Public Document Pack

Northumberland
County Council

Your ref:
Our ref:
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Tel direct: 01670 622613
Date: 1 November 2022

Dear Sir or Madam,

Your attendance is requested at a meeting of the **HEALTH AND WELL-BEING BOARD** to be held in **COUNCIL CHAMBER, COUNTY HALL, MORPETH** on **THURSDAY, 10 NOVEMBER 2022** at **10.00 AM**.

Yours faithfully

Rick O'Farrell
Interim Chief Executive

To Health and Well-being Board members as follows:-

G Binning, J Boyack, N Bradley, C Briggs, J Daniel, P Ezhilchelvan (Chair), S Lamb, J Mackey, P Mead, R Mitcheson, L Morgan, R O'Farrell, W Pattison, G Reiter, G Renner-Thompson, G Sanderson, E Simpson, G Syers (Vice-Chair), M Taylor, D Thompson, P Travers, C Wardlaw, J Watson and C Wheatley

AGENDA

PART I

It is expected that the matters included in this part of the agenda will be dealt with in public.

1. APOLOGIES FOR ABSENCE

2. MINUTES (Pages 1 - 8)

Minutes of the meeting of the Health and Wellbeing Board held on Thursday, 13 October 2022 as circulated, to be confirmed as a true record and signed by the Chair.

3. DISCLOSURES OF INTEREST

Unless already entered in the Council's Register of Members' interests, members are required where a matter arises at a meeting;

a. Which directly relates to Disclosable Pecuniary Interest ('DPI') as set out in Appendix B, Table 1 of the Code of Conduct, to disclose the interest, not participate in any discussion or vote and not to remain in room. Where members have a DPI or if the matter concerns an executive function and is being considered by a Cabinet Member with a DPI they must notify the Monitoring Officer and arrange for somebody else to deal with the matter.

b. Which directly relates to the financial interest or well being of a Other Registrable Interest as set out in Appendix B, Table 2 of the Code of Conduct to disclose the interest and only speak on the matter if members of the public are also allowed to speak at the meeting but otherwise must not take part in any discussion or vote on the matter and must not remain the room.

c. Which directly relates to their financial interest or well-being (and is not DPI) or the financial well being of a relative or close associate, to declare the interest and members may only speak on the matter if members of the public are also allowed to speak. Otherwise, the member must not take part in discussion or vote on the matter and must leave the room.

d. Which affects the financial well-being of the member, a relative or close associate or a body included under the Other Registrable Interests column in Table 2, to disclose the interest and apply the test set out at paragraph 9 of Appendix B before deciding whether they may remain in the meeting.

e. Where Members have or a Cabinet Member has an Other Registerable Interest or Non Registerable Interest in a matter being considered in exercise of their executive function, they must notify the

Monitoring Officer and arrange for somebody else to deal with it.

NB Any member needing clarification must contact monitoringofficer@northumberland.gov.uk. Members are referred to the Code of Conduct which contains the matters above in full. Please refer to the guidance on disclosures at the rear of this agenda letter

4. NORTHUMBERLAND FIRE & RESCUE SERVICE'S COLLABORATIVE APPROACH TO SAFETY AND WELLBEING

To receive a presentation from Graeme Binning, Deputy Chief Fire Officer, Northumberland Fire & Rescue Service.

5. JOINT HEALTH & WELLBEING STRATEGY THEMATIC GROUPS UPDATES

To receive verbal updates from each thematic group on what its plans are likely to be going forward and what the governance and membership may be.

6. INEQUALITIES PLAN - COMPACT

To verbally receive progress updates from representatives of partner organisations about their sign up to and commitment to the plan.

7. LIVING WITH COVID

To receive a verbal update by Liz Morgan, Interim Executive Director for Public Health and Community Services.

8. DRAFT ICB INTEGRATED CARE STRATEGY (Pages 9 - 46)

To receive a presentation from Peter Rooney, Director of Strategy and Planning. The draft Strategy and a document explaining the development of the Strategy are attached for information.

9. HEALTH AND WELLBEING BOARD – FORWARD PLAN (Pages 47 - 56)

To note/discuss details of forthcoming agenda items at future meetings; the latest version is enclosed.

10. URGENT BUSINESS (IF ANY)

To consider such other business as, in the opinion of the Chair, should, by reason of special circumstances, be considered as a matter of urgency.

11. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 1 December 2022, at 10.00 a.m. at County Hall, Morpeth.

IF YOU HAVE AN INTEREST AT THIS MEETING, PLEASE:

- Declare it and give details of its nature before the matter is discussed or as soon as it becomes apparent to you.
- Complete this sheet and pass it to the Democratic Services Officer.

Name:		**Date of meeting:**	
Meeting:			
Item to which your interest relates:			
Nature of Interest i.e. either disclosable pecuniary interest (as defined by Table 1 of Appendix B to the Code of Conduct, Other Registerable Interest or Non-Registerable Interest (as defined by Appendix B to Code of Conduct) (please give details):			
Are you intending to withdraw from the meeting?			Yes - ☐ No - ☐

Registering Interests

Within 28 days of becoming a member or your re-election or re-appointment to office you must register with the Monitoring Officer the interests which fall within the categories set out in **Table 1 (Disclosable Pecuniary Interests)** which are as described in "The Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012". You should also register details of your other personal interests which fall within the categories set out in **Table 2 (Other Registerable Interests)**.

"Disclosable Pecuniary Interest" means an interest of yourself, or of your partner if you are aware of your partner's interest, within the descriptions set out in Table 1 below.

"Partner" means a spouse or civil partner, or a person with whom you are living as husband or wife, or a person with whom you are living as if you are civil partners.

1. You must ensure that your register of interests is kept up-to-date and within 28 days of becoming aware of any new interest, or of any change to a registered interest, notify the Monitoring Officer.

2. A 'sensitive interest' is as an interest which, if disclosed, could lead to the councillor, or a person connected with the councillor, being subject to violence or intimidation.

3. Where you have a 'sensitive interest' you must notify the Monitoring Officer with the reasons why you believe it is a sensitive interest. If the Monitoring Officer agrees they will withhold the interest from the public register.

Non participation in case of disclosable pecuniary interest

4. Where a matter arises at a meeting which directly relates to one of your Disclosable Pecuniary Interests as set out in **Table 1**, you must disclose the interest, not participate in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation. If it is a 'sensitive interest', you do not have to disclose the nature of the interest, just that you have an interest.

   Dispensation may be granted in limited circumstances, to enable you to participate and vote on a matter in which you have a disclosable pecuniary interest.

5. Where you have a disclosable pecuniary interest on a matter to be considered or is being considered by you as a Cabinet member in exercise of your executive function, you must notify the Monitoring Officer of the interest and must not take any steps or further steps in the matter apart from arranging for someone else to deal with it.

Disclosure of Other Registerable Interests

6. Where a matter arises at a meeting which ***directly relates*** to the financial interest or wellbeing of one of your Other Registerable Interests (as set out in **Table 2**), you must disclose the interest. You may speak on the matter only if members of the public are also allowed to speak at the meeting but otherwise must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation. If it is a 'sensitive interest', you do not have to disclose the nature of the interest.

Disclosure of Non-Registerable Interests

7. Where a matter arises at a meeting which ***directly relates*** to your financial interest or well-being (and is not a Disclosable Pecuniary Interest set out in **Table 1**) or a financial interest or well-being of a relative or close associate, you must disclose the interest. You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation. If it is a 'sensitive interest', you do not have to disclose the nature of the interest.

8. Where a matter arises at a meeting which ***affects*** –

    a. your own financial interest or well-being;

    b. a financial interest or well-being of a relative or close associate; or

    c. a financial interest or wellbeing of a body included under Other Registrable Interests as set out in **Table 2** you must disclose the interest. In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied

9. Where a matter (referred to in paragraph 8 above) ***affects*** the financial interest or well- being:

    a. to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;

    b. a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest

    You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise, you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

    If it is a 'sensitive interest', you do not have to disclose the nature of the interest.

Where you have an Other Registerable Interest or Non-Registerable Interest on a matter to be considered or is being considered by you as a Cabinet member in exercise of your executive function, you must notify the Monitoring Officer of the interest and must not take any steps or further steps in the matter apart from arranging for someone else to deal with it.

Table 1: Disclosable Pecuniary Interests

This table sets out the explanation of Disclosable Pecuniary Interests as set out in the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012.

Subject	Description
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain. [Any unpaid directorship.]
Sponsorship	Any payment or provision of any other financial benefit (other than from the council) made to the councillor during the previous 12-month period for expenses incurred by him/her in carrying out his/her duties as a councillor, or towards his/her election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract made between the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners (or a firm in which such person is a partner, or an incorporated body of which such person is a director* or a body that such person has a beneficial interest in the securities of*) and the council — (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land and Property	Any beneficial interest in land which is within the area of the council. 'Land' excludes an easement, servitude, interest or right in or over land which does not give the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners (alone or jointly with another) a right to occupy or to receive income.
Licenses	Any licence (alone or jointly with others) to occupy land in the area of the council for a month or longer
Corporate tenancies	Any tenancy where (to the councillor's knowledge)— (a) the landlord is the council; and

	(b) the tenant is a body that the councillor, or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners is a partner of or a director* of or has a beneficial interest in the securities* of.
Securities	Any beneficial interest in securities* of a body where— (a) that body (to the councillor's knowledge) has a place of business or land in the area of the council; and (b) either— i. the total nominal value of the securities* exceeds £25,000 or one hundredth of the total issued share capital of that body; or ii. if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the councillor, or his/ her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

* 'director' includes a member of the committee of management of an industrial and provident society.

* 'securities' means shares, debentures, debenture stock, loan stock, bonds, units of a collective investment scheme within the meaning of the Financial Services and Markets Act 2000 and other securities of any description, other than money deposited with a building society.

Table 2: Other Registrable Interests

You have a personal interest in any business of your authority where it relates to or is likely to affect: a) any body of which you are in general control or management and to which you are nominated or appointed by your authority b) any body i. exercising functions of a public nature

ii. any body directed to charitable purposes or
iii. one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union)

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NORTHUMBERLAND COUNTY COUNCIL

HEALTH AND WELL-BEING BOARD

At a meeting of the **Health and Wellbeing Board** held in County Hall, Morpeth on Thursday, 13 October 2022 at 10.00 a.m.

PRESENT

Councillor P. Ezhilchelvan
(Chair, in the Chair)

BOARD MEMBERS

Binning, G.	Pattison, W.
Blair, A.	Sanderson, H.G.H.
Boyack, J.	Syers, G.
Bradley, N.	Thompson, D.
Lamb, S.	Travers, P.
Morgan, L.	Wardlaw, C.

IN ATTENDANCE

A Bell	NENC ICB Northumberland
L.M. Bennett	Senior Democratic Services Officer
D. Cummins	NENC ICB Northumberland
R. Hay	NENC ICB Northumberland
P. Lee	Public Health Consultant
C. Lynch	NENC ICB Northumberland

93. APOLOGIES FOR ABSENCE

Apologies for absence were received from G. Reiter, P. Mead, R. Mitcheson, H. Snowden, M. Taylor, C. Wheatley, Councillors G. Renner-Thompson and E. Simpson.

94. MINUTES

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 8 September 2022, as circulated, be confirmed as a true record and signed by the Chair.

95. NORTHUMBERLAND HEALTHY WEIGHT DECLARATION

Members were asked to consider adoption of the Healthy Weight Declaration and how it could contribute towards ongoing work within Northumberland using Whole Systems approach to support healthy weight.

Liz Morgan, Interim Executive Director of Public Health and Community Services, presented the report. The Healthy Weight Declaration was being progressed jointly with North Tyneside Council and Northumbria Healthcare NHS Foundation Trust. It aimed to raise awareness of healthy weight and it was known that unhealthy weight and obesity was becoming an increasing issue especially in children. Members' support for the Healthy Weight Declaration was sought and it would act as a launch pad for a range of activities across the whole of the system over the next few years. Prior to the pandemic, work had been ongoing to support a whole system approach to healthy weight and this was a good opportunity to continue this work and make an impact.

The following comments were made:-

- Activity would be focused on childhood obesity as overweight children tended to become overweight adults. The focus on children would be part of the best start in life approach and the importance of focusing on children and their families at the earliest possible stage. There would be engagement with the Education Department to see what could be done within the school environment.
- There was a close link to the current cost of living issue with some families having to spend a considerable part of their budget on providing a health plate for their families. This was not sustainable for many families.

RESOLVED that

(1) the Healthy Weight Declaration (and its 16 commitments for action) for Northumberland County Council be adopted.

(2) A joint launch of the Healthy Weight Declaration between Northumberland County Council, North Tyneside Council and Northumbria Healthcare NHS Foundation Trust be supported.

96. NORTHUMBERLAND JOINT STRATEGIC NEEDS ASSESSMENT

Members were informed of the proposed process to refresh the Joint Strategic Needs Assessment (JSNA) and received an update on progress from Pam Lee, Public Health Consultant.

The newly created webpage on the Northumberland County Council website was displayed for Members' information prior to going live to the public. Pam Lee explained that, in order to provide some structure and to refresh the JSNA, it was proposed to create a Steering Group. This would include refreshing the Joint Health & Wellbeing Strategy by working through other plans such as the Inequalities Plan and taking into account the cost of living crisis.

