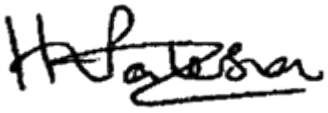
Northumberland
County Council

Your ref:
Our ref:
Enquiries to: Lesley Bennett
Email: Lesley.Bennett@northmberland.gov.uk
Tel direct: 01670 622613
Date: 1 August 2023

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, MOPRETH** on **THURSDAY, 10 AUGUST 2023** at **10.00 AM**.

Yours faithfully



Dr. Helen Paterson
Chief Executive

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

G Binning, A Blair, J Boyack, N Bradley, C Briggs, P Ezhilchelvan (Chair), V Jones, S McCartney, V McFarlane-Reid, R Mitcheson, R Murfin, G O'Neill, W Pattison, G Reiter, G Renner-Thompson, S Rennison, G Sanderson, E Simpson, H Snowdon, P Standfield, G Syers (Vice-Chair), C Wardlaw and J Watson

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, 8 June 2023 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. ANNUAL REPORT OF SENIOR CORONER (Pages 9 - 38)

To receive an update on the Coroner Service and to present the 2023 Annual Report of the Senior Coroner, Andrew Hetherington. The report will be presented by Karen Lounten, Service Manager Registrars, Coroners and Archives.

5. HEALTHWATCH ANNUAL REPORT 2022/23 (Pages 39 - 66)

To receive the Healthwatch Annual Report presented by Derry Nugent.

6. BETTER CARE FUND PLAN 2023-25 (Pages 67 - 140)

To request the Board formally to sign off the Northumberland Better Care Fund (BCF) Plan 2023-25, and to make proposals about the sign-off process for future BCF plans. The report will be presented by Alan Bell, North East and North Cumbria ICB.

7. NOTIFICATION OF CLOSURE OF 100 HOUR PHARMACY IN CRAMLINGTON (Pages 141 - 148)

To receive an update report following notification of the closure of the 100 hour pharmacy in Sainsburys supermarket, Manor Walk, Cramlington. Report presented by Anne Everden, Pharmacy Consultant to Public Health.

8. ICB DRAFT JOINT FORWARD PLAN (Pages 149 - 200)

To receive a copy of the Integrated Care Board Draft Joint Forward Plan.

9. HEALTH AND WELLBEING BOARD – FORWARD PLAN (Pages 201 - 206)

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, 14 September 2023, 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)

NORTHUMBERLAND COUNTY COUNCIL

HEALTH AND WELL-BEING BOARD

At a meeting of the **Health and Wellbeing Board** held in County Hall, Morpeth on Thursday 8 June 2023 at 10.00 a.m.

PRESENT

Councillor P. Ezhilchelvan
(Chair, in the Chair)

BOARD MEMBERS

Binning, G.	O'Neill, G.
Blair, A.	Pattison, W.
Bradley, N.	Reiter, G.
Iceton, A	Simpson, E.
McFarnlane-Reid, V.	Syers, G.
Mitcheson, R.	Thompson, D.
Murfin, R.	Whittaker, L. (Substitute)

IN ATTENDANCE

L.M. Bennett	Senior Democratic Services Officer
J Harland	Northumbria Healthcare NHS Foundation Trust
K Higgins	Employability and Inclusion Manager
D. Nugent	Healthwatch
L Robinson	Senior Public Health Manager
R Taggert	Northumbria Healthcare NHS Foundation Trust

1. MEMBERSHIP AND TERMS OF REFERENCE

Members noted the membership and terms of reference which had been agreed by the Full Council meeting on 17 May 2023.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from S. McCartney, H. Snowdon, and Councillors D. Ferguson, G. Renner-Thompson, J.G. Watson.

3. MINUTES

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 11 May 2023, as circulated, be confirmed as a true record and signed by the Chair.

4. THE COMMUNITY PROMISE UPDATE

Members received a presentation and summary from Alistair Blair, Executive Medical Director at Northumbria Healthcare NHS Foundation Trust, on the latest work being done to support communities and staff through the award winning corporate social responsibility programme. Presentation filed with signed minutes.

The following key points were raised:

- Northumbria Healthcare NHS Foundation Trust was the first NHS Trust in the country to commit to focusing on a full range of ways it could make a difference to improving the community it served.
- The commitment was based around six key themes; poverty, education, economy, employment, environment and wellbeing. It was acknowledged that some staff were deprived or came from deprived communities.
- Across the Trust area the following had been provided:-
    - Financial wellbeing clinics
    - 42 days of free main meals
    - Access to the Community Bank for 1,040 members
    - 1,300 free places at Alnwick Gardens
    - 545 discounted travel passes
    - 3,800 subsidised fresh food boxes
- Events were held in schools to show school children how they could have a career within the NHS.
- A further list of positive results to date was provided which included:-
    - A 30% increase in apprentices over three years. 25% of apprentices came from deprived communities and 5.5% had a disability compared to NHS average of 3%. Recruitment from BAME groups had increased.
    - Two Widening Participation Officers had engaged with 73 career events.
- There was potential for joint work with other organisations and to develop work with ex-offenders and the homeless. There could be further strategic work with Northumberland County Council.

Members welcomed the presentation and made the following comments:-

- Use of the community bank encouraging financial wellbeing were also priorities for Northumberland County Council. It would be good to collaborate with other organisations to share learning with them.
- Staff were more likely to engage with initiatives if they were local and at the right scale.
- There was a cost to the initiatives but that had to be balanced with a decrease in staff illness and absence.
- This work could be looked at and built on at the Inequalities Round Table which was being held in July.

RESOLVED that the presentation be received.

5. HEALTH INEQUALITIES – NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST

Members received presentations from Jill Harland and Robert Taggert, Northumbria Healthcare NHS Foundation Trust, updating Members on the Trust's work on inequalities. Presentations filed with signed minutes.

Jill Harland highlighted the following key points:-

- It was important to recognise that approximately 80% of health inequalities and the influence surrounding them was outside the NHS and was about the wider determinants of health. However, the NHS still had a key role to play.
- The Health Inequalities Programme Board had been set up post Covid and it had strategic oversight on what the Trust was doing. Its objectives were how to understand health inequalities and quantify and embed that understanding into the Trust's routine reporting.
- Everything would be brought together under one umbrella and raise the profile of health inequalities, bring partners together and to work with a collective lens.
- The Board met monthly and considered the different priorities, what was known about them, where the inequalities were, what could be improved and what was needed to make changes.
- Priority areas had been identified along with the actions that needed to be taken. Priorities included:-
    - Health while waiting – to look at quality of a patient's life while waiting for treatment
    - Staff Health Needs Assessment – to look at what the health inequalities were for staff. Two 'deep dives' relating to musculoskeletal health and financial wellbeing in salary bands 1 to 3.
    - Local Health Index – joint working with public health colleagues to look at local data for a more granular understanding of place. There was now an experimental version of the local health index to look at three domains; healthy people, healthy lives and healthy places to make comparison with the national average. A proposal had been submitted to NHS England and it was hoped that it would be able to be opened up and used at an ICS level.
    - Lung Cancer Case Finding Pilot – Over 55s with COPD and living in more deprived areas were at higher risk of developing lung cancer. A pilot scheme had resulted in a higher than international average detection rate. Pilot scheme based on Valens PCN.
    - Tobacco Dependency Treatment Service – patients were offered Nicotine Replacement Therapy within two hours of admission. Connection with patients was maintained for a time after discharge.
    - Best Start in Life – smoking cessation services to promote healthier pregnancies.

    - The Community Promise – initiatives by the Trust to promote staff and wellbeing.
    - Colposcopy – addressing health inequalities in attendance. Non-attendance at appointments was highest in gynaecology and colposcopy and in younger women and in more deprived areas. Reasons were mainly due to transport issues, anxiety, and health literacy. Interventions had resulted in an improvement in attendance rates.
    - A Quality Improvement Approach had been developed – Planning Pilot, Evaluate and Disseminate
- Three areas of focus for year 2 were:-
    - Developing the capacity and capability for a population health laboratory approach – health inequalities metrics in routine reporting
    - Embed and integrate approaches to tackle health inequalities across the Trust's work.
    - Complete initial pilot projects, adopt good practice and disseminate widely – new projects.

Robert Taggert highlighted key points relating to the Interactive Public Health Dashboard:-

- The aim was to create a more interactive format for the dashboard. Metrics would be updated in real time, easy to use and navigate and be informative.
- Five dashboards were currently in development looking through an inequalities lens with the Cancer SOF metrics dashboard being close to completion. Self harm and RTT SOF metrics dashboards were ready for review and the dashboards for A&E waiting times and fuel poverty and respiratory A&E visits were in progress.
- Cancer SOF Metrics Dashboard had three caveats:–
    - First treatment for new tumour or metastatic tumour only
    - 62 day wait clock starts at time of first appointment to time of first treatment
    - Appointment and treatment both with the Trust only
- Information available on the dashboard was shown along with the levels of information available interactively. Further information was available on average waiting times by rurality, IMD quintile, referral type and cancer site. Waiting times were greater for those in more deprived areas compared to the more affluent.
- Other possible future SOF dashboards included access rates for mental health and safe high quality care looking at C.Diff and gram negative infection rates.

The following comments were made:-

- Only patients whose treatment was totally within the Trust would be included. There was no control over waiting times for other Trusts.
- The dashboards started with facts and figures but there would be a focus on speaking to patients about their experience.

- It was acknowledged that there may be pockets of health inequalities within more affluent areas, and it was important to ensure that they were not missed.
- The Trust was looking at inequalities from a patient perspective whereas the Health & Wellbeing Board was looking from a residents' perspective, however, these were the same people. It was hoped that there would be much closer alignment with datasets.
- A link up should be considered between Adult Social Care and Public Health Consultants and a connection with CNTW regarding mental health would be useful.

RESOLVED that the presentations be received.

6. TOWARDS A COLLABORATIVE APPROACH TO REDUCING INEQUALITIES IN EMPLOYMENT OUTCOMES FOR OUR POPULATION

Members received a presentation from Liz Robinson, Senior Public Health Manager, and Kevin Higgins, Employability and Inclusion Manager. Presentation filed with signed minutes.

Liz Robinson and Kevin Higgins highlighted the following key points:-

- Reminder of key issues
  - High level of inactivity with 46,700 working people being economically inactive with 10,800 due to long term sickness and 7,900 wanting to work.
  - Relatively low unemployment rate but high incidence of long term unemployment
  - Health inequalities in labour market intensified post Covid.
  - Mental health, muscular skeletal issues and diabetes were the main causes of inactivity
  - Place disparity across the county.
- Reminder of Northumberland responses including
  - The ICB, North of Tyne Combined Authority, Public Health and Economy Leads were collaborating on a North of Tyne Work and Health Strategy and improving service integration.
  - Northumberland Inequalities Plan 2022-32
  - Establishment of Northumberland Employment Partnership and Employability Network
  - Health & Wellbeing Board's consultation.
  - Major Employers Forum and Employer pledge summer 2023
  - Refreshed Northeast Work and Health Network to share learning and good practice.
- Findings from North of Tyne Combined Authority and ICB commissioned research
  - Seize the opportunity of devolution and strengthening our strategic partnerships
  - Make strategic connections and develop a shared programme of Public Service Reform to address inequalities by pooling capacity

and decision making. Develop robust evidence base on what worked to inform the investment principles of strategic partners.

- Integrating frontline health and employment support.
  - Co-design formal work and health system to connect primary care, voluntary sector and employment support services.
  - Develop local models of intensive and integrated support.
- Creating and promoting opportunities for good work in the local public and private sector including
  - Work with anchor institutions to widen local employment pathways
  - Improve local supply chains and improve employment conditions and increase socially productive use of wealth and assets.
  - Work with local employers to improve job retention for people with health conditions.
  - Promote the principles of good work through initiatives like the Better Health at Work Scheme and Good Work Pledge.
- Response from Health & Wellbeing Board survey including
  - **What would support people with long term health conditions to get into and stay in work?** Responses including:-
  - Flexible working, reasonable adjustments supportive sickness absence policies. Preparing for work earlier in health recovery. Transferrable skills. Open dialogue about work and training needs as part of health discussions. Link workers/health coaches to offer health, employability self help, support referrals whilst on waiting lists.
  - **Where could we go further?** Responses including:-
  - Employability triage services to go to community settings. Place work coaches in GP practices. Upskill link workers to understand barriers/benefits of work and employability support. Develop Northumberland anchor institutions network to maximise economic levers of large organisations. More employer engagement about the economically inactive and the asset they could be to the workforce. One skills platform to share training opportunities. Pooling funds, co-commissioning and co design of health and employability services.
- Next Steps
  - There was a Major Employer Forum in July
  - Continue to work in collaboration with partner organisations to develop the North of Tyne Work and Health Strategy and produce short, medium and long term proposals. Report back on the draft strategy to a future meeting of the Health & Wellbeing Board.
  - Scope the opportunities of developing shared core Social Value commitments as Anchor Institutions.
  - Seize opportunities to expand the North of Tyne Combined Authority strategic development on work on health to a wider footprint.

The following comments were made:-

- There were many people whose parents and grandparents were not economically active and so these people had no experience of working. Their aspirations were reinforced by their family's inactivity. It was

acknowledged that people needed to see that having a job was a realistic option.

- It was also important to note that investment and innovation in an area or town may not result in job opportunities for local residents and the economically inactive. In these instances, many jobs were filled by people from other areas.

RESOLVED

(1) that the presentation be received.

(2) the Health & Wellbeing Board survey be recirculated to Members.

7. JOINT HEALTH AND WELLBEING STRATEGY

Members received a verbal update from Gill O'Neill, Executive Director for Public Health (DPH), Inequalities & Stronger Communities.

Gill O'Neill informed Members that the update of the Joint Health and Wellbeing Strategy was taking longer than anticipated to complete. An officer group had been set up to look at the strategy. It was complex to align measures to demonstrate what progress was being made other than overarching progress. A summary report would be provided to show the significant amount of work done to date and also to appreciate that we are in a completely different place to five years ago when the Strategy was first produced. The membership of the Health & Wellbeing Board had changed in order to reflect the wider determinants of health. It was also planned to align the Joint Strategic Needs Assessment Steering Group with the strategy group.

RESOLVED that

(1) the update report be received

(2) a summary report be provided for the October Health & Wellbeing Board meeting.

8. HEALTH AND WELLBEING BOARD – FORWARD PLAN

Members noted details of forthcoming agenda items at future meetings.

9. INTEGRATED CARE BOARD – UPDATE

Members were informed that, unfortunately, Levi Buckley, ICB Executive Place Director for the North, was unable to attend the meeting. Rachel Mitcheson, Director of Place and Integrated Services, reported that the ICB was required to find a 30% running cost reduction by the end of 2025/26 and this would obviously lead to more change and transformation. The Board would be updated at future meetings.

10. CHAIRMAN'S ANNOUNCEMENTS

1. Pharmacy Update

The Chair reported that he had discussed the concerns of the Health & Wellbeing Board about the closure of pharmacies with officers and had written to the Secretary of State for Health to request that the funding model be reconsidered and to stress the need for more trained pharmacists.

2. David Thompson – Healthwatch

The Chair informed Members that David Thompson was retiring as Chair of Healthwatch and this would be his last meeting. On behalf of the Board he thanked him very much for his service to the Board.

11. URGENT BUSINESS

Better Care Fund

Neil Bradley informed the Board that the Discharge grant now formed part of the Better Care Fund (BCF) and the format for reporting had only been received three weeks ago for submission by the end of June. This did not allow time to present the BCF plan to the Board for approval. In consultation with the Chair, it had been agreed to submit the plan, virtually, to all Board Members to allow a short time for any comments. The plan would then be submitted retrospectively to the Board's August meeting for approval and consideration.

12. DATE OF NEXT MEETING

It was noted that the July meeting was cancelled to enable the Inequalities Round Table to take place. The next meeting will be held on Thursday, 10 August 2023, at 10.00 am in County Hall, Morpeth.

The following future meeting dates were noted:-

14 September 2023
12 October 2023
9 November 2023
14 December 2023
11 January 2024
8 February 2024
14 March 2024
11 April 2024
9 May 2024

CHAIR _____

DATE _____

Northumberland County Council

Briefing Note to Executive Team

Directorate:	**Public Health, Inequalities and Stronger Communities**
Subject:	**Annual Report of Senior Coroner, Andrew Hetherington**
Date:	**8 June 2023**

Purpose of Briefing Note

To provide a brief update to Executives on the Coroner Service, and to present the 2023 Annual Report of Senior Coroner, Andrew Hetherington.

Background

Office of and role of the Senior Coroner

The coroner is an independent judicial officer, appointed by but not employed by the local authority. This is an important distinction to make to maintain judicial independence. The autonomy of the office is an important safeguard for society and a key element in the investigation into a cause of death. A coroner can only be removed from office by the Lord Chancellor with the agreement of the Lord Chief Justice on grounds of incapacity or misconduct.

Coroners carry out their role with resources and administrative support from the local authority, as well as workforce and the investigative abilities of Northumbria Police. A

successful Coroner Service requires and embraces effective collaboration across coroner, local authority, and police.

It is the role of the coroner to investigate and if necessary, conduct an inquest in the following circumstances:

- if the coroner has reason to suspect that the deceased died a violent or unnatural death;
- where the cause of death is unknown;
- where the person had died in custody or state detention.

An inquest is not to determine matters of civil or criminal liability, or to look to apportion blame for a death. The purpose is simply to determine the following:

- Who is the person who has died?
- Where did they die?
- When did they die?
- How did they die?

Office of the Chief Coroner

The Chief Coroner is head of the coroner service nationally, providing leadership for coroners in England and Wales. The appointment of the Chief Coroner is made by the Lord Chief Justice in consultation with the Lord Chancellor. The current Chief Coroner is His Honour Judge Thomas Teague KC.

The Chief Coroner visited the Northumberland Coroner Service on 10 February 2023 as part of his national welfare tour. During the visit he met with the Senior Coroner and his team of Coroner's Officers and administrative staff, Northumbria Police, along with representatives from Northumberland County Council (NCC) including Cllr Glen Sanderson, Gill O'Neill, Executive Director of Public Health, Inequalities and Stronger Communities and Nigel Walsh, Director of Stronger Communities.

The Chief Coroner commended NCC for providing excellent facilities to not only support the Senior Coroner and his staff, but also bereaved families. At the Chief Coroner's national Local Authority Conference hosted at Central Hall, Westminster on 2 March 2023, Andrew Hetherington Senior Coroner for Northumberland and Karen Lounton, Interim Head of Service were invited to speak about the excellent service delivered in Northumberland during pandemic and the best way of working deployed to mitigate backlogs and ensure timely service delivery.

Northumberland Coroner Service

The Coroner Service for Northumberland is based within the Public Health, Inequalities and Stronger Communities directorate. Since October 2020, under the judicial leadership of Senior Coroner Andrew Hetherington, the service has built upon the transformation which commenced in 2019.

This has seen the new court facilities created in County Hall, Morpeth utilised to maximum effect with inquests listed on a near weekday daily basis. Technology provided as part of the court design enables witnesses and interested persons to appear in court virtually where necessary. This is of particular use when pathologists

and doctors are required to provide evidence, ensuring they themselves can experience minimum disruption to their work commitments but also secure their attendance at court. It has also enabled families who are not local and, in some cases, overseas, to still participate in an inquest hearing into the death of a loved one.

The excellent court facilities also enabled the Senior Coroner to deliver a near normal service during pandemic resulting in the service emerging from this period with no backlog of cases, somewhat of an exception when compared to many jurisdictions across both the region and England and Wales.

Deaths referred to the Senior Coroner have continued to rise, with 2,028 deaths referred during the calendar year 2022. This is the highest volume of referrals Northumberland has experienced. There are several reasons which underpin this increase in referrals. Deaths are now appropriately captured and referred, in line with the Notification of Deaths Regulations 2019. Align this with the continued grown, reach and impact of NSECH (Northumbria Specialist Emergency Care Hospital) in receiving seriously unwell people from not just Northumberland but all over the region and it is unsurprising that this increase in referrals has emerged.

Recommendations

Executives are recommended to:

- Acknowledge the 2023 Annual Report of the Senior Coroner.
- Consider the previous performance and achievements since the last report of the Senior Coroner (2021).
- Note the future ambitions of the service.

The Annual Report of the Senior Coroner will also be presented as an update with SLT on 13 June 2023, Health and Wellbeing OSC on 4 July 2023 and Health and Wellbeing Board on 10 August 2023.

Key Issues

It is established good practice that the Senior Coroner for a coroner area prepares an Annual Report for the local authority within which the judicial area sits. The Annual Report will typically include useful information on the geographical coroner area and its configuration, along with details of the previous period's performance, any cases over 12 months old, information regarding workload and referred cases, challenges, and opportunities.

The Senior Coroner Annual Report 2023 is linked below:

Senior Coroner Annual Report 2023

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HM Senior Coroner Andrew Hetherington

Senior Coroner for North Northumberland and

Acting Senior Coroner for South Northumberland

Annual Report

May 2023

Contents

Introduction

1. This is my second annual report.

2. COVID-19 has had a significant impact on all areas of life including the coronial system and the families and organisations with whom we interact. As restrictions have eased and we have moved to a recovery phase with a return to pre-pandemic working practices.

3. Many of the provisions of the Coronavirus Act 2020 expired at midnight on 24 March 2022. Some provisions were extended by the Coronavirus Act 2020 (Delay in Expiry: Inquests, Courts and Tribunals, and Statutory Sick Pay) (England and Wales and Northern Ireland) Regulations 2022, SI 2022/362 until 24 September 2022. Some provisions have been set in legislation including extending the time period within which an attending doctor must have seen the deceased before death from 14 to 28 days and suspension of the requirement for a confirmatory medical certificate (known as Cremation 5 Form) before cremation.

4. In Northumberland the Coroner's Office worked throughout the pandemic as near normal as possible respecting the restrictions in place and adapting practices in line with temporary easements that were introduced. That was not the case for all Coroner's areas in parts of England and Wales who entered the recovery phase of the pandemic with a large backlog of cases and inquests that must be heard. Some areas were unable to hear any inquests at all and were struggling to deal with day to day referrals. The resources in coronial areas throughout England and Wales vary. Coronial areas implemented plans in order to achieve recovery. I am pleased to confirm that in Northumberland we leave the pandemic (although COVID remains with us) with no backlog of cases and have been able to clear cases, many involving juries that pre-dated the pandemic.

5. I would like to thank Northumberland County Council for their continued support and acknowledge the hard work and dedication of those who work in the Coroner's Office together colleagues locally within the Council, Registration and Bereavement Services, NHS and organisations who we have contact with.

Contents of report

6. I have provided an overview of the current position with regard to the coroner service in Northumberland following my last review in 2021 with a comparison of neighbouring areas, the number of deaths referred to Northumberland over the period, notable trends and patterns, an update on the area and the road ahead.

Statistics

7. The Ministry of Justice publish coroner statistics annually for the period January to December which are then published in the month of May of the following year. The annual statistics for 2021 (period January 2021 to December 2021) can be found here:

Coroners statistics 2021: England and Wales

Coroners statistics 2021: England and Wales (statistical tables)

Annual statistics for England and Wales 2021

8. For England and Wales, the statistics showed the following: **195,200** deaths were reported to coroners in 2021 (in the period January to December 2021), the lowest level since 1995. This figure was down 5% (10,258 deaths) compared to 2020.

9. 33% of all registered deaths were reported to coroners in 2021.

10. There were **580** deaths in state detention reported to coroners in 2021, up 7% on the previous year (which was up 18% compared to 2019). Seven state detention deaths were reported in Northumberland in 2021.

11. There were **84,599** post-mortem examinations ordered by coroners in 2021, a 7% increase compared to 2020. Post-mortem examinations were carried out on 43% of all deaths reported in England and Wales in 2021, an increase of 5% compared to the previous year.

12. **32,800** inquests were opened in 2021, up 2% compared to 2020. The estimated average time taken to process an inquest increased from 27 weeks in 2020 to 31 weeks in 2021.

Annual statistics for North and South Northumberland 2021

13. In 2021 the total number of deaths referred to the Coroner in Northumberland (North and South) were **1,918.** This represents an increase of **10**% for deaths referred for 2021 as compared to 2020.

14. The increase in the number of referrals was anticipated. Northumberland (North and South) as a coronial area is the only one in the Northumbria Police sphere to have a prison and there are two secure mental health hospitals. The law provides there must always be an inquest following a death in custody or a death in state detention, even if the death is of natural causes. If the death is unnatural, the Coroner will be required to sit with a jury.

15. Northumberland contains a section of the A1 motorway as well as several major A-roads, the east coast main rail line to/from London as well as the east/west rail link to/from Newcastle to Carlisle. In this area I hear a number of deaths following Road Traffic Collisions.

16. The primary hospital within this area is the Northumbria Specialist Emergency Care Hospital (NSECH) at Cramlington. This opened in 2015 and continues to expand being the first vanguard, purpose built specialist emergency care hospital

in England. NSECH's influence and capacity receiving seriously unwell people from all over the region (let alone this area) is increasing.

17. Northumberland has a large NHS trust being Northumbria Healthcare NHS Foundation Trust which also has Alnwick Infirmary, Berwick Infirmary, Blyth Community Hospital, Haltwhistle War Memorial Hospital, Hexham General Hospital, Morpeth NHS Centre, Rothbury Community Hospital and Wansbeck General Hospital located within this area.

18. There were **213** post-mortem examinations ordered in North Northumberland (32% of deaths reported) and **464** post-mortem examinations were ordered in South Northumberland (37% of deaths reported). This represents a total number of post-mortems for both areas of **677**. This is an increase in the number of post-mortem examinations by 17% for North Northumberland and a 19.8% increase for South Northumberland compared to last year.

19. The average post mortem rate for England and Wales is 43% of deaths referred. The post mortem rate as a percentage of deaths referred in Northumberland (North and South) is 35%. Overall we have the lowest post mortem rate locally.

20. Please see Table 1 below. As a comparator with the neighbouring coroner's areas (Newcastle and North Tyneside are due to merge), Northumberland (North and South) have the second highest number of deaths referred to the coroner and concluded the second highest number of inquests.

Table 1: Comparison of statistics Coroner's areas in the North East of England January 2021 to December 2021

Coroner's area	Number of Deaths reports 2021	% change in reports deaths	Inquests opened	Post Mortem Examinations	Post Mortem rate as % of referrals
Newcastle upon Tyne	2112	+ 22%	352	835	40%
North Tyneside	963	-9%	95	345	36%
Sunderland	1203	+ 5%	157	442	37%
Gateshead and South Tyneside	1725	-53%	223	697	40%
North Northumberland	667	+7%	62	213	32%
South Northumberland	1251	+13%	161	464	37%
TOTAL Northumberland	**1918**	**+10%**	**228**	**677**	**35%**

21. **62** inquests were opened in 2021 in North Northumberland and **161** inquests were opened in South Northumberland.

22. **97** inquests were concluded in 2021 in North Northumberland and **234** inquests were concluded in South Northumberland.

23. The estimated average time taken to process an inquest in North Northumberland increased to **27** weeks (from 21 weeks in 2020) and in South Northumberland the average time increased to **25** weeks (from 18 weeks in 2020).

Cases over 12 months

24. Annually it is my responsibility to submit a return detailing cases over 12 months to the Chief Coroner who has in turn a statutory duty to report those cases to the Lord Chancellor.

25. There are a number of reasons why some cases are outstanding. For instance, if there are ongoing police enquiries, criminal investigations and prosecutions, investigations overseas, Health and Safety Executive (HSE) or Prisons and

Probation Ombudsman (PPO) inquiries, Independent Office of Police Complaints (IOPC) inquiries or investigations by one of the specialist accident investigation bodies. In those instances, the coroner's inquest is put on 'hold' pending the outcome of those enquiries or investigations. In some cases, those other investigations are very lengthy. This can result a delay sometimes amounting to years.

26. In addition, for many Coroner's areas the impact of the COVID-19 pandemic has seen an increase in the numbers of death referrals to coroners and a reduction in the ability of coroners to hold inquest hearings. The period of lockdown has meant that many inquests have had to be adjourned or postponed. Some court rooms were not suitable for holding anything but the most straightforward of inquest hearings because they are too small. The Chief Coroner issued guidance to assist with the holding of remote hearings, but there are some large or complex inquests that can only be held with all participants present.

27. Many jury inquests had to be postponed. A jury is required by law in certain inquests, including non-natural deaths in custody or other state custody or where the police forces were involved. Holding inquests with juries has been a particular issue during the pandemic due to social distancing requirements, especially where for coroners whose area, such as Northumberland which includes a prison and secure mental health hospital.

Cases over 12 months in Northumberland 2021

28. In North Northumberland there were **17** cases that are over 12 months. In South Northumberland there was **34** case over 12 months. All cases over 12 months have been concluded.

Annual statistics for North and South Northumberland 2022

29. I am seeing an increase in the number of deaths referred to Northumberland year on year. Please see table 2 below for a comparison of neighbouring areas.

30. In England and Wales 208,430 deaths were reported to coroners in 2022, the highest level since 2019. This is an increase of 13,250 (7%) from 2021.

Table 2: Comparison of statistics Coroner's areas in the North East of England January 2022 to December 2022

Coroner's area	Number of Deaths reports 2021	% change in reports deaths	Inquests opened	Post Mortem Examinations	Post Mortem rate as % of referrals
Newcastle upon Tyne	1977	-6%	266	754	38%
North Tyneside	960	0%	70	370	39%
Sunderland	1084	-10%	138	451	42%
Gateshead and South Tyneside	1591	-8%	167	744	47%
North Northumberland	800	+20%	88	242	30%
South Northumberland	1228	-2%	182	490	40%
TOTAL Northumberland	**2028**	+6%	**270**	**732**	**35%**

31. In Northumberland in 2022 we saw a 6% increase in death reported as compared to 2021 The total number of deaths referred to Northumberland was **2,028.**

32. The Annual Statistics can be found here: Coroners statistics 2022 - GOV.UK (www.gov.uk)

33. Since 2020 the number of deaths referred in Northumberland has increased by 17% (1737 deaths referred in 2020 with 2028 deaths referred in 2022).

34. There are a number of reasons for the increase. Firstly I am satisfied that deaths are now being appropriately referred and captured. Secondly the growth, reach and expansion of NSECH receiving seriously unwell people from all over the region who previously are likely to have attended hospitals outside of Northumberland in other (coronial) areas (and therefore formed part of their reported deaths).

35. There were **242** post-mortem examinations authorised in North Northumberland (30% of deaths reported down from 32% in 2021) and **490** post-mortem examinations were ordered in South Northumberland (40% of deaths reported up from 37% in 2021). This represents a total number of post-mortems for both areas of **732**. Overall the post mortem rate has remained at 35% despite a 6% increase in the number of deaths reported.

36. **88** inquests were opened in 2022 in North Northumberland (up 42%) and **182** inquests were opened in South Northumberland (up 13%).

37. The estimated average time taken to process an inquest in England and Wales decreased from 31 weeks in 2021 to 30 weeks in 2022. The estimated average time taken to process an inquest in North Northumberland remained at **27** weeks and in South Northumberland the average time increased to **26** weeks (from 25 weeks in 2021.

Cases over 12 months in Northumberland 2022

38. In North Northumberland there were **17** cases that were over 12 months. In South Northumberland there were **34** cases that were over 12 months. All of those cases over 12 months have now been concluded.

Notable trends and patterns

39. As above, in 2021, 32,300 inquest conclusions were recorded in total in England and Wales, up 4% on 2020. The number of suicide conclusions increased by 8% to 4,820 compared to 2020, to the highest level since 1995. The increase was higher in females (16% compared to 2020) than males (which increased by 5%) compared to 2020.

40. In Northumberland in 2021 we also saw an increase in suicide conclusions returned in line with the observed tend in England and Wales.

41. Reflecting on previous years, I have considered the annual returns dating back to 2018/2019 (please see Table 3 below). In Northumberland in 2019 the number of suicide conclusions returned were 18. (This was a decrease of 33% compared to 27 suicide conclusions returned in 2018). From 2019, the number of suicide conclusions increased by 66% to 30 suicide conclusions. In 2020 there were 44 conclusions of suicide retuned being an increase of 47% from 2020 as compared to 2021.

42. In England and Wales Suicide conclusions have gone up year on year since 2016, except for 2020. The highest number of suicide conclusions was recorded in 2022 driven by an increase in male suicides which went up by 3% to its highest recorded level since records begun. However, it is worth noting that in 2022 we have seen the number of suicide conclusions (post *Maughan*) return to the level seen in 2019 (being a decrease of 52%).

Table 3: Suicide conclusions returned in Northumberland over the period 2019 to 2022

Year	**Suicide conclusions**	**Increase/decrease from previous year as %**
2019	18	- 33%
2020	30	+ 66%
2021	44	+ 47%
2022	21	-52%

43. There are a number of explanations for the increase in suicide conclusions. Firstly the increase may be a consequence of the change in the standard of proof established by the Supreme Court in the case of *Maughan*.

44. On 13 November 2020 the Supreme Court gave judgment in the case of *Maughan* (R (on the application of Maughan) v. HM Senior Coroner for Oxfordshire [2020]

UKSC 46). By a majority of three to two the Supreme Court ruled that all conclusions in coronial inquests, whether short form or narrative, are to be determined on what is known as the civil standard of proof i.e. the balance of probabilities. This is a test that coroners are used to dealing with as they (and juries directed by them) apply in many inquests. The legal rule had previously been that a conclusion of suicide could only be returned if the coroner or jury were satisfied to the criminal standard (i.e. beyond reasonable doubt).

45. Secondly although the inquests in England and Wales concluded in either 2021 or 2022, some of the deaths occurred prior to 2021 and their respective inquests were delayed for a number of reasons in particular the restrictions in place due to COVID and lockdown.

46. It remains unclear the extent to which the COVID-19 pandemic, the restrictions that were in place and any anguish and concern may have had on this trend. A lot of work is being undertaken now that we return to 'normality' following the pandemic through data returns and some clarity may flow from the public inquiry. Certainly, in some inquests that I heard in the last three years where a conclusion of suicide was returned, in some matters it was not uncommon for the deceased prior to their death to have expressed anguish regarding COVID-19, a fear or concern of contracting COVID-19 and falling ill themselves or a concern of passing COVID-19 to a family member or loved one. In other instances, a deceased person had expressed feelings of loneliness or despair during periods of lockdown.

47. Whilst I am unable to comment on specific cases where the inquest has not yet concluded and where evidence has not been heard in open court, I have identified a worrying trend involving the number of potential self-inflicted deaths in younger persons where a conclusion of suicide is a likely conclusion.

48. One inquest that I am able to refer to in anonymised terms involved the death of 12 year old young person who died in October 2020 and whose inquest concluded in October 2022. I returned a conclusion of suicide.

49. I heard that the young person had suffered with low mood and anxiety relating to several factors including the restrictions in place due to COVID-19, relationship difficulties with peers and other influences. The young person had also suffered bullying in the period leading up to death through electronic means. The young person had also had two known previous instances of self-harm. On one occasion the young person had attended accident and emergency after an incident of self-harm and having been assessed was referred two and seen by the psychiatric liaison team. The young person wanted support with anxiety and low self-esteem and to learn positive coping strategies for times of emotional distress due to several factors. A referral was made to the Young Persons Universal Crisis Team and was assessed by them but at that time did not meet the criteria for referral to Children and Young Peoples Services.

50. In evidence I heard that in 2020 if the criteria had been met for referral to Children's Adolescent Mental Health Services there would have been a triage of the child or young person within 8 weeks, treatment within up to 19 weeks with the number of referrals at that time being 1595.

51. At the time of the inquest in 2022 subject to meeting their criteria for referral there would be a triage of the child or young person within 3 weeks but that the waiting time for treatment had increased from up to 19 weeks to up to 63 weeks with the number of referrals being 2,275.

52. In evidence from the school where the deceased was a pupil, I heard that since the death they have strengthened their support for children suffering from anxiety and other mental health issues by increasing the mental health team employing two emotional literacy teaching assistance, a mental health and

wellbeing practitioner, another Thrive Practitioner and increased the number of deputy safeguarding leads to five.

53. I also heard from a Paediatric Nurse Practitioner based in the Accident and Emergency department who told me that in 2020 it was the case that they would see a referral from a child or young person struggling with emotional distress, anxiety, mental health difficulties and instances of self-harm and overdose once a week but that since the coronavirus pandemic the incidence of assessments for children and young people with those issues has risen from once per week to once per shift.

54. The mental health trust told me that in May 2020 they would see 100 referrals a month from children experiencing anxiety and mental health difficulties but by May 2022 the number of referrals had increased to 300 children per month. The reason for the referrals were complex but included the impact of the pandemic with staff seeing an increase in demand in the numbers of young people suffering with anxiety, low self-esteem, body image OCD and instances of self-harm and overdose.

55. Sometimes a coroner's investigation will show that something could be done to prevent other deaths. If the coroner considers this to be the case the coroner must write a report bringing it to the attention of an organisation or a person who may be able to take action to prevent future deaths. This is known as a "report to prevent future deaths" or a "Regulation 28 Report". The organisation or person must send the coroner a written response, within 56 days, to the report, saying what action it will take as a result.

56. In light of the concerns I heard during the course of the inquest given the increase in the number of children and young people who were being seen with regard to their emotional well-being, psychological distress and mental health difficulties having impacted on them requiring support and assessment since the

coronavirus pandemic and the delays that now exist before they receive treatment and support, I wrote to the then Secretary of State for Health.

57. In light of the evidence I had heard I asked for consideration to be given for an assessment of the services and resources that can be offered to meet the increasing demand in the number of children and young people seeking support with regard to their emotional well-being, psychological distress and mental health difficulties which have impacted on them since the coronavirus pandemic and to reduce the delay in receiving early support in order to avoid her mental health crisis.

58. The Minister with responsibility for Mental Health at the Department of Health and Social Care provided a response in conjunction with NHS England and the Care Quality Commission (CQC).

59. In that response there was recognition of the increase in probable mental health conditions amongst children and young people, that it has increased in the context of, firstly, historical underfunding for mental health services and the COVID-19 pandemic.

60. I was referred to the NHS Long Term Plan and the NHS Mental Health Implementation Plan 2019/20 – 2023/24 which commits to an additional £2.3billion a year for mental health services by 2023/24. This will see an additional 345,000 children and young people able to access mental health support in 2023/24 compared to the number accessing support in 2018/19. A large part of the increase in funding for mental health will be made through integrated care board (ICB) baselines and will increase in line with the Mental Health Investment Standard, which requires ICBs to increase investment in mental health services in line with their overall increase in allocation each year. In 2021/22, 100% of ICBs met the Mental Health Investment Standard.

61. It is acknowledged that the pandemic has had an effect on the mental health and wellbeing of children and young people and that prevalence of probable mental health disorders is increasing, with 18% of children aged 7 to 16 years in 2022 having a probable mental disorder, compared to 17.4% aged between 6 and 16 in 2021 with a probable mental health disorder, which is itself an increase 11.6% in 2017. Whilst not every person with a probable mental disorder has needed, or will want to access, mental health services, it is nevertheless clear that there is increased demand.

62. I am informed there is additional funding with an additional £79 million to expand children's mental health services in the 2021/22 financial year allowing around 22,500 more children and young people to access community health services and 2,000 more to access eating disorder services. The response included "*…..over 689,000 children and young people under 18 had at least one contact with NHS-funded mental health community services in the twelve months to July 2022. This is a 12% increase from the same period to July 2021 when over 615,000 children and young people were supported by services*.

63. An additional £79 million in funding also supported a faster increase in the coverage of mental health support teams (MHSTs) in schools and colleges, which we committed to rolling out to 20-25% of the country by 2022/23. This was part of the Government's 2018 response to the Green Paper consultation on the transformation of children and young people's mental health provision, which was published in 2017. MHSTs support the mental health needs of children and young people in primary, secondary and further education and use an evidence-based approach to provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety. MHSTs now cover 26% of pupils in England and this will increase to cover around 35% of pupils by April 2023. There are 21 MHSTs in operation or being set up across the North East and North Cumbria Integrated Care System, with another five planned (as of May 2022) for 2023/24.

64. The Department for Education has committed to offer all state schools and colleges a grant to train a senior mental health lead by 2025, enabling them to introduce effective, whole school approaches to mental health and wellbeing.

65. With regard to increasing access and reducing waiting times, I am informed that in joint working with NHS England the next steps are to introduce a range of new mental health waiting time standards, including four for children and young people, which NHS England consulted on as part of its Clinically-led Review of NHS Access Standards. The four standards for children and young people are:

- For an 'urgent' referral to a community based mental health crisis service, a patient should be seen within 24 hours from referral, across all ages;
- For a 'very urgent' referral to a community based mental health crisis service, a patient should be seen within four hours from referral, for all age groups;
- Patients referred from Accident and Emergency should be seen face to face within one hour, by mental health liaison or children and young people's equivalent service; and
- Children, young people and their families/carers presenting to community-based mental health services, should start to receive care within four weeks from referral.

Update - The Coroner Service in Northumberland

66. I have discussed below the changes and developments in the coroner's service in Northumberland since my last report.

Appointment of four Assistant Coroners

67. There was a joint recruitment between Northumberland County Council, Newcastle City Council and North Tyneside Council to appoint four new Assistant Coroners to support myself as the Senior Coroner in North and South Northumberland and the Senior Coroner in the City of Newcastle and North

Tyneside across the full range of coroner duties in order to deliver a high-quality coroner service to the people of Northumberland, Newcastle upon Tyne and North Tyneside.

68. The interviews were held at County Hall, Morpeth on Monday 19th and Wednesday 21st July 2021. The interview panel comprised of HM Senior Coroner Karen Dilks, Senior Coroner for the City of Newcastle upon Tyne and North Tyneside, Karen Lounton, Service Manager Registration, Coroner and Archives – Northumberland County Council and myself.

69. There were 45 applications and following the sift, 15 candidates were taken forward to interview following approval from the Office of the Chief Coroner.

70. As above, the interviews were held across two days on 19th and 21st July 2021.

71. All candidates completed a declaration in writing confirming they are not subject to or have had findings made in respect to disciplinary proceedings or criminal proceedings. At interview, all candidates were asked to declare if there was anything they believe should be brought to the attention of the local authority.

72. Four candidates were appointed as Assistant Coroners in the areas of North and South Northumberland, City of Newcastle and North Tyneside as follows:

- James Thompson
- Tom Crookes
- Kirsten Mercer
- Georgina Nolan

73. The consent of the Chief Coroner was received on 26 July 2021 and the consent of the Lord Chancellor was received on 29 July 2021.

74. Under the terms of the Coroners and Justice Act 2009 the compulsory retirement age for these posts will be 70 years, unless the post-holder chooses to resign or is removed by the Lord Chief Justice and Lord Chancellor prior to their 70th birthday.

Cross-jurisdictional appointments

75. On 5 March 2021 I requested the consent of the Chief Coroner to the appointment of HM Senior Coroner Derek Winter, the Senior Coroner for City of Sunderland (and Deputy Chief Coroner) and HM Senior Coroner Karen Dilks, the Senior Coroner for City of Newcastle and Acting Senior Coroner for North Tyneside to be appointed as assistant coroners in North Northumberland and South Northumberland. The appointments were a consequence of the need to provide additional judicial resource and resilience for Northumberland. I continue to be appointed as an Assistant Coroner in those areas and the appointment of all Senior Coroners with cross jurisdictional authority provides resilience in the event of a mass fatality or major incident.

76. Karen Dilks retired as HM Senior Coroner City of Newcastle and North Tyneside in January 2023. Following an open competition Georgina Nolan was appointed HM Senior Coroner for City of Newcastle and North Tyneside as of 26 January 2023. She continues to be an Assistant Coroner in Northumberland (as I continue to be an Assistant Coroner City of Newcastle and North Tyneside) for resilience and cross jurisdictional working.

Coroner's Officers

77. Coroner's Officers in Northumberland are employed by Northumbria Police.

78. I am sorry to see some departures. Coroner's Officer Michael Allen retired after 46 years employment with Northumbria Police in December 2021 and 17 years as

a Coroner's Officer. Keith Lamb also retired in June 2022 after 47 years service with Northumbria Police and 15 years as a Coroner's Officer. Karen Edger took early retirement and left in June 2022.

79. In October 2022 we were joined by Sarah Abrahams and in January 2023 Rebecca Moss joined the team.

80. I am grateful for the continued support from Northumbria Police and recognise the considerable budget pressures placed upon them. However, I have requested greater resourcing.

81. As above, Northumberland is getting busier, we are stretched, there is a disparity in the number of Coroner's Officers deployed in Northumberland as compared to other areas locally. The number of deaths referred to this area has increased considerably over the short term (17% over the period 2020 to 2022) while the number of coroner's officers has remained the same. The number of in person inquests has also increased. There is a prison and two secure mental health hospitals. The law provides there must always be an inquest following a death in custody or state detention, even if the death is of natural causes and if the death is unnatural, I will be required to sit with a jury.

82. This is discussed below but when the Chief Coroner visited our area I submitted my concerns to him and he has endorsed my proposal that there should be 6 coroner's officers allocated to this area.

Treasure inquests

83. Northumberland is a county of treasure. In 2022 there were 8 reported treasure finds and I concluded 3 treasure inquests.

84. The Department of Digital, Culture, Media and Sport are responsible for the Treasure Act 1996. The department is proposing to introduce an additional class of treasure based on what they term 'significance', and to redraft the Code of Practice. Their aim is to ensure important finds that are currently not Treasure because they are not made of precious metal become available for museums to acquire. The Code of Practice has not been updated for 15 years.

Recovery from the COVID-19 pandemic

85. Throughout the pandemic the Coroner's Office in Northumberland worked as near normal as possible in line with the guidance and restriction in place. Unlike other Coroner's areas in England and Wales, I am pleased to confirm that we have been left with no backlog.

86. The coroner's service in Northumberland has been able to function well due to the modern facilities we have available to conduct inquests, IT provision and the capacity to hold remote hearings, the systems we have in place including Civica and referrals through the Portal. But importantly thanks to the hard work and resilience of the Coroner's Officers and Coroner's Administration staff.

87. We benefit from a large court room that can be well ventilated with capacity to hold juries (of 7 – 11 persons). We have from the outset used IT and conducted remote hearings with families from Hong Kong and New Zealand who were able to actively participate inquests.

Discontinuing an investigation

88. Prior to the recent amendment, coroners could not discontinue an investigation unless a post mortem examination revealed a natural cause of death. That meant that if a natural cause of death became clear after an investigation had commenced, the coroner either had to order an unnecessary post mortem or proceed with an inquest.

89. On 28 June 2022, section 4 Coroners and Justice Act 2009 ('CJA') was amended to enable coroners to discontinue an investigation when a death from natural causes becomes clear before inquest, even where there has been no post mortem examination. Corresponding amendments were also made to The Coroners (Investigations) Regulations 2013, The Cremation (England and Wales) Regulations 2008 and Form Cremation 6.

90. The amendment has widened the circumstances in which discontinuance can occur. However there is an exception where the death occurred in custody or state detention, an inquest must still be held.

91. This means that investigations can now be discontinued either where there has been a post mortem or where there has been no post mortem but the cause of death has become clear by other means.

Remote hearings

92. With the principle of open justice, legal hearings including those in the coroner's court are to be transparent and open to scrutiny. Coroners must ensure that there is appropriate public access to all hearings, including those that are conducted using remote means.

93. On 28 June 2022, section 85A of the Courts Act 2003, and the Remote Observation and Recording (Courts and Tribunals) Regulations 2022 ('the Regulations') came

into effect. These provisions allow the remote observation of proceedings in any court, tribunal or body exercising the judicial power of the State, including coroners' courts. As a result it is lawful to use video/audio livestreaming to transmit proceedings to the public and/or press, either to premises designated by the Lord Chancellor, or to specific individuals.

94. A coroner must be physically present in a courtroom when conducting hearings. Individuals have the option of either observing hearings in person, or applying for permission to observe hearings remotely. No-one has the right to observe a hearing remotely. Individuals are entitled to apply for permission (explaining why it is in the interests of justice to allow them to observe a hearing remotely when there is the option to attend in person) applications are considered on a case-by-case basis and may be refused. Individuals include interested persons, witnesses and legal representatives.

95. It is now open to members of the press/media to apply for permission to attend an inquest remotely.

96. As the law currently stands, the coroner and any jury must be physically present in the courtroom.

97. Remote participants are remined that they are attending a formal hearing, and to dress and act accordingly despite the informality of their own surroundings. Warnings are also given should be given, for example that witnesses should not confer on their evidence.

98. As previously outlined, from its inception the Coroner's Court at County Hall was "future proofed" and ready for legislative changes to enable the wider use of remote inquests. It may be the case that if applications from the press or media are received a dedicated live stream camera would need to be installed. This will be kept under review.

Inquests in writing and Rule 23 evidence

99. On 28 June 2022, new provisions came into effect allowing inquests to be held in writing. Section 9C Coroners and Justice Act 2009 creates a new power for coroners to decide that an inquest will be held in writing. When conducting an inquest in writing under Section 9C, inquests will be opened in the usual way, but then no further hearing will be required.

100. There are many straightforward and uncontentious cases in which a hearing in writing might be appropriate. The benefits include avoiding a stressful hearing for the family and saving witnesses the stress and inconvenience of having to give oral evidence.

Implementation of the Statutory Medical Examiner Scheme

101. The Written Ministerial Statement published on the 27th April 2023 sets out the Government's commitment to implement a statutory medical examiner system from April 2024. The non-statutory scheme will continue for the time-being. We continue to work closely with medical examiners as the implementation work develops.

The Chief Coroner - His Honour Judge Thomas Teague QC

102. The Chief Coroner - His Honour Judge Thomas Teague QC, the third Chief Coroner of England and Wales, and his office visited every Coroner's Area in England and Wales

103. In Northumberland we welcomed the Chief Coroner and his office to County Hall on 10 February 2023. The Chief Coroner met with Councillor Glen Sanderson, Gill O'Neil, Nigel Walsh, representatives of Northumbria Police and the Coroner's Officers and Coroner's Administration Team.

104. The Chief was very impressed by the Court facilities, offices and accommodation. He also offered an insight as to the expected number of deaths in the next few years which he anticipates will increase. In line with this anticipated increase the Chief recommended to Northumbria Police that that the provision of Coroner's officer be increased to six.

Conclusions

105. This is my second annual report. It has been a challenging time for all. We have moved into a period of recovery from the COVID-19 pandemic, and, unlike many coronial areas in England and Wales, Northumberland left with no backlog of COVID cases.

106. Towards the end of 2022 and into 2023, we experienced exceptional winter pressures which increased stress on mortuary capacity. In Northumberland in 2022 we saw an increase in the number of deaths referred (which reflects the position in England and Wales). In England and Wales 208,430 deaths were reported to coroners in 2022, the highest level since 2019. The early data being proffered suggests the potential for a larger cohort of excess deaths in 2022 than in any of the pandemic years with the numbers of registered deaths in 2022 maybe having jumped to around 650,000.

107. I continue to seek improvements and work to provide the best Coroner's service for the deceased and bereaved in Northumberland. There have been significant changes with staff leaving the Coroner's service and there has been the impact of the pandemic but also enormous positive advantages: settling into new dedicated offices and Court accommodation, the co-location of Coroner, Coroner's officers and Registration Services, a case management system Civica, portal reporting for the electronic reporting of deaths by authorised agencies and the future; the recruitment of Assistant Coroners and the potential for improved pathology services locally for the benefit of the bereaved in Northumberland.

108. The COVID-19 pandemic has increased the need to use technology in enabling remote participation in Coroner's hearings. In using technology and with the benefit of the modern facilities that have been provided by Northumberland County Council, the Coroner's service has been able to reduce delays in some inquests and minimise what would have been a greater backlog in overdue cases.. There will continue to be improvements and developments to benefit all of those who encounter the Northumberland Coroner's service.

109. At the local Authority Conference in March 2023 the Chief Coroner said "*Almost universally, behind every well-run coroner area is a good Local Authority that understands the unique needs of coroner service and does its best – with increasingly limited resources – to provide the senior coroner and the officers and staff with everything they need*". I would like to take the opportunity to thank the enormous contributions made by those within Northumberland County Council, the Coroner's Office, Registration and Bereavement Services, NHS colleagues, neighbouring councils through Local Resilience Forums and stakeholders for all their hard work, support and co-operation.

Andrew Hetherington

HM Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland

Signed……

Dated……

Together

we're making health and social care better

Annual Report 2022–23

healthwatch Northumberland

Contents

"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari, Healthwatch National Director

Message from our Chair

David Thompson
Healthwatch
Northumberland Chair

Now that the COVID-19 pandemic is less of a concern than in recent years, everyone would have anticipated that health and care services would by now have been more 'normal'. That has not materialised as the relentless capacity pressures and the intermittent industrial actions have presented continuing challenges to the system.

It is to the eternal credit of the staff of all descriptions that the health, safety and wellbeing of patients continue to be maintained at a very high level in Northumberland. That is no mean achievement!

And within all of this, let us not forget the contributions of volunteers who do sterling work throughout health and care. This certainly applies to Healthwatch Northumberland itself, where volunteers young and old undertake so much invaluable work. It is also worthy of mention here that Emma Grimwood has moved on from our organisation, and to express appreciation for her commitment and professionalism in her role as Volunteer Officer.

Also departing at the end of June will be Margaret Young, Deputy Chair. She has been a stalwart during her six years at Healthwatch Northumberland, her wisdom and enthusiasm having made such a meaningful and lasting contribution. She and the team of board members can be relied upon to represent the views of people from throughout Northumberland, sensibly and appropriately.

I should also like to pay tribute to Derry Nugent, Project Coordinator, and the Healthwatch Northumberland staff for their wide-ranging and dedicated efforts. They have ensured that the patient voice is independently heard, listened to and acted upon in various ways and means across the county. There is no doubt in my mind that engagement and involvement of the public is now high profile within health and care organisations. Long may it continue and prosper to ensure that Healthwatch Northumberland has a respected role to play, wherever and whenever it is able to present its findings.

Finally, this will be my final foreword as I also retire at the end of June. The past six years have flown by and it has been a real privilege to have shared a journey with such a dedicated band of staff, board members and volunteers. Meeting members of the public and professionals has been very rewarding as there has been, and remains, a determination from everyone to improve services even further.

All I can add is to write a heartfelt thank you for your support and advice during the past six years. I wish you all well for your futures.

Message from the Chair of Adapt (NE)

It has been another successful year for Healthwatch Northumberland which has seen us make real progress on the health and social care issues that matter most to the communities in Northumberland.

I must thank the public for sharing their experiences at meetings, online and through surveys. It is only because of this that Healthwatch Northumberland can know, understand and can represent your views to service commissioners and providers and so influence changes.

We can only do this through the dedication of the staff team and our volunteers who have all worked very hard to maximise our reach into communities across the county.

This is a time of great change for the Healthwatch Northumberland Board as we say goodbye to David Thompson and Margaret Young. As Chair and Vice Chair respectively, they have led Healthwatch Northumberland with insight, tact and tenacity for six years through immense changes and of course the pandemic. They go with the heartfelt thanks of everyone at Adapt (NE) and Healthwatch Northumberland.

The next Chair of Healthwatch Northumberland is Peter Standfield. Peter's background in health, social care and the voluntary and community sector, along with his experience of veteran's affairs means he is well placed to lead Healthwatch Northumberland into its next phase.

Lorraine Hershon
Adapt (NE) Chair

About us

Healthwatch Northumberland is your local health and social care champion.

We make sure NHS leaders and decision makers hear your voice and use your feedback to improve care. We can also help you to find reliable and trustworthy information and advice.

Our vision

The people of Northumberland have their health and social care needs met and their experience of using services heard and understood by those responsible for commissioning and providing services

Our mission

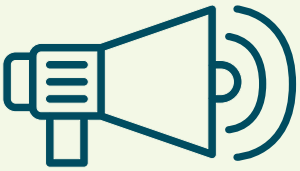
To ensure that the people of Northumberland can give their views and are involved in and can influence decisions made about their health and social care

Our values are:

- **Listening** to people and making sure their voices are heard.
- **Including** everyone in the conversation – especially those who don't always have their voice heard.
- **Analysing** different people's experiences to learn how to improve care.
- **Acting** on feedback and driving change.
- **Partnering** with care providers, Government, and the voluntary sector – serving as the public's independent advocate.

Year in review

Reaching out



1953 people
shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

4883 people
came to us for clear advice and information about topics such as mental health and the cost of living crisis.

Making a difference to care

We published
17 reports
about the improvements people would like to see to health and social care services.

Our most popular report was
Autistic young people and mental health services which highlighted how some NHS mental health services aren't working for local families.

Health and care that works for you

We're lucky to have
14
outstanding volunteers who gave up over 500 hours to make care better for our community.

We're funded by our local authority. In 2022-23 we received
£200,000
which is the same as the previous year.

We currently employ
six staff
who help us carry out our work.

How we've made a difference this year

Spring

We helped Brockwell Medical Group to hear patients' views on the proposal to relocate the surgery to a new site at the Northumbria Specialist Emergency Care Hospital.

We commissioned a project to find out what is working well for people who use home care services and to make recommendations for improvements.

Summer

People who attended our care home forums helped us create a useful resource called 'things I wish I'd known before my loved one went to live in a care home'.

We supported the Heathwatch England #BecauseWeAllCare campaign which saw 54,000 people come forward to share the issues they faced with services.

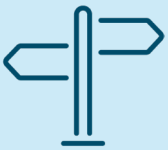
Autumn

We promoted a survey to understand what needs improving for people who develop mental health difficulties relating to their maternity experience.

To support the COVID-19 vaccination programme we asked how it went when you booked your appointment, visited the vaccination centre and how things might be improved for the future.

Winter

With the NHS under extra pressure during winter, we listened to your experiences of care to help services understand what was working and spot issues affecting support for you and your loved ones.



As part of our Signposting and Information Service we shared support and guidance information around the rising cost of living, plus ways to stay safe and well.

10 years of improving care

This year marks a special milestone for Healthwatch. Over the last ten years, people have shared their experiences, good and bad, to help improve health and social care. A big thank you to all our Healthwatch Heroes that have stepped up and inspired change. Here are a few of our highlights.

How have we made care better, together?

Mystery shopping

Mystery shopping highlighted ways to improve the OneCall system for social care enquiries and pharmacy services for young people.

Home care

Two reports highlighted the problems of providing care in a large rural county and the impact on patients and carers.

Patient Participation Groups

We showed how important Patient Participation Groups are to primary care and worked with local Primary Care Networks to support new groups.

End of life care

We ensured local people influenced the Northumberland End of Life Strategy and said what they wanted from services for people who are dying and their families.

Service changes

From the instigation of Northumbria Specialist Emergency Care Hospital, closure of GP surgeries and dentists, changes to maternity care and Patient Transport eligibility, we have made recommendations to improve people's experiences.

Listening to your experiences

Services can't make improvements without hearing your views. That's why over the last year we have made listening to feedback from all areas of the community a priority. This allows us to understand the full picture, and feed this back to services and help them improve.

Autistic young people and mental health services

This year we heard from local families that some NHS mental health services aren't working for their autistic children. To get a better picture of what was happening we asked people to tell us about their experiences of the neurodevelopmental assessment process and mental health support including what is working well and what could be better.

We had 90 responses to our call for feedback. Whilst there was praise for individual staff and services, we heard repeated themes around the struggles parents faced accessing suitable suppor. This included difficulties in getting an initial referral to services, high thresholds for accessing support, long waiting times and being referred between different services.

We worked with parents to develop the feedback form and co-produced the recommendations with Northumberland Parent Carer Forum. Thank you to everyone who helped us with this piece of work.

Recommendations include:

- Foster a culture of celebration and valuing neurodiversity throughout the diagnostic process; explore and look at positives rather than perceived deficits
- Review packages of mental health support to ensure they meet needs of neurodivergent children and young people particularly in relation to 'time-limited' therapy, waiting times and communication
- Simplify the pathways for accessing support for autistic children and young people, both for the diagnostic process and pre and post diagnostic mental health support to deliver holistic support. Mental health services to continue to run alongside the neurodevelopmental assessment process

What difference will this make?

The feedback we received has been considered as part of the review into the Northumberland Autism Strategy and of the graduated mental health pathway for children and young people.

"We welcome the opportunity to hear about the experiences of young autistic people and their parents and carers in this Healthwatch Northumberland report. It's important for us to learn about and understand the challenges people accessing our mental health services face."

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Exploring A&E attendances by 0-5 year olds living in Blyth

During 2022 Blyth Primary Care Network identified that some children aged under five years old from the Cowpen and Kitty Brewster estates in Blyth had a higher-than-expected attendance rate at A&E at Northumbria Specialist Emergency Care Hospital than other similarly aged children living in Northumberland.

We worked with Northumberland County Council, Public Health, the council's Family Hubs, Heart of Blyth project and Blyth Primary Care Network to investigate this.

In conjunction with the different project partners, we organised four separate sessions in Blyth to engage with parents of pre-schoolers: two drop-in sessions that ran alongside existing Family Hub activities, a session to catch parents as they dropped off their children at Briardale Nursery, and a focus group with a group of black women from the Buffalo Centre.

Our ability to bring people and decision makers together is a vital part of our role. Overall, we found that parents were taking their pre-school children to A&E appropriately and in almost half of the attendance cases the parents had been directed to attend A&E by another health professional including, on one occasion, their GP.

We also promoted the 'Healthier Together' app and website as a useful tool for parents with poorly children.

Care homes forums

We have continued hosting quarterly online forums for relatives and loved ones of those living in care homes. During one forum the Carers Northumberland team were able to raise a specific issue they were hearing from carers about difficulties pre-planning respite care for holidays, directly with the Senior Commissioner for Adult Social Care. As a result it has been confirmed that adult social care is going to block book one bed for respite care and look to further changes to this vital service.

Feedback from attendees of the forum helped us shape our 'things I wish I'd known before my loved one went to live in a care home' guidance - a simple list of things to think about before your friend or family member moves into a care home.

The forums also continue to have an impact in providing individual support and reassurance for people who attend.

> "The Healthwatch Northumberland care homes sessions offer an opportunity to vent problems, issues and frustrations to a group of people who understand and are able to support me in my decisions on care home options, respite care, who to go to for certain issues etc. It is greatly valued as a group/service because it is a problem shared and that makes a difference to not feeling so isolated or misunderstood."
>
> **Care home forum attendee**

Advocating for fairer NHS dentistry

Some issues can only be solved at national level. Dentistry is one such issue. NHS dentistry is in desperate need of reform and this year we have successfully kept NHS dentistry on decision maker's agendas locally and nationally, making it easier for people to find a dentist taking on NHS patients.

We have continued to raise concerns about a shortage of NHS dental appointments in Northumberland. This has been an issue we continued to hear about over the past year, particularly with the residents of Berwick-upon-Tweed and the surrounding areas.

Ensuring the issue has remained high on the agenda with the North East and North Cumbria Integrated Care Board (ICB) has been a priority, and, together with 134 other Local Healthwatch nationally, we provided written feedback to the Parliamentary Health and Social Care Select committee's inquiry into the state of NHS dentistry in England.

Healthwatch has seen a shortage of NHS appointments across England, which has affected people on the lowest incomes the most, meaning they were less likely to have dental treatment than those on higher incomes. Healthwatch England made renewed calls on NHS England and the Department of Health and Social Care to put a reformed dental contract in place.

Changes to NHS dental contracts

Healthwatch's findings achieved widespread media attention and as a result NHS England announced changes, including:

- Increasing the payments for dentists when treating patients with complex needs, for example, people needing work done on three or more teeth
- Requiring dental practices to regularly update the national directory as to whether they are taking new NHS patients
- Moving resources from dental practices that are under-performing

What difference will this make?

This announcement showed the power of people's feedback – with decision makers listening to your voice and taking action.

With these changes in place it should eventually be easier for people to find a new dentist taking on NHS patients, allieviating the stress and worry so many suffer when they cannot afford to go private.

Outpatient appointments

Working with Healthwatch North Tyneside we helped Northumbria Healthcare NHS Foundation Trust to hear from patients using outpatient clinics and to gather views on new approaches. We visited clinics at Hexham General Hospital, Alnwick Infirmary, Berwick Infirmary and Wansbeck General Hospital.

Patients welcomed many aspects of new approaches to outpatient appointments including more choice of days and times and face-to-face and telephone appointments. However local options and timely communication were two key areas where patients want to see improvements.

Talking about how it will use this information to improve services, Northumbria Healthcare said:

"Healthwatch Northumberland carried out research on behalf of Northumbria Healthcare last autumn about patient experiences of outpatients appointments and to gather views of a new patient initiated follow up (PIFU) pathway. Over 550 patient's views were collected and analysed.

The findings of the report will be used to inform patient information on our website and leaflets about the new service to ensure people get the information they need to make informed choices.

We are also using the key findings to develop a new patient portal which will be launched later in 2023 to improve communications with patients about their appointments and health information.

It is also contributing to ongoing work to address health inequalities and improve access to healthcare including the cost of travel for attending appointments."

Out-of-area COVID-19 vaccinations

A member of the public contacted us because they and a family member had received their first COVID-19 vaccination outside of England (in this case Scotland). They were told vaccine records would have to be changed before they could receive second and booster doses.

The family were also told this would have to be done in person at a centre outside of the North East. This would have extremely difficult for them due to age and disability restrictions.

We raised this with NHS England and said this did not meet NHS England's responsibilities under the Equality Act and Duty.

Although it took some time we were pleased to receive the following response from the Vaccination Programme Manager at the Regional Vaccination Operations Centre:

"As you have highlighted, there have been concerns about the availability of the service because the original service model for overseas was that this could only be offered from large vaccination centre sites, and the majority of these closed in 2022 across the North East and Yorkshire. The plan as we move forward is that the service will be a digital/ postal service rather than face-to-face, and this will ensure that future access is not impacted by the availability of large sites that are open across a system or region."

We have informed the family and will promote this information for others in similar circumstances.

Waiting Well

Eight places across the North East and North Cumbria received funding to deliver a programme of support for patients waiting for NHS surgery.

The aim of the 'Waiting Well' programme is to:

- Support patients to adopt healthier lifestyles, initially while waiting for surgery
- Help them with recovery after their surgery
- Inspire patients to continue their healthier lifestyle choices in the long-term

The North East and North Cumbria ICB asked Local Healthwatch to find out what people thought about the idea. The focus group in Northumberland told us three words summed up what patients needed from the programme – Continuity, Consistency and Clarity.

One person said the programme would be good as long as it doesn't mean people on the programme can jump the queue ahead of patients who aren't on it. The group agreed the benefits of what it means to be on and not on the programme were important.

We made a specific recommendation about the importance of peer support groups/ networks and shared user stories. The group felt that being able to speak to other people in similar situations would be useful and improve people's engagement with the programme.

What difference will this make?

The findings from this work will be used by the NHS when planning the roll-out of the Waiting Well programme across the North East and North Cumbria and help people maximise the benefits of their surgery.

Lloyds Community Pharmacy Closure

In early 2023 the owners of the Lloyds pharmacy network of community pharmacies announced the network was to be sold and branches would close, in particular those located within Sainsbury's supermarkets. While Lloyds operates a number of pharmacies in Northumberland, the biggest impact is in Cramlington where the store in Sainsbury's, Manor Walks, was open for 100 hours per week. Lloyds informed NHS England of its plan to close the pharmacy by mid-summer 2023.

This 100-hour pharmacy is one of five across the county which form the network of out of hours provision of pharmacy services. The conclusion of the Northumberland Pharmacy Needs Assessment 2022 states:

"The council considers that the network of extended hour pharmacies are essential to meet patients' needs by widening access to pharmaceutical services outside core hours when other pharmacies are closed. Any loss of 100-hour pharmacies or reduction in supplementary hours may lead to gaps in pharmacy services."

We raised concerns about how this closure was communicated to patