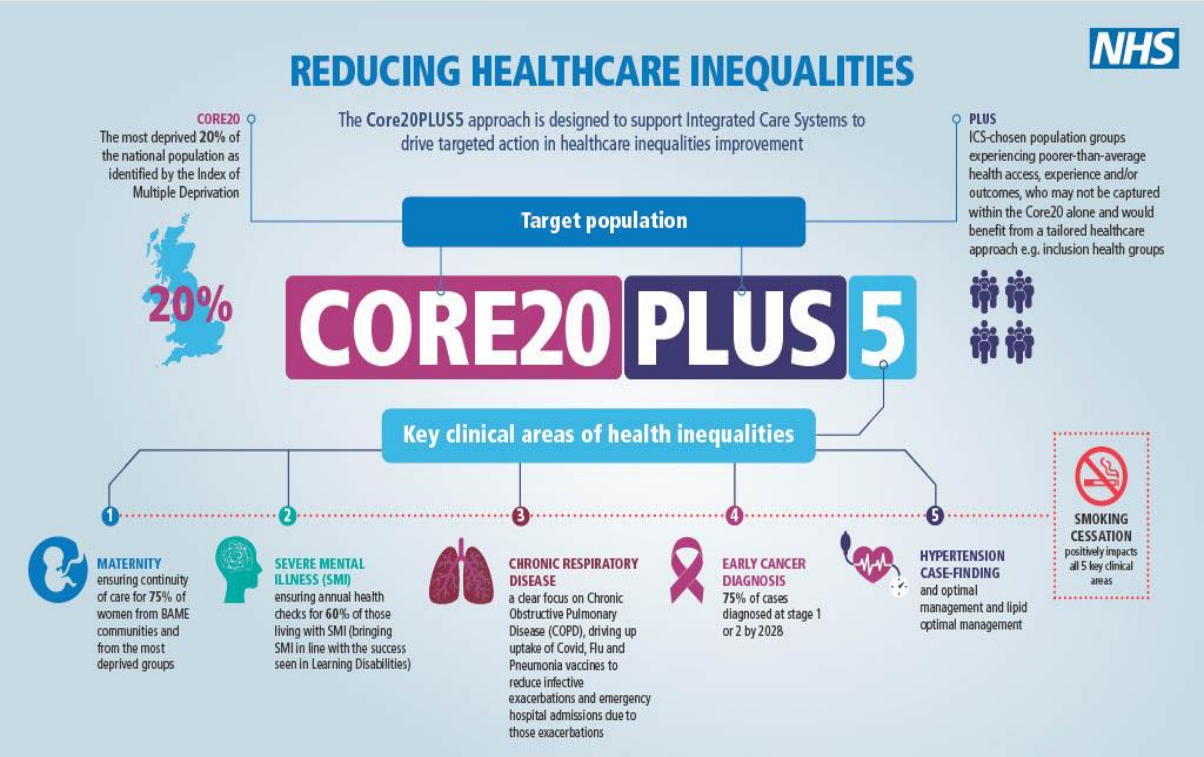
- Are a result of complex interaction between factors to produce differences across population groups
- Occur by socio-economic status, geography, protected characteristics or social exclusion, vulnerability and deprivation
- Are not inevitable and addressing them requires cross sector action by organisations, communities, business and government
- Require understanding, approaches to tackle health inequalities need to reflect the complexity of how inequalities are created, made worse and perpetuated.

These are complex issues and reducing health and wellbeing inequalities will be challenging. In this section, we outline some of the key approaches that will begin to turn around the current position and move us towards fairer outcomes.

6.2 Core20Plus5 for adults

Core 20 PLUS 5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The equivalent children and young people's framework is described in section 7.

The approach defines a target population cohort – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement, as summarised in the graphic below.



The most deprived 20 per cent of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

Across the North East and North Cumbria, a third of our population lives in the 20% most deprived areas of the country. This is not uniformly distributed with some of our local authority areas having much higher proportions of their populations living in the most deprived 20% of neighbourhoods nationally.

The PLUS population groups within the Core20Plus5 include a number of groups where the outcomes are poorer compared to the rest of the population. These include people from Black Asian and Minority Ethnic groups, people living with a learning disability and/or autism, coastal communities with pockets of deprivation; people with multi-morbidities; and protected characteristic groups; people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in the justice system, victims of modern slavery and other socially excluded groups.

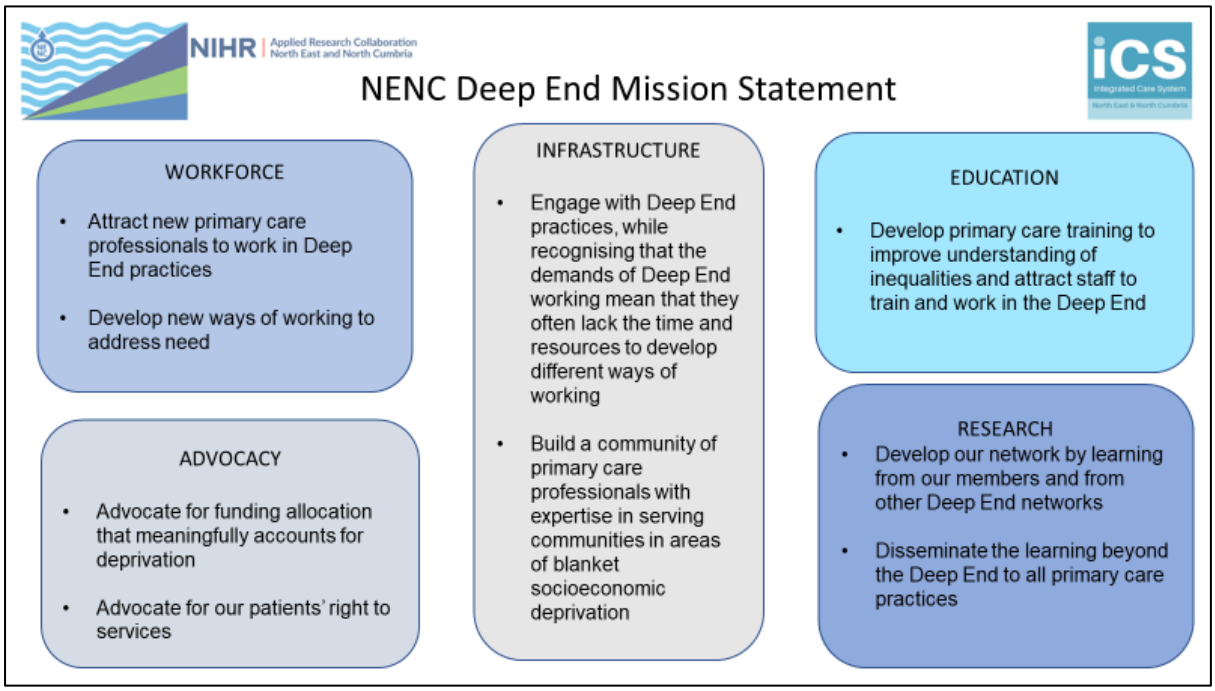
The final part of Core20plus5 sets out five clinical areas of focus:

1. Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid-19, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
5. Hypertension case-finding and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The partners within the ICP will work together to deliver these priorities across the North East and North Cumbria, although noting the impact of Covid-19 and the current position, we are working towards 2030 for the early cancer diagnosis aim.

