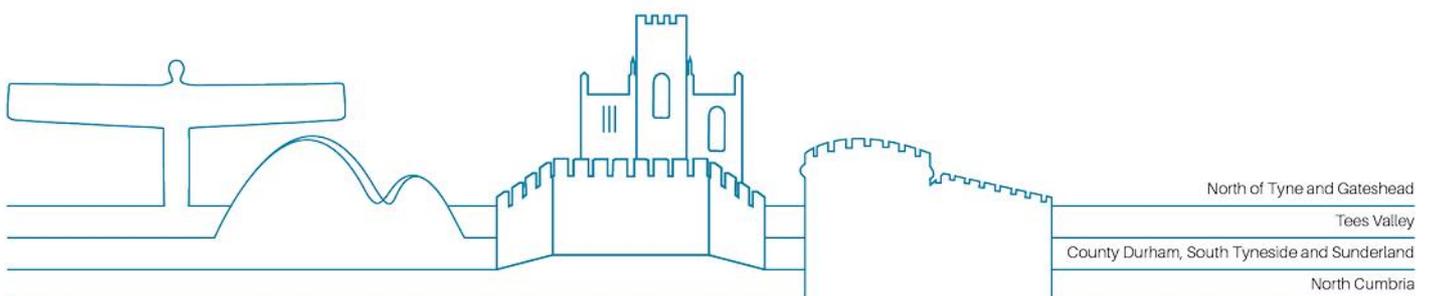


# North East and North Cumbria Integrated Care System Strategic Five-Year Plan 2019

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## Foreword by Alan Foster MBE, Integrated Care System Executive Lead

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Over 70 years on from the creation of the NHS it remains one of the greatest achievements in UK history within the last 100 years. One that has and continues to transform the lives and health outcomes of communities and an organisation woven into the fabric of our way of life.

In more recent years, the NHS has been the conduit that has enabled patient access to many revolutionary advancements in medicine. Advancements that have not only saved lives but ones that support recovery from serious and life-threatening illness such as heart disease, stroke and cancers.

Diseases and health issues that once limited life are now cured or curable. As a result, more and more people are living longer. But to get to this point from its inception in 1948, the NHS has been constantly evolving and adapting to meet changing needs and expectations; from a growing and older population to new treatments and technologies.

Like all institutions, the NHS does have its challenges. Every year demands on NHS services grow and the cost of keeping up to date with modern technology and drugs also grows. This coupled with financial challenges, significant issues with recruitment of clinical staff, in particular doctors and nurses, means change is not an option but an imperative.

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*'This evolution must embrace more effective partnership working across social care, public health, education and a range of other local services.'*

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We also know that some of the demands on NHS services are, too often, created through a range of lifestyles linked economic and social issues. Tobacco smoking, illegal drug taking, alcohol consumption, unhealthy diets coupled with a more sedentary lifestyles and lack of physical activity impacts dramatically on demands for services and addressing these is central to our prevention work programme.

We recognise that mental ill health is one of the key factors determining health inequality. Our plan sets out an ambitious programme of service transformation to ensure that integrated systems of mental health and physical health care are provided to meet the needs of the population. There is a clear responsibility not only to provide mental health services for people experiencing mental ill health, but to also ensure people with serious mental illness have access to, and experience, good physical health care. A joined-up approach to mental health, physical health and social care will improve the life expectancy of people with complex mental health

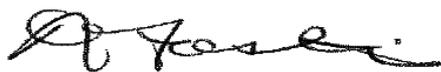
conditions who die on average 15-20 years earlier than the rest of the population. It is equally important to ensure that individuals with physical health issues have access to appropriate and timely support to address any mental health and well-being needs. Significant priority is given to addressing the prevention of mental ill health to ensure parity of esteem.

It is however clear that not one organisation can address these challenges alone. As we have evolved in the past, the NHS must evolve in the future. This time, this evolution must embrace more effective partnership working across social care, public health, education and a range of other local services. Partnerships with Local Authorities, voluntary and third sector organisations are therefore a priority as we formulate our ambition for the future.

This collective ambition must tackle health inequalities and access to equitable health and care. It must maximise the opportunities brought by the NHS and care system as a major employer. It must drive up the quality of services whilst improving overall health and wellbeing outcomes. We have the ambition to have the best health and wellbeing outcomes in England and we now need to make this happen.

To do this we have created an Integrated Care System (ICS) for the North East and North Cumbria (NENC). This ICS will act as the conduit for partnership working across the areas served. Covering a population of 3.2m people it will collectively aim to, not only address the challenges we have as a system but also plan collectively to be the best in England when measured against all public health and national indicators of good population health.

This plan is our local response to the NHS Long Term Plan. I therefore commend this to you; together we can meet the challenges and transform our collective impact on our local communities.



**Alan Foster MBE**  
**ICS Executive Lead**  
**North East and North Cumbria**



## Section 1.0 An introduction to the North East and North Cumbria

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Health and care across the North East and North Cumbria (NENC) is evolving. Together with our partners in local and national government we are continuing to change, innovate and adapt to the challenges we face now and, in the decades, to come.

The need for change is urgent for we face some of the most serious challenges of any health system with; above average levels of deprivation, an increasingly ageing population, chronic ill health and persistent workforce pressures, which all add up to ever greater demands on our services.

In recognition of our commitment to work together to address these issues, in June 2019 NENC was confirmed by NHS England as one of a small number of 'Integrated Care Systems' (ICSs) across the country.

Our ICS, shown in the map overleaf, is a collaboration of NHS commissioners and providers, and our partners, and not a new organisation with statutory powers. Subsidiarity remains our guiding principle, with the majority of our work remaining focused in our 'places' and neighbourhoods. But, alongside this, our ICS provides a mechanism to build consensus on those issues that need to be tackled at scale. Working together across organisations in a coordinated and targeted way can have a major impact on health outcomes.

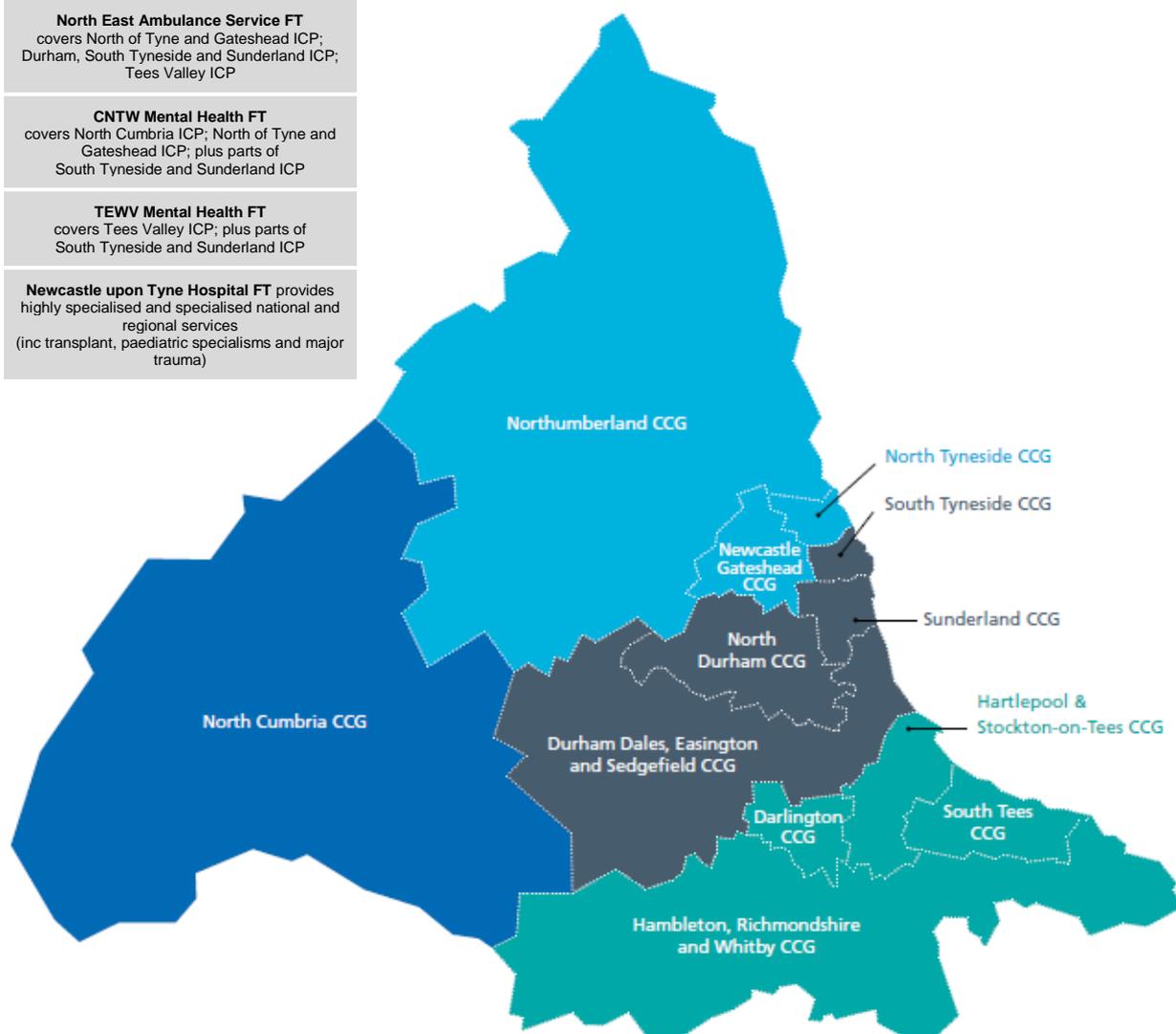
As part of the evolution of the ICS geographies across the North East and Yorkshire, there will be some minor changes to the geography covered by NENC ICS, linked to the planned merger of three CCGs across North Yorkshire, namely Hambleton, Richmondshire and Whitby (HRW) CCG, Harrogate and Rural District CCG and Scarborough and Ryedale CCG. With effect from April 1<sup>st</sup> 2020, when the three CCGs will become one called North Yorkshire CCG, the geography currently covered by HRW CCG, will join the Humber Coast and Vale STP and discontinue its active engagement as a full member of NENC ICS.

This change would result in an approximate reduction of 145,000 people in the overall population covered by NENC ICS and will require some engagement with the newly formed North Yorkshire CCG, particularly in relation to patient flows to South Tees NHS Foundation Trust.

Securing ICS status is a real vote of confidence in the strength of how NHS organisations, and our partners, work together as a system, but we know that there is much still to do to improve the health and wellbeing of the communities that we serve.

## Map of NENC Integrated Care Systems

NENC ICS-wide
<b>North East Ambulance Service FT</b> covers North of Tyne and Gateshead ICP; Durham, South Tyneside and Sunderland ICP; Tees Valley ICP
<b>CNTW Mental Health FT</b> covers North Cumbria ICP; North of Tyne and Gateshead ICP; plus parts of South Tyneside and Sunderland ICP
<b>TEVV Mental Health FT</b> covers Tees Valley ICP; plus parts of South Tyneside and Sunderland ICP
<b>Newcastle upon Tyne Hospital FT</b> provides highly specialised and specialised national and regional services (inc transplant, paediatric specialisms and major trauma)



ICP	North of Tyne and Gateshead	North Cumbria	Durham, South Tyneside and Sunderland	Tees Valley
Population	1.079M	324k	997k	852k
Clinical Commissioning Groups	Northumberland, North Tyneside, Newcastle, Gateshead	North Cumbria	South Tyneside, Sunderland, North Durham*, DDES*	HAST*, Darlington*, South Tees*, HRW
Primary Care Networks	24	8	24	17
Foundation Trusts	Northumbria, Newcastle, Gateshead	North Cumbria Integrated Care NHS FT (NCIC)	South Tyneside & Sunderland, County Durham and Darlington	County Durham & Darlington, North Tees and Hartlepool, South Tees
Council	Northumberland, North Tyneside, Newcastle, Gateshead	Cumbria County Council (with 4 district councils)	South Tyneside & Sunderland, County Durham	Hartlepool, Stockton-on-Tees, Darlington, Middlesbrough, Redcar & Cleveland, North Yorkshire
	North West Ambulance Service		County Durham CCG from 1/4/20	*Tees Valley CCG from 1/4/20 Yorkshire Ambulance Service

This document is our response to the requests in the NHS Long Term Plan, outlining how we will:

- Bring together local organisations in a pragmatic and practical way to deliver the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.
- Ensure patients get more options, better support, and properly joined-up care at the right time in optimal care settings.
- To relieve pressure on A&Es through more effective population health management, service coordination and removing traditional boundaries between hospital and community-based services .
- Strengthen our contribution to prevention and tackling health inequalities that will help people stay healthy and moderate demand on the NHS.
- Develop a new ‘system architecture’ that delivers strategic action on workforce transformation, digitally-enabled care, and the collaborative approaches to innovation and efficiency that will restore our ICS to financial balance.

## 1.1 Changing demands on health systems

The nature of how and where care is provided - whether that is in hospitals, community clinics, GP surgeries or at home is changing fast. For example, many operations and treatments that would previously have needed long recovery in bed are now routine, done in a day, and carried out in local hospitals, or even clinics and GP surgeries.

Patients now have access to a wider range of treatment, using new technology, techniques and medicines, and provided by a changing workforce who have new skills and expertise. Positive outcomes have increased, with more people living longer and healthier lives, often as a result of personalised support for long-term conditions and more successful treatment for serious illness or injury.

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*‘Spending less time in hospital is better for patients’ recovery’*

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How we manage the increasing number of frail elderly people in our population, often with multiple cognitive and medical issues, and complex social needs, including balancing provision between social care in residential and community settings, is a growing challenge. This group present a challenge to both social care and health, which manifests as increased and unmet need in the community with repeated and prolonged episodes of hospitalisation that may not always be appropriate. We need to get much better at sustaining health and well-being among older people and if they do become unwell, ensuring that we can optimise their recovery. Spending less time in hospital is better for patients’ recovery and we know most people prefer to be

cared for at home if possible. New technologies and ways of working allow this to happen more easily, which also means a greater need for social care and community health services to be coordinated, and new approaches to prevention and wellbeing, patient-centred care and integration of services across all health settings.

We are also home to some of the most rural and isolated communities in England, alongside densely populated urban areas in the industrial heartlands. While technological developments and new delivery models will help us to deliver equitable care across a varied range of urban, coastal and rural areas, meeting these challenges will mean working smarter as an integrated health and care system to deliver outstanding care and the best possible outcomes for our local communities.

The NHS and social care system also faces major challenges with shortages of key staff, which is exacerbated by the fragility of the independent social care market and the gaps in its workforce. This results in an increased dependency upon agency or temporary staff with the associated risks of escalating costs, variation and loss of continuity of care. Recruitment and training of new staff takes time, and with national guidelines on safe-staffing levels, we will have to make some hard choices that balance the need to maintain certain clinical services (particularly those that are most reliant on scarce specialist clinicians), whilst maintaining equitable access for all our communities.

## 1.2 Making a wider impact in our region

In 2019 the NHS is more than just a healthcare provider; we hold a much wider role in ensuring the economic, social and environmental well-being of all our local communities. With a combined budget of £6.3bn, in 19/20, NHS organisations play a key role as vital ‘anchor institutions’ whose workforce and buying power are hugely significant factors in the local economy.

We therefore have a huge opportunity to contribute both to improving population health and well-being, whilst also tackling the wider socio-economic determinants of health, including child poverty, substance misuse and economic exclusion, that have such an impact on the communities that we serve.

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*‘We are also committed to playing our part in tackling climate change and carbon reduction.’*

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We are already taking positive steps towards increasing employment opportunities for local people in the health and care system, working with schools and colleges so that our young people aren’t driven to leave the area to build their careers and increasing volunteering and apprenticeship opportunities to support more local people into work.

We are also committed to playing our part in tackling climate change and carbon reduction, with some of our Trusts and Local Authorities having already declared a ‘climate emergency’, in recognition of the benefits both to the environment, and to local people through better air quality and increased access to green space in our communities. As a system we are committed to developing a consistent approach

with our partners in the public and voluntary sectors to sustainability, recycling and carbon reduction across all NHS organisations. We have joined a cross-sector coalition working to enable our region to “Become England’s Greenest Region”, and are developing a strategy that will set out our contribution as a system to this aim.

### 1.3 System Successes

As a health and care system we have much to be proud of, with some of the most accessible primary care services and best performing emergency care in the country, alongside a record of ground-breaking surgery and pioneering new treatments, world class facilities and national centres of excellence. We also have some of the best research and development programmes of any health system, developing the next generation of treatments, procedures and cures (including world leading genetic research programmes) alongside dedicated research capacity through our Academic Health Science Network and Applied Research Collaborative.

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*‘We are building an ICS that can transform health outcomes.’*

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We are proud too of ‘an outstanding record of being outstanding’, with high and improving CQC scores across NENC, and a commitment to education and development across all professions. Our medical training is rated as among the best in the UK (scoring first in 17 out of 18 quality indicators in the national GMC training survey), 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 in our communities and our future generations.

Yet whilst the quality of some of our health and care services has been amongst the best in the country we are still not making fast enough improvements in improving the overall health of our population, driving much of the pressure that health and social services struggle to manage, so we know things need to change.

By working with local communities and staff, gathering the views of service users and by ensuring system leaders and clinical frontline staff spend time together to develop and agree joint priorities, we are building an ICS that can transform health outcomes, and deal more effectively with the daily pressures faced by our services.

## 1.4 Ambition to improve health and care outcomes

Our ambition is to significantly improve health and care outcomes for people in NENC and by working with communities, partner organisations and our staff, we will:

<b>Quality</b>	Continue to raise standards so services are high quality and delivered effectively. This includes making sure everyone has access to safe, quality care, at the right time and in the right place – whether in the community, hospital or another setting.
<b>Integrated Care</b>	Joining the dots between organisations so that patients experience seamless care. People are living longer often with more complex health and social needs and long-term conditions, all of which require the support of many different health and social care professional and services across different organisations.
<b>Prevention</b>	Move from treatment to prevention; working to keep people healthier for longer. We recognise that our health is strongly influenced by other factors; where we live, our lifestyle, and loneliness and isolation can all impact on our overall health, both physical and mental.
<b>Workforce</b>	Build staff satisfaction, empowering our workforce with the skills and tools they need, and encourage cross-organisational working through strengthened clinical networks.
<b>Digital</b>	Make improved use of information and technology to personalise health and care services, reduce duplication of effort and speed up access to services, particularly for people who are at greatest risk of poor health outcomes.
<b>Innovation</b>	Innovate, and bring new insights to bear on some of most challenging issues, scaling up good practice in new models of care.

All of this will depend on embedding continuous improvement, sustaining high quality engagement with the public, supporting the local workforce to embrace new ways of working, and promoting a culture where improving outcomes is everybody's responsibility. By doing this, we are confident that we can increase the health and wellbeing of the local population, increase the impact and success of health interventions (especially outside hospital settings), and restore our system to financial balance.

## Section 2.0 Our operating model

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### 2.1 The importance of working at 'place' with the added value of working 'at scale'

Our ICS footprint is based on a longstanding track record of joint planning. It recognises the deep connections, historic patient flows and long-established clinical networks. NENC covers a population of 3.2 million and 14 upper tier local authorities. The vast majority of our patients stay within NENC; our main specialist tertiary provider (Newcastle upon Tyne Hospitals) delivers services to patients across our entire patch and beyond, and our ICS is coterminous with NENC hub for specialised commissioning.

Our geography is also reflected in several well-established clinical and professional networks which creates further opportunities for greater synergy and innovation, including the Northern Clinical Senate, Northern Deanery and Northern Cancer Alliance. We also plan and deliver prevention initiatives on NENC footprint, including our highly-regarded and effective tobacco and alcohol control programmes FRESH and Balance which have been developed and delivered in partnership with our Directors of Public Health Network.

Our ICS will build upon existing local place-based leadership and responsibilities of clinical commissioning groups to plan and arrange services for local populations. This will involve local primary care networks (GPs and other health and care professionals) and NHS foundation trusts, working with local authority and voluntary sector partners, in improving health and wellbeing through extending the reach and effectiveness of our services.

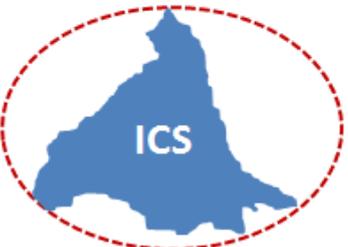
While recognising that for most people their health and care needs are best met by integrated, place-based services, NHS organisations are committed to working together 'at scale' on a small number of strategic issues where that makes sense and adds value, harnessing our collective resources and expertise to make faster progress on improving health outcomes. We see the advantage of working at scale, allowing us to:

- Collectively prioritise based on a shared understanding of need.
- Target our investment on shared priorities.
- Mobilise our collective resources, including the 170,000 health and care workforce.
- Set stretching & consistent service standards, especially for vulnerable groups.
- Manage pressures together as a system.
- Share and spread best practice.
- Make better use of technology and digital resources.
- Develop shared functions and reduce duplication.
- Act with 'one voice' to represent the region, securing additional resources and influencing the direction of national health and care policy.

## 2.2 One integrated care system, supporting our ‘places’ and integrated care partnerships.

As an ICS we are clear it is in our ‘places’ where the majority of services will continue to be planned, commissioned and delivered, whilst also recognising that those places can still work together with their neighbours at scale where this genuinely adds value. As one of the largest ICSs we recognise that our operating model is therefore different to other areas, and that our constituent organisations work across three levels of scale:

**‘Place’** – populations of circa 150,000 to 500,000 people will be the main focus for partnership working between the NHS and local authorities in our cities, boroughs and counties. Within these areas, primary care networks (providing services to populations of circa 30,000-50,000 people) will support collaboration between GP practices, social care, other community-based care providers and voluntary sector organisations and build upon work already underway.

<p><b>Places and neighbourhoods</b></p>		<ul style="list-style-type: none"> <li>• Partnership working between NHS and local authorities via <b>Health &amp; Wellbeing Boards</b></li> <li>• Ensuring the quality, safety and accountability of local health services</li> <li>• Primary Care Network development</li> <li>• Health and Social Care Integration initiatives</li> <li>• Joint-working with the local voluntary sector (eg social prescribing)</li> <li>• Embedding population health management</li> <li>• Public and political engagement and consultation</li> </ul>
<p><b>Integrated Care Partnerships</b></p>		<ul style="list-style-type: none"> <li>• Focus on acute services sustainability: clinical networking between neighbouring FTs and coordination of service development proposals</li> <li>• One streamlined commissioning hub per ICP</li> <li>• Working towards a single, shared approach to finances, and risk-sharing.</li> <li>• Joint capital planning and sharing premises</li> <li>• Identify and share best practice, reducing unwarranted variation in care and outcomes</li> </ul>
<p><b>Integrated Care System</b></p>		<ul style="list-style-type: none"> <li>• Strategic Commissioning (e.g. ambulance)</li> <li>• Overarching clinical strategy and clinical networks</li> <li>• Shared policy development</li> <li>• Emerging ICS-level priorities:             <ul style="list-style-type: none"> <li>- Population Health &amp; Prevention</li> <li>- Optimising Health Services</li> <li>- Workforce Transformation</li> <li>- Digital Care</li> <li>- Mental Health</li> <li>- Learning Disabilities</li> </ul> </li> </ul>

**Integrated care partnerships (ICPs)** – populations of around one million (with the exception of North Cumbria, which has unique geographical and demographic features). These are focused on collaboration and clinical networking between neighbouring NHS hospital trusts, to ensure safe and sustainable secondary care services. The geographies of our four integrated care partnerships are based on where people live, how patients use secondary care services and the location of hospital sites.

Through hospitals and clinical commissioning groups working more closely, our ICPs will be able to plan and tailor care to the needs of the local population, while reducing some of the costs associated with planning and delivering services. Our ICPs are also exploring how to share and spread best practice in primary and community care from their constituent 'places', working with local and combined authorities on local economic development and workplace health, and extending NHS employment opportunities to local people.

The four ICPs are the key delivery vehicles for our ICS ambitions, working towards a single, shared approach to financial management, and risk-sharing, where appropriate. They will also make best use of their existing premises and facilities, and jointly plan capital investments. Each ICP has their own plan and a summary of their ambitions for Health, Wealth and Wellbeing, their Clinical Strategy and plans for local integration at place is set out in Section 9.

**Whole ICS level** – a population of 3.2 million people, focussed on 'at scale' priorities that multiplies our collective impact around overarching clinical strategy and clinical networks, strategic commissioning and shared policy development. Through the ICS we have agreed six priority workstreams and the decision-making structures to deliver them

These overarching system partnership arrangements do not supersede the local clinical leadership and statutory responsibility of CCGs to plan and commission services for their local population, or the independence of NHS foundation trusts and their accountability for the quality and efficiency of the services they provide.

Our ICS, our four ICPs and our 'place' based partnerships will each provide vehicles for collective working and ensure that our system has a clear focus on transformation and innovation and a forum for the effective exchange of ideas and good practice at all levels.

## **Quality and Safety**

As an ICS we are fully committed to the following:

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*'Quality must be the organising principle of our health and care service. It is what matters most to people who use services and what motivates and unites everyone working in health and care'*

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The National Quality Board define quality as patient safety, experience and effectiveness. For people who use services this means;

- **Safety:** people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned.
- **Effectiveness:** people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.
- **Positive experience:**
  - **Caring:** staff involve and treat you with compassion, dignity and respect.
  - **Responsive and person-centred:** services respond to people's needs and choices and enable them to be equal partners in their care.

As an ICS we will work collectively to ensure that we promote quality through everything we do, support and encourage improvement, and coordinate action. This will be underpinned by our Quality Strategy which is in development which will align to key national drivers and take account of any changes resulting from planned national reviews, policy and guidance.

This will include a review of the national Patient Safety Incident and Response Framework once launched which contains the new Serious Incident (SI) and National Reporting and Learning System (NRLS) reporting. In NENC we have seen a continuous decline in the number of Serious Incidents reported across the footprint.

The ICS will address a number of quality priorities as a system, all of which have been identified at Local ICP level. This includes, for example:

- HCAI/AMR- recognising that North East and North Cumbria are a national outlier in relation to gram negative/E-coli.
- Never Events, with an initial focus on dental, and the promotion of a 'just culture' aligned to the revised Patient Safety Strategy.
- CAMHS and Mental Health, with the aim of supporting improvements across the sector to proactively achieve sustainable quality outcomes.
- Workforce is a key enabler to quality and this is recognised by the ICS as core to delivery of our plan as a whole.

The governance in place to oversee quality is well established and consists of a single Quality Surveillance Group (QSG) operating across the entire footprint. System quality risks are escalated to the QSG for reporting nationally to the National Quality Board (NQB). These arrangements will enable the ICS to identify early themes, concerns and issues at a system level. Further work is progressing to ensure that ICS workstreams report by exception into the QSG and the QSG into the ICS workstreams.

## Safeguarding:

The ICS is committed to ensuring the statutory responsibilities of Safeguarding both in relation to children and adults is delivered, through sustainable partnership working at an ICS, ICP and place-based level. The role of Safeguarding Childrens Partnerships and Safeguarding Adult Boards and Child Death Overview Panels (CDOPs) will be pivotal in identifying system priorities, to support and drive transformational change, promote , and share learning and provide assurance of impact , building a positive learning and outcome focused culture.

### 2.3 How will we make decisions together?

Engagement with patients and service users will remain at the heart of how we make decisions, at whatever level we work, but particular at 'place' (CCG and local authority level) where we will continue to work through existing Health and Wellbeing Boards, which provide a crucial forum for local authorities, CCGs and wider partners to assess the needs of local populations and jointly commission services; as well as the governing bodies of CCGs and the boards of Foundation Trusts.

The performance of local health services will continue to be examined by both local and regional Health Scrutiny Committees, and through the development of an ICS Partnership Assembly made up of system leaders from across the NHS, local authority, and wider public and voluntary sector partners.

Subsidiarity will remain our guiding principle, with the majority of our time and effort spent on locally specific issues at place and ICP level. But for those small number of strategic issues that do cut across geographical boundaries, we are developing decision-making structures that help us to build consensus on strategic priorities, whilst respecting the ultimate decision-making authority and accountability of the statutory bodies – CCGs, Foundation Trusts and Local Authorities – for the services commissioned and delivered at 'place' level.

**Our governance** - The ICS cannot and will not replace or override the authority of ICS members' boards, councils and governing bodies. Instead, the ICS's governance has been designed to provide a strategic mechanism for collaborative action and common decision-making for issues which are best tackled on a wider scale. Therefore, the governance model for the ICS has two main features;

- The development of a strategy and shared priorities, through a Health Strategy Group and Partnership Assembly.
- The execution of these priorities through an ICS Management Group and then the ICPs themselves.

**The ICS Health Strategy Group (HSG)** will meet quarterly, with membership encompassing CEOs of each of our statutory NHS organisations, alongside clinical leaders and representation from our emerging primary care networks, the Association of Directors of Adults and Children's Social Services, the Directors of Public Health Network, Public Health England, and the Academic Health Science Network.

In conjunction with the ICS Partnership Assembly (see below), and ensuring the principle of ICP subsidiarity, the role of the HSG will be to:

- Agree an overall ICS strategy based on an understanding of both shared challenges, the objectives in the Long-Term Plan and the priority workstreams that will deliver these priorities.
- Develop a single leadership architecture, including system rules, behaviours and leadership development.
- Share information and showcasing effective practice from across the ICS.

The development of an **ICS Partnership Assembly** is now in discussion with our partners but will have a key role in shaping our shared priorities for collaboration across health and care, and the wider determinants of health including, for example, inclusive economic development, the environment, and climate change that can drive improvements in population health.

This Assembly will have an independent chair and vice-chair, and its membership is likely to comprise nominated representatives from each ICP, which could include Health and Wellbeing Board chairs as well as lay members and non-executive directors from NHS organisations. How this body is constituted will be subject to further discussions with our partners over the coming months.

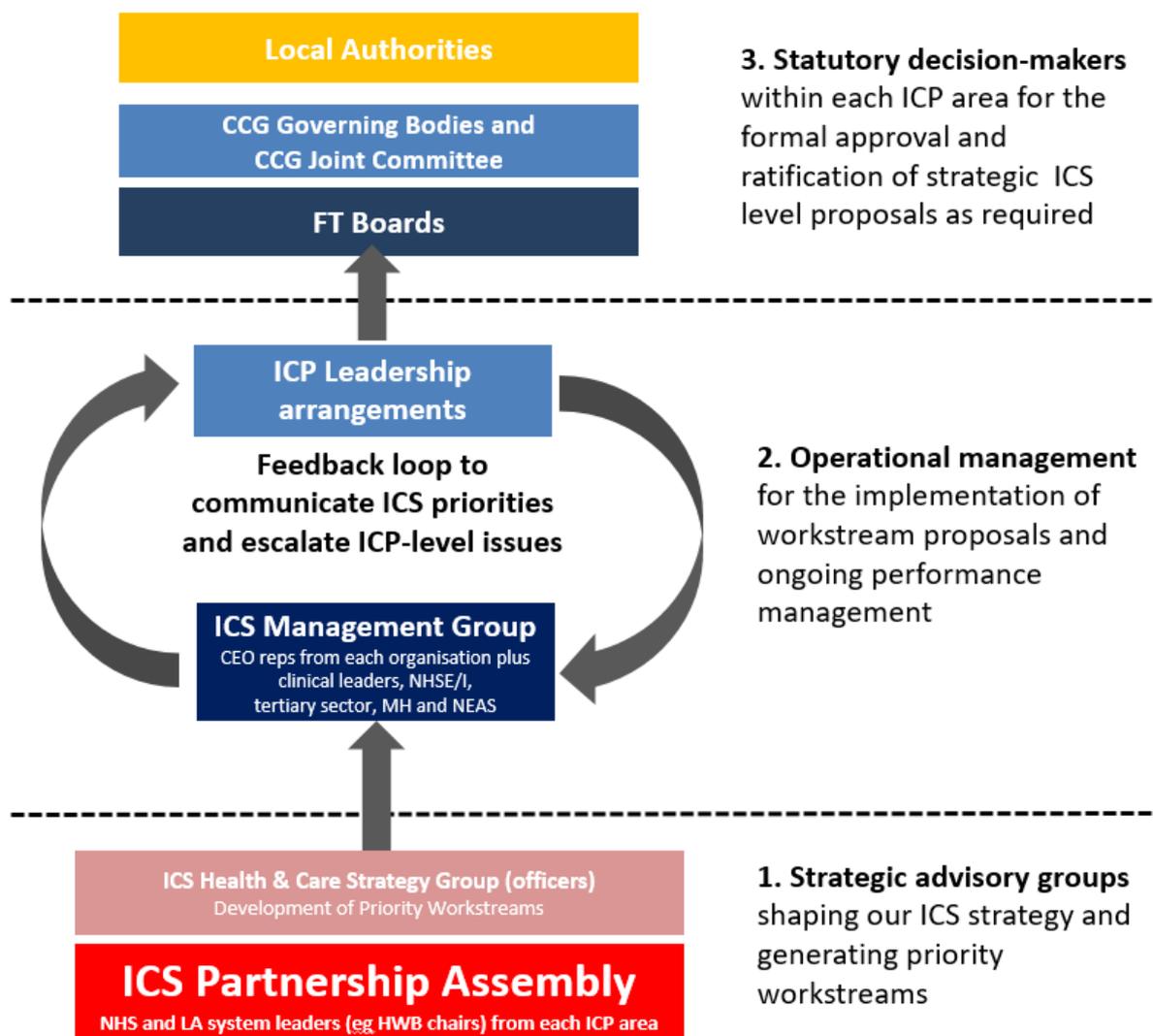
**The ICS Management Group** will meet monthly, under the chairmanship of the ICS Executive Lead, CEO-level representatives from each organisation (NHS commissioner and NHS provider), plus senior clinical leaders, representatives from tertiary, secondary care and mental health providers, and NHS England/NHS Improvement.

The role of the Management Group will be to

- Strengthen our system leadership capacity to tackle shared challenges.
- Oversee the delivery of the LTP and the ICS's strategic priorities.
- Provide mutual support and accountability for the development of our ICPs.
- Manage performance challenges and ensure robust oversight of emerging quality issues.
- Jointly develop plans as a system to bridge financial gaps, and agree systems for prioritising, distributing and holding each other to account for transformation funding.
- Assess the recommendations emerging from our ICS workstreams, referring them on to ICPs for implementation if the proposals are supported.

The ICS Management Group will have a symbiotic relationship with the governance arrangements of each ICP. These arrangements are now under development in each of our ICPs, and will need to agree their own governance model, including the relationship between the ICP and their constituent statutory bodies, as well as the role of clinical leaders and non-executive and lay members.

The ICS Management Group will ensure mutual accountability by focusing on the delivery of strategic macro-level system work - with the ICPs taking forward a detailed work programme that fits the needs and requirement of their local populations. ICPs will also be able to escalate any challenges that cannot be addressed locally to the ICS, calling upon the wider system for advice, support and mutual aid.



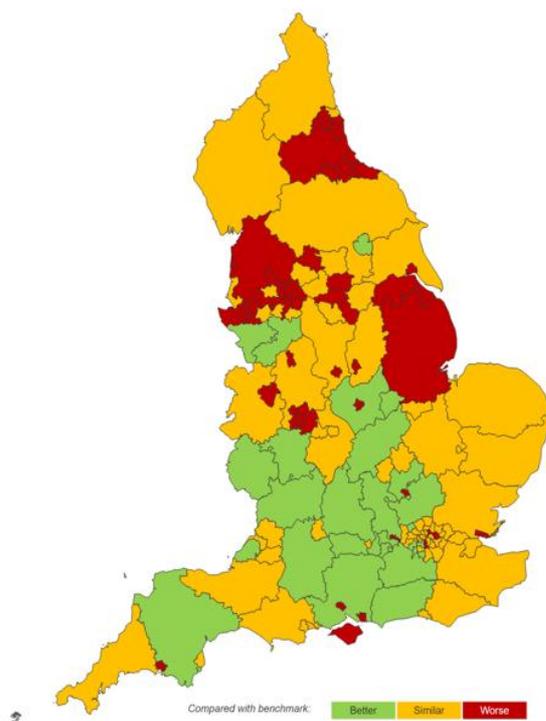
## Section 3.0 Our ambition and vision for the future: health, wealth and wellbeing

### 3.1 Context

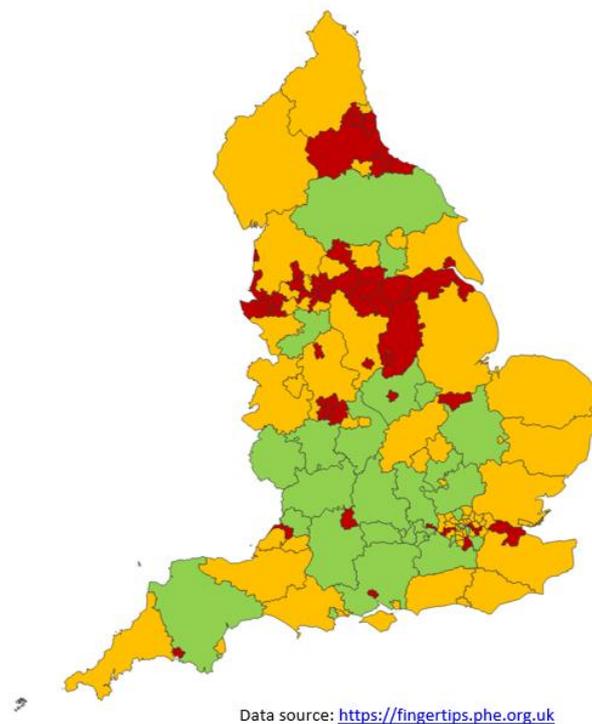
Across NENC ICS footprint we are proud of our high quality and frequently high performing public health, health and care services. We have a strong recent legacy of innovation and partnership working that yielded reductions in some aspects of health inequalities such as teenage pregnancies, smoking prevalence, cardiovascular disease mortality and, quite spectacularly, mortality from myocardial infarctions. However, despite very good NHS services that remain amongst the best in the country, strong public health partnerships and the long-standing NHS and local government commitment to addressing health inequalities, there is no hiding from the fact that health outcomes remain poorer than they should be and that health inequalities within the ICS footprint, and between the ICS and the rest of the country, remain stubbornly high.

On this basis we now set out our challenging ambition to do better. Healthy life expectancy (HLE) in NECN is way behind the rest of the country with great variation within our ICS. We are setting out to give our citizens a healthier future by pledging to do all we can to eradicate the gap in HLE between NECN and the rest of the country. The challenge is starkly illustrated in the two figures below.

**Healthy Life Expectancy at Birth –  
Male (2015-17)**



**Healthy Life Expectancy at Birth –  
Female (2015-17)**



## 3.2 Ambition and Pledges

Furthermore, closer analysis reveals that 9 of the 14 local authorities within NECN ICS have an average HLE, for both men and women, of under 60. In the entire south of England including London, there are only 4 out of 67 such authorities and this leads us to our central main ambition:

**To eradicate the gap in healthy life expectancy (HLE) between NECN ICS and the rest of the country. This includes setting an ambition to raise the minimum HLE to 60 for every local authority in NECN, and for those over 60 now to improve at the same rate.**

Our ambition will be delivered by building on the successful work of the past and to apply what we have learned, to use the partnerships we have forged and to use our combined determination and resources to make a real difference to the unjustified health inequalities in population. Our ICS work and ambition will be based upon seven pledges:

<b>Increase life expectancy</b>	We will increase life expectancy for men and women in our ICS faster than the rest of the country, until the gap between ourselves and the England average is no more.
<b>Close the gap</b>	We will increase healthy life expectancy for men and women faster than the rest of the country, until the gap is gone, enabling our population to live happier, healthier lives now and in future generations.
<b>Invest in people</b>	We will invest in people and our staff – we will personalise care for individuals, encouraging them to confidently look after themselves, recognising that people are themselves experts in their own health and wellbeing.
<b>Invest in communities</b>	We will invest in communities and the assets within them, working with people to help to live healthier, happier lives.
<b>Putting our population first</b>	We will consider the collective impact of our decisions and our actions on our population and the communities in which we live, before we consider the impacts on our organisations, our professions or ourselves.
<b>Focus on life course</b>	We will focus our plans, our energy and our investment across the life course, supporting people to start well, live well and age well.
<b>Proportionate investment</b>	We will deploy our plans, our energy and our investment across our communities in proportion to the needs of those communities, thereby contributing to our efforts to reduce the inequalities we find.

It is important to reflect on how we have arrived at such a challenging ambition and the seven pledges to help us deliver it.

### 3.3 Learning from the Past

In 2008 Better Health, Fairer Health set out how, the health and care system, would work together to bring about overall improvements in the health and well-being of our citizens through a combined life course approach in parallel with specific action on key lifestyle risk factors. Crucially, this was underpinned by the recognition that the key to long term sustainable improvements in health outcomes and reductions in health inequalities is through building a strong economy.

Shortly before Better Health, Fairer Health was published, the NHS in the North East had collectively developed and agreed a radically ambitious set of aims that became known as the seven NOs, based on strong clinical consensus, which were:

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

These were quite rightly described as ‘highly aspirational’ but they provided a laser sharp focus for relentless improvement in search of excellence for the patients and populations we serve.

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*‘Preventing poor health and well-being and addressing inequalities is at the heart of what we should be doing.’*

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The context in which we work today has changed radically since 2008 as the NHS now works in a very different way and many public health responsibilities now sit within local government. There are statutory health and wellbeing boards in every local authority, whilst the whole public sector faces the challenge of demand increasing faster than the resources to cope with it. What has not changed since 2008 are the health needs of our population and the solutions offered by Better Health, Fairer Health still hold true. The challenge for us today is to take the lessons from the past, successful and unsuccessful, and apply them to the needs of today, making the very best use of our collective resource to do so.

Since 2014 we have seen the publication of three important reports highlighting the structural inequalities across the whole north of England.

- 2014 - *Due North* chaired by Dame Margaret Whitehead.
- 2016 - *Health and Wealth, Closing the gap in the North East*.
- 2018 - *Health for Wealth*, a report by the Northern Health Science Alliance.

Like *Better Health Fairer Health*, they all conclude that building a strong fairer economy is vital to reducing health inequalities. They all conclude that preventing poor health and well-being and addressing inequalities is at the heart of what we should be doing, not only for moral and ethical reasons, but for very strong economic reasons.

The NHS Long Term Plan (2019) pledges ***'More NHS action on prevention and health inequalities'*** with the development of a range of NHS funded services to improve prevention through a number of different services. These include targeted smoking cessation schemes, tackling obesity, establishing more specialist alcohol care teams, action on air pollution and antimicrobial resistance, all with a focus on the NHS taking stronger action on health inequalities. Funding will be allocated to CCG budgets to ensure these are driven forward. Crucially, there is an emphasis on joint working with local government and recognition that "action by the NHS is a complement to, but cannot be a substitute for, the important role for local government".

There are some strong and consistent messages from these reports spanning the last decade. We must be ambitious, we must work in partnership, we must make the most of our precious resources and we must collectively strive to improve the economic prospects of our population. Hence our challenging ambition noted earlier.

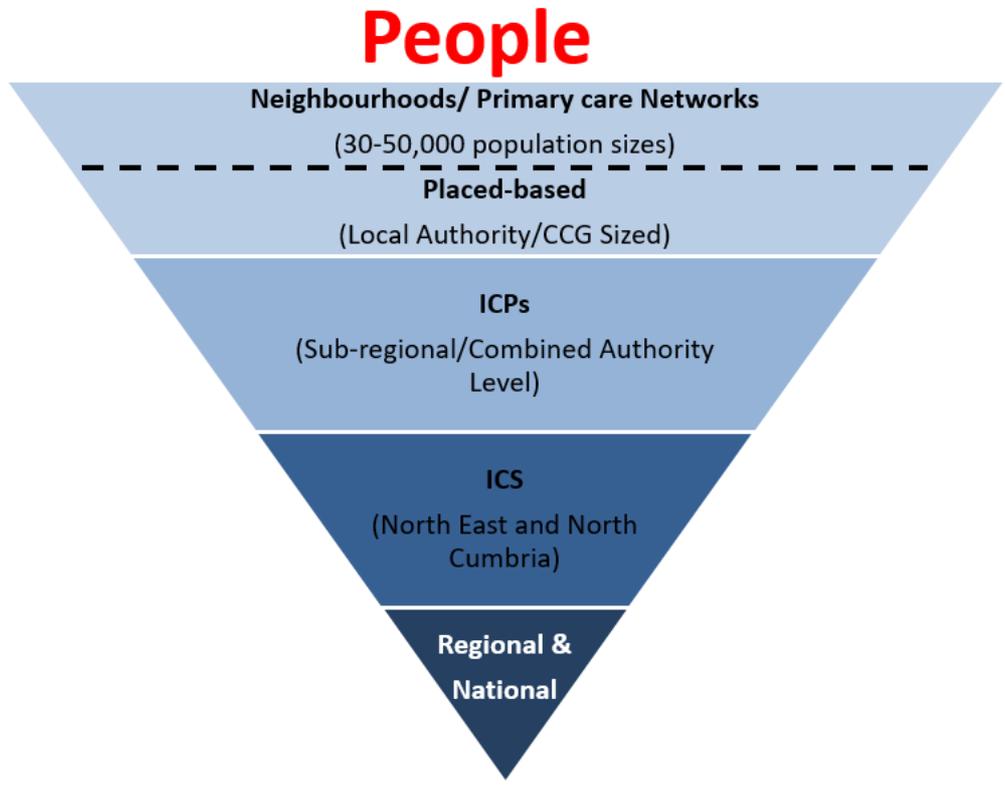
**An example of a specific supporting ambition is our collective commitment to reduce smoking prevalence across the ICS to 5% by 2025. Across the North East every health and well-being board has signed up to this pledge. Making this pledge is important but not sufficient and there is still much to do. We must radically increase on efforts to reduce the harm caused by tobacco if we are to achieve this ambition.**

Achieving this will make a big difference but it is not enough. We need to make an impact on healthy life expectancy where there are stark inequalities within the North East and between the North East and the rest of the country.

We will achieve our ambition through using our understanding of local communities and their assets to drive a place based local approach. This will be through our health and well-being boards and local system plans underpinning the work that local authorities undertake in partnership with communities, the voluntary sector and the NHS at local level. This will be supported by an ICS wide single approach to

population health management that will be delivered through the 70 new primary care networks in our ICS. This is illustrated in our inverted triangle:

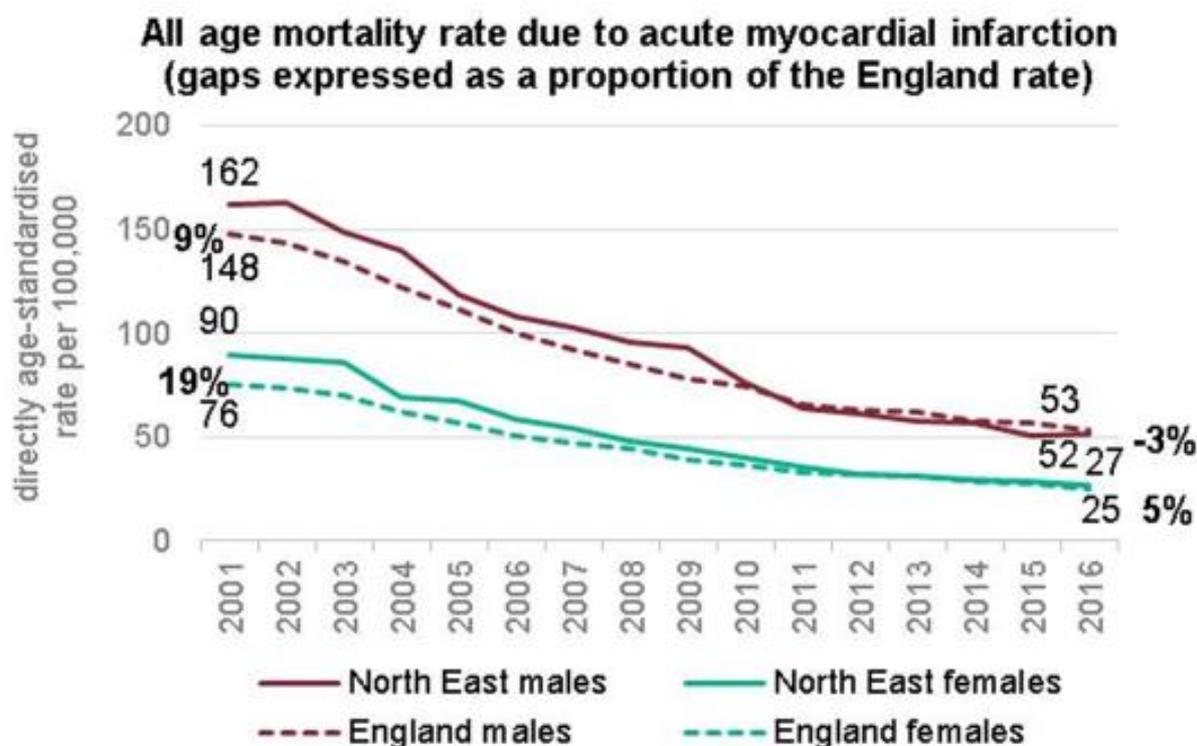
**Key Challenge: Do the right things, at the right level, with the right partners.**



### 3.4 Celebrating our success

Within the ICS footprint we have made huge progress in some areas, for example the continued fall in the rates of stroke and heart attack and the decline in adult smoking prevalence. One particular example stands out to remind us that some inequalities can be reversed over a relatively short period of time as this figure on mortality from myocardial infarctions illustrates.

#### All age acute myocardial infarction mortality



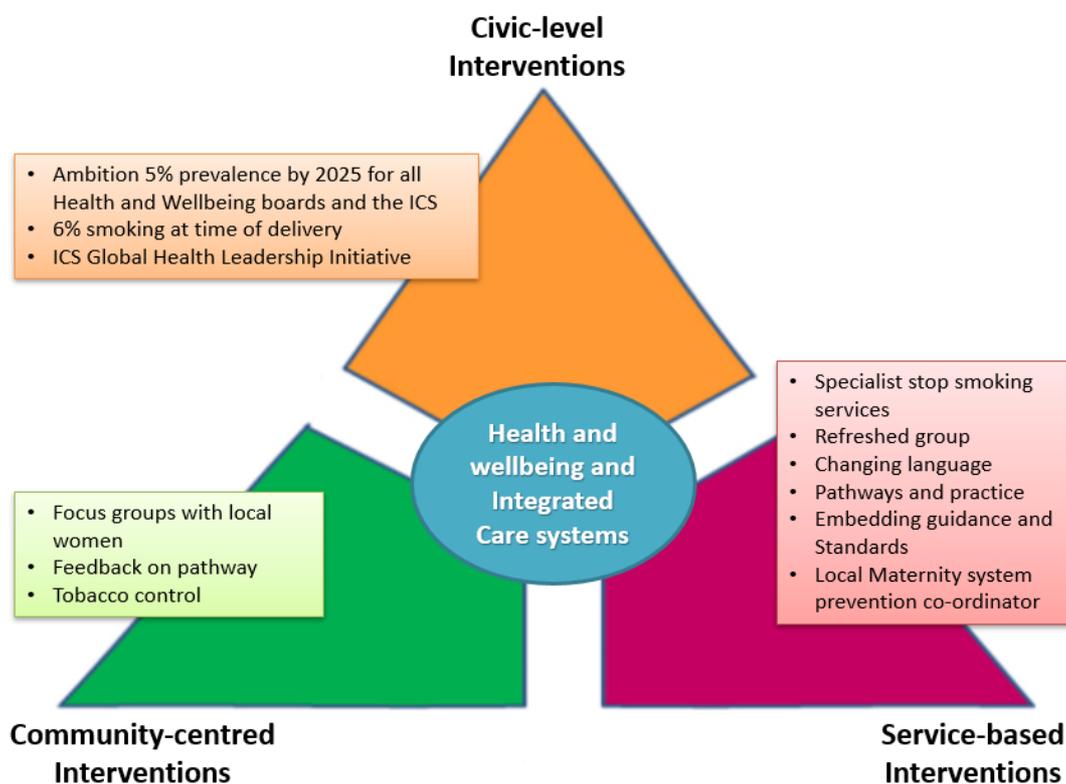
Source: NHS Digital, Indicators Portal at <https://digital.nhs.uk/data-and-information/publications/ci-hub/compendium-indicators> to 2014; 2015 and 2016, Public Health England

The figure shows that within a decade, the inequality in mortality from myocardial infarctions was eliminated for men and is on track to do so for women. This was not an accident or good fortune, rather a result of the concerted and co-ordinated efforts of public health, primary care, secondary care and systems leaders. This is the approach we will bring to radically improving health life expectancy.

### 3.5 Ways of working to reduce Health Inequalities

The foundations of our ICS build upon the successes we have experienced as a system to date. We recognise that we have a collective strength and commitment to deliver much more for the people that we serve. However, we must continue to recognise the most important level of working for us all must continue to be 'place' based work for the people who live within the boundaries of each of the local authorities.

Partnership working at a place level is key to the achievement of our ambition. We will use evidence-based tools and techniques to support our ambition to change our system approaches to deliver better health and wellbeing outcomes in a way that meets the different needs of all our local people. This is illustrated in the interventions for health inequalities triangle recently published by PHE, using an example of tackling smoking.



This neatly illustrates the contribution that different parts of the whole system need to make to systematically reduce harm from tobacco and hence health inequalities.

The detailed goals and actions of the Population Health and Prevention work programme are outlined in the programme executive summaries in Appendix 3.

## Section 4.0 Our clinical strategy and shared strategic priorities

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### 4.1 Our Ambition

Our ambition is twofold: to drive at scale and pace improvement in health and care outcomes and to deliver safe and sustainable services. Achieving this will depend upon empowering our workforce to embrace new ways of working, embedding a culture of continuous improvement and innovation where improving outcomes is everybody's responsibility, and an ongoing genuine dialogue with the public and our service users.