The Officer Steering Group would determine the priorities for the JSNA, which areas would be worked on and in which order.as well as taking ownership of the recommendations and actions. It would come back to the Health & Wellbeing

Board if an action needed to be escalated. Within the JSNA framework, assets were referred to but this was not explicit in the title. The JSNA would, therefore, now be known as the Joint Strategic Needs and Assets Assessment. Other important documents such as the Inequalities Plan and Pharmaceutical Needs Assessment would also be linked via the webpage.

Members welcomed the report and the website which it was hoped would go live to the public later in the day.

RESOLVED that

(1) The JSNA should include both needs and assets to reflect the Northumberland Inequalities Plan 2022-32.

(2) The establishment of a JSNA Steering Group to co-ordinate current work attached to the report as Appendix 5 be agreed.

(3) the priorities and timelines as attached to the report as Appendix 5 be agreed.

97. POPULATION HEALTH MANAGEMENT UPDATE

Members received a Population Health Management update from David Cummins and Alan Bell, NENC ICB Northumberland Place.

The following key issues were raised:-

- The seven Primary Care Networks in Northumberland had each identified a project(s) which they would be focus on. These included child poverty, obesity, smoking and cancer.
- In areas of the South East of Northumberland, there were significant levels of inequalities, deprivation and low income. For example, average household income after tax in Morpeth was £44,000 compared to £26,000 in Ashington. There were big gaps in life expectancy for both men and women between different parts of the county.
- PCN population health management projects were detailed as follows and each was assigned a Public Health Consultant
    - **Cramlington/Seaton Valley** – Chronic disease/depression. 100-150 patients aged 35-65 living within the most deprived decile and suffering with depression and CVD/COPD would be invited to be part of the project.
    - **Valens** – Frequent Flyers (High Intensity Users) – 433 patients with 10+ GP appointments in the last 12 months. Provide with bespoke intervention such as links with local pharmacies and practice nurse etc.
    - **Wansbeck** – Child Poverty – Hotspots in Hirst and Ashington Central and focus on 15 patients aged 11-12). Child poverty in Wansbeck 26% compared to the national average of 17%. Multiple

stakeholders including Cygnus Support, local regeneration groups, safeguarding team and CAB.

- **Well Up North** – Obesity – Targeting parents of children in top 20% of weight. Workshops with stakeholders had been held. Referrals from Health Visitors, school nurses, early years settings, GPs etc.
- **Northumbria** – Smoking/Cancer – Focus on deprived areas of Cramlington and variable uptake of cancer screening. Hope to identify a vulnerable cohort for the project.
- **West** – Alcohol Identification and Brief Advice – Focus on 30-60 patients with BMI of 30+ and anxiety. Cohorts less likely to be asked about alcohol to be identified. Include Mental Health practitioners and include the Northumberland Recovery Project.
- **Blyth** – A&E attendances (0-4 years). There had been a significant increase in the number of A&E and Urgent Care attendances. Focus on Cowpen and Kitty Brewster which had the highest rates. Engaging with families to find why they are using A&E and using Healthwatch to survey families. Secondary focus on childhood obesity

- Common themes running throughout the projects were data sharing/access to data/analysis of data/complexity and engagement. It was hoped to get data sharing agreements in place.
- Next steps and conclusions
  - Wide range of projects which support the inequalities agenda
  - PCN workshop planned for October with an opportunity to share initial learning
  - Importance of long-term data sharing agreements/MOUs between all health and care providers.

The following comments were made:-

- Patient Participation Groups could have an important role in engagement within each PCN. Their involvement would be raised with the leader of each project. Within the Valens PCN, there was a move towards the PPG changing its focus to health inequalities
- It was important that this work along with the Health Inequalities Plan dovetailed and that neither went off at a tangent.
- Many of the projects aligned closely with thematic leads within the restructuring and remodelling of the 0-19 service. Key posts would be appointed to including a community anchor post which would develop partnerships and ensure strong links with all partners. There needed to be a single point of contact within the 0-19 service.
- Monitoring progress was important, and the Health & Wellbeing Board was the ideal body to do this. Remaining focused on the issues in hand was vital.
- Work was already ongoing regarding the low level of uptake of benefits and helping individuals to make claims. It was hoped that benefit advisers would have a presence in GP surgeries.
- Childhood obesity was a very complex area.

- Data sharing issues were currently hindering the projects and it was a tricky problem to resolve. A solution would be found with support from all involved.

The Chairman thanked Alan Bell and David Cummins for their presentation.

RESOLVED that

(1) the presentation be received

(2) regular updates be received every three months.

98. LIVING WITH COVID

Members received a verbal update from Liz Morgan and an update on the covid and flu vaccination programme from Richard Hay and Claire Lynch, NENC ICB Northumberland.

Liz Morgan raised the following key points:-

- ONS data for the week ending 24 September 2022 showed that prevalence in England and Northern Ireland had risen from 1:65 to 1:50.
- Prevalence was highest in the North East in primary age children, the over 35s and over 70s.
- Although there were a few variants in circulation it was likely that the increases were due to waning immunity and behavioural factors such as spending more time indoors.
- Australia had suffered its highest level of flu cases compared to recent and pre-pandemic years and the flu season had started earlier in May/June.
- It was hoped to avoid concurrent peaks in both flu and Covid.
- The important message was to encourage everyone to have a vaccination as it was the best way to reduce the risk of Covid. If symptoms developed, then people should stay at home if they could. 'Hands Face Space' remained an important message.
- The Northumbria Healthcare NHS Foundation Trust currently had 84 positive inpatients and two in ITU. Most patients had been admitted with Covid rather than because of it.
- 1% of staff sickness was due to Covid which created logistical issues such as cancellation of operations and other pressures. There was not the depth of statistics that had been available previously.

Richard Hay and Claire Lynch, NENC ICB, updated Members on the current vaccination programmes and raised the following key points:-

Covid and Flu Vaccination Programmes

Covid

- The two vaccination programmes were running alongside each other but remained separate.
- The Covid booster programme had begun in early September at 21 designated sites in Northumberland and was starting by prioritising the most vulnerable residents. Eligible cohorts were
    - Residents and staff in care homes for older adults
    - Frontline health and social care workers
    - All adults aged 50 and over
    - Persons aged 5-49 in a clinical risk group or who are household contacts of people with immunosuppression
    - Persons aged 16-49 who were carers.
- Vaccination sites comprised PCN centres, community pharmacies, the hospital hub, a roving vaccine unit, the school immunisation service, community nursing team and local pop up clinics.
- Updated versions of the mRNA Covid vaccines (Pfizer and Moderna). Half of the dose targeted the original virus strain and the other targeted the Omicron variant. The booster was shown to trigger a strong immune response. Novavax vaccine was available for those at clinical risk e.g. allergic reactions.
- Bookings could be made either via the National Booking Service or locally through PCN sites and local pop up clinics.
- PCNs would be offering local appointments to eligible cohorts in order. However, more invitations had been sent out than there were currently appointments available.
- Booster uptake was strong and it was important that public confidence and trust was maintained. Vaccination was the best way to protect against serious illness.
- The need for patience was stressed as there was sufficient vaccine for all.

Flu

- Eligible cohorts were aligned with the Covid booster programme but including pregnant women, children aged 2-3 years, all primary school children and secondary school children in Years 7, 8 and 9.
- All 36 of Northumberland GP surgeries had signed up to deliver the programme along with a number of community pharmacies and the school age immunisation service.
- Uptake of the vaccine, so far, was good and slightly ahead of some cohorts in 2021. Where supplies allowed there was coadministration of Covid and flu but patients were encouraged not to wait and to take each vaccine when offered.
- Work was ongoing to improve uptake amongst pregnant women and 2-3 year olds.
- There were a number of local and national campaigns aimed at maximising uptake. A wide network of providers and partners were working together to maximise uptake along with the Northumberland Vaccine Collaborative and NENC Vaccination Board. Reducing inequalities was a key priority

The following comments were made:-

- It was suggested the national booking system be improved to show where sites were even if there were currently no available appointments. More locally it would be possible to share a map showing all the sites and the various routes to obtain a vaccination. It was important that messaging was clear to ensure that people did not give up.
- The evergreen offer remained open to anyone who had missed an initial vaccination and/or boosters.
- West PCN was operating out of Hexham Mart and good levels of uptake were reported. There was also the potential for and outreach service reaching Bellingham and Haltwhistle. Age UK operated transport to PCN sites.

99. DEVELOPMENT SESSION DISCUSSION

Health & Wellbeing Strategy

Graham Syers reported that following the Development Session in July, the following leads had been assigned to different themes and there was the expectation that they would come back having developed an action plan against it:-

Theme	Lead Member	Executive Director	Public Health Support
Best Start in Life	Cllr. Wayne Daley	Graham Reiter/ Audrey Kinghorn	Jon Lawler
Empowering Communities	Cllr. Caroline Ball	Liz Morgan/Gill O'Neill	Karen McCabe
Wider Determinants	Cllr. Veronica Jones	Rob Murfin	Liz Robinson
Whole System Approach	Cllr. Paul Ezhilchelvan	Rachel Micheson/ Alistair Blair	Jim Brown

The leads would be contacted and asked to go back to the Health & Wellbeing Strategy within the appropriate timeframes for reporting back to the Health & Wellbeing Board.

Compact

Part of the Inequalities Plan had a compact which was to say that our Partner members would take this compact to their organisations, to discuss and request that they sign up to ensure everyone was committed to taking action. A progress update should be provided at the next meeting.

RESOLVED that the verbal report be noted.

100. HEALTH AND WELLBEING BOARD FORWARD PLAN

RESOLVED that the Forward Plan be noted with the addition of the following items for the next meeting:

- Health & Wellbeing Strategy Themes
- Compact

101. URGENT BUSINESS

The Chair reported that he had been made aware of the following and agreed that they be raised as items of urgent business.

The Chair presented a copy of the agenda for the next Joint OSC for the North East and North Cumbria ICS and North & Central ICPS. He was happy to raise any issues at the meeting which Members may give to him. The following issues was raised:-

- It was important that the ICS did not think of the NHS workforce in isolation and must also include the social care workforce. The inclusion of the voluntary workforce was also very important or there would be limitations in what could be achieved.
- Mental Health Collaborative and Mental Health Partnership were to be decision makers going forward and what were the implications at Place? Previously there had been close working arrangement with the CCG but it was uncertain how this would move forward with the ICB and the allocation of funds across the system.
- ICS Structures – there had been discussion at the monthly meeting of Chairs, Council Leaders across the footprint and there had already been the first ICP meeting. There was now work to be done about what the Sub ICP would look like and to ensure that Local Authorities were working in partnership with health. These meetings were likely to meet quarterly. Plans for the Sub ICP membership would be reported to a future Health & Wellbeing Board.

102. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 10 November 2022, at 10.00 a.m. in County Hall, Morpeth.

CHAIR _____

DATE _____

Developing the Integrated Care Strategy

National Requirement

All Integrated Care Partnerships (ICPs) are required to publish an Integrated care Strategy by December 2022. On 29 July 2022 the Department for Health and Social Care published guidance for the development of the Integrated Care Strategies.

Steering Group

In anticipation of the national guidance we established a steering group to oversee the development the strategy. The steering group is jointly chaired by Jane Robinson, Corporate Director, Adult and Health Services, Durham County Council and Jacqueline Myers, Executive Director of Strategy and System Oversight, North East and North Cumbria ICB. The steering group includes representatives from local government, the NHS, and the Office for Health Improvement and Disparities (OHID, previously Public Health England). The steering group is supported by task and finish groups, for example a data and intelligence group.

Call for Evidence and Data

In July the steering group issued a 'call for evidence', requesting key documents including Joint Strategic Needs Assessments (JSNAs) from a wide range of partners. In total over 300 documents were received. The call for evidence has strongly informed the content of the draft strategy, alongside the population health data, which can be viewed through the link: Picture of Health - ICS edition 2022.

Draft Document Engagement Phase

During September and October we began to draft the strategy. On 26 October we will publish the draft through the ICP page on the ICB website as a public facing document. We have developed a short survey to enable members of the public and stakeholders to give feedback throughout late October until 25 November. The feedback will be used to inform the final strategy. We will also take the opportunity, wherever practically possible, to speak with key stakeholders during this phase, for example through Health and Wellbeing Board meetings.

Integrated Care Partnership

On 20 September the joint chairs of the steering group gave an update presentation to the ICP, including on the process to develop the strategy. The ICP will be asked to approve the final strategy in mid-December, informed the feedback from all stakeholders across the ICP geography, public and partner organisations.

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NORTH EAST AND NORTH CUMBRA INTEGRATED CARE PARTNERSHIP

DRAFT INTEGRATED CARE STRATEGY

DRAFT: 21/10/2022

FOREWORD – ICP CHAIR

To be inserted in the final strategy.

EXECUTIVE SUMMARY

To be inserted in the final strategy.

1 INTRODUCTION AND BACKGROUND

1.1 Introduction to the Strategy

The Health and Care Act 2022 enables health and care organisations to improve services and outcomes through stronger joint working, and to take shared responsibility for tackling growing health inequalities. The Act established Integrated Care Boards (ICBs) as statutory NHS organisations. It also requires ICBs and partner local authorities to form a joint committee, termed the Integrated Care Partnership (ICP). A key accountability for the ICP is to produce an Integrated Care Strategy, setting out how the assessed needs of the local population will be met, including from Joint Strategic Needs Assessments (JSNAs).This includes social care, primary and secondary care, physical and mental health, and health related service across the whole population regardless of age.