A key intervention we will continue to develop is a work programme supporting general practice and partners at neighbourhood level through our Deep End Network, summarised below. Deep End General Practices are those working in our most disadvantaged communities.



More generally, the ICP will develop a process to ensure all significant decision and investments consider the impact on the fairness of health and wellbeing outcomes.

6.3 Inclusion health

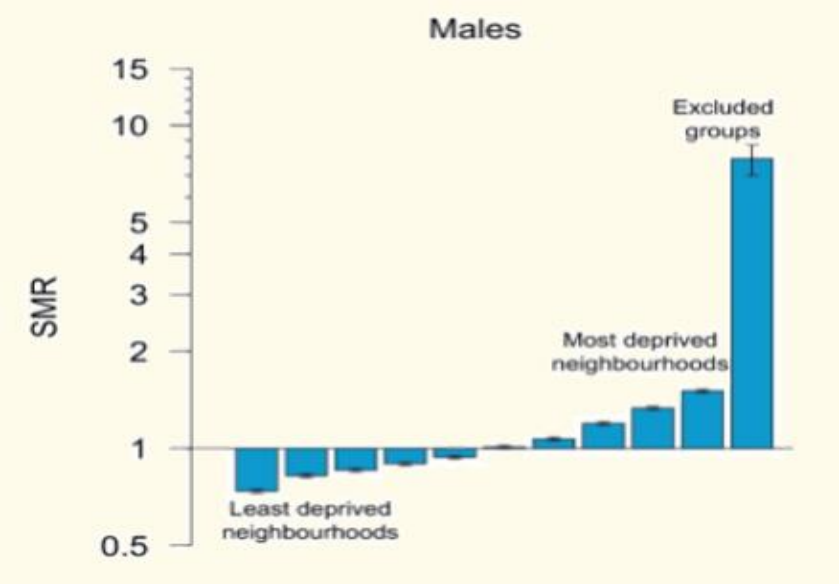
We know that some groups of people are especially disadvantaged and vulnerable. People who are socially excluded, experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), stigma and discrimination and are not consistently accounted for in databases. This includes for example:

- People experiencing homelessness

- Vulnerable migrants, including asylum seekers
- Gypsy, Roma, traveller communities
- Sex workers
- People involved in the criminal justice system

People from these and other socially excluded groups often have higher use of crisis and acute services, and for example emergency admissions, longer inpatient stays, delayed transfers of care and more frequent re-admittance. This is in part because they also experience significant barriers in access to health and social care.

They also have significantly worse health outcomes. The chart below shows the Standardised Mortality Rate (SMR) for men in excluded groups compared to men across the least and most deprived neighbourhoods.



Our approach to inclusion health will seek to properly recognised and respond to the needs of the most excluded groups of people. This will include:

- Using evidence and taking opportunities for research where there are gaps in evidence of health and care need, or needs might be effectively met
- involving people, including seldom heard voices
- developing approaches to health and care which are responsive to multiple dis-advantage.

6.4 Inequalities in health and care

The way health and care services are delivered can contribute to health inequalities. Some groups of the population have lower participation in routine screening programmes or present at a later stage of disease progression, due to the barriers people need to overcome in order to engage with services. These barriers include the cost of travel to health services, convenience, health literacy, unconscious bias,

diagnostic overshadowing and lack of agency and advocacy support. A key part of our work is to ensure that we eradicate, and at least minimise, those inequalities.

We will work with a focus on inequalities in access, experience and outcomes from how people interact (or have a lack of interaction) with health and care services. Some of the key issues we will seek to address are:

- Inequitable access can result in patient groups receiving less care or sub-optimal care than others leading to poor experience and poor outcomes
- The relationship, or intersection, between medical and social vulnerability
- The inverse care law is an example of healthcare inequalities – those with the greatest need having the least access
- Reduce unwarranted variation in access, experience and outcomes
- Access to services that prevent ill-health as well as primary, secondary and community services for people with ongoing health conditions.

6.5 Challenges for rural and coastal areas

Rural poverty and economic challenges

Rural areas in the North East and North Cumbria tend to be less deprived compared to the system's urban areas, and some of the most affluent areas in the region are found in rural areas. However, even in affluent areas there are pockets of deprivation, especially amongst older people. Furthermore, the low population density in rural areas creates some specific challenges for health and wellbeing in rural areas. There are dispersed market towns, coastal, ex-coal mining, commuter villages that experience some poorer health outcomes. Those areas of rural deprivation face many of the poorer health outcomes to deprived urban areas. Some of the highest levels of deprivation are in our former coal mining villages. In fact, an overlay of the collieries in the second part of the twentieth century corresponds to rural indices of deprivation.

People with less income in rural areas are prone to fuel poverty because homes in rural areas are typically less energy efficient and can be more reliant on potentially more expensive heating fuels.

Many young people leave to pursue higher education as most universities are situated in cities. The drain of skilled workers inhibits the opportunities for economic growth in rural areas.

Geographical isolation

Transport to healthcare is more difficult in rural areas owing to less public transport and less efficient roads. This is particularly a problem for people on low income who can't afford to run and maintain a car. These longer distances mean that rural residents can experience 'distance decay' where there is decreasing rate of service

use with increasing distance from the source of health care. Research by Age UK found that cuts to bus services had made it more difficult for older people to access their doctor’s surgery and to get to hospital appointments.

7 Best start in life for our children and young people

7.1 Introduction

A strong theme in the feedback to our initial draft strategy was the need to focus on children and young people. All of the sections in this strategy apply implicitly to children and young people, but we have now included as a key goal the need to ensure we give our children and young people the best start in life.

Our ambition is for all children and young people to be given the opportunity to flourish and reach their potential, and to improve outcomes for children who face the most disadvantage. Partners within the ICP will work together and through co-production with children, young people and their families and carers, to provide a better start in life and enable all children to reach their potential.

Children and young people represent nearly 25% of our population, but more importantly hold 100% of the future outcomes. Evidence shows that adversity in childhood can lead to long term, and even life long, adverse health outcomes.

Children and young people in our region have multiple challenges to overcome:

- The voice of the child is not being heard strongly and consistently in an adult focused system
- The significant but unheard impact of Covid-19 pandemic on our young people followed by the unprecedented cost of living crisis in already high levels of poverty which impacts future health outcomes
- The complexity of the child system - diverse professional, organisational and child perspective as well as the family
- Children and young people are more likely to be living in neighbourhoods with higher levels of socio-economic deprivation than any other age group in the population. We have some of the highest levels of childhood poverty in England
- Half of all mental health problems are established by the age of 14 and 75% by the age of 24.