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*'Improving outcomes is everybody's responsibility.'*

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A programme of engagement with system leaders, partners and frontline staff has helped us to identify and prioritise our key strategic challenges and opportunities into six priority workstreams, each of which has dedicated CEO-level leadership and jointly resourced delivery capacity. Each of these have a detailed delivery plan set out in Appendix 3.

## 4.2 Aims of six priority workstreams

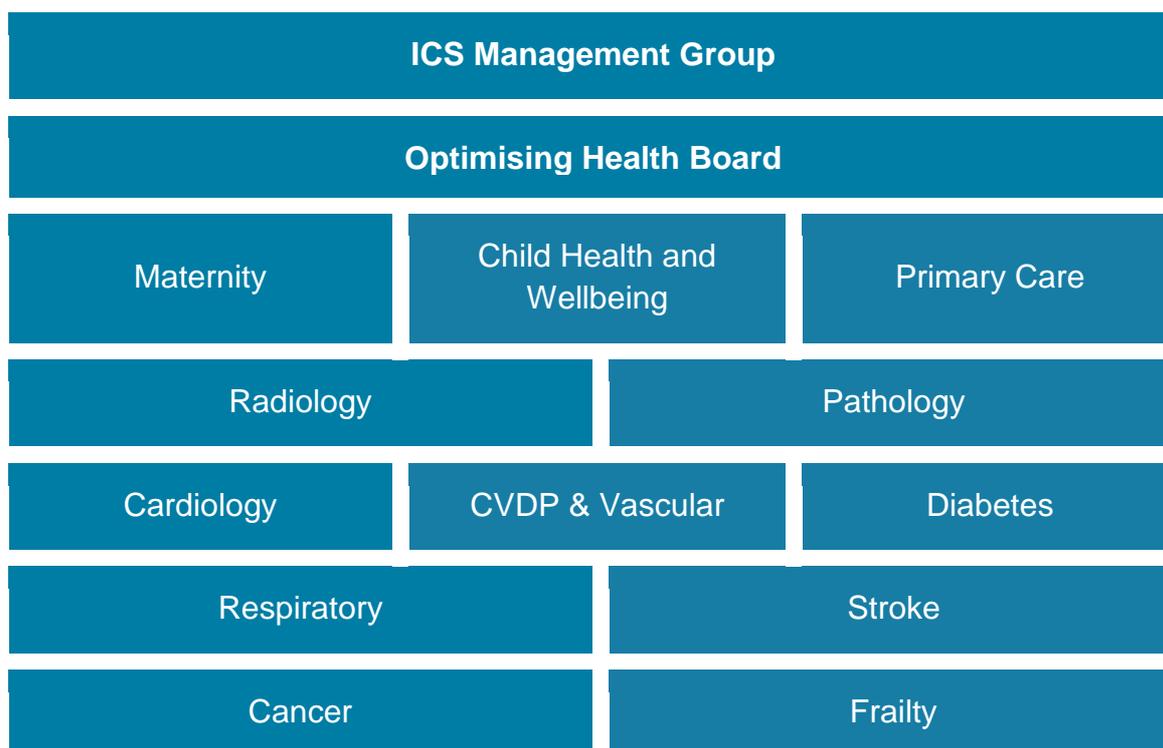
<b>Population Health and Prevention</b>	Improve population health and prevention through increasing public awareness and developing screening to better prevent, detect and manage the biggest causes of premature death: cancer, cardiovascular disease and respiratory disease, through a focus on tobacco and alcohol consumption.
<b>Optimising Health Services</b>	Optimise the quality and sustainability of health services – setting clinical standards, addressing unwarranted clinical variation, maintaining oversight on quality and coordinating initiatives across the ICS to find sustainable solutions for our health services under the greatest pressure, supported by the expertise within our clinical networks.
<b>Mental Health</b>	Improve outcomes for people who experience periods of poor mental health, particularly those with severe and enduring mental illness, and doing more improve the emotional wellbeing and mental health of children and young people and breaking down the barriers between physical and mental health services.
<b>Learning Disability Autism, or both</b>	Improve quality of care and outcomes for people with a learning disability, autism or both so that as citizens individuals can live fulfilling lives in the community, with the right support, and close to home.
<b>Digital Care</b>	Improve how we use digital care and information technology to meet the needs of care providers, patients and the public, helping people to make appointments, manage prescriptions and view health records online.
<b>Workforce</b>	Build a motivated and flexible workforce, looking after their health and wellbeing and ensuring that they have the skills and support that they need, whilst strengthening our joint arrangements to recruit and retain staff in priority areas.

## Section 5.0 Our ICS Clinical Strategy: Optimising Health Services (OHS)

### 5.1 Purpose

The aim of this programme is to provide oversight and coordination of clinical strategy, standards, service design and quality to support equitable local delivery of the long-term plan and local innovation. The programme ensures that the ICS workforce vulnerabilities are addressed through system working, and their transformational solutions are embedded in the priorities of our ICPs.

The programme draws upon existing workstreams addressing clinical variation (Getting It Right First Time (GIRFT) and Right Care), nationally mandated clinical networks, the Northern Cancer Alliance, the three Local Maternity Systems (LMS) that have been established across NENC and new networks focussing on delivering new models of care to develop and implement clinically led solutions for the stabilisation and transformation of services. Underpinning and enabling this work are the enabling Digital and Workforce workstreams.



## 5.2 Context and Engagement

The overall ICS strategic plan has been developed to reflect the health priorities of the region and has been informed by significant patient and stakeholder engagement undertaken over a number of years by local CCGs, foundation trusts and Health and Wellbeing Boards. To further increase the insight underpinning the OHS workstream, two specific streams of engagement have taken place:

- Engagement with the clinical and nursing community to understand immediate vulnerabilities in secondary care services.
- Engagement with staff, stakeholders, partners and the public within each ICP area on wider health and care improvement.

### **Clinical engagement to understand potential vulnerabilities in hospital services**

The ageing of the population and increase in multi-morbidity coupled with advances in technology and specialist treatments mean that the long-held model of District General Hospital model of care across the NHS is becoming less sustainable

Our ICS is experiencing the impact of this change as our hospitals come under greater pressure to sustain traditional models of care. To truly understand the situation in NENC, a series of large-scale engagement events were convened in 2016/17 bringing together over seventy senior clinicians and nurses from providers and CCGs to identify services which were most vulnerable and agree principles on which future transformation could be based.

The principles agreed as part of this process were that clinically led solutions, via managed clinical networks where appropriate, would maintain services as close to patients as possible. Wherever possible, services would be supported by new models of care and digital solutions.

### **Engagement on wider health and care improvement**

During 2018/19 we sought to widen engagement with our evolving clinical strategy and through a series of large-scale events in each ICP, we worked with over 600 colleagues from health and social care, voluntary sector, patient groups and public to explore how we could further develop our strategy.

The events were targeted at staff and people who may not routinely be invited to share opinion and attendees were asked to identify their local priorities and potential solutions for transforming health and care. Output from all the events was used to develop an instructive animation\* and a summary event was held with system leaders as a 'call to arms' to make urgent progress.

[www.youtube.com/watch?v=iAdBXD3qJko&feature=youtu.be](https://www.youtube.com/watch?v=iAdBXD3qJko&feature=youtu.be)

The key message from this work was the need for senior leaders to be brave, support change to enable health and care staff to work across traditional boundaries, to expedite workforce and digital transformation models and to maximise the potential of the real expertise we have across NENC in the delivery of services.

Based on these key messages the OHS work stream programmes are aimed at:

<p><b>Ensuring high quality and sustainable secondary care services</b></p>	<p>Initial focus on those currently most vulnerable to workforce pressures) through the development of ICP-level Managed Clinical Networks and reconfiguration of services (but only when all other options have been ruled out).</p>
<p><b>Focusing on region-wide health improvement</b></p>	<p>Using ICS-level clinical networks and alliances supported by aligned transformation capacity (e.g. GIRFT and RightCare).</p>
<p><b>Developing strong Primary Care Networks</b></p>	<p>As the foundational element of service delivery at community and neighbourhood level.</p>
<p><b>Alignment</b></p>	<p>As well as overseeing delivery of these work programmes, the OHS workstream will also ensure alignment with the other ICS workstreams, in particular Digital and Workforce as key enablers to success.</p>

## 5.3 The North East and North Cumbria Clinical Strategy

### Developing Primary Care Networks at place and neighbourhood

Across all the events there was a consistent message that true integration will take place at a neighbourhood level and many excellent examples were shared. The opportunity additional funding brings to establish and develop Primary Care Networks (PCNs) is core to our strategy to deliver integrated services locally and support the workforce in primary care.

PCNs can enhance leadership in primary care and in each ICP the PCN directors will form a network that will be represented at ICP executive level giving us that much needed representative voice for primary care and general practice; essential for true collaboration and innovation. As the largest ICS we will host 70 PCNs that will be responsible for leading place/neighbourhood-based integration of services.

NENC successfully piloted the Community Pharmacy Referral Service and so we are in an advantaged position in now rolling out the Community Pharmacy Consultation Service across our practices and community pharmacies. The community pharmacy consultation service (CPCS) is building on the local walk-in access to medicines and minor illness advice supporting self-care that is already in place, to formally divert patients from urgent care services in a timely and safe manner. Further expansion of this scheme to include referral from GP Practices is being piloted locally and referral from UTCs and A&E is being explored. We have supported the sustainable delivery of NHS dentistry through the creation of Local Dental Networks (LDNs) notably in Cumbria where workforce remains a significant challenge. Pharmacy will also support PCN Pharmacists through networks.

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*‘Recognising the success of the strategy is contingent upon wider engagement.’*

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Working with the developing PCNs the ICS is supporting the workforce priorities of the primary care strategy. The rapid expansion of the pharmacy and paramedic workforce into primary care is a potential risk to existing providers. A Pharmacy Workforce and Talent Workstream has been established to maximize the long-term and sustainable contribution of the pharmacy workforce across the ICS including support for clinical pharmacists in PCNs. The ICS also provides for a vehicle to support the introduction of rotations between ambulance service, secondary care pharmacy and primary care all of which leads to a system wide sustainable and developed workforce. The regional AHP groups will also work through these channels.

## Pharmacy and Medicines

Pharmacy professionals, an increasing number of which are independent prescribers, are working in an increasing range of health and social care settings across the ICS. The NHS England Integrating NHS Pharmacy and Medicines Optimisation (IPMO) pilot programme has enabled the ICS to develop a framework to systematically tackle the pharmacy and medicines priorities for the local population and use the expertise of pharmacy professionals in the strategic transformation of systems in order to deliver the best patient outcomes from medicines and value to the taxpayer. The Pharmacy and Medicines Strategy Group, which reports via the OHS, ensures that their work and strategy, supports and is aligned with, ICS clinical priorities and also national programmes, priorities and policies including the Pharmacy Integration and the Medicines Value Programmes and the Long-Term Plan. The Pharmacy Workforce and Talent Workstream and the NENC Prescribing Forum report into the OHS via the Pharmacy and Medicines Strategy Group.

Pharmacy is responding to clinical priorities such as the Antimicrobial Resistance 5-year action plan and 20-year vision and antibiotic stewardship through building on programmes such as the point of care CRP testing pilot in Sunderland GP practices and in an AHSN funded pilot in community pharmacy. Antimicrobial stewardship through promotion of TARGET (Treat Antibiotics Responsibly Guidance Education Tools) and other tools is underpinned by monitoring, support and incentives to promote best prescribing practice.

Pharmacy and Medicines groups will deliver against the national Medicines Safety Programme in many ways including an increasing number of pharmacist independent prescribers; structured medicines reviews, focussing on key clinical areas and tackling polypharmacy through shared decision making; identifying and supporting those most in need of review and support in hospitals; use of digital systems and tools such as EPMA and PINCER and facilitating better and safer admission and discharge utilising links between sectors.

### Developing Managed Clinical Networks (MCNs) within ICPs

Defined as “*a linked group of health professionals and organisations from primary, secondary, and tertiary care, working in a coordinated way that is not constrained by existing organisational or professional boundaries to ensure equitable provision of high quality, clinically effective care (Scottish Executive 1999)*”, MCNs offer a different way of delivering services to patients designed to lead to a focus on services and patients rather than upon buildings and organisations.

Across the ICS we are now supporting clinicians to work together in MCNs at an ICP level that can sustain and develop services where appropriate within and across ICPs. Importantly, this work has defined the geographies for ICP provider collaborations and a framework for developing services around.

The proposed aims of the Managed Clinical Networks are expected to:

- Address gaps in the provision of patient-centred, safe, and efficient clinical services.
- Reduce barriers to the coordinated provision of services.
- Enable release of, or joint investments in scarce or costly resources.
- Improve clinical outcomes, quality and performance.
- Improve efficiencies and effectiveness.
- Vehicle to facilitate service development.
- Accountable for service performance across health care systems.

In keeping with the principles of ensuring access, equity and delivery through managed clinical networks, this work will define future services based around specialist services in each of the four geographies (complex interventions that cannot be delivered by all providers) and specialised (direct commissioned highly complex services) most appropriately consolidated in our two specialised centres.

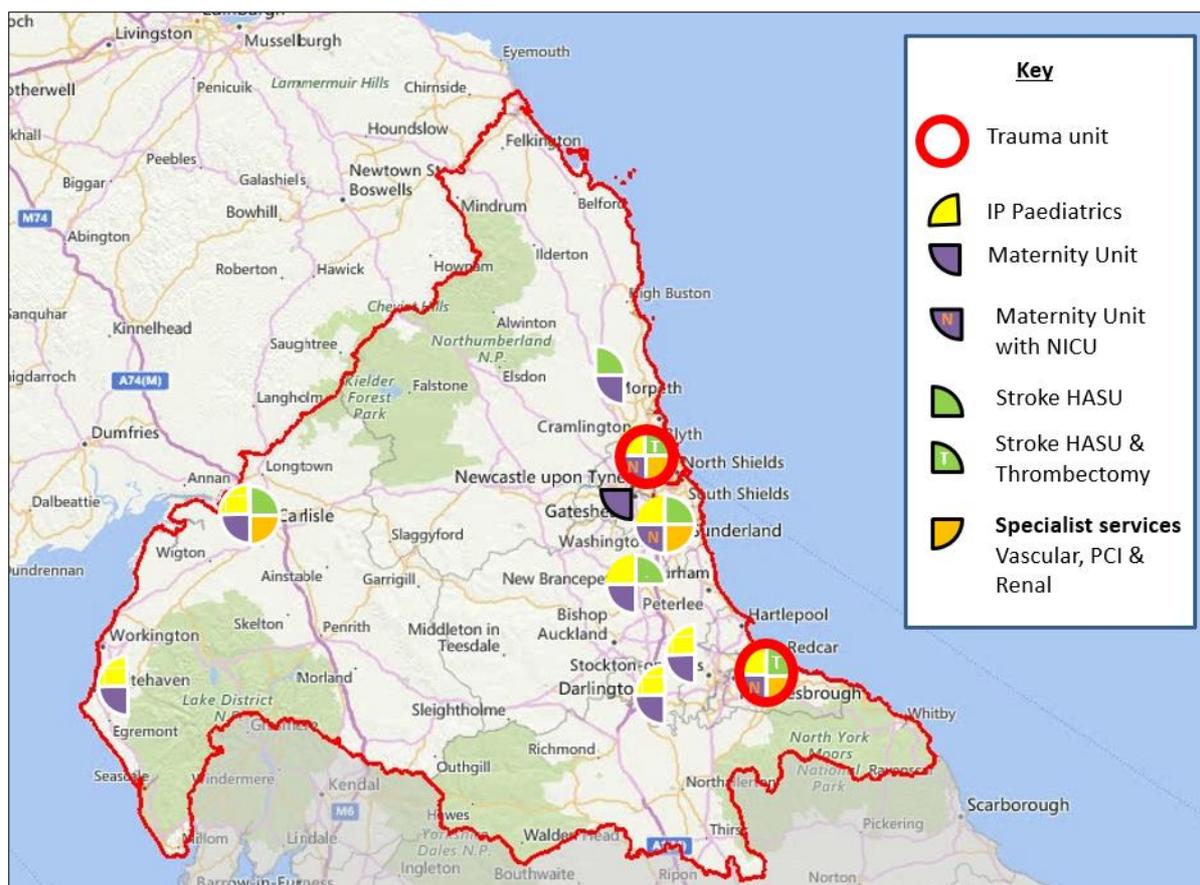
For example, for women and children's services, the North of Tyne and Gateshead ICP has a model consolidating complex in-patient paediatric services alongside paediatric intensive care, children's cardiac services and specialist maternity services (Great North Children's Hospital) whilst still providing short stay children's services and obstetric care in the local hospitals; local care wherever possible with timely networked pathways to highly specialised intervention as required.

### **Sustainable acute secondary care clinical services**

The geography of NENC naturally defines four areas of population density clustered around the three river valleys of Tyne, Wear and Tees in addition to Cumbria in the West. The map below represents current configuration within which models of clinical excellence that are emerging and reflect our aspirations to provide services of excellence in each ICP.

These aspirations incorporate recommendations from GIRFT and national specialist bodies where consolidation is considered best for patient outcomes and service delivery. NENC hosts two major trauma centres each supported by specialised services including neurosurgery and cardiothoracic services.

Within this model, the specialist emergency hospital at Northumbria provides for a new and benchmark model of emergency care and the tertiary and quaternary services delivered by Newcastle Upon Tyne Hospitals NHS FT underpin the ICS and beyond.



The above map is not intended to be a full list of all hospitals in the NENC geography. The Foundation Trusts by ICP are listed below.

ICP	North of Tyne and Gateshead	North Cumbria	Durham, South Tyneside and Sunderland	Tees Valley
<b>Foundation Trusts and Sites</b>	Northumbria Healthcare NHS FT, The Newcastle upon Tyne Hospitals NHS FT, Gateshead Health NHS FT.	North Cumbria Integrated Care NHS FT (NCIC) Cumbria, Northumberland Tyne and Wear NHS Foundation Trust	South Tyneside and Sunderland NHS FT, County Durham and Darlington NHS FT	County Durham and Darlington NHS FT (Darlington site), North Tees & Hartlepool NHS FT, South Tees NHS FT.
<b>Mental Health Foundation Trusts</b>	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust	Tees, Esk & Wear Valley NHS FT	Tees, Esk & Wear Valley NHS FT

In keeping with this model of excellence and sustainability, throughout the ICS we have re-designed neonatal intensive care in the specialist centres, underpinned by network support from Newcastle as our highly specialised tertiary centre. Recent changes have seen the re-design of vascular services to the specialist centres in the ICPs with a networked service between Newcastle and Cumbria sustaining local provision. Future work will ensure the equitable delivery of complex interventions for stroke (mechanical thrombectomy) across NENC whilst ensuring all patients have timely access to acute stroke unit care linked to early supported discharge and community rehabilitation schemes.

### Mental Health and Learning Disability

The North of England has some of the highest levels of mental illness in England three quarters of which are established by the age of 24 years. Mental Health (Section 6) and Learning Disability (Section 7) are separate workstreams to OHS

because of the high level of priority given to these work programmes. Although they are separate priority workstreams the work is fully integrated into the OHS programme. This ensures that work is integrated and there is best use of resources.

## **Specialised Services**

Specialised services have an important part to play in the delivery of the long-term plan for NENC. Many of the specialised services which the NHS England specialised team commission are part of broader pathways of care. Working in the ICS, specialised commissioning will explore ways to deliver a new service model for advanced place-based arrangements to integrate specialised services into care pathways, focussing on population health for the ICS. We will do this through lead provider and collaborative commissioning approaches, exploring opportunities for more advanced integrated arrangements where these will support the delivery of outcomes for our population.

To optimise equity of access for specialised services while ensuring care as close to home as possible we will build on our current clinical engagement to expand new models of service delivery through network approaches. For example, in 2019/20 we will implement a hub and spoke model in North of Tyne and Gateshead ICP, Durham South Tyneside and Sunderland ICP and Tees Valley ICP for vascular services and a managed network approach to spinal services. This will ensure that we can deliver care for our population while improving clinical governance and oversight.

These successes will help us to develop networked solutions that are appropriate for the population and geography of the North East and Cumbria, with a focus on the following areas:

### **Cancer**

- Establish the Operational Delivery Networks for radiotherapy and Children/Teenage and Young Person's cancer.
- Implement new service specifications for radiotherapy.
- Support the lung health check pilot programme.
- Continue to support the implementation of the North Cumbria Cancer Centre.

### **Mental Health and Learning Disability**

- Implement provider collaboratives to improve and standardise the whole pathway, supporting investment in community services and preventing the need for the most specialised services.
- Implement the findings of the Mental Health service review to ensure the appropriate level of care in the right place.
- Reduce the overall number of people with a learning disability or autism in an in-patient bed in line with Long Term Plan trajectories.

## **Cardiovascular**

- Work with the national Specialised Cardiovascular Improvement Programme as a test site for the model of care programme.
- Lead on the specialised commissioning workstreams of the 'Let's Talk Cardiology' programme.
- Develop a sustainable solution for mechanical thrombectomy through a managed clinical network.

## **Healthy Childhood**

- Support the Neonatal Intensive Care Operational delivery network and the implementation of the neonatal critical care review action plan.
- Implement the new Paediatric Intensive Care and Specialised Surgery in Children Operational Delivery Network, working with the ICS to develop step up/step down approach for children across the whole pathway.
- Work with Newcastle Upon Tyne NHS Foundation Trust to implement the improvements to paediatric cardiac services.

## **Equity of access**

- Work with the national team to establish a configuration of providers for new service specifications for gender dysphoria services for adults.

## **Health and Justice**

The Long-Term Plan includes important commitments to improve the health and wellbeing of people within the justice system, many of whom experience greater health problems than the rest of the population but do not regularly access timely healthcare. Plans for NENC are summarised below:

### **Mental health**

- Additional investment will be made in services for people experiencing mental health crisis. It is our intention to work across organisations to improve the pathways for referral and treatment of prisoners requiring admission to mental health hospital beds. This includes reduction of times to assessment, inconsistency of referral methodologies and reducing the need for multiple assessments. We have introduced a revised mental health specification for prison healthcare, which includes crisis intervention and 7-day week cover to support this.
- Across the NENC, work has commenced to review MH pathways with all key stakeholders. Work will commence to support the Provider Collaboratives to develop an enhanced evidence-based care pathway for prisoners presenting with severe mental ill-health (SMI) to ensure improved assessment, care, transfer into MH beds and remittal back to prison.

## **Reconnecting with services on release from custody**

- It can be challenging to link prisoners back into services in the community often due to poor links with services and homelessness. There is an opportunity to ensure that Community Teams can swiftly reconnect with those on release or that those in custody remain on caseload and information is shared effectively between prison and community mental health teams.

## **Liaison and Diversion and Community Service Treatment Programme (CSTR)**

- This programme enables courts to require people to participate in community treatment, instead of a custodial sentence. Continuity of care following a period of detention (remand) is essential, particularly in the case of prisoners requiring access to mental health, substance misuse or immediately necessary medications. The importance of this and the need for effective pathways into community care is recognised by the ICS. The ICS will work with Health and Justice Commissioners to ensure effective arrangements are in place.

## **Supporting justice system victims**

- Good progress has been made across the north in developing sexual assault referral centre services for victims of sexual assault and expansion of services to offer integrated therapeutic mental health support, both immediately after the incident and to provide continuity of care where needed. These services are co-commissioned with Police and Crime Commissioners. Work is underway with Her Majesty's Prison and Probation Service to ensure that those who have been sexually assaulted in prison get access to services.

## **Additional support for children**

- To provide additional support to the most vulnerable children at risk of being in contact with the criminal justice system there will be a focus on wrap around care.
- There has been significant work across the North to improve commissioned services within secure children's homes and implement Secure Stairs within Secure Children's Homes (SCH) and Young Offender Institutes (YOI) for 15-18 year olds. Work is also underway to develop an enhanced model of care for those young people transitioning from SCH or YOI into adult prisons.

## **Integration and Personalisation**

Personalised care is integral to plans to support people across the life course, from giving the best start in life to ageing well and is relevant across all programme areas. Personalised care brings a range of benefits and can:

- Improve people's health and wellbeing, joins up care in local communities, reduces pressure on stretched NHS services and helps the health and care system to be more efficient.
- Help people with multiple physical and mental health conditions make decisions about managing their health, so they can live the life they want to live, based on what matters to them, as well as the evidence-based, good quality information from the health and care professionals who support them.
- Recognise that, for many people, their needs arise from circumstances beyond the purely medical, and will support them to connect to the care and support options available in their communities.
- Provide an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health and recognises the role and voice of carers. It recognises the contribution of communities and the voluntary and community sector to support people and build resilience.

NENC will use the '*Comprehensive Model of Personalised Care*' and offer personalised care through six key approaches that are based on a growing evidence base of what has worked:

- Shared decision making.
- Personalised care and support planning.
- Enabling choice, including legal rights to choice.
- Social prescribing and community-based support.
- Supported self-management.
- Personal health budgets and integrated personal budgets.

Successful implementation and spread of integrated personalised care is dependent on effective work at neighbourhood and place levels and support by a systemwide commitment. Better Care Fund (BCF) plans have been agreed by all Health and Wellbeing boards describing integration of health social care and related joint funding. BCF plans aim to support people in their own homes and include personalisation as strong feature. The ICP plans in section 9 and the programme executive summaries in Appendix 3 describe some specific strands of work.

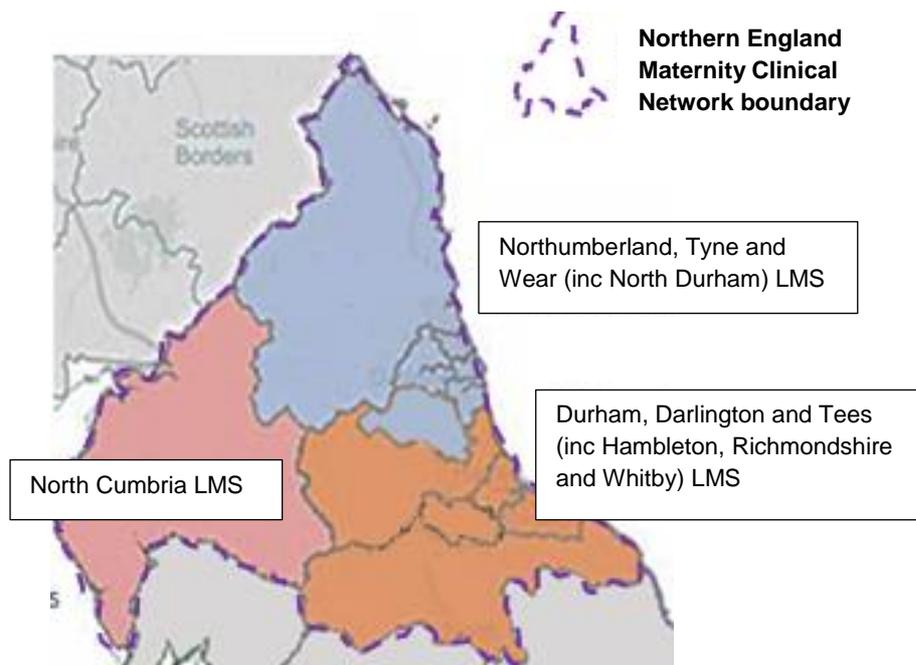
#### **5.4 Supporting people across the life course**

NENC ICS recognises that if it is to reduce health inequalities and improve health outcomes across the region it will need to focus on the population from birth and support people to live and age well. This will include looking at both the NHS delivered aspects of care and joint working through our ICPs with our partners and communities to address the wider determinants of ill health and wellbeing.

## Supporting the Best Start in Life

The OHS workstream will do this by linking together already established clinical networks (including the Northern Maternity Network, Northern Perinatal Mental Health Network Neonatal Operational Delivery Network, Northern Children and Young Persons Mental Health Network) and newly formed networks and groups such as Local Maternity Systems (LMSs), Northern Paediatric Critical Care ODN and the ICS Child Health and Wellbeing Network. The coordination of workplans across these ICS-wide networks with both the ICPs and other workstreams with mutual interest (Northern Cancer Alliance and NENC Learning Disability Network) will support the introduction of national priorities outlined in the Long-Term Plan and local priorities identified through our extensive engagement work in these areas.

To support the delivery of Better Births and local LMS priorities, the ICS has established three Local Maternity Systems, with a Senior Responsible Officer, Clinical Lead, Midwifery Lead and lay representative as part of the each LMS Board which will ensure representation from all providers involved in the delivery of maternity and neonatal care, as well as relevant senior clinicians, commissioners, operational managers and primary care.



On behalf of the ICS, the LMSs are responsible for the development of a local vision for improved maternity services and outcomes which ensures that there is access to services for women and their babies, regardless of where they live. They will ensure the co-production of services with service users and local communities and put in place the infrastructure that is needed to support services to work together effectively.

The LMS priorities are:

- To implement the national maternity services review "Better Births" on behalf of NENC ICS including the improvement of Continuity of Carer rates.
- To focus on reduction of health inequalities and variations in standards of care.
- To encourage collaboration between providers to provide the best care, in the most appropriate setting, closer to the home wherever possible.
- To determine optimal service models based on multiple considerations including quality of care, financial stability and workforce sustainability – as well as support for clinical work via a functioning digital care record (e.g. Great North Care Record).
- To change the focus from hospital-based services to community hubs – building services around the family.

For children, the importance of a strong start in life is paramount and we have established a new and growing child and adolescent health network with over 500 members to support the development of integrated services across NENC ICS. Importantly, this group is working across health, social care, education, the voluntary sector and local businesses to identify and maximise opportunities to reduce inequalities, improve mental health, wellbeing and self-respect so that our children have the best opportunities.

The network has seven clearly defined priorities from the system including poverty which is particularly prevalent in our region leading to significant inequalities including health outcomes. The work with the children and young people of today will importantly impact the future outcomes of our region's adults.



Collectively across the programme areas there is a vast amount of work to support the best start in life; a few examples of the goals are shown below.



### Supporting recovery from ill health

Cancer survival in NENC may still be lower than more affluent parts of the country but major improvements have been achieved with one-year survival from cancer diagnosis increasing from 62-72% between 2001-2017. Priorities of our cancer strategy are to increase the early diagnosis of cancer through better screening programmes and early access to diagnostic facilities.

Working into each ICP, staff from the Northern Cancer Alliance are supporting prevention initiatives across smoking, alcohol and screening programmes such as cervical screening where population uptake is variable. Significant progress has been made to support the delivery of diagnostic pathology and radiology services. This includes the funding and roll out of a digital pathology diagnostic imaging solution that removes the need for preparation and transportation of traditional glass slides and enables rapid electronic transfer of tissue biopsy images between hospital diagnostic pathologists; providing for more rapid diagnosis, double reporting (accuracy and second opinion) and resilience managing staff absences.

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*‘A single pathology patient record accessible by clinicians across primary and secondary care irrespective of geographical and organisational boundaries.’*

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There are national challenges to delivering greater access to diagnostic imaging (radiology) due to workforce pressures and NENC ICS host one of only four trailblazer NHSI Radiology Imaging Networks. The Network has collaborated with Health Education North East and Northern Cancer Alliance to provide two IT enabled

training laboratories for radiology and radiography staff and increased our training capacity which has created capacity to train more doctors in radiology. This in turn has realised the capacity for senior trainees to support out of hours on-call diagnostic services.

The Network is currently collaborating with the Cancer Alliance to procure a digital system that will enable the sharing of radiology images across organisations thereby creating capacity and resilience to reduce reporting times and accelerate diagnosis. This is an ICS wide collaboration and in line with our digital strategy to improve the interconnectivity of organisations, reduce barriers and improve access. We are also concluding a similar piece of work in haematology which again enables the digital transfer of images tests between laboratories following patient diagnostic to accelerate diagnostic times and network these specialties.

Pathology laboratory services are fundamental to all clinical services. NENC has already demonstrated the efficiency and workforce benefits of centralising high-volume diagnostic tests through a laboratory hub in Gateshead and the next steps in this strategy is to establish a hub in the Tees Valley providing quality, easy access and rapid turn-around laboratory services across primary and secondary care. This hub will create a flexible and sustainable pathology workforce model with reduced reliance on temporary staff and overtime and a workforce with access to the appropriate levels of training and development. In line with our digital strategy, there will be a single pathology patient record accessible by clinicians across primary and secondary care irrespective of geographical and organisational boundaries.

Cardiology and respiratory services are two of our biggest health priorities and working with Specialised Commissioners and CCGs we are reviewing current provision of cardiology services. The aim is to ensure equitable and timely access to diagnosis and complex cardiac interventions whilst addressing the traditional barriers between primary and secondary care and enhance community support and management of patients.

A Respiratory Network has been established which seeks to identify and standardise the uptake of proven interventions to improve the care of people with acute and chronic respiratory conditions. The work of the network will be further supported by the Child Health and Wellbeing Network looking at innovative ways to address the unnecessary deaths of children in our region due to asthma.

Taking the Northern England Stroke Network as a starting point, we will further strengthen the coordination of stroke services through the establishment of an Integrated Stroke Delivery Network (ISDN). Establishing the nationally defined ISDN within the ICS with further strengthen the local oversight and governance for delivery of the Long-Term Plan for stroke. It will bring continue to bring together key stakeholders together to facilitate a collaborative approach to service improvement of the stroke pathway that is patient centred, evidence based and focused on delivering transformational change. This will focus on the implementation of the optimal thrombectomy and hyperacute stroke service configuration supported by improved early supported discharge and rehabilitation services which will see improvement in Sentinel Stroke National Audit Programme (SSNAP) rates across the ICS.

Examples of NENC goals for supporting recovery from ill health include:

<p><b>Diabetes</b></p> <p><b>By 2021</b></p> <p>100% ICS coverage of HeLP.</p> <p>Over 30,000 individuals referred onto NDPP across the region.</p> <p>20% of Type 1 receiving flash glucose monitoring sensors (every pregnant woman with T1).</p>	<p><b>Cardio Vascular</b></p> <p><b>By 2020</b></p> <p>Launched a Cardiovascular Disease Prevention Strategy for North East and North Cumbria.</p> <p><b>By 2028</b></p> <p>Reduced health inequalities and CVD related incidences in North East and North Cumbria.</p>	<p><b>Stroke</b></p> <p><b>By 2020</b></p> <p>ISDN structure in place.</p> <p><b>By 2021</b></p> <p>ICS specifications for Mechanical Thrombectomy, ESD &amp; stroke rehabilitation agreed.</p>	<p><b>Pathology</b></p> <p><b>By 2020</b></p> <p>LIMS system - implementation of phase 1 commenced; implementation of the Durham and Tees Valley Pathology Service commenced.</p> <p>Regional pathology strategy agreed.</p>
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## Supporting our population to age well

Over the last two years, the ambitious [FrailtyICARE](#) programme shown below has been active in NENC. Driven by the national Ageing Well Strategy, this programme created a shared leadership platform for local clinical leaders and the Academic Health Science Network to develop a cohesive infrastructure for creating, shaping and influencing the care of those living with frailty across the region.

The aim of FrailtyICARE was to build an approach through frontline professionals that enabled the benchmarking of care and services against an agreed range of metrics and develop tools for local health and care professional to use to make measurable improvements.

The FrailtyICARE team is committed to support the work of the Nursing Now England Programme, which now has a regional 100 strong army of ambassadors for older peoples' nursing and have also influenced the development of national agendas such as the Frailty Capability and Enhanced Health for Care Homes frameworks.

This benchmarking and toolkit creation was supported by a Community of Practice Network, which comprises professionals from all the care and enabling services to facilitate optimised care for an ageing population. In addition, the Community of Practice Network began to forge the relationships with relevant agencies, academic institutions (such as the local Institute for Ageing and Vitality at Newcastle University) and other ICS workstreams with an interest in supporting the population to age well.

The ICS recognised the potential of the FrailtyICARE programme and its Community of Practice to really change the way people innovate and learn together, in order to transform

care services and as such has supported the further strengthening of the Community of Practice Network into an overarching ICS-wide Ageing Well Network. This network will help shape ICS and ICP strategy, inform the prioritisation of Ageing Well Transformation Funding and continue to support and spread innovative practice and workforce development. An area of focus will be to improve the quality of care for patients being assessed for Continuing Health Care (CHC) eligibility, in order to address the variation against the National Framework and ensure that resources are managed effectively.

As well as supporting our population to age well, when the time comes we want to support them to have a 'good death'. The ICS-wide End of Life (EoL) Network has a work programme aimed at supporting the personalisation of care for individual's needs and preferences. The EoL Network provides strong clinical engagement, leadership and support to embed local and national strategies, ensuring delivery of high-quality End of Life Care. Workstream objectives include:

- Each person is seen as an individual.
- Each person has fair access to care.
- Maximise comfort and wellbeing.
- Coordinated care.
- All staff are prepared to care.
- Each community is prepared to help.

Recognising the importance of Palliative and end of life care to so many of our clinical pathways, we will be working with Hospices North East (a collaboration of independent hospices across the region), to create a coordinated and sustainable strategy for palliative and end of life care. Core to this will be developing a system wide approach to education and training to support local delivery strategies which will be facilitated and delivered through the ICPs and PCNs. Importantly, working with our clinical networks we will develop new approaches to end of life care for those with complex needs including children and young people and patients with chronic disease.

Examples of NENC goals for supporting our population to age well include:

<p><b>Frailty</b></p> <p>Through clinical leadership and expertise, our ambition is to provide a Regional Centre of Excellence around Frailty and Aging Well.</p>	<p><b>Cancer</b></p> <p>By 2021 - We will agree differential time to treatment pathways for each tumour site.</p>	<p><b>Cancer</b></p> <p>By 2023 We will increase the proportion of cancers diagnosed at Early Stage by 7% (~1,900 additional early stage cancers).</p>
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Preventing frailty and supporting older people, carers, families and communities living with frailty

## CONSIDER

### Groups with high frailty prevalence:

- People living in care homes
- People with dementia
- People aged over 65 who have experienced frailty syndromes
- People aged 65 or above with 4 or more long term conditions
- People on 10 medications
- People with complex neurological conditions, cancer, EOL or with severe mental illness
- People housebound, in sheltered housing or in housing with 'telecare' aids
- People known to community nurses or social care and support services with continuing needs
- People aged over 85.

(Toolkit for general practice in supporting older people living with frailty, NHS England, [www.england.nhs.uk](http://www.england.nhs.uk) – with modification)

### Frailty screening Tools:

- Electronic frailty index (population screening in GP)
- CFS, Prisma 7, Gait speed, timed up and go test or Edmonton Frailty Scale (individual screening)

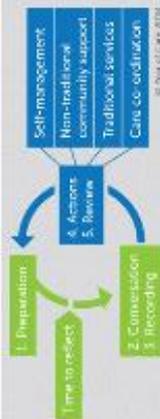
## INVOLVE

Enhance the voice of older people, carers and families to tackle the frailty challenge together at a:

- community level for service redesign
- individual level that encourages a person's involvement in their own care and support.

## CARE & SUPPORT PLANNING

To ensure that people living with frailty have better, solution focused conversations with care professionals based on what matters to them.



## ASSESS

**Verify frailty**  
(Using Clinical Judgement + the Clinical Frailty Scale)

**Vulnerable (non-frail)**

**Mild**

**Moderate**

**Severe**

**Classify severity**  
(Using the Clinical Frailty Scale)

## MAKING IT HAPPEN

(through local delivery and pathways)

COMMUNITY OF PRACTICE

WORKFORCE

DIGITAL

## EVALUATE

Frailty assessment  
Frailty category

Severe frailty, recorded fall  
Written care plan

Aged 65+ years with 10 or more medications

Aged 65+ with dementia

Flu immunisation rate (65+ years).

Control over their daily life

Social Contact

Reduced loneliness

Social prescribing schemes

referrals

Patients on the MH registers

Carer reported quality of life.

AGE attendance rates (65+)

Unplanned admission rates (65+)

Emergency readmissions within 30 days

Stranded patient: LOS 7+ and 21+ days.

91 days after discharge into rehab

Admission to care homes

Death in usual place of residence.

Aged 65+ years conversion rates

Hospital activity in the last year of life (65+).

## RESPOND

### Healthy Ageing and Optimum Caring:

keeping active and independent with access to frailty friendly homes.

**Community connectivity** with access to Voluntary Community and Social Enterprise Sector.

### Specific, tailored support for Long Term Conditions

Optimise support for falls, immobility, mental health and medication/polypharmacy.

**Specialist access for Comprehensive Geriatric Assessment and Case Management**

Optimise support for nutrition, bowel and bladder care, vision/hearing, cognition, end of life and dementia care.

### Crisis response and recovery

services close to home.

Frailty-focused **transport services.**

### Timely transfers of care

from hospital involving families and carers.

Timely access to experts offering **frailty-based care in hospital.**

## 5.5 Summary

Through the OHS programme, our clinicians, partners and patients have helped frame a strategy at the heart of which is local system working to sustain and transform services for patients in the place in which they live. Developing and enhancing collaborations at ICP level will network some core and specialist services to ensure timely and equitable access for all patients whilst reducing unwarranted variation. Informed by strong clinical networks, our digital strategy is enabling mobile working, interconnectivity and the early use of video consultations to transform the way we deliver care.

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*‘Our challenge to deliver the care we aspire to for the population of NENC is significant.’*

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We have moved from prioritising the sustainability of our vulnerable services to collaboration and engagement across the system, maximising the potential of primary care networks and community services through an integrated workforce strategy that is able to rapidly access patient information on line from all partner organisations. Our challenge to deliver the care we aspire to for the population of NENC is significant, but the progress we have made to date is evidence of a system wide commitment and understanding.

Examples of NENC goals for OHS programme include:

### By 2020

We will have comprehensive ICS Clinical engagement and influence addressing the priority areas of the Long-Term Plans.

### By 2021

We will have started delivering across the ICS on key LTP metrics such as rapid community responses and earlier cancer diagnosis rates.

### By 2028

Our current clinical vulnerabilities across the ICS will have been addressed and sustained through place based, ICP and ICS level working.

## Section 6.0 Mental Health

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The Mental Health work stream runs parallel to our OHS programme focusing on physical health in our Mental Health work stream. The ICS recognises the need to ensure the parity of esteem between both physical and mental health and the implications this has for the design and delivery of our services and also how we need to ensure robust transitional arrangements for children and young people with mental health conditions as they move into adulthood.

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*‘Break down barriers between mental health, physical health and social care provision.’*

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Most importantly, the ICS knows that fundamentally this can only be achieved if it works effectively in partnerships across the full range of stakeholders. Our mental health workstream is overseen by an ICS Mental Health Steering group; a partnership of key NHS organisations working collaboratively with public health, local authorities and wider stakeholders to develop a framework of mental health priorities, and to oversee the delivery of the long-term plan.

A significant amount of work has already gone into securing multiagency relationships and agreeing shared principles in order to progress a delivery plan that is owned by the system leaders and informed by the people using and providing services. The Steering Group has focussed on developing standards, sharing best practice, and looking to break down barriers between mental health, physical health and social care provision.

The socioeconomic and human costs associated with mental ill health are also well publicised and the priorities identified by the mental health work stream focus on addressing health inequalities and delivering parity of esteem to prevent illness, promote wellbeing and improve the outcomes for people who experience mental ill health. The 7 priority work streams are:

- Child health.
- Zero suicide ambition.
- Employment.
- Optimising Health Services.
- Long term conditions and persistent physical symptoms.
- Older people.
- Improving the physical health of people in receipt of treatment for a mental health or learning disability condition.

By implementing our mental health programme with our partners, we will deliver the key ICS aim to implement the requirements of the long-term plan to support the wider health needs of our local populations and to support our whole system to address the wide health inequalities that currently exist, and the gaps in health outcomes.

The detailed goals and actions of the Mental Health work programme are outlined in the programme executive summaries in Appendix 3.

Examples of NENC goals for mental health include:



## Section 7.0 Understanding the needs of people with a Learning Disability, Autism or both

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Across NENC, we are striving to make our region the best place for people with a learning disability, autism or both to live.

Our ICS commitment is to empower all citizens to 'have a voice', support and drive transformation in joined up ways which, positively impacts on the health and wellbeing of local communities.

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*'To ensure that consideration of people with a learning disability, autism or both is an integral feature of all the ICS programmes and services.'*

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This will see the ICS Learning Disability Network continue to lead in the shaping and delivery of the prevention strategy and reducing health inequalities programme of work, to bring about an increased awareness among professionals in achieving better health, care and quality of life for people with a learning disability, autism or both.

This will include building on our existing strands of work which consists of:

- the Learning Disability Mortality Review Programme.
- the improvement of GP registers for people with a learning disability
- increasing the uptake of annual health checks.
- enhancing the uptake of Flu immunisation.
- STOMP and STAMP campaigns.
- Workforce and leadership development (via the Leading Together for a Change Programme and roll-out of a Total Attachment train the trainer programme).

Our future programme will also commit to improve hearing, sight and dental checks for children and young people in special schools in line with national developments. This will involve working with local partner services to develop care pathways which reduce waiting times, especially for those children and young people in the SEND population.

As an ICS our focus is to ensure that consideration of people with a learning disability, autism or both is an integral feature of all the ICS programmes and services. Whether that is in the development of our mental health, or cancer, or child

health and wellbeing services, our immunisation and vaccination programmes and our maternity services, we will consider the needs of people with a learning disability, autism or both.

Alongside the Learning Disability Network, the ICS Learning Disability and Autism Transformation Hub will support delivery of key priorities. This will encompass the following:

- Realising the goals set out in Building the Right Support (BRS).
- Strengthening Care and Treatment Reviews (CTRs) and Care, Education and Treatment Reviews (CETRs)
- Standardising Dynamic Support Registers (DSRs).
- Leading implementation of initiatives which facilitate early intervention, such as the Children and Young People (CYP) Accelerator site pilot, working with schools, health and justice, SEND and education together with the Mental Health Trailblazer sites.
- Introducing the CYP key worker model.
- Establishing collaborative care models.
- Developing a framework to promote consistency in Quality Checking in relation to the Learning Disability Improvement Standards.
- Ensure commissioners undertake 6-8-week quality checks for those people out of area as part of the host commissioner model.
- Promote the uptake of personal health budgets for those in receipt of health and care services.
- Embed the principles of the Citizenship Partnership (which includes an employment pledge, expanding opportunities for Housing, personalised care and support and advocacy).

In addition, the Operational Delivery Network (ODN) will provide clinical and professional leadership and capacity to support innovation, and continuous quality improvement in areas such as:

- The Community Model (e.g. crisis services).
- Care Pathways (e.g. autism, rehabilitation).

As one of the six identified ICS workstreams, our approach to delivery is underpinned by our Participation, Engagement and Involvement Strategy. We believe that by taking this approach, enabled by being an ICS, we will be able to deliver our ambitious vision for people with a learning disability, autism or both across the North East and North Cumbria.

The detailed goals and actions of the Learning Disabilities, Autism or both work programme are outlined in the programme executive summaries in Appendix 3.

## Section 8.0 System Enablers

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### 8.1 System Enabler: Digital Care

#### Management of our Populations health and prevention

The Great North Care Record (GNCR) will include the creation a Trusted Research Environment (TRE), which can be used for population health management, academic and genomics research longer term. There is also a clear opportunity to utilise Artificial Intelligence, Assistive Technologies and Machine Learning in the future, however we acknowledge the need for the basic building blocks to be in place first; linking directly to our regional digital maturity aspirations.

Our intention is, where possible, practical and affordable, to utilise existing regional assets for delivery of population health management and supporting analytics tools, such as RAIDR provided by NECS and progress delivery at pace. This key transformation will require significant behavioural change that can then be potentially delivered by emerging PCNs.

#### Patient and Citizen centred care

Aligning perfectly with the personalisation agenda, the Patient Engagement Platform (PEP) will facilitate patients' and citizens' on-line interactions with access their health and care data for a range of services, this will align with the delivery and functionality within the NHS App as a "single digital front door".

As part of our patient and citizen (consumer) centred approach, we will deliver an appropriate "*preference*" model, to allow consumers to select who and how they want their data to be shared with. This tool is likely to be delivered through the NHS Health Call platform. To expand on this, NENC ICS is making significant progress with patient self-management using the NHS Health Call services; this is a collaboration of seven NENC NHS Providers.

NHS Health Call has already implemented a regional licence model for a range of clinical pathway applications and services that are already being delivered at scale.

#### System Interoperability

Another link to the GNCR - inter-organisational record sharing - will be delivered via a Health Information Exchange (HIE). We now have a regional platform being implemented with a contract awarded to Cerner.

This service will be hosted by Newcastle Upon Tyne Hospitals NHS Foundation Trust on behalf of the region. However, it should be noted that phase one of the GNCR is already operational, with primary care (GP record data) now available in all Foundation Trusts, Ambulance, Mental Health, 111 and Out of Hours services, across NENC via an existing solution called the Medical Interoperability Gateway (MIG).

As a system, we plan to undertake a regional digital maturity baseline assessment to better understand areas of strength and weakness; to focus attention and resources to the organisations that need the most help, whilst at the same time allowing the more mature organisations to lead the agenda.

Where appropriate and necessary, ICP level system convergence will enable the standardisation of operational level Electronic Patient Record (EPR) systems and facilitate learning from others.

We have very strong and growing links to local government via the Association of Adult Social Services (ADASS). This group is part of our formal GNCR programme governance and will ensure that we think and act as an integrated health and care system where information and record sharing / access is required.

**Other key programmes of work are as follows:**

PROGRAMME AREA	KEY ACTIONS AND OBJECTIVES
Optimising Health Services	<p>Radiology services Create an interoperable service at scale for Picture Archiving and Communications (PACS).</p> <p>Digital Imaging for Pathology programme.</p> <p>Laboratory Information Management (LIMS).</p>
Primary Care	<p>Implementation of the strategy to support the specific requirements for Primary Care; Optimising Resources, Collaboration and Integrated Working, Information Sharing, Digital First Primary Care, Infrastructure and Population Health Management.</p>
Secondary care	<p>Support organisations that require some degree 'system level' support to help raise their levels of digital maturity.</p>
Mental Health and Learning Disabilities	<p>Digital offer for citizens and patients with mental health and learning disabilities.</p> <p>Supporting personalisation through self-management technologies.</p> <p>NHS Health call platform that will seamlessly interoperate with the GP record.</p> <p>Legitimate and appropriate inter-organisational record sharing via the GNCR.</p>
Workforce	<p>Supporting the Interim NHS People Plan – enabling a digitally capable, professional informatics community.</p> <p>Creating a health and care eco-structure that enables staff to work in agile and flexible ways.</p> <p>Implementation of federated Active Directory infrastructure to enable staff to move between organisations without the need for separate system access credentials.</p> <p>Exploit the Electronic Staff Record, underpinned by streamlined and standardised organisational policies and procedures to enable a more flexible workforce model to be realised. Supported by implementation programmes such as the clinician (or staff) passport.</p> <p>Education, training and continual development of all staff is central to the new ways of working.</p>

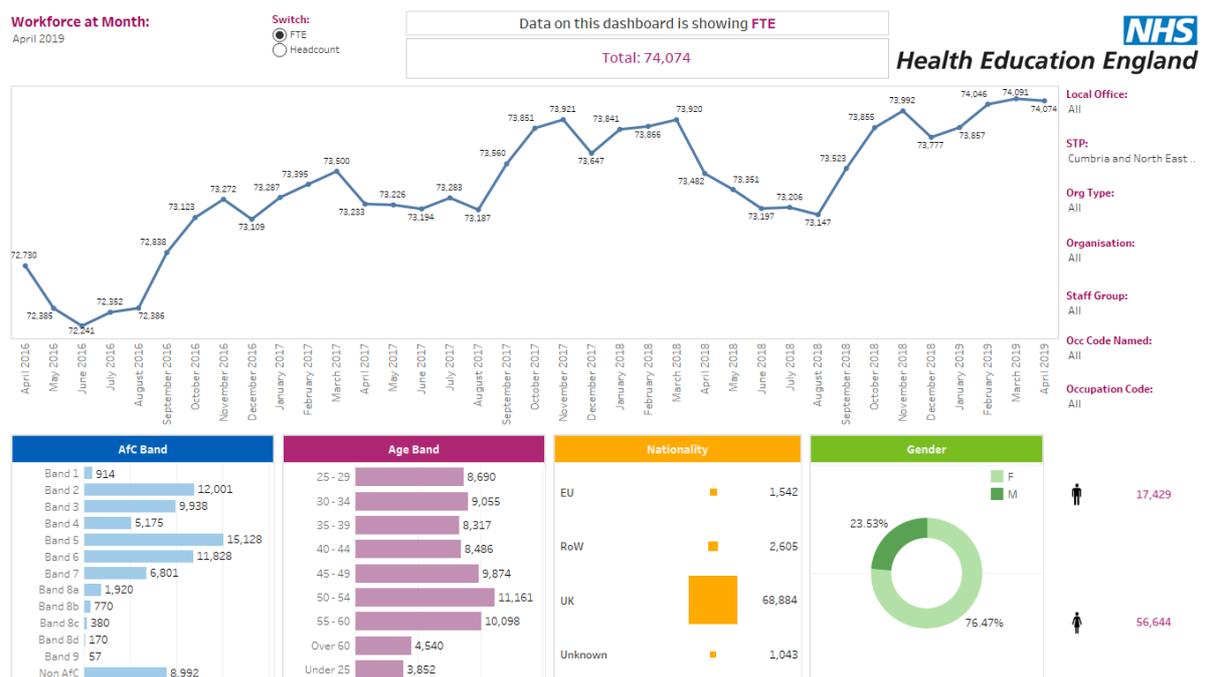
## The role of NHSX

As NHSX starts to support the broader health and care system from a digital thought leadership perspective, it would be appropriate to seek NHSX support in assisting the less digitally mature organisations to move at pace and if appropriate encourage rapid ‘blue-printing’ from the installed local asset base within our regional footprints. This could be further enabled if the existing Global Digital Exemplar programme was extended to move further, faster. The detailed goals and actions of the Digital Care work programme are outlined in the programme executive summaries in Appendix 3.