This document sets out the Integrated Care Strategy for the North East and North Cumbria Integrated Care Partnership (ICP), in the context of our existing partnership working arrangements and the national guidance.

1.2 Our Integrated Care Partnership

The ICP Board is a statutory joint committee between the thirteen Local Authorities from across the North East and North Cumbria (which will become fourteen in 202023/24 as two new unitary authorities begin in Cumbria) and the Integrated Care Board (ICB). It is an equal partnership between Local Government and the NHS, with a key purpose to align the ambition and strategies of partners across the area. The Department for Health and Social Care, NHS England and the Local Government Association have jointly developed five key expectations for Integrated Care Partnerships as follows:

- Be a core part of the Integrated Care System, driving direction and priorities;
- Be rooted in the needs of people, communities and places;
- Create space to develop and oversee population health strategies to improve health outcomes and experiences;
- Support integrated approaches and subsidiarity;
- Take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights

The ICP will bring together not just Local Government and the NHS, but also the diverse Voluntary, Community and Social Enterprise and Independent Sectors to find effective shared solutions to improve the health and wellbeing of our region.

The North East and North Cumbria ICP has the second largest population in England at 3.14 million (Greater Manchester is very slightly larger by around 7, 000 people) across a large and diverse geography. The landscape of the region is characterised by urban and inner city conurbations, coastal areas and rural areas. Whilst this makes for beautiful terrain and serene environments, it also presents a number of unique and specific challenges for the people living in those areas. To maximise the opportunity to work together at scale where beneficial, but balanced with more localised approaches, we have committed to working together through a single overarching ICP alongside four local ICP arrangements covering

the areas in the graphic below.

Local ICPs will develop a strategic picture of health and care needs from their constituent local authority 'places' working with partners including existing health and wellbeing boards. These provide a vital forum for partners to assess the needs of local people and set local priorities for health and care improvement, building on the existing work of health and wellbeing boards in each Place. We will continue to focus at Place, and will:

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

1.3 Strategic Planning Context

The ICP Integrated Care Strategy provides a strategic direction and key commitments at a headline level. This is based on the understanding of health and care needs across the region and at the 13 places, and the nationally mandated functions. It is not a detailed operational plan. Local authorities and the NHS are required to give full attention to the ICP Strategy in considering how they plan, commission or deliver services. The ICB and NHS partners develop more detailed delivery plans to support the anticipated national requirement of a five year NHS Joint Forward Plan for each ICB area.

1.4 The Data

Information in the draft strategy have been calculated taking data published at local authority geographies and applying a population weighted method to generate estimates as actual data is not available for the ICP geographic area. The estimates have been provided by Office for Health Improvement and Disparities (OHID) LKIS. Source data at local authority level is taken from Office for Health Improvement and Disparities (OHID) Fingertips platform and Life Expectancy Segment tool.

2 OUR VISION, LONG TERM GOALS AND ENABLING PROGRAMMES

2.1 Summary Vision, Goals and Enabling Programmes

The graphic below provides a summary of overall vision, long term goals and key enabling actions. We will develop fuller plans under each of these areas to demonstrate how we will deliver our commitments.

2.2 Guiding Strategic Commitments

Our guiding strategic commitments for each of those areas are:

Our Vision: 'Better and Fairer Health for all of our People and Communities'

- Local Authorities, the NHS and Partner Organisations will be clear where they need to lead, collaborate and advocate to work effectively and efficiently together
- We will develop a clear leadership and accountability framework to ensure the delivery of our strategy, with transparent reporting of progress across the ICP
- We will deliver a renewed partnership with experts by experience and the people who use our services, including through stronger partnerships with Health Watch and third sector organisations who know our communities best.

Goal: Longer, Healthier Life Expectancy

- We will reduce the gap in healthy life expectancy between our ICP and the England average by 25% by 2030, and aim to raise the average healthy life expectancy to a minimum of 60 years in every Local Authority by 2030
- We will reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below by 2030.

Goal: Fairer Health Outcomes

- We will reduce the inequality in life expectancy within our ICP between the most deprived and least deprived deciles by at least 25% by 2030

- We will reduce the suicide rate from 13 per 100, 000 population (2019/2021) to below the England average (10.4 per 100, 000 population 2019/2021) by 2030.

Goal: Excellent Health and Care Services

- We will commission and deliver high quality and joined up health and care services, delivering improving outcomes and safety with more equitable access. We will reduce unwarranted variation and healthcare inequalities across all services.

Enabler: Workforce:

- We will ensure a well-supported, sustainable, diverse workforce including ensuring the physical and mental wellbeing of the workforce.

Enabler: Places and Neighbourhoods.

- We will ensure place remains at the forefront of our actions and delivery of this strategy with decisions made at the most appropriate level and deliver integrated neighbourhood teams in all Places by March 2025.

Enabler: Technology, equipment and facilities

- We will deliver a digital, data, intelligence and insights strategy that aligns with our ambitions for placing population health management (PHM) at the centre of our decision making and transformation of health and care services.

Enabler: Resources and protecting our environment.

- We will advocate for our ICP to receive fair financial allocations and will deploy our resources to ensure improvement across the whole area but with the greatest improvement in areas with the poorest outcomes
- We will fully participate and contribute to the cross-sector coalition working to enable our region to become England's greenest region by 2030.

3 OUR STRENGTHS AND ASSETS TO BUILD ON

Across our Integrated Care Partnership are we much to be proud of. We have a broad range of outstanding assets and capabilities, providing a strong foundation for improvement. They also provide a credible source of hope, we will make real improvements with confidence and realistic optimism.

We have strong communities, with hundreds of thousands of people providing unpaid care to support their loved ones, and who freely give their time and skills through volunteering. Our Voluntary, Community and Social Enterprise sector is an amazing asset, and makes a huge contribution to the health and wellbeing of our region and our communities.

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

We have an outstanding health and care workforce, delivering high quality services across the ICP in all sectors, 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.

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 and our future generations.

Finally, we have a very strong foundation of partnership and collaborative working, across the ICP and at Place level in each of our Local Authority areas. These and our many other strengths and assets provide a fantastic foundation for us to make a real and lasting difference to the health and wellbeing of or population.

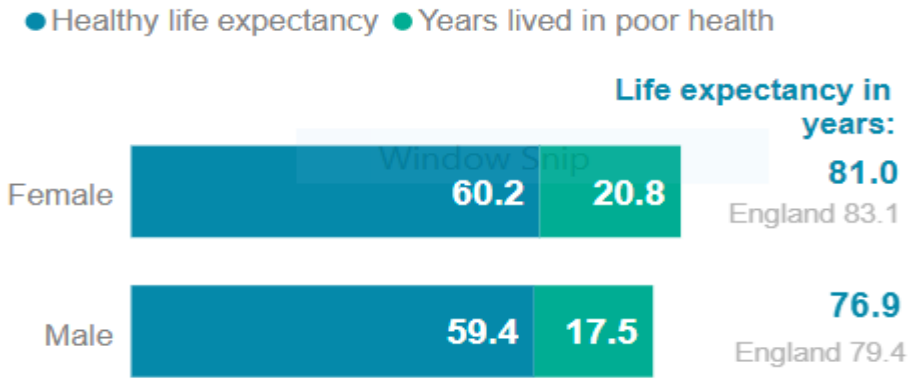
4 OUR ICP HEALTH OUTCOMES

4.1 Introduction

The quality of health and care services in the North East and North Cumbria is consistently rated amongst some of the best in England across a range of metrics. We are realistic about the challenges in sustaining our services, but we have optimism because of a strong track record of innovation and transforming care. There have been many improvements in recent years, for example the number of people dying from cancer or heart disease has decreased, fewer people are smoking and many are living longer. Despite this, overall healthy life expectancy remains amongst the poorest in England, and needs to change.

4.2 Life Expectancy and Healthy Life Expectancy

4.2.1 Life expectancy at birth in our Integrated Care Partnership area was lower than the England average in 2018-20 for both women and men as shown in the graphic below, and people also spend a significant time in living in poor health

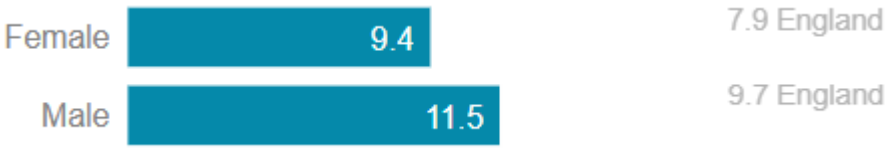


Source: Population weighted estimates (experimental) for NENC via Picture of Health - ICS edition 2022 based on data available from OHID Public Health Profiles 2022.

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

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

4.2.3 The difference in life expectancy at birth between the most and the least deprived areas within our ICP was approximately 9.4 years for women and11.5 years for men in 2018-20 (based on weighted averages, this is an indicative figure only). This difference is much larger than the inequality gap for England as shown below.



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

4.3 Economic Inclusion, Socio-Economic Deprivation and Health Outcomes

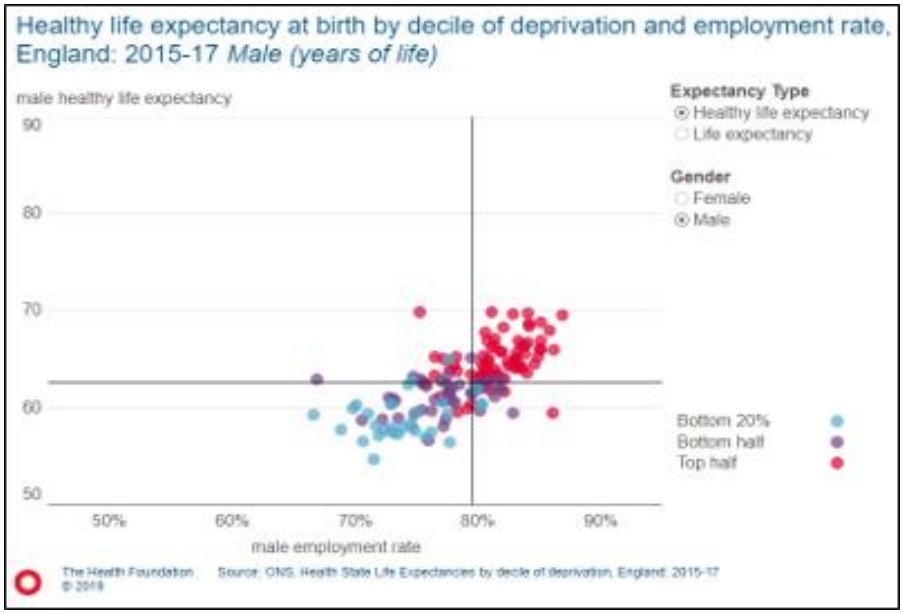
There is a strong two-way relationship between health and economic outcomes. Poor social and economic circumstances affect health throughout life. People living in poverty and multiple disadvantage have greater risks of serious illness and premature death, face increasing health inequalities and spend a greater proportion of their shorter lives living with long term conditions and disabilities.

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

Our ICP population faces a particular challenge in the context of the current cost of living crisis, for example:

- Average pay growth is currently 6%, but significantly less for many workers, and well below the current rate of inflation
- Throughout the next year we are anticipating the largest fall in real incomes since records began and will have a disproportionate impact on more deprived households.

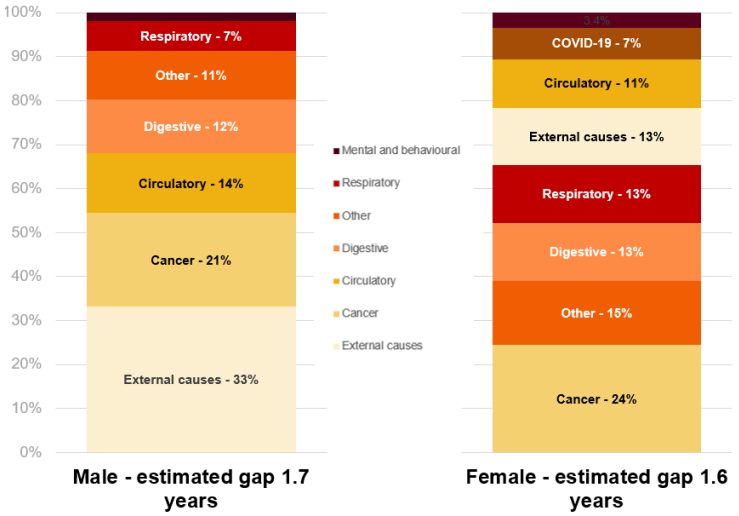
The chart below illustrates the relationship between healthy life expectancy at birth for men (the picture is very similar for women) and deprivation and employment.



4.4 Inequality in health outcomes

The graphic below shows the main causes of inequality in health outcomes between our ICP and England by disease groups for 2020 – 21. External causes, which include suicide and accidental poisoning, are particularly significant for men, the single biggest cause for women is cancer.