7.2 Maternity services

Our aim is for maternity and neonatal services across the North East and North Cumbria to become safer, more personalised, kinder, professional and more family friendly.

Our ambition is to be the safest place to be pregnant, give birth and transition into parenthood – with all women who use or maternity and neonatal services receiving

the best care possible. Our commitment to reducing health inequalities and unwarranted variation will be crucial to this.

Planning and preparing for good health in pregnancy significantly influences a baby's development in the womb which, influences long-term health and educational outcomes. By giving every baby the best start in life, we will help them fulfil their potential.

Our maternity and neonatal services need to respond to each person's unique health and social situation, with increasing support as health inequalities increase, so that care is safe and personal for all.

This includes ensuring every woman has access to information to enable her to make decisions about her care and that every woman and her baby can access support that is centred around their individual needs and circumstances.

In the North East and North Cumbria, we know that most mothers and babies have a healthy pregnancy and birth. However, national and local research tells us that mothers and babies from a Black, Asian or mixed ethnicity background and those living in our more deprived communities are more likely to be unwell and although rare, to experience serious complications during pregnancy and birth.

Such serious health implications are made more likely by a range of factors linked to genetics, where and how they live, these are often referred to as risk factors.

People who live in more deprived areas also experience higher levels of other 'risk factors' like smoking, being overweight, not using folic acid, having limited access to services, being younger or older when pregnant.

Our areas of focus will include:

- Setting clear priorities to continue to deliver our maternity and neonatal safety ambitions and provide more personalised care
- Bringing together actions from the recently published national maternity reports into one delivery plan for maternity and neonatal services. For example the final Ockenden report, the report into maternity services in East Kent, the NHS Long-Term Plan and our maternity Transformation Programme deliverables.
- Reducing health inequalities and address any unwarranted variation across maternity and neonatal services
- Co-produce our work with service users, frontline colleagues, system leaders and wide range of stakeholders from across the integrated care system.

7.3 Health and care services for children

We will work in partnership to strengthen health and care services for children and young people - recognising the need to work together but also reflecting the key roles of organisations. For example, the NHS plays a leading role in universal

services for pre-school children, and local authorities have a key leadership role in relation to education and support to families.

Since 2020 there has been a sustained increase in demand for a wide range of children's services including:

- Emotional wellbeing and mental health services
- Referrals for autism, attention deficit and hyperactivity disorder (ADHD) and other developmental disorder assessments
- Services to effectively support children and young people (and their families and carers) with Special Educational Needs and Disabilities (SEND)
- Complex packages of care across education, social care and health care
- Safeguarding

Working in partnership, we will seek to:

- Improve access to social care, physical and mental health services

- Improve pathways for children with long term conditions and life limiting illness, including access to effective psychological support

- Ensure measures to tackle the wider determinants of health include a focus on children and young people, and in particular those from our poorest communities

- Support mental wellbeing through 'Mental Health First Aid' and increase early intervention and prevention for mental and emotional wellbeing

- Ensure a focussed improvement in all tiers of child and adolescent mental health services (CAMHS), delivering and learning from the CAMHS whole pathway commissioning 'pilot'. This is one of only four successful pilot sites across the country.

- A focussed improvement in transitions from children and young people's services to adult services

- Work across sectors to more effectively commission jointly funded packages of care for children and young people with complex support needs across education, social care and health care

- Address the challenges and opportunities highlighted in Special Educational Needs and Disabilities (SEND) inspections across local authorities and the NHS. We recognise that SEND goes up to the age of 25 and therefore transitions into adult services

- Ensure specific support when children and young people experience adverse life events such as a bereavement, abuse, neglect, or experiencing a parent being involved in the criminal justice system. Childhood trauma can have a life-long impact, including in physiological as well as psychological changes.

7.4 Core20Plus5 for children and young people

In Autumn 2022, NHS England published the Core20Plus5 framework for children and young people. This is summarised in the graphic below.

In the North East and North Cumbria we will adapt and adopt the Core20Plus5 programmes as one of our key areas of work with children and young people.

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level.

This approach defines a target population cohort and identifies ‘5’ focus clinical areas requiring accelerated improvement.

Core20 is the most deprived 20% of the national population as identified by the national Index of multiple deprivation (IMD).

Target populations

PLUS population groups include ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others.

Specific consideration should be taken for the inclusion of young carers, looked after children/care leavers and those in contact with the justice system.

Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

Clinical areas of focus

The final part sets out five clinical areas of focus:

- Asthma: Addressing over reliance on reliever medications and decreasing the number of asthma attacks.
- Diabetes: Increasing access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; as well as increasing the proportion of those with Type 2 diabetes receiving recommended NICE care processes.
- Epilepsy: Increasing access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
- Oral health: Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.
- Mental health: Improving access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

7.5 The voice of children and young people

We will work to ensure the voice of children and young people is strongly represented so that high quality engagement is in place in the development and delivery of strategies and work plans and ensure supporting systems are in place to in achieve high quality engagement through the sharing of good practice.

The vital involvement of children, young people and families must take place in earnest to give validity to this strategy. This will include the development of media that is accessible and engaging to young people.

8 Improving health and care services

8.1 Core principles and cross cutting services

8.1.1 Improving quality and safety

Improving the quality of health and care services including experience, access, safety and outcomes is a key area of focus of our plans. The ICP and its partners will deliver the improvements needed as highlighted by people using services, people working in our services, and regulators.

We will do this by

- Improving safety culture within our provider organisations so that incidences are reduced
- Identifying the causes of adverse events and learn from them, ensuring improved practice is implemented and sustained
- Reducing the unwarranted variability of the service offer and increase the consistency of the care.

We will deliver fairer access to our services by adapting and personalising services, so they reach vulnerable people, of all ages. We will target those groups of people that our data show do not currently access services at a level we would expect for their needs. For example, people from our poorest neighbourhoods, those from Black and Minoritised Ethnic communities and people with a learning disability.

The ICP recognises the critical role of the Care Quality Commission (CQC) and other regulators, such as the Office of Standards for Education, Children's Services and Skills (OFSTED), play in assuring quality and safety and in supporting improvement where needed. We will work closely with our regulatory bodies to maximise the impact of our collective efforts to oversee the quality of care provided.

We acknowledge that there have been some serious failings in relation to safety. As an ICP we begin from a clear position that all serious harm is avoidable. We will work to ensure that all serious incidents or other safety failures are properly recorded, reported and most importantly shared with a focus on learning and improvement.

We will develop an open, transparent and supportive learning environment. An environment where staff members feel confident to report adverse incidents and risks to safety and are actively supported to address them by making changes to the way in which services are delivered. We will promote the effective use of qualitative and quantitative data to identify themes for improvement and act upon them.

8.1.2 Sustainable services

Health and care organisations are facing major challenges in sustainability. Many are long standing and have been compounded by the impact of the Covid-19 pandemic. In some parts of our system, there are intractable difficulties in providing stable and

high-quality services. The ICP partners will work together to improve sustainability in the most fragile services including:

- Intensive support and improvement, including drawing in learning
- Supporting local teams to implement new models of care
- Implementing networked and collaborative models of care from the wider North East and North Cumbia system where local solutions cannot deliver sustainability on their own
- Joint planning and aligned commissioning, particularly to support the management of the Social Care market and providers of services funded through Continuing Health Care and joint section 117 arrangements.