### 8.2 System Enabler: Workforce

Throughout this ICS strategy we have already seen references to workforce, the importance of our people and the establishment of our ICS Workforce Programme. The workforce programme wraps around the ICS ambition of improving healthy life expectancy, supporting a population health management approach and a focus on prevention and wellbeing.

The current health and care workforce across the region totals c.180,000 Full Time Equivalent (FTE) with c.74,000 FTE working for the National Health Service in secondary/specialist healthcare roles alone. Our primary care workforce totals another c.9,500 FTE.



The NHS in NENC has an overall vacancy rate of approximately 5.6% within which there are 1,700 FTE nursing vacancies, however, by way of wider context, by 2030 potentially our ICS could be short by 11,000 FTE healthcare workers; we are therefore facing a significant workforce challenge, sometimes described as a ‘wicked’ problem which requires us to think, work and collaborate in different ways. Our commitment, passion and enthusiasm for working together to address these challenges stands us in good stead.

As well as continuing to focus on employing new people into the NHS we need to increase our efforts to make the NHS, and wider health and care services, the best place to work. With a more engaged, productive and effective workforce and further development of our relationships and working practices across the system, we will advance our collective efforts to retain staff across our services.

We need to embrace a new 21st century approach to working; adopting collaboration across services and embracing digital technology. To be able to meet demand and focus on improving population health, working in health and care in the future will need to be a different employment experience; 'more but different' is the frequently used phrase by some of our national leaders.

We need to ensure that employers and employees are able to embrace a variety of different working approaches, with flexible and innovative solutions to how we best serve and support our populations

We want our leadership cultures to be the best they can be, with a focus on being positive, inclusive, people and population health centred with a collective leadership approach at the heart of our work.

In some places, acute workforce shortages across the ICS (health and care) mean some services are not sustainable and urgent action is underway to alleviate these pressures with a view to longer term innovative solutions to enable sustainable health and care delivery, including the development of managed clinical networks. We are proud to have our successful Find Your Place campaign, which continues to attract junior doctors to the region and now expanding its focus to include nursing and, in time, Allied Health Professionals (AHPs) and social workers.

We will be embedding system wide workforce planning that looks to align our future workforce to a population health management approach. This has been innovative work, with wide system stakeholder engagement, and we have plans for the next phases to focus on workforce planning across patient pathways; frailty, cancer and learning disability as well as supporting ICPs to develop this approach at a more local level. Our ongoing learning and reflections from this will lead to even greater use of this approach.

We will continue to work together and embrace the opportunities arising with regards to the equality, diversity and inclusion agenda, improving the employment experiences and representation across our workforces for BAME staff whilst also supporting, engaging and developing staff from all protected characteristic groups. We are planning our first ICS EDI conference and a collective presence at regional PRIDE and MELA events. At an organisation level, trusts will be working to improve performance across the WRES metrics and the recently communicated goals for 2028 with regards to increases of BAME colleagues in senior leadership roles.

We need to be clear about where responsibilities for workforce are best placed; locally, regionally and nationally and seek to create greater local ownership and empowerment, with good governance arrangements in place which will enable this change to happen. Our Workforce Transformation and Strategy Board is integral to this and ensures our programme is well led with a continuous improvement mind set.

As a result of our work towards integration and improved collaboration across health and care services, we expect to see improved experiences and outcomes for the population and more rewarding careers for staff working in the sector, all brought together through a consistently adopted workforce strategy for Health & Care in NENC.

Over the next few years there will be greater levels of wellbeing for staff, better job satisfaction, high levels of motivation, engagement and inclusion and lower levels of absence. There will be higher retention rates and fewer vacancies, with less use of bank and agency staff and we will be using collective approaches to workforce problems and have increased collaboration on resourcing and deployment with new roles embedded across the system and strong, collective oversight on the primary care workforce through our newly established ICS primary care workforce board.

There will be increased flexibility in the deployment of the workforce in our ICS in terms of what they do, where they do it, who they do it with and the tools available to support their work.

We continue to build relationships with organisations such as Universities and the Academic Health Science Network (AHSN) to really embrace and encourage the use of ground-breaking technologies, such as Artificial Intelligence (AI), Simulation and Virtual Reality (VR).

All of this work will be underpinned with effective communication and engagement with partners, stakeholders, staff, trade unions and the public but most importantly the population/citizen/patient/service user will genuinely be at the centre of all decisions and practices.

These are bold ambitions and we will continue to be proactive in seeking opportunities, such as those to field test the Workforce Development and Readiness Tool to influence future operating models. The outcomes from this recent work will further influence our core programme activities and initiatives notably across the nine areas within the operating model.

We welcome the outputs arising from this work and will focus on the core recommendations and opportunities, with a particular focus on scaling up the numerous examples of good practice across the region, seek to understand the impact of our digital strategy on the workforce and agree together what we do at scale, be that ICS or ICP, or responsibilities across the ICS Workforce and HEE teams, to enable us to go further faster with our ambitions, with consideration of resources needed to successfully deliver this.

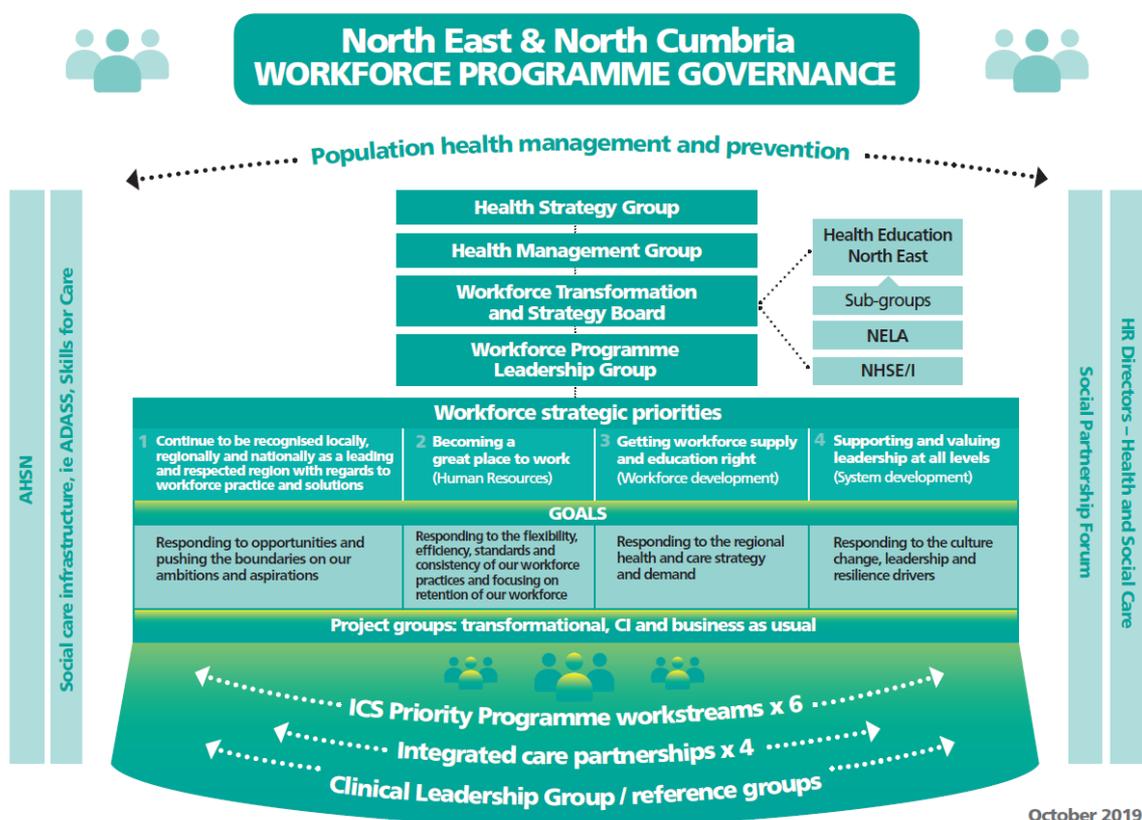
### **Workforce programme overview and emergent local workforce strategy**

Our Workforce Programme is ambitious in its vision for our ICS ***'to be the best place to work in health and care, with a focus on adaptability, wellbeing and population health'***. This dovetails with the spirit and commitments in the interim People Plan and yet to be published final People Plan.

Locally, at its most simple level, we are focused on recruiting, developing, appreciating and retaining NENC workforce and our workforce programme is structured around a small number of strategic objectives to deliver our ambition:

- Continuing to be recognised locally, regionally and nationally as a leading and respected region with regards to workforce practice and solutions;
- Getting supply and education right; responding to the regional health and care strategy and demand;
- Becoming a great place to work; responding to the flexibility, efficiency, standards and consistency of our workforce practices and focusing on retention of our workforce;
- Supporting and valuing leadership at all levels; responding to the cultural change, leadership and resilience drivers.

We are particularly proud of our “Great Place to Work” initiative which builds from a successful regional Streamlining Programme, which attracted national interest from NHSI with regards to sharing learning across other regions. We believe we are at the forefront of collective, system working on this important agenda, with a clear and established Great Place to Work Board and sub groups, comprising representatives across health and care. We look forward to this work making a positive difference, improving employment experiences and moving towards standardising best practice across NENC.



Our work is framed within the national interim People Plan and the themes within and we will continue to embrace opportunities to influence this work at a national

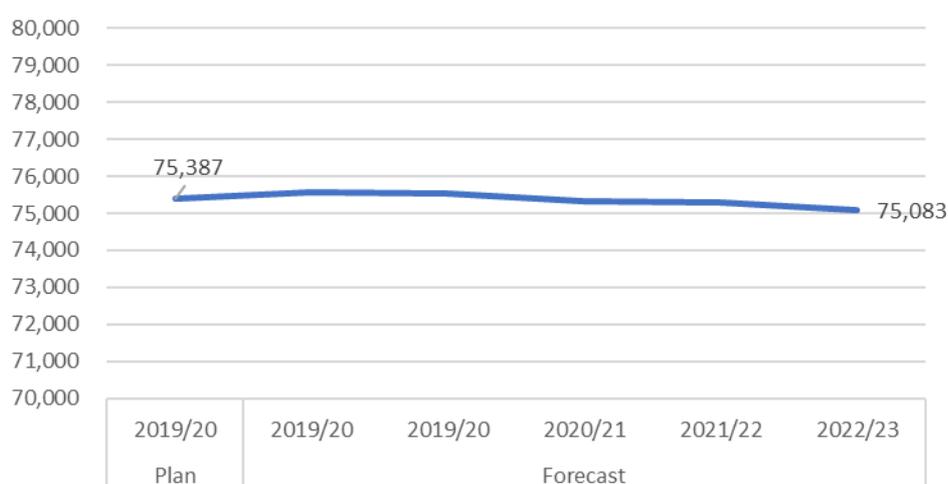
level. Whilst we await the publication of the final People Plan, we are developing our own ICS workforce strategy. Our workforce strategy will be visionary and inspirational with a key focus on prevention and wellbeing and will be finalised as we move into 2020, following stakeholder engagement activities.

From our historical knowledge and the recent national workforce planning round and use of an additional workforce tool, e workforce, we know 'supply' needs to be a core theme of our local strategy.

These recent returns (specialist and secondary care NHS employers) projected demand for posts forward to March 2024 as part of the Long-Term Plan submissions in October and November 2019 and have now been analysed. The following information has been prepared as an abridged and general overview of employers projections in terms of posts for the next five years.

Overall there is very little change across all staff groups, with a minor whole-time equivalent change of -304 FTE (-0.4%) which is mainly due to participation rates going down in some areas, which is generally associated with an ageing workforce.

#### Changes in FTE NENC All providers



Even though the overall change seems minor, there are some posts which see significant change in terms of FTE demand. Below is a list of major changes across the ICS (for all providers):

Significant increases by provider Trusts in FTE by 2024:

- Apprenticeships: an increase of 586 to 2,395.
- Nurse Associates: an increase of 305 to 425.
- Pharmacists: an increase of 79 to 600.
- Pharmacy Technicians: an increase of 106 to 486.
- General and Adult Psychiatry (medical): an increase of 20 to 276.
- Histopathology (medical): an increase of 9 to 93.
- Clinical Radiology (medical): an increase of 9 to 194.

Significant decreases by provider Trusts in FTE by 2024:

- Adult Nursing (Registered): a decrease of 556 to 14,239.
- Support to Nursing: a decrease of 623 to 10,924.
- Other Clinical Support: a decrease of 588 to 5,976.
- General and Vascular Surgery (medical): a decrease of 11 to 212.
- Trauma and Orthopaedic Surgery (medical): a decrease of 11 to 189.

There is a direct correlation between the support to nursing category and the nurse associates, meaning that most of these posts are re-coded to account for the additional training received as part of 'conversion' to nurse associate roles.

The reduction in registered adult nursing posts reflects a slight skill mix change (cumulative 5-year -3.9% reduction over the 5-year period).

We will continue to monitor any changes in regard to recruitment and retention of staff from the EU, given the current situation with Brexit. Whilst to date there appears to have been little impact, notably compared to some other regions, this remains high on the workforce agenda within organisations.

Further analysis and discussion now needs to take place, with oversight at the Workforce Transformation and Strategy Board, and a collective review of the summary position in line with wider ICS ambitions.

We have recently developed our first ICS workforce dashboard and will continue to refine this, to enable our Workforce Transformation and Strategy Board to oversee risks, delivery of our projects and enable progress towards the achievement of our vision to be the best place to work in health and care.

The detailed goals and actions of the Workforce work programme are outlined in the programme executive summaries in Appendix 3.

### **8.3 System Enabler: Estates**

Our estates ambition, as set out in our July 2019 Estates Strategy, is to provide a fit for purpose, flexible, more cost efficient and sustainable estate across NENC ICS area. This will facilitate service transformation in line with the ICS Clinical Strategy, provide sustainable delivery of high-quality health and social care services to enhance the patient experience, reduce backlog maintenance and deliver wider social benefits for our communities. Our intention is to release surplus land to construct additional housing as well as economic development and increased employment opportunities for local people.

This Estates Strategy summarises how we will use the estates strategically to support and enable emerging ICS Service priorities. It demonstrates how working together as partners, provider trusts, primary care and commissioners, we will ensure that with Capital Investment our estate will create the right landscape for the transformation and sustainability of care at all levels. It outlines the critical decisions we need to take in order to achieve this.

Governance of the Estates function within the ICS is through the ICS Estates Programme Board which feeds into the Optimising Health Service Group. The Estates Programme Board provides a forum for knowledge and resource sharing across the ICS and is represented by Senior Members of the ICS Organisations.

The four key drivers for the Board are to:

- Maximise use existing estate.
- Support emerging clinical models and pathways.
- Consolidate activity into modern fit for purpose flexible buildings and release of underutilised buildings / land.
- Enable quality healthcare, care in the community wrapped around general practice.

The Board will make best use of our estate data, workforce, skills and expertise, ensuring that we work effectively across organisational boundaries.

Some key examples of how delivery of the Estates Strategy will support the core ICS clinical programme workstreams are:

- **Cancer** – Delivery of the new Cancer Centre at Carlisle will provide the Cumbria ICP with its rapid diagnostic unit and enable networked working.
- **Mental Health** – The mental health estate has improved markedly in recent years giving a much safer environment for patient care. The delivery of the STP wave 4 mental health reconfiguration in the North of Tyne and Gateshead ICP will significantly add to this.
- **Child Health** – The Estates Strategy will deliver the co-location of children’s cardiovascular heart surgery unit with the Great North Children’s Hospital.

The Estates Strategy is intertwined with workforce and digital enablers. Better quality estate provides a safer and more attractive working environment contributing to staff retention and recruitment. New buildings are designed to be flexible and can be easily adapted as clinical pathways and service demand changes in response to digital innovations.

Estates priorities in supporting the ICS deliver the Long-Term Plan ambitions are:

- Monitoring and resourcing the successful delivery of the ICS Estates Strategy.
- Delivery of the national STP Wave capital funded projects:
  - 3 Wave 1 Cumbria schemes: £32.7m Carlisle Cancer Centre; £33m West Cumberland Hospital; £2m North Cumbria Community Hospital reconfigurations.
  - Wave 4 NTW £64.6m Mental Health Reconfiguration.
  - £47.1m Newcastle Paediatric Heart Unit move to the RVI.

- Delivery of ICS disposals pipeline. Partner organisations have identified around 40 sites to go in next 5 years. This will release 92.3 Ha of land, enabling the building of 1,056 new housing units and generating circa £46.1m capital receipts. As the Clinical Strategy comes to fruition this will release further opportunities for disposals of surplus land in years 5 to 10 of the Long-Term Plan delivery.
- Working with our provider trusts to eliminate all critical backlog and significantly reduce other backlog maintenance issues and increase the efficiency of our estates. We are on target to achieve a reduction in the secondary care estates running costs of over 10% by 2022, an annual target cost of £420m. We are already performing better than our national Carter Metric target of 35% for total non-clinical floorspace and aim to reduce this further to 30% by 2022. We are currently significantly behind the national 2.5% Carter target for unoccupied floor space. The delivery of the funded STP capital schemes will reduce the current figure of 6.37% to 3.87% by 2021 and successful delivery of the wider capital pipeline will get this down to the 2.5% national target level in the next 10 years.
- Working with CCG's and Primary Care Networks to ensure our Primary Care Estate is fit for purpose and meets the service delivery needs of the Primary Care Networks. There are plans within each ICP area to deliver new Primary and Community Care hubs.
- Working as a system to find sources of capital to enable delivery of the ICS identified priority schemes that are currently do not have specific funding identified. The Estates related capital funding requirements for the next 5 years is circa £1 billion.
- Promoting the environmental sustainability agenda and ensuring that estate is greener and more energy efficient.
- Considering the impact and acting upon the opportunity for Trusts to take back NHSPS and CHP properties.
- Partner organisations intend to work together as a combined system so that the estates expertise of staff within individual partner organisations is shared and deployed across the ICS as and when needed to minimise the reliance on external consultants.

#### 8.4 System Enabler: Innovation Capacity

We are fortunate as an ICS to have significant applied research capacity and capability within NENC. Our **Academic Health Science Network (AHSN)** is one of the strongest in the country, supporting innovation in all its forms within the NHS and Social Care. The AHSN helps us to identify, evaluate, adopt and disseminate transformative innovation, and works with industry on the development, testing and deployment of products and services that are the basis of a strong Life Sciences sector in our region.

The AHSN is dedicated to a triple aim of:

- Improving population health.
- Facilitating transformational patient safety and quality improvement.
- Supporting economic growth.

The AHSN already leads on initiatives such as the GNCR, the Patient Safety Collaborative and the Innovation Pathway which involve organisations and practitioner networks that cover the entire ICS. Our network includes a range of collaborating organisations from across the region, representing the health care sector, business and academia. The network are collectively committed to improving both the health and economic prosperity of the region through innovation, research and the dissemination of knowledge, as well as the adoption of new and improved products and services.

Our capacity in this area has been further augmented with national funding for our **Applied Research Collaborative (ARC)**, a collaboration between universities, the NHS, (providers and commissioners across all sectors) local authorities (social care and public health), voluntary organisations, charities and businesses to tackle issues causing health and care inequalities in the region.

The aim of the ARC is to support, facilitate and increase the rate at which research findings are taken up into practice, and its research themes have been informed by engagement with key stakeholders and aligned to the following priorities.

- Multimorbidity, Ageing and Frailty.
- Supporting Children and Families.
- Prevention, Early Intervention and Behaviour Change.
- Integrating Physical, Mental Health and Social Care.
- Inequalities and Marginalised Communities.
- Assistive Technologies/Data Linkage.

## 8.5 Cross-cutting themes

### Urgent and Emergency Care

The NENC Urgent and Emergency Care (UEC) Network enables the ongoing focus of our ICS organisations to ensure the quality, safety and equity of services across the ICS footprint.

The UEC Networks' programme of work is overseen by the UEC Operational Board (the Board), which meets monthly to coordinate UEC planning and delivery, respond to surge and prepare for seasonal demand, and is made up of representation from all of our Local Accident and Emergency Delivery Boards as well as further Primary Care, Pharmacy, North East Ambulance Service (111 and 999), NHS England and Local Mental Health and Hospital Trust providers. The Board is jointly chaired by the Chief Executive of North East Ambulance Service NHS FT and Chief Officer of Durham Dales, Easington and Sedgfield Clinical Commissioning Group and is

accountable to the North East and North Cumbria Integrated Care System Management Group. A dedicated network delivery team ensures the network achieves the objectives of its programme of work and will evidence this through progress reports.

The UEC Network ensures collaboration and co-ordination of effective Urgent and Emergency Care Services across the North East and North Cumbria in the implementation of the UEC requirements of the NHS Long Term Plan. The aim of the UEC Network is to have a highly responsive, 24/7, seamless urgent and emergency care model, which reduces demand on emergency services through whole system collaboration, whilst reducing unwarranted variation across the ICS.

Since its establishment over five years ago the Network has delivered a successful UEC Vanguard programme, bringing in excess of 2.9 million pounds into the region enabling our system to road-test a series of changes to improve and ease the pressure on services. These have included:

- Implementation of enhanced clinical support for both 999 and 111 call handling services.
- UEC-RAIDR Urgent Care Application and 'flight deck' demand monitoring systems.
- Digital care with every North East GP sharing patient records with emergency doctors, nurses and paramedics.
- Development and publications of the NHS Child Health App.
- GPs and Urgent Treatment Centres accepting directly booked appointments from NHS111.
- Provision of NHS Falls training to our Care Home staff.
- Implementation of the award-winning Respond mental health training.
- Roll out of the NHS111 online service to the population of the North East.

This vital work will continue with further ambitions to reduce hospital admissions and A&E attendances, make better use of GPs and pharmacists, and help patients improve their own health and has seen the region as one of the best performing Urgent and Emergency Care systems nationally.

## Section 9.0 Integrated Care Partnerships

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The delivery plans of each of our four Integrated Care Partnerships are set out below; these describe their ambitions for Health, Wealth and Wellbeing, their Clinical Strategy and plans for local integration at place.

These link to NENC ICS wider vision, aims and clinical strategy, but are reflective of the history and unique challenges of each ICP local health and care system, and its strengths, challenges and key assets.

Each of the ICPs are fully engaged with NENC ICS 6 priority workstreams described in other sections of this document, as such general content is not repeated.

### 9.1 North of Tyne and Gateshead Integrated Care Partnership (ICP)

#### Introduction

The North of Tyne and Gateshead ICP continues to build on a long history of partnership working across health and social care, and through this collaboration the results continue to be positive and greater than any individual organisation could have achieved alone. As a footprint we have grown and developed and have a greater understanding of what we can achieve as a system despite the challenges ahead.

We have a collective strength and commitment to deliver much more for the people that we serve, under the broad headers of health, wealth and wellbeing. However, the most important level of working for us all must continue to be 'place' based work for the people who live within the boundaries of each of the local authorities.

We have two strategic principles that guide our approach to the ICP, the first being the relationship between Local Authority defined Places, the ICP and the ICS, based on principles of subsidiarity.

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*'The North of Tyne and Gateshead ICP constitutes a number of predominantly high performing organisations some of whom have national recognition.'*

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The second principle is recognition that the ICP is a collaboration of equal partners, i.e. the NHS and Local Authorities, building up from strong partnership arrangements in each of the four Local Authority areas.

Recognising the pre-eminence of 'place' based working we are proceeding on the principle that work that we wish to undertake at an ICP level will be driven from our individual place-based agendas. For example, mental health and mental wellbeing is central to our place-based vision, therefore mental health services will be an integral part of our place-based system and planned accordingly.

However, where it makes sense to do so we will continue to agree areas of ICP level work together on wider geographies, and, where there is an expectation that we might deliver additional benefits for the people living in each of the local authority and CCG areas. Noting also that a number of our North of Tyne and Gateshead ICP providers span multiple ICP geographies and need to plan accordingly.

The North of Tyne and Gateshead ICP constitutes a number of predominantly high performing organisations some of whom have national recognition. Our unique position due to the high performance across the North of Tyne and Gateshead ICP provides us with a solid platform to work together and to deliver more for our public and patients with the help of a wide range of partners.

The North of Tyne and Gateshead ICP is a particularly strong area in relation to the financial position. This has enabled the Directors of Finance to develop a set of principles which support system working and system financial management.

As a system we also have a strong history of research, pioneering and innovation. We have excellent links with universities across the region and we are all, as organisations, active participants in the Academic Health Sciences Network (AHSN). This work continues to encourage further active participation and the subsequent use of research and evidence (R&E) in service delivery and the commissioning of services.

## **Health, Wealth and Wellbeing**

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

Given the relative strength of the North of Tyne and Gateshead ICP, Local Authority and NHS Chief Officers are proposing to focus our joint work across the ICP on three priority areas, noting that collectively our health and social care system is one of the largest employers in the area, and we have an opportunity to consider what we can do to influence and support a wider agenda over and above our current joint work in respect of social care and health issues as follows

## Climate Change and Sustainability

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

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

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

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

## Workforce, Employment & Skills

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

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

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

Leading from place for the North of Tyne and Gateshead ICP, the Local Authorities will lead this work, Newcastle Local Authority Chief Executive, co-ordinating the development of two scoping documents to consider and respond to these areas of focus.

The scoping documents will be reviewed in November 2019 by the North of Tyne and Gateshead ICP Chief Executives with a view to moving to action plans thereafter.

## Prevention

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

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

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

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

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

### **Clinical Strategy and delivery of the Long-Term Plan requirements**

Over and above the key thematic areas of focus for the North of Tyne and Gateshead ICP, we will continue to develop the clinical strategy in order to ensure the delivery of the Long-Term Plan requirements as they relate to our ICP.

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*‘We will share best practice and learning across the North of Tyne and Gateshead ICP in relation to the development of Primary Care.’*

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### **Collaboration across the ICP**

The North of Tyne and Gateshead ICP planning group (which includes representatives from across the North Health and Care system) followed a standard process to identify opportunities in clinical areas where collaboration at ICP level will add value to existing place based and ICS level implementation.

The group has considered the detailed place-based plans and has identified areas which we will consider at an ICP level for collective action:

## Referral to Treatment Times (RTT) / Shorter planned care waits

Given the waiting list pressures at both Newcastle and Northumbria originating last year, joint CCG meetings have been established to discuss specialty-based pressures at commissioner level, to understand where the pressures are coming from across the ICP and agree, wherever possible, joint actions to manage this. We will establish a North of Tyne and Gateshead ICP demand management group to review referral thresholds.

- **Expanding capacity:** This is one of the priority areas for us collectively as an ICP. We are working together to review the issues impacting on waiting times and are developing plans to describe how these will be addressed. Where appropriate, place based actions are also being developed.
- **Rightcare and GIRFT:** Across the North of Tyne and Gateshead ICP commissioners and providers utilise GIRFT and RightCare, to identify and address unwarranted variation and support the delivery of shorter waits for planned care. Where appropriate, we work together, across CCGs/Trusts on Rightcare, including undertaking data analysis, pathway reviews etc.

Similarly, RightCare packs are used by the CCG to help reduce health inequalities and health outcomes for our local populations alongside the local intelligence such as the JSNA /NFNA to ensure our plans focus on the opportunities which have the potential to provide the biggest improvements in health outcomes and reductions in health inequalities.

- **Advice and Guidance (A&G):** Across the North of Tyne and Gateshead ICP we have increased the number and range of specialities that are now using advice and guidance, and work will continue to promote uptake of A&G. We are committed to the continued roll out of A&G where it is practicable to do so and this option features highly in the transformation discussions which are taking place between providers and commissioners given we feel that it has impacted positively in our efforts to manage demand.

## Developing Primary Care

We will share best practice and learning across the North of Tyne and Gateshead ICP in relation to the development of Primary Care. We will consider the use of digital technology within Primary Care and consider how we develop capacity and capabilities for the future.

## Cancer

We will share best practice and learning across the North of Tyne and Gateshead ICP for example sharing learning from the Targeted Lung Health Check pilot across Newcastle and Gateshead. We will continue to work closely with the Cancer Alliance to address ICP wide pressures e.g. in relation to workforce.

## **Mental Health**

We will continue to work with the Mental Health work stream of the ICS to address wider ICS priorities. However, in doing so, we will consider how we manage our mental health contracts across the ICP and how we are able to join up the commissioning of services or vulnerable groups e.g. addictions, homelessness and suicide prevention.

## **Learning Disabilities, autism or both**

Across the North of Tyne and Gateshead ICP the availability of learning disabilities in-patient and community provision is in line with the national Transforming Care agenda, but also ensure that it safely and appropriately meets the needs of individuals in our area to a high standard.

We are working together to review how we can stimulate the local provider market and also how we can ensure that providers and workers are skilled and trained to meet people's needs in both in-patient and community settings.

## **Stroke**

Hyper-acute services have already been centralised in line with national recommendations. NuTH are now leading on the development of mechanical thrombectomy.

## **Respiratory**

We will identify areas of best practice within the ICP footprint and share the learning. We will consider a system wide approach to the management of breathlessness with pathways cutting across primary, community and secondary care. NHCT have implemented a Hospital at Home pathway for patients who would otherwise require hospital care for their exacerbation of chronic obstructive pulmonary disease (COPD.) The service has reduced the average length of stay for this group of patients by 4 days (Hospital at Home = 1 day; usual care = 5 days).

## **Tyne Provider Alliance – providers working in collaboration**

The three secondary care Foundation Trusts within the North of Tyne and Gateshead ICP - Gateshead Health, Northumbria Healthcare and Newcastle Hospitals, created an approach to alliance working across the three organisations in May 2018.

Part of the role of alliance is to review specific services across all three Trusts to improve the quality and experience of care and ensure the sustainability of service delivery across our ICP hospital systems. This includes working collaboratively on workforce issues, initially focussing on clinical areas, with consideration of the use of honorary contracts and clinician passports and use of information technology.

Aims of our alliance working include:

- Reducing variation in service delivery across the ICP.
- Sharing learning and developing fast follower sites.
- Developing integrated pathways of care to ensure sustainable services.

In the North of Tyne and Gateshead ICP, the Tyne Provider Alliance has already made significant progress through working collaboratively in bringing together stroke, vascular and MSK services. Building on these successes, they will now be embarking on the following areas for cross alliance working:

- Interventional Radiology.
- Mechanical Thrombectomy.
- Pathology Services (links to NENC-wide discussions about Pathology Networks).
- Cardiology.
- Paediatric Services.
- Breast Services – Diagnostic and operative work.

These areas are also aligned with the North East and North Cumbria ICS Optimising Health Services work stream.

Cancer provision is also a key part of the inter-Trust alliance work, in partnership with CCGs, recognising the changes to the 28-day Faster Diagnosis standard which is being implemented in shadow format in April 2019 and will go live from April 2020. Delivery of all 8 existing cancer waiting time standards remains a priority.

### **Local integration at place**

The need to bring care closer to home is greater than it is has ever been, and with a growing and ageing population there are more demands on our health and social care services, and the NHS needs to evolve to meet them. People are also living longer, often with more complex health and social needs and long-term conditions too. All of which require a personalised approach to community support, often across different organisations.

Patients want care to be tailored to their needs, and they want to be involved in decisions about their care to enable them to live life to the full, and as independently as possible; they want and expect to be cared for at home or as locally as possible.

However, we know that general practice and community health services face multiple challenges with insufficient staff and capacity to meet rising patient need and complexity.

Therefore, across the North of Tyne and Gateshead ICP, a Place-Based approach to integrating services is being developed. Our aim is to increase the scale and integration of out of hospital services, based around communities and improve

population health outcomes. This will be done through a focus on prevention and, more importantly, the delivery of care closer to home.

Our ambition is that services will be delivered at home or as close to home as possible with hospitals only providing services that cannot be delivered in this way and, as community service transformation continues, the opportunity to absorb more traditionally secondary care work into a community setting will further increase. We will continue to work with our partners to develop further care models that support the balancing of capacity and demand across the health economy.

There continues to be a clear commitment to joint commissioning, and the creation of joint governance arrangements at place level. Place based integration across Health and Social Care is maturing through integration governance arrangements e.g.

- Northumberland System Transformation Board.
- North Tyneside Future Care Programme.
- Newcastle Joint Executive Group and Joint Delivery Group.
- Gateshead Health & Care System.

Primary Care Networks are a key component of the place system across the ICP, and we strongly believe therefore that their development should be driven by place partnerships. Our PCNs continue to develop excellent relationships with their local authority and community partners at place. We have a total of twenty-two PCNs, across the North of Tyne and Gateshead ICP with Clinical Directors appointed into the networks and engaged in the various local system boards which underpin our Place based working with health and social care partners.

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*‘We continue to develop mechanisms to engage and consult with broader system stakeholders.’*

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The Networks are starting to develop local priorities, with many focusing on complex care for frail elderly, mental health and community services. All our providers are supporting the PCNs across the ICP to explore new models of working that are designed around the patient, including opportunities for staff to rotate through community and secondary care settings that will strengthen local Place based integrated care and systems.

Our ICP partners play an active role in the ICS work streams, so we have therefore ensured our ICP and place-based work is aligned.

Our approach to integrating services is aligned to the Place-Based approaches to Health, Wealth and Wellbeing in Northumberland, North Tyneside, Newcastle and Gateshead. Better Care Fund plans are a key component of our transformational work and are the catalyst to support us in developing new models of integrated delivery and commissioning based on the needs of communities. Our approach is also supported by Section 75 agreements.

## **Conclusion**

We will continue to rely on our collaborative working approaches between partners across health and social care to further develop the North of Tyne and Gateshead ICP supporting governance structures and enable decision making 'at scale'. This will help to maximise our collective impact to deliver the triple aim whilst reducing duplication and overheads.

We continue to develop mechanisms to engage and consult with broader system stakeholders including our workforce, patients, service users and the public, to help us co-produce a clear and compelling vision for our system. We will continue to focus on the delivery of all of our work through an approach that is clinically-led and evidence based, engaging with the wider workforce and community, building trust across the system.

## 9.2 Durham, South Tyneside and Sunderland Integrated Care Partnership (ICP)

### Introduction

This five-year plan sets out our ambitions and priorities to deliver the NHS Long Term Plan commitments and address shared challenges in order to deliver safe and sustainable services for our population. We will work collaboratively and, where appropriate, combine resources and maximise economies of scale.

We will develop a culture that promotes alliance working between organisations and our citizens across the ICP. We will continue to engage with patients and service users and the public at place and ICP level to help us develop and realise our ambitions for the system, while contributing to and collaborating with the wider ICS, including strategic enablers such as finance, workforce, digital and estates.

Our ambition is to transform health and care outcomes building on the primacy of place-based working across health and social care, underpinned by a long history of partnership working. We already have strong and active engagement with local government and community and voluntary sector partners.

This partnership offers an exciting opportunity to learn, share and spread the good work that has already started and, where appropriate, accelerate progress. It will also be the vehicle to address our local challenges including:

- Reframing the conversation about health across the ICP to ensure that the whole health and care system connects people into communities and assets in their lives, rather than creating a reliance on high cost, institution centred care.
- Tackling vulnerable hospital services.
- Addressing the challenges to specific services.
- Meeting workforce challenges.
- Further developing out of hospital services, including accelerating the development of primary care networks (PCNs).
- Improving mental health and access to mental health services through our commitment to the mental health investment standard (IMHS).
- Managing financial risks together.
- Tackling unwarranted variation in service quality.
- Building on existing individual place-based approaches to improve access to services such as MSK and rheumatology.
- Delivering integrated urgent care.
- Commitment to delivering the NHS Constitution.

## Health and Wellbeing and Wealth

We are committed to working 'at scale' on strategic issues, where it makes sense and adds value. Our ambition is to shift our focus from a system that treats ill health to one that helps to keep people well for longer. We will support people to build knowledge, skills and confidence to live well and stay well with their health condition by enabling them to make informed decisions and choices when their health needs changes. We have identified the following areas as opportunities to harness collective resources and expertise to make faster progress on improving health and care outcomes:

### Personalised care

There is an emerging understanding of the opportunities that the ICP presents in delivering some of the components of personalised care, including approaches to influencing workforce cultures through the use of Patient Activation Measures, and Shared Decision Making.

### Prevention

- Reducing tobacco dependency in pregnancy will continue to be a key area of focus to support the Local Maternity System and local delivery change.
- Investing in public health consultant capacity in the NHS, by increasing the number of consultants in public health in Foundations Trusts across the ICP.
- Scaling up and embedding a model of Making Every Contact Count (MECC) across the NHS and Local Authorities.

Excellent work continues to be carried out at 'place', led and supported by the Health and Wellbeing Boards, delivered collaboratively by health, local authorities and voluntary and community partners and supported by the Better Care Fund. This positively impacts people's lives and improves their health, wellbeing and wealth, e.g.

- Partnership approach in County Durham to addressing issues relating to health and housing.
- In South Tyneside the local plan includes work on strategic housing developments and system wide recruitment development under the 'Love South Tyneside' banner.
- Focussing on the key elements of the Healthy City Plan as part of the overall Sunderland City Plan including smoking, alcohol and a good early start in life.

Health and Wellbeing Boards are a crucial forum where local authorities, CCGs and provider partners to assess the needs of local populations and jointly commission services. The Health and Wellbeing Boards within our ICP are currently refreshing their Joint Health and Wellbeing strategies and developing their priorities for the coming five years based upon information from Joint Strategic Needs Assessments. The delivery of the identified priorities will support and complement any proposed collaborative work at ICP and ICS.

## Clinical Strategy

We are committed to developing a single ICP transformation plan that sets out our long-term clinical priorities, which includes implementing the outcomes of Path to Excellence phase one and progressing Path to Excellence phase two. Our clinical strategy will broaden across County Durham, South Tyneside and Sunderland, due to common challenges faced by specific services, patterns of patient flow across place boundaries and ensuring the delivery of the NHS Constitution standards where there are known issues. We will focus on shared priorities including:

- Shorter planned waits for care to reduce and maintain referral to treatment times in pressure specialties e.g. T&O, cardiology.
- Cancer treatment standards e.g. urology 62 day waits.
- Urgent and emergency care, addressing challenging A&E waiting times.
- Develop robust and sustainable services e.g. dermatology, breast cancer services.
- Priorities for operational efficiencies, e.g. same day emergency care.

We recognise that it makes sense to develop solutions to these areas together managing economies of scale, whilst respecting justifiable local differences. We will ensure that we maintain close links and alignment with the South Integrated Care Partnership's priorities for secondary care transformation and the ICS Optimising Health Services work stream.

We intend to develop the interface between hospital-based care and integrated primary and community services to ensure in and out of hospital clinical redesign are aligned and complimentary for the benefit of patients.

The ICP provides an opportunity to organise the efforts of partners and to streamline how we plan and commission at a level above the three places where it adds value, to deliver our ambitions and aspirations.

## Integration at place

Whilst not diminishing what can be achieved by working together 'at scale', the health and care needs of the majority of people are best met by integrated, place-based services. County Durham, South Tyneside and Sunderland are building on a long history of effective partnership working to deliver quality, person centred, joined up care that meets the needs of the local population and improves health and wellbeing.

Collaborative working arrangements and collaborative decision making between the NHS and local authorities already exist in the three places across our ICP. We intend to achieve greater integration by:

- Joining up the planning and delivery of health and care services through integrated strategic and operational commissioning, e.g. County Durham's Integrated Community Care Partnership, formal integration between South Tyneside CCG and South Tyneside Council building on the successes of

the joint commissioning unit; developing an integrated commissioning function in Sunderland between the council and CCG and linking into All Together Better, the vehicle for integrating services across the city.

- Developing senior joint roles at place level with each of the three councils to support the development of a partnership culture and to create and sustain system wide improvement including identifying opportunities to strengthen integration across the ICP footprint.
- Using formalised collaboration agreements, e.g. All Together Better and South Tyneside Alliance.

The 22 primary care networks established across our ICP are central to integrated care with neighbourhoods and will build on and consolidate existing partnership working across GP practices, health and social care to join up services and develop population health approaches through the creation of locality-wide teams across organisational boundaries.

We have made significant progress in County Durham, South Tyneside and Sunderland in the development and implementation of new models of person centred, holistic and proactive models of integrated care through Teams around Patients across County Durham and Community Integrated Teams across South Tyneside and Sunderland that deliver more coordinated and proactive services across people and organisations. Whilst some of the features of the place-based models of integrated care are common there will be differences reflecting the stage that each area is at in its journey.

The added value here of the ICP is in optimising opportunities sharing, learning and spreading good practice at place level over a wider scale including driving greater integration through the development of operating models for the clinical model.

## **Conclusion**

The County Durham, South Tyneside and Sunderland ICP Executive brings together senior leaders from each of the constituent statutory partner organisations with Primary Care Network Clinical Director input from the current four CCG areas. It will provide strategic leadership across the whole population of the ICP, including overseeing a single plan covering operational and long-term transformational priorities, building on and aligning place level plans. We will take collective responsibility for managing financial and operational performance.

## 9.3 Tees Valley Integrated Care Partnership (ICP)

### Introduction

Working across Hartlepool, Stockton, Darlington, South Tees, Hambleton, Richmondshire and Whitby our ICP has been set up to focus on “place” and ensure the sustainability of services for the local population that meets quality and clinical standards as well as workforce challenges, core performance and financial standards.

We have a clear ambition across our ICP to improve health and wellbeing, support delivery of the best possible outcomes and to ensure our system is sustainable. We will do this through building on the strong foundations we have developed in terms of our collaborative approach to place-based working across health and social care.

Transformation across our ICP footprint will deliver a positive shift towards improving “population health”; – moving from fragmentation to integration in care delivery, but also tackling the significant wider determinants of the health and wellbeing for our population.

Our system wide collaborative approach creates an opportunity to learn, share and spread the significant work that has been progressed in each of our places. It also provides a platform from which we can continue to progress the overarching objectives of the Tees Valley ICP, which are:

- To ensure our population has access to the best possible care through the system wide delivery of a joint programme of hospital services consolidation and transformation – **our clinical strategy**; including mental health care and services for those with Learning Disabilities, Autism or both.
- To improve our population’s **health, wealth and wellbeing** through increased use of Population Health Management approaches, more targeted prevention activities and increased application of personalised care.
- To ensure optimal use of resources for patient pathways through increasing **local integration at place** to support more integrated out of hospital services based around communities; aiding our financial recovery and driving service sustainability.
- To attract and retain a skilled workforce across clinical networks – to address our current workforce pressures.

## **Health, Wealth and Wellbeing**

It is our collective ambition to develop a local Population Health and Population Health Management (PHM) strategy that supports integrated working and enables a focus on the very local needs of our populations. We will use a population health management approach to tailor how we deliver, improve and commission responsive and tailored local health and care services from a Primary Care Network level and at scale where possible and practical to do so. This will include joining up how we deploy our health promotion and prevention resources in our Local Authority Public Health Teams to tackle the significant inequalities, early ill-health and poor lifestyles and lifestyle choices of many of our local residents.

Population Health Management will be a key feature of our longer-term financial recovery and sustainability, helping support a shift from reactive hospital-based care to proactive prevention, early help and community-based support.

Our key goals associated with the health and well-being of our population are in targeting measurable reductions in the inequalities and unwarranted variation in health and health outcomes. We will achieve this through stronger working with Local Authorities, Public Health and other key stakeholders.

Whilst we are focused on the place-based approaches that will help achieve our goals and deliver our ambition we are also cognisant that there is significant work being progressed at an Integrated Care System level, to this end we have focused on detailing the local place-based initiatives proposed and being implemented within this plan. Initiatives include;

### **Personalised Care**

Whilst the health and care system has been changing at both a national and local level, the population itself has also changed. People are now living for longer with more complex health and care needs. People are often unable to make appropriate decisions about their own health and health care, or exercise control over decisions about their health.

The ICP will empower people through Integrated Personal Commissioning, including proactive case finding, personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets. The ICP will support people to build knowledge, skills and confidence and to live well with their health conditions through proactive case finding and personalised care. The ICP will support people to stay well by building community resilience, enabling people to make informed decisions and choices when their health changes.

Our approach across the Tees Valley ICP is to work with Primary Care Networks to implement the Personalised Care Directed Enhanced Service (DES), including the creation of new Social Prescribing roles in a primary care / practice setting. We will ensure continued use of shared decision making, along with the development of effective care navigation in primary care that will sign-post suitable individuals to social prescribers or organisations that can better support them and promote self-care. Link workers within primary

care networks will work with people to develop tailored plans and connect them to local groups and support services.

## **Prevention**

Our population is ageing, living longer in ill health and stubborn inequalities persist. For patients and the sustainability of the NHS and other services, we must increase our efforts to prevent illness. We also know that increasing our focus on prevention, as opposed to treatment; will support our financial recovery in the longer term.

The ICP will deliver a reduction in health inequalities, with an emphasis on addressing key risks of smoking, high blood pressure, obesity and alcohol and drug use. We acknowledge the significant impact that drug use and alcohol consumption is having on our population and services, both in terms of physical health and mental health. To this end we are progressing a range of specific initiatives to target reductions in these areas and bolster our capacity.

Our collective future vision, driven significantly by collaborative working across Public Health, health and care providers, the voluntary sector and making best use of emerging primary care networks, will ensure a range of benefits for our patients and populations.

We have identified an ICP wide programme of work, with colleagues from our Local Authority Public Health Teams to begin to tackle some of the underlying causes of ill health. The programme is aimed at the following key areas;

- Making every contact count.
- Reducing; tobacco dependency, excess weight, and the impact of alcohol.
- Air quality.
- Antimicrobial resistance.
- Screening and immunisation.
- Health inequalities.

## **Clinical Strategy and delivery of the Long-Term Plan requirements**

We have been working together across the ICP for some time in order to understand how we can transform the way we deliver health services to positively impact on health outcomes for the population we serve. We are aware that some of our current models of delivery are outdated and inefficient, whilst others are experiencing significant workforce pressures mirroring the position at both a regional and national level. These factors significantly contribute to our financial pressures across the ICP and impact on our ability to deliver the various investment standards required in the NHS Long Term Plan.

Clinical and managerial leaders from across our system have been working together to understand those services that represent the biggest risk to the system in terms of

vulnerability and opportunities to transform them in order to deliver the best possible outcomes in a sustainable and affordable way.

Our approach to service transformation is to build on the inception of managed clinical networks, with a clear mandate for them to consider opportunities that will improve quality, effectiveness and outcomes for the population.

We have identified the following priority areas that require urgent attention in terms of expediting our thinking around how and where these services are delivered, to ensure sustainability;

- Urgent and Emergency Care.
- Maternity and Paediatric Services.
- Stroke Services.

We have also developed, and continue to progress, a number of significant service transformations relating to the provision and delivery of support services including both Pathology and Radiology.

Alongside this approach to transforming clinical services we will also continue to review and consider the organisational form of the constituent parts of our ICP in order to ensure that these best support service provision and delivery of improved outcomes, whilst continuing to address our collective financial pressures. Where it makes sense to do so, we will implement organisational change in pursuit of our ICP goals.

We have already made considerable progress in developing and implementing integrated models of commissioning and provision for mental health services through the inception of a Durham and Tees Valley Mental Health Partnership. The aim of the Partnership arrangement is to bring together partner organisations, to collaborate to meet the needs of our mental health, learning disability and autism population, by taking shared responsibility for the planning and delivery of quality care for the population within an agreed budget. The aim is to avoid duplication of services so that people receive the right care at the right time in the right place and that services developed have the correct clinical input right from the start.

The strategic partnership aim is that;

*The County Durham, Darlington and Tees Valley Mental Health and Learning Disability Partnership will work together as one responsive system to plan, buy and deliver high quality, best value health services for those living with learning disability, autism or mental health needs.*

The partnership has facilitated the individual constituent CCGs in successfully bidding for additional resources to support progressing the Children and Young People Trailblazer and Crisis services.

It is expected that through delivering the transformational changes necessary in relation to hospital-based care we can support greater investment in community, out of hospital and mental health & learning disability care in line with the investment standards detailed in the NHS Long Term Plan.

It is our collective expectation that by working in this way, we will be able to better understand and respond to the workforce/staffing and financial pressures that each organisation is experiencing. Using our collective resources to develop and deliver shared solutions that span organisational boundaries and presenting better opportunities to attract, recruit and retain staff across all aspects of our service delivery.

In support of this approach we have already implemented robust governance arrangements across the partner organisations including the four Clinical Commissioning Groups and provider Trusts. These arrangements include specific groups focusing on financial recovery, service transformation, workforce and organisational redesign, allowing collective decisions to be made on behalf of the ICP partners.

The NHS Long Term plan also sets out a range of requirements that, as an ICP, we are collectively responding to. Examples of those areas where local place-based approaches are being progressed include:

### **Cancer**

There is a significant gap between life expectancy across the ICP footprint and that of England. There is a significant inequality gap within communities across our localities, more people from our deprived communities die from cancer or their quality of life post cancer treatment is worse than what it should be when compared to the local, regional and English averages.

It is our goal that year on year; an increased number of patients will survive their cancer for at least 5 years after diagnosis and receive personalised follow up support.

The Tees Valley ICP have collectively bid for funding from the Northern Cancer Alliance for 2019/20 to provide Cancer Trackers and Cancer Care Co-ordinators to help push/pull patients through the system. This resource will sit in the most challenged cancer sites such as Head and Neck, Lung and Transferring patients across sites.

Provider Trusts are also working to introduce optimal pathways in colorectal, prostate, Upper GI and Lung. Part of this work includes stratification of patients who are low risk having their follow up appointments carried out either virtually or in primary care. It is intended that this will release capacity in secondary care to support achievement of the cancer standards and improving outcomes for patients.

### **Urgent & Emergency Care**

Urgent and Emergency Care demand has increased year on year. To ensure that we continue to meet the needs of our most unwell patients, we must ensure that patients are treated in the most appropriate setting and in the most appropriate timeframes, reducing pressure on our most stretched services. Staffing remains a challenge, with large gaps in most sectors, due to difficulties in increasing staff numbers within limited financial budgets; we must reduce activity in order meet the most urgent needs of the population.

Our goal is to have a highly responsive, 24/7, seamless urgent & emergency care service. We will aim to do this by reducing demand on Urgent and Emergency Care Services whilst improving patient flow experience and performance. We aim to reduce unwarranted variation across the Region, standardising services and delivery.

A single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services has been operational since 1st October 2018. We continue to review the impact of these services whilst progressing further demand management initiatives and opportunities to promote appropriate self-management and in ensuring that members of the public are accessing the right services at the right time.

It is recognised that the Urgent Treatment Centre (UTC) model will support with demand management, this model is already in place within the Darlington UTC and North Tees Hospitals NHS Foundation Trust UTC and will be implemented in South Tees Hospitals NHS Foundation Trust by 1st October 2019. The permanent service model at the Friarage Hospital for implementation of an UTC will commence in 2020.

The ICP is committed to the continued delivery of the 4-year investment programme that will see NEAS be able to deliver the required national standards. This will be through increased paramedic recruitment and through increased vehicle capacity and improved operational efficiencies.

### **RTT / Shorter planned care wait**

Our goal is to redesign outpatient services so that over the next five years patients will be able to avoid up to a third of face-to-face outpatient visits. All systems and trusts will implement proven initiatives, including the Model Hospital, Rightcare and GIRFT and the major opportunities identified within the Long-Term Plan.

Alongside outpatients, diagnostic services are a key capacity constraint within our ICP, resulting in increased waiting times pressures. This is prevalent across a number of key pathways but most notably in relation to 'faster diagnosis' for our cancer patients. We will continue to work collaboratively across our ICP to ensure that we maximise the available diagnostic capacity for the whole population and exploit any further opportunities to innovate our pathways of care. Specific recent examples include the ICP implementation of both Faecal Cal-Protectin and FIT testing to reduce the numbers of avoidable endoscopies.

Across the Tees Valley ICP there are a range of schemes in place to reduce waiting times and improve RTT performance. One such scheme is the MSK First Contact Practitioner Model we are piloting in South Tees and Hambleton, Richmondshire & Whitby which brings expertise to the front end of the MSK pathway. The expectation is that this pilot will reduce demand by enabling prompt access to expert assessment, diagnosis, treatment and self-management advice and for many patients prevent short term problems becoming long term conditions. If successful we will look to implement this approach across the ICP.

Significant progress has also been made across the ICP in further developing the local offer in relation to advice and guidance. This has been supplemented across our local places with specific programmes of GP referral support provided through 'rapid specialist opinion' type services, providing local GPs with guidance on the treatment options available and the appropriateness of onward referrals to secondary care services.

As a system we collectively acknowledge the need to ensure that no patient will wait more than 52 weeks from referral to treatment. The actions outlined above will support delivery of this key standard; however, where necessary we will work together across the system to implement a planned process of NHS-managed choice supporting those patients who have waited 26 week or more to access services with shorter waiting times.

## **CVD**

Our goal is to continue to work with Public Health and other stakeholders on the CVD Prevention Agenda to allow greater detection and management of conditions.

We are working to implement an ICP wide approach to an Atrial Fibrillation Optimisation and Detection Programme. This 18-month project is designed to optimise management of patients identified as having or at high risk of AF. The scheme will enable;

- Identification of patients from clinical systems.
- Support the undertaking of clinically led appointments in order to risk assess, educate and prescribe optimal medication.
- Include an educational programme for Primary and Secondary care clinicians.

## **Respiratory**

Over the next ten years we will be targeting investment in improved treatment and support for those with respiratory disease, with an ambition to transform our outcomes to equal, or better, our international counterparts.

Our goal is to improve services and outcomes for patients by taking an integrated approach to delivery which involves communities, voluntary organisations and the health and care system. We will focus on prevention, early detection and diagnosis and optimal treatment options, concentrating interventions initially on populations at greater risk.

Working in partnership across the ICP we have developed approaches to support improved management in a primary care setting, reducing the burden on secondary care and urgent and emergency care services. This is being further underpinned by a collective and collaborative approach to promoting self-management, including making system wide use of the myCOPD app.