Causes of death that drive inequalities in life expectancy between England and NENC (experimental estimates NENC 2020 to 2021)



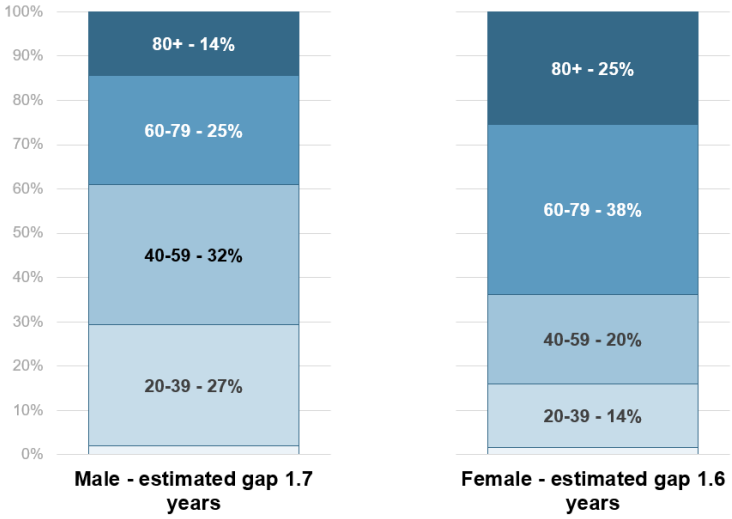
Main cause for the life expectancy gap between the area and England in females is cancer, whereas in males it is external causes which includes deaths from injury, poisoning and suicide

Figures for breast cancer are only displayed for females. Deaths from breast cancer occurring in males are included in the Other cancer category. Circulatory includes heart disease and stroke. Respiratory includes flu, pneumonia, and chronic lower respiratory disease. Digestive includes alcohol-related conditions such as chronic liver disease and cirrhosis. External includes deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease.

Source: Population weighted estimates for NENC (unpublished) based on data from OHID Segment tool.

There are differences between women and men age groups that drive the inequality in life expectancy between out ICP and England. For women, a higher percentage of the life expectancy gap is associated with excess deaths at an older age than for men.

Causes of death that drive inequalities in life expectancy between England and NENC by age group
(experimental estimates NENC 2020 to 2021)



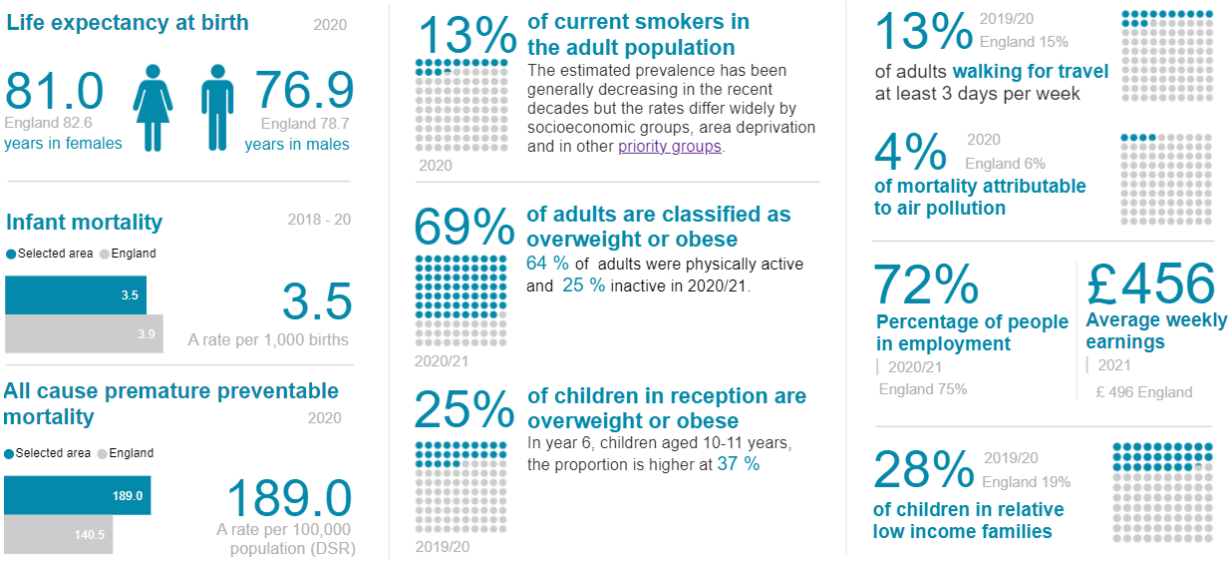
The life expectancy gap is mostly due to excess deaths in ages 60-79 in females whereas in males it is age group 40-59, an age group which makes the biggest proportion of the gap in life expectancy between England and the ICS.

Source: Population weighted estimates for NENC (unpublished) based on data from OHID Segment tool.

5 LONGER AND HEALTHIER LIFE EXPECTANCY

5.1 The Current Position

Health outcomes are not as good as they should be, we need to achieve a real improvement. The graphic below summarises some of the key factors influencing healthy life expectancy in our ICP.



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

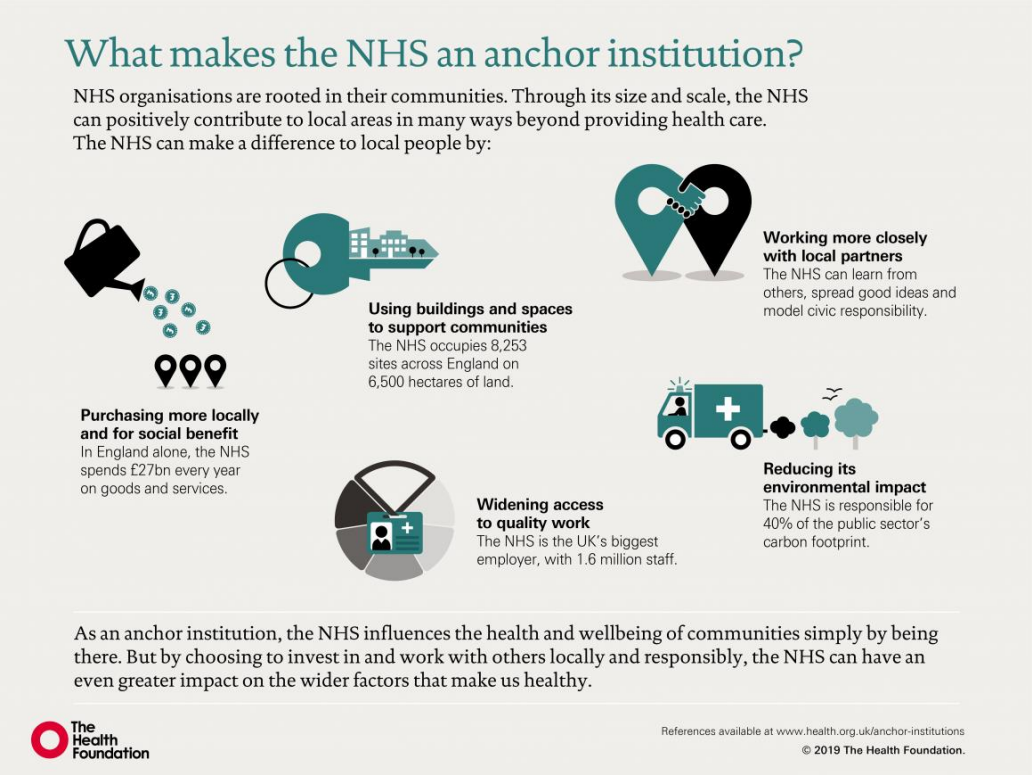
5.2 Our Key Commitments to achieve longer, healthier life expectancy are:

- We will reduce the gap in healthy life expectancy between the North East and North Cumbria and England average by 25% by 2030, and aim to raise the average healthy life expectancy to a minimum of 60 years in every Local Authority by 2030
- We will reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below by 2030.

5.3 To achieve our Key Commitments we will:

5.3.1 Greatest improvement where most needed: Many of our key work programmes to work towards longer, healthier expectancy will also have a positive impact on achieving fairer health outcomes (see section 6). We will raise overall levels of health at the same time as flattening the gradient in health by improving the health and wellbeing at pace where the need is higher. In technical language this approach is called Proportionate Universalism.

5.3.2 Anchor Institutions**:** Large partner organisations, rooted in their local communities, can make a big difference to social determinants by acting as Anchor Institutions. The term anchor institutions refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities. The Health Foundation and other partners have developed the graphic below to show how NHS organisations act as anchor institutions in their local communities. Although the graphic refers to the NHS, the same principle applies to a partners, including Local Authorities, Universities and large employers.



5.3.3 Community Centred and Asset Based Approaches: Asset-based approaches emphasise the need to redress the balance between meeting needs and nurturing the strengths and resources of people and communities. We will use asset-based approaches

to address health inequalities in access, experience and outcomes building on the knowledge, skills, experience, resilience, and expertise that lie within the communities we serve. We will build on the learning from the covid-19 pandemic in which community centred approaches across the region played a key role in a number of the key strands for the pandemic response.

5.3.4 Prevention and Health Promotion: We will continue to implement evidence-based programmes of preventive interventions that are effective across the social gradient – for example, proven smoking cessation, alcohol reduction, and excess weight reduction programmes. We will build on this to make the prevention efforts more targeted including supporting and empowering patients to manage their health and well-being where appropriate.

5.3.5 Embedding prevention across health and care services**:** Across our ICP we will contribute to the wider systems that support people to enjoy good education and employment, fair pay and incomes, and good quality homes and neighbourhoods.

5.3.6 Health Protection: The experience of the Covid 19 Pandemic brought to the fore the vital importance of effective Health Protection Programmes. We will work with partners, including the UK Health Security Agency (UKHSA) to:

- Maximise routine adult and childhood vaccination programmes
- Ensure effective delivery of the Covid and seasonal flu vaccination programmes
- Adopt effective practices to protect the population from new and emergent threats
- Reduce iatrogenic harms, by which we mean harms caused by health and care services, for example the transmission of viruses in Hospitals and Care Homes.

5.3.7 Partnership Working: Partnership working at a place level is key to the achievement of our ambition. We will use evidence-based tools including opportunities for co-production, and understanding lived experience to deliver better health and wellbeing outcomes in a way that meets the different needs of all local people. Importantly, we will be attentive at all levels to ensuring that we acts as good partners, recognising the strengths and challenges of all partner organisations and stakeholders.

6 FAIRER HEALTH OUTCOMES

Health inequalities arise because of variations in the conditions in which we are born, grow, live, work and age; this means that not everyone has the same opportunities to be healthy. We are committed to delivering fairer health outcomes by reducing health inequalities across the entire population. Health Inequalities are defined as the systematic differences in health between groups of people. Inequalities in life expectancy, the difference in how long groups of people in they live average, are one of the key measures of health inequality.

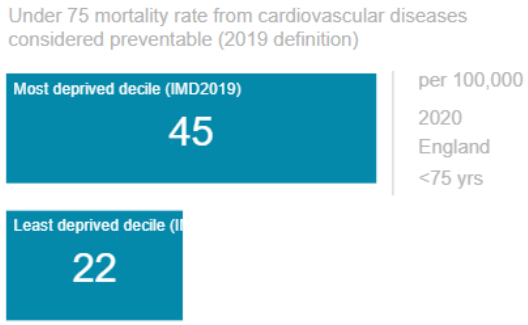
6.1 The Current Position

6.1.1 Health inequalities within our ICP, and between our ICP and the rest of the country, remain stubbornly high. We have high levels of unemployment (and poorly paid or insecure employment), low levels of decent housing, and significant areas of deprivation. These contribute to some of the starkest health inequalities, early death rates and highest sickness levels in England.

6.1.2 Positive health outcomes strongly correlate with a social factors, including strong communities, access to preventative and responsive health services, healthy and varied and diet and regular exercise, well-paid employment and secure accommodation and a

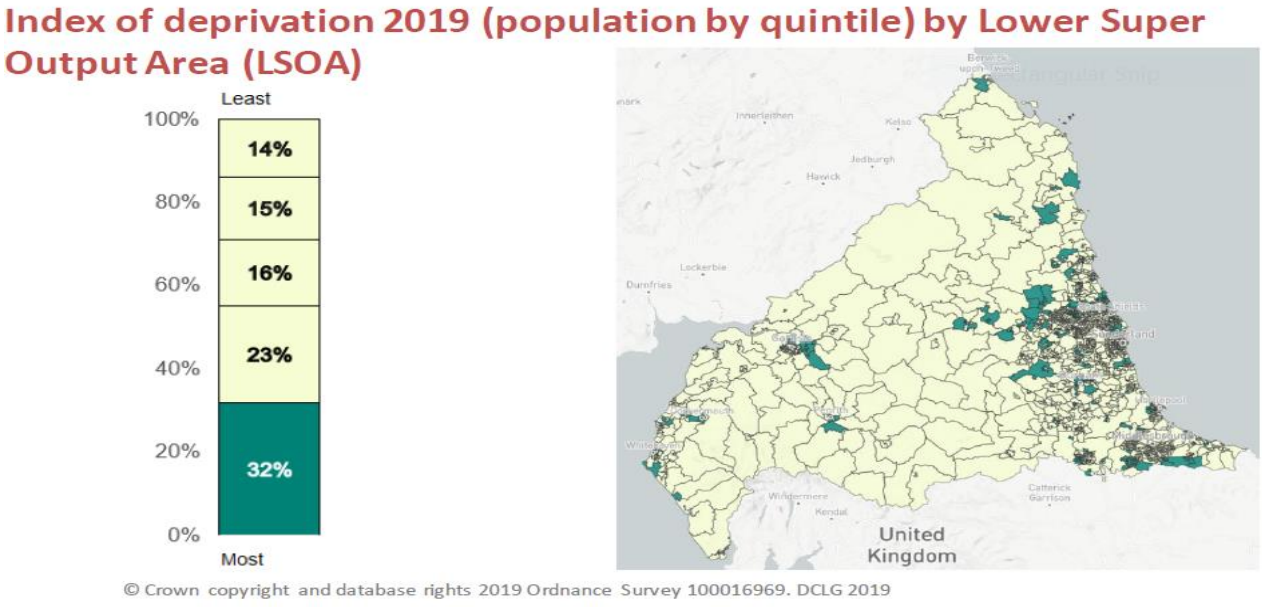
financially secure and supported childhood. Equally, poor health outcomes strongly correlate with relative levels of deprivation, a major challenge for the North East and North Cumbria.

6.1.3 Equally, poor health outcomes strongly correlate with relative levels of deprivation, a major challenge for the North East and North Cumbria. The graphic below shows that premature mortality from cardiovascular diseases (under 75 mortality) considered to be preventable in 2020 in England was double in the most deprived decile of the population compared to the least deprived.



Source: Picture of Health - ICS edition 2022. Data available via OHID Public Health Profiles.

6.1.4 The graphic below shows that a far higher percentage of our population live in the most deprived quintile and second quintile than the national average for England. We also know that there is a significant amount of rural poverty and disadvantage which is often not recorded through official data sets.



6.1.5 The way health and care services are delivered can contribute to health inequalities. Some groups of the population have lower participation in routine screening programmes or present at a later stage of disease progression, due to the barriers people need to overcome in order to engage with services. These barriers include the cost of travel to health services, convenience, health literacy, unconscious bias, diagnostic overshadowing and lack of agency and advocacy support. A key part of our work is to ensure that we eradicate, and at least minimise, those inequalities.

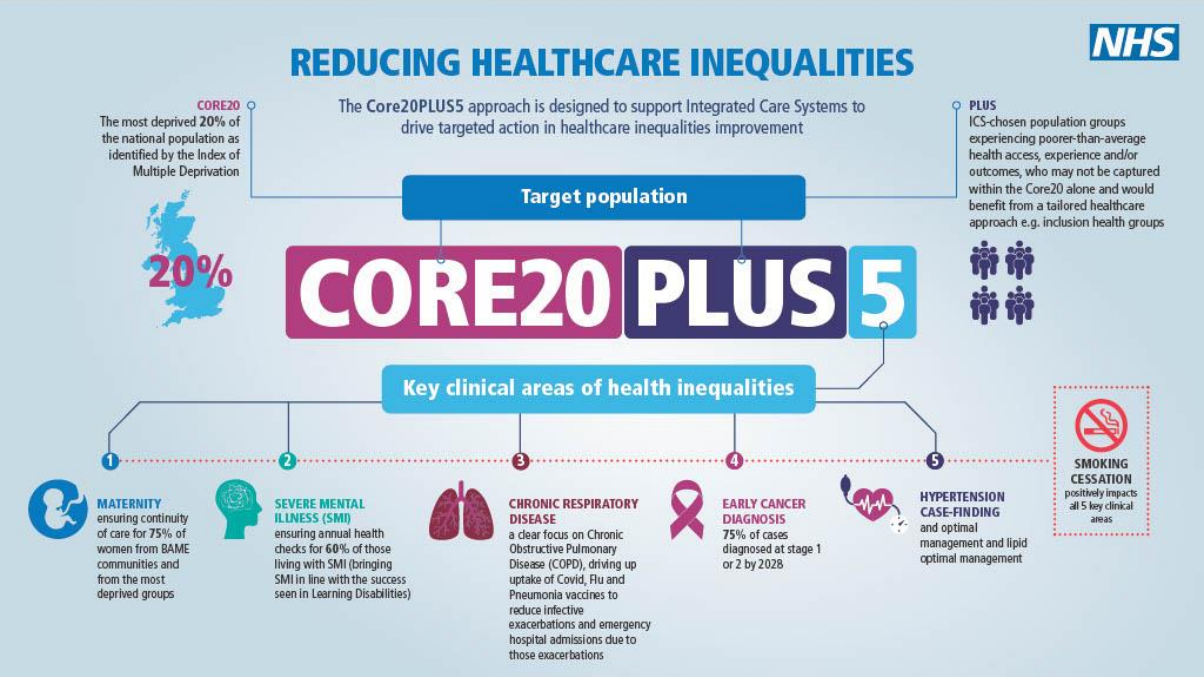
6.2 **Our Key Commitments** to achieve fairer outcomes are:

- We will reduce the inequality life expectancy between the most deprived and least deprived deciles within our ICP by 25% by 2030
- We will reduce the suicide rate from 13 per 100, 000 population (2019/2021) to below the England average (10.4 per 100, 000 population 2019/2021) by 2030.

6.3 **To achieve our Key Commitments** we will deliver Core 20Plus5:

Core 20 PLUS 5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. Focusing resources on the Core20PLUS5 approach across the ICP, working in partnership with local authorities, communities, and the voluntary and community sector, healthcare systems have the potential to have the greatest impact in narrowing the inequalities gap.

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



The most deprived 20 per cent of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health. Across the North East and North Cumbria a third of the population lives in the 20% most deprived areas of the country. This is not uniformly distributed with some of the local authority areas having much higher proportions of their populations living in the most deprived 20% nationally.

The PLUS population groups within the Core20Plus5 include a number of groups where the outcomes are poorer compared to the rest of the population. These include people from Black Asian and Minority Ethnic groups, people with a learning disability and autism, coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller

communities, sex workers, people in the justice system, victims of modern slavery and other socially excluded groups.

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

1. Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
5. Hypertension case-finding and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

7 EXCELLENT HEALTH AND CARE SERVICES

7.1 Introduction to Health and Care Services in the North East and North Cumbria

The NHS and Social Care workforce across the North east and North Cumbria totals around 180, 000 full time equivalent staff. This includes around 74, 000 full time equivalent people working in NHS Secondary care roles alone, and a General practice workforce of around 9, 500 full time equivalents. Within the NHS our ICP includes:

- General Practices, grouping together to deliver services jointly across 64 Primary Care Networks
- Community Pharmacies and Dental Practices
- Eight NHS Foundation Trusts predominantly (though not exclusively) delivering physical health community and hospital based services
- Two Mental Health and learning Disability NHS Foundation Trusts delivering community and in-patient services
- North East Ambulance Service, covering most of the region, and North West Ambulance Service covering North Cumbria, delivering NHS 111, Patient Transport Services and paramedic Emergency Services
- A range of Independent Sector organisations providing NHS commissioned, free at the point of delivery services

Similarly, within Social Care there is a huge service infrastructure, across:

- Over 1, 900 care establishments and more than 550 regulated care providers
- Nearly 90, 000 jobs, with more than 125, 000 unpaid carers providing more than 20 hours a week support to a family member, friend or loved one
- Organisations providing home care to enable people with long term care needs
- Reablement and rehabilitation services to enable people to regain the skills and confidence to live as independently as possible through asset based, rather than deficit based approaches
- Services supporting people with Learning Disabilities and/or Autism and long term Mental Health conditions

- Social Care work to assess need and plan care packages to meet need, and vital interventions to ensure the safeguarding of vulnerable and at risk adults and children
- Joint care, education and health packages for children with complex needs.

There are 120,000 registered carers across our ICP providing at least 20 hours a week of (unpaid) care for family members, friends and loved ones. The total number is likely to be much larger. Many of the people being supported in this way are living with long term, often life long, care and support needs. Without the amazing commitment and dedication of unpaid carers the health and care system would quickly come to a standstill. We need to collectively find better ways to support carers across the North East and North Cumbria.

Similarly, the diverse Voluntary, Community and Social Enterprise (VSCE) sector makes an enormous contribution to the wellbeing of our region. This includes established charitable organisations, and none profit making organisations with charitable aims delivering valued services, but also the vital work of thousands of informal self-help and community groups which often rely entirely on volunteers freely giving their time and voluntary contributions.

7.2 Overarching Strategy

This section of the Integrated Care Strategy is the overarching quality and clinical and care services strategy for the ICP. It does not seek to set out a comprehensive strategic plan for each and every service provided. It does provide a framework by identifying the high-level strategic priorities for the system as a whole and for each of the provider sectors.

The major causes of mortality and morbidity in our ICP are preventable diseases and much of this disease burden is driven by social circumstances. The approach to service provision is nonetheless a key factor in people's health and wellbeing and is more directly influenced by the partners within the ICP.

The health and care services in our ICP have a proud record of excellence; delivery of timely, safe and effective interventions and high rates of patient and service user satisfaction with the care received. In recent years, however, we have seen a growing gap between the need for services and the capacity to provide them. This is most clearly seen in the lengthening waits to access services across all parts of the health and care system.

We will ensure the care service users experience is evidence based, person centred, and uses all of our resources thoughtfully, to achieve the best possible outcomes for people across the North East and North Cumbria. There will be a relentless focus on supporting staff to design and operate models of care that transcend organisational barriers and remove duplication and unwarranted variation. The ICP will support work with the provider sectors to learn from the best and where there are service sustainability issues, to foster collaboration to overcome them.

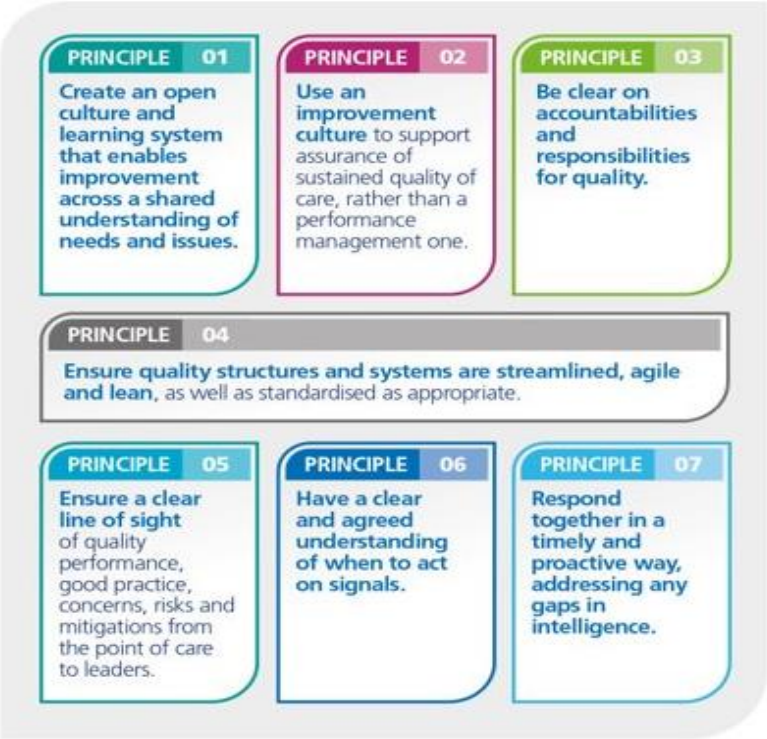
7.3 Quality and Assurance and Improvement

The ICP recognises the vital role that partners have in providing oversight of the quality of care provided, and in creating and sustaining a culture of openness, learning and continuous improvement. Through its quality assurance and improvement arrangements, the ICP partners will deliver ambitious and significant improvements in the quality of care, focussing on the areas our patients, service users, staff and regulators highlight as of concern. We will share learning from our best performing providers; reducing the variability of the service

offer, increasing the reliability and consistency of the care we give and ensuring our staff members are supported to be kind and compassionate.

We will deliver fairer access to our services, by adapting and personalising services so they reach vulnerable people, of all ages, and those groups of people that our data show are not currently accessing services at a level commensurate with their needs, for example people from the poorest neighbourhood from BAME communities or those with a learning disability.

The ICP Quality System Group will provide a strategic forum across health and social care, to support the formal quality governance processes within each part of the system. Within this forum the partners will share intelligence, consider new ways to promulgate learning and develop approaches to support improvement in the most challenged parts of the system where there may be quality concerns across a number of providers, for example in places where there are severe workforce shortages.



The System Quality Group will use the principles developed by the National Patient Safety Improvement Programme, shown here.

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

7.4 Sustainability of Services

Across our ICP partner organisations are facing major challenges regarding clinical, operational and financial sustainability. Many of these challenges are long standing but have also been compounded by the impact of the Covid-19 pandemic. In some parts of our system, there are particularly intractable difficulties in providing stable and high quality services. In some cases there have been repeated efforts to address these difficulties, with limited success. The ICP partners will work together, using the opportunity that convening

health and social care organisation together at scale brings, to improve sustainability in the most fragile places and services. We will apply a multi-pronged approach to this endeavour:

- Intensive support and improvement resource provision, including drawing in learning;
- Supporting local teams to implement new models of care where they see the opportunity to improve;
- Implementing networked and collaborative models of care from the wider North East and North Cumbia system where local solutions cannot deliver sustainability.

To deliver sustainable service provision form should follow function. As care models evolve, some organisational change may need to follow, for example in GP practices or groups of hospitals. There will also need be active management of the social care market, with all partners in the ICP working together to ensure sustainable social care.

Our enabling strategies, set out in section 8 of this document, will complement the work we undertake with specific partners or places, by focussing on sustainability, for example through a comprehensive workforce plan that addresses the areas of greatest challenge, or the prioritisation of digital investment. We will be mindful of avoiding adverse unintended consequences in our future service design work and will consider sustainability alongside reducing inequalities.

7.5 Parity of Esteem and integration of mental and physical health services

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

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

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

7.6 Personalising Health and Care

Personalised Care is the practice of enabling people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences. We will deliver a Personalised Care Programme across the ICP, which invests in meeting health and wellbeing needs, using the Universal

Personalised Care model. Our key guiding principle will be 'what matters to me', enabling service users to have greater control.

We will embed personalised care approaches (Shared Decision Making, Personalised Care and Support Planning, Supported Self-Management, Personal Health Budgets, Choice, Community based support) in all programmes and pathways.

7.7 Supporting Carers

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

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

We will create a widespread movement at all levels of the system based on 'Thinks Carer'.

- Engage unpaid carers and Carer Organisations as partners in an approach to improve outcomes, and to co-produce a shared vision of 'what good looks like'

- Engage all of the ICP partners in setting out a clear case for change for supporting carers more effectively
- Identify and share best practices, supported by practical tools to enable all partner organisations to positive actions

We will become better at identifying carers and provide more support to them in terms of their own health and wellbeing, and to the person or people for whom they care. In particular, we will improve access to respite care, fund local networks of peer support and ensure access to social prescribing and benefit advice.

7.8 Better integration and co-ordination of care

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

- Health and Social Care
- Primary Care and Secondary Care
- Mental and Physical Health

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

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

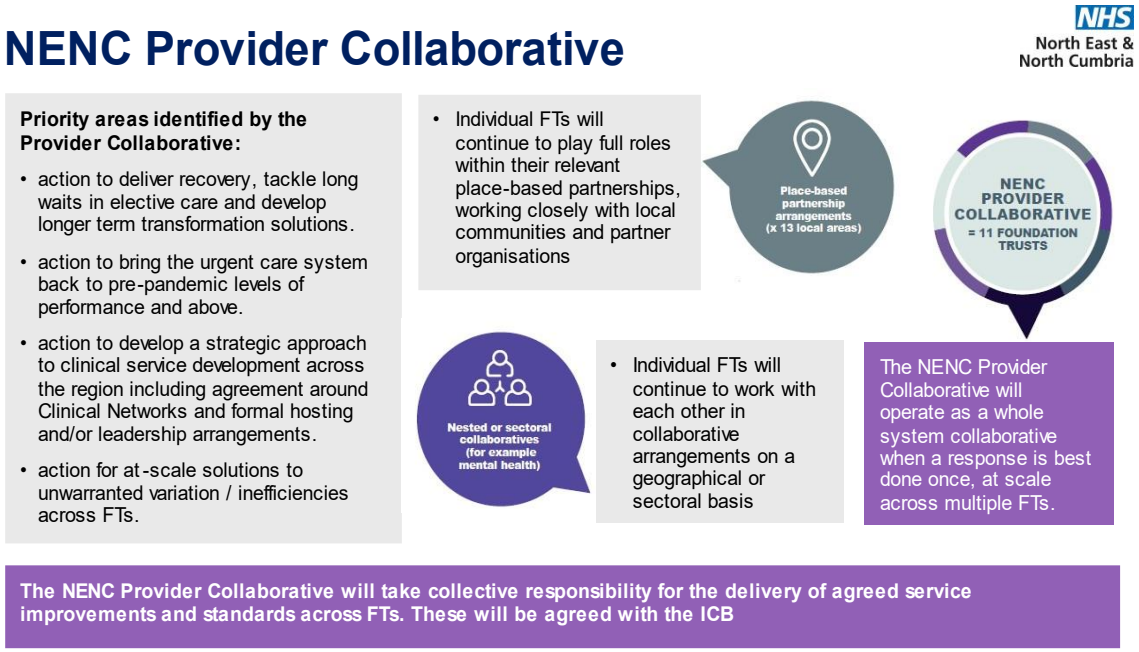
At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations. This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

We will strengthen the impact of our clinical networks and strategic programmes so they are a powerful force driving improvement the quality and sustainability of services and reducing inequalities.

7.9 Provider collaboration

Organisations across the ICP will build effective collaborative arrangements. This will include networks of Primary Care Networks and General Practice Federations working together at scale, supported by the Primary Care Collaborative, the Mental Health Collaborative responsible for some specialist services under delegation from NHS England, and the NHS Foundation Trust (FT) Provider Collaborative. The latter will play a key role in enabling improved Urgent and Emergency, Elective and Cancer Care particularly, and in ensuring sustainable services through networks of care provided across NHS Foundation Trusts.

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



7.10 Our overarching commitments for excellent health and care services are:

- Providers that are regulated by the CQC will achieve a 'Good' or 'Outstanding' rating
- Measurable improvement in the sustainability of the most challenged parts of our system, in relation to quality indicators, workforce and finance – we will define the specific target areas of this work in our forward plan.
- We apply the waiting times standards in the NHS constitution to all mental health, learning disability and autism services and achieve parity with physical health waits
- Personal Health Budget or Personal Wheelchair budget assessments and offers will be made to all those who are eligible.
- We will increase the number of unpaid carers and accessing an array of strengthen support offers
- We will support the development of provider collaboration, through the 3 linked collaboratives for primary care, FTs and mental health, learning disabilities and Autism

7.11 KEY ISSUES FOR HEALTH AND CARE SERVICE SECTORS

7.11.1 Primary Care and Community Services

The majority of NHS patient interactions are delivered in primary care, through general practice, dentistry, optometry and community pharmacy. The ICP recognises that ensuring the provision of high quality and sustainable primary care is a critical factor in the health and wellbeing of the population. Whilst we are fortunate to have relatively strong primary care services in our area, they have been stretched by the ongoing impact of the Covid 19

pandemic. There are some parts of our geography that are struggling to maintain their primary care services due to severe workforce shortages, particularly of general practitioners (GPs) and dentists.

Within general practice, shortages are being partially mitigated by the recruitment of other types of clinicians and practitioners and through the use of new pathways and technologies, with opportunities to introduce more innovation in the future.

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

The Fuller Report, published by NHS England earlier this year, makes a range of recommendations for the improvement of primary care. One of its most significant recommendations is the creation of multi-disciplinary neighbourhood teams, with a focus on caring for people with the most complex needs, for example frail older people or those living with long-term conditions. The ICB will make implementing the Fuller Report recommendations a priority, working closely with the primary care networks (PCNs) that have been set up to support primary care development. This will build on the neighbourhood and locality teams that already exist and are delivering real improvements already, rather than a tip down imposition of a new model.

The ICB will further develop primary care collaboration, in partnership with the PCNs to develop models of care and cross-patch working to support sustainability and resilience in the places where staffing levels are lowest in relation to population served.

From April 2023, the ICB will take on the commissioning of pharmacy, optometry and dentistry. The ICP recognises there are significant challenges with timely access to dentistry in parts of the region and that this is a matter of significant public concern. The ICB will work with the dentistry sector to improve access, through a combination of new models of care and a concerted effort on recruitment. The ICP will also work with NHS England to press for improvement to the national dentistry contract.

Our enabling People Strategy will include specific measures to support the development and maintenance of the primary care workforce to ensure that we are able to deliver our ambitious plans to invest in our primary and community services.

Our key commitments for Primary Care are:

- Multi-disciplinary neighbourhood teams will created to cover all of our population and we will align secondary care specialist to these teams
- We will implement integrated care models for frail older people, those living with long term conditions and those approaching the end of life and in doing so, reduce admissions to hospital for these groups
- The arrangements for same day urgent care in primary care will be aligned with the overall urgent and emergency care strategy

7.11.2 Children's Services

The ICP includes areas with some of the highest child poverty rates in the country. There has been a sustained increase in demand for a wide range of children's services including:

- Emotional wellbeing and mental health services

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

Across our ICP local Place systems are addressing multiple operational challenges simultaneously in order to meet the needs of children.

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

Our key commitments in children's services are:

- We will improve access to effective services and for the NHS services achieve parity with waiting times to access physical health services
- We will increase the numbers of children learning disabilities and Autism who are safely supported to live at home
- We will ensure measures to tackle the wider determinants of health include a focus on children and in particular those from our poorest communities.

7.11.3 Adult Social care

Adult Social Care experienced extremely difficult challenges through the peaks of the Covid 19 Pandemic, which exposed the longstanding and underlying fragility in many social care services. Additionally, Adult Social Care is experiencing significant pressure from:

- Increased referrals because of mental health issues, domestic abuse, safeguarding concerns and the breakdown of unpaid carer arrangements
- Supporting service users to access the right care in the right place, including supporting people who need to be discharged from Hospital
- Increased complexity of need
- Challenges in sustaining the independent sector care market in both the residential and nursing home sector and for home care provision
- The implementation of social care reforms including charging and funding

Adult Social Care is often talked about as a burden on public finances, but it is important to note the enormous contribution to the local economy and social infrastructure from Adult Social Care. Across our ICP Social Care is well over £1billion annually, with over £200 million of self-funded care, and a much higher value-added contribution (at least in excess of £2.5 billion and probably over £3 billion per year) to local economies.

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

Across our ICP partners are committed to working together to transform adult social care and in doing so engage the widest possible coalition of partners to develop new ways of supporting people to live well within their communities. This has never been more important as the escalating cost of living in the UK is causing ever more people to struggle to afford the

basic needs to sustain their health and wellbeing. The wide range of challenges faced by people with insufficient resources can include:

- Difficulty maintaining a warm home
- Inadequate amounts of food and/or of a balanced diet
- Mental health difficulties as a result of the stress caused

Within the NHS there has been a sustained focus on the difficulties discharging patients from hospital who no longer require inpatient care but who cannot go home without a package of home care or who need to move into a nursing or care home for their needs to be met.
It is also recognised that some people are not accessing support at home at an early enough juncture and if they were able to access earlier support, whether from adult social care or primary and community health services, many hospital admissions could be avoided altogether. This would result in a better experience for the people concerned and reserving hospital for care and treatment of those for whom an inpatient stay is essential.

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

Beyond the focus on the workforce, the ICP members will work together to innovate in the field of community health and social care, investing in technology and building partnerships to tackle the wider determinants of health, for example working with the housing sector to support the building of well insulated affordable homes in places people will enjoy living. Communities with access to green spaces and places to exercise, and community spaces that allow the VCSE sector to support the development of community resilience and support and combat loneliness and isolation that many older people experience.

We will work in partnership with the Voluntary, Community and Social Enterprise sector, and our NHS partners, to deliver a much stronger prevention offer to the population, so that vital capacity in the regulated care sector is reserved for the people who most need it

Our key commitments for Adult Social Care are:

- We will strengthen the provision on Home Care and Extra Care Housing, and reduce the reliance on Residential and Nursing Homes
- We will work with the care market and increase capacity and sustainability
- We will reduce the time spent in hospital by people awaiting access to social care
- We will expand the adult social care workforce
- We will develop shared solutions alongside Housing, and maximise the opportunities of digital and technology

7.11.4 Urgent and Emergency Care

Urgent and emergency care (UEC) services across our ICP are facing significant pressure. Demand has returned to, and is now often exceeding, pre-pandemic levels. At the same time NHS organisations are struggling to clear a backlog of planned work. This includes pressure in primary care and community services, as well as within our emergency departments and

acute hospitals, within mental health crisis response services and also our ambulance services. It will take all parts of the system working together to ensure strong sustainable urgent and emergency care services.

Although the performance of the ICB exceeds the national average against the various national standards for urgent and emergency care (UEC), we know that we need to substantially improve it, so we can confidently meet the needs of our population and cope with surges of demand at times of pressure.

The partners within the ICB will work together to deliver an ambitious redesign of the provision of urgent and emergency care. The system will use senior clinical decision making as close to the start of patients' pathways – expanding and enhancing our staffing for the 999 and 111 services so they can better assess patients and connect them into the most appropriate service for their needs. We will invest in additional ambulance call handlers, clinical assessors (from a range of clinical disciplines) and vehicles, to ensure we can improve and sustain our call response times to within the national standards.

We will invest in community based urgent care services, making sure that all communities benefit from access on the day primary care, urgent treatment centres (UTCs) and a 2 hour urgent care community response service. We will develop the clinical support offer to care and nursing homes, providing a tailored array of primary and community services and to a single point of contact to access them.

The development of integrated neighbourhood teams as described in the primary care section above, will be connected to speciality teams to facilitate the care of frail older people and those with long term conditions. People will be supported to shape their own care plan and those nearing the end of life to make an advanced care plan. Virtual wards will be available to support patients with an exacerbating or deteriorating condition that is amenable to home care with specialist input.

We will further develop our community mental health crisis response and explore the opportunity to establish community safe havens.

The Northern Care Record will be further developed to facilitate the sharing of care plan and patient preferences across organisational boundaries. Through these measures we will reduce the number of patients we convey to acute hospitals.