To deliver sustainable service provision form should follow function. As care models evolve, some organisational change may need to follow, for example in GP practices or groups of hospitals. There will also need be active management of the social care market, with all partners in the ICP working together to ensure sustainable social care. We will be mindful of avoiding adverse unintended consequences in our future service design work and will consider sustainability alongside reducing inequalities.

Partly our work to improve sustainability will be delivered through organisations working together in closer partnership, including:

- Work to establish stronger partnerships between Social Care providers
- Networks of Primary Care Networks and General Practice Federations working together at scale, supported by the Primary Care Collaborative
- The Mental Health Collaborative responsible for some specialist services under delegation from NHS England. We will seek to further develop the potential for a wider focus to mental Health collaboratives
- The NHS Foundation Trust (FT) Provider Collaborative.

Over time, our provider collaboratives will play an increasingly important role within the ICP, taking on leadership of clinical networks and strategic programmes and brokerage of key deliverables with their members. Each provider collaborative will be supported with programme resource from both the ICB and their members.

Some parts of the North East and North Cumbria geography have sustainability challenges across multiple parts of their health and care system. Partners will give an appropriate level of focus and resource to these geographies and ensure an holistic response for them to achieve all of the goals set out in this strategy.

8.1.3 Equal value of mental and physical health services

We will deliver services with a key principle of parity of esteem – giving as great a focus to emotional and mental wellbeing, mental health, and learning disability and/or autism as we do for physical health. Mental wellbeing and mental illness needs to be focussed on in its own right, but there is a major interplay between mental health and physical health, as summarised by the Centre for Mental Health:

- Mental illness reduces life expectancy - it has a similar effect on life-expectancy as smoking, and a greater effect than obesity
- Mental ill health is also associated with increased chances of physical illness, increasing the risks of the person having conditions such as coronary heart disease, type 2 diabetes or respiratory disease.
- Poor physical health increases the risk of mental illness - the risk of depression is doubled for people with diabetes, hypertension, coronary artery disease and heart failure, and tripled in those with stroke, end-stage renal failure and chronic obstructive pulmonary disease
- Children experiencing a serious or chronic illness are also twice as likely to develop emotional disorders. Prevention, early detection and early intervention can all have a positive impact.

We will be purposeful in ensuring parity of esteem. In particular we will pay attention to access to mental health servies, applying the NHS consitutional waiting times and achieving parity with physical health waiting tiimes.

8.1.4 Personalising health and care

Personalised Care is the practice of enabling people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences. We will deliver a Personalised Care Programme across the ICP, which invests in meeting health and wellbeing needs, using the Universal Personalised Care model. Our key guiding principle will be ‘what matters to me’, enabling service users to have greater control.

We will embed personalised care approaches including shared decision making, personalised care and support planning, supported self-management, personal health budgets, choice and community-based support in all programmes.

8.1.5 Supporting unpaid carers

Unpaid carers are a very diverse group. It includes Young Carers - children and young people who support family members, usually one or both of their parents or their siblings, who have additional caring needs. This might result from a long-term disability, long term condition or an acute illness. It also often relates to social circumstance, for example children of drug or alcohol dependent parents. Young carers often experience multiple dis-advantage, through reduced time available to focus on their education, or to build peer social groups, and often also experience other features of socio-economic deprivation.

Adult Carers include parents providing support to their children and adult children, including those with physical care needs, learning disabilities or severe and enduring mental illness. It also includes carers providing support for older adults, particularly elderly family members who need support for the normal functions of daily living, for example due to a significant cognitive impairment or dementia. Carers themselves often experience poorer health outcomes, and consistently report that the experience of care for their loved one, and indeed for themselves, could be improved.

We will become better at identifying carers and provide more support to them in terms of their own health and wellbeing, and to the people for whom they care.

8.1.6 Better integration and co-ordination of care

Too often, service users and their families and carers experience care which is disjointed; they have interactions with multiple health and care teams which are not co-ordinated, and certainly not around working together to meet the service user needs holistically. To do this we will ensure a key work programme to deliver integration between:

- Health and Social Care
- Primary Care and Secondary Care
- Mental and Physical Health, including the delivery of the Mental Health Community Transformation programme

We will be highly focussed on delivering the recommendations of the Next Steps for Integrating Primary Care: Fuller Report Stocktake May 2022. We already have strong programmes of integration at neighbourhood and locality level, which provide a foundation to build on. In taking this work forward we will be recognise the work that already been done and build on the existing strengths rather than imposing a new model.

A key element of the report is to join up servies through integrated neighbourhood teams, building on the development of primary care networks (PCNs) and local partnerships.

8.1.7 Ageing well

All areas in our ICP have an increase in the 65 and older population. This is more marked in rural areas, for example Northumberland and North Cumbria have hyper-ageing populations. The hyper ageing population has more complex health needs. As the number of people over 65 continue to increase and particularly those aged over 85, the need to understand how to live well with not only the main long-term condition but also the impact of other related conditions greatens, for example:

- More older people are affected by depression in later life than any other age group, with higher rates of disability or illness, loneliness and isolation.
- The prevalence of social isolation increases with age, often due to the loss of friends or family, decreased mobility or reduced income. Loneliness impacts adversely on quality of life and on health. Those who frequently suffer from loneliness are much more likely to report a lower level of satisfaction with their lives overall. Research has shown that social interaction can be key to enjoying later life.
- Increased long term conditions, including diabetes, dementia, depression, heart disease and chronic obstructive pulmonary disease.
- Dementia is characterised by progressive deterioration of mental faculties ending in severe incapacity. As people grow older, their health needs become more complex with physical and mental health needs impacting on each other.

- Unintentional injuries, particularly falls, are the most frequent type of injury suffered among older people in the UK.
- Acute Frailty Syndrome, some older people live with acute frailty and multiple long-term conditions.

We will work with partners across the system to develop specific plans to support people to age well, promote independence, and to take asset-based approaches.

8.1.8 Better end of life care

We will all die. Death is a natural part of the life cycle which will affect everyone. We will enable a dedicated overarching plan to improve palliative and end of life across the health and social care system that goes beyond the need for advanced care planning. This will include working closely with the providers of hospice services, the NHS, social care and the voluntary, community and social enterprise Sector. It will also include the approach for children and young people with life limiting illness.

There is currently significant unmet need for palliative and end of life care. High quality and end of life care in community settings can also help to reduce wider system pressures, including the reliance on residential and nursing home care and hospital admissions. The latest figures on emergency admissions at the end of life show that across England 7% of deaths are preceded by at least three emergency admissions in the last three months of life. We will enable people to live well in their own homes, with the right support, for as long as possible, recognising that most people wish to stay at home, and ultimately to die well at home.