## **Diabetes**

Our goal is to support people at risk of developing Type 2 diabetes and those living with diabetes to significantly improve treatment compliance and thus improve outcomes for patients.

Work is already progressing to plan and implement an expansion to the NHS Diabetes Prevention Programme. This will support eligible patients across our ICP to reduce their risk of developing Type 2 diabetes with particular emphasis on health inequalities and the BAME community.

## **Mental Health**

The North East has some of the highest rates of mental illness in England; our provider trust led Partnership has developed a recovery focussed approach to care looking at changing our processes and culture to support personalised, well-being focussed services. Our goal is to help service users find connectedness, hope, identity, meaning and empowerment.

Another initiative being led by our provider trust is the Right Care, Right Place scheme which is in place to support the development and delivery of the new community-based models of care, in line with the national framework for community mental health services. Our goal is to ensure the mental wellbeing and resilience of our population is maximised by delivering the right support/care in the right place at the right time. The initiative will include wrapping service around PCNs as appropriate, delivery of enhanced community based, early intervention support and stabilised specialist provision.

The life expectancy of mental health service users is 20-30% less, in terms of years lived, than the rest of the population. The gap in the Tees Valley ICP is higher than the national average, our goal is to reduce this premature mortality by enabling more people to have their physical health needs met through increased early detection and access to evidence based physical care, assessment and intervention. In the Tees Valley ICP we are committed to "Make Every Contact Count" and a brief interventions toolkit will support patient-facing services in engaging with clients around depression, generalised anxiety disorder, social anxiety disorder, alcohol use disorder, smoking cessation and gambling awareness.

Suicide is the leading cause of death for men aged 15 – 49 and women aged 20-34. Our ICP has an ambition to implement NENC ICS regional Zero Suicide Ambition strategy at a locality level to reduce the number of lives lost to suicide.

Half of all mental health problems are established by the age of 14 and 75% by 24 years, to this end the Partnership put forward an application and was successful in gaining a place on a CAMHS Whole Pathway Commissioning 'pilot' (one of only four successful pilot sites across the country). This pilot provides us with the opportunity to bring together specialised and non-specialised commissioning for the provision of children and young people's mental health services.

## **Learning Disabilities, Autism or both**

Adults with learning disabilities, autism or both are one of the most vulnerable groups in society, experiencing health inequalities, social exclusion and stigmatisation. In general, adults with learning disabilities, autism or both have greater and more complex health needs than the general population, and often these needs are not identified or treated. People with a learning disability, autism or both are four times more likely to die of something which could have been prevented than the general population.

Approximately a third of people with learning disabilities, autism or both currently in hospital have been in an inpatient setting for five years or longer. Life expectancy of this group is shorter than the general population adults often experiencing barriers to accessing healthcare services, and poor levels of care. They are more likely to die from a preventable cause than the general population.

Across the North East and Cumbria Transforming Care Programme Network 0.6% of the population were registered with a learning disability, the highest across the network being Tees Valley ICP.

Developing community-based services and support for people with a learning disability and/or autism has been a key priority for stakeholders within the Tees Valley ICP and we continue to progress the delivery of robust community alternatives to inpatient care for those people whose needs are more complex, with a focus on people living in their own homes receiving personalised care and support.

## **Local integration at place**

The NHS Long Term plan emphasises a shift of focus away from hospitals and towards community and primary care and sets out a new service model for the 21st century. Our goal is to increase the scale and integration of out of hospital services, based around communities and improved population health outcomes.

We recognise the significant importance of working at place and neighbourhood level with the added value of working at scale when this makes sense to do so.

Our ICP will build upon existing local place-based leadership and responsibilities of the clinical commissioning groups, to plan and arrange services for our populations. This will involve all 18 of our local primary care networks (GPs and other health and care professionals) and NHS foundation trusts, working with local authority and voluntary sector partners, in improving health and wellbeing through extending the reach and effectiveness of our services.

Our place-based approaches vary from place to place across the ICP based on the needs of the local population, the configurations of services that have historically been available and the relationships in place between the various health and care organisations.

While recognising that for most people their health and care needs are best met by integrated, place-based services, our NHS organisations are committed to working together 'at scale', where appropriate to harness our collective resources and expertise to make faster progress on improving health outcomes.

We want to maximise the value of the local 'health and care pound', to ensure we deliver seamless and high-quality care for patients and the public. Health and care services can make faster progress on tackling health inequalities and improving outcomes when different organisations work together at scale towards common goals such as in preventing cardio-vascular disease, or in working together on tobacco and alcohol control. Across the ICP we have jointly invested our Better Care Fund (BCF) in a range of initiatives that support delivery of the key BCF metrics, including working to reduce avoidable admissions, reducing delayed transfers of care and supporting a reduction in long term residential care placements. BCF continues to be a key tool in supporting the progression of our local Health and Social Care integration agendas.

The integration of primary care, social care and hospital care will be vital to the delivery of effective and high-quality services. Within our ICP we are progressing a number of approaches to local integration between health and social care including;

- In Hambleton, Richmondshire and Whitby work is progressing with North Yorkshire County Council to develop Integrated Locality Teams and redesign processes to deliver integrated discharge pathways and prevent hospital admissions. Significant progress has been made to date with the implementation of Three 'Discharge to Assess' pathways which include trusted assessment, joint assessment documentation to provide greater clarity and avoid duplication, and increased communication between health and social care. Progress has also been made in relation to Step Up/Step Down Care and in the development of an integrated end of life care pathway. Immedicare, a telemedicine system enabling 24/7 access to skilled multi-disciplinary health care teams, has been introduced into care homes and extra care housing facilities throughout HRW and consistently keeps patients at home in a crisis.
- In Middlesbrough and Redcar & Cleveland we have progressed work to develop a single place-based set of priorities overseen by the establishment of a single joint Health and Wellbeing Board. The approach has been underpinned by a joint Integration Team who are supporting progressing key initiatives such as delivery of BCF and transformation schemes and the implementation of PCNs. A new model of joined up place-based delivery for Health and Social care has been developed in partnership and we are now working to implement this across South Tees.
- In Darlington an Integration Board has been established between health and social care partners. This includes joint commissioning arrangements between health and social care and supports delivery of the Health and Wellbeing Board priorities and joined up services for residents. This incorporates the Darlington Healthy New Town programme that has successfully co-coordinated health and social care services with a particular emphasis on 'place', engaging the local community to shape the built environment and to align community-based health and care services including networked primary care, to improve outcomes and experience for residents.
- In Stockton we are developing a community pathfinder with health and social care partners to deliver an asset-based offer to address health

inequalities, wider determinants of health and improvement outcomes for residents. This work is underpinned by collaborative working across secondary care, community and social care partners within the ICP exploring innovative approaches to how we commission and provide services to our populations.

- In Hartlepool we are continuing to support the delivery of the Hartlepool Plan, developed collaboratively with the people of Hartlepool and the health and care agencies responsible for their care. Joint working across these health and care agencies, in conjunction with the newly emerging Primary Care Networks, will be a key success factor in delivering the plan.

## **Development of Primary Care Networks**

Our goal is to develop a strong and stable primary care that meets the aims of the Long-Term Plan through increased collaboration and integration across health, social care and VCSE. This will achieve seamless care and treatment for patients as close to home as possible from a diverse and motivated cross organisational workforce, underpinned by the use of digital technology as an enabler.

These networks will offer care on a scale which is small enough for patients to get the continuous and personalised care they value, but large enough in their partnership with others in the local health and care system to be resilient and ensure a whole systems approach. Through the development of Primary Care Networks and their involvement in the wider ICP this will ensure the delivery of more joined up care for the population including a population health focussed approach to both commissioning and delivery. The development of Primary Care Networks will improve closer working with clinical leads, networks of practices, Patient Participation Groups and the wider ICP including community, social care, voluntary and secondary care providers.

In the first year, Primary Care Networks will focus on establishing their foundations, including developing a wider set of workforce roles to support care needs and promote closer working with other local partners. Beyond this they will ensure delivery of the seven network services to their populations through working in a collaborative approach to delivery and workforce sustainability across the wider ICP foot-print.

## **Conclusion**

The Tees Valley Health and Care Partnership Board of the Tees Valley ICP brings together senior Executive leaders from across the system, representing the statutory partner organisations across the four CCG geographical boundaries.

This Board provides strategic leadership across the whole of the ICP, including the development and delivery of plans to progress operational and longer-term transformational priorities that build on our place-based plans and approaches.

The Board will oversee the alignment of these various place based, operational and transformational plans into a single overarching plan that will respond to, and address, our financial and operational performance.

## 9.4 North Cumbria Integrated Care Partnership (ICP)

### Introduction

In North Cumbria our health and care providers and commissioners are working in partnership with the County Council, the Third Sector and our community to develop an integrated care partnership. This means that instead of working just within our individual organisations, we are working together and collaborating across all parts of the health and care system to improve outcomes for our local population.

We have already started to make changes, responding to the needs of our communities. Many of the NHS Long Term Plan intentions reflect initiatives already underway here. Our local needs will help shape how we deliver other national priorities.

In 2016 we held our 'Healthcare for the Future' public consultation about some of the services where there were concerns about the sustainability and this has given us clear priorities. In 2018 North Cumbria was recognised nationally as a leading system for Integrated Health and Care.

We are working collaboratively with frontline staff and our communities who have ideas about how things could be better.

By working together, we have already made some real improvements such as:

- We have created eight Integrated Care Communities in North Cumbria where teams of Health and social care professionals, GPs, the voluntary sector and the community are working together as one team to support the health and wellbeing of local people. Their focus is to help people manage long term health conditions, improve access to information about healthier lifestyles and provide more care out of hospital so people can stay as well and independent as possible.
- We have developed a Delirium Reach Out Service (Reduce, Educate, Assess and Care with Hope). The service provides proactive management support and intervention, so our patients receive the best possible care.
- Preventing strokes - Cumbria Fire & Rescue Service is helping to detect Atrial Fibrillation (AF) - an irregular or fast heartbeat. Copeland Community Stroke Prevention project is holding community health checks.

Our health services, North Cumbria Integrated Care NHS Foundation Trust (formerly North Cumbria University Hospitals NHS Trust and Cumbria Partnership NHS Foundation Trust) and NHS North Cumbria Clinical Commissioning Group, have been making shared decisions and setting system priorities for some time. Sharing the challenges of finance, workforce and improvement has enabled us to remove the distraction of organisational priorities, helping us to focus our collective resources on patients and communities.

We are also working in partnership with Cumbria County Council to ensure our plans support the overarching aims of the ten-year Health and Wellbeing Strategy for Cumbria.

Working collaboratively with our out of hours GP service Cumbria Health on Call (CHOC), our 39 GP practices we are supporting our primary care networks. Our partners include; North West Ambulance Service (NWAS), community pharmacies, our vibrant Third Sector and our regulators NHS England / Improvement.

We are listening to our staff to help us innovate and improve the way we do things and we are building co-production as the way we involve our communities in our system improvement and development.

We have a lot to do to tackle historic and ongoing challenges, but we believe that by working together with our communities, we can ensure that North Cumbria will be the better place to 'Start Well, 'Live Well' and 'Age Well'.

As one of four integrated care partnerships in NENC ICS we are working closely with our partners recognising the benefits of an 'at scale' approach to those priorities to amplify the collective impact and reduce duplication. This ICP plan outline forms part of the wider NENC ICS strategic plan.

## **Health, Wealth and Wellbeing**

### **Climate Change & Sustainability**

Climate Change is now recognised as the biggest public health threat this century and there is a substantial body of evidence around how climate change is affecting our world. As a health and social care organisation, we recognise that climate change has significant implications for our current and future health and wellbeing.

Underpinning our strategic vision and aims are ten key priority areas which support the delivery of that vision, including *'engaging stakeholders, demonstrating leadership for SDMP, corporate and social responsibility and strategically positioning both NCUHT and CPFT services'*. The Trust has a genuine responsibility and opportunity to tackle climate change and influence the health and sustainability of our local community.

As one of the largest local employers, consumers and provider of goods and services, NCIC recognise the need and responsibility to undertake our activities in a way which minimises our environmental impact and ensures we have a wider impact as a Good Corporate Citizen on the local environment, economy and community.

Our Sustainable Development Management Strategy and plan sets out our key commitments, objectives and actions to improve the environmental sustainability of our organisations, deliver real bottom line savings through a combination of quick wins and spend to save carbon reduction initiatives. Underpinning this will be a combined Trust wide staff awareness and behavioural change campaign.

We are committed to working in partnership and maintaining a positive and on-going dialogue with our key stakeholders to deliver this strategy and the associated actions.

## **Workforce, Employment and Skills**

The workforce in North Cumbria is also the most valuable asset in health and social care and can be at the forefront of empowering people's independence, choice and improving their social inclusion and social wellbeing. Delivering this vision for North Cumbria requires a confident, capable, well-trained, motivated and engaged workforce.

We have difficulty in attracting people to work here and pursue their careers in the region. We also have an aging workforce, of which 3.15% could retire now and a further 15.73% within the next five years. Therefore, need to consider flexible job plans and roles to enable and encourage individuals to remain working here and be attracted to the area.

Our People Plan identifies the objectives which need to be achieved to ensure that we have the optimum number of the workforce, with the best mix of skills, to support our communities in 2025.

### **Prevention**

Working with all health and care partners we are building a population health system that focuses on prevention, supporting patients to make the right choices about their health and reducing variation in outcomes that exist across our communities.

The North Cumbria Population Health Steering Group has identified five prevention 'high impact' changes to help reduce the burden of the most prevalent conditions on health and care services:

- Improving stop smoking pathways for high risk groups.
- Establishing a weight management pathway for children and adults.
- Developing a physical activity pathway.
- Maximising the effectiveness of the NHS Health Check programme.
- Improving the management of Cardiovascular Disease risk factors.

These form part of a wider population health approach that also includes work to e.g. address the wider social determinants of health. All five high impact changes will directly support the developing social prescribing programme (and wider personalised care agenda) in North Cumbria (by strengthening the interventions and referral options for patients/clients into a range of community-based services).

In addition, over the next 18 months, North Cumbria Integrated Care Partnership will be providing population health management (PHM) training to staff involved in the eight Integrated Care Communities (following a successful bid to the Health Foundation's Applied Analytics Fund). This means there will be a legacy programme to help implement ongoing PHM work when involvement in accelerator programmes end.

## **Clinical Strategy and delivery of the Long-Term Plan requirements**

### **Collaboration across the ICP**

#### **RTT / Shorter planned care waits**

Primary and secondary care are collaborating in new ways with the introduction of two key programmes of work. An Advice and Guidance system has already been introduced, successfully improving the pathways of care for patients and reducing referrals to outpatient care. The Healthpathways system will also be implemented across North Cumbria in 2020/21, improving collaboration, providing clear pathways of care, further reducing variation in services and driving up the quality of referrals.

A number of interventions have been implemented in the community including; the musculo-skeletal service, focused on reducing referrals into the acute sector.

We are committed to delivery against GIRFT recommendations and use the Model Hospital data to drive improvements, enabling us to maximise our capacity by reducing variation and improving efficiency across our services.

#### **Developing Primary Care**

There is a plan to develop primary care significantly over the next five years by delivering:

- Personalised care including social prescribing.
- First contact physiotherapists already working in General Practice.
- The enhanced care home model.
- Healthpathways model improving the pathways between primary and secondary care.
- Population Health.
- Continue to develop strong partnership working through our Integrated Care Communities, working with; community services, hospitals, third sector social care, council services and other local services.
- Develop our primary care networks.
- The North Cumbria Advice and Guidance system has been a great success with GPs and reduced unnecessary referrals to secondary care. The use of this system will continue to expand and support GPs across the area.

## **Cancer**

Exciting work is ongoing between Newcastle upon Tyne Hospitals NHS Trust and North Cumbria Hospitals Trust to build and run the new Northern Cancer Centre in Carlisle. This will support the provision of:

- Better local services for the population of North Cumbria which comply with national service specifications for radiotherapy and chemotherapy, and deliver cancer waiting times (CWT) standards.
- A resilient, efficient and cost-effective clinical oncology service from a major Cancer Centre.
- A modern oncology centre on the Cumberland Infirmary site which integrates day case oncology services for WNE Cumbria.

A joined up and system working approach to prevention, early diagnosis and timely referrals/treatment of cancer across our North Cumbria Health and Care ICP provides significant opportunities to help us manage some of the issues and challenges that we face.

## **Mental Health**

Mental Health and Learning Difficulty services for adults and children in North Cumbria have experienced a number of long-standing challenges over the years which have not been sustainably addressed. From October 2019, Northumberland Tyne and Wear NHS Foundation Trust will become Cumbria Northumberland Tyne and Wear NHS Foundation Trust and will provide services in North Cumbria and across the entire ICS.

North Cumbria will make significant progress towards developing innovative and evidence based integrated pathways. These will have been developed by the people who use mental health and learning disability services and their families and carers and will be across all care provision to meet the physical health, mental health and wellbeing needs of our population.

We will have the right staff in the right place and in the right numbers. North Cumbria will be regarded as an excellent place to train and develop.

Mental health will be at the forefront of all decisions around strategy and spending in North Cumbria – there will be no health without mental health.

## **Stroke**

In North Cumbria ICP we are making significant changes to our secondary care and community stroke services. We will be rolling out a new Hyper Acute Stroke Unit at the Cumberland Infirmary Carlisle. Also, an Early Support Stroke Discharge (ESSD) service will cover the whole area and enable patients to receive the right support in the community.

## **Respiratory**

The aim for respiratory care is to move away from a reactive based treatment to a more proactive model of care delivery with the focus on prevention, conservative treatment and managing escalation within the community whenever appropriate.

We will bring Primary and Secondary care much closer together within the respiratory pathway where, for example, GPs will be increasingly supported by hospital-based consultants through the use of Consultant Connect and Advice and Guidance. Additionally, "Attend Anywhere" will facilitate the delivery of some outpatient activity in local communities making access for patients easier.

The delivery of pulmonary rehabilitation will change and will integrate the use of health coaches and trans-diagnostic education programmes which will provide support for a wider range of conditions.

## **Local integration at place**

We have created eight Integrated Care Communities in North Cumbria where teams of Health and social care professionals, GPs, the voluntary sector and the community are working together as one team to support the health and wellbeing of local people. Their focus is to help people manage long term health conditions, improve access to information about healthier lifestyles and provide more care out of hospital so people can stay as well and independent as possible.

Below are some of the specific changes that we plan to deliver to support local integration in our communities:

- Further develop ICCs to include mental health, muscular treatment service and children's services.
- Develop pathways of care for patients that join together primary, community and secondary care, improve quality and experience.
- Communities will be involved in shaping future services, linked to developing thriving communities.
- Utilise technology to monitor people's health at home and develop interventions and target disease areas across communities.
- An increase in use of the Third Sector and social prescribing.
- Primary Care Networks (PCNs) delivering significant changes to how care is provided in communities.

Our Better Care Fund will continue to support the progression of integration across Health and Social Care in North Cumbria, with a focus on reducing avoidable hospital admissions, reducing delayed hospital discharge and helping people to stay well at home. There will be continued support for our Integrated Care Communities (ICCs). ICCs are the vehicle for delivering integration at place, with more joined up support in our communities, close to where people need it.

## **Conclusion**

Our ICP has three core strategic aims and four strategic enabling aims as per the below. These set the foundation for delivery of new health and care future based on: The NHS Long Term Plan and a full and comprehensive engagement with our partners, residents and communities.

### **North Cumbria ICP Strategic Aims:**

1. Improve the health and care outcomes of our local communities and support people of all ages to be in control of their own health.
2. Build health and care services around our local communities.
3. Provide safe and sustainable high-quality services across our sparsely populated area.

### **North Cumbria ICP Strategic Enablers:**

- A. Be a great place to work and develop.
- B. Integrate how health and care organisations work together.
- C. Live within our means and use our resources wisely.
- D. Deliver digitally enabled care.

## Section 10.0 ICS Financial Strategy

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### 10.1 Introduction

The overarching system financial strategy is designed to ensure all organisations within Cumbria and the North East return to a more sustainable financial position over the medium term and that the ambitions of the ICS, including delivery of national priorities are met.

The ICS, through ICPs, has a key role in supporting organisations to collectively drive financial sustainability, improve productivity and monitor performance. ICPs will be the vehicles through which the financial strategy is developed and driven at local level, with the ICS having a key role in ensuring all parts of the system work effectively together to deliver the overall strategy.

### 10.2 ICP Financial summary

In 19/20, the overall ICS system financial plan highlighted a £72m deficit position. If the plan is met, the system will access national sustainability and recovery support funding of £115m which would enable delivery of a £43m system surplus.

Whilst most organisations are on track to achieve plans, significant risks to delivery in year are evident within two ICPs, namely in the South and North Cumbria. Both systems have a history of financial challenges and the inherent underlying financial deficits will take time and significant support to resolve. Loss of sustainability and recovery support funding for organisations which do not achieve plan will place further pressure on finances. Access to this funding will be critical to alleviating the significant cash pressures evident within certain organisations within the patch.

Looking ahead to 20/21, the ICS is expected to improve the underlying deficit position by c£11m to £61m. Current plans indicate the majority of organisations within the patch will be able to meet trajectory, with the exception of four organisations in the North and South ICPs. Further work is ongoing with those organisations and with the ICPs to determine how the residual gap of c£25m across those organisations will be closed. National financial recovery support of £78m has been indicatively allocated to Cumbria and the North East.

Consolidated plans demonstrate that, with the right support and by delivering the strategy set out, our system should return to overall balance by 23/24. This ambition is however clearly underpinned by very high-level planning assumptions and an ambitious efficiency programme.

More work is required within all ICP communities to develop the detailed implementation plans in support of organisational and system strategy delivery. Further work is required at organisational, ICP level and across the ICS to consider how financial sustainability will be achieved and maintained over the longer term and to what extent mutual aid and support may be provided through local risk share arrangements to enable the broader ICP and ICS to deliver trajectories.

## 10.3 System Investment

Allocations have been published for the five-year period for CCGs, specialised commissioning and primary care.

In addition to these core allocations, the Long-Term Plan signalled significant national investment funding to be allocated to Integrated Care systems to fund a number of national initiatives associated with Cancer, Primary Care, Mental Health, Ageing Well and other programmes. The ICS will benefit from c£22m in 19/20, rising to c£96m in 23/24, alongside other targeted funding and will be responsible for maintaining oversight of the application of this national programme funding.

Plans for 20/21 and 21/22 in particular also/assume access to CCG reserves through drawdown of historic surpluses. This is a key enabler in plans and will be required to ensure transformation of services to achieve a more sustainable longer-term service and cost base.

The Long-Term plan signals an ambitious agenda to improve and transform services. Specific priority investment areas for CCGs and Specialised Commissioners over the five-year period are outlined below and include:

- Delivering new service models – focusing on population health with support for collaborative approaches towards making a shared, single set of integrated commissioning decisions.
- Cancer – faster diagnostic standards and safer tests, investment in diagnostic imaging, advanced radiotherapy and immunotherapy techniques. Investment in a new Cancer Centre in Cumbria.
- Mental Health - investment to meet the MH Standard to include new integrated models, ending out of area placements and upgrading the physical environment. Additional mental health bed capacity supporting the Mental Health Service Review including the Northumberland, Tyne and Wear FT STP/ICS capital investment programme.
- Reconfiguration and additional neonatal cot capacity.
- Development of a Paediatric Palliative Care Service and co-location of the Paediatric CHD service.
- Healthy childhood – 50% reduction in neonatal mortality by 2025, specialist pre-term birth clinics, high quality perinatal mental health, redesign neonatal critical care services and expanding mental health services for children and young people.
- Learning disability and autism – improve health and wellbeing and reduce waiting times for specialist services.
- Cardiovascular – preventative treatments for high risk conditions, better support through primary care networks and saving lives of people suffering cardiac arrest.
- Personalised medicine and genomics.

- Prevention, long term conditions and equity of access – focus on gender dysphoria, mechanical thrombectomy, hepatitis C and HIV.
- Rollout of additional Operational Delivery Networks (Congenital Heart Disease (CHD), Radiotherapy, Children’s and Teen and Young People’s Cancer, Paediatric Critical Care and Surgery).
- Investment in ageing well – responsive community services.
- Meeting the Community Investment Standard i.e. further developing services in Primary, Community & Continuing Healthcare.
- Ringfencing of primary care delegated funding and further investment in Primary Care Networks (PCNs) – Continued funding at £1.50 per head of population for PCN development from core CCG funding and GP Extended Access.
- 0.5% Contingency requirement generating c£28m headroom annually for pressures

#### 10.4 Improving Efficiency and productivity

The system efficiency requirement to achieve the planned trajectories is estimated at c£1bn over the 5-year period from 19/20 to 23/24.

Commissioner efficiencies are estimated at £327m over the five years from 19/20, reducing from 1.7% in 19/20 to c1% per annum by 23/24. Provider efficiency requirements are £676m over the five-year period estimated at 3.4% in 19/20 reducing to 2% by 23/24.

Whilst longer terms efficiencies will be challenging to achieve the ICS has a strong focus on a number of key themes in relation to driving productivity and efficiency opportunities. The ICS level diagnostic highlights the 3 following drivers behind system variation:

- Prevention and Detection.
- Care of the Elderly.
- Urgent and Emergency Care.

The ICS Model Hospital, Rightcare and GIRFT analysis has shown that further opportunities exist within workforce and productivity; however, such efficiencies are very site / provider specific.

Whilst detailed plans for 20/21 will take time to develop, key system wide initiatives are being progressed in the following themes:

## **Clinical integration of services and pathway redesign**

The ICS recognises significant opportunities exist in working together to deliver at scale solutions and integration of services and improved pathways are key tenets of our clinical and financial strategy. In addition to reconfiguration of services to reduce duplication across hospital sites, managed clinical networks are being established to support vulnerable services. The creation of managed clinical networks has also enabled us to support services in Cumbria, creating a stable workforce and reducing locum dependency. Other acute hospital initiatives such as reconfiguration of pathology services to one specialist centre and two hubs will generate significant savings.

A focus on mental health pathways is also evident across NENC with delivery through community productivity programmes. Redesigning pathways with a single point of access, assessment clinic models, packages focussed on therapeutic interventions and supporting people to recover in their own communities are all key themes. Considerable success has been achieved through New Care model partnership working across NENC with secondary mental health providers managing care budgets for tertiary mental health services. CYP has already delivered significant savings to fund enhanced Community and Crisis Teams and savings are now being realised through providers taking lead responsibility for reviewing Continuing Health Care packages.

## **Prevention, demand and capacity initiatives**

By enhancing clinical engagement through the Right Care, GIRFT and Model Hospital programmes we have realised reductions in bed occupancy in certain areas, notably in respiratory disease. Similar programmes in Rheumatology and Dermatology will radically change delivery models, reducing dependency upon the senior medical workforce and maximising care through primary care networks. The ICS is focussing on management of patient demand through better education, investment in prevention and streamlining of primary and community care through development of PC Networks, Integrated Care Communities and New Care Models. Tackling urgent and emergency care growth remains a key challenge for the ICS

Key efficiency schemes include strengthening the interface between primary, community and specialist staff with the aim of moderating and reducing demand in secondary care. Telephone advice lines, outpatient service reforms, reducing inappropriate activity in diagnostic and pathology costs, focusing on promoting self-care and transforming community services to reduce unwarranted variation in acute admissions and providing care in more appropriate settings are key themes.

## **Focus on workforce**

The ICS is developing a workforce strategy which will focus on greater staff productivity – improving the availability and deployment of clinical workforce, including e-rostering and e-job planning standards. This will include “Bank First” initiatives, reducing locum costs, hourly rates, maximising apprenticeship levy benefits and innovative new skill mix models and generic care workers. Workforce challenges invariably have excessive locum/agency spend and core to the strategy

is to introduce measures to enable the movement of clinicians to network across sites via a clinician passport.

### **Better medicines management and better management of long-term Continuing Health Care packages**

Medicines optimisation schemes are aimed at driving standardisation and use of generics, Biosimilars and alternative medicines such as Avastin. Reducing waste, better management of repeat prescribing and reducing over the counter medications in line with NHSE guidance are also key themes.

Stemming growth in long term CHC packages remains an ongoing issue – however standardising approaches, closer working between health and social care, improving discharge to assess rates and peer review are all helping to manage back costs appropriately.

### **Back office, admin, estate and procurement savings**

Significant back office and corporate administration savings will be delivered in both the commissioner and provider sectors and all CCGs will achieve the required 20% admin cost reductions by 20/21 through direct cost reduction and through working with our CSU to rationalise support costs. Significant benefits are also anticipated nationally from the introduction of the new provider-based procurement arrangements and a continued focus on rationalisation and management of NHS Estate is a key initiative.

### **Greater use of technology**

Our digital strategy places a clear focus on transformative technology and continuous improvement to deliver productivity gains year on year. In specialities such as radiology and haematology we are implementing a digital solution enabling the electronic transfer of images between sites, enabling clinicians to report remotely and maximising the flexibility of the workforce.

## **10.5 System Financial management and support**

Given the complexity and longer-term nature of the plan, there are a number of significant financial risks and uncertainties. The most significant being the ability of all organisations to continue to drive recurrent efficiencies to meet the £1bn requirement over the long-term plan timeline in the face of growing demand, workforce and capacity pressures, coupled with the unknown financial impact of Brexit.

We are working in collaboration to drive a system response to the financial challenges we face and to take the necessary actions to achieve financial sustainability within the resources available. As an ICS, we have agreed a set of principles for working together which include adopting a transparent, open-book approach to financial planning, in year reporting and a collective approach to financial risk management. ICP plans have been developed with agreed common financial planning assumptions but tailored to local priorities and circumstances.

Working within our ICS, each ICP has regular forum to discuss and agree financial plans and in year performance issues. Local financial governance and accountability arrangements have been established within each ICP and principles associated with management of risk have been agreed.

The ICS has a strategic co-ordination role and will oversee both the development and achievement of system plans to deliver the Long-Term plan ambition. In the event that the ICPs are unable to support delivery of locally agreed financial plans, the ICS has a clear role in negotiating broader system solutions across the wider NENC system within the flexibilities available at system level.

## 10.6 Capital

Access to capital will be a key constraint for NENC as it is for all systems. Plans currently estimate the need for £1.2bn of capital investment over five years from 19/20. The ICS is currently developing proposals to minimise the capital requirement and to understand in the context on ongoing resource constraints how resources are appropriately managed within allocations.

The ICS is now better placed to understand its capital and financing requirements and is working together to ensure we have a coherent strategic forward capital plan that links clearly to our ICS Estate and Digital strategies.

We are looking at a number of ways to make more efficient use of the estate and equipment currently available within the patch to reduce the need for further investment. For example:

- Through managed clinical networks and service reconfiguration we are seeking to reduce duplication of provision across sites. This approach potentially allows for better utilisation of estate and reduces the need for capital expenditure on equipment, moves clinicians to patients and enables alternative means of assessment and follow up to be implemented.
- Improved utilisation of NHS Estate through promoting disposal of surplus land, energy efficiency, reductions in void costs, maximising and rationalising clinical space utilisation. Critical to this, we believe, is capitalising on the opportunity to bring back, on a larger scale, the properties currently under the control of NHS Property Services and we are seeking to build a credible outline case to support this.
- Moving from traditional capital funding solutions to managed service provision where appropriate, for example managed solutions for the provision of medical and diagnostic equipment.

## Section 11.0 Delivering the Plan

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### 11.1 Delivery infrastructure

The NENC ICS plan can only be delivered through collaborative working between health and social care with strong clinical leadership and ongoing meaningful engagement with people and stakeholders as well as efficient use of financial resources to support transformation.

The ICS governance arrangements described earlier in this document provide the architecture to make decisions and monitor the delivery of the LTP and other local commitments. The governance arrangements are still developing, and the proposed ICS Partnership Assembly will have a key role in shaping priorities going forward.

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*‘The individual priority programmes have an identified senior responsible officer.’*

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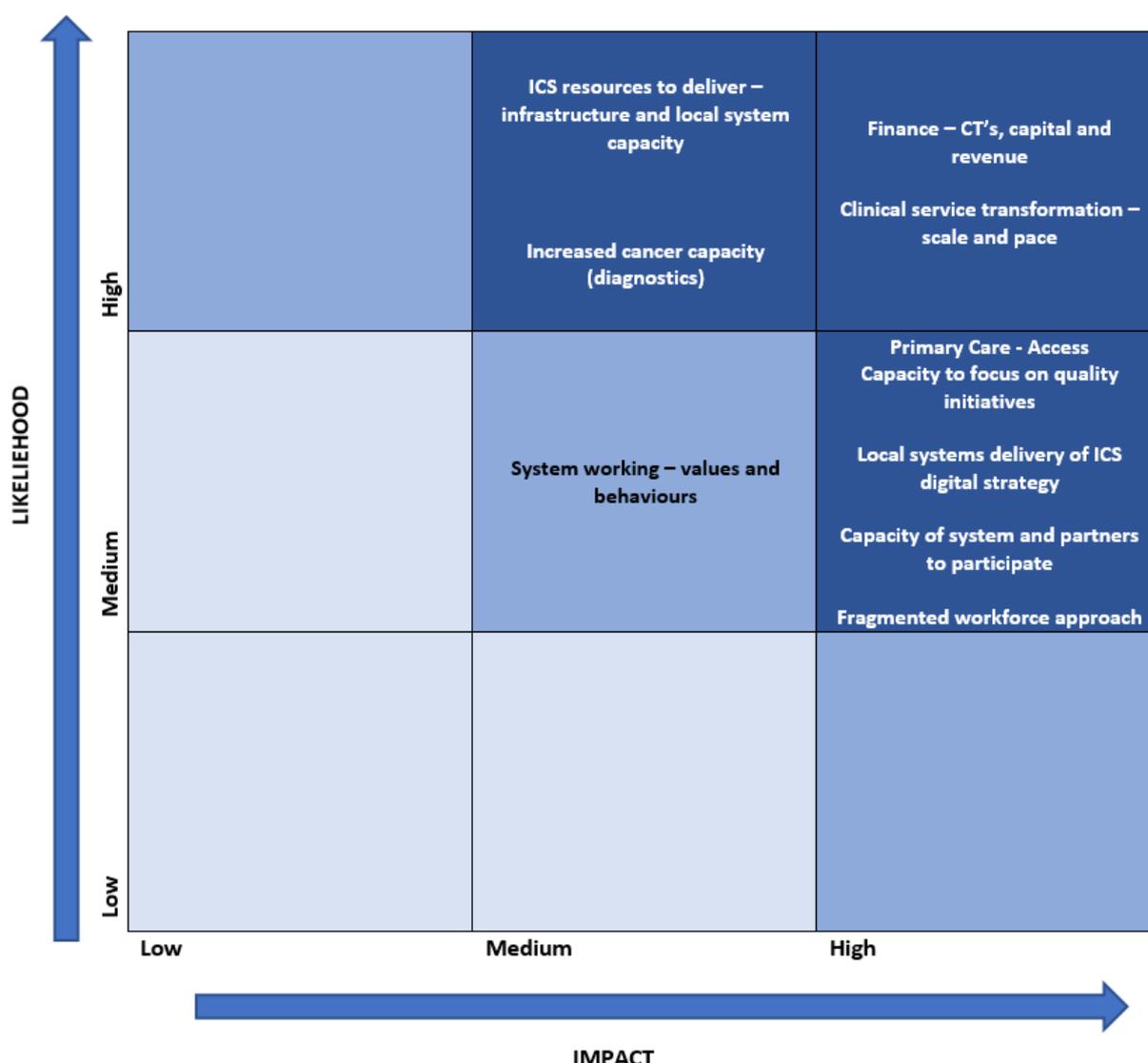
The ICS Management Group will maintain overall oversight of the plan and will consider any specific areas by exception where there are risks to delivery; the group is well placed to determine if a system intervention is needed to support delivery.

Importantly the individual priority programmes have an identified senior responsible officer and a form of steering group made up of a range of people from across the health and care system. These groups provide clinical leadership and play an important role in maintaining oversight of the delivery of their workplan and can provide expertise and support where relevant. Many of these programme groups have well established and long-standing arrangements.

### 11.2 Systematic approach to delivery and risk management

A risk register will be used as part of the ICS programme management arrangements to track known any emerging risks to delivery that are escalated by the ICS workstreams to ensure that system wide mitigating actions are quickly put in place to reduce the risk of non-delivery. Individual programme risks have been identified with mitigating actions and these are included in the programme executive summaries in Appendix 3.

Early work has identified the following potential high-level risks:



### 11.3 Performance and key metrics

As part of the ongoing monitoring of the implementation of the Long-Term Plan in NENC, we will use the Long-Term Plan metrics and 20 headline measures included in Appendix 1 and 2 to ensure our plan is on track.

As previously described each of the programme executive summaries include operating framework metrics and other local metrics.

Underpinning the ICS working programmes, we continue to operationally monitor and develop service delivery performance working with partners to support improvement. In many instances, the ICS performance continues to be stronger than the national average across England, however it is becoming increasingly difficult to sustain this performance in the context of increasing demand and workforce pressures. There are several challenging areas that are important to patients/carers and require special attention:

- Urgent and Emergency Care - A&E four-hour standard.
- Cancer 62 day waiting time standard.
- Referral to treatment time 18 week standard.
- Waiting list.
- Diagnostics 6 week waiting time standard.
- Improving access to psychological therapy (IAPT).
- Learning disabilities inpatient care.

As a system we are committed to improve performance in these areas whilst progressing delivery of the long-term plan commitments.

## Section 12.0 Permissions, Freedoms and Flexibilities – National Support

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### 12.1 Becoming a thriving ICS: our asks of the system

We believe that our ICS has strong collaborative and inclusive system leadership, with a track record of delivery, and supported by transparent and robust governance, with multi-professional leadership aligned around the system and system working closely with health and wellbeing boards.

We have put in place dedicated clinical and management capacity and infrastructure to execute system-wide plans, supported by an ICS financial framework that will allow us to manage our resources collectively and share financial risk.

Given our ambition and commitment to system working, we are keen to explore with national regulators and arm's length bodies what opportunities there are to:

- Secure greater influence over the ICS financial framework and devolve multi-year capital allocations to our ICS to support local prioritisation.
- Secure a modest amount of pump priming funding to incentivise system improvement.
- Embed regional resources within our system to operate under the direction of the ICS.
- Devolve workforce funding and responsibility for system facing workforce transformation, supporting local innovation projects alongside national mandates.
- Transfer of NHS Property Services properties to support our estates strategy.
- Ensure that any guidance on commissioning models allows for local flexibility, and the importance of maintaining local relationships.
- Devolve more control over specialised commissioning to avoid pathway fragmentation.
- Influence the future model of organisation and system assurance, working with NHSE/I so that our system can move to the most advanced stage of oversight progression - i.e. self-assurance, with clear communication and relationships with regional team.

## Section 13.0 Conclusion: A New Way of Working

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As the Long-Term Plan sets out this new way of working will draw together people and capabilities, resources, activities and leadership to collectively deliver greater value for the whole health and care system and its patients and service users.

This 'revitalised culture of support and collaboration' will be underpinned in our ICS by a new approach, with a move away from a reliance on arms-length regulation and performance management to drive service improvement, towards a collaborative, system-wide approach based on shared accountability and mutual aid.

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*'Our ICS is built on strong and effective providers and commissioners.'*

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We think that our ICS is well placed to ensure that the NHS as a whole can secure the best value from its combined resources, with multi-level leadership at Board, Governing Body and local system ICS level for adopting standards of best practice and making our contribution to critical national improvement programmes.

Our ICS is built on strong and effective providers and commissioners, accountable for the quality of care they provide for patients and for the financial resources and staff they manage. But alongside this it is only through working collaboratively, both within the NHS and with our partners, that we can make faster progress on improving population health, and ensure the ongoing quality, affordability and equitable access to health and care services across the whole of NENC.

# Appendices

## Appendix 1: Foundation Commitments

Long term plan Foundation Commitments	Metrics	ICS workstream
Primary and community services: annual implementation milestones for 5-year GP contract; new community services response times.	Percentage of overall NHS revenue spent on primary medical and community health services.	
	GP contract / Primary Care Network Patient reported access measure – measure to be confirmed*.	Optimising Health
	Community rapid response 2 hour/2 day measure to be confirmed.	
Comprehensive ICS coverage.	Percentage of population covered by ICS.	
Emergency care: on agreed trajectory for Same Day Emergency Care.	Percentage of non-elective activity treated as Same Day Emergency Care cases.	Optimising Health
Prevention: increase uptake of screening and immunisation.	Population vaccination coverage – MMR for two doses (5 years old).	Population Health Management & Prevention
	Bowel screening coverage, aged 60-74, screened in last 30 months.	
	Breast screening coverage, females aged 50-70, screened in last 36 months.	
	Cervical screening coverage, females aged 25-64, attending screening within target period (3.5 or 5.5 years).	
Inequalities: inequalities reduction trajectory.	Measure that reflects the inequalities focus of local plans – measure to be confirmed.	Population Health Management & Prevention
Prevention: Alcohol care teams, tobacco treatment services, and diabetes prevention programme.	Coverage of ACTs – percentage of hospitals with the highest rate of alcohol dependence-related admissions with ACTs in place.	Population Health Management & Prevention
	Number of people supported through the NHS Diabetes Prevention programme.	
	Percentage of people admitted to hospital who smoke offered NHS funded tobacco treatment services.	
Maternal and Children's health: On agreed Trajectory for 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025.	Reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury, based on MBRRACE data.	Population Health Management & Prevention

Improve cancer survival: on agreed trajectory so that 75% of cancer patients diagnosed at stage 1 or 2 by 2028.	Proportion of cancers diagnosed at stages 1 or 2.	Cancer
	Proportion of people that survive cancer for at least 1 year and 5 years after diagnosis.	
Learning disability and autism: on agreed trajectory for halving inpatient rate by 2023/24 and increasing learning disability physical health checks to 75% of people over 14.	Reliance on specialist inpatient care for people with a learning disability and/or autism.	Learning Disabilities, Autism or both
	Proportion of people with a learning disability on the GP register receiving an annual health check.	
Mental health: on track for locally agreed service expansion, and increase in investment for mental health services as a share of the NHS budget over the next five years, worth in real terms at least a further £2.3 billion a year by 2023/24.	Number of people accessing IAPT services.	Mental Health
	Number of children and young people accessing NHS funded mental health services.	
	Mental health access standards once agreed.	
	Percentage of overall NHS revenue funding spent on mental health services.	
Implementation of agreed waiting times.	Percentage of patients in A&E transferred, discharged or admitted within four hours.	
	Percentage of patients starting cancer treatment within 62 days of GP referral.	
	Percentage of patients with incomplete pathway waiting 18 weeks or less to start consultant led treatment.	
	Patients waiting more than 52 weeks to start consultant-led treatment.	
	Elective waiting list size.	
Workforce metrics will be agreed through development of the NHS People Plan.	Staff retention rate.	Workforce
	Proportion of providers with an outstanding or good rating from the CQC for the "well led" domain.	
	Workforce diversity measure to be agreed.	
	Number of GPs employed by NHS.	
	Number of FTEs, above baseline, in the Primary Care Network additional role reimbursement scheme.	
	Nurse vacancy rate.	
Staff well-being measure to be agreed as part of the People Plan.	Workforce Transformation	

	Sickness absence.	Workforce
Outpatient reform: Avoidance of up to a third of outpatient appointments (including outpatient digital roll out).	Percentage reduction in the number of face to face outpatient attendances.	Optimising Health
Empowering People: Summary care Record roll out, EPR roll out.	Proportion of population registered to use NHS App.	Digital
Access to online/telephone consultations in primary care.	Proportion of the population with access to online consultations.	Digital
	Access to general practice appointments.	
The NHS will return to financial balance.  NHS in overall financial balance each year.	Percentage of organisations in financial balance.	Finance
	Aggregate forecast end of year financial position of providers, commissioners and NHSE central budgets against agreed budgetary limits.	
The NHS will achieve cash-releasing productivity growth of at least 1.1% per year.	Total Cash releasing productivity growth (covering secondary care, mental health and community providers initially).	Finance
The NHS will reduce growth in demand for care through better integration and prevention.	Cost weighted non-elective activity growth.	Optimising Health
The NHS will reduce variation in performance across the health system.	Measure on reduction in unwarranted variation achieved by the NHS.	Optimising Health
The NHS will make better use of capital investment and its existing assets to drive transformation.	[Metrics to support this test to be confirmed following the Spending Review and the development of the new NHS capital regime].	Optimising Health

## Appendix 2: Long Term Plan Headline Metrics

Indicator Ref	Programme	Indicator Name	Granularity
E.D.16	Digital	Proportion of the population with access to online consultations.	CCG
E.D.20		Citizen facing tools: Proportion of the population registered to use NHSApp.	CCG
E.D.21		Cyber Security.	CCG, Provider
E.A.3	Mental Health	IAPT roll-out.	STP
E.H.12		Inappropriate adult acute mental health Out of Area Placement (OAP) bed days.	Provider
E.H.13		People with severe mental illness receiving a full annual physical health check and follow up interventions.	STP
E.H.15		Perinatal Mental Health: Number of women accessing specialist perinatal mental health service.	CCG
E.H.16		Mental Health Liaison services within general hospitals meeting the "core 24" service standard.	Provider
E.H.17		Number of people accessing Individual Placement and Support.	STP
E.H.18		EIP Services achieving Level 3 NICE concordance.	CCG
E.H.19		Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illnesses.	STP
E.H.20		Coverage of 24/7 crisis provision for children and young people.	CCG
E.H.9		Improve access to Children and Young People's Mental Health Services (CYPMH).	CCG
E.K.1c	LD/Autism	Reliance on inpatient care for people with a learning disability and/or autism - for both care commissioned by CCGs and NHS England for children.	TCP
E.K.1a		Reliance on inpatient care for people with a learning disability and/or autism - adults - CCG Commissioned.	CCG
E.K.1b		Reliance on inpatient care for people with a learning disability and/or autism - adults - Spec Com commissioned.	CCG
E.K.3		Learning Disability Registers and Annual Health Checks delivered by GPs.	CCG

E.M.23	UEC	Ambulance Conveyance to ED.	Provider
E.M.24		Delayed Transfers of Care.	STP
E.M.25		Length of stay for patients in hospital for over 21 days.	Provider
E.N.1	Personalised Care	Personal Health Budgets.	CCG
E.N.2		Social Prescribing Referrals.	CCG
E.N.3		Personalised Care and Support Planning.	STP
E.P.1	Cancer	One Year Survival from Cancer.	Cancer Alliance
E.P.2		Proportion of cancers diagnosed at stages 1 or 2.	Cancer Alliance
E.Q.1	Maternity	Stillbirth rate.	LMS
E.Q.2		Neonatal mortality rate.	LMS
E.Q.3		Percentage of women placed on a continuity of care pathway at booking appointment.	LMS
E.Q.4		Brain Injury Rate.	STP
E.R.1	Diabetes	Number of people supported through the NHS Diabetes Prevention programme.	STP
E.S.1	Stroke	Proportion of patients directly admitted to a stroke unit within 4 hours of clock start.	STP
E.S.2		Percentage of applicable stroke patients who are assessed at 6 months.	STP

### Appendix 3: Programme Executive Summaries

The following are programme executive summaries for the ICS programmes of work.

- Population Health Management and Prevention
- Mental Health
- Learning Disabilities, Autism or both
- Workforce
- Digital Care
- Optimising Health Services
  - Maternity
  - Child Health and Wellbeing
  - Primary Care
  - Radiology
  - Pathology
  - Cardiology
  - CVDP & Vascular
  - Diabetes
  - Respiratory
  - Stroke
  - Cancer
  - Frailty
- Urgent and Emergency Care

## APPENDIX 3.1 POPULATION HEALTH MANAGEMENT AND PREVENTION

**Population Health Management & Prevention SROs:** Peter Kelly, Centre Director for the North East, Public Health England; Stephen Childs, Managing Director, NECS

**Programme Management Support:** Emma Roycroft, NECS; Lisa Dodd, NECS

**Chair of the Prevention Board:** Dr Guy Pilkington, Newcastle GP and Clinical Lead for Prevention, Newcastle Gateshead CCG

### Why is change needed?

Across the North East and North Cumbria (NE&NC) ICS footprint we are proud of our high quality and frequently high performing public health, health and care services, yet our population is ageing, living longer in ill health and stubborn health inequalities persist.

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

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

### Planned impact of our ambition

- Reduced health inequalities and unwarranted variation in health outcomes through stronger action by all of the NHS partners at a local level (NHS Trusts, primary care, PCNs, CCGs) to deliver actions contained within Joint Health and Wellbeing Strategies and Health and Wellbeing Boards. This will include the transparent use of the CCG health inequalities funds and work programmes of PCNs.
- Collective action at ICP and ICS level (where appropriate), working with a range of partners across all ICS workstreams (e.g. ARC), to make evidence-based interventions to improve healthy life expectancy.
- Build on our existing successes across the ICS, to develop a whole systems approach for tobacco, alcohol, obesity and sexual health.
- For the NHS to be able to clearly articulate their role in tackling the wider determinants of health, for example through action on air pollution, their contribution to the local economy, improved access to employment for those from highest areas of deprivation, and promotion of green spaces to increase physical activity.
- Build the capacity of our population to self-care including embedding social prescribing across the system.
- Increase public health capacity and skills (including MECC and brief interventions) within the NHS in order to support the move from reactive care towards a model of NHS services that embodies population health.
- Make full use of the excellent data resource available to identify, inform and deliver at scale, the most effective evidence-based systematic interventions to improve population health in line with our ambition and priorities – this is our PHM approach.

### Our ambition

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

#### By 2025

**We will have reduced adult smoking prevalence to 5% or below.**

#### By 2029

**We will raise the average healthy life expectancy for men and women to a floor target of 60 years.**

#### By 2029

**We will halve the gap in average healthy life expectancy for both men and women between the NECS ICS and the England average.**

# APPENDIX 3.1 POPULATION HEALTH MANAGEMENT AND PREVENTION

## Strategic priorities and timeline

	2020/21				21/2	22/2	23/2
	Q1	Q2	Q3	Q4	2	3	4
<b>Tobacco/Smokefree NHS</b>							
All NHS Trusts to implement Smokefree NHS NICE Guidance (PH48) by Q1 2020/21							
Develop and implement a strategy to treat tobacco dependency in primary care							
Establish NHS maternal smoking cessation services for expectant mothers and their partners with a new smoke-free pregnancy pathway including focused sessions and treatments (to be led by the LMS, working closely with Local Authorities)							
Establish an integrated tobacco treatment offer to all smokers admitted to hospital							
Develop a new universal smoking cessation offer as part of specialist mental health services for long-term patients and in learning disability services							
Drive forward action on COPD for smokers through the newly formed respiratory network							
Ensure the NHS understands the breadth of tobacco harm and is supportive of evidence-based population levels to drive down prevalence							
<b>Alcohol</b>							
Identify clinical champions and agree a regional programme of work with partners from NHS, Local Authorities, voluntary and community sector, patients and their families to reduce the harm caused by alcohol							
Ensure the NHS understands the full breadth of harm that alcohol causes by the development of a primary prevention plan which enhances social marketing activity and advocates for action on price, promotions and availability and ensures every child has a future free from alcohol related harm							
Ensure the NHS continues to embed alcohol screening and brief interventions, and that every Acute Trust has an Alcohol Care Team (ACT) which are part of the integrated treatment pathway within the community							
<b>Workforce</b>							
Continue to scale up activity and embed a model of Making Every Contact Count (MECC) across the ICS							
Increase NHS and Local Authority participation in the evidence-based and nationally-recognised Better Health at Work Award (BHAWA)							
Increase the number of Consultants in Public Health working in Foundation Trusts across the North East and North Cumbria and maximise the opportunities presented by the investment in public health skills working across the NHS, Local Authorities and Public Health England (PHE)							
Support a PHE-funded GP Clinical Champion so that the NHS workforce can increase understanding of work as a health outcome							
<b>Communication and Engagement</b>							
Undertake a programme of engagement with staff and the public around prevention, looking at changing the narrative from illness and treatment, to health and wellbeing including developing a set of recommendations for training, communications and further engagement							
Develop an ongoing programme of work with staff and the public in line with the recommendations from this engagement project							
<b>Social Prescribing</b>							
Support local system leaders to develop and deliver shared local social prescribing plans including an ICS Social Prescribing plan							
Support the embedding of social prescribing link workers into Primary Care Networks across the region							
<b>Population Health Management</b>							
Develop a system-wide, consistent understanding and interpretation of Population Health Management (PHM)							
PHM system embedded across the ICS with the infrastructure, processes, capabilities and capacity to deliver PHM in place							
Following identification of key stakeholders across the ICS, develop an Operational group, an ICS-wide Steering group and a PCN PHM Development group to implement a PHM approach across the ICS, aligned to and linking with the Prevention Board	X	X					
Undertake test-bed and proof of concept work on PHM for specific work areas of tobacco addiction as part of an NHS smoke-free model, reducing alcohol-related harm, and the ABC of cardiovascular disease. Exploring within each area the impact of deprivation and all work examined through the lens of reducing the inequality in healthy life expectancy (these areas meet the priorities and ambitions of the ICS LTP and the Prevention Board)	X						
Following test-bed work above and an ICS CVD pilot, agree future priorities for PHM and keep under review	X	X					
Support to geographical areas (PCN, Place, ICP, ICS) to assess local population by risk of unwarranted health outcomes and working with the relevant components of the system to make support available to people where it is most needed							
Evaluation of approaches and identification of opportunities for further development							
<b>Interdependencies</b>							
Support effective mechanisms to ensure the interdependencies with other areas of work across the ICS are maximised (such as CVD Prevention Network maximising use of NHS Health Checks; LMS supporting increase in breastfeeding rates)							

## APPENDIX 3.1 POPULATION HEALTH MANAGEMENT AND PREVENTION

### Strategic priorities and timeline (continued)

	2020/21				21/2	22/2	23/2
	Q1	Q2	Q3	Q4	2	3	4
<b>Obesity</b>							
Organise an event across the ICS in partnership with the Cancer Alliance to share the whole system approach to obesity (Durham), the development of the healthy weight plans for NTW and TEVV for people with SMI and LD and the pilots in North Tyneside and Middlesbrough to reduce adult and childhood obesity							
Ensure the physical activity champions (x4) funded by PHE provide a systematic training package to NHS staff working across FTs and primary care and promote the new CMO guidance on physical activity amongst staff and patients							
Identify funding to develop PCN pilot sites to explore and test the specific 'input' and 'outputs' and the associated costs and benefits of an enhanced weight management support offer for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+							
Contribute to the National Diabetes Prevention Programme (NDPP) rate by establishing a target number of referrals for each PCN in NENC for the NDPP							
Share the progress from the 1b CQUIN (17-19) and support the implementation of new hospital food standards (published in 2019) to ensure patients, staff and carers have access to healthy food							
Ensure all front-line staff feel equipped to talk to patients about nutrition and achieving a healthy weight in an informed and sensitive way							
Consider inclusion of adult obesity as a future Prevention Board priority, particularly looking at weight management within a system approach							
<b>Air Pollution</b>							
Ensure at least 90% of the NHS fleet will use low-emission engines (including 25% Ultra Low Emissions) by 2028							
Ensure primary heating from coal and oil fuel in NHS sites is fully phased out							
<b>Antimicrobial resistance</b>							
Continue to support implementation and delivery of the government's new five-year action plan on Antimicrobial Resistance							
<b>Stronger NHS action on health inequalities</b>							
We will develop and implement a plan to set out how we will specifically contribute to a reduction in health inequalities by 2023/24 and 2028/29, which will include targeted action in areas of high deprivation as well as opportunities for the NHS to contribute to the wider determinants of health							
<b>Sexual health</b>							
Teesside is the only place in the country to co-commission sexual health services between LAs (x4), CCGs (x2) and NHSE and is highlighted nationally as a model of good practice. We will share this approach with partners across the ICS							

## APPENDIX 3.1 POPULATION HEALTH MANAGEMENT AND PREVENTION

### Key performance metrics to track delivery

#### Operating framework measures

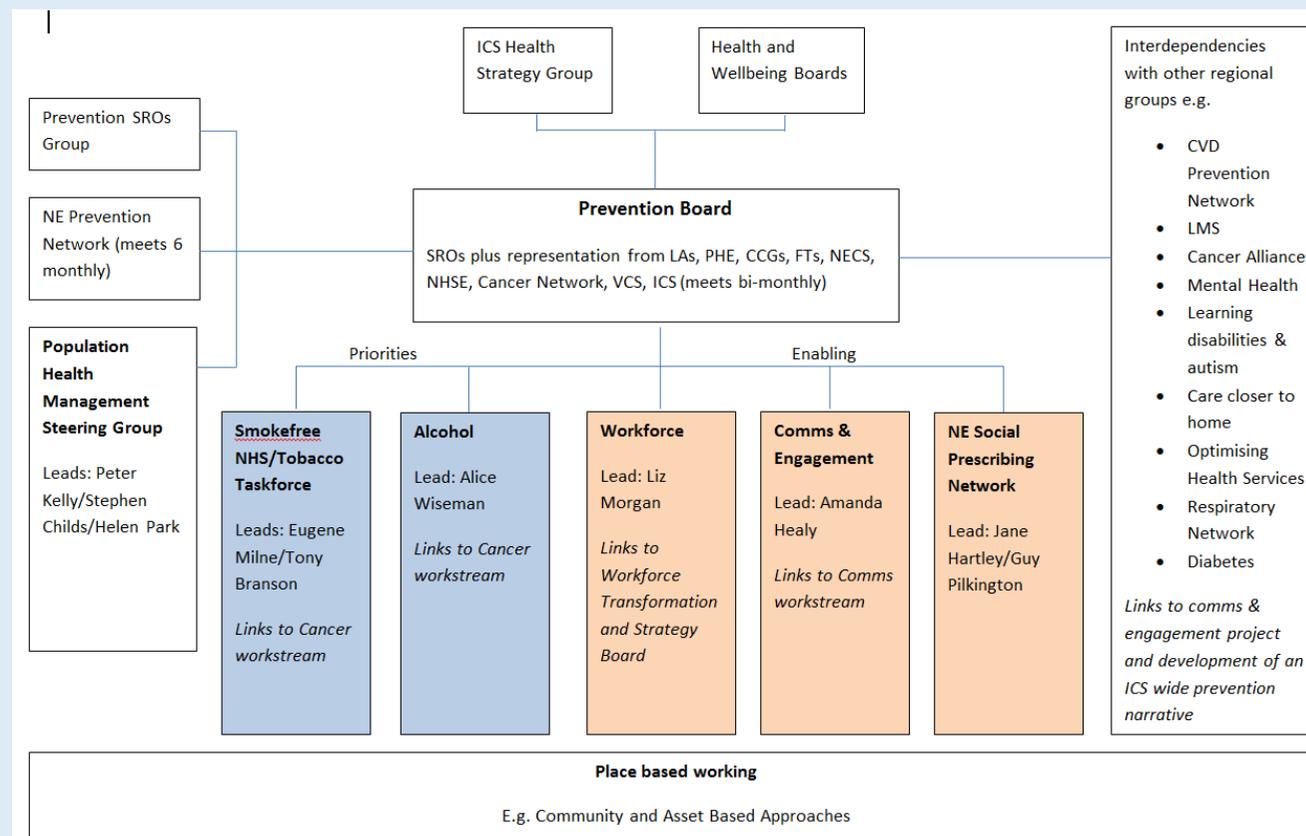
- Inequalities: inequalities reduction trajectory - Measure that reflects the inequalities focus of local plans – measure to be confirmed.
- Prevention: Alcohol care teams, tobacco treatment services, and diabetes prevention programme.
- Coverage of ACTs – percentage of hospitals with the highest rate of alcohol dependence-related admissions with ACTs in place.
- Number of people supported through the NHS Diabetes Prevention programme.
- Percentage of people admitted to hospital who smoke and who are offered NHS funded tobacco treatment services.

#### Other/local measures

- Adult smoking prevalence to reach 5% by 2025.
- PCNs supported to assess their local population at risk of unwarranted health outcomes and to work with local community services to make support available to people where it is most needed by 2020/21.
- Further specific measures around PHM to be added once priorities are agreed.

### Prevention Board priorities

The 2 priority areas and 3 enabling task groups provide updates via the Prevention Board. The Board reports escalating risks and issues to the NENC Health Strategy Group. Prevention Board Network events to be held regularly to bring together wider stakeholders to reflect on progress and support future action. Population Health feeds into the Prevention Board meetings.



## APPENDIX 3.1 POPULATION HEALTH MANAGEMENT AND PREVENTION

### National deliverables and allocated resource

#### National milestones

- By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services and there will be clear referral pathways into community services, including primary care.
- The above model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway across the ICS which is being developed by the LMS and will include focused sessions and treatments.
- A new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.

#### Finance and resource requirements (inc staffing)

- Allocations for all STPs and ICSs, from 2021/22, for the phased implementation of NHS smoking cessation services for all inpatients who smoke, pregnant women and users of high-risk outpatient services.
- Funding will be required to support the development of Alcohol Care Teams in secondary care, using funding from their clinical commissioning groups (CCGs) health inequalities funding supplement.
- NECS surplus to support the expansion of public health capacity in Foundation Trusts, Trusts to pick up funding for posts after first year.
- Cancer Alliance provides funding for Clinical Lead for Tobacco as well as short term funding for Alcohol Clinical Lead, Tobacco Project Lead and Alcohol Project Lead posts.

#### Infrastructure support to the Population Health and Prevention workstream

- 0.2 wte NECS Commissioning Delivery Manager.
- 0.2 wte NECS Senior Commissioning Development Manager.
- 0.2 wte PHE Health and Wellbeing Programme Lead.
- Strategic Smokefree NHS Manager (Funded until March 2021 by Cancer Alliance).
- Strategic Alcohol Manager (Currently being recruited – 12 month post funded by Cancer Alliance).
- Tobacco Clinical Lead (Cancer Alliance funded).
- Alcohol Clinical Lead (Currently being recruited – Cancer Alliance funded).

## APPENDIX 3.1 POPULATION HEALTH MANAGEMENT AND PREVENTION

### Interdependencies with other ICS and regional workstreams

Workforce	Mental Health
<ul style="list-style-type: none"> <li>• A Director of Public Health and PHE Deputy Director for Workforce are members of the ICS Workforce Transformation and Strategy Board.</li> <li>• Ensure MECC programme links with wider regional workforce plans.</li> <li>• Ensure screening and brief interventions for tobacco and alcohol are embedded into workforce plans.</li> <li>• Findings from the Prevention engagement work with staff around 'changing the narrative' need to feed into the Workforce workstream.</li> <li>• Build social prescribing skills into strategic workforce development plans.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure regional Suicide Prevention group is aligned with local plans in each Local Authority area.</li> <li>• Ensure staff mental health and wellbeing is part of workforce strategies.</li> <li>• Ensure MECC includes mental health and wellbeing.</li> <li>• Tobacco/Smokefree NHS Taskforce to work closely with Mental Health leads to develop a universal stop smoking offer as part of specialist mental health services.</li> <li>• Ensure the needs of people with dual diagnosis (MH &amp; drug/alcohol) are included within planning.</li> </ul>
Cancer	Optimising Health
<ul style="list-style-type: none"> <li>• The Cancer Alliance is a member of the Prevention Board to ensure plans are aligned.</li> <li>• The Cancer Alliance provides financial support for the Smokefree NHS initiative including clinical and project lead posts.</li> <li>• A clinical lead from the Cancer Alliance is co-chair of Tobacco/Smokefree NHS Taskforce.</li> <li>• The Cancer Alliance has agreed to provide financial support for any agreed alcohol initiatives including clinical and project lead posts.</li> <li>• The Cancer Alliance will assist the delivery of MECC recommendations – e.g. screening.</li> <li>• The Cancer Alliance is leading the delivery of an obesity event and will support subsequent actions.</li> <li>• The Cancer Alliance is the lead on cancer screening.</li> </ul>	<ul style="list-style-type: none"> <li>• Links to LMS and Smoking in Pregnancy programme.</li> <li>• Development of Smoking Cessation services in secondary care.</li> <li>• Development of Alcohol Care Teams in secondary care.</li> <li>• Links into Clinical Networks.</li> <li>• Development of PHM offer to Primary Care Networks.</li> </ul>
Learning Disabilities and Autism	Digital
<ul style="list-style-type: none"> <li>• Tobacco/Smokefree NHS Taskforce to work closely with Learning Disability and Autism leads to develop a universal offer for long-term users of specialist learning disability services.</li> <li>• Work with ICS Learning Disabilities and Autism Leads to identify opportunities for closer working.</li> <li>• Weight Off Your Mind Plan is focused on people with SMI and LD. Need to ensure community leisure providers are able to support and increase access for people with SMI and LD.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure our digital work can help to connect citizens and professionals to 'community assets' and local voluntary sector services.</li> <li>• Work with ICS Digital Leads to identify opportunities for closer working.</li> <li>• The Great North Care Record strategy to include a PHM system.</li> </ul>
CVD Prevention Network	Respiratory Network
<ul style="list-style-type: none"> <li>• Work with the CVD Prevention Network to reduce the prevalence of cardiovascular disease by focusing on their priorities of cholesterol, atrial fibrillation and blood pressure.</li> </ul>	<ul style="list-style-type: none"> <li>• Network currently being established and interdependencies to be agreed.</li> </ul>

## APPENDIX 3.1 POPULATION HEALTH MANAGEMENT AND PREVENTION

### Risks and mitigating actions

Risks	Mitigating actions
Fresh (Tobacco Control Office) and Balance (Alcohol Office) are only funded by 7 of the ICS LAs.	The tobacco and alcohol Programme Lead posts have been funded by the Cancer Alliance to work across the ICS.
Existing data available for PHM is not fully utilised and opportunities for improving population health are missed.	This risk will be reduced by: strong support from the ICS for the PHM approach; fully engaged system leaders supportive of the PHM approach; collaborative leadership to fully engage key stakeholders and maximised engagement. The Prevention Board is key to all of these mitigating approaches.
Alcohol Care Teams will be prioritised to the top 25% of hospital sites with highest percentage of alcohol dependency admissions. We believe this should be triangulated with data on alcohol specific, alcohol attributable (rates) and unmet need data.	We are currently reviewing the data to ensure the rationale for an ACT is fully understood, that we build on ACTs where they still exist and ensure the pathways into community services (funded by Local Authorities) are in place.

### Implications for operational planning 2020/21

The development of Alcohol Care Teams in secondary care will require financial resource which will need to be funded by CCGs in some areas. Targeted funding from 2020/21 for ACTs in top 25% for alcohol dependency related admissions.

The provision of services in areas with high obesity rates and deprivation (prioritising those areas where there are no existing free at the point of access services i.e. tier 2 or 3 weight management services) will need to be funded by CCGs in some areas. Targeted funding for 2020/21 and 2021/22 for a small number of pilot sites to test and refine an enhanced weight management support offer.

## APPENDIX 3.1 POPULATION HEALTH MANAGEMENT AND PREVENTION

### Partner organisations

Partner organisations on the Prevention Board	Prevention network includes:
<ul style="list-style-type: none"><li>• NHS representatives from North, Central and South ICPs</li><li>• 4 Director of Public Health representatives, one from each ICP</li><li>• NHS England and NHS Improvement (NENC)</li><li>• Public Health England (NE)</li><li>• Cancer Alliance</li><li>• Mental Health representative</li><li>• Voluntary and Community Sector representative</li><li>• NECS</li><li>• NE Applied Research Collaborative (ARC)</li></ul>	<ul style="list-style-type: none"><li>• 12 CCGs</li><li>• 8 secondary care providers</li><li>• All NENC Local Authorities</li><li>• NHS England and NHS Improvement (NENC)</li><li>• Public Health England (NE)</li><li>• Cancer Alliance</li><li>• 2 Mental Health Trusts</li><li>• Voluntary and Community Sector</li><li>• NECS</li><li>• Fresh</li><li>• Balance</li></ul> <p>Wider Partners</p> <ul style="list-style-type: none"><li>• CVD Network</li><li>• Respiratory Network</li><li>• NHSE/I regional team</li><li>• LMS</li></ul>

**SRO:** Alex Morton, Regional Director of Primary Care and Public Health Commissioning

**Programme management support:** TBC

### Why is change needed?

The screening and immunisations services commissioned by our team are an important contributor to the prevention agenda, where these programmes are in place to reduce avoidable mortality and morbidity from a range of diseases and conditions.

In many of these programmes there is:

- Need for improvement in uptake, so that the preventative benefits of the programmes can be realised by a greater part of the population.
- Need to identify, understand and address unwarranted variation in uptake.
- Need to modernise and improve processes and ensure they are safe.

### Planned impact of our ambition

- Reduce or eliminate the incidence of vaccine preventable diseases.
- Detect (or prevent) cancers early to reduce mortality and burden of treatment required.
- Reduce deaths from rupture of abdominal aortic aneurysms.
- Reduce avoidable sight loss from retinopathy.
- Ensure that serious conditions for new-borns are detected and managed or avoided.
- New / modernised services are introduced to improve detection/patient experience/cost effective use of NHS resources.
- Maximise patient awareness choice for our programmes.

### Our ambition

#### By 2020

Implement an \*HPV (\*human papilloma virus) vaccination programme for boys

Implement \*HPV Primary cervical screening.

Implement bowel \*\*FIT (\*\*faecal immunochemical test) screening test.

#### By 2021

Identify and reduce variation in GP Practice vaccination coverage.

Contribute to regaining measles elimination status in the UK.

#### By 2028 to 2038

Contribute to national eradication of cervical cancer through screening and vaccination.

Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Implement FIT for bowel cancer screening</b>									
The programme which commenced in June 2019, will be embedded and made sustainable through:									
- Team support, advice and contracting to BCSP providers to increase endoscopy capacity to meet the demand of the new screening FIT test.									
<b>Implement HPV vaccination programme for 12/13-year-old boys</b>									
- Team support, advice and contracting to School based immunisations providers to deliver the new programme as per the team action plan.									
<b>Implement the new HPV primary cervical screening while mitigating the transitional capacity problems in the incumbent lab areas</b>									
- Oversee and closely support the mobilisation of the robust implementation plans for the new North East and Yorkshire Lab.									
- Proactively monitor the capacity and mitigations action plans of the incumbent labs and take further action as necessary.									
<b>Complete and share/embed the lessons of the audit of new-born infant examinations</b>									
- Complete the audit, share & agree the findings provide a report and associated communications.									
- Take commissioning and S&I team actions to ensure the improvements are embedded in our services.									
<b>Improve flu vaccination uptake rates in specific target groups</b>									
- Implement and evaluate the reminder "letter" initiative for 2 & 3-year olds.									
- Support all the maternity services to fully implement and then evaluate the midwifery flu vaccination delivery.									
- Work with CCG (and local authority) partners to reduce practice level variation and maximise flu uptake.									
- Extend the delivery of flu vaccinations to include all primary aged children via school-based immunisations programme.									
Commission providers to implement flu vaccinations to a variety of target groups.									
<b>MMR Vaccinations</b>									
- Evaluate the "ages 5-19" intervention through GP practice and determine next steps working with local partners in local authority, CHIS and CCGs.									
- Determine if a school-based programme for MMR catch-up is viable and then implement as necessary.									
- Measure and report on the take-up of the GP system "alert flag".									
<b>Bowel Scope Screening</b>									
- Given the priority of implementing Fit screening, support and commission services to complete implementation of bowel scope.									
<b>Improve vaccine uptake by identifying and addressing areas and practices with low uptake</b>									
- Improve monitoring systems which enable timely identification of the areas/practices.									
- Undertake direct work with practices, CCGs and partners to improve the uptake.									
<b>Commission services to be ready and then safely deliver "2 yearly screening" in Diabetic Eye Screening</b>									
<b>Commission Child Health Information Services to fully meet the information responsibilities within of the Digital Child Health Strategy and Health Child programme</b>									

**National deliverables**

**National deliverables** (\* - key to terms)

- By 2020 Human Papilloma Virus (HPV) primary screening for cervical cancer will be in place across England.
- By 2019 implement Faecal Immunochemical Test (FIT) for Bowel Cancer Screening.
- By 2020 implement the HPV Vaccination Programme for Boys.
- Health inequalities and unwarranted variation.
- Proactive prevention.
- Population health – moving to ICS.
- Improving cancer outcomes.
- Improve performance of childhood screening and immunisation.

**Interdependencies with other ICS workstreams**

Optimising Health	Workforce
<ul style="list-style-type: none"> <li>• Pathology configuration and workforce.</li> <li>• Breast imaging workforce.</li> <li>• Endoscopy workforce.</li> <li>• Prevention and Population Health Management.</li> <li>• Local Maternity systems.</li> <li>• Links with wider system to ensure alignment and promotes integration.</li> </ul>	<ul style="list-style-type: none"> <li>• Link with workforce programme to address challenges in breast imaging, endoscopy, ophthalmology and pathology configuration.</li> <li>• Support workforce development through Making Every Contact Count (MECC), to increase public health capacity in Acute Trusts.</li> </ul>
Prevention and Population Health Management	Digital
<ul style="list-style-type: none"> <li>• Optimising health.</li> <li>• Mental health.</li> <li>• Learning disabilities and autism.</li> <li>• Population health &amp; prevention.</li> <li>• Digital.</li> <li>• Workforce.</li> </ul>	<ul style="list-style-type: none"> <li>• NHS Digital Child Health Transformation Programme.</li> <li>• Acting as a conduit between ICS workstream and national IT/Digital programme changes across screening and immunisation programmes, e.g. Diabetic Eye, and Ante-Natal New-born Screening.</li> </ul>

## Risks and mitigating actions

Risks	Mitigating actions
Workforce – external – across most S&I programmes there are significant national and local workforce pressures, e.g. Primary Care: GPs, vaccinators and cervical screeners; Secondary Care: Breast Imaging, Cancer Pathology, Endoscopy and Ophthalmology.	Links with Health Education England. Action planning and Demand & Capacity forecasting. Robust commissioning and support, including across wider stakeholder groups, e.g. CCGs and Local Authorities.
Workforce – internal – Team capacity to address and lead on the full range of commissioning and public health requirements laid out above, especially work to address inequalities.	Maintain full staff contingent within budget. Work with partners, e.g. CCG/LA. Support integrated commissioning; links with wider system to ensure alignment and promotes integration.
Managing delivery and consequences of concurrent, multiple significant large-scale programme changes on regional footprint: to embed and others to procure and implement.	Programme/project management approach and aligning team resources to mirror demands. Engagement with ICS workstream leads.
Competing LTP priorities.	ICS governance structures for escalation and priority agreement.

## Key performance metrics to track delivery

## Operating framework measures

- Population vaccination coverage – MMR for two doses (5 years old).
- Bowel screening coverage, aged 60-74, screened in last 30 months.
- Breast screening coverage, females aged 50-70, screened in last 36 months.
- Cervical screening coverage, females aged 25-64, attending screening within target period (3.5 or 5.5 years).

## Other/local measures

- In accordance with national standard KPIs and uptake rates for the relevant programmes above.

## APPENDIX 3.3

# MENTAL HEALTH

### Mental Health SROs:

John Lawlor, Chief Executive of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust  
Dr David Hambleton, Chief Officer for South Tyneside NHS Clinical Commissioning Group

### Programme Management Support:

Gail Kay, Mental Health ICS Programme Director, Vicky Donegan, Business Manager, North of England Commissioning Support

## Why is change needed?

- The North East has some of the highest rates of mental illness in England.
- Half of mental health problems are established by the age of 14, 75% by 24 years.
- 1 in 4 adults are diagnosed with mental ill health at some stage in their life.
- There is a significant inequality gap within communities across our localities, more people from our deprived communities die younger and their quality of life is worse than what it should be when compared to the local, regional and English averages.
- This inequality increases for those with mental illness, life expectancy is 20-30% less than the rest of the population. The gap in the North East and North Cumbria is higher than the national average.
- There is an ageing population in North East and North Cumbria - in people over 65 years 7% have dementia, 28% have depression - the rate of depression is higher than the England average.
- Suicide is the leading cause of death for men aged 15 – 49. Among women aged 20-34, suicide is the most common cause of death.
- Only 8% of people on CPA are in employment.
- Poor mental health can drive a 50% increase in physical care costs.

## Planned impact of our ambition

Our strategic objectives:

**1.Regional oversight and monitoring of the mental health delivery objectives outlined in the NHS LTP - The 7 priority area work plans have been mapped to align with the delivery of the NHS LTP.**

**2.Implementation of accessible, integrated mental health care and support systems that reduce the impact on primary care and acute services.**

- Joint mental health commissioning across public sector organisations.
- Integrated arrangements to oversee regional bids to maximise the impact of investment, reduce the risk of duplication and inequality of provision.

**3.Enable and support a flexible workforce equipped to deliver the ambitions of the NENC mental health work plan.**

A shared understanding of, and planning in response to, the population needs profile of the North East and North Cumbria region has shaped delivery objectives:

- Reduce the number of children falling behind the rest of England in educational attainment, this increases their risk of mental illness.
- Reduce the high proportion of young people experiencing adverse childhood events
- Enable people with persistent physical health problems to live their lives in the most effective way.
- Reduce the premature mortality of people living with severe mental illness by enabling more people to have their physical health needs met.
- Reduce the high levels of substance misuse, particularly for people suffering with their mental health.
- Reduce the high rates of emergency hospital admissions for people with dementia and mental health needs.
- Reduce the number of people who self-harm, particularly those with repeat incidents.
- Implement the NENC ICS regional Zero Suicide Ambition strategy to reduce the number of lives lost to suicide.
- Implement innovative whole system prevention and early identification with a needs-led focus on multi-morbidity that recognises older persons needs.
- Increase the number of people with mental health needs in employment, education or volunteering through IPS and exemplar employer scheme.
- Joint mental health commissioning across public sector organisations.
- Integrated arrangements to oversee regional bids to maximise the impact of investment, reduce the risk of duplication and inequality of provision.
- Improving the culture of thinking of systems and systems leadership in terms of key systems leader's roles', responsibilities' and principles'.

## Our ambition

### By 2020

We will have well established multi agency working groups in place that will have clear plans aligned to the delivery of the ICS MH Strategic Objectives.

### By 2021

We will be able to demonstrate measurable progress against delivery plans that will ensure accessible, integrated mental health care and support systems will be in place.

### By 2028

We will have needs led services in place to address the population health needs and wellbeing of our communities. This will be achieved through joint commissioning arrangements and a flexible, skilled work force.

Strategic priorities and timeline	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Strategic Priority 1 - Regional oversight and monitoring of the mental health delivery objectives outlined in the NHS LTP</b>									
<b>Transform Children &amp; Young People’s Services to Improve Mental Health and Wellbeing</b>									
Working group to progress ‘Scaling up integrated care’ (resilience, crisis & packages of care) across health, social care, education and the voluntary sector, using tools such as the evidenced-based ‘iThrive’ operating model									
Use of the Future in Mind data dashboard’s clinical and social outcome measures (working group to pilot its use)									
Joint agency Local Transformation Plans (LTPs) aligned to STP plans are in place and refreshed annually									
Comprehensive 0-25 support offer that reaches across mental health services for CYP and adults in all STPs/ICSs by 2023/24									
100% coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions									
CYP mental health plans to align with wider delivery plans , such as Learning Disabilities									
<b>Enable People with Persistent Physical Symptoms to live their lives in the most effective way</b>									
IAPT Long Term Conditions Service in place (maintaining current commitment) year-on-year									
Designing a whole systems model, that includes LTC, for Psychological Therapies, Multiagency Workshop - developing solutions and proposal for the region									
Development of a LTC & PPS model that includes best practice									
Education and training roll out – development of an online, interactive training solution for LTC & PPS									
<b>Optimising Health - enable people with mental health needs to access the right care at the right time</b>									
24/7 adult Crisis Resolution and Home Treatment Teams operating in line with best practice – progress requests for equitable funding across region									
All acute hospitals will have mental health liaison services that can meet the specific needs of people of all ages									
Roll-out of mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response in line with clinical quality indicators									
Review of evidence base and positive practices to progress innovations across system and inform place based actions									
24/7 age-appropriate crisis care via NHS111.									
Complementary crisis care alternatives in place in each STP/ICS									
Increase access to mental health expertise to improve parity of esteem across care pathway through joint working with acute services to improve patient care outcomes and reduce the impact of high intensity service users.									
<b>Optimising Health Services (Maternity and paediatrics) – increased access to specialist perinatal mental health support in the community or inpatient mother and baby units</b>									
Maternity Outreach Clinics in all STPs/ICSs									
Pathway structure in place; ensuring prioritised access to IAPT, referrals to Perinatal Mental Health Team via any professional outlined in algorithms									
Extended period of care from 12-24 months in community settings through the development of community hubs, that will include midwife, obstetrician, mental health team, health visiting etc.									
Evidence-based assessments for partners offered and signposting where required									
Gap analysis across the region to understand where teams need to be developed via Wave 2 funding									
Training plan and competency framework in place to address the large geographical area and limited specialist resource									

Strategic priorities and timeline continued	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Older People ICS working group</b>									
Depression - identification in older people and suitable responses.			■	■	■	■			
Crisis services - rapid holistic (physical and mental health) response to deterioration. Standards and best practice.			■	■	■	■			
Consider and act on the views and needs of carers			■	■	■	■			
CCG ambitions to achieve 66.7% dementia diagnosis rate and increase in access to treatment	■	■	■	■	■	■			
<b>Improving the physical health of people in receipt of treatment for a mental health or learning disability condition ICS working group</b>									
Communications - Increase awareness of need to improve Physical Health including public/service users/carer/commissioners/primary care			■	■	■	■			
Increase in people receiving care in new models of integrated primary and community care for people with SMI			■	■	■	■			
Increase in the number of people with SMI receiving physical health checks								■	■
<b>Employment - increase in education, training, volunteering and employment opportunities for people with mental health</b>									
Increase in people with SMI accessing Individual Placement and Support services								■	■
<b>Zero suicide ambition</b>									
Localised suicide reduction programme rolled-out across all STPs/ICSs								■	■
Suicide bereavement support services across all STPs/ICSs								■	■
<b>Strategic priority 2 - Implementation of accessible, integrated mental health care and support systems that reduce the impact on primary care and acute services</b>									
Joint mental health commissioning across public sector organisations	■	■	■	■	■	■	■	■	■
Integrated arrangements to oversee regional bids to maximise the impact of investment, reduce the risk of duplication and inequality of provision.	■	■	■	■	■	■	■	■	■
<b>Strategic Priority 3 – Enable and support a flexible workforce equipped to deliver the ambitions of the NENC mental health work plan</b>									
The mental health steering group will work collaboratively with the ICS work force leads, commissioners, provider organisations, HEE and other partners to inform a system workforce implementation plan	■	■	■	■	■	■	■	■	■

**National deliverables and allocated resource**

**National deliverables**

Strategic priorities and timeline section and key performance metrics section highlights the requirement for regional oversight and monitoring of the mental health delivery objectives outlined within in the NHS LTP:

- Specialist Community Perinatal Mental Health Children & Young People’s Mental Health.
- Adult Common Mental Illnesses (IAPT).
- Adult Severe Mental Illnesses (SMI) Community Care.
- Mental Health Crisis Care and Liaison.
- Therapeutic Acute Mental Health Inpatient Care.
- Suicide Reduction and Bereavement Support.
- Problem Gambling Mental Health Support.
- Rough Sleeping Mental Health Support.

The national deliverables and timeline have been mapped to the 7 priorities identified by the mental health steering group and monitoring arrangements are in place.

**Finance**

- There has to date been no allocated ICS budget for the mental health programme. The ICS work programme delivery has been supported through the initiation phase by partner organisations via contributions of staff time (dedicated roles and contributions to collective delivery meetings) and funding for workshops and engagement events. A financial report of investment has been prepared for the mental health operational group.
- The Mental Health Steering Group is working closely with CCGs to agree the Mental Health Investment Standard allocation and support transformation bids; this includes support for wider investment to improve pathways.

STP priority areas	Funding source	Lead commissioners	Amount allocated
<ul style="list-style-type: none"> <li>• Child Health</li> <li>• Zero Suicide Ambition</li> <li>• Employment</li> <li>• Optimising Health Services – Mental Health</li> </ul>	Transformation Funding	All NENC CCGs	£17,504,721

Interdependencies with other ICS and regional workstreams

Prevention	Learning Disabilities and Autism
<p>Mental health links in place with Prevention leads – MH work plan underpinned by Prevention priorities; information sharing and feedback structures in place via representation at key meetings.</p>	<p>Mental health links in place with work stream leads –shared work plan priorities identified; information sharing and feedback structures in place via representation at key meetings.</p>
Workforce	Digital
<p>Representation at work force leads meeting; progress reviews via MH operational group. Structures to manage work force agenda from MH perspective are emerging. Oversight and support role recognised.</p>	<p>Digital opportunities in context of mental health need further scoping and evaluation; digital representative on MH steering group (board) – bespoke meeting arranged to progress working arrangements.</p>
Optimising Health Services	
<p>Links in place via representation at OHS board. OHS MH subgroup reporting to OHS board; position paper completed and presented to align plans and inform ICP developments.</p>	

### Key risks/challenges to the delivery of the mental health programme

#### Implications for operational planning 2020/21

- Uncertainties with regards to funding to ensure continued delivery.
- Information sharing to support seamless pathways across services.
- Consistent reliable data to inform progress and ensure continued momentum and engagement.
- Workforce.

Risks	Mitigating actions
Information / data sharing.	Concerns escalated via programme leads meeting – NECS regional delivery unit progressing regional information sharing arrangements: awaiting update.
Resource to support mental health work streams and task and finish groups.	Year 1 expenditure report completed to inform investment requirements – resource request submitted via ICS Health Strategy Group: Project manager confirmed August 2019 – March 2020. Awaiting confirmation re additional resources and funding for current posts.
Consistency and reliability of data.	Multi agency work shop with NECS business intelligence team to inform mental health plan – ongoing work occurring, follow up meetings arranged to develop pathway data sources.
Managing work force implications.	Strategic objectives agreed by work force board – work plans now progressing via multi agency leads meeting. Mental health work shop arranged to progress work force planning (4th October).
Long Term Plan - possible additional priority areas.	Mapping report completed to align LTP required outcomes to 7 ICS MH priorities; priority group reviewing and including in delivery planning. Discussion regarding gaps occurring via MH ICS operational group.
Roles, responsibilities and authority to act.	Role of the ICS Mental Health Steering Group is to influence and support the delivery of the standards set out in the NHS Long Term Plan, however, the statutory NHS bodies remain accountable for the delivery of the performance targets.
Restructure at NHSE / I leading to uncertainty with regard to resources to support delivery via oversight and priority working groups.	Communication regarding impact of changes to current resource commitments: awaiting outcome of consultation.

Partner organisations

Partner organisations	Network
<ul style="list-style-type: none"> <li>• People who use services</li> <li>• ICP leads</li> <li>• Primary care and emerging PCN CD's</li> <li>• NHS England and NHS Improvement (NENC)</li> <li>• Public Health England (NE)</li> <li>• Health Education England (NE)</li> <li>• 12 CCGs</li> <li>• 8 acute providers</li> <li>• Specialised Commissioning</li> <li>• All 15 local authorities</li> </ul>	<ul style="list-style-type: none"> <li>• VCS</li> <li>• Supporting organisations – NECS</li> <li>• National organisations aligned to 7 priorities, for example, Zero Suicide Alliance, Age UK</li> <li>• Schools, colleges and universities</li> <li>• ARC / FUSE</li> <li>• ICS priority area work stream leads</li> <li>• Police, ambulance and fire services</li> <li>• Prisons</li> <li>• Chamber of commerce / employers</li> <li>• Third sector providers</li> </ul>

## APPENDIX 3.4 LEARNING DISABILITIES, AUTISM OR BOTH

**Learning Disabilities, Autism or both SRO:** Nicola Bailey, Chief Operating Officer, Durham Dales, Easington and Sedgefield CCG and North Durham CCG  
**Programme Manager:** Patricia Churchill, NHS England/ Improvement

### Why is change needed?

People with a learning disability, autism or both and their families who live in North Cumbria and North East (NCNE), have told us things need to change and population data sources provides evidence of why change is needed

People with a learning disability, autism or both tell us they want to be valued and respected equally as citizens with human rights. They want to be active members of their local communities, have friends and family around them, be healthy and have a home and employment opportunities.

People with lived experience tell us they are unable to access health services in the same way as other people and people are dying too young. They want to see a reduction in health inequalities and preventable deaths.

When using health and wellbeing services, experts by experience tell us the quality of care and support needs to be better. People want services to be of a good standard with a value based, skilled workforce with early support that is responsive to individual needs and aspirations.

Parents tell us there are too many missed opportunities in childhood which leads to family crisis and to children and young people moving to 39/52 week residential/education placements out of area or into hospital. We know we have a high use of bed-based provision and people stay in hospital too long.

### Planned Impact of our Ambition

- North Cumbria and the North East will be the best place in England to live if you have a learning disability, autism or both.
- The Seven Keys of Citizenship are intrinsic in everything we do, and people are leading fulfilling lives with family and friends.
- Early identification and timely support is available within their local community to enable children and young people with learning disability, autism to realise their aspirations.
- More people with a learning disability, autism or both are in paid employment.
- More people with a learning disability, autism or both live in their own homes and receive personalised care and support from education, health and social care.
- People with learning disability, autism or both are valued by all ICS partners, evidenced by being active leaders and service development is coproduced.
- People with a learning disability, autism or both and their families will feel supported, have confidence to speak up, be more resilient, and feel they are valued as “experts” as vital members of the workforce.
- There is a reduction in the number of people with a learning disability, autism or both who die prematurely unnecessarily.
- More children and young people and adults with a learning disability, autism or both each year will have an annual health check.
- Medication is used appropriately where there is a diagnosed need because there is greater awareness of the appropriate use of psychotropic medication.
- The Citizenship Partnership is proud to report the quality and availability of services is good, with a range of housing options and evidence of reasonable adjustments in mainstream services. All partner organisations talk to each other, they are joined up and easily accessible to people and families.
- The workforce will have appropriate skills to support people with learning disability, autism or both well, across all services and to make reasonable adjustments.
- There is a reduction in the number of people in specialist learning disability, autism, mental health hospitals, and lengths of stay for people are shorter.

### Our ambition

**By 2020**

Reduction in reliance on inpatient care for people with a learning disability, autism or both to 37 inpatients per million adult population.

**By 2023/24**

Reduction in reliance on inpatient care for people with a learning disability, autism or both to 30 inpatients per million adult population.

75% of people on the learning disability register will have had an annual health check.

Seven day, intensive, crisis and community services will be available for all children and adults with learning disability Autism or both.

Health checks will be in place for children in residential schools

Children with complex needs will have a designated Keyworker

Digital flagging will be in place by 2023/24.

By 2023/24 Children with complex needs will have a designated Keyworker.

**By 2028**

Citizenship model will be fully embedded.

Reduction in Out of area / 52-week residential placements.

## APPENDIX 3.4 LEARNING DISABILITIES, AUTISM OR BOTH

### Strategic priorities and timeline

Strategic priorities and timeline	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>1. Implement and embed the seven key principles of Citizenship and develop, deliver and evaluate a coproduced focused programme of initiatives</b> which address: housing, employment, leadership, personalised care and support, advocacy, implementation of the 'We are all Citizens Workbook', hearing the voice of people with a learning disability, autism or both and their families.		Blue	Blue	Blue	Blue	Blue	Blue	Green	Green
<b>2. Early intervention and support for children and young people including implementation of Stage 2 of the Accelerator Schools Programme.</b> Establish uniform standards in relation to Dynamic Support Registers. Embed a consistent understanding of Positive Behavioural Support (PBS) and family support in schools. Establish Care Education and Treatment Reviews (CETR) compliance through access to robust training and support packages. Implement the Key Worker role and promote the learning from the Cumbria Early Intervention Project.	Blue	Blue	Blue	Blue	Blue	Blue	Blue	Green	Green
<b>3. Helping people with a learning disability, autism or both to have improved health and wellbeing by:</b>	Blue	Blue	Blue	Blue	Blue	Blue	Blue	Blue	Blue
<b>a. Reducing Health Inequalities.</b> Demonstrate impact and further promotion of shared learning in relation to Annual Health Checks, appropriate use of medication: STOMP and STAMP and learning from early deaths; LeDeR programme: Wider health inequality initiatives include: cancer screening, immunisation (e.g. Flu) digital flagging and promotion and availability of reasonable adjustments; (Learning disability Network)	Blue	Blue	Blue	Blue	Blue	Blue	Blue	Green	Green
<b>b. Deliver Building the Right Support:</b> Reducing reliance on inpatient services: Monitor the reduction in inpatient service usage and bed capacity, each quarter in accordance with agreed local planning assumptions.	Blue	Blue	Blue	Blue	Blue	Blue	Blue	Green	Green
<b>c. Understanding quality in inpatient services:</b> Monitor the implementation of the Learning Disability Improvement Standards Assessment of patient experience; Monitor the Implementation of Ask, Listen, Do			Blue	Blue	Blue	Blue	Blue	Blue	Green
<b>d. Autism - Improve Care Pathways;</b> Operational Delivery Network (ODN) Priority for 2019-20; development of Autism care pathway, understand pre/post diagnostic needs, self-help, crisis support		Blue	Blue	Blue	Blue	Blue			
<b>e. Transformation of community services:</b> Full development and implementation of the enhanced community model.	Blue	Blue	Blue	Blue	Blue	Blue	Green	Green	Green

Blue = actions; Green = sustainability

## APPENDIX 3.4 LEARNING DISABILITIES, AUTISM OR BOTH

### Key performance metrics to track delivery

#### Operating framework measures (19/20 Planning Guidance)

- Reduction in reliance on inpatient care for people with a learning disability, autism or both (CCG-funded) to 18.5 inpatients per million adult population by March 2020.
- Reduction in reliance on inpatient care for people with a learning disability, autism or both (NHS-England funded) to 18.5 inpatients per million adult population by March 2020.
- At least 75% of people on the learning disability register should have had an annual health check.
- CCGs are a member of a Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility.
- There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.
- CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.
- An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.

#### Key measures- milestones (monthly NHSE/I reporting)

- CETR Compliance.
- Quarterly CCG AHC trajectories.
- Inpatient numbers and trajectories- maintain / increase 35% discharge rate.
- LeDeR backlog

#### ICS performance - NHSE/ I monthly quality assurance and delivery monitoring

- Principles of Citizenship embedded.
- Housing Strategic commitment.
- Employment Pledge.
- Waiting times for Children & Young People (CYP) for an autism diagnosis.
- By 2023/24 maximum of 12-15 children with a learning disability, autism or both will be in a CAMHS inpatient service.
- By 2023/24 no more than 30 adults with a learning disability, autism or both in an adult inpatient service.
- Reduced Length of stay for inpatient admissions.
- Reduction in Out of Area (OOA) 39/52-week placements.
- Hearing, sight, and dental checks will be given to young people in residential schools.
- Annual health checks (primary care) for people over 14+ 75%.
- Learning Disability Improvement Standards (includes Ask, Listen, Do).
- Digital flagging in place, inpatients.
- LeDeR.
- Keyworker role.

#### Existing requirements

- New Care Models.
- Contract quality standards.
- CQUIN initiatives.
- Quality Priorities.

#### Additional requirements

- Building on Citizenship may result in at scale measures and outcomes.
- Impact of coproduction may result in a change in priorities.

## APPENDIX 3.4 LEARNING DISABILITIES, AUTISM OR BOTH

### National deliverables and allocated resource

#### National deliverables

- By 2023/24, a "digital flag" in patient records will signify to staff that someone has a learning disability or autism.
- By 2023/24, children with a learning disability, autism or both with the most complex needs will each have a designated keyworker to ensure that they are being best supported.
- By March 2023/24, inpatient provision will have reduced to less than half of 2015 levels (on a like for like basis and taking into account population growth) and, for everyone million adults, there will be no more than 30 people with a learning disability, autism or both cared for in an inpatient unit. For children and young people, no more than 12 to 15 children with a learning disability, autism or both per million, will be cared for in an inpatient facility.
- By 2023/24, all care commissioned by the NHS will need to meet the Learning Disability Improvement Standard, with a particular focus upon seclusion, long-term segregation, and restraint.

#### Primary Care Networks

- Roll out, as part of new PCN arrangements the Stopping Over Medication of People with a learning disability or autism and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes – available from 2020/21.

#### Key measures- milestones (monthly NHSE/I reporting)

- CETR Compliance.
- Quarterly CCG AHC trajectories.
- Inpatient numbers and trajectories- maintain / increase 35% discharge rate.
- LeDeR backlog.

#### Finance and estate implications

- **Estate strategy** - under review with partners
- **Finance** - refer to existing NCNE Programme/Workstream Finance Plan; CFO Strategic Finance Group lead. Additional details; Learning Disability Network funding, Capital investment programme to support the development of housing options, New Care Models Funding Transfer Agreement.

## APPENDIX 3.4 LEARNING DISABILITIES, AUTISM OR BOTH

### Interdependencies with other ICS regional workstreams

All Workstreams	Workforce
<ul style="list-style-type: none"> <li>All ICS workstreams will need to explore within their plans how they will make reasonable adjustments to address health inequalities (LTP Framework).</li> </ul>	<ul style="list-style-type: none"> <li>Learning disability, Autism Workforce Plan in development to support delivery and sustainability of future ways of working and system transformation. Linked into the ICS workforce.</li> </ul>
Digital	Mental Health
<ul style="list-style-type: none"> <li>NHS LTP requirements including 'develop the technical specification so that a 'digital flag' can be integrated into the patient record from 2020' LPT Framework.</li> <li>Learning Disability Network working on the national reasonable adjustment flag; (further details of Network digital work to be confirmed).</li> </ul>	<ul style="list-style-type: none"> <li>Improvement in autism diagnosis rates and the local offer for CYP with autism; 'develop and test best practice diagnostic pathways, including support packages, for autistic children and young people so that systems can roll out proven evidence-based diagnostic pathways from 2022' LTP Framework.</li> <li>Development of keyworkers for children and young people with the most complex needs and their carers/families from 2020/21. Roll out 23/24. LTP Framework.</li> <li>Reduce the use of seclusion, segregation and restraint.</li> <li>Ensure CETR/CTR policy compliance and quality.</li> </ul>

## APPENDIX 3.4 LEARNING DISABILITIES, AUTISM OR BOTH

### Risks and mitigating actions

Risks	Mitigating actions
Failure to achieve planned discharges and bed closure trajectories.	Actions include use of 12 point discharge plan, escalation processes, CETR/CTR TCP training programme, RCA completion and Dynamic Support Register (DSR) Refresh Audit planned. Consideration of alternative accommodation, care and support solutions.
Demand exceeds supply of skilled providers.	ODN (Operational Delivery Network) to look at developing service specification for forensic support, CCHs collaborating on wider footprint, Housing LIN to work with targeted providers.
System inpatient capacity has reached its maximum and this could lead to patients being placed Out of Area (OOA).	Lead Commissioners (SPOC) identified coordination of dialogue re inpatient bed availability, weekly CCG calls.
Finance; affordability and sustainability.	CCGs continue to fund care packages without prejudice, FTA agreement and Dowries in place.
There is insufficient capacity to provide, deliver and maintain Workforce solutions.	Local solutions through targeted recruitment campaigns, ICS priority which ensures it remains high profile and attracts investment.
Failure to clear LeDeR backlog due to local system issues.	National solution for completion of backlog reviews implemented and directed local work programme to monitor completion of ongoing /new reviews.
Inconsistent approach to Autism Care Pathways resulting in poor post diagnosis support and care.	ODN to lead review/development of proposal.

## APPENDIX 3.4 LEARNING DISABILITIES, AUTISM OR BOTH

### Implications for operational planning 2020/21

- Further development and expansion of an enhanced community model in all areas.
- The community model includes the provision of intermediate care and crisis provision.
- Lead provider/commissioner arrangements to be considered in light of inpatient bed capacity risks.
- Finance plan updated monthly and reflects TCP position in relation to the number of hospital inpatients and planned discharges.
- Dedicated resource required to clear the LeDeR backlog.
- CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.

### Partner organisations – Transforming care stakeholders

- People with a learning disability, autism or both.
- 11 CCGs across North Cumbria and North East.
- 13 Local Authorities across North Cumbria and North East.
- 2 mental health Foundation Trusts – Cumbria Northumberland Tyne and Wear and Tees, Esk and Wear Valley.
- Local Acute Trusts – Learning Disability Standards.
- NHS England and NHS Improvement Specialised Commissioning.
- NHS England and NHS Improvement.
- Health Education England.
- North East and Cumbria Learning Disability Network.
- Confirm and Challenge Group.
- National and Local Parent Carer Forum.
- Voluntary and Community Sector including Inclusion North, Sunderland People First, Skills for People.
- Northumbria University – PBS Programme.
- Primary Care Networks.
- Education.

**Workforce SRO:** Ken Bremner, CEO, South Tyneside & Sunderland NHS Foundation Trust

**Programme Director:** Lisa Crichton-Jones

**Programme Manager:** Catherine Withington

### Why is change needed?

By 2030 the world will be short of 18 million healthcare workers; we are facing a workforce crisis, described as a 'wicked' problem which needs us to think, work and collaborate in different ways.

We need to make the NHS the best place to work with more engaged, productive and effective staff and further develop good relationships and working practices across health and care, improving our collective efforts to retain staff across our services.

A new 21st century approach is needed to working in Health & Care; adopting integration across services, and embracing digital transformation. Working in health and care in the future will be a different employment experience. We need to ensure that employers and employees are enabled to embrace a variety of different working approaches, with flexible and innovative solutions to how we best serve and support our populations.

As a workforce programme we need to wrap around the ICS ambition of improving healthy life expectancy and support a population health management approach and a focus on prevention and well-being.

We need to be clear about where responsibilities for workforce are best placed; locally, regionally and nationally and seek to take greater local ownership and responsibilities for these with due governance arrangements in place.

We need to improve leadership culture with a focus on being positive, inclusive, people and population health centred with a collective leadership approach at the heart of our work.

### Our ambition

**For the North East and North Cumbria to be the best place to work, with a focus on adaptability, wellbeing and population health.**

**Recruiting, developing, appreciating and retaining the best people.**

**Continue to be recognised locally, regionally and nationally as a leading respected region with regards to workforce practice and solutions.**

**Becoming a great place to work**

**Getting, Workforce, Supply and Education Right.**

**Supporting and valuing leadership at all levels.**

### Planned Impact of our Ambition

- Integration and improved collaboration across health and care services will lead to improved experiences and outcomes for the population and more rewarding careers for staff working in the sector.
- Consistently adopted workforce strategy for Health & Care in our ICS.
- System wide workforce planning that looks to align our future workforce to a population health management approach.
- Improved wellbeing for staff, better job satisfaction, high levels of motivation engagement and inclusion, lower levels of absence.
- Higher retention rates and fewer vacancies, with less use of bank and agency staff.
- Collective approaches to workforce problems and increased collaboration on resourcing and deployment.
- Increased flexibility in the deployment of the North East and North Cumbria (NECN) workforce.
- The population/citizen/patient/service user genuinely at the centre of all decisions and practices.
- Effective communication and engagement with partners, stakeholders, staff and the public.

Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Continue to be recognised locally, regionally and nationally as a leading and respected region with regards to workforce practice and solutions</b>									
Take a proactive approach in a wide range of workforce initiatives to influence national and regional thinking and practice, on behalf of our ICS.									
Develop and begin to implement an ICS workforce strategy, delivery plan and system workforce metrics for our NENC health and care workforce, incorporating People Plan and other national requirements.									
Complete field testing for the Workforce Development and Readiness Tool and develop our ICS baseline assessment for workforce.									
Contribute to the 3 local enterprise partnerships (LEPs), understanding and influencing local industrial strategies, contributing to Skills Advisory Panels for our region and taking account of wider determinants and contexts for the NENC workforce.									
Further develop workforce programme communications and engagement approaches; regular bulletins, social media, flow of information and stakeholder events.									
Further develop and improve interdependencies with the other ICS work streams and ICPs supporting and enabling workforce ambitions and needs.									
Determine longevity of workforce programme and ICS workforce infrastructure beyond March 20 and 2021, establishing and embedding as required.									
<b>Getting supply and education right; responding to the regional health and care strategy and demand</b>									
Develop a strategic workforce planning approach, focused on population health management needs for 2025 and redesign workforce activity accordingly.									
Understand issues within each sector and support the development of the primary care and social care workforces.									
HEE to develop a workforce Transformation Hub to explore opportunities to flex delivery and priorities resources for workforce development based on the ICS vision around 3 core strands of work; Primary Care Training Hub, Faculty of Advance Practice and Talent for Care.									
Widen participation; more in reach into schools, careers events, increased NHS Ambassadors, understand the needs of the generation z.									
Develop flexible models of working across health and care, including the deployment and expansions of existing roles (Trainee Nursing Associate, Physicians Associates, Advanced Practitioners etc) but also the design and testing of new roles working across pathways and sectors.									
Reintroduction of post graduate pre-registration nursing programme and increase in placement capacity, notably for nurses but for other identified areas.									
Expand the Find Your Place Campaign, with an expanded remit notably on nurses and social workers.									
Develop and implement an ICS approach to international recruitment, expanding activity at scale.									
<b>Becoming a great place to work; responding to the flexibility, efficiency, standards and consistency of our workforce practices and focusing on retention of our workforce</b>									
Improve employment experiences. Launch the ICS Great Place to Work Board with new work streams, ICS standards and clear objectives for 18 month period; including Streamlining, Health and Wellbeing, equality diversity inclusion and Flexible Working.									
Improve flexibility of employment and easier movement of staff across health and care (employment models and regional passport).									
Supporting appropriate career progression including; Better collective use of the apprentice levy, implementing an employer led commissioning consortium and transfer across health and social care and nurse degree apprenticeships.									
Creating a supportive managerial culture at all levels.									
<b>Supporting and valuing leadership at all levels; responding to the cultural change, leadership and resilience drivers</b>									
Supporting system leaders at ICS, ICP and place; delivery of programmes for the ICS leadership community (ICS and ICP focus), building capacity for OD practitioners, the approach to strategic, values based commissioning and a new North East Leadership Academy (NELA) system leadership development programme.									
Supporting and developing leaders with new ways of working and their focus on population health management via expansion of Cumbria learning and improvement collaborative (CLIC) activities, a new North East Leadership Academy Population health management programme (Kings Fund supported) and a new clinical engagement programme for PCN clinical directors.									
Implement system talent management, supporting Leadership Academy work but also developing talent approached across digital and workforce communities and an approach across health and care.									
Preparing the workforce for challenges to come: e.g. data, technology, Artificial Intelligence. (A digitally enabled workforce).									
Better understand and meet the needs of the leadership community.									

## Key performance metrics to track delivery

### Long term plan measures

- Staff retention rate.
- Proportion of providers with an outstanding or good rating from the CQC for the “well led” domain.
- Workforce diversity measure to be agreed.
- Number of GPs employed by NHS.
- Number of Full Time Equivalents (FTE), above baseline, in the Primary Care Network additional role reimbursement scheme
- Nurse vacancy rate.
- Staff well-being measure to be agreed as part of the People Plan.
- Sickness absence.

### Other/local measures of added value

Continue to be recognised locally, regionally and nationally as a leading and respected region with regards to workforce practice and solutions.

- Greater responsibility for workforce devolved to the ICS with appropriate governance in place.
- Workforce strategy and delivery plan developed, agreed by partners, and in use across the ICS.
- Strategic, population health management approach to workforce planning completed, actions agreed and workforce plans in place.
- Strong interdependencies across all ICS work streams and ICPs in place.
- Regular communication – newsletter, bulletin, social media.

Getting supply and education right; responding to the regional health and care strategy and demand.