Within Emergency Departments (EDs) we will ensure access to an alongside UTC with access to urgent GP appointments and which meet the extended specification for UTCs in terms of the injuries and ailments they treat.

We will ensure all acute hospitals develop same day emergency care services and have provide clear arrangements for both GPs and the ambulance services to access them without recourse to the ED.

The combined impact of all the system pressures outlined in the sections above leads to delays in patients who are no longer requiring hospital care leaving their hospital beds, if they require a package of care or a community, care or nursing home bed to do so. It is well known that an extended stay in hospital brings unnecessary risk of harm to patients, as well as causing delays for patients awaiting admission. It is expected that the redesign of the UEC pathways and services, as outlined above, will reduce or at least slow the growth of urgent admissions to hospitals.

In addition to the action outlined to support the expansion and sustainability of social care, ICP partners will collaborate to plan and commission sufficient provision to meet the needs

of patients requiring support to be discharge, applying the home first and discharge to assess approaches. We will work with the VCSE sector to provide additional support and deploy technology to provide real time understanding of capacity and demand.

We will develop the escalation processes and surge response arrangements within places and at system level to ensure any mounting delays are tackled as effectively as possible.

Our key commitments for urgent and emergency care are:

- We will increase the proportion of urgent care which is delivered in community settings including in the home
- We will increase the proportion of 111 and 999 calls that are clinically assessed and reduce the proportion the result in a conveyance to an ED
- We will eradicate 12 hour waits in ED departments
- We will eradicate ambulance handover delays in excess of 30 minutes

7.11.5 Elective Care

The Covid-19 pandemic has created pressure within Elective services across the North East and North Cumbria (NENC) geography. The nationally directed suspension of elective activity during the first wave of Covid 19 and the impact of infection control measures for the majority of 2020 and 2021, resulted in a large growth in the number of patients waiting for elective care and the time they wait. The position improved during 2022 for the very longest waits, but the overall list continued to grow, both nationally and locally.

Reducing elective waiting times will be a significant challenge for the NHS given the array of pressures in the system. It will demand a mix of increasing capacity to diagnose and treat patients and a redesign of patient pathways and service delivery models to ensure clinical capacity is optimally utilised.

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

- Development of additional elective diagnostic and treatment capacity, utilising the investments available from the Elective Targeted Investment Fund and the Community Diagnostic Centres
- System-wide joint working to ensure the longest waiters are treated in line with national targets, including use of available independent sector capacity and mutual aid (offering patients from other Trusts earlier treatment dates if waiting times are shorter in some providers)
- Implementation of an Outpatient Transformation Programme, including increased use of advice and guidance services, personalised follow up pathway and virtual clinics, and the redesign of diagnostic pathways
- To implement best practice pathways across the high volume low complexity pathways identified by the Getting It Right First Time Programme
- A 'waiting well' programme to support patients experiencing long waiting times patients to be a fit as possible for their treatment, especially those in our most deprived communities

Our key commitments for elective care are:

- To eliminate waiting times over 1 year by April 2025 (and to all but eliminate 78 week waiters by April 2023)

- To achieve the 6 week wait target for routine diagnostic

7.11.6 Cancer

Cancer Research UK estimates that 38% of cancers are preventable (2015). It is therefore important that we all try to reduce our risk of developing cancer for ourselves, families, friends and the communities in which we live.

Cancer screening and treatment referral rates in NENC are generally higher than the national average but the outcomes (mortality) for the population are worse. 2020/21 data does show a large reduction in screening activity nationally and NENC have followed a similar trend. Public Health analysis highlights the inequalities in the cancer mortality by area of deprivation. It is estimated for every 1000 people aged 65+ with cancer, 142 within the most deprived areas will die compared with 88 in the least deprived.

The National Cancer Plan sets the ambition that by 2028, 80% of cancers diagnosed will be stage 1 or 2 cancers; early-stage cancers that are more amenable to curative treatment, leading to improvement in the 5-year survival rates for cancers.

Within the 'Healthier Life Expectancy' section of this strategy, the ICP commits to large scale population programmes relating to reducing smoking and alcohol use and obesity, the ICP will increase uptake in screening programmes; particularly in communities where uptake is relatively low. We will use population data to deliver targeted case finding and surveillance to enable people to access diagnostics, assessment and treatment earlier.

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

The improvements in cancer care have led to major pressures on the specialist cancer workforce, both locally and nationally. In order to be able to deliver our ambitious programme for cancer care, we will deliver a transformation plan for the specialist cancer workforce; extending the roles of the members of multidisciplinary teams such as therapy radiographers and pharmacists and developing new innovative and emerging roles for future medical and clinical staff

Our commitments for cancer care are:

- To make progress towards the early diagnosis national target
- To achieve and sustain the national faster diagnosis target
- To exceed the national standards for screening uptake for all population segments
- To reduce avoidable new cases of cancer
- Improve Experience and Care and Quality of Life for people living with and beyond cancer as measured by the National Cancer Patient Survey

7.11.7 Mental Health

The Covid pandemic significantly impacted the mental wellbeing of the whole population, including for example direct effects such as experiencing bereavement and illness, social isolation, anxiety about personal finances and employment, and an increase in domestic violence. This has exacerbated already high levels of poor mental wellbeing and mental illness. The demand for both children's and adult mental health services has risen

significantly, and many services are currently operating with long waiting lists and operational pressures.

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

The ICP will develop a comprehensive plan for improving the mental health of its population, building up from the services provided at neighbourhood and place, with close working with the VCSE sector as a full and valued partner. In particular, the plan will set out the approaches to:

- Strengthening core community, in-patient and crisis services, including peri-natal mental health services and psychiatric liaison services
- Delivering the Mental Health Community Transformation programmes, which focus on enabling patients in long term hospital care to move into a community setting with a package of support
- A particular improvement in all tiers of Child and Adolescent Mental Health Services, delivering and learning from the CAMHS Whole Pathway Commissioning 'pilot' (one of only four successful pilot sites across the country). Half of all mental health problems are established by the age of 14 and 75% by 24 years,
- Moving towards trauma informed, and psychologically informed services across all of health and car services, recognising the often life-long impact of trauma (for example Adverse Childhood Experiences)
- A concerted and universal suicide prevention programme
- Improving the physical health of people with severe and enduring mental illness, including targeted prevention and health programmes and participation in screening programmes
- An improved service offer for people with a substance misuse and mental illness

Our commitments for mental health are**:**

- We will reduce the gap in life expectancy for people with a severe and enduring mental illness compared to the general population by at least 25% by 2030
- To increase the percentage of people with severe and enduring mental illness who receive an annual health-check to at least 85% by 2030.

7.11.9 Learning Disability and/or Autism

Compared to the whole population, people with a learning disability, and autistic people, on average die at a much younger age. This makes it crucial that as an ICP we tackle the long waits people can experience accessing a diagnosis and treatment for their learning disability or autism and we take specific action to tackle health inequalities that exist in access to physical health care.

The plan we develop will include the delivery of training across health and social care services including the Oliver McGowan Mandatory Training. We will implement the new learning from death reviews (LeDeR) policy to review the deaths of people with a learning

disability and identify learning, opportunities to improve, and good practice. We will redesign pathways to reduce waiting times for autism assessment and diagnosis.

Our key commitments for learning disability and autism are:

- We will reduce the gap in life expectancy for people with a learning disability and/or autism compared to the general population by at least 25% by 2030
- To increase the percentage of people with a learning disability and/or autism or who receive an annual health-check to at least 85% by 2030.
- Ensure people receive services in appropriate environments by reducing the number of people in specialist in-patient services to no more than 30 adults and 15 people under 18 per million of the population by March 2024
- To reduce emergency admissions to hospital through provision of strengthened community services by March 2025
- Develop stronger joint commissioning frameworks across health and social care to improve community provision.

8 ENABLING STRATEGIES

8.1 A Skilled, Compassionate and Sufficient Workforce

People are at the heart of our health and care services and are our biggest strength. We have a highly skilled, dedicated and committed workforce across ICP area. Our workforce showed exceptional resilience throughout the covid pandemic, including adopting new practices to sustain services for the benefit of the population. But our workforce is stretched:

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

Our ICP area is not exempt from those challenges. Some organisations are experiencing severe challenge in the recruitment and retention of staff.

Our Key Commitments are:

We will reduce the vacancy rate across health and social care services by 50% by 2029. The North East and North Cumbria will be the best place to work in health and care, becoming the employer of choice.

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

- Workforce supply
- Workforce health and wellbeing
- Health Inequalities System Leadership and Talent
- Equity, Inclusion and Belonging

- The development of the learning and improvement community
- Build on existing workforce plans, e.g. the North East ADASS Workforce Strategy

8.2 Working Together to Strengthen our Neighbourhoods and Places

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

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

Our Key Commitments are:

- we will agree formal of local governance arrangements at Place level by March 2023
- we will work with local partners to develop a plan for place based governance, to be improved over time, and for place based plans to address shared local priorities
- we will implement integrated neighbourhood teams, by March 2025, and will typically align to Primary Care Network areas.. This will build on existing partnership working, strengthening how teams already work together at neighbourhood and locality level.

8.3 Innovating with Improved Technology, Equipment and Research

8.3.1 Research and Innovation

A large number of highly successful healthcare research and innovation infrastructures, institutes and organisations are operating across our ICP. Some of our opportunities for improvement across the system include:

- Increasing the pace of adoption and spread of impactful innovation, and our risk appetite for trying new ideas
- Developing inclusive frameworks and approaches for involving service users and staff in identifying and articulating system wide unmet needs
- Making the use of data, research evidence and insights more accessible to support researchers, commissioners and innovators
- Reducing obstacles for innovators and SMEs with potentially impactful solutions for the health & care sector to gain traction across the system
- Increasing investment in innovation and research in the primary and social care sectors and exploring new opportunities at the intersection of acute, community, primary and social care
- Increasing socially focused research on challenges experienced across our communities, clinical practice and the wider determinants of health.

Our Key Commitments are:

To establish a culture of innovation, with a higher risk appetite for testing out new ideas and disseminating knowledge and good practice. We will develop an Innovation & Research steering group across the ICP level, and develop a shared research and innovation plan, by

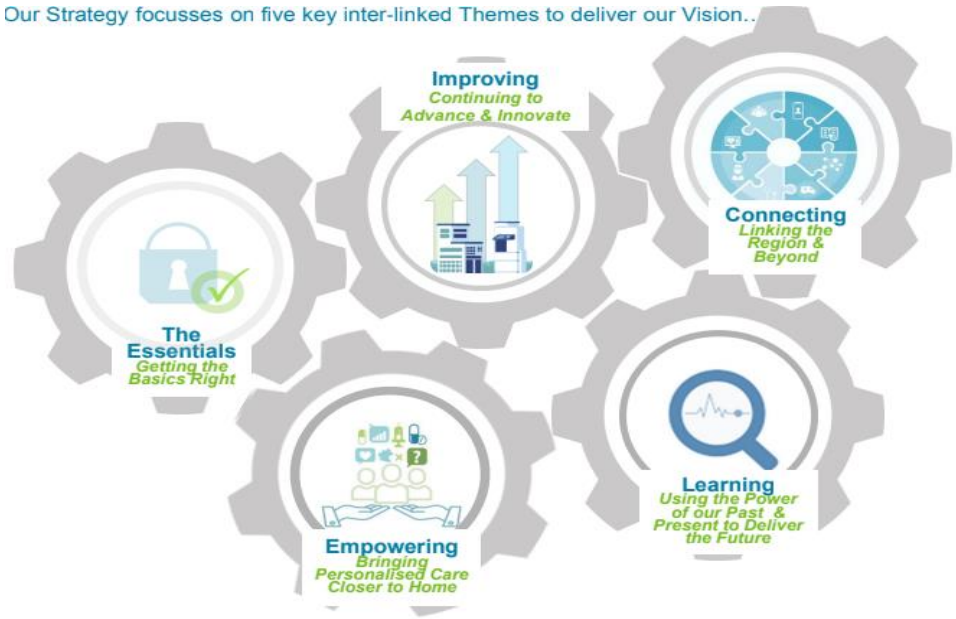
March 2023. This will bring together the National Institute for Health and Care Research, academic partners and organisations delivering services to provide strategic leadership to key priorities including:

- knowledge management systems to support decision makers, researchers and innovators, and the services which could benefit from adopting innovation
- incentives to support idea development and the testing of small scale innovation
- communication systems to support learning from the adoption of innovation
- leadership and accountability to foster implementation science
- closer working relationships with health determinant research infrastructures.

8.3.2 Digital

Digital technology has changed our lives beyond recognition in the last twenty years. Whilst we frequently manage our financial affairs, retail and leisure time online, we have yet to fully exploit the benefits digital technology can bring to the health and care system. We have been laying down the solid foundations on which to build digital services, for example to help meet the technical challenge of linking complex systems together, putting in the right infrastructure, standards and security measures. With the emergence of new digital systems and services we will support and equip our workforce to be ready to embrace these digital opportunities.

We have already developed an Integrated Care System Digital Strategy for 2020 – 24, and have made real progress in our shared work programme, which includes the five interlinked themes in the graphic below:



Our Key Commitments are:

We will deliver the commitments in our existing ICS Digital Strategy, and review and revise that Strategy by March 2023 to support the delivery of the ICP Integrated Care Strategy.

8.4 Making Best Use of our Resources and Protecting our Environment

8.4.1 Finance and Resources

The North East and North Cumbria ICB received £6.5bn of funding in 2022/23 equating to roughly £1,800 per head of population. This is the highest level of funding per head of population but it is over-funded using a national formula and we expect to receive the lower levels of funding growth than other parts of the country in future years, with much reduced additional central support for individual NHS organisations inherent financial challenges.

Nationally and in our ICP, local authorities are facing financial pressures in Adult and Children's Social Care, Public Health and the broader services that impact health and wellbeing outcomes.

At the same time the Health and Care system faces further activity, workforce and financial challenges going forward across the NHS, local authorities and the voluntary sector in an area with high levels of deprivation and health inequalities. It is evident that as a system we need absolute focus on system transformation and efficiency. We will need to work together on system level responses where needed, and not just within individual across the partner organisations.

Our Key Commitments are:

Our system ambition is to achieve Best Value for Money, making effective use of resources together to ensure a financially sustainable health and care. We will collectively develop a balanced Five Year ICP Financial Plan addressing system sustainability by March 2023. As part of our financial plan we will:

- work with partners to tackle areas of inefficiency and inequity, recognising touch points between services and collective ambition and challenges
- commit to improving funding arrangements for VCSE, creating innovative solutions that enable the sector to deliver outcomes that support our shared aims
- harness the strength of integrated working at place to drive transformation and efficiency across health and care.

8.4.2 Protecting Our Environment

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

Our Key Commitments are:

We will have to cut our collective carbon footprint at a faster rate than the NHS national targets of 2040/2045. As an ICP we will publicly declare a Climate Emergency and commit to fast-track the decarbonisation of our regional health and care services, as part of a broader strategy to become the greenest region in England by 2023.

The NHS has committed to reaching carbon net zero. The Health and Care Act 2022 placed new duties on NHS to contribute towards statutory emissions and environmental targets. We will meet the following for carbon emissions in our ICP area:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

8.5.3 Our Estates

Our Health and Care Services are delivered across a huge number and range of buildings. For example this includes over 490 Primary care sites alone. Maintaining high quality estates is a significant challenge, in some cases our estate is undersized for the population, or has significant backlog maintenance or even surplus space in the wrong place.

Our Key Commitments are:

We will develop a collective Estates plan by March 2023, focussed on providing contemporary, sustainable, fit for purpose estate that is accessible and capable of reacting to changes in population size and demand. Where beneficial, this will include:

- consolidating services onto fewer sites to maximise the use of existing infrastructure and to promote joint working where it is in the best interests of service users
- adopt 'one public estate' principles at Place level, including the potential to use shared estates to deliver jointed up clinical and care services
- prioritising capital investment to effectively meet need
- promoting opportunities to reduce cost within the estate and maximises capital
- working from the ground up at neighbourhood, Place and local ICP level
- support to Primary Care Networks and provider collaboratives to ensure well planned and prioritised capital investments.

9 COMMUNICATION AND INVOLVEMENT

9.1 Collaborative Design

We have developed the draft strategy based on:

- a multi-agency steering group, supported by subject matter experts including an intelligence and analytics group
- our call for evidence, we received and considered over 300 documents including joint strategic needs assessments and organisational strategies
- input from each of the ICS work streams
- our pre-existing ICS strategy

9.2 Review of the draft strategy

During November 2022 we will:

- publish the strategy, and invite feedback from the public and stakeholders
- work with Health Watch and the voluntary, community and social enterprise sector to gain feedback from experts by experience
- engage with our partner organisations and place based partnerships, including Health and Wellbeing Boards

We will then consider all of the feedback to inform the final strategy for publication in December 2022.

10 DELIVERING THE STRATEGY

10.1 Data and Intelligence

To improve health outcomes and reduce inequalities it is important to understand population health for groups and areas. We have a strong foundation including:

- Health and Wellbeing Board Joint Strategic Needs Assessments
- Health assessments for particular population and service user groups
- Service utilisation data across sectors
- Comparative data from other areas, including through tools from the Office of Health Improvement and Disparities
- Insight work with particular population groups

Our Ambitions is to develop an integrated data and analytic system across the ICP, and wherever possible at local Place and Neighbourhood. We will continue to draw on the best evidence and listening to what communities tell us about the services they need. We will support partner organisations to improve data systems by ethnicity, accessibility and the communication needs of their populations in records. We will provide 'actionable insights' from the data at all levels, and across service sectors

10.2 North East and North Cumbria Learning and Improvement Collaborative

To achieve our goal of 'being the best at getting better' we created the Learning and Improvement Collaborative to mobilise people from across the region. This will include:

- Enable "boundary-less" learning across the region; making connections and sharing data and learning - across geographical, system, organisational and sector boundaries.
- Acknowledge and celebrate the existing strengths and assets of our system for learning and improvement.
- Create energy, build insight and work together as a system.
- Agree actions to co-create the future.

10.3 Partnership Structures

As outlined in section 8.2 we will develop strong governance arrangements across partner organisations in each Place, including a clear interface with Health and Wellbeing Boards. This will be supported by the formation of four Local ICPs, and an overarching strategic leadership role across the whole region through our ICP. This formal governance will be enhanced by partnership arrangements across the whole ICP, including for example:

- Association of Directors of Adult Social Services (ADASS) Network
- Directors of Children's Services Network
- Directors of Public Health Network
- The Directors of Finance and ADASS group
- Emerging shared forums for Housing

- The Provider Collaborative
- Emerging networks for General Practice, including a strong collaboration between Primary Care Networks
- Using the networks across Health Watch and Voluntary, Community and Social Enterprise Sectors ensure strong partnerships with communities, experts by experience and third sector organisations

10.4 Implementation and Delivery Plans and Measuring Progress

To support the delivery of this Strategy we will develop Delivery plans for each of our key work programmes across the ICP, including frameworks to support delivery at place level where appropriate. We will also develop a clear dashboard to measure and report progress in our delivery of our strategy on a quarterly and annual basis. This will be publicly available to ensure transparency and promote accountability.

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NORTHUMBERLAND COUNTY COUNCIL

HEALTH & WELLBEING BOARD

FORWARD PLAN 2022 - 2023

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Updated : 27 October 2022

FORTHCOMING ITEMS

ISSUE	OFFICER CONTACT
10 November 2022	
• Joint Health & Wellbeing Strategy – Update on each theme (Best Start in Life, Empowering Communities, Wider Determinants and Whole System Approach) • Presentation Safety & Wellbeing Visits and link to Heath & Wellbeing Strategy (Fire & Rescue Service) • Inequalities Plan - Compact • Living with Covid • Draft ICB Integrated Care Strategy	Graeme Binning Liz Morgan Peter Rooney
8 December 2022	
• Tobacco Control Partnership • Crisis Cafe • Living with Covid	Pam Travers Liz Morgan
12 January 2023	
• Northumberland Safeguarding Children Board (NSCB) Annual Report and Update of Issues Identified • Safeguarding Adults Annual Report and Strategy Refresh • Living with Covid	Paula Mead Paula Mead/Karen Wright Liz Morgan
9 February 2023	
• Director of Public Health Annual Report	Gill O'Neill

Updated : 27 October 2022

• Thematic Groups - Update • • Living with Covid	
9 March 2023	
• Living with Covid • Closed Development Session – Physical Activity Strategy	

MEETING DATE TO BE CONFIRMED

• Wider Determinants Sub-Group – Planning and Health Update • Impact of COVID pandemic on SEND services • CNTW Priorities Report • Urgent and Emergency Care - Strategic Care • Child and Adolescent Mental Health •	Rob Murfin Nichola Taylor Pam Travers Siobhan Brown Cath McEvoy-Carr

REGULAR REPORTS

Regular Reports • Joint Health & Wellbeing Strategy Refresh Thematic Groups – Update (Quarterly – Feb/May/Aug/Nov) • System Transformation Board Update • SEND Written Statement Update - progress reports • Population Health Management - (Oct/Jan/Apr/July)	 Sir Jim Mackey/Siobhan Brown ?? Rachel Mitcheson

Annual Reports ● Public Health Annual Report ● Child Death Overview Panel Annual Report ● Northumbria Healthcare Foundation NHS Trust Annual Priorities Report ● Healthwatch Annual Report ● Northumberland Safeguarding Children Board (NSCB) Annual Report and Update of Issues Identified ● Safeguarding Adults Annual Report and Strategy Refresh ● Annual Health Protection Report ● Northumberland Cancer Strategy and Action Plan ● Child Death Overview Panel Annual Report	Liz Morgan (APR) Paula Mead/Alison Johnson (APR) ??? (MAY) David Thompson/Derry Nugent (JULY) Paula Mead (JAN) Paula Mead (DEC) Liz Morgan (OCT) Robin Hudson (DEC/JAN) Paula Mead (FEB)
2 Yearly Report ● Pharmaceutical Needs Assessment Update	Liz Morgan (MAY 2022 and SEP 2022)

NORTHUMBERLAND COUNTY COUNCIL
HEALTH AND WELLBEING MONITORING REPORT 2022-2023

Ref	Date	Report	Decision	Outcome
1	10.5.22	Living with Covid	Receive Report	
2	10.5.22	Pharmaceutical Needs Assessment Update	(1) the draft plan be approved for progression to formal consultation (2) comms be produced in liaison with the Local Pharmaceutical Committee regarding pharmacy opening arrangements and pharmacist availability.	
3	10.5.22	Northumberland Oral Health Strategy Update	(1) the report be received. (2) the impact on dental and oral health action and delivery caused by the COVID-19 pandemic be acknowledged. (3) the extension to the strategy period from 2022/25 be approved	
4	10.5.22	Population Health Management – Quarterly Update	Receive Report	
5	14.7.22	Integrating Services Supporting Children and Young People	(1) the comments of the Board be noted. (2) The evolution/expansion of the Family Hubs model as the mechanism to drive forward CYP integration and the	

			governance process be approved; (3) The proposed approach to culture and leadership change and interface with community centred/place-based approaches to tackle inequalities be supported.	
6	14.7.22	Ageing Well Service Review	(1) the comments of the Board be noted. (2) the refresh of a strategic Northumberland Healthy Ageing Board accountable to the Health and Wellbeing Board be supported. (3) Inclusion of the importance of volunteering to be considered during the refresh. (4) The refreshed Northumberland Health Ageing Board be chaired by the Director of Public Health. (5) the decision to appoint an independent chair of the Health Ageing Board be delegated to the Director of Public Health in consultation with the portfolio holder for Adult Wellbeing.	
7	11.8.22	ICS Update	Note presentation and comments	
8	11.8.22	A Health Needs Assessment of Benefits and Debt Advice for Northumberland	(1) Members' comments on the evidence in the report and Advice Services Health Needs Assessment Summary be noted.	

			(2) The importance of the role that advice services have in reducing inequalities be acknowledged. (3) The role of advice services with Northumberland's system-wide Inequalities Action Plan be noted; and (4) The contribution of partners to support access to welfare and benefits advice for their staff, patients, and residents, be agreed.	
9	11.8.22	Board Development Session – Review	(1) the update be received and noted. (2) Liz Morgan and Rachel Mitcheson to discuss development of the task and finish group.	
10	8.9.22	Northumberland Inequalities Plan 2022-23	(1) the proposals for the shorter term supporting and enabling actions be agreed. (2) The proposed short, medium and long term indicators be agreed. (3) The levels of ambition and Board members' contribution to the plan be agreed. (4) The mechanism to continue to the next stage and development the long term	

			plan be agreed (5) Board partners will present the plan at a strategic level within their ow organisation for endorsement and agreement on their contribution.	
11.	8.9.22	Pharmaceutical Needs Assessment Consultation Report	Updated Northumberland Pharmacy Needs Assessment approved.	
12.	8.9.22	Family Hub Development	(1) to proceed with the funding for the Family Hub offer. (2) the development of the governance and wider processes to underpin this be supported.	
13.	8.9.22	Healthwatch Annual Report 2021-22	Report and presentation received.	
14.	8.9.22	Membership and Vice-Chair of Health & Wellbeing Board	(1) that Northumbria Police and the Fire & Rescue Service be invited to each send a representative to join the Health & Wellbeing Board. (2) Dr. Graham Syers remain as Vice-Chair of the Health & Wellbeing Board until further notice.	
15.	13.10.22	Northumberland Healthy Weight Declaration	(1) the Healthy Weight Declaration (and its 16 commitments for action) for Northumberland County Council be adopted.	

			(2) A joint launch of the Healthy Weight Declaration between Northumberland County Council, North Tyneside Council and Northumbria Healthcare NHS Foundation Trust be supported.	
16.	13.10.22	Northumberland Joint Strategic Needs Assessment	(1) The JSNA should include both needs and assets to reflect the Northumberland Inequalities Plan 2022-32. (2) The establishment of a JSNA Steering Group to co-ordinate current work attached to the report as Appendix 5 be agreed. (3) the priorities and timelines as attached to the report as Appendix 5 be agreed.	
17.	13.10.22	Population Health Management Update	(1) the presentation be received (2) regular updates be received every three months.	
18.	13.10.22	Health & Wellbeing Strategy	Action plan for each theme to be developed and reported to future Board meeting.	

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