8.2 Protecting health and wellbeing

8.2.1 Safeguarding

Safeguarding is an integral part of providing high-quality health and care. Safeguarding children, young people and adults is a collective responsibility. It's crucial that as an Integrated Care Partnership we ensure the safe and effective delivery of our statutory safeguarding functions as they align to all the integrated care strategic goals. We will continue to build on the foundations of the integrated working that support our local safeguarding arrangements.

We will ensure effective safeguarding arrangements are in place including safeguarding oversight, support, supervision and training, delivered in partnership to prevent harm and safeguard our people, their families and communities. We will use our collective resources in the most effective way possible to support local partnerships and organisations.

We will give due regard to the need to eliminate discrimination, harassment and victimisation and to advance equality of opportunity and to the need to reduce inequalities between people in their access to and the experience of and outcomes from healthcare services and to all Articles of the Human Rights Act.

We will ensure a well-supported, sustainable and skilled safeguarding leadership across all health and care services to enable staff at all levels to be confident and competent in delivering person centred safeguarding practice.

We will use data, intelligence and consistent narrative to drive practice improvements that will connect national, regional and local intelligence to routinely describe the safeguarding “landscape”. This will enable more responsive planning and inform service developments at local authority place and across the ICP.

We will promote a strong culture of learning that directly supports lessons learnt and drives safeguarding practice improvements, reduces risk and promotes prevention and early intervention.

8.2.2 Health protection

The UK Health Security Agency (UKHSA) Health Protection Team are responsible for providing specialist public health advice to support the NHS, local authorities, and other agencies in preventing and reducing the impact of infectious diseases and environmental hazards. The experience of the COVID-19 Pandemic brought to the fore the vital importance of effective Health Protection Programmes. We will work with partners, including the UK Health Security Agency (UKHSA) to ensure:

- High uptake of all relevant vaccinations across our population, including occupational vaccination across the health and social care workforce.
- The health of the population is protected from new emerging and re-emerging infectious diseases
- Harms are mitigated when incidents involving chemicals, poisons or radiation threaten the health of the population.
- That people are kept safe from unintended harm when engaging with health and care services
- That services, protocols, and pathways are in place to respond to cases or incidents of infectious disease.

8.2.3 Emergency preparedness, resilience and response (EPRR)

The COVID-19 pandemic emphasised the importance of effective emergency preparedness, resilience and response in delivering a co-ordinated whole system response. We will deliver our statutory duties and work with partners to deliver their statutory duties under the Civil Contingencies Act 2004 including:

- Fully engaging with Local Resilience Forums (LFR) and the Local Health Resilience Partnership (LHRP)
- Ensuring robust response plans are in place across organisations
- Co-ordinating joint system training and exercising opportunities
- Facilitating the sharing of lessons and notable practice
- Embedding cross system learning from COVID-19.

8.3 Long term conditions and cancer

8.3.1 Cancer

Evidence shows that up 4 out of 10 cancers are preventable. The biggest long-term difference we can make is through effective prevention programmes, as referenced in section 5.

Public Health analysis highlights the inequalities in the cancer mortality by area of deprivation. It is estimated for every 1, 000 people aged 65+ with cancer, 142 within the most deprived areas will die compared with 88 in the least deprived. We will use population data to deliver targeted case finding and surveillance to enable people to access diagnostics, assessment and treatment earlier.

The National Cancer Plan sets the ambition that by 2028, 75% of cancers diagnosed will be stage 1 or 2 cancers. Early-stage cancers that are more amenable to curative treatment, leading to improvement in the 5-year survival rates for cancers.

Further improvements in cancer diagnosis and treatment will increase the population living with and beyond cancer. We will increase the personalisation and accessibility of support for people following their diagnosis and treatment, so people know the signs and symptoms of recurrence and have access to support services and personalised follow up care.

To deliver our ambitious programme for cancer care, we will deliver a transformation plan for the specialist cancer workforce. This will include extending the roles of the members of multidisciplinary teams such as therapy radiographers and pharmacists and developing new innovative and emerging roles for future medical and clinical staff. Specific improvements we will work to deliver include:

- Delivering the early diagnosis and faster diagnosis national targets
- Exceeding the national standards for screening uptake for all population segments
- To reduce avoidable new cases of cancer
- Improve the experience, care and quality of life for people living with and beyond cancer as measured by the National Cancer Patient Survey

8.3.2 Long term conditions

Nearly all of us will live with one or more long term condition during our life, and particularly in later life we are likely to live with multiple long-term conditions. Common long-term conditions, including diabetes, heart failure, hypertension asthma and chronic obstructive pulmonary disease are major causes of poorer health outcomes and inequalities in our ICP. Some long terms conditions begin in childhood, while others become more common the longer we live. Some are deeply associated with age, for example dementia.

We need to improve how we respond to long term conditions across all services and throughout the life course, including:

- Pathways, from prevention to end of life care
- Prevention, reducing the occurrence of preventable long-term conditions
- Case finding, improving our detection of long-term conditions
- Support for self-management, we need to equip people with the knowledge, skills and strategies to successfully manage their own condition, for example through structured education programmes
- Providing effective interventions that reduce the progression of long-term conditions and reduce exacerbations
- Physical health psychology, people living with a long-term condition often require bespoke psychological support
- Social care and voluntary, community and social enterprise sector services play a huge role in supporting people to live more successfully and independently without unnecessary health interventions.

8.4 Mental health, learning disability and/or autism and substance misuse

8.4.1 Mental health

The COVID-19 pandemic significantly impacted the mental wellbeing of the whole population, including for example direct effects such as experiencing bereavement and illness, social isolation, anxiety about personal finances and employment, and an increase in domestic violence. This has exacerbated already high levels of poor mental wellbeing and mental illness. The demand for both children's and adult mental health services has risen significantly, and many services are currently operating with long waiting lists and operational pressures.

Mental illnesses have a major impact on overall health outcomes and health inequalities. People with a severe and enduring mental illness have much poorer physical health outcomes and are likely to die as much as twenty years younger than the general population. In our ICP area we have some of the highest rates of suicide in England. Suicide is the leading cause of death for men aged 15-49 and women aged 20-34.

The ICP will develop a comprehensive plan for improving the mental health of its population, building up from the services provided at neighbourhood and local authority place, with close working with the VCSE sector as a full partner, including:

- Strengthening core community, in-patient and crisis services, including peri-natal mental health services and psychiatric liaison services
- Delivering the Mental Health Community Transformation programmes, which focus on enabling patients in long term hospital care to move into a community setting with a package of support

- Moving towards trauma informed, and psychologically informed services across all of health and car services, recognising the often life-long impact of trauma (for example Adverse Childhood Experiences)
- A concerted and universal suicide prevention programme
- Improving the physical health of people with severe and enduring mental illness, including targeted prevention and health programmes and participation in screening programmes
- An improved service offer for people with substance misuse issue and poor mental wellbeing or mental ill health.

8.4.2 Learning disability and/or autism

Compared to the whole population, people with a learning disability, and autistic people, on average die at a much younger age. We will focus on tackling long waits for people to have assessments for autism spectrum conditions and for people assessed as having a learning disability, making sure that their health and social care needs are properly assessed and met in both health and social care.

We will work to ensure that health and care services make reasonable adjustments, provide holistic care, and do not miss other health and care needs by over focussing on a person's learning disability.

In July, the Health and Care Act 2022 introduced a requirement that regulated service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff to undertake. It is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training. It is the only training with permission to include Paula McGowan OBE, telling Oliver's story and explaining why the training is taking place. Training across health and social care services will include the Oliver McGowan Mandatory Training.

We will implement the new learning from death reviews (LeDeR) policy to review the deaths of people with a learning disability and identify learning, opportunities to improve, and good practice. We will redesign pathways to reduce waiting times for autism assessment. We will reduce the number of people in specialist in-patient services and reducing the number of emergency admissions to hospital.

A key focus will be to develop stronger joint commissioning frameworks across health and social care to improve community provision.

8.4.3 Substance misuse

As described in our case for change, illnesses associated with alcohol, and alcohol and drug related deaths, are a major cause of health inequalities in the North East and North Cumbria. For the last nine years we have had the highest rate of drug related deaths in England, and we have high rates of alcohol related hospital

admissions. This is population health challenge, requiring multi-agency working, to address the complex nature of drug and alcohol related harms. This will include:

- Increasing the delivery of brief interventions in all settings
- Increasing the participation in treatment services for dependent drinkers and drug users, including both harm reduction and abstinence-based programmes
- Improved support for children of alcohol or drug dependent parents, and for carers of people with drug or alcohol dependence
- Population focussed interventions as outlined in section 5.

8.5 Adult social care

8.5.1 Demand for services

Adult social care experienced extremely difficult challenges through the peaks of the COVID-19 pandemic, which exposed the longstanding and underlying fragility in many services. Additionally, adult social care is experiencing significant pressure from:

- Increased referrals because of mental health issues, domestic abuse, safeguarding concerns and the breakdown of unpaid carer arrangements
- Supporting an increasing number of people to access the right care in the right place, at the right time.
- Increased complexity of need – people who need social care support are needing a much higher level of care, for a longer period of time.
- Challenges in sustaining the independent sector care market in both the residential and nursing home sector and for home care provision
- Supporting people being discharged from hospital to access the support they need in a timely manner
- The implementation of social care reforms
- Workforce challenges, partly as some staff pay rates have fallen below competing sectors such as retail and hospitality.

The majority of adult social care is provided to older adults, as the number of older people increases it will drive demand for services, which is compounded by a much lower growth in the number of working age adults to provide these services.

8.5.2 Economic contribution

Adult social care is often viewed as a burden on public finances. It is important to note the enormous contribution to the local economy and social infrastructure from adult social care.

Across our ICP, social care is well over £1 billion annually, with over £200 million of self-funded care, and a much higher value-added contribution (at least in excess of £2.5 billion and probably over £3 billion per year) to local economies.

Across the ICP, local authorities support more than 55,000 people with long term care and support needs, with a further 4,000 people in receipt of NHS-funded continuing health care (CHC).

Local authorities fund 9.3 million hours of home care provision each year. The level of demand rises when the numbers of people funding their own care are taken into account.

There are an estimated 5,800 care home residents in the North East who pay for their own care home accommodation, whilst self-funders also buy an additional 4 million home care hours pa. Local Authorities also support 13,000 people through direct payments and personal budgets meaning an estimated 3,900 individual employers in the region. It is also estimated that there are 286,000 unpaid carers in the region, of whom around 120,000 people were providing 20 or more hours of unpaid care each week.

Across our ICP partners are committed to working together to support adult social care, and to develop new ways of supporting people to live well within their communities. This has never been more important as the escalating cost of living in the UK is causing ever more people to struggle to afford the basic needs to sustain their health and wellbeing.

8.5.3 Sustainability

The ICP recognises that in order make this possibility a reality, a significant and sustained investment in required into social care. A particular challenge is the pay rates for staff in home care and care home roles. In recent years this has changed from being slightly higher than alternative jobs within the retail and hospitality sector than slightly lower. The ICP will develop and deliver a plan to expand and sustain the care workforce across our region. We will work with partners to deliver a comprehensive workforce strategy, where social care is valued, rewarded, and allows people to learn use skills within a carer progression structure.

8.5.4 Prevention and promoting independence

We will work in partnership with the VCSE sector and NHS partners to deliver a much stronger prevention offer to the population. This will support people to live independently and ensure that vital capacity in the regulated care sector is reserved for the people who most need it.

8.5.5 Areas of focus

Some of the key programmes we will deliver include:

- Strengthening the provision on Home Care and Extra Care Housing, and reduce the reliance on residential and nursing homes
- Working with the care market to increase capacity and sustainability
- Reducing the time people spend in hospital whose needs could be better met by access to social care

- Expanding the adult social care workforce
- Developing shared solutions alongside housing, and maximise the opportunities of digital and technology
- Working to identify and support more people who are providing unpaid care within the region.

8.6 NHS services

8.6.1 Primary care and community services

The majority of NHS patient interactions are delivered in primary care, through general practice, dentistry, optometry and community pharmacy. Some parts of our geography are struggling to maintain their primary care services due to severe workforce shortages, particularly of general practitioners (GPs) and dentists.

Primary care does not work in isolation. Community services, including mental health services, play a vital role in meeting patient needs in the community, often working in partnership with social care and the VCSE sector.

The Fuller Report, published by NHS England earlier this year, makes a range of recommendations for the improvement of primary care. The ICP will make implementing the Fuller Report recommendations a priority, working closely with the primary care networks (PCNs) that have been set up to support primary care development. The ICB will further develop primary care collaboration, in partnership with the PCNs to develop models of care to support sustainability and resilience in the places where staffing levels are lowest in relation to population served.

8.6.2 Urgent and emergency care

Urgent and emergency care (UEC) services across our ICP face significant pressure. We will work together to deliver an ambitious redesign of the provision of urgent and emergency care to:

- Increase the proportion of urgent care which is delivered in community settings including in the home
- Increase the proportion of 111 and 999 calls that are clinically assessed and maximise hear and treat and see and treat pathways
- Eradicate 12 hour waits in emergency departments, and ambulance handover delays in excess of 30 minutes, and improve ambulance response times
- Expand the range and uptake of 2 hour community response services, to enable people to receive timely care in the right place
- Enable people to return to their permanent place of residence with the right support once they no longer need medical treatment in hospital.

8.6.3 Elective care

The COVID-19 pandemic has created pressure within elective services across the North East and North Cumbria geography. Reducing elective waiting times will be a significant challenge for the NHS given the array of pressures in the system. It will demand a mix of increasing capacity to diagnose and treat patients and a redesign of patient pathways and service delivery models to ensure clinical capacity is optimally utilised.