- Improvements in recruitment and retention rates for acute workforce shortage areas.
- Agree scope and approach for a ‘flexible worker’, pilots underway and a system wide approach and expansion to new roles embedded, e.g. Trainee Nursing Associate (TNA), physicians associates and advanced practitioners.
- Increased usage and flexibility of the apprenticeship levy, nurse degree apprenticeship in place.
- Post graduate pre-registration nursing programme in place alongside expanded placement capacity.
- Programme of activity for widening participation in place and evaluating well.
- Expanded Find Your Place campaign implemented and monitored for impact on nursing and social worker vacancies.
- Programme of activity for ICS international recruitment in place with reductions in vacant posts and positive feedback from recruited employees.

Becoming a great place to work; responding to the flexibility, efficiency, standards and consistency of our workforce practices and focusing on retention of our workforce.

- Clear ICS standards for HWB, EDI collectively developed and agreed with work in place to achieve positive changes in WRES and WDES metrics.
- Objectives for all 6 Great place to work (GP2W) work streams agreed and programmes in place.
- Restricted advertising rebranded, relaunched and embedded to protect employment within the ICS.
- Agreement and use of regional passport.
- Active participation in Regional Talent Board and regional talent approaches embedded with local priorities scoped and underway.

Supporting and valuing leadership at all levels; responding to the cultural change, leadership and resilience drivers.

- Commissioned programmes held with positive evaluation, future work commissioned and impact on system and operational performance.
- Implications of a digitally enabled workforce better understood and activity designed accordingly to support staff.

**National deliverables and allocated resource**

**National milestones**

- Ensure Interim People plan recommendations are incorporated in ongoing work and Workforce Strategy.
- ICS Workforce Development & Readiness tool work with KPMG completed and work / plans informed by the baseline assessment.
- Reassess any ICS implications and recommendations arising from final People Plan, whilst supporting activity ICP and place levels.

**Finance and resource requirements (inc. staffing)**

Current: (note, all resources interim)

- Programme Director – 1 x VSM (funded HEE).
- Workforce Programme Transformation Lead – 1 x 8b (commenced April 19, funded AHSN).
- Regional Talent Lead – 1 x 8c (commenced June 19, funded Leadership Academy / HEE).
- Great Place to Work Programme Manager – 1 x 8b (funded by trusts and HEE).
- Programme Manager – 1 x 8b (commenced Sept 19) and 0.2 x 8d (funded NECS).
- Project Manager – 1 x 7 (funded NECS).
- Admin/PA – 1 x 8a (short term, commenced July 19, NHSE/I resource).
- Communications Advisor – 1 x 5 (commenced September 19, funded NELA / HEE).
- \*Head of PR – 0.2

**Interdependencies with other ICS and regional workstreams**

Prevention	Mental Health, Learning Difficulties, Optimising Health Care
<p>For true workforce transformation, the workforce programme needs to align to support the delivery of the ICS ambition and ultimately the work, direction and priorities set by the Prevention Board. There needs to be a thread from this overarching programme to the other 5 work streams.</p>	<p>The ambitions and needs of these and other clinical work streams need to be understood, with workforce requirements clearly identified. There needs to be a programme of work which equips ICS work streams to consider their future workforce needs in accordance with the strategic objectives and spirit of the workforce programme (how do they align to get supply and education right, enable their future workforce to experience great places to work, where leadership is valued and supported at all levels?).</p>
Digital	All Programmes
<p>Whilst a clear commitment exists between the workforce and digital programmes, considerable work is yet to be done to align the two as we work to create a digitally enabled workforce. We need to better understand the impact of our digital strategy on the workforce.</p>	<p>All programmes will need to review the outputs of the strategic workforce planning project and consider approaches and changes needed to realign skills and ways of working to meet the population health needs for 2025 and beyond. These interdependencies will only be fully realised if programmes are suitably resourced.</p>

## Risks and mitigating actions

Risks	Mitigating actions
There are low levels of engagement with the workforce programme across the region impacting negatively on the speed of progress and delivery of key actions.	Diverse membership of workforce programme leadership group and transformation strategy board. Communications post established within the team and close working with ICS Comms leads and use of Join our Journey website.
Limited resources at ICS level impacting negatively on the ability to manage the scale of work and delivery to required timescales.	Strong links with ICS management team, Health Strategy Group and Health Management Group to ensure transparency and openness around expectations, timescales and longevity of the programme.
There are capacity pressures across the system with workforce and wider colleagues identifying difficulty in freeing up time for ICS work, impacting on pace and levels of engagement.	Ongoing dialogue, ICS level support where possible, clearer identification of priorities.
Minimal programme management support in place resulting in weakness across the programme management approach.	Programme Management support agreed (commenced Sept) and interim admin support now in place.
Programme resource is via short term secondments with interim funding arrangements risking loss of subject matter expertise and a longer-term approach to the ICS programme.	Resources for April 2020 onwards being sought.
There is not yet a fully integrated ICS workforce approach resulting in a continued fragmented workforce position.	Continued development of relationships, interdependencies and work across the ICS, ALB's and other stakeholders. Workforce Strategy to be finalised Q4. Actively involved in workforce operating model work streams.
There is no data sharing agreement in place resulting in arising IG risks and key workforce data / analysis not being shared with the ICS to share workforce information and inform key actions.	Raised concerns to regional Director of People NHS E/I and HEE are seeking advice and intending to pilot an approach in SWY area.

### Implications for operational planning 2020/21

#### Workforce

As above with drafting of more detailed work plan to set out delivery.

#### Digital

We will work closely with the other enabling work stream to ensure any specific implications are addressed as they arise and we work towards a digitally enabled workforce.

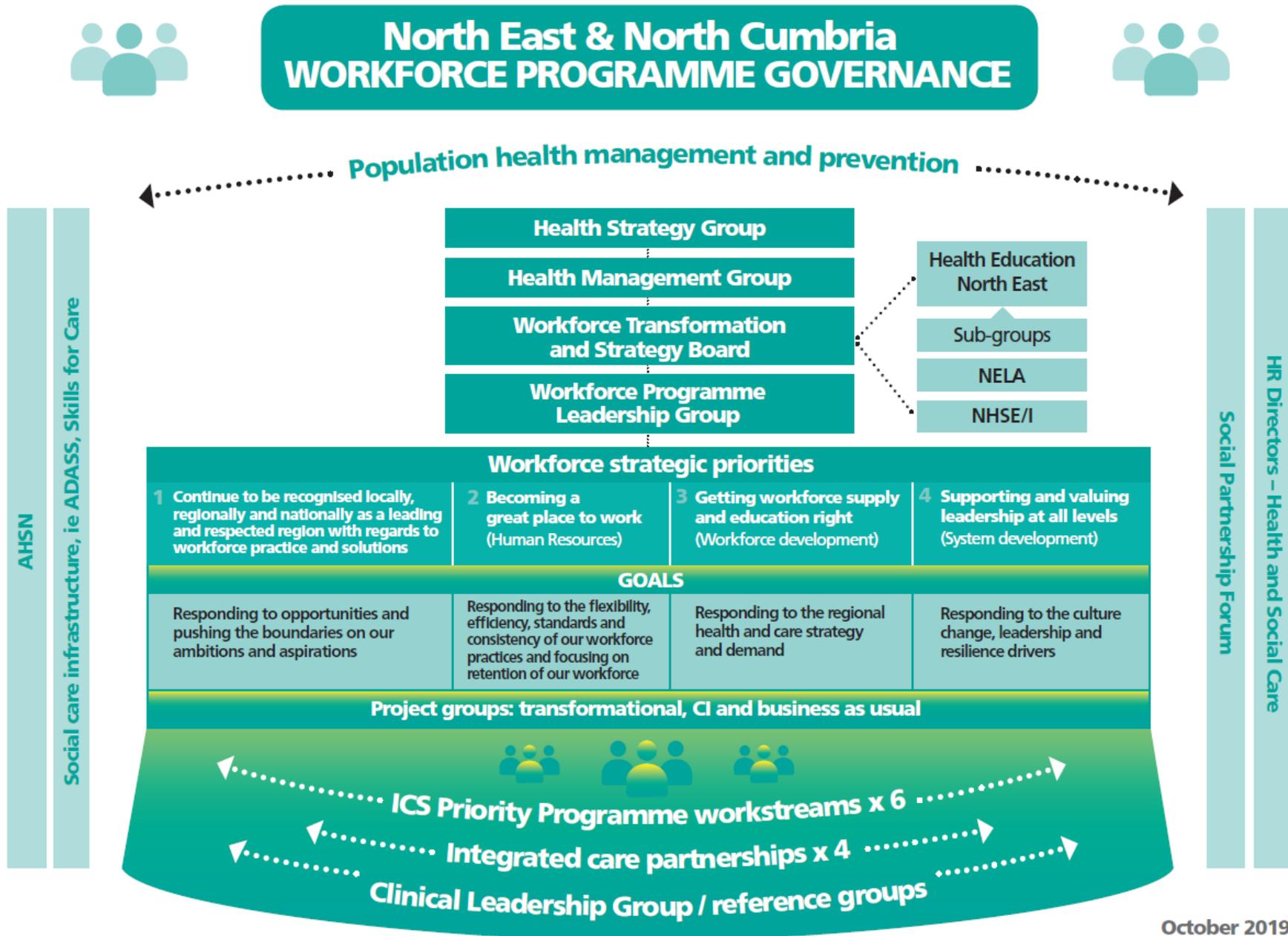
#### Estate

As the workforce becomes more flexible and tech advances, estate requirements may change both in the amount of estate required and the way in which work environments are configured. For non-clinical staff there may be more home or peripatetic working.

### Partner organisations

#### Anticipated business change required to deliver the work stream, from our partners:

- Partners working under the leadership and guidance of our ICS, underpinned with a firm foundation of collective, shared leadership, transparency and openness.
- Increased involvement and collective leadership approach to ICS initiatives with partners Health Education England –North East and North East Leadership Academy.
- Progression towards a health and care whole systems focused approach.
- Trust; working towards a collaborative, collective approach for the good of the local system and a move away from traditional organisational boundaries, uni-organisational focus' and dominant national mandates to a population health focus for the NE & NC.



**Digital Care SRO:** Dr Mark Dornan, GP and Clinical Chair, Newcastle Gateshead CCG

**ICS Chief Digital Officer:** Professor Graham Evans

**Programme Manager:** Maria Williams

## Why is change needed?

Digital technology has the potential to not only address many of the issues in the health and care system for the North East and North Cumbria, it can also be used to help **prevent ill health** and potentially assist in **identifying at risk citizens and patients**, before they become ill.

The NHS Long Term Plan recognises **digital as an enabler** and highlights the need for the NHS and social care to harness the information revolution to meet the fundamental challenges facing us - the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap.

The NHS in England has been asked to:

- Enable people to have more control over their own health and more personalised care when they need it.
- Develop digitally-enabled primary and outpatient care, which will become mainstream across the NHS.
- Reduce pressure on emergency hospital services and cut delays in patients being able to go home.

The NHS is made up of hundreds of separate but linked organisations, and the burden of managing complex interactions and data flows between trusts, systems and individuals is vastly time consuming. Investing in **data interoperability** gives the **opportunity to release time and resources to focus on clinical care and health promotion**.

Technology is a significant part of our everyday lives improving the way we socialise, shop and work. It also has great potential to improve how the NHS delivers its services in a new and modern way; providing **faster, safer and more convenient care**.

## Planned impact of our ambition

- To enable the secure, timely, seamless and legitimate **sharing of Patient information** and records; continually optimising the regional health and care services with digital solutions.
- Enable the **flow of activity data** between provider and commissioning organisations for the provision of better patient care, support research and enable the implementation of **Population health management** infrastructure and services; to truly drive health and care transformation regionally.
- To **Digitise services**, laying down the cultural and digital foundations on which to collectively build or transform patient/citizen-centred high-quality sustainable services.
- To continually raise the level of **organisational digital maturity**, including data and Cyber security controls by design; to achieve the NHS ambition to have all trusts fully digitised by 2024, including clinical and operational process across all settings, locations and departments. Implementation of robust digital solutions that adhere to core standards set across interoperability, accessibility, cyber security and key quality standards achieved in collaboration with our partners.
- Enable **patient access to their health and care information** and **deliver self-service/self-management** capabilities, where appropriate and necessary. **Supporting personalisation** and empowering citizens and patients to manage their health, access services and view their clinical information using digital solutions. *These solutions are provided in addition to the current methods of accessing health and care services.*
- Enabling a **digitally enabled and capable workforce**, in order to embrace new technologies and new ways of working.
- **Transform clinician mobile working** capabilities and access to contemporaneous medical records at the point of care; through provision of the infrastructure, devices, tools and digital services required.

## Our ambition

**Our Five-Year Strategic Vision**  
To enable the delivery of high quality, easily accessible and efficient health and care services, to the people of the North East and North Cumbria through digital solutions.

### By 2020

The first NHS Trust(s), Mental Health Trust, Primary Care settings and Local Authority will be connected to and sharing information via the Great North Care Record Health Information Exchange.

### From 2021

- Citizens will have access to the regional Patient Engagement Platform.
- Digital enablement of clinician passport.
- Video/online consultations in primary care.

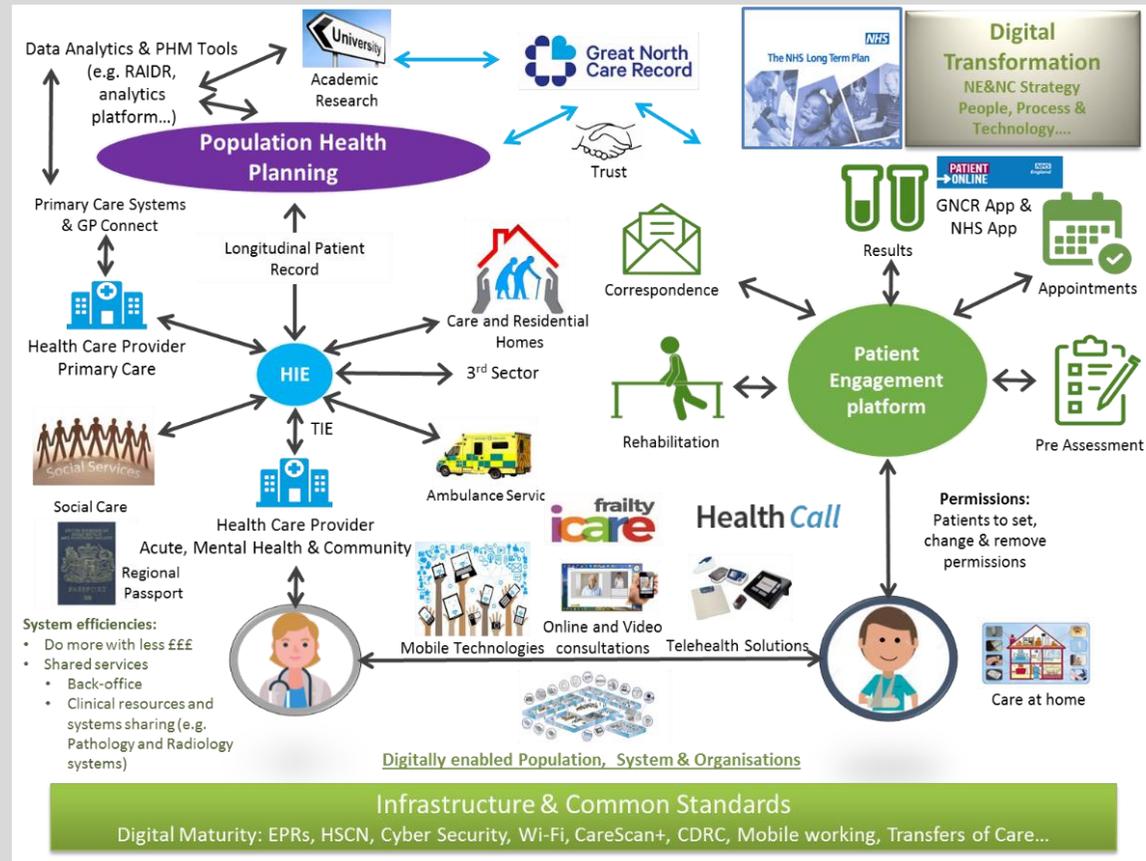
### By 2028

We will embrace and utilise, where appropriate, evolving digital innovations; to continually enhance and transform the care system, including the use of Artificial Intelligence, Machine Learning and Precision Medicine

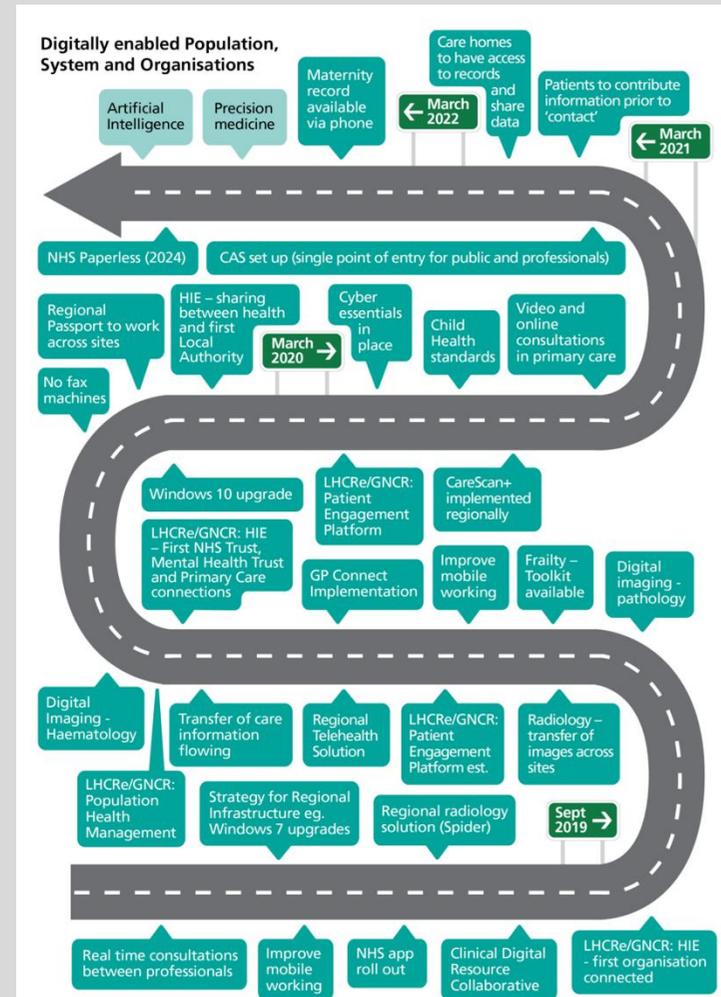
Strategic priorities and timeline

Strategic priorities and timeline	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Robust, secure and appropriate Infrastructure</b>									
Warranted systems and cyber security.									
Implementation of HSCN.									
Mobile devices with secure and robust remote access software installed will be available to primary care clinicians.									
<b>Mature digital providers and associated services</b>									
Establish a region-wide assessment and baseline of organisational digital maturity using an internationally recognised standard (HIMSS).									
All organisations and trusts to be fully digitised and paperless by 2024.									
Removal/elimination of fax machines and pagers.									
CareScan+ implemented regionally.									
Explore and identify additional opportunities within the Global Digital Exemplar (GDE) expansion programme (either to obtain GDE status or identify a fast follower arrangement).									
Digitisation of primary Lloyd George care records.									
<b>Interoperable and collaborative systems and resources</b>									
Delivery of a fully interoperable health and care record – first health and social care connections to be in place.									
Development of the Patient Engagement Platform, linked to the NHS App to enable citizen and patient access to health and care information.									
Create a digitally enabled health and care system, with digitally capable staff, supported through development and learning programmes.									
Agree a convergence and standardisation approach to both clinical and line of business systems across the ICS, to facilitate greater staff mobility and flexibility (regional clinician passport to enable working across sites).									
Care homes to have access to records and share data.									
Frailty Toolkit availability.									
All commissioning datasets to be submitted to SUS+ on a weekly basis with. Emergency Care datasets on a daily basis.									
Improve the transfers of care process using functionality such as FHIR and ERS.									
Expansion of the ERS system to include mental health referrals.									
Use digital functionality to improve the sharing of child protection information across health and care settings.									
<b>Digital innovations to deliver self-sufficient care; delivered closer to home in neighbourhoods and communities</b>									
Provision of citizen / patient self-service and self-management capabilities through technology enabled health and care services, including telehealth solutions and HealthCall.									
Availability of video and online consultations in primary care.									
Patient self-access to maternity record via smartphone devices.									
The NHS App, online consultations and GP Online to provide secure ways for citizens to access digital NHS services such as 111 and GP record, book appointments and register for organ donation.									
Development of a communications strategy to support the engagement of patients in the use of digital solutions.									
<b>Dynamic system planning and delivery; use of robust data, effective analytical services; underpinned by evidence and research</b>									
Digital tools and supporting digital infrastructure, to enable delivery of a Population Health Management Strategy.									

Rich picture vision of ICS



Digital roadmap



### Key performance metrics to track delivery

#### Operating framework measures

- From 1st April 2020, 100% of all NHS organisations are to **discontinue the use of fax machines** for communications with other NHS organisations and / or patients.
- By 2024, 100% of all providers across acute, community and mental health settings are to advance to a **attain core level of digitisation**, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and LHCRs will cover the whole country.
- Consultations with patients are to be 100% **paper free** at the point of care by 2024.
- In 2020/21, 100% of the population will have the ability to access their care plan and communications from their care professionals via the **NHS App**.
- By Q2 2021, there is to be 100% compliance with mandated **cyber security** standards across all NHS organisations in the health and care system.
- By 2023/24 every patient in England will be able to access **digital first primary care functions**.
- By 2023/24 100% of women will have the ability to access their **online maternity record**.
- By 2024, **digital solutions enable outpatient activity reductions** by a third, compared to agreed baseline.

#### Other/local measures

- By March 2020, the regional **Health Information Exchange (HIE)** will enable the sharing of health and care information between primary, secondary care and the first Local Authority.
- By 2021/22, 100% **patients will have the ability to contribute information** prior.
- **Measures** will be agreed, monitored and managed for the following:
  - Patient usage and satisfaction of digital solutions, including:
    - NHS App
    - Online Consultations
    - GP online
    - Patient Engagement Platform
    - HealthCall
  - The Number of organisations configured to use the Health Information Exchange shared record.
  - Number of views of the Health Information Exchange shared record.
  - Improved Digital Maturity ratings.
  - The number of data / security breaches recorded.
  - The number of incidents relating to technology.
  - Volume of patient complaints relating to digital solutions.

## National deliverables and allocated resource

### National deliverables

- In 2019/20, 100,000 women will be able to access their **maternity record** digitally with coverage extended to the whole country by 2023/24.
- Develop and expand the successful **Diabetes Prevention Programme** to offer digital access from 2019.
- By 2020, the NHS aim is to endorse a number of technologies that deliver digitally-enabled models of therapy for depression and anxiety disorders for use in **IAPT** services across the NHS.
- By 2020, every patient with a long-term condition will have access to their health record through the Summary Care Record accessed via the **NHS App**. This will also be available to all urgent and emergency care services, with appropriate permission.
- By 2023, the **Summary Care Record functionality will be moved to the PHR** held within the LHCR systems, which will be able to send reminders and alerts directly to the patient.
- By 2022 **Staff working in the community** to have access to mobile digital services, including the patient's care record and plan that will help them to perform their role.
- All providers, across acute, community and mental health settings, will be expected to advance to a **core level of digitisation** by 2024.
- By 2021, **pathology networks** will mean quicker test turnaround times, improved access to more complex tests and better career opportunities for healthcare scientists at less overall cost. Mandated open standards in procurement will ensure that these networks are ready to exploit the opportunities afforded by AI, such as image triage, which will help clinical staff to prioritise their work more effectively, or identify opportunities for process improvement.
- By 2022/23, the **Child Protection Information system** will be extended to cover all health care settings, including general practices.
- By 2023, **diagnostic imaging networks** will enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret. This open standards-based infrastructure will enable both the rapid adoption of new assistive technologies to support improved and timely image reporting, as well as the development of large clinical data banks to fuel research and innovation.
- In 2021/22, we will have systems that support **population health management** in every Integrated Care System across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation.
- Systems need to develop a **comprehensive digital strategy** and investment plan consistent with the Tech Vision. Outlining how digital technology will underpin their local system's wider transformation plans over the next five years. This includes their approach to ensuring all secondary care providers are fully digitised by 2024 and that they integrated with other parts of the health and care system. This plan is expected to include:
  - How and when each organisation will achieve a defined minimum level of digital maturity.
  - How will the Global Digital Exemplar (GDE) blueprints be adopted and an approach based on IT system convergence to reduce unnecessary duplication and costs.
  - How will controls and approved commercial vehicles (e.g. Health System Support Framework) be adhered to ensure technology vendors and platforms comply with national standards for capturing, storing and sharing of data.
- Systems are expected to set out plans for how they will significantly **improve the provision of services** through digital routes aligned to national standards and guidance. The newly created NHSX will ensure that clear guidance is provided to organisations and support to accelerate progress in this area. Local systems are advised to drive forward digitisation focussed on the user needs and engage staff and patients in its development.
- The NHS will support organisations to digitise care to core standards supported by a **robust IT infrastructure**. By 2024 it is expected that:
  - NHSX will drive a standards-based approach to provider digitisation to deliver a core level of digitisation across the system and local sharing of records to support integrated care by 2024.
  - By 2021/22 all staff working in the community will have access to mobile digital services.
  - By 2022 a new system for Integration Child Protection will replace dozens of legacy systems.
  - NHSX will monitor progress against the Secretary of State's commitment to cease the use of fax machines for communication between NHS organisation with patients.
- Expand upon the monitoring of autism and learning disabilities patients within primary care.

### Finance

There are several funding streams enabling much of the initiatives highlighted to be mobilised. There are others for Primary Care and for the Great North Care Record.

From an organisational perspective, several digitisation initiatives have been funded from the **Global Digital Exemplar (GDE)** programme, however, this has not been a "system wide" approach. The **Health System Led Investment Programme (HSLI)**, has been used to enable key regional transformational activities, however, the nature of the capital funding model does present some challenges that may need to be considered in order to ensure long term delivery and sustainability.

New models of care need to be provided within an agreed financial envelope, at a cost that is sustainable for the health economy. Where it makes sense, we can and should aim to converge systems, services and resources for both clinical and line of business (administrative) functions, where appropriate, shared back-office services and use a 'do once and share' approach, should be our aim, in order to operate efficiently and effectively. By collaborating, we can aim reduce our collective costs and make our services more efficient and effective at the same time. We need to make sure financial investments can be made in the best interests of the broader system, at both ICS and ICP levels.

Interdependencies with other ICS and regional workstreams

As an enabling programme, the NENC Digital Care Programme will work closely with all other ICS programmes and Workstreams, including Workforce and Estates; to identify, prioritise and address specific implications as they arise.

Workforce	Estates
<p>Digital Transformation will require all NHS staff to make adjustments in <b>how people work</b>. The NHS People's plan addresses the needs for an <b>increase in the technical skills</b> of the NHS workforce (or both specialist and non-specialist staff).</p> <p>The NHS Digital Academy will support an increase in skills among senior technology and digital leaders enabling further cohorts of NHS staff to become <b>Digital change leaders</b>.</p>	<p>Digital solutions can <b>reduce the need for increased estate</b> for the provision of health and care services as it offers the opportunity for staff to work more flexibly and introduces alternatives to traditional face to face methods.</p> <p>In the development and utilisation of estate, information technology infrastructure needs to be prioritised to ensure accessibility to digital solutions, such as provision of high quality Wi-Fi services for staff and patients <b>to improve services</b>.</p>

Risks and Mitigating Actions

Risks	Mitigating Actions
<p>There is a potential risk to the capacity to deliver the Digital Care Programme initiatives, due to lack of / reductions in <b>capital</b> funding nationally.</p>	<ul style="list-style-type: none"> <li>• Accept the risk and reduce impact through rationalising and prioritising programmes / projects; to ensure those that are crucial and committed to are <b>adequately resourced</b>.</li> <li>• Identify and exploit potential <b>economies of scale</b> where possible.</li> <li>• Identify and exploit <b>funding opportunities</b> wherever available.</li> <li>• Measurement of benefits to support the <b>prioritisation</b> of initiatives appropriately.</li> </ul>
<p>There is a risk that unless <b>people, processes and technologies align</b>, the initiatives being implemented may not achieve the vision.</p>	<ul style="list-style-type: none"> <li>• The Digital Care Programme acknowledges that significant service changes must be underpinned by a set of corresponding people, processes and technology.</li> <li>• The Digital Care Programme will link in closely with other enabling ICS Workstreams, such as Workforce to ensure an aligned approach to the technology development within the region.</li> </ul>
<p><b>Engagement</b> – There is a risk that patients do not engage with initiatives.</p>	<ul style="list-style-type: none"> <li>• <b>Communications Strategy</b>.</li> <li>• <b>Coaching of staff</b> to support patients.</li> </ul>
<p>Security and integrity of patient <b>information</b>.</p>	<ul style="list-style-type: none"> <li>• Ensuring all systems are compliant with <b>national security standards</b>.</li> </ul>
<p>There is a risk, where there are interdependencies that other ICS Workstreams may not have the <b>capacity to access and work</b> with the Digital Care Programme.</p>	<ul style="list-style-type: none"> <li>• Introduction of a <b>Technical Design Authority</b> – with associated Digital Input Request Form supported by a robust and visible process.</li> <li>• Linking in and communicating regularly with other ICS Workstreams; to capture interdependencies and feedback around appropriate innovations and initiatives.</li> </ul>

### Implications for operational planning 2020/21

The **Great North Care Record (GNCR)** is a key priority to enabling regional sharing of health and care information, accessed by authorised health and care practitioners.

- Phase one of the GNCR provided Foundation Trusts, Ambulance, Mental Health, 111 and Out of Hours services access to views of GP patient records using the **Medical Interoperability Gateway (MIG)**. The solution assists clinical staff in making informed decisions using up-to-date, real-time information including previous diagnoses, medication and hospital admissions. Clinicians are now safely accessing over 120,000 patient records each month using the MIG. Across the North East and North Cumbria, 100% of GP practices are now enabling and have activated the sharing of patient records.
- Development of Phase two of GNCR is now underway with Newcastle upon Tyne Hospitals NHS Foundation Trust leading on the implementation of a **Health Record Exchange (HIE)** solution, on behalf of the region. The HIE is planned to present a consolidated view of relevant patient information, pulled from multiple contributing data sources, in addition to GP practice patient information.
- In parallel to the HIE, the GNCR strategy also includes a **Patient Engagement Platform** and a **Population Health Management** system.
- The longer term operational and delivery model of the GNCR and digital services generally will require a more sustainable funding approach.

Funding linked to system-wide transformations will (as detailed in the Finance Section) will require some careful consideration given the nature in which systems as a service and cloud offerings are moving to subscription models, and do not readily align to a capital funded service delivery approach.

## Partner organisations

**Clinical Commissioning Groups**

- NHS Northumberland CCG
- NHS North Tyneside CCG
- NHS Newcastle Gateshead CCG
- NHS South Tyneside CCG
- NHS Sunderland CCG
- NHS North Durham CCG
- NHS Durham Dales, Easington & Sedgefield CCG
- NHS Hartlepool & Stockton CCG
- NHS Darlington CCG
- NHS South Tees CCG
- NHS Hambleton Richmondshire & Whitby CCG
- NHS North Cumbria CCG

**Acute Trusts**

- Northumbria Healthcare NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- South Tyneside and Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- North Cumbria University Hospitals NHS Foundation Trust

**NHS North of England Commissioning Support Unit (NECS)****NHS England / Improvement****NHS Digital****NHS X****The voluntary sector****Ambulance Trusts**

- North East Ambulance Service NHS Foundation Trust
- North West Ambulance Service NHS Trust

**Mental Health Services**

- Northumberland Tyne & Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust

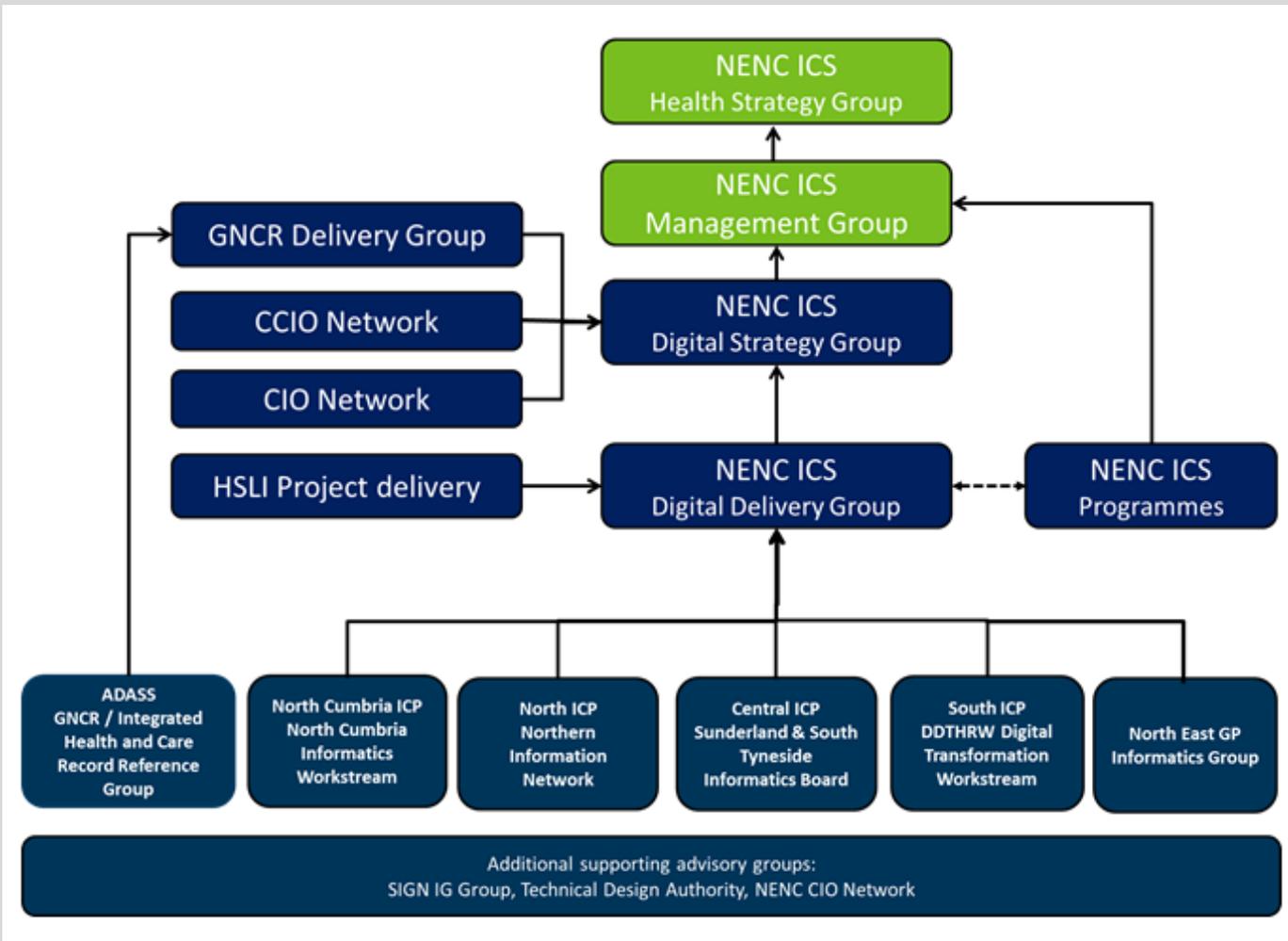
**Local Authorities**

- Northumberland County Council
- North Tyneside Council
- Newcastle City Council
- Gateshead Council
- South Tyneside Council
- Sunderland City Council
- Durham County Council
- Hartlepool Borough Council
- Stockton on Tees Borough Council
- Darlington Borough Council
- Middlesbrough Council
- Redcar and Cleveland Borough Council
- North Yorkshire County Council
- Cumbria County Council

**Health Watch****CHC / AHSN / Great North Care Record**

Governance

The NENC Digital Care Strategy, approved by the NENC Health Strategy Group can be found at: <https://nhsjoinourjourney.org.uk/what-we-are-doing/priorities/digital-care/>



**Optimising Health Services SRO:** Ken Bremner, Chief Executive, South Tyneside & Sunderland NHS Foundation Trust

**Programme Manager:** Heather Corlett

### Why is change needed?

Change is needed to support our local health systems to deliver the highest quality of services within their resources and address our current challenges:

- Scarcity of specialist skills make some services vulnerable which impacts on quality.
- Our valuable workforce is working under unprecedented pressures making services increasingly vulnerable.
- Competition has created barriers to achieving benefits of effective partnership working.
- Service change in one part of the system can negatively impact other areas.
- Unwarranted variation in services is inequitable. Our cancer survival rates can be improved.
- Too much time and resource is spent on face to face appointments.
- Social prescribing is not available to enough of our population.
- Mortality rates for respiratory diseases in the most deprived deciles is increasing - our ICS has an estimated 4,700 individuals living with undiagnosed COPD.
- Delivery of the long-term plan cannot be achieved without clinical support and oversight.

### Planned Impact of our Ambition

The purpose of The Optimising Health Services (OHS) Board is to have Clinical oversight and coordination of standards, strategy, service redesign and quality to support equitable local delivery of the long-term plan. It ensures that the ICS's service vulnerabilities are addressed and their transformational solutions are embedded into the evolving Clinical Strategy.

Our services will be able to achieve more through transformation supporting for example earlier cancer and COPD diagnosis and improving the outcomes for our children and young people. Our workforce will feel better supported and our vulnerable services sustained and quality improved.

### Our ambition

#### By 2021

We will have comprehensive ICS clinical engagement and influence addressing the priority areas of the Long-Term Plans.

#### By 2021

We will have started delivering across the ICS on key LTP metrics such as rapid community responses and earlier cancer diagnosis rates.

#### By 2028

Our current clinical vulnerabilities across the ICS will have been addressed and sustained through place based, ICP and ICS level working.

Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>More NHS action on prevention and health inequalities (examples below of areas progressing this priority)</b>									
Respiratory network.									
Antimicrobial resistance review.									
Child Health and Wellbeing Network/Maternity Network.									
<b>A strong start in life for children and young people (examples below of areas progressing this priority)</b>									
Neonatal workstream.									
Maternity Clinical Network.									
Child Health and Wellbeing network.									
Local Maternity Systems.									
Integrated Care Partnerships.									
Place based initiatives.									
<b>Better care for major health conditions (examples below of areas progressing this priority)</b>									
<b>Cancer</b> –Cancer Alliance, OHS Radiology Workstream, Pathology Collaboration & local initiatives.									
<b>Cardiovascular disease</b> – OHS workstreams, Mandated Clinical Networks & local initiatives.									
<b>Stroke care</b> - OHS workstreams, Mandated Clinical Networks & local initiatives.									
<b>Diabetes</b> – Mandated Clinical Networks & local initiatives.									
<b>Respiratory disease</b> – OHS Workstream PCNs, Mandated Clinical Networks & local initiatives.									
<b>Radiology workstream</b> – OHS Workstream & local initiatives.									
<b>New service model for the 21st century (examples below of areas progressing this priority)</b>									
Boost out of hospital models – <ul style="list-style-type: none"> <li>- Frailty Network.</li> <li>- Primary Care Networks &amp; Medicine’s Strategy Group.</li> <li>- Child Health and Wellbeing Network.</li> <li>- ICPs.</li> <li>- Place based initiatives.</li> </ul>									
<b>NHS staff will get the backing they need (examples below of areas progressing this priority)</b>									
Vulnerability oversight and support – Place, ICP and ICS.									

### Key performance metrics to track delivery

#### Operating framework measures

- Numerous metrics and measures are relevant to this work at place, ICP and ICS levels.
- Those being monitored at an ICS level will be signed off by the board and monitored accordingly.

#### Other/local measures

- Numerous metrics and measures are relevant to this work at place, ICP and ICS levels.
- Those being monitored at an ICS level will be signed off by the board and monitored accordingly.

### National deliverables

#### National deliverables

- Each of the individual ICP, workstream, network and specialities within the Optimising Health Services Programme work to their specific metrics and national deliverables recorded within their individual templates.

#### Finance

- Each of the individual workstream, networks and specialities within the Optimising Health Services Programme work to their specific finances, recorded within their templates. The OHS Programme has no allocated budget. It has an inadequate level of resources currently and no dedicated resource after March 2020.

Interdependencies with other ICS regional workstreams

Board members	Direct with the programme
<p>OHS Board membership gives direct connections into key ICS workstreams:</p> <p><b>Digital</b> – via ICS Digital Lead  <b>Workforce</b> – Via Joint SRO and HEE membership  <b>Mental Health</b> – Via MH Clinical Lead</p> <p>Elective Care and Demand management is also represented                      Presentation and papers have also been used to inform dialogue across workstreams for example <b>Population Health</b> and <b>Mental Health</b> Priorities.</p>	<p>Connections occur directly between the workstreams, specialties and clinical networks to facilitate progress and will be listed within their templates.</p> <p>Workstream lead calls have included items to ensure connection across the programme:</p> <ul style="list-style-type: none"> <li>• Workforce Programme</li> <li>• Health Education England</li> <li>• Right Care</li> <li>• GIRFT</li> <li>• NICE</li> </ul>
OHS	
<p>OHS updates are scheduled to the Workforce leadership Forum and regular contact with the ICS Mental Health Director.</p> <p>Connections into Learning Disabilities has been through the Learning Disabilities Local Clinical Network.</p> <p>A Meeting planned for CE Public Health England is being planned in partnership with Prevention Workstream.</p>	

### Risks and mitigating actions

Each of the individual ICP, workstream, network and specialities within the Optimising Health Services Programme work to their specific risks within their individual templates.

Risks	Mitigating actions
Capacity and resource to deliver the OHS workstream is currently inadequate and needs to be secured longer term to deliver its remit.	Escalated and requested funds within the ICS and looking to pragmatic opportunities to recruit short term.
Evolving nature of the new ICS and its developing relationships and governance may slow decision making and hamper engagement of all partners.	Develop a robust communication plan and ensure governance and decision-making processes are clear within the programme.

### Implications for operational planning 2020/21

Each of the individual ICP, workstream, network and specialities within the Optimising Health Services Programme work to their specific implications for operational planning recorded within their individual templates.

### Partner organisations

Each of the individual ICP, workstream, network and specialities within the Optimising Health Services Programme work to their specific risks within their individual templates. Examples of current Board partners include:

- 4 ICP leads (with connections into local authorities)
- North East Ambulance Services
- Acute and tertiary providers
- NHSE&I - Primary Care Programme and Medicine's Strategy
- Specialised Commissioning
- CCG Commissioning
- NHSE - Medical Director
- Health Education England
- Mental Health Workstream
- ICS Communications and Engagement
- NHSE&I Elective Care and Demand Management
- NHSE&I Clinical Networks

**Local Maternity System SROs:** Andy Beeby, Julie Lane and Alison Smith

**Programme Management Support:** Kathryn Hardy, Nicola Jackson

### Why is change needed?

Better Births (2016), report of the national maternity review found that despite the increase in the number of births and the increasing complexity of cases, the quality and outcomes of maternity services have improved significantly over the last decade. However, the quality of clinical and emotional outcomes for pregnant women and their families in the UK continues to lag behind those seen in many other developed countries.

Stillbirths and / or neonatal deaths are less common than previously, but the need for further improvements to the quality of maternity care has been highlighted by studies showing that:

- Deficiencies in care are present in at least half of term, singleton normally formed antepartum stillbirths.
- 76% of babies experiencing major adverse outcomes during labour at term might have had a different outcome with higher quality care.
- There is clear evidence of unwarranted variation in stillbirth rates across the country even when controlling for deprivation and other confounding factors.
- While perinatal and maternal mortality rates appear to have fallen over the last decade, the rates of improvement have 'stalled' over the last 2-3 years.

There are three LMSs across the ICS North East, Darlington, Tees, Hambleton and Richmondshire and Whitby (DTHRW), Northumberland, Tyne and Wear and Durham (NTWD) and West North East Cumbria (WNEC), hosting approximately 30,000 annual births. The ICS has significant widening health inequalities which have been highlighted in the Due North Health Inequality report (Whitehead, 2014) and are reflected in the maps of English deprivation (<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>) and Public Health England (PHE) statistics (PHE, 2018).

Disadvantaged groups are disproportionately affected by health inequalities, with economically deprived and socially vulnerable groups being at higher risk. 7% of women booking in pregnancy are recorded as having complex social circumstances, for example, the North East has a higher than average teenage pregnancy rate and has the highest rates of smoking in pregnancy (16.1% opposed to 10.7% in England) (PHE, 2018). Pregnancy provides an excellent opportunity to support women and their families to make and sustain better health choices which will positively impact on pregnancy outcome, and the current and future health of the mother.

Breastfeeding is a major contributor to public health. It has an important role in the prevention of illness and reducing health inequalities. If sustained for the first six months of life, breastfeeding can make a major contribution to an infant's health, wellbeing and development and is also associated with better health outcomes for the mother. Improving breastfeeding rates forms part of key national drivers in child health and is highlighted in numerous government policy documents, supported by the evidence (UNICEF, 2018). Across the region 59% of women initiate breastfeeding following delivery compared to 74.5% in other parts of England. Breastfeeding rates reduce quickly up to 6 weeks post delivery. Supporting women to Breastfeed for longer will have a positive impact on health and wellbeing across the North East and North Cumbria.

### Our ambition

#### By 2020

We will work to ensure that 35% of women are booked onto a Continuity of carer pathway.

#### By 2021

We will work to ensure Continuity of carer is provided to >51% of women at booking.

We will roll out SBLCB v2 with the aim to reduce still birth, neonatal and maternal death by 20%.

#### By 2025

Support enhanced Continuity of carer for 75% vulnerable women and women from BME groups.

Continue to support Trusts to reduce still birth, neonatal and maternal death by 50% ensuring all elements of SBLCBv2 are in place.

## Planned impact of our ambition

Implementing the Better Births Vision, especially for vulnerable groups of women in our region, will improve pregnancy outcomes. Providers and commissioners operating as Local Maternity Systems, with the aim of ensuring that women, babies and families are able to access the services they need as close to home as possible, provides the opportunity to bridge the widening health inequality gap.

The quality of care and clinical/emotional outcomes for women and their families in the North East and North Cumbria will be at least equivalent to, or even better than, those seen in the rest of the UK. The LMS will collaborate with Women and their families to continuously improve maternity services by supporting and further developing the voice of women via Maternity Voices Partnership (MVP) within all provider trusts.

The Pregnancy and birth choices APP for the North east and North Cumbria, developed in collaboration with women, allows families to decide where they would like to deliver their baby. It signposts women to a wealth of information to empower them to make informed decisions about their maternity care. [www.pregnancyandbirthchoices.co.uk](http://www.pregnancyandbirthchoices.co.uk).

Working closely with the clinical networks has allowed shared learning following serious incidents. External review between each provider trust has resulted in better communication, sharing referral pathways and guidance to achieve measurable improvements in safety outcomes for women. We are working closely with HSIB to evolve our shared learning from incidents to complement the work that they are leading.

We will work to book the majority of women onto a Continuity of Carer pathway which will allow women and their families to establish a trusting relationship with their healthcare professional who will have effective oversight of their care. This will improve safety, clinical outcomes as well as better experience of their pregnancy journey.

Full implementation of the SBLCB v2 will work towards halving stillbirths, neonatal and maternal deaths.

We will be on track to reduce Tobacco dependency of pregnant women in line with national trajectories by implementation and sustainability of a regional narrative regarding smoking cessation which was launched in September 2019.

The LMS boards have pledged to improve the health of the population by setting the following public health ambitions;

- Reduce tobacco dependency in pregnancy.
- Increase vaccination uptake in pregnancy.
- Improve perinatal mental health.
- Reduce alcohol consumption in pregnancy.
- Increase breastfeeding at initiation and at 6-8 weeks.
- Improve management of obesity and promote healthy weight in pregnancy.
- Increase in Making Every Contact Count.

Better Births recognises that care in the postnatal period is equally important as during pregnancy and birth and we improve this service to ensure a personalised plan for women which transfers smoothly between other disciplines. It is important to ensure the mothers return to physical health is supported appropriately and that clear pathways for referral are in place if follow up is required. By 2024 postnatal physiotherapy will be offered to all women if physical complications because of birth are experienced.

The LMS will ensure that all provider Trusts have an accredited Infant feeding strategy (Baby Friendly Initiative) to support women to successfully feed their babies.

Improvement plans will also include improved mental health assessment, identification and access to emotional and mental health support.

The LMS will collaborate and support with other stakeholders to ensure maternity care across the North East and North Cumbria aligns with all national guidance, for example, Screening programmes and Neonatal Care Provision.

The LMS will work to support the maternity workforce by making available training opportunities regarding continuity of carer models, provide e-learning packages to support implementation of SBLCBv2 and ensure that all opportunities to develop the workforce are delivered.

**Delivery mechanisms across the ICS**

**Local maternity systems**

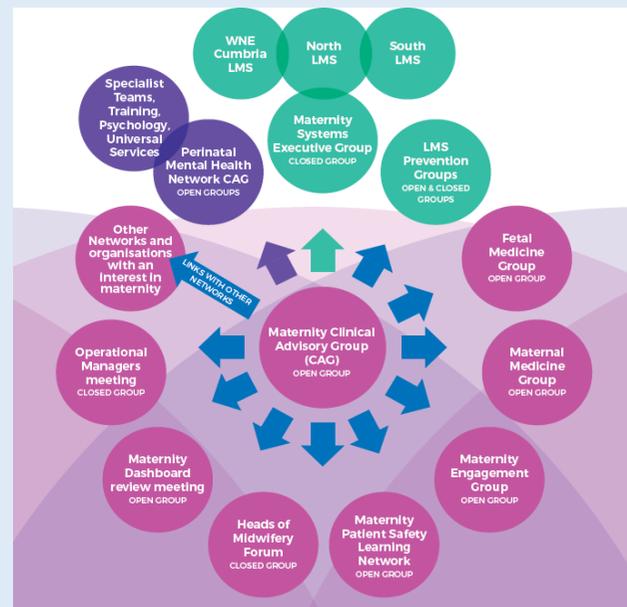
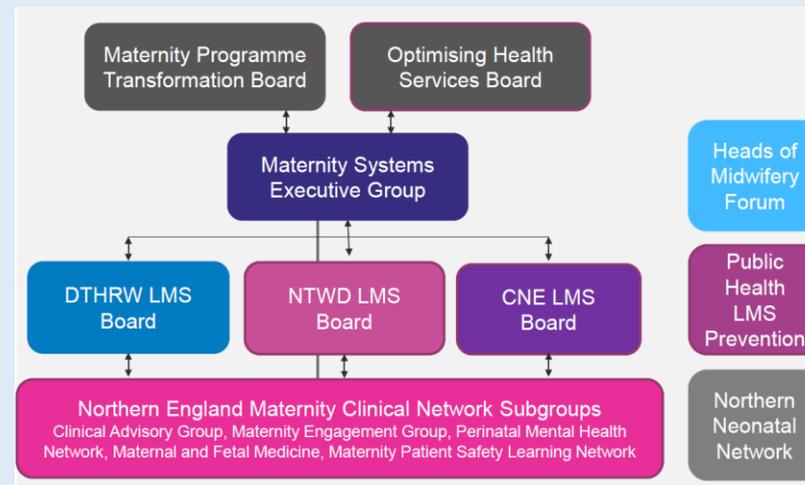
Local Maternity Systems (LMS) were established in 2016, as recommended by Better Births (2016) the national maternity review, to develop and delivery locally the vision and recommendations of Better Births. They were set up to be coterminous with the local infrastructure of the time, the three Sustainable Transformation Partnerships (STPs). As the ICS and its ICP subregions develop the LMS will work closely with them to ensure that plans and initiatives align and complement each other.

**Maternity and perinatal mental health clinical networks**

The networks support the LMSs to deliver by providing expert clinical advice, constructive challenge and peer support to solve problems and build momentum for positive change, as well as leading programmes of work that span the ICS footprint.

The national maternity transformation programme provides funding to the Maternity Network and LMS to fulfil these functions. Funding plans are approved at LMS Board and OHS Board in collaboration with all stakeholders and MVP.

**Governance Structure**



The diagram to the left demonstrates the close links that the LMS has with the maternity and perinatal mental health networks. The groups that the LMS are linked consist of a broad and diverse group of people, passionate about improving the care and outcomes of women, their babies and families.

The networks are led by clinical leaders, experts in their field who work as a conduit for sharing information across the North East and North Cumbria between the local, regional and national teams.

Other groups linked are the work we are undertaking with the Great North Care Record ensuring maternity is present developing a digital solution across the North East and North Cumbria.

Strategic priorities and timeline	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Reduce stillbirth, neonatal death and maternal death</b>									
Reduce rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by end of 2020/21.									
Reduce rates of stillbirth, neonatal death, maternal death and brain injury during birth by 50% by 2025.									
Fully implement the Saving Babies' Lives care bundle (version 2) by March 2020.									
Establish Maternal Medicine Networks to further ensure women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy. Operational by March 2024.									
<b>Neonatal critical care</b>									
By April 2020, ODNs and LMSs to produce local plans to implement the neonatal critical care review.									
<b>Continuity of carer</b>									
35% of women booked onto a continuity of carer pathway in March 2020.									
Most women (>51%) receive continuity of the person caring for them during pregnancy, birth & postnatally by 2021.									
Implement an enhanced and targeted continuity of carer model, ensuring that by 2024, 75% of women from Black/Black British Asian/Asian British communities and women from the most deprived areas or vulnerable groups will receive continuity of carer.									
<b>Postnatal care</b>									
All women receive improved postnatal care, in line with an improvement plan agreed by commissioners and providers by October 2019.									
Postnatal physiotherapy is offered to women with physical complications because of birth by March 2024.									
<b>Perinatal Mental Health</b>									
Establish maternity outreach clinics which integrate maternity, reproductive health and psychological therapy for women who experience mental health difficulties arising from, or related to, the pregnancy or birth experience.									
66,000 women across UK with <b>moderate to severe perinatal mental health</b> difficulties will have access to specialist community care from preconception up to 2 years after birth, with increased availability of psychological therapies. Their partners will have access to mental health assessment /signposting if required.									
<b>Digital</b>									
All women can access their electronic maternity personal health records by 2024.									
Maternity, Neonatal and Perinatal mental health workforce can access the information they need to provide safe and high-quality care through the Health Information Exchange of the Great North Care record.									
<b>Prevention</b>									
<b>Smoking</b> - By 2023/24 establish NHS maternal smoking cessation services for expectant mothers, and their partners for with a new smoke-free pregnancy pathway including focused sessions and treatments.									
<b>Infant feeding</b> - Ensure that maternity services that do not currently deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, begin the accreditation process in 2019/20.									
North East LMS 7 Must Dos / West North Cumbria LMS 8 Must Do's including:									
• By 2020 reduce the number of smoke free pregnancies by 20%, by 2025 by a further 5%.									
• Increase vaccination uptake in pregnancy by 2020 90% uptake and 95% by 2025.									
• Improved perinatal mental health for women by 2020 90% women will be assessed and appropriate referred into an evidence-based intervention in pregnancy, 100% by 2025.									
• Making Every Contact Count by 2020 80% of staff and 100% by 2025.									

Key performance metrics to track delivery

Operating framework measures

- Maternity pathway tariffs non-mandatory, but still an expectation that these prices be used for contracting in 2019/20.
- NHS Resolution (NHSR) Maternity Incentive Scheme.
- Digital maternity records.
- Continuity of carer.
- Specialist smoking cessation.
- Reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.
- All trusts part of Maternal and Neonatal Health Safety Collaborative, supported by Local Learning Systems.
- Saving Babies Lives Care Bundle implementation.
- Accredited, evidence-based infant feeding programme.

Other/local measures

- CNE Maternity Dashboard – data collected from provider trust monthly and reported on a quarterly basis in the form of a regional dashboard. Shared at Clinical Advisory Group and LMS Boards.
- National Maternity Services Dataset (MSDS) version 2.
- Each Baby Counts.
- MBACE - Perinatal Mortality Review Tool.
- Learning from local investigations and from the national Health and Safety Investigation Board (HSIB).
- Prevention measures as agreed at LMS Boards.
- Continuity of carer project reports.

National deliverables and allocated resource

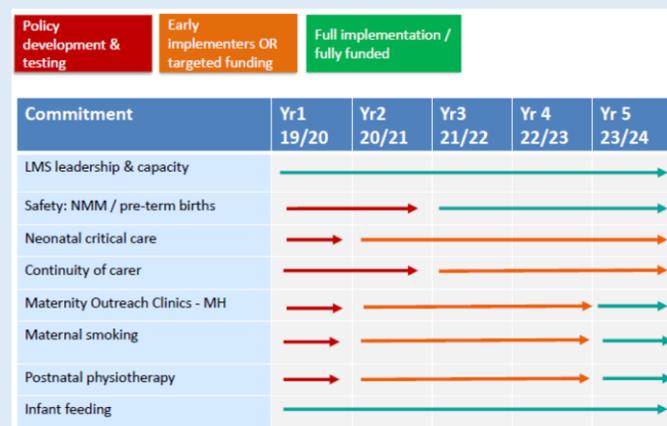
National key lines of enquiry and trajectories

- Reduction of still births and neonatal deaths.
- Number of personalised care plans.
- Number of women able to choose three places of birth.
- Number of women receiving continuity of carer during pregnancy, birth and postnatally.
- Estimated number of women giving birth in a midwifery setting (at home, in an FMU, in an AMU).

Finance

	2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24
Maternity Network	£118,000	Not known	Not known	Not known	Not known
NTWD LMS Total funding	£1,136,000				
Tranche 1 Leadership	£150,000	Not known	Not known	Not known	Not known
Tranche 2 Delivery of specific projects	£744,000				
DTHRW LMS Total	£894,000				
Tranche 2 Leadership	£150,000	Not known	Not known	Not known	Not known
Tranche 2 Delivery of specific projects	£744,000				
N Cumbria LMS Leadership and Capacity	£550,000	Not known	Not known	Not known	Not known

DRAFT National funding and implementation timeline for maternity and neonatal sections of the long term plan



## Risks and mitigating actions

Risks	Mitigating actions
Funding and staffing to reach 35% of women booked to deliver on a continuity of carer pathway and >50% women by 2021.	Local continuity plans have been reviewed and it has been agreed to build on these and develop a CNE wide transformation approach.
Ensure ongoing recurrent funding for specialist perinatal mental health services.	CCGs and mental health providers keep this commitment under review.as part of the LMS.
Ongoing funding to establish and sustain Maternity Voices Partnerships.	LMS commissioners working with the Maternity Engagement Group are exploring possible solutions.
Short term year on year maternity transformation funding for long term transformation maternity services.	Raised with the regional and national teams and LMS will continue to work with the ICS to consider sustainability of the LMS programme as part of the wider programme of work.
Scanning capacity across the region to implement fully Saving Babies Lives Care Bundle v2.	Develop an action plan to identify the problems in each provider and develop a system wide approach.

## Implications for operational planning 2020/21

To truly implement the vision held within Better Births calls for whole scale transformation across maternity systems in CNE. We are mindful of the following issues and work with all stakeholders across CNE to address collaboratively:

- Workforce pressures such as vacancies and retention of staff, new skill set required to work in different ways, ability to manage large scale change, recognising and broadening leadership capabilities across the multidisciplinary team.
- Intensive ongoing staff engagement is required for the change to be sustainable.
- Cost implications when introducing a new system whilst still operating the previous system.
- Issues of working across organisational boundaries e.g. removing barriers between provider trusts such as IT, HR, protocols, governance, training.

## Partner organisations

### Partner organisations in the LMS

- Neonatal network
- Perinatal Mental Health network
- Mat Neo Safety Collaborative and Learning Systems
- Academic Health Science Network
- Maternity networks

### On LMS Boards

- CCGs
- Acute providers
- Specialised Commissioning
- Screening and Imms Team (SIT)
- NHS England and NHS Improvement (NENC)
- Public Health England (NE)
- Health Education England (NE)
- All 15 local authorities via one nominated rep
- Lay Representatives (Maternity Voices Partnership)

### Wider partners

- Other clinical networks – e.g.
  - Regional and National Maternity Transformation Programme Team
  - Other maternity networks and LMS

### Trusts within our Local Maternity System

- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- South Tyneside & Sunderland N H S Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- North Cumbria Acute Hospitals NHS Trusts

**Child Health and Wellbeing SRO:** Professor Chris Gray

**Clinical Lead:** Mike McKean, Clinical Director Great North Children's Hospital

**Programme Manager:** Heather Corlett

## Why is change needed?

There is a compelling evidence base around the link between child health and wellbeing and the outcomes and prospects of these children in adult life:

- Babies with a low birth weight are five times more likely to die as an infant than those of normal birth weight.
- A child's early development score at 22 months is an accurate predictor of educational outcomes at age 26 which in turn is related to long-term health outcomes.
- Children who are overweight or obese when they start school have a greater risk of poorer school attainment, emotional difficulties, of cardiovascular disease and diabetes in later life.
- 75% of all mental health problems are established by the time someone is 18.
- Experiences in early life (known as Adverse Childhood Experiences (ACEs) are increasingly being recognised as having a lasting effect on adult health both directly and through influencing adult health behaviours (both physical and mental).

The North East and North Cumbria has some of the poorest health and wellbeing outcomes and worst prospects for children and young people and there are significant levels of inequality in child health and wellbeing both across and within localities and communities within the ICS. Whilst the ICS has many excellent Children's and Paediatrics services, there are challenges to their sustainability driven by workforce pressures, rising demand and unmet need that will require significant planning, transformation and integration to address them.

- In 2016/17 the England rate for A&E attendances for children aged 0 – 4 years was 601.8 attendances per 1,000 population. In the North East it was over 50% higher at 928.5 per 1,000 population.
- In 2017/18 the percentage of children classified as Obese at 4 – 5 years in England was 9.5%. In the North East it was 10.9%.
- In 2016/17 the percentage of Children and Young People in England at 5 years old with poor oral health (defined by Decayed Missing or Filled Teeth – DMFT) was 23.3%. The North East average was very close at 23.9% but this included a wide range – from 19.3% Newcastle up to Middlesbrough at 32.1%.
- In 2016/17 hospital admission rates for asthma for children under 19 years stood at 202.8 admissions per 100,000 population across England. The North East had a much higher rate overall (266.2) which included a wide range of variation from 198.3 in North Tyneside to 406 in Middlesbrough.
- In 2016/17 hospital admission rates as a result of self-harm (10 – 24 years) was 404.6 admissions per 100,000 population across England. The North East had a higher rate (425.3) which included a wide range of variation from 275.8 in Hartlepool to 603.3 in North Tyneside.
- In Carlisle Eden and Copeland the excess weight levels at reception are the highest in North Cumbria.
- In North Yorkshire hospital admission as a result of self harm (10-24yrs) are well above the regional and England average.

## Our ambition

*'In the North East and North Cumbria we believe all children and young people should be given the opportunity to flourish and reach their potential, and be advantaged by organisations working together.'*

### By 2020

We will have established a Child Health & Wellbeing Movement across our ICS with system derived priorities & plans & system membership of >700.

### By 2021

Working across our system we will demonstrate the benefits of new partnerships and access new funding streams to improve health and wellbeing of our CYP.

### By 2028

Outcomes will be improving, not only for our CYP but the adults that they become – creating a healthier and happier environment.

**Planned impact of our ambition**

The ambition of the Child Health and Wellbeing programme is to improve outcomes, reduce inequality and create sustainable and integrated models of care for children, young people and their families aligned to joined up plans with our partners addressing the wider determinants of health and wellbeing.

These ambitions will have been informed and developed on the back of continuous and consistent engagement and leadership from the children and young people of the North East and North Cumbria.

These ambitions will be achieved by a combination of national Long-Term Plan and local North East and North Cumbria ICS transformation priorities.

These priorities have been informed by our work to date working with stakeholders and children and young people to truly understand what they need from an effective set of services.

**Our priority areas**

Between January 2019 and May 2019, the North East and North Cumbria ICS Child Health and Wellbeing Network have undertaken significant levels of engagement and involvement of children and young people, stakeholders and partners in local government and the third sector and NHS staff to understand the local priorities.

This engagement took the form of:

**Survey feedback** from over 1000 professionals, children and young people – This was conducted predominantly through an on line survey but some facilitated discussions also fed into the work to identify the priorities that the network should address and examples of good practice.

**Engagement events** were conducted across the region between February and June 2018 with three residential events for 12 core system leaders (health, local authorities and VSO) and three one day regional events for c 120 professionals. The participants were from a broad range of system representatives (including business, education, research). The second event focused on the voice of the child and had many young people from across our region attended, our final event was chaired by young people themselves. The events helped to get support for the ambition and priorities and identify what the system wanted from a network and suggest opportunities the network could progress.

This information was reviewed and analysed by a group of core leaders from different sectors to produce the final set of priorities, enabling plan of actions and cross cutting themes that are being used to frame and align the key transformation programmes, initiatives and relationships that will deliver the ICS ambitions. An overview of these priorities can be seen in the figure to the right. In some cases, these programmes and initiatives will be directly delivered by the CHWB Network team but in others they will be delivered with communities, Integrated Care Partnerships or by other ICS workstreams.



Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Strategic Initiative 1 - Establish local leadership through our child health and wellbeing network (long term plan priority)</b>									
Finalise CHW Network Governance Structure, Terms of Reference and engagement mechanism (including voice of the child).									
Develop a Child Health and Wellbeing Framework and Children’s Charter for NENC – understanding what forums harness the voice of CYP and families.									
Finalise and share Take plans to system partners for endorsement.									
Establish co-production delivery mechanism (timeline dependent on funding).									
Develop ICS CHWB Website page to enable spread and sharing of good practice.									
Scope Existing disease specific clinical (delivery) networks.									
Map out how local system plans will deliver long term plan commitments.									
<b>Strategic Initiative 2 - Develop age-appropriate integrated care services for children and young people (long term plan priority)</b>									
Support the development of sustainable Women and Children’s model of care in each of the four ICS Integrated Care Partnerships.									
Support the review of NENC children’s asthma, epilepsy, diabetes, and complex needs pathways.									
Deliver the NENC CYP Mental Health Network delivery plan and support ICPs and localities to deliver CAMHS transformation plans.									
Support the Northern Cancer Alliance to deliver their plan to improve outcomes for children and young people with cancer.									
Support the NENC Learning Disabilities Network to develop and deliver a plan to improve services for children with autism or learning disability.									
<b>Strategic Initiative 3 – Prevention and health promotion for child health and wellbeing</b>									
Treating and managing childhood obesity.									
Oral health promotion.									
Childhood screening and immunisation programmes.									
<b>Strategic Initiative 4 – Test, share and spread of innovative practice</b>									
Health in Schools approach.									
Film narrative focusing on teenagers MH/maternal/family support.									
“Poverty proofing the child health experience” pilot.									
Football foundation outreach pilot – focus on obesity with oral health tba.									
Northern Ballet - primary schools/social prescribing intervention pilot – deprivation focus.									
<b>Strategic Initiative 5 – Workforce development</b>									
Making Mental Health First Aid Training available to support those working with young people.									
Toolkit to support professionals in the community with learning on issues important to young people.									

**Key performance metrics to track delivery**

**Process measures**

Will be defined with each piece of work as the network progresses.

**Outcome measures**

NHS Outcomes Framework Measures:

- Domain 1: Preventing people from dying prematurely: 1.a.ii, 1.6i and 1.6ii.
- Domain 3: Helping people to recover from episodes of ill health or following injury: 3.7ii.

**Public Health Outcomes Framework Measures**

- B - Wider determinants of health: B01a, B01b, B02a, B02b, B02c, B02d, B03 and B05.
- C - Health improvement: C08a, C08b, C08c, C09a, C09b, C09c, C10, C11a, C11b, C12, C13a, C13b and C14a.
- E - Healthcare and premature mortality: E01 and E02.

**Interdependencies with Other ICS Workstreams**

Interdependencies with other NENC workstreams	Interdependencies with other NENC ICS clinical networks	Interdependencies with other NENC ICS groups
Prevention – to support delivery of promotion and prevention programmes for children’s health and wellbeing.	Northern Cancer Alliance.	North Cumbria ICP.
Learning Disabilities- to support delivery of improvement of services for children with autism or a learning disability.	North East and North Cumbria CYP Mental Health Network.	North of Tyne ICP.
Mental Health – to deliver the CYP. Mental Health programme.	North East and North Cumbria Learning Disabilities Network.	Durham, South Tyneside and Sunderland ICP.
Digital - to help develop CHW dataset to support GNCR.	North East and North Cumbria Local Professional Network – Oral Health and Dentistry.	Tees Valley ICP.
Workforce – to support children’s services workforce transformation.	Paediatric Critical Care Operational Delivery Network.	

**National deliverables and allocated resource:**

**National deliverables**

- Reduce A&E attendances from children by improving children’s health services, and making sure children with conditions like asthma, epilepsy and diabetes get the support they need to stay well
- Treat a further 1,000 children a year for severe complications related to their obesity, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health.

**Finance**

2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24
0.025	0.025			

## Risks and mitigating actions

Risks	Mitigating actions
Funding to enable delivery of the planned programme.	Opportunities are progressed when there is a passion to test out initiatives on a small scale and evidence impact to then apply for future funding to scale up.
Secure dedicated capacity to drive this work forward.	Flexibly used resource available, escalated concerns to Programme Board and Health Strategy Group regarding impact of this. Aware that national funding should be available.
As children and young people are supported by a whole range of services outside of health so a system approach is vital but increases the stakeholders and drivers of those involved.	Developed a network that's ambition is to be a movement based on commitment of those involved. Ensuring that we reach out to and appeal to the broader system. Ensure that our leadership plans are developed by the system and endorsed by key organisations.
Children, young people and their families are at the core of what we do and their voice must be heard. The ways to engage and connect with this group varies more widely than most groups due to the different approaches needed for age related communication and development, specialist approaches for hard to reach groups – teenagers, vulnerable young people, as well as the individual family communication.	Innovative engagement approaches and digital solutions will be developed alongside more traditional approaches as well as working with system experts and systems such as education and voluntary sector.

## Implications for operational planning 2020/21

- Need to ensure the implications for children and their family support networks are understood across ALL areas of operational delivery.
- Need alignment of all child health and wellbeing initiatives to priority areas.

## Partner organisations

**Numerous possibilities – we currently have a network of over 500 members and are working in partnership with many organisations already including:**

Those delivering health care, social care and education, those supporting families in poverty and those working with children out of school in clubs, sports and faith settings.

Examples of current connections are shown here:

- Voice of the child - Children in Care Council, YPAG, Barnardos.
- Health and Care providers – Acute/Tertiary Trusts, Community/Primary Organisations, Local Authorities, Voluntary services.
- Local Authorities – public health and children’s services.
- Voluntary sector specialists – Children’s North East, VONNE, Girl Guiding Association.
- Education and Research – Schools, Colleges, Universities (Teesside, Newcastle, Sunderland, Cumbria, Northumbria), North East ARC.
- Sport and Dance Organisations - Dance City, Football Foundations, Northern Ballet, Grangetown netball club.
- Department of Work and Pension – Reducing Parental Conflict Programme.
- National network – Network established with Cornwall, Nottingham.
- International Connections in Canada – University of British Columbia and USA – University of Los Angeles, Netherlands – Movement and wellbeing Eldridge Labinjo, Australia’s Gold Coast University – GEN V programme.
- Business – Greggs, NE Chamber of Commerce.
- Public organisations such as - Office of Public Scrutiny, NHS Confederation.

**Primary Care SRO:** Professor Chris Gray

**Programme Management Support:** Tracey Johnstone

### Why is change needed?

The changing health needs of the population is putting pressure on our Primary Care Services across the region, people are living longer but often with multiple and complex long-term conditions with one of the main tasks changing from treating individual episodes of illness, to helping people manage long-term conditions. In addition to this the steady expansion of new treatments gives rise to demand for an increasing range of services. This is further compounded by the workforce pressures being experienced in General Practice, where the growth in numbers of GPs is not in line with the increasing demand, these issues are also mirrored in Primary Care Dentistry. Access continues to be an issue across general practice and dentistry with the changing expectations and needs of patients further supporting the need for an integrated holistic approach to patient care.

The NHS Long Term Plan places Primary Care at the centre by, developing Primary Care Networks as the foundation for Integrated Care Systems, focusing on preventing ill health and tackling health inequalities, supporting the workforce, as well as maximising the opportunities presented by data and technology with a continued focus on efficiency and introduces a key role for community pharmacy in helping to deliver this ambition.

The 5-year GP and Community Pharmacy contract reforms further support the delivery of the plan all of which provides a strong platform to set the ambition of going further and faster at a local level across the next 5 years to integrate care.

### Planned impact of our ambition

Continue to develop the capabilities of PCNs with partners such as CCGs, PCN Clinical Directors, Secondary care providers, third sector and public health partners to deliver truly integrated care systems.

Support the faster development of the Maturity and capabilities of PCNs through targeted pilots and programmes such as Population Health Management approaches.

Focus on improving access to the full range of Primary Care services for all ensuring adequate provision and that patients are seen by the right person, at the right time in the most appropriate setting for their needs.

Promote early diagnose and intervention of major health conditions such as CVD through targeted approaches in Primary Care.

Develop Clinical Director Networks to coproduce strategies to address health inequalities.

Strengthen and develop the role of community pharmacy and Dentistry as a key intervention for public health issues such as smoking, obesity and alcohol issues as well as identifying major health conditions such as CVD and Diabetes maximising on the open access of the service.

Ensure alignment and involvement of Primary Care with the wider ICS strategies for prevention and workforce.

### Our ambition

**By April 2020**

**Mobilising PCNS e.g. 100% PCNs delivering services to improve:**

- Optimisation of medication across the ICS
- Enhanced health in care homes
- Anticipatory Care
- Supporting early cancer diagnosis
- Personalised Care

**Support Urgent Care e.g.**

- Community Pharmacy Consultation Service delivered by 60% Pharmacies.
- Dental Unscheduled care services in place and integrated into 111.

**By 2021**

**Integrated prevention and diagnosis pathways in place across primary care in line with ICS Priorities (CVD)**

**By 2024**

**Local Access standards agreed and achieved across all Primary Care.**

**All contract reforms embedded.**

Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>1. New Service Model</b>									
Undertake maturity assessment of 100% of PCNs to understand the aspiration and development needs.									
Development plans to be in place for 100% PCNs and investment targeted to the advancement of maturity.									
Develop system level Development support offers as appropriate for PCNs (Annually Funding to be confirmed).									
Undertake Population Health management pilot to establish ways of working to roll out good practice across all Primary Care Services.									
Develop networks for PCN Clinical Directors to share good practice and develop the system at pace.									
Establish Primary Care programme board with PCN Clinical Director and Local Professional Network representation to ensure coproduction of delivery plans.									
100% PCNs delivering improvements in Personalised Care across the ICS (New Service).									
100% PCNs delivering improvements in improvements in Enhanced Health in Care Homes across the ICS (New Service).									
100% PCNs delivering improvements in Anticipatory Care across the ICS (New Service).									
Implement new Community Pharmacy Consultation Service in x Pharmacies, enabling people to access pharmacist consultations for low acuity conditions and urgent medications, being sign posted from 111 and GP practice (2020), (Urgent Treatment Centres and A and E 2024).									
Roll out of National Dental reformed prevention led contract and National Dental Standards for Specialities.									
Delivery of Transformed & Fully Integrated Unscheduled Urgent & Emergency Dental Care Pathway.									
Access.									
<b>2. Action on Prevention and Health Inequalities</b>									
Work with Prevention board to ensure population health management approaches are embedded across all PCNs.									
100% PCNs delivering improvements in Anticipatory Care across the ICS (New Service).									
100% PCNs delivering improvements in Supporting early Cancer diagnosis across the ICS (New Service).									
100% PCNs actively contribute to improvements in CVD Prevention & Diagnosis across the ICS (New Service).									
100% PCNs actively contribute to improvements in Tackling Neighbourhood Inequalities across the ICS (New Service).									
Develop CVD case finding initiatives within community Pharmacy before evaluation and roll out.									
Work with PCNs, Prevention board and community pharmacy and LPNs to develop integrated prevention and diagnosis pathways for areas such as CVD.									
Develop strategy with prevention board to expand the use of [REDACTED] Smoking and Alcohol misuse.									
Engage with Prevention board to agree Plan to address inequalities in [REDACTED]									
<b>3. Care Quality and Outcomes</b>									
Review and Implement improvements in in paediatric Oral Health pathway.									
Review and implement improvements in Adult Special Dental Care.									
Support PCNs to implement Social prescribing as an intervention to contribute to the improvement in wellbeing of patients with Mental Health issues, Dementia, Learning Disabilities Cancer and Co-morbidities.									
<b>4. NHS Staff Will Get the backing they need</b>									
Develop and implement a joint Primary Care Workforce Strategy with HENE to support the introduction of new roles and to address recruitment and retention of GPs and Dentist.									
Engage with PCNs and the wider professions to ensure workforce planning is undertaken at all levels of the system.									
Work with partner organisations to develop system level Clinical Director Leadership program (To roll to all professions).									
<b>5. Digitally Enabled Care</b>									
Maximise the potential of new technology to improve patient pathways and wider integration of health systems.									
Prioritise interoperability across organisation and sectors to deliver fully integrated care.									
100% Patients to have access to online consultations (by 2020).									

**Key performance metrics to track delivery**

**Operating framework measures**

- NHS Digital Data (GPFV Monitoring Survey, Workforce data).
- GP Patient Survey Data.
- NHS England, National Epidemiology Benchmarking (Population Oral Health).
- NHS England, National Dental Benchmarking (Access, Wait Times & Satisfaction Metrics).
- NHS England, National Primary Care Assurance Frameworks Benchmarking (Clinical Quality & Safety).
- NHS England, National Dental Standards (Compliance).

**Other/local measures**

- Local Dental Network (LDN) & Priority Managed Clinical Networks established with formally established links secured within the ICS and emerging PCNs by 2020/21.
- PCNs Maturity Baseline.
- PCN Workforce Baseline.

**National deliverables and allocated resource**

**National deliverables**

- From 2019 the new Primary Care roles will start to be implemented in PCNs.
- In 2020 new enhanced services will start to be delivered to enhance patient care.
- From 2020 roll out of Dental Contract reform.
- 2019-2025 National Dental Standards Compliance e.g. Urgent Care.

**Interdependencies with other ICS and regional workstreams**

Workforce	Digital
<ul style="list-style-type: none"> <li>• The Primary Care workforce strategy is a key enabler to deliver Primary Care Transformation.</li> <li>• Close working, co-design and delivery with HENE is required to ensure the new roles in Primary Care are supported and strategies to address recruitment and retention for GPs and Dentists are developed.</li> <li>• To deliver this ambitious programme oversight will be through the workforce board ensuring delivery.</li> <li>• General Practice new roles to be supported including, Clinical pharmacists (from2019/20), Social prescribing link workers (from2019/20), Physiotherapists (from 2020/21), Physician associates (from2020/21), First contact community paramedics (from2021/22).</li> <li>• Strategy to develop the role of Community pharmacist is in progress.</li> </ul>	<ul style="list-style-type: none"> <li>• Digital and Technology is a key enabler for Primary Care Transformation</li> <li>• Digital First Primary Care.</li> <li>• Enabling Digital referrals in Primary Care and Across sectors.</li> <li>• Supporting innovation e.g. remote consultations and use of apps.</li> <li>• Improving access to patient health records for the wider Primary Care.</li> <li>• Appropriate access to Great North Care Record.</li> <li>• Electronic Prescription Services (EPS) and Electronic Repeat Dispensing (ERD).</li> <li>• Implementation of NHS mail to wider Primary Care.</li> <li>• Supporting integration with systems such as 111.</li> </ul>
Prevention	Optimising Health
<ul style="list-style-type: none"> <li>• Primary Care membership on the Prevention Board to ensure plans are aligned.</li> <li>• Embedding Population Health Management approaches in PCNs and wider Primary Care system.</li> <li>• Public Health and Prevention Campaigns-All Primary Care.</li> <li>• MECC-In Primary Care.</li> <li>• Dental alignment to all Prevention programmes e.g. Oral Cancer.</li> </ul>	<ul style="list-style-type: none"> <li>• Oversight of the Primary Care Strategy and Programme Board.</li> <li>• Links with wider system to ensure alignment and promotes integration.</li> <li>• Oversight of Pharmacy and Medicines Optimisation Pilot.</li> </ul>

## Risks and mitigating actions

Risks	Mitigating actions
PCNs are newly formed organisations and the expectation for them to deliver is high, they are currently overwhelmed by the ask and the offers of support.	Maturity assessment will provide a base line of the current capabilities of the PCNs. Development programmes and support will be developed in response to these.
The role of PCN Clinical Directors is new and delivery is highly depended on the role to provide leadership and direction.	The development of the Primary Care Programme board, a system wide Clinical Director programme and network will seek to support the role.
PCNs are at different levels of maturity across the patch, it will therefore be difficult to achieve consistent delivery of some of the related co-dependent work streams.	The ICS has been working with the CCGs to ensure key areas of development are identified and target. Support will be wrapped around the development of the PCNs and the delivery of the ICS plan.
The rapid implementation of the Community Pharmacy contract changes will require support from other workstreams and will need a rapid education of the system.	Detailed delivery plans will be developed, and the Optimising Pharmacy and medicines pilot will be utilised to support this.
Dental Initiatives will require recurrent investment to deliver sustainable solutions.	Work with finance and Local Dental Networks and Managed Clinical Networks to ensure maximum impact of pathways.
Workforce pressures are significant in General Practice and Primary Dental service and potentially will impact on delivery of the plan and stability of services.	Working with HENE joint initiatives are being considered with regards to recruitment and retention.
Competing LTP priorities.	Engagement with ICS workstream leads. ICS governance structures for escalation and priority agreement.

### Implications for operational planning 2020/21

Indicative development funding is in place for the PCNs for 5 years, although this has not been quantified past 19/20 at this stage planning is therefore difficult and pilots are often too short to evaluate, future funding of initiatives needs to be considered at the outset.

Recurrent funding of dental services needs to be considered to provide adequate access in areas of greatest need.

Workforce across primary care is a significant issue the shortfall may impact on the ability to deliver, careful consideration is required with regards to the pace of change.

The current ask of PCNs is significant the ICP needs to consider the reliance on PCNS in all its plans as a means of delivery and the required development.

New posts in primary care require a system wide approach to see them fully embedded.

The rapid implementation of the pharmacy contract reforms will be greatly aided with a focus on digital advancement.

To ensure PCN are successful, strategies need to focus on building capability.

Developing PCNs into truly integrated systems requires new ways of working which will be dependent on partnership working.

Investment to deliver certain aspects of the plan such as social prescribing (services to refer to), prevention including smoking and population health management approaches will be depended organisations other than the NHS, including local authorities.

Development of formal managed clinical networks to support dental pathway development and transformation is required.

### Partner Organisations

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• NHS England and Improvement</li> <li>• North East Commissioning Support Unit (NECSU)</li> <li>• Local Representatives Committees</li> <li>• NHS Digital</li> <li>• Local Authorities</li> <li>• Health and Wellbeing Boards</li> <li>• Clinical Commissioning Groups (CCGs)</li> <li>• Primary Care Networks (70)</li> <li>• Local Professional Networks</li> </ul> | <ul style="list-style-type: none"> <li>• Public Health England</li> <li>• Healthwatch</li> <li>• North East Ambulance Service (NHS 111)</li> <li>• North East Leadership Academy</li> <li>• National Association of Primary Care</li> <li>• Health Education England</li> <li>• Integrating Pharmacy and Medicines Optimisation Programme</li> <li>• Workforce Board</li> <li>• Primary Care Independent contractors</li> </ul> |
|--|---|

**Radiology SRO:** Alison Featherstone, Programme Director

**Clinical Lead:** Dr Richard Cooper

**Programme Management Support:** Lynn George, Delivery Lead, Laura Hope, Programme Manager

**Why is change needed?**

There is a severe workforce crisis in radiology services as well as a growing demand for services. The regional outsourcing cost has risen from £1.5m four years ago to £10.1m last year due to lack of consultant radiologists. The vision for transforming Radiology Services is to ensure sustainability over the next 2 years to design excellent long-term imaging services for patients in Cumbria and the North East, addressing current workforce and technological challenges to support Acute and Community Medical services. This is broken down into three major workstreams for delivery: People, Place, Process.

**Planned impact of our ambition**

A collaborative approach to implement the recommendations of the Cumbria and North East Clinical Imaging Group to futureproof services. The key approaches are:

- Enabling the workforce to work flexibly by utilising IT solutions to enable movement of images between Trusts.
- To collaborate and make best use of resources to improve outcomes for patients, wherever they live in our region.
- To implement networking solutions and deliver the workforce strategy.

**Our ambition**

**By 2020**

We will continue implementation of digital connectivity.

**By 2021**

We will have a networked solution agreed and in place for radiology.

**By 2028**

We will have a more sustainable radiology service in place.

**Strategic priorities and timeline**

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Led by CNEIG design excellent long-term imaging services, addressing current workforce and technological challenges to support services.</b>									
- Implement Digital system – system convergence.									
- Agree regional standards for system working.									
- Implement new ways of working supported by digital system including hub and home reporting.									
- Utilise the workforce – passports.									
- Increase workforce – training recruitment skill mixing.									

**Key performance metrics to track delivery**

**Operating framework measures**

- Diagnostic waiting times standard.
- 28 day faster diagnostic standard.
- Cancers diagnosed at an early stage.

**Other/local measures**

- Workforce plans in place – training and role development changes.
- Diagnostics access and capacity building.

**National deliverables and allocated resource**

**National deliverables**

- By 2028 the NHS will diagnose 75% of cancers at stage 1 or 2.
- By 2019 we will start to roll out Rapid Diagnostic Centres.

**Finance**

- Cancer project support 0.4 wte band 8a and clinical lead time from NCA.
- HSLI monies have been secured for 19/20; and a bid is in place to implement hubs and home working.

**Interdependencies with other ICS and regional workstreams**

Workforce	Digital
<ul style="list-style-type: none"> <li>• Work with ICS workforce lead to consider future workforce needs in accordance with the strategic objectives and spirit of the workforce programme - align supply and education needs to enable the future workforce to experience great places to work, where leadership is valued and supported at all levels.</li> <li>• Review the outputs of the strategic workforce planning project and consider approaches and changes needed to realign skills and ways of working to meet the population health needs for 2025 and beyond.</li> </ul>	<ul style="list-style-type: none"> <li>• Networking radiology – continued implementation of integration and convergence of systems to support the radiology strategy.</li> <li>• Utilise the HSLI bid to implement hub and home working.</li> </ul>
Cancer	Optimising Health
<ul style="list-style-type: none"> <li>• Implement Rapid Diagnostic Centres.</li> <li>• Improve time to diagnose.</li> </ul>	<ul style="list-style-type: none"> <li>• Radiology workstream delivery.</li> </ul>

## Risks and mitigating actions

Risks	Mitigating actions
Indicative funding is in place for Alliances but the details and the uncertainty about the funding for long term projects makes planning long term difficult.	
Pressures in system due to increased demand caused by the cancer strategy to increase referrals.	Pathway boards to develop. new ways of working and sharing capacity.
Workforce shortages in key staff groups.	Engagement with workforce ICS workstream.
Timeframes for implementation of the cancer workplan may be impacted by competing ICS LTP priorities.	Engagement with ICS workstream leads to align programmes of work ICS governance structures for escalation and priority agreement.

## Implications for Operational Planning 2020/21

- Programme is dependent on Cancer Alliance funding which is only indicative at present.
- Radiology strategic direction requires new ways of working which may require changes to contracts – for example hosting arrangements.
- HSLI funding is not yet confirmed for 20/21 and 21/22 which would impact on ability to implement plan.
- Increased demand due to cancer strategy to lower referral thresholds could mean insufficient capacity is in place.

## Partner Organisations

All provider trusts.

**Pathology SRO:** Sue Jacques, CDDFT, Professor Chris Gray, NHS E & I

**Programme Director:** Ruth James

**Programme Management Support:** TBC

### Why is change needed?

The North East and North Cumbria Regional Pathology Programme was established in 2017 to drive forward a network approach to pathology delivery. The objectives of the Pathology Programme are:

- Ensure high quality patient outcomes are achieved through a sustainable Pathology Service which is fit for the future and makes the best use of scarce resources, including our workforce.
- Improve collaboration, knowledge sharing and best practice across the Pathology profession.
- Improve the quality of Pathology and reduce variation across the North East and Cumbria.
- Develop a system wide approach to the payment mechanism for Pathology.

### Planned impact of our ambition

The planned impact of the programme are to:

- To create a flexible and sustainable pathology workforce model with reduced reliance on temporary staff and overtime and a workforce with access to the appropriate levels of training and development.
- To implement a standardised pathology service model across the local health economy reducing duplication, delays and waste.
- Reduce the unit cost of pathology testing within the local economy.
- Reduce the overall revenue costs of the pathology service.
- Create a single pathology patient record accessible by clinicians across primary and secondary care irrespective of geographical and organisational boundaries.
- Ensure that services are compliant with accreditation, ISO and regulatory requirements.
- Take forward the digital agenda including linking with the Cancer network re digitisation of Cellular pathology and moving laboratories onto a single Laboratory Information Management system.

### Our ambition

#### By 2020

LIMS system - implementation of phase 1 commenced.

Implementation of the Durham and Tees Valley Pathology Service commenced.

Regional pathology strategy agreed.

#### By 2021

LIMS roll out underway.

Durham and Tees Valley Pathology service established as single entity.

Implementation of regional scientific workforce model.

Regional pathology procurement strategy in place and operational.

#### By 2028

An integrated pathology service operational across the region.

Strategic priorities and timeline	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
Programme overseen by OHS Board.									
NC and North Steering Group established.									
DTV Pathology Board established.									
NC and NE Laboratory managers – operational group established.									
<b>Digital and IT</b>									
Agreed LIMS Procurement strategy including specification, interoperability and phasing of organisations onto new system.									
Procurement live.									
Preferred providers notified.									
Roll out of system underway.									
Haematology digitisation roll out.									
<b>Workforce Strategy and plan</b>									
Develop regional strategy for developing the scientific workforce including the development of new roles.									
Work with the pathology consultant workforce to increase collaboration and joint working supported by new digital technology and new service models.									
<b>Standardise job descriptions and working practices where appropriate</b>									
Implement the new workforce model to support the Durham and Tees Valley Pathology Service.									
<b>Estates Strategy</b>									
Ensure most effective use of pathology estate, reduce duplication and waste.									
Develop regional pathology logistics solution.									
<b>Finance, Contracting and organisational form</b>									
<b>Procurement</b>									
Implement regional LIMS procurement.									
Develop and implement regional pathology procurement strategy.									
<b>Durham and Tees Valley Pathology project - consolidation</b>									
Project team established.									
OBC Signed off by FT Boards.									
FBC signed off by Boards.									

## Risks and mitigating actions

Risks	Mitigating actions
<p>Due to the need for collaborative agreement across the health economy on a feasible option for implementation, there is a risk that the full benefit of a consolidated pathology service will not be achieved if one or more organisations do not fully engage.</p>	<ul style="list-style-type: none"> <li>• Frequent comms and engagement and a stakeholder plan developed to ensure any early discussions can be managed.</li> <li>• MOU developed although not signed by all – to be refreshed.</li> <li>• ICS governance structure. All organisations included in development and planning.</li> </ul>
<p>Due to the potential change to the organisational structure and commercial model for pathology services, there is a risk that laboratory accreditation in place for the individual laboratories will not apply to the new network pathology service, leading to regulatory and contractual breach.</p>	<p>Work with UKAS guidance to plan for maintenance of accreditation. Maintain links with NHSI Pathology lead as this will be a National issue.</p>
<p>Due to the uncertainty of future employment arrangements, there is a risk that staff turnover will increase, leading to a loss of skills and expertise.</p>	<ul style="list-style-type: none"> <li>• Staff engagement in the project.</li> <li>• Robust HR processes underpinned (where needed) by legal advice and expertise.</li> <li>• An offer of flexible working options and retention strategies</li> <li>• Good communications.</li> <li>• Staff support framework in place, including resilience training and coaching model.</li> <li>• Partnership approach and engagement with trade unions.</li> </ul>

## Partner organisations

- All NC and NE FTs
- NHSI/E
- HEE
- NC and NE CCGs

## APPENDIX 3.13 CARDIOLOGY

**Cardiology SRO:** Professor Chris Gray, David Gallagher, Penny Gray

**Programme Management Support:** Elaine Stephenson

### Why is change needed?

- CVD causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. Early detection and treatment of CVD can help patients live longer, healthier lives.
- Long Term Plan sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.
- NECN Let's Talk Cardiology Programme sets out the commitment from stakeholders to drive future service improvement for cardiac services across the ICS.

### Planned impact of our ambition

- Increased efficiency of the whole care delivery system, while promoting care excellence; the impact would be a more efficient delivery system, improvements in access, pathways and productivity, reduced waste/duplication and better patient outcomes and experience.
- To support delivery, we will develop a new operating model, based on the principles of co-design and collaboration, working with leaders from across the NHS and with our partners.
- The development of new NHS roles and careers will be shaped to reflect the future needs and priorities of NE&NC cardiac services, reflected by the LTP & Let's Talk Cardiology programme.

### Our ambition

#### By 2020

Leadership Forum in place to drive the Let's Talk Cardiology Programme.

ICS agreement to defined and detailed programme of work including supporting plan resources and governance arrangements.

#### By 2021

Baseline cardiology provision established across the ICS.

Collaborative working across ICS Option appraisals completed for key service developments.

#### By 2028

Reduced variation and improved access, provision & sustainability of services across the ICS.

Patients receiving the right care at the right time in the right place.

Increased uptake and completion of rehabilitation.

## APPENDIX 3.13 CARDIOLOGY

Strategic priorities and timeline	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Diagnostic Imaging</b>									
Establish clinical algorithm for 'what test is best'.									
Validate current state – what test is available where, activity levels, wait times, gaps.									
Develop future state options on service delivery/coverage, including capacity and workforce implications.									
Develop financial model including savings and investment.									
<b>Cardiac Emergencies</b>									
Agree scope (acute presentations of coronary disease, heart failure and rhythm disturbance).									
Map provision across system – capability/capacity.									
Define current state – of all services in scope, incl. current performance, variation, mortality & survival, QOL metrics, access times, workforce.									
Develop options for future state to deliver ambition incl. resource modelling.									
NECVN-wide inter-hospital transfer referral IT system (i.e.: NSTEMI, pacing / device patients / surgery).									
<b>Heart Failure</b>									
Data analysis of echo services, NT ProBnp testing and access to rehabilitation to evidence inequities of provision.									
Increase number of HF patients diagnosed in primary care.									
Development of primary care guidance and pathways for the investigation & management of HF.									
Options appraisal to improve provision of rehabilitation services accessible to people with HF.									
Option assessment for implant services complex cardiac devices.									
<b>Arrhythmia</b>									
Validate current state – activity levels, waiting times, gaps.									
Develop future state options on service delivery/coverage, including capacity and workforce implications.									
<b>Adult Congenital Heart Disease</b>									
Development of ACHD Operational Delivery Network.									
NECN Clinical Network has set up a ACHD sub group, the remit of this group is to currently support the clinical teams until an ODN structure is in place.									
<b>CVD Prevention</b>									
<b>Maintain momentum on existing priority areas from 2018-19 workplan:</b> AF, high blood pressure, raised cholesterol (including FH).									
<b>Development of ICS strategy will inform further ambition, key deliverables and milestones.</b> 24 July – strategy planning meeting; 9 October - strategy development day.									
<b>Rehabilitation</b>									
Development of the national accreditation and national audit programmes for cardiac rehabilitation, with support to act on results to improve service quality by the end of 2020/21; increase uptake across the NENC.									
Define current state of all services in scope, current performance, variation, access times, workforce.									
Increase rehabilitation uptake to 85%.									

## APPENDIX 3.13 CARDIOLOGY

### Key performance metrics to track delivery

#### Operating framework measures

- Impacts on population health, e.g. reduced mortality from heart attacks?
- Evidence of integrated pathways (joint commissioning) resulting in better value for money?
- Evidence of digital developments to enhance secure information sharing across and between providers?

#### Other/local measures

- Annual Review of implantation of pacemakers and complex devices.
- Annual review of PPCI delivery, MINAP.

### National deliverables and allocated resource

#### National milestones

- Increase uptake of Cardiac Rehabilitation to 85%.
- Deliver Non-ST Elevation MI treatment within 72 hours.
- Deliver Primary PCI treatment, 'call to balloon' – the time interval between first call for professional help (ambulance) and the start of the PPCI procedure (target?), 'door to balloon' – the time interval between arriving at the Heart Attack Centre and the start of the PPCI procedure (PPCI within 90mins).
- National Service Specification Cardiac MRI, 2275 scans per million adults per year.

## APPENDIX 3.13 CARDIOLOGY

### Interdependencies with other ICS and regional workstreams

Primary Care	Workforce
<ul style="list-style-type: none"> <li>CVD prevention network and development and implementation of pathways.</li> </ul>	<ul style="list-style-type: none"> <li>Workforce demand and capacity; developing new ways of working to address skills gaps. Clinical Passports.</li> </ul>
Prevention	Specialised Commissioning
<ul style="list-style-type: none"> <li>Collaboration with PHE, Local Authorities and Third Sector Organisations to meet requirements for CVD prevention.</li> </ul>	<ul style="list-style-type: none"> <li>Cardiac Emergencies, (Primary PCI, implanted cardiac devices, Cardiac MRI).</li> <li>Cardiac MRI.</li> <li>Complex Devices Implantation.</li> <li>ACHD ODN.</li> </ul>
Personalisation	Mental Health
<ul style="list-style-type: none"> <li>Embedded in ESD and rehabilitation workstream.</li> </ul>	<ul style="list-style-type: none"> <li>IAPT and LTC.</li> </ul>
Digital Workstream	
<ul style="list-style-type: none"> <li>Information sharing across and between providers.</li> </ul>	

## APPENDIX 3.13 CARDIOLOGY

### Risks and mitigating actions

Risks	Mitigating actions
Workforce (Recruitment/Retention and Skill mix).	Ensure sustainable overall balance between supply and demand across all staff groups.
Variability of access and provision to services.	Reduce unwarranted variation and provision to services that ensures timely assessment and treatment for all who require it
Historical competitive practices/Clarity on Governance.	Create a “Managed Cardiac Network” which brings together local organisations to redesign care and improve population health, creating shared leadership and action

### Implications for operational planning 2020/21

- Funding/Budget.
- Clarity on Governance.
- Collaboration – requirement to develop and resource Managed Clinical Network.
- Clinical Leadership.
- Transformational Change/Programme Management resources.
- Patient Involvement.
- Digital resources/information sharing.

### Partner organisations

<ul style="list-style-type: none"> <li>• BHF</li> <li>• Stroke Association</li> <li>• Northumbria University</li> <li>• Trusts</li> <li>• GP Practices</li> <li>• Heart Rhythm Alliance</li> </ul>	<ul style="list-style-type: none"> <li>• Healthwatch</li> <li>• Public Health England</li> <li>• HENE</li> <li>• AHSN</li> <li>• CCGs</li> <li>• NHS England &amp; NHS Improvement Specialised Commissioning</li> <li>• Local Authorities</li> </ul>
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## APPENDIX 3.14    **CARDIOVASCULAR DISEASE PREVENTION and VASCULAR**

**SROs:** Wendy Burke, Tim Butler

**Programme Management Support:** Lynn Hamil

### Why is change needed?

- Cardiovascular Disease (CVD) causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. Early detection and treatment of CVD can help patients live longer, healthier lives.
- Too many people are still living with undetected, high-risk conditions such as high blood pressure, raised cholesterol, and atrial fibrillation (AF). Where one hundred people with AF are identified and receive anticoagulation medication, an average of four strokes are averted, preventing serious disability or death.
- Indeed one-size-fits-all statutory services have often failed to engage with the people most in need, leading to inequalities in access and outcome
- The North East & North Cumbria continue to have the highest rates of lower limb amputations in England. Improvements are needed across prevention, early diagnosis of PAD and the implementation of early interventions to address this.

### Planned impact of our ambition

- Reduced inequalities and unwarranted variation in health through stronger action and partnership working.
- Strategy development will enable greater promotion and increased awareness of cardiovascular disease.
- Improving and increasing early detection and optimised treatment of high-risk conditions.
- Reduced Cardiovascular Disease related incidences across a North East and North Cumbria ICS. Meet Long Term Plan ambition in relation to Cardiovascular Disease Prevention.
- Rates of lower limb amputations in line with or lower than the England average.
- Improved pathways for the diagnosis and management of PAD including early diagnosis in primary care.
- Early interventions for those with diabetes via multidisciplinary diabetic footcare teams.

**The NHS Long Term Plan also identifies prevention opportunities relating to out of hospital cardiac arrest, heart failure and cardiac rehabilitation that STP/ICSS will want to consider alongside the CVD prevention ambitions.**

### Our ambition

**By 2020**

**Launched a Cardiovascular Disease Prevention Strategy for North East and North Cumbria.**

**By 2028**

**Reduced health inequalities and CVD related incidences in North East and North Cumbria.**

**Vascular**

**By 2020**

**Agreed Vascular work plan Agreement on configuration of arterial centres.**

**By 2021**

**Rehabilitation programme.**

**By 2028**

**Reduction in rates of PAD. Amputation rates in line with or lower than England average.**

## APPENDIX 3.14 CARDIOVASCULAR DISEASE PREVENTION and VASCULAR

Strategic priorities and timeline	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Cardiovascular Disease Prevention Network</b>									
ICS Strategy development – level of ambition, in terms of numbers to be determined.									
<b>High Cholesterol</b>									
Increase detection of Familial Hypercholesterolemia to 25%.									
75% of people aged 40-74 receive a formal valid CVD risk assessment and cholesterol reading on primary care data system.									
45% of people aged 40-74 identified as having 20% or greater 10-year risk of developing CVD in primary care are treated with statins.									
<b>Atrial Fibrillation</b>									
85% expected number of people with AF detected by 2029. In the North East and North Cumbria there has been a two year NHS England national programme run through the AHSNs involving rollout of Pulse Detection devices across the area. A national target of 85% detected prevalence was given for March 2020 forecasting by NEQOS suggests that the majority of CCGs will exceed the 85% prevalence target by this date.									
90% patients with AF who are known at high risk of stroke adequately anticoagulated by 2029. NHS England Atrial Fibrillation optimising demonstrator programme delivered in 23 CCGs across England. Northumberland CCG, North Tyneside CCG and North Cumbria CCG are part of this programme. Evaluation to inform best practice service specification.									
<b>High blood pressure</b>									
80% of total number of people already diagnosed with high blood pressure treated to target as per NICE guidelines by 2029.									
80% of the expected number of people with high blood pressure are diagnosed by 2029.									
<b>Reduce Health Inequalities</b>									
Implement CVD PREVENT Audit.									
Meet national deliverables.									

## APPENDIX 3.14 CARDIOVASCULAR DISEASE PREVENTION and VASCULAR

Strategic priorities and timeline	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Vascular priorities</b>									
<b>Diagnosis of PAD in primary care</b>									
Guideline implemented across ICS.			■	■	■				
Referral pathways in place.			■	■	■	■			
Provision of ABI sessions locally to support early diagnosis.						■	■	■	
<b>Rehabilitation</b>									
Develop accessible model of rehabilitation.	■	■	■	■	■	■	■		
<b>Prevention</b>									
Development and implementation of ICS CVD prevention strategy.	■	■	■	■	■	■	■		
<b>Arterial Centres</b>									
Agreed model for the delivery of arterial surgery in North Cumbria.	■	■	■						
<b>Carotid Endarterectomy</b>									
Reduction in waiting time to meet national guidance.	■	■	■	■	■				
<b>Workforce</b>									
Contribute to the development of new ways of working to address workforce shortages	■	■	■	■	■	■	■	■	■

### Key performance metrics to track delivery

#### Other/local measures

- % of people on optimal treatment with high risk CVD conditions.
- % of people newly diagnosed and on optimal treatments.
- CVDPREVENT Audit is implemented and adopted by 100% practices.
- CCGs identified as most deprived and at risk groups such as BME are demonstrating an improvement in the proportion of people who are on optimal treatment via NHS Health Check.
- Overall, an improvement in the NHS Health check uptake.
- Number of people going through Diabetes Prevention Programme.
- National Vascular Registry (NVR) Audit.

## APPENDIX 3.14 CARDIOVASCULAR DISEASE PREVENTION and VASCULAR

### National deliverables and allocated resource

#### National milestones

- Prevent up to 150,000 heart attacks, strokes and dementia cases over next 10 years.
- Develop and roll out CVD PREVENT audit.
- Increase numbers of people with CVD who are treated for high risk conditions (Atrial Fibrillation, Blood Pressure, Cholesterol).
- Increase genetic testing for Familial Hypercholesterolemia to 25% by 2025.
- Increase in detection of FH to 25% (next 5 years).
- Reduction in gap in CVD deaths between most and least deprived areas every year over 10 years.
- Optimise treatment of 3 high risk conditions.
- Personalised care experience that support adherence to optimal treatment.
- Increase in GP capacity to better manage CVD Prevention.
- Develop QoF Quality improvement module for CVD Prevention.
- Reduction in emergency admissions
- Standardised evidence based pathways

### Risks and mitigating actions

Risks	Mitigating actions
Clarity on Governance.	Links into ICS Prevention Board, LA and PHE reporting lines. May be helped by additional SRO with prevention focus e.g. Peter Kelly (PHE National Lead for CVD Prevention).
Some legacy politics around responsibility for prevention.	Continue to develop, engage and grow CVD Prevention Network.
Impact of National Review of NHS Healthchecks programme.	Continue to keep linked with Directors of Public Health Network and Lead DoPH for Health checks around impact.

## APPENDIX 3.14 CARDIOVASCULAR DISEASE PREVENTION and VASCULAR

### Interdependencies with other ICS and regional workstreams

<b>Mental Health</b>	<b>Primary Care</b>
<ul style="list-style-type: none"> <li>IAPT services and long-term conditions.</li> </ul>	<ul style="list-style-type: none"> <li>Early detection and treatment.</li> <li>Effectively utilising primary.</li> </ul>
<b>Workforce</b>	<b>Medicines Optimisation</b>
<ul style="list-style-type: none"> <li>Ensure appropriate workforce to meet demands of work programme in terms of roles and responsibilities.</li> <li>Collaborate with HENE where appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>Increased working and development of the community pharmacy role.</li> <li>Development of a PCN service specification to include medicines optimisations reviews.</li> </ul>
<b>Health Inequalities</b>	<b>Prevention</b>
<ul style="list-style-type: none"> <li>CVDPREVENT Audit will support identification of health information.</li> </ul>	<ul style="list-style-type: none"> <li>Smoking, alcohol harm and obesity is disproportionately prevalent across almost all health exclusion groups as well as deprivation decile.</li> <li>Diabetes Prevention, obesity and wider CVD Disease impact.</li> <li>Reduce and prevent AF related strokes.</li> </ul>

### Implications for operational planning 2020/21

- Increase cost of medication.
- Capacity to carry out activities/screening.

### Partner organisations

#### Stakeholders:

- **ICS CVD Prevention network** brings together a range of key partners and stakeholders.
- **Patients and carers.**
- Public Health England.
- LAs and NHS Healthchecks.
- Primary Care Networks.
- Local Pharmacy Committees.
- NICE.
- NHS Right Care.
- British Heart Foundation.
- Stroke Association.
- ICS Prevention Board.
- AHSN AF and FH programmes.
- Regional (North) CVD Prevention Forum.
- Stroke and Footcare networks re: AF.
- Vascular clinical network and PAD.
- Potential link to Heart Failure (detection).

**SRO:** Michael Houghten, Director of Commissioning County Durham CCG

**Programme Management Support:** Karen Eastwood, Rachel Henwood, Anna Scamans

### Why is change needed?

- According to the National Diabetes Audit, the total number of people with Type 2 diabetes in 2017/18 is around 3.5 million with a national prevalence of 6.8% (QoF) and regionally this is higher than the national average at around 7.2%.
- The number of people diagnosed with diabetes has increased from 2.6 million in 2009 – a “do nothing” approach would see this number continue to increase and is currently 200,000 diagnoses annually.]
- There are around 200,000 people in the region living with Diabetes (QoF), with approximately 40% over the age of 65 (higher than national average).
- The prevalence of non-diabetic hyperglycaemia is estimated to be around 250,000 people for the region and over 5 million people nationally (PHE).

### Planned Impact of our ambition

- Reduce the incidence of Type 2 Diabetes.
- Improve quality of care and patient choice for individuals with Type 1 & Type 2 Diabetes.
- Reduce the incidence of complications associated with diabetes: heart, stroke, kidney, eye and foot problems related to diabetes.
- Reduce inequalities associated with the incidence of diabetes.

### Our ambition

#### By 2020

100% coverage and rollout for new framework for NDPP.

New governance arrangements with MoU to ICS Diabetes Steering Group & Clinical Network.

#### By 2021

100% ICS coverage of HeLP.

Over 30,000 individuals referred onto NDPP across the region.

20% of Type 1 receiving flash glucose monitoring sensors (inc every pregnant woman with T1).

#### By 2028

Reductions or delay in diabetes incidence by 26%.

Reductions in Length of Stay for people with diabetes across the region.

Proportionate representation on NDPP from identified vulnerable groups.

Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>Diabetes Prevention</b>									
Support for the National Diabetes Prevention Programme to reach 50,000 participants nationally.									
Support for rollout of digital prevention options with 100% coverage regionally in 2020/21.									
<b>HeLP Diabetes</b>									
Product development and support facilitation as identified early adopter ICS.									
Establish governance arrangements for ICS ensuring readiness for adoption.									
Roll out HeLP Diabetes across the ICS (may vary depending on phased rollout selection determined nationally).									
<b>Low Calorie Diets</b>									
Develop ICS specification for LCD and EOI submitted.									
Development and growth of the pathway inc readiness check.									
Pilot optimal delivery approaches (dependent on selection as a delivery site).									
<b>Type 1 Resources</b>									
Support and monitoring of rollout of LIBRE devices across region.									
Review of Diabetes and Pregnancy pathway.									
Review of Children & Young People Services transition pathway.									
<b>Treatment and Care</b>									
Support of assurance and delivery function for established projects (MDFT, Treatment Targets, DISN, Structured Education) inc development of sustainability plans.									
Supporting preparation for targeted funding for sites that don't yet have access to MDFTs and DISNs and ongoing monitoring for evidence of benefits.									

Key performance metrics to track delivery

Operating framework measures

- NDPP – MoU in place between local health economies and NHSE.
- Existing Treatment and Care programmes – MoU in place between local health economies and NHSE committing to sustainability of services/offering 2 years post initial funding.
- HeLP.
- Low Calorie Diets.

Other/local measures

- National Diabetes Audit.
- Transformation Treatment.

## National deliverables and allocated resource

## National milestones

- NDPP to reach 200,000 patients nationally.
- Improving achievement of the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure) and reducing variation.
- Improving uptake of structured education (currently 7% nationally).
- Reducing amputations by increasing availability of multidisciplinary footcare teams.
- Reducing lengths of stay for in-patients with diabetes by increasing availability of diabetes inpatient specialist nurses.
- All pregnant women with type 1 diabetes to be offered continuous glucose monitoring by 2020/21.

## Finance

	2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24
	0.164 ICS Funding to support all aspects of NDP  0.211 Diabetes Clinical Network funding	0.862 ICS treatment and care Funding	0.862 ICS treatment and care Funding	0.754 ICS treatment and care Funding	0.754 ICS treatment and care Funding

## Interdependencies with other ICS and regional workstreams

Primary care	Workforce
Engagement around primary care network, collaboration with GPs and development and implementation of pathways.	
Prevention	Specialised commissioning
Collaboration with PHE, Local Authorities and Third Sector Organisations to meet requirements, especially for NDPP.	Collaboration with NDPP for translation services.
Personalised care	Mental health
	Refining national programmes of work (inc NDPP) for individuals with MH.

## Risks and mitigating actions

Risks	Mitigating actions
Workforce – DISN.	Support to national programme of more long-term initiatives where funding can be in place 1 year+. Shared learning to increase.
Long term sustainability of programmes established by the transformation funding.	Collaborative work with CCGs to develop business cases to ensure locally sustained programmes of work based on evidence based information.
Lack of evidence to support efficacy of interventions for diabetes and prevention especially for vulnerable groups.	Support to national programme of increasing monitoring and identification of suitable pilots especially for LD & MH groups.  Utilisation of a devolved budget to pump prime local initiatives.

## Partner organisations

<ul style="list-style-type: none"><li>• NHS Trusts</li></ul>	<ul style="list-style-type: none"><li>• AHSN</li></ul>
<ul style="list-style-type: none"><li>• CCGs</li></ul>	<ul style="list-style-type: none"><li>• Local Authorities</li></ul>
<ul style="list-style-type: none"><li>• Representatives from North, Central, South &amp; N Cumbria ICPs</li></ul>	<ul style="list-style-type: none"><li>• Diabetes UK</li></ul>
<ul style="list-style-type: none"><li>• PHE</li></ul>	<ul style="list-style-type: none"><li>• JDRF</li></ul>

**Respiratory SRO:** Professor Chris Gray  
**Programme Management Support:** TBC

### Why is change needed?

- Lung conditions, including lung cancer, are estimated to cost wider society around £9.9 billion each year.
- Respiratory disease affects one in five people in England and is the third biggest cause of death.
- Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally and remain a major factor in the winter pressures faced by the NHS.
- Incidence and mortality rates for those with respiratory disease are higher in disadvantaged groups and areas of social deprivation, where there is often higher smoking incidence, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.
- It is recognised that the design, capacity and capability of current services is insufficient to cope with projected numbers of people with respiratory disease e.g. Chronic Obstructive Pulmonary Disease (COPD). The NHS need to do more to detect and diagnose respiratory problems earlier.

### Planned impact of our ambition

- Increased equitable, early and accurate diagnosis for people with respiratory disease.
- Medicines management: to promote appropriate prescribing of respiratory medication and inhaler use to promote better compliance and prevent avoidable acute admissions and deaths from poor self-management.
- Good access to continued education and training for professionals.
- Flexible learning: to develop an accredited education programme for individuals diagnosed with common respiratory diseases such as COPD, asthma and bronchiectasis.
- Expansion of pulmonary rehabilitation: to increase the number of patients who would benefit from Pulmonary Rehabilitation and are referred to and complete a good quality programme.
- Community-acquired pneumonia: to reduce avoidable admissions and bed days for patients with community acquired pneumonia, achieved through implementation of risk stratification tools and ambulatory care services such as nurse-led supported discharge services.
- Breathlessness models: A model of care for breathlessness management is designed for patients who have either cardiac or pulmonary disease and have symptoms of breathlessness in common, to include the diagnostic pathway and joint rehabilitation models.
- Increased access to CBT for COPD as a Long-Term Condition.
- Reduced tobacco dependency to 5% smoking prevalence by 2025.

### Our ambition

**By 2020**

Establish a North East and North Cumbria ICS Respiratory Network.

**By 2021-24**

NENC network agreed pathways and guidelines agreed and implemented (based on the NENC network owned workplan priorities).

**By 2028**

Reduction in hospital admissions across NENC ICS.

Move away from reactive based treatment to a proactive model of care delivery.

Early and accurate diagnosis of COPD and Asthma.

Increased access to pulmonary rehabilitation, Optimisation of medication for all patients with COPD /Asthma.

Effective management of Pneumonia.

Reduction in tobacco dependency.

Increased access to CBT for patients with COPD.

Improved skills in management of respiratory conditions for staff and patients.

Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>ICS Establish a North East and North Cumbria Respiratory Network</b>									
Establish a North East and North Cumbria Respiratory Disease Advisory Group.									
Appoint Clinical Lead/s for Respiratory Disease.									
North East and North Cumbria Respiratory Disease Launch Event.									
Establish a NENC workplan priorities owned by the Network based on the outputs from the launch event and National priorities.									
Fully functioning Respiratory Network by April 2020 with associated governance in place.									
Pathway development (based on the NENC network owned workplan priorities).									
New rehabilitation models in place (based on the NENC network owned workplan priorities).									
<b>ICP Smoking Cessation</b>									
Work with ICPs to ensure they are offering targeted advice and support for COPD and asthma patients and their families in collaboration with the tobacco dependency workstream within the NENC ICS prevention programme.									
<b>ICP Pulmonary Rehabilitation</b>									
Work with ICPs to ensure review and implement changes to existing pulmonary rehabilitation service models to improve access, uptake and outcomes.									
Work with ICPs to ensure primary care to identify eligible patients from COPD registers who haven't previously been referred for rehabilitation and consider economies of scale with generic breathlessness support and third sector models of ongoing rehab (e.g. breathe easy).									
<b>ICP Flu &amp; Pneumonia</b>									
Work with partners to ensure an increased offer and uptake of vaccinations in at risk population.									
<b>ICP Avoiding unnecessary admission to hospital</b>									
Work with ICPs to ensure they implement changes to primary and community pathways (and services) enabling rapid access to support for stable patients to be managed in the community – including enhancing psychological, early intervention and prevention support.									
Work with key partners to ensure emergency care plans are in place for those at risk of admission (care homes).									
Work with ICPs to ensure they design and implement a model of care (or pathway) to better support community acquired pneumonia in line with national guidance and roll out use of DECAF tool and Hospital at Home model.									
<b>ICP Self-Care</b>									
Work with ICPs to ensure they support patients to self-manage their respiratory condition working with key partners to roll out the 'MyCOPD' app.									
Work with ICPs to ensure they improve pathways to IAPT/CBT to support patients diagnosed with LTC to manage anxiety and reduce risk of exacerbations.									
Work with ICPs to ensure they work with key partners to ensure that those at risk of respiratory infections & exacerbations are able to access available winter warmth support & advice.									
Work with ICPs to ensure they work with services and key partners to embed opportunities to deliver education and advice around self-care and self-management; and implement any future national recommendations relating to patient education.									
<b>ICP Primary Care Management</b>									
Informed by national guidance and working with local clinical respiratory leads; develop and implement local clinical guidelines to improve the management of respiratory patients.									
Design and implement enhanced education across primary care to support improvements in management of COPD, asthma and bronchiectasis.									
Reduce variation in quality of management of patients with asthma and COPD within primary through use of clinical support systems and standardised templates.									
Implement enhanced medicines management support to primary care networks to increase appropriate prescribing and promote increased compliance.									
Improve the quality of diagnostic spirometry through implementation of ARTP training across primary care networks.									
Work with PCNs and key partners to ensure all networks have access to quality assured diagnostic spirometry (recording and interpretation).									
Standardise Medicines Use Reviews (MURs) for Asthma Patients in Community Pharmacy settings.									
Improve inhaler technique and use educating both patients and professionals.									

### Key performance metrics to track delivery

#### Operating framework measures

- Within 5 years increase PR referral rates to 60% and completion rates to 90%.
- Numbers ARTP registered.
- Reported to estimate prevalence of COPD.
- Smoking quitters.
- % of patients with COPD who have had a review.
- % of patients with Asthma who have had a review.
- % of patients with COPD who have had influenza immunisation.
- % of patients with COPD and (MRC) dyspnoea scale  $\geq 3$  with a subsequent record of an offer of referral to a pulmonary rehabilitation.

#### Other/local measures

- Reduction in A&E attendances and emergency admissions associated with respiratory problems.
- Enhanced spirometry care in place.
- Increased access to pulmonary rehab exercise and education programmes.
- Number of people referred and completing pulmonary rehab programmes.
- Number of MyCOPD licences issued.
- Reduction in COPD exacerbations.
- Reduced length of stay associated with respiratory problems.
- Enhanced digital solutions in place to support community COPD management.

## National deliverables and allocated resource

## National milestones

- Commission suitable local spirometry service, where all staff delivering, and interpreting spirometry are accredited and listed on the ARTP register.
- Achieve revised QOF measures for COPD and asthma.
- Implement the NHS RightCare Asthma pathway once published in 2019.
- Improve adherence and inhaler technique; promote inhaler films and the NICE shared decision aid on inhalers.
- Primary care to deliver the requirements as set out in the 'Network Service Specification for Medication Reviews' from April 2020.
- Implement new asthma discharge bundle BPT once implemented from 2020/21.
- Prepare for GPs to offer a nationally accredited respiratory patient education programme, at point of diagnosis from 2024/25.
- Expand provision of PR services, focusing on increased referral and addressing the inequalities gap from 2022/23 onwards.
- Potentially prepare to adopt new breathlessness / shared rehab models in 2023/24 for cardiac and respiratory patients, once optimal models have been identified nationally through testing and evaluation.

## Finance

	2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24
	Not identified				

## Interdependencies with other ICS and regional workstreams

<b>Workforce</b>	<b>Mental Health</b>
Engagement around development and implementation of pathways.	Workforce demand and capacity; developing new ways of working to address skills gaps.
<b>Cancer</b>	<b>Optimising Health</b>
Collaboration with PHE, Local Authorities and Third Sector Organisations to meet requirements for prevention of respiratory disease.	IAPT and LTC. Addressing inequalities in morbidity.
<b>Learning Disabilities and Autism</b>	<b>Digital</b>
Including self-management.	Addressing significantly higher rates of death from respiratory disease.

## Risks and mitigating actions

Risks	Mitigating actions
Lack of engagement of key stakeholders across the ICS.	<ul style="list-style-type: none"> <li>• Use of existing network links to establish contact e.g. NHS RightCare.</li> <li>• Senior Leadership buy in.</li> <li>• NENC wide Respiratory Disease Launch event.</li> </ul>
No identified national funding for 19/20 to establish and appropriately resource a network.	<ul style="list-style-type: none"> <li>• Raised with the National team.</li> <li>• Exploring funding options locally.</li> </ul>

## Partner organisations

- NHS Trusts
- CCGs
- Specialised Commissioners
- PCNs
- General Practice
- Public Health England (PHE)
- Academic Health Science Network (AHSN)
- Local Authorities
- Third Sector
- FRESH
- British Thoracic Society
- NHS England and Improvement
- Getting It Right First Time (GIRFT)
- NHS RightCare

## APPENDIX 3.17 STROKE

**SRO:** Professor Chris Gray

**Programme Management Support:** Sue Long

### Why is change needed?

Stroke is the fourth single leading cause of death in the UK and the single largest cause of complex disability.

Without further action, the number of people having a stroke will increase by almost half, and the number of stroke survivors living with disability will increase by a third by 2035.

### Planned impact of our ambition

- Integrated Stroke Delivery Network (ISDN) covering geography of ICS.
- 24/7 dual site mechanical thrombectomy service.
- Meet targets of LTP in relation to thrombolysis, rehabilitation and prevention.

### Our ambition

**By 2020**

**ISDN structure in place.**

**By 2021**

**ICS specifications for Mechanical Thrombectomy, ESD & stroke rehabilitation agreed.**

**By 2028**

**24/7 Mechanical Thrombectomy services on 2 sites.**

## APPENDIX 3.17 STROKE

### Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>ISDN (Integrated Stroke Delivery Network)</b>									
ISDN governance structure in place (one ISDN for the ICS).									
ISDN fully operational.									
<b>Mechanical Thrombectomy</b>									
Develop ICS specification for Mechanical Thrombectomy pathway.									
Development and growth of the pathway.									
8% people having mechanical thrombectomy following stroke.									Target
<b>ESD and community rehabilitation</b>									
Develop ICS specification for ESD and community rehab pathway.									
Development and growth of the pathway.									
60% people having 6 month review following stroke.									Target
<b>HASU reconfiguration and performance improvement</b>									
North Cumbria HASU Operational.									
Single Tees HASU Operational.									
80% patients accessing stroke unit within 4 hours of arrival at hospital.									Target
20% patients thrombolysed after a stroke admission.									Target
<b>Stroke Prevention</b>									
Atrial Fibrillation detection and management meets national targets.								Target	
Hypertension detection and management meets national targets.									Target
All services meet 7-day target for vascular surgery assessment of patients with severe carotid stenosis.								Target	

### Key performance metrics to track delivery

#### Other/local measures

- SSNAP – National Stroke Audit.
- Local audit of carotid endarterectomy pathways.
- CVD Prevent.

## APPENDIX 3.17 STROKE

### National deliverables and allocated resource

#### National milestones

- 20% of stroke patients receive thrombolysis by 2025.
- 90% of stroke patients receiving specialist stroke unit care by 2028.
- 10% of stroke patients receiving mechanical thrombectomy by 2028.
- All eligible patients getting person-centred therapies through Early Supported Discharge (ESD) from hospital by 2028.

### Interdependencies with other ICS and regional workstreams

<b>Primary Care</b>	<b>Workforce</b>
Engagement around CVDPrevent, CVD prevention network and development and implementation of pathways.	Workforce demand and capacity; developing new ways of working to address skills gaps. Credentialing in Mechanical Thrombectomy. Clinical passports.
<b>Prevention</b>	<b>Specialised Commissioning</b>
Collaboration with PHE, Local Authorities and Third Sector Organisations to meet requirements for CVD prevention.	Mechanical Thrombectomy.
<b>Personalised Care</b>	<b>Mental Health</b>
Embedded in ESD and rehabilitation workstream.	IAPT and LTC.

## APPENDIX 3.17 STROKE

### Risks and mitigating actions

Risks	Mitigating actions
Workforce – Interventional Neuroradiology.	Support credentialing in line with national programme. Collaborative work with specialised commissioning to implement incremental hours of provision as workforce develops.
Capital/Estate – North Cumbria – access to second scanner.	Mobile scanner in interim.
Decision Making – North/South Tees.	Development of Local Stroke Network to promote collaborative working.

### Partner organisations

- NHS Trusts
- CCGs
- PHE
- AHSN
- Stroke Association
- Local Authorities
- British Heart Foundation

**Cancer SRO:** Andy Welch, Medical Director NuTH FT

**Programme Manager:** Alison Featherstone

### Why is change needed?

In this ICS too many people have their lives cut short or significantly affected by cancer. Within NENC overall one-year survival figure hides a variation from 69.2% (Darlington CCG) to 73.5% (Hambleton, Richmondshire & Whitby CCG). Cancer survival is the highest it has ever been in NENC the percentage of people surviving at least one year following diagnosis increased from 62.4% in 2001 to 71.5% in 2016. More cancers are being diagnosed early, when curative treatment is more likely, and patient reported experience of care is high (CPES).

However, cancer performance in NENC stills lags behind many other cancer alliances in the country.

Some places with lower survival rates also perform less well than comparable populations across England, these local differences in outcome cannot be explained away by population mix. Poverty and deprivation is a key issue for health outcomes and across NENC 28.2% of the population are in the most deprived quintile nationally. Again, this aggregate figure hides large variation with CCGs ranging from 46.7% (S Tees) to 2.9% (HRW CCG). This 5-year strategy gives us the opportunity to build on successes, to focus our ambitions on tackling variation and to accelerate what we know works, to improve outcomes for the whole population. We need to get behind a system strategy that allows for local implementation, which is adapted to suit our geographical and demographic differences.

### Planned impact of our ambition

- A strong Alliance of all partners including secondary care providers, commissioners, primary care networks, third sector and public health partners will achieve our strategic priorities - despite the tensions of achieving individual operational standards.
- More cancers are diagnosed at an early stage - **National ambition by 2028: 75% of people will be diagnosed with cancer at an early stage (stages 1 and 2)** – this is roughly an additional 4,000 more cancers per year across the Alliance. We will implement **new Rapid Diagnostic Services, increase screening rates and be a test site for the targeted lung health checks.**
- Reduced variation in patient experience, diagnosing cancer within the **faster diagnosis standard** and improved access to services for all including **stratifying follow up to enable personalised care.**
- Translate faster innovation and research into practice by working closer with academia, AHSN, pharma and research networks.
- Strengthened existing links with primary care to improve patient interfaces by working closely with emerging Primary Care Networks.
- Coproduction and involvement will be integral to every decision and process across NENC particularly in **personalising cancer care.**

### Our ambition

**By 2020**

**TBC% of patients will receive a diagnosis of cancer within 28 days.**

**By 2023**

**We will increase the proportion of cancers diagnosed at Early Stage by 7% (~1,900 additional early stage cancers).**

**By 2023**

**We will increase 1-year Survival across all cancers by over 4% in NCA.**

## Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
<b>1 - Work as a system to utilise resources to achieve cancer waiting times standards</b>									
Implement site specific pathway boards to review diagnostic capacity, inter provider transfers and ways of working collaboratively to balance supply and demand whilst improving the patient experience.									
Agree regional treatment standards that are tumour site specific (13 sites) and offer the best patient outcomes – begin with 5 in 19/20.	1	4	8	9	11	13			
Implement and oversee the operational delivery networks for Radiotherapy and Children and Young People.	R				CYP				
Undertake specific pathway reviews as required - initially Breast, Head and Neck, Gynae and Oncology provision.	B	H&N	G	O					
Develop networking for radiology & pathology and work with pathway boards on further opportunities to network in other staff groups.		p				R			
Implement the regionally agreed MDT recommendations across all 67 MDTs.									
<b>2 - Improving time to diagnosis</b>									
Implement pathways to deliver the new faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening.									
Introduce low risk FIT symptomatic pathways in each CCG (12).	9	11	12						
Implement the OG optimal pathway in all 8 Trusts.		6	7			8			
Achieve the times lines for the national optimal pathways (8 trusts and 3 pathways).									
<b>3 - Improve Cancer Screening Uptake</b>									
Cancer locality groups to increase screening rates in targeted populations and increase cancer awareness – Utilising cancer champions and community workers in 19/20.	?								
Implement HPV primary screening for cervical cancer and roll out a tested regional approach to increase rates.	?								
Introduce FIT for screening and modernise the Bowel Cancer Screening Programme.		?							
<b>4 - Implement Targeted Lung Health Checks</b>									
Implement the national TLHC in Newcastle Gateshead CCG.									
Support current local COPD case finding initiatives before evaluation and extending the programme further.									
<b>5 - Develop a minimum of one rapid diagnostic service within each ICP</b>									
Implement two services according to the national specification in 19/20.									
Support local vague symptoms pathways to develop into models appropriate for each ICP (e.g. rural populations).									
<b>6 - Develop Personalised Care Pathways for cancer patients</b>									
Stratified follow up in place in all pathways by 2023 – start with Breast, Prostate and Colorectal.			B	P	C				
Increased use Holistic Needs assessment and care planning in partnership with third sector.									
Primary care networks to increase rates of access via planned routes and to support cancer personalisation including follow up and direct access to services.									
Pilot the national quality of life tool and prepare the regional for roll out.									
Support implementation of personalised end of life care.									
<b>7 - Preventing Cancers</b>									
As part of the ICS Prevention board implement the smoking strategy with FRESH, develop an alcohol plan for cancer with BALANCE, implement MECC to screening programmes.									
Develop initiatives to tackle obesity in cancer with cancer locality groups.									
<b>8 - Ensure we have a workforce equipped to deliver the ambitions of the NENC cancer plan</b>									
Every pathway board, pathway review and cancer project will develop a workforce implementation plan.									
With HEE and the guidance and leadership of the ICS workforce workstream implement phase 1 and 2 of the national cancer workforce strategy.									
<b>9 – Translate Faster Innovation and Research into Practice</b>									
Strengthen links with AHSN, Academia, Pharma and research networks.									
Work with the regional hub to support use of genomics to target treatments more effectively.									
Increase numbers of cancer patients at all ages, children, young people and adults entered into clinical trials building on evidence around the link between active research & development and improved outcomes.									

### Key performance metrics to track delivery

#### Operating framework measures

- New 31 day and 62-day cancer waiting times from 2020.
- 28-Day Faster Diagnosis Standard- monitored from 2020.
- Cancers diagnosed at an early stage.
- Emergency presentations.
- 1-year and 5-year survival from all cancers.
- Cancer patient experience.
- National personalised care standards (still in development).
- Screening rates.

#### Other/local measures

- Regionally agreed standards for each tumour site from time to diagnosis to treatment.
- Adult smoking prevalence to reach 5% by 2025.
- Inequalities – measures of variation to be developed and agreed.
- Diagnostics access and capacity building – agreed local targets.
- MDT Standardisation compliance.
- Workforce plans in place – training access and role development/changes.
- Further specific measures around PHM to be added once priorities are agreed.
- [Work underway on further metrics].

## National deliverables and allocated resource

### National deliverables

- From 2019 we will start to roll out new Rapid Diagnostic Centres across the country.
- In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days.
- By 2020 HPV primary screening for cervical cancer will be in place across England.
- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.
- By 2022 the lung health check model may be extended.
- By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers.
- By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.

### Finance (section in development)

- National Cancer Transformation funding is allocated via NCA and utilised to pump prime initiatives which can be locally commissioned following evaluation. Indicative Northern Cancer Alliance funding does not include national innovation funding (e.g. rapid diagnostic centres and TLHC)

	2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24
Northern Cancer Alliance	7.28	5.45	4.25	4.07	4.06

- Capital bids in place for further implementation of Radiology strategy (hubs and home working) with HSLI

Interdependencies with other ICS and regional workstreams

Workforce	Digital
<ul style="list-style-type: none"> <li>• Work with ICS workforce lead to consider future workforce needs in accordance with the strategic objectives and spirit of the workforce programme - align supply and education needs to enable the future workforce to experience great places to work, where leadership is valued and supported at all levels.</li> <li>• Review the outputs of the strategic workforce planning project and consider approaches and changes needed to realign skills and ways of working to meet the population health needs for 2025 and beyond.</li> <li>• Work with CNEIG to design excellent long-term imaging services, addressing current workforce and technological challenges to support cancer services.</li> </ul>	<ul style="list-style-type: none"> <li>• Remote monitoring and patient support required by 2021 but is dependent on GNCR for implementation so may be appropriately delayed.</li> <li>• Networking radiology –Continued implementation of integration and convergence of systems to support the radiology strategy.</li> <li>• Haematology may require a new digital system.</li> <li>• Exploring digital opportunities along the cancer pathway (e.g. Referral and IPT) – exploit opportunities as the digital roadmap progresses.</li> <li>• Continue the implementation and monitor the utilisation of the digital pathology system.</li> </ul>
Prevention	Optimising Health
<ul style="list-style-type: none"> <li>• Cancer Alliance membership on the ICS Prevention Board to ensure plans are aligned.</li> <li>• Clinical and project support for the smoke free hospitals initiative.</li> <li>• Clinical and project support for any agreed alcohol initiatives.</li> <li>• Deliver the MECC recommendations – e.g. screening.</li> <li>• Cancer prevention workplan agreed by the ICS prevention Board.</li> </ul>	<ul style="list-style-type: none"> <li>• Oversight of the breast diagnostic services reviews in each ICP.</li> <li>• Radiology workstream delivery.</li> <li>• Oncology services review delivery.</li> <li>• Links with pathology workstream to ensure alignment.</li> <li>• Support for the haematology workstream.</li> <li>• Other cancer pathways/service models may need to be reviewed over next 5 years.</li> </ul>

## Risks and mitigating actions

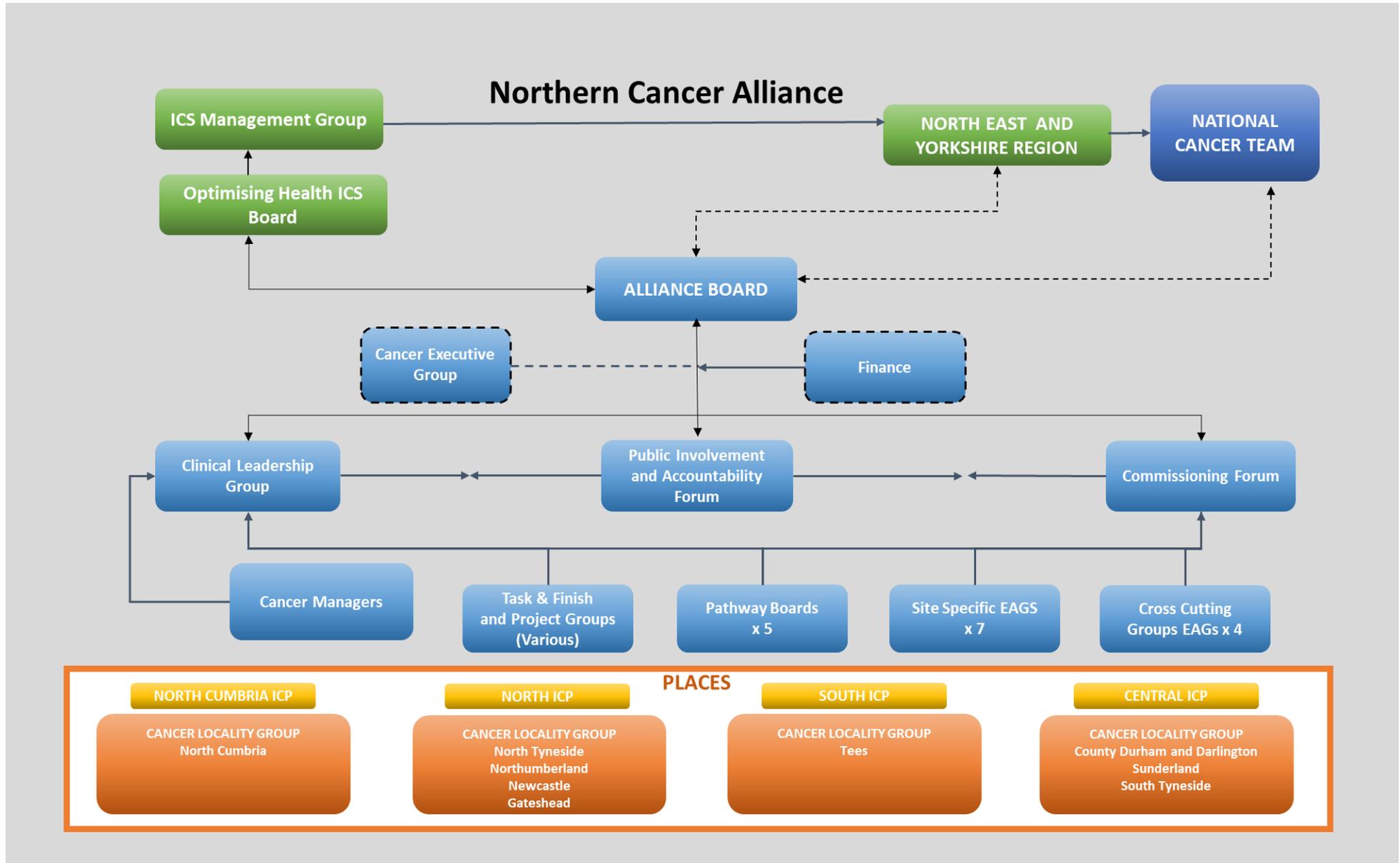
Risks	Mitigating actions
Indicative funding is in place for Alliances but the details and the uncertainty about the funding for long term projects makes planning long term difficult.	Continue to work with Cancer Localities (ICPs) and the Commissioning forums to develop contingency plans and prioritisation.
Delays to publication and engagement about new CWT.	Agree an Alliance wide standard, work with Trusts and continue to input into national guidance.
Inability to get system wide agreement on initiatives including differential standards and optimal pathways as the ICS is newly forming and decision-making processes are not yet mature.	NCA has invested in project management support to the emerging ICP's and senior management of the NCA is represented on relevant ICS work groups to support and influence.
Pressures in system due to increased demand caused by the cancer strategy to increase referrals.	Pathway boards to develop: <ul style="list-style-type: none"> <li>• Interfaces between primary and secondary care</li> <li>• New ways of working</li> <li>• Sharing capacity</li> </ul>
Workforce shortages in key staff groups.	Working with local HEE – joint post for cancer. Workforce planning in place for the 7 key roles. Pathway Boards in place to look at new ways of working to maximise capacity.
Timeframes for implementation of the cancer workplan may be impacted by competing ICS LTP priorities.	Engagement with ICS workstream leads to align programmes of work ICS governance structures for escalation and priority agreement.

Implications for operational planning 2020/21

- Indicative funding is in place for Alliances, but the details are not known so there is uncertainty about the funding for long term projects which makes planning difficult particularly for example in rapid diagnostic centres.
- New posts currently being piloted in most Trusts (patient navigators) will require on going funding post evaluation.
- Networking digital system for radiology has a revenue tail which all providers will need to pick up.
- Consideration will need to be given to both process and service following the oncology services review. Public consultation may be required once model agreed.
- Radiology strategic direction requires new ways of working which may require changes to contracts for example hosting arrangements.
- Collation of ICP plans will need to take place to align breast service diagnostic provision.
- Significant workforce shortages may mean that we need to review the service models in place for other cancers for example urology.
- Consideration needs to be made for succession planning in key cancer roles.
- Increased demand due to cancer strategy to lower thresholds could mean insufficient capacity in place particularly for diagnostics.

Partner organisations

Partner organisations on the Board	Network includes
<ul style="list-style-type: none"> <li>• All 12 CCGs</li> <li>• All 8 acute providers</li> <li>• Specialised Commissioning</li> <li>• Screening and Imms Team (SIT)</li> <li>• NHS England and NHS Improvement (NENC)</li> <li>• Public Health England (NE)</li> <li>• Health Education England (NE)</li> <li>• All 15 local authorities via one nominated rep</li> <li>• Cancer Research UK</li> <li>• Macmillan Cancer Support</li> <li>• Lay Representatives</li> </ul>	<p>Age UK (specific project for cancer)                      Catalyst (specific project for cancer)                      Mind (specific project for cancer)</p> <p><b>Cancer Alliance Public Involvement Group includes links to</b></p> <ul style="list-style-type: none"> <li>• Healthwatch</li> <li>• Voluntary Organisations North East</li> <li>• Learning Disability Community Organisations</li> <li>• BAME Community Organisations</li> <li>• LGBT Community Organisations</li> <li>• Mental Health Community Organisations</li> <li>• Older People Community Organisations</li> </ul> <p><b>Wider partners</b></p> <ul style="list-style-type: none"> <li>• Clinical Networks</li> <li>• National Cancer Programme Team</li> <li>• Other Cancer Alliances</li> <li>• NHSE/I regional team</li> </ul>



## APPENDIX 3.19 FRAILITY

**SRO:** Janet Probert

**Programme Management Support:** Lesley Bainbridge, Lou O’Kello

### Why is change needed?

The presence of frailty, and its severity, correlates with poor outcomes, such as poor quality of life, institutionalisation, mortality and increasing cost to health and care systems.

Looking after the frail elderly is one of the biggest challenges facing primary care, GPs, dentists and community pharmacy services. It also presents huge challenges to social care, housing and residential care providers and the whole spectrum of third sector services.

There is a spectrum of frailty from mild through to severe, ultimately leading to end of life. Frailty is most common amongst older adults, with the overall prevalence of frailty in people aged over 60 estimated to be around 14%.

In England, there are 1.8 million people aged over 60 and 0.8 million people aged over 80 living with frailty. The prevalence of frailty increases with age, resulting in 5% of people aged 60-69 living with frailty and up to 65% of people aged over 90 living with frailty. Frailty is also considered more common in women 16% versus 12% in men.

### Planned impact of our ambition

- We will support the understanding and delivery across the North East and North Cumbria of the National Aging Well Framework.
- Provide expertise to the ICS and ICP’s to make key strategic decisions around the Frailty/Aging Well Agenda. Supporting them with the delivery of the ambitions set out in the LTP.
- Supporting ICP’s with decisions around delivery plans and investment decisions.
- To support the ICP’s by evaluating local ICP plans as regards Frailty/Aging Well.
- Local health and care economies will be able to benchmark existing care provision and metrics against others in the region through the use of the agreed 23 metrics (inclusive of the national frailty RightCare and SDEC).
- Local health and care economies will be able to identify their priorities and draw on the Frailty ICARE Toolkit to introduce new initiatives and improve the care and support offered.
- There will be a reduction in financial costs, time spent and resource utilisation across the health and care system by improving current practice, streamlining and aligning services to avoid duplication, thereby working more efficiently and cost effectively whilst improving patient experience.
- The Regional Frailty ICARE Toolkit will improve the frailty journey in localities through the sharing of evidence-based approaches, key resources and local examples of good practice.
- The Frailty/Aging Well Network (Community of Practice) will provide a forum where initiatives are shared, learning and recommendations agreed, plans made for wider sharing through local forums and the ICARE Toolkit kept iterative.
- The Network will offer access to clinical and wider place-based expertise to both the ICS and ICP’s, supporting them to deliver their plans by acting as critical friend or a supportive advocate of innovation through testing of new initiative with robust evaluation.
- A workforce competency framework has been developed for registered and non-registered staff working with those who have frailty, anywhere in the care system and plans are afoot for testing it in a variety of settings in the coming months. A longer-term vision is for the development of an apprenticeship.
- We are collaborating with local universities as part of an ARC bid where Frailty has been chosen to be one of the key themes, supported by ‘evaluation’ CoPpers.
- Academics and librarians are supporting the evaluative methodology surrounding the Toolkit to strengthen the presentation of supporting evidence.

### Our ambition

**Through clinical leadership and expertise, our ambition is to provide a Regional Centre of Excellence around Frailty and Aging Well.**

**This will offer clinical and wider system expertise along with project support to ICPs and local areas to enable people living with frailty, carers and communities to look after themselves and remain well, independent and healthy but when needed, be offered care and support at or close to their homes, in a way that identifies what’s important to them as well as any issues facilitating prompt resolution to ensure hospital care only when absolutely necessary.**

#### By 2028

**The provision of a vibrant out of hospital sector will have been established, wrapping itself around the needs of its registered patients and will attract and retain the right workforce.**

## APPENDIX 3.19 FRAILITY

### Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
To identify recurrent funding to cover staffing cost of the Regional Frailty working group beyond March 2020.									
To continue to develop the Frailty Toolkit to offer a region-wide common understanding of Frailty.									
To establish a supportive way for learning and sharing best practice to support local health and care system planning through the use of the Frailty Icare Toolkit.									
To continue to facilitate and support a region-wide CoP and for the CoP to be re-branded as a Frailty/Aging Well Network, and to include a Clinical Reference Group to support clinical and medical discussions and to deliver the ambition set out in the LTP.									
To raise the profile of the work and clarify linkages with other regional networks and the Optimising Health ICS work programme.									
To work across the whole health and care system to support carers and family member, taking a 'whole family' approach and supporting people with daily living tasks, promoting independence and the ability to live at home for as long as possible.									
To empower patients and carers to better manage care, improve knowledge and understanding through access to digital solutions.									

### Key performance metrics to track delivery

- 100% of frailty experts within the community of practice to sign as a Network member to facilitate system thinking across localities by building on regional and ICS work.
- 90% of CoPpers to be actively engaged in being CoP/Network members e.g. sharing experience and examples to influence and improve local and regional frailty services.
- 100% of localities operate with active frailty forums/steering groups in place.
- 100% of localities are using ICARE metrics to set local priorities.
- (A list of metrics has been agreed by regional and national experts that has been shared with CoPpers/ Network members to support planning and prioritisation.
- 100% of localities are using ICARE to map local system frailty services.
- 100% of localities with an active and up to date frailty delivery plan.
- 100% of localities are actively considering workforce development.
- 100% of localities are actively considering digital components of care.
- 90% of CoPpers/Network members report an understanding of ICARE.
- 90% of CoPpers/Network members report feeling supported by the Regional Frailty Team.
- 90% of outcomes and timeframes identified for each of 23 metrics.

## APPENDIX 3.19 FRAILITY

### National deliverables and allocated resource

1. Primary Care Network contract DES - improving the care of people with multiple long term conditions.
2. Acute frailty Care - by 31 December 2019 all trusts with type 1 EDs to be providing an acute frailty service for at least 70 hours per week.

	2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24 (£m)
Improved digitalisation of the Frailty ICare Toolkit	£130.000				
Ongoing sustainable funding for the Frailty Working Group (Incl Clinical Leadership, Program Leadership and Project Support)		TBC			
Ongoing maintenance of digital solutions		£50,000	£50,000	£50,000	£50,000

### Partner organisations

- AHSN
- NE CCGs
- NE FTs
  - Acute, Community, Mental Health and Learning Disability Services.
- NE PCNs
- NE Local Authorities
  - Social Care Services
  - Public health
- Residential Care Providers
- Housing Providers
- Primary Care
  - GPs, Pharmacists, Dentists and Optometrists

## APPENDIX 3.20 URGENT AND EMERGENCY CARE

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### Why is change needed?

Urgent and Emergency Care demand has increased year on year and for services to meet the needs for those who most need it changes to the current system must be made. To ensure that we continue to meet the needs of our most unwell patients, we must ensure that patients are treated in the most appropriate setting and in the most appropriate timeframes, reducing pressure on our most stretched services. Staffing remains a challenge, with large gaps in most sectors, due to difficulties in increasing staff numbers within limited financial budgets, we must reduce activity in order to need the most urgent needs of the population.

### Planned impact of our ambition

- Ensuring there is simple and convenient access to uniformly, high standard urgent and emergency care services, in a way in which is primarily determined by clinical need and not by patient demand.
- Ensuring patients are assessed and treated by the right professional with access to the right interventions, at the right time, in the right place.
- Ensuring that quality and safe services are provided which are evidenced based, effective and consistent for patients across Northumberland and North Tyneside.
- Making system/services less complex and easier to understand and navigate for patients and staff with effective patient flows between staff and services.
- Ensuring services pro-actively target and support people with chronic, long-term conditions and the rapidly increasing frail, elderly population through improved, comprehensive and standardised care planning as the vast majority of our emergency admissions result from acute exacerbations of one or more long-term conditions or is frailty related.
- Ensuring out of hospital services are enhanced and available so that there are alternatives to admission and where patients are admitted - acknowledging that some patients do need to be admitted to hospital - they can be transferred from an inpatient environment to a community setting with no delays and are able to continue their rehabilitation therapy at home (or normal place of residence) with the same intensity and expertise that they would receive in hospital.

### Our ambition

#### By 2020

All hospitals with a major ED dept will:

- Provide SDEC services at least 12 hours a day, 7 days p/w.
- Provide an acute frailty service for at least 70 hours per week.
- Record 100% of patient activity in ED, UTCs and SDEC via ECDS.
- Implement the Clinical Standards Review.
- Further reduce DToC, in partnership with LAs by TBC%.

#### By 2021

CAS will typically act as the single point of access for patients, carers and health professionals for IUC and discharge from hospital care.

#### By 2028

We will have established a sustainable, high quality and equitable urgent and emergency care system, enabling Right Care, Right Place, Right Time.

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### Strategic priorities and timeline

	19/20		20/21				21/22	22/23	23/24
	Q3	Q4	Q1	Q2	Q3	Q4			
CAS - review against National 111 IUC Specification, Long Term Plan requirements and local UEC system requirements – overseen by the Ops group – leading to action plan for service developments supporting the current and future requirements for the 111 IUC service, maximizing opportunities for 'hear and treat'.									
Continue DoS standardisation programme with specific focus on minimum expected profiles for extended access primary care services, UTC services in later Tranches of the national plan, community services and ensure all services are consistently staffed to the appropriate level in order to deliver the standardised profiles.									
Completion of the regional UTC programme, with all areas commissioning a compliant UTC by December 2019.									
A&E Delivery Boards to prepare plans for the ongoing development of ED streaming models including redirection to primary care services where applicable, as comparable to the highest performing services regionally.									
A&E Delivery Boards to confirm arrangements for secondary care providers to support community Health Care Professional decision making to avoid ED attendance / admission, i.e. utilising telephony solutions such as Consultant Connect or Vocera.									
A&E Delivery Boards to prepare and implement plans for enhancing community services to comply with LTP requirement of urgent response within 2 hours.									
All Hospital Trusts to provide a comprehensive model of SDEC, at least 12 hours a day, 7 days per week and in both medical and surgical specialties. Regional variation to be assessed and minimised.									
All Hospital Trusts to provide a comprehensive acute frailty model, at least 70 hours per week, achieving clinical frailty assessment within 30 minutes of arrival at ED. Regional variation to be assessed and minimised.									
All Hospital Trusts to implement the findings of the Clinical Standards Review, building on the learning and experience of our local pilot site, North Tees and Hartlepool FT.									
Enhanced health in care homes – using the learning gained and evidence collected during the Vanguard Project to inform service delivery, ensure that all parts of the region continue to upgrade support to all care home residents. Regional variation to be assessed and minimised.									
Implement a collective approach to ambulance handover, turnaround and a joint collective target to ensure as a system we achieve the target of 30-minute maximum arrival to clear time in all locations.									
Implement NEAS Pathfinder programme across the region, building on the pilot work undertaken in Sunderland, maximising opportunities for 'See and Treat'.									
All relevant organisations and services compliant with ECDS reporting requirements.									
All UEC Network organisations will support and actively encourage the universal and consistent use of the UEC-RAIDR Urgent Care App and Flight Deck and support further developments and enhanced functionality of the UEC-RAIDR Urgent Care App including additional providers' data flows.									
Ensure all parts of the region have effective plans in place for the integration of emerging Primary Care Networks as key partners in and components of local urgent care systems.									
Ensure full implementation of SAFER patient flow bundle across all hospitals, all wards.									
In partnership with ICS Mental Health Workstream, agree programme of work to deliver Crisis Team accessibility directly via 111 for both NTW and TEVV provided services, and consider expansion of this objective to include broader range of mental health cases to be channelled to evolving Mental Health SPoA access points.									
Assimilate local initiatives/priorities into regional programme of work. Emerging local plans include: <ul style="list-style-type: none"> <li>• Closer integration of community pharmacy and Minor Ailments services into urgent care pathways.</li> <li>• Supporting paramedic decision support through collaborative working with local secondary care providers.</li> <li>• Multi-agency community based falls prevention service, accessible to all parts of the UEC system, and including further roll out of Falls Rapid Response Service (FRRS).</li> <li>• Evaluate community paramedic models.</li> </ul>									

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### Key performance metrics to track delivery

#### Operating framework measures

The measures below are taken from the NHSE assessment of headline LTP metrics relevant to UEC.

KEY:

	To be included in the Strategic Planning Tool (Submitted through SDCS)
	To be included in LTP Performance Metrics Template
	To be covered in plan narrative
	Out of scope for system plans

Agreed Headline	Potential Measure description	Comments	Mapping to LTP programme
Primary and community services: annual implementation milestones for	Community rapid response 2 hour/2 day measure to be confirmed	To be covered in plan narrative	Optimising Health Services
Emergency care: on agreed trajectory for Same Day Emergency Care	Percentage of non-elective activity treated as Same Day Emergency Care cases	To be covered in plan narrative whilst measures still under development	Optimising Health Services
Mental health: on track for locally agreed service expansion, and increase in implementation of agreed waiting times	Mental health access standards once agreed	To be covered in plan narrative whilst measures still under development	Mental Health
The NHS will reduce growth in demand for care through better integration and prevention	Cost weighted non-elective activity growth	To be included in the Strategic Planning Tool (Submitted through SDCS)	Optimising Health Services
The NHS will reduce variation in performance across the health system	Measure on reduction in unwarranted variation achieved by the NHS	To be covered in plan narrative	Optimising Health Services
The NHS will make better use of capital investment and its existing assets to drive transformation	[Metrics to support this test to be confirmed following the Spending Review and the development of the new NHS capital regime]	To be covered in plan narrative whilst measures still under development	Optimising Health Services
	Percentage of patients in A&E transferred, discharged or admitted within four hours	Out of scope because Clinical Review of Standards has not reported	

#### Other/local measures

- ECDS: existing standards and future standards identified through the Clinical Standards Review.
- 111 IUC KPIs (noting ongoing review of KPIs – expected to lead to changes from March 2020).
- Improved public and patient satisfaction.
- Volume of contacts with Community Pharmacists (and outcomes).
- Proportion of patients seen within 30 mins of appointment time for booked appointments.
- Utilisation rate of pre-booked appointments in all sites and settings.
- Volume of patients who self-present vs volume that have a pre-booked appointment (and outcomes).
- Volume of patients conveyed to UTC by ambulance (and outcomes).
- Self-presentations triaged as 'low acuity'.
- Re-attendance rates at ED for patients who presented at UTC/GP Extended Access within the previous 7 days
- Emergency admission rates.
- Community service utilisation.
- Proportion of patients dying in their preferred place of death.
- NEAS performance (hear and treat / see and treat /see treat and convey (non-ED) / see, treat and convey (ED)).
- Utilisation of SDEC (and outcomes).
- Average LoS, DToC, Stranded and super-stranded patients.

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### National deliverables and allocated resource

#### National deliverables

- Pre-Hospital Care - a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services, ensuring patients receive the most appropriate clinical advice and direction to the most appropriate services.
- Timely and accurate data flowing through the ECDS for all EDs, UTCs and CDES from 2020 and the National Ambulance Dataset to be implemented.
- Adults, children and young people experiencing mental health crisis will be able to access the support they need – single point of access through NHS 111, access to crisis care 24/7 and intensive follow-on to reduce future use.
- The Urgent Treatment Centre model universally implemented by Autumn 2020.
- Ambulance services, at the heart of urgent and emergency care system, providing timely responses and patients treated at home or in more appropriate care settings outside of hospital. Ambulance staff will also be trained and equipped to respond effectively to mental health crisis, including mental health transport, mental health nurses available for ambulance EOC, and mental health training for front-line crews.
- Improved responsiveness of community health crisis response services to deliver the services within two hours of referral in line with NICE guidelines.
- All parts of the country delivering reablement care within two days of referral.
- Enhanced health in care homes – upgrade NHS support to all care home residents who would benefit by 2023/24.
- Evening and weekend GP appointments in place through Extended Access Services.
- All hospitals with a major A&E department will have a comprehensive model of Same Day Emergency Care at least 12 hours a day, every day, in both medical and surgical specialties; and provide an acute frailty service for at least 70 hours a week achieving clinical frailty assessment within 30 minutes of arrival.
- Implement the findings of the Clinical Standards Review to focus on patients with the most serious illness and injury.

#### Finance

- Financial commitments to be identified at Local A&E Delivery Board level, which will inform aggregate regional financial position linked to specific objectives.

### Interdependencies with other ICS and regional workstreams

Workforce	Digital
<ul style="list-style-type: none"> <li>• Work with ICS workforce lead to ensure UEC workforce needs are understood and development opportunities are maximised.</li> <li>• Understanding of shared workforce risk – e.g. PCN requirements potentially affecting sustainability of UEC service providers.</li> </ul>	<ul style="list-style-type: none"> <li>• Many of the UEC objectives will be dependent on effective interoperable solutions between operating systems.</li> </ul>
Mental Health	Optimising Health
<ul style="list-style-type: none"> <li>• National requirement for mental health crisis services to be effectively accessed via 111 on a 24/7 basis – will require joint working across UEC and Mental Health programmes.</li> </ul>	<ul style="list-style-type: none"> <li>• OHS group provides a forum for aligning the work of Networks and ICS workplans.</li> <li>• Helping to ensure consistent approach to joint working with the Clinical Senate across all clinical networks.</li> </ul>

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### Risks and mitigating actions

Risks	Mitigating actions
UEC Network governance changes introduced in August 2019 could destabilise the Network and present challenges in progressing the delivery plan.	Continued efforts of UEC Leaders and Delivery Team to retain the integrity and credibility of the Network through this period of change.
Uncertainty regarding funding requirements and the availability of funding at local and regional levels to support delivery plan.	Integration of UEC Network within the ICS structures and ongoing engagement with local systems and ICPs to articulate funding requirements as they become clearer.
Demand pressures – increasing system demand beyond forecast and with seasonal pressures can impact the delivery plan and priorities for UEC Network member organisations.	Continued collaborative approach to support each other through ongoing pressures as a unified Network, alongside ongoing analysis to understand, anticipate and plan for system pressure.
Workforce pressures – availability of clinical workforce (e.g. GPs and Advanced Practitioners) and competition between providers and impact from other system developments (e.g. PCNs).	Linkage to the ICS Workforce Workstream to plan effective pipelines for clinical recruitment. Robust Network planning to facilitate rotational workforce models and minimise competition between provider organisations.

### Implications for operational planning 2020/21

- Changing patterns of demand for services and patient expectations.
- Uncertainties with regards to funding to ensure continued delivery.
- Information sharing to support seamless pathways across services.
- Addressing workforce shortages and anticipated growth in workforce requirements to manage ever increasing demand.

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### Partner organisations

Partner organisations	Wider Partners
<ul style="list-style-type: none"><li>• Representatives from all A&amp;E Delivery Boards across North East and North Cumbria</li><li>• Representatives from:<ul style="list-style-type: none"><li>○ Acute Trusts</li><li>○ Mental Health Organisations</li><li>○ Local Authority</li><li>○ Ambulance Service / 111 Provider</li><li>○ Clinical Commissioning Groups</li></ul></li><li>• NHS England and NHS Improvement (NENC)</li><li>• UEC Delivery Team</li><li>• Primary Care Networks</li><li>• Reports directly to ICS Management Group.</li><li>• Supported by Clinical Reference Group, comprised of representatives across professions and provider organisations in primary care, acute care, and mental health.</li></ul>	<ul style="list-style-type: none"><li>• Clinical Networks</li><li>• NHSE/I regional team</li><li>• Healthwatch</li><li>• Rightcare</li><li>• LMCs</li><li>• Local Professional Networks</li></ul>