The ICB Elective Recovery Programme, which is led by the Foundation Trust Provider Collaborative, will incorporate the following elements:

- Additional elective diagnostic and treatment capacity
- System-wide joint working to ensure the longest waiters are treated in line with national targets
- Outpatient Transformation Programme
- Implementation of the best practice pathways identified by Getting It Right First Time Programme (a clinically led national evidenced based improvement programme)
- Implementation of a Waiting Well Service to support patients experiencing long waiting times patients to be a fit as possible for their treatment, especially those in our most deprived communities
- Eliminating waiting times over 1 year by April 2025.

8.6.4 NHS England delegation

From April 2023, the ICB will take on the commissioning of pharmacy, optometry and dentistry. The ICP recognises there are significant challenges with timely access to dentistry in parts of the region and that this is a matter of significant public concern.

The ICB will work with the dentistry sector to improve access, through a combination of new models of care and a concerted effort on recruitment. The ICP will also work with NHS England to press for improvement to the national dentistry contract.

The Specialised Commissioning and Health and Justice Team are responsible for commissioning services across a diverse portfolio of care that is provided at specialist tertiary centres, within prison settings as well as in specialised inpatient mental health units across the region. These services are planned at a regional level due to low volume, complexity of the services, and the potential financial risk associated with provision. The responsibility for commissioning some of these services will transfer to the ICB in April 2024, with joint working during 2023/24 as a transition year.

Working in partnership with the ICB, the NHSE specialised commissioning will explore ways to deliver new service models for advanced place-based arrangements to integrate specialised services into care pathways, focussing on population health for the ICB. We will do this through joint collaborative commissioning approaches as set out in the roadmap for integrating specialised services within Integrated Care

Boards, published in May 2022. We will explore opportunities for more advanced integrated arrangements where these will support the delivery of outcomes for our population.

To optimise equity of access we will build on our current clinical engagement to expand new models of service delivery through network approaches.

9 Enabling strategies

9.1 A skilled, compassionate and sufficient workforce

People are at the heart of our health and care services and are our biggest strength. We are fortunate to have a highly skilled, dedicated and committed. People working in health and care services showed exceptional resilience throughout the COVID-19 pandemic, but our workforce is stretched:

- Nationally as of September 2021 the NHS was advertising nearly 100, 000 vacant posts, and Social Care a further 105, 000
- Nationally an estimated extra 475,000 jobs are needed in health and 490,000 in social care by the early part of the next decade
- Workforce wellbeing remains a key priority, for example in August 2021 the NHS lost 560,000 days to sickness and absence due to anxiety, stress and depression.

Our ICP area is not exempt from those challenges. Some organisations are experiencing severe challenge in the recruitment and retention of staff, but we want the North East and North Cumbria will be the best place to work in health and care, becoming the employer of choice.

We will aim to reduce the vacancy rate across health and social care services by 50% by 2030.

To achieve this we will ensure safe staffing levels across all of our services and sectors, in every local authority place, and we will enable our workforce to enjoy satisfying careers, feeling valued and able to make their best contribution. Our collective leadership to deliver these commitments will be organised through the North East and North Cumbria People Board. It will act as the system convenor, supported by a Stakeholder Engagement Forum, and will be structured around 6 priority areas:

- Workforce supply, including enabling local people to be able to access employment and career structures in our local services
- Workforce health and wellbeing
- System Leadership and Talent
- Equity, Inclusion and Belonging
- The development of the learning and improvement community
- Build on existing workforce plans, for example the North East ADASS Workforce Strategy.

A key focus will be on developing improved career structures across and between health and social care. This will include better ways to enable people living in in our communities to enter the health and social care workforce, with good training and

support, recognising that many talented and committed people currently face barriers to joining our workforce.

We will also work to maximise the terms and conditions of staff across sectors and services, wherever possible ensuring that people are appropriately rewarded for their work.

To achieve our aim of ‘being the best at getting better’ we have created the Learning and Improvement Collaborative to mobilise people from across the region. This work is very much at an early stage. We will work with people and partner organisations across the ICP to build the learning and improvement collaborative.

9.1.1 Becoming a learning system

There is an excellent record of research, innovation and quality and service improvement in the North East and North Cumbria. The ICB has signalled its intent to build on this with the launch of the Learning System, with a stated aim of supporting staff and partner members, teams, organisations and the system to become 'The best at getting better’. This work is very much at an early stage. We will work with people and partner organisations across the ICP to build the Learning System as a culture, a community and a collection of assets that support learning at every opportunity.

The ICB will build a learning approach into its operating model, for example into its governance arrangements and its oversight framework.

The ICP will also ensure it develops and maintains an open learning culture, that whilst being 'tough on problems' is kind and supportive to people. Achievement of this aim will be measured through the NHS staff survey and other bespoke staff engagement measurement tools across our partners.

9.2 Working together to strengthen our neighbourhoods and places

Our collective services, including the work of unpaid carers and the VCSE sector, rely on strong joint working at local neighbourhood and local authority place level. We have strong partnership-based foundations particularly through the leadership of our Health and Wellbeing Boards, and over time across the four local ICPs.

The government's Integration White Paper 'Joining-Up Care for People, Places and Populations' set out further expectations for place-based working by 2023. This includes strengthening governance arrangements between Integrated Care Boards and local authorities, with joint accountability for delivering of local shared plans.

To further support local partnership working we will agree formal of local governance arrangements at local authority place level by March 2023, and encourage local networks and collaboratives across sectors in each local authority area. A key focus

will be to implement integrated neighbourhood teams, in line with the Fuller report, bringing together all partners, including the primary care, voluntary sector, social care and Ambulance services. This will build on existing partnership working, strengthening how teams already work together at locality level.

9.3 Innovating with improved technology, data, equipment and research

9.3.1 Research and innovation

The ICP is home to many research and innovation organisations, institutes and infrastructure, that collectively result in a vibrant ecosystem that is unique across England. Some of our opportunities for improvement include:

- Develop inclusive approaches for involving service users and staff in identifying unmet needs.
- Making the use of data, research evidence and insights more accessible.
- Continuing to support both frontline NHS and industry innovators.
- Support for potentially impactful solutions to gain traction across the system, and through strong evaluation drive adoption of new solutions.
- Increasing investment in innovation across health and care services.
- Expanding socially focussed research on challenges experienced across our communities, clinical practice and the wider determinants of health.
- The creation of a 'Health and Life Sciences Pledge' involving all organisations across the research and innovation ecosystem, that results in recognition for the region, on both a national and international stage.
- Building on the work of the AHSN in further establishing and embedding the NENC Innovation Pathway as a recognised regional brand.

9.3.2 Digital technology and data

Digital technology has changed our lives beyond recognition in the last twenty years. We have yet to fully exploit the benefits digital technology can bring to the health and care system, and to enable people to manage their own health and wellbeing. We have been laying down solid foundations for improvement, for example to help meet the technical challenge of linking complex systems together, putting in the right infrastructure, standards and security measures. With the emergence of new digital systems and services we will support and equip our workforce to be ready to embrace these digital opportunities.

We will continue to deliver the commitments within our existing digital strategy, and where necessary, will review and revise the strategy to align and support the delivery of the ICP Integrated Care Strategy.

The health and care system collects a significant amount of data from patients, carers and service users. The majority of data is not used beyond care delivery,

performance management and contract management. Through the advances in computing powers, abilities to link datasets and use this data to develop insights and deep understanding of the communities we serve. We will develop and implement a complimentary, data, intelligence and insights strategy placing information at the centre of our collective decision making.

We will accelerate the use of technology to support people to live as independently as possible, for example older people living with frailty and/or a cognitive impairment. We will also invest in technology that supports people to make healthy choices and prevent ill health or slow the progression of their long-term conditions.

9.3.3 Estates

Our health and care services are delivered across a huge number and range of buildings, with over 490 primary care sites alone. We will develop a collective estates plan, focussed on providing contemporary, sustainable, fit for purpose estate that is accessible and capable of reacting to changes in population size and demand. Where beneficial, this will include:

- Consolidating services onto fewer sites to maximise the use of existing infrastructure and to promote joint working
- Adopt ‘one public estate’ principles at local authority place level, including the potential to use shared estates to deliver jointed up clinical and care services
- Prioritising capital investment to effectively meet need
- Support to health and social care provider organisations to ensure well planned and prioritised capital investments.

9.4 Making the best use of our resources

Nationally and across our ICP, local authorities are facing financial pressures in adult and children’s social services, public health and the broader services that impact health and wellbeing outcomes. All NHS organisations are experiencing severe financial pressure. Key to our financial planning will be:

- Using the strength of our collective voice to advocate for more resources to be provided to the North East and North Cumbria across all sectors – bringing our health outcomes into line with the rest of England requires funding
- Over time we will target resources to where they are most needed to improve health outcomes and to reduce health inequalities. Our commitment to fairer outcomes must be supported by investment
- Removing the barriers to using resources flexibly between organisations, so that we can achieve best value from a whole system perspective
- Living within our means, with good financial stewardship across and within organisations
- Work with partners to tackle areas of inefficiency and inequity, recognising touch points between services and collective ambition and challenges

- Improve the productivity of our services, utilising the Model Hospital Data and learning from others
- Redesign service delivery models where there is evidence that better or comparable outcomes can be achieved in less resource intensive ways
- Commit to improving funding arrangements for VCSE, creating innovative solutions that enable the sector to deliver shared outcomes
- Harness the strength of integrated working at local authority place to drive transformation and efficiency across health and care.

9.5 Protecting the Environment

The North East and North Cumbria Health and Care system is committed to playing its part in tackling climate change. To this end it launched its Green Plan in July 2022. This set out targets and actions for the NHS members of the partnership to meet the sustainability challenge through an agreed programme of activity and by exploiting synergies between the member organisations. Many of our local authorities and NHS foundation trusts have already declared a climate emergency recognising the scale and urgency of the challenge.

Many local authorities already have clear plans to achieve a carbon net zero ambition. The Health and Care Act 2022 placed new duties on NHS to contribute to statutory emissions and environmental targets. We will meet the following for carbon emissions:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045.

As an ICP we will publicly declare a climate emergency and commit to fast-track the decarbonisation of our regional health and care services, as part of a broader strategy to become the greenest region in England by 2030.

9.6 Involving people

In the development of the strategy we relied on engaging with partnerships and organisations. We fell short of our intention to really focus on good co-production with citizens and experts by experience, due to the infancy of our new organisation and the timeframes set nationally for development of the strategy. We are deeply committed to ensuring an active and real commitment to involving people and will ensure future strategy and plan developments are properly co-produced.

Community participation in decision making at all levels will be given greater significance. We acknowledge that too often there remains a tendency for decisions to be made ‘within’ institutions whereas community engagement and involvement can provide invaluable knowledge from ‘without’.

We will work to ensure that people are actively involved in how we take forward the delivery of the strategy. This will include tapping into the extensive community assets people are already involved in, and sometimes represented by. For example, the voluntary, community and social enterprise sector, pre-existing and potential networks, and trusted institutions such as community centres. We will also recognise and respect the role of elected members in local authorities as community leaders, and we will work closely with the Health Watch organisations and network.

The approach to involving people will be inclusive all ages, specifically including children and young people.

The ICP is committed to involving people in the design and delivery of care, which is essential if health and care services are to become more responsive, personalised, valued and efficient.

10 Delivering the strategy

10.1 Partnership working at all levels

Neighbourhoods

Delivering this strategy will require focussed work at community and neighbourhood level. A key foundation will be strengthening the approach to integrated neighbourhood teams everywhere, and really engaging with local people to understand their assets and needs. Each local authority place based local system, with support, will find ways to enable and support neighbourhood approaches, including devolving decision making to as near to people as possible.

Place and local authority areas

Our Integrated Care Strategy aims to be complementary to existing plans in each local authority area and is not about 'imposing' requirements.

Partnerships in each local authority area will be supported to consider the strategy and seek to align local work to the key areas of the strategy. Delivering the strategy will require:

- The leadership of our health and wellbeing boards
- The leadership of local authority place-based structures, including broad 'collaboratives' across sectors for each local authority place.

Local ICPs

The four local ICPs will provide:

- A forum to support groups of local authority places to work together where beneficial across a broader geography
- A bridge between the work in local authority areas and the whole North East and North Cumbria ICP.

ICP level

The ICP will provide an overarching strategic leadership role across the whole region. This formal governance will be enhanced by partnership arrangements across the whole ICP, including for example:

- Association of Directors of Adult Social Services (ADASS) network
- Directors of children's services network
- Directors of public health network
- The directors of finance and ADASS group
- Emerging shared fora for housing
- Provider collaboratives covering the whole of the ICP area
- Emerging networks for general practice, including a strong collaboration between primary care networks

- Using the networks across Health Watch and voluntary, community and social enterprise sector to ensure strong partnerships with communities, experts by experience and third sector organisations
- Clinical networks, for example the Northern Cancer Alliance
- Networks focussed on population groups, for example the Child Health and Wellbeing Network.

Each of these whole ICP arrangements will be responsible for supporting local authority places, and for whole ICP working.

10.2 Delivering the strategy

Delivery plans and measuring progress

To support the delivery of this strategy we will develop delivery plans for:

- Local areas covered by each Integrated Neighbourhood Team
- Local authority places
- Each of our key work programmes (for example each enabler in section 9) across the ICP, including frameworks to support delivery at local authority place level. We will review our strategic programmes to align them to the key deliverables within the strategy.

We will also develop a clear dashboard to measure and report progress in our delivery of our strategy on a quarterly and annual basis. This will be publicly available to ensure transparency and promote accountability. This will be based on our goals and supporting commitments outlined in section 4.

Communicating the strategy

Once agreed for publication, the ICB will on behalf of the ICP develop a range of materials to support the communication of the strategy and make these available to all partners and interest groups. This includes commissioning easy read versions of this document.

Reviewing the strategy

The ICP will undertake an annual review of the strategy and as part of this will agree whether to recommit to it for a further year, refresh elements of it or fully review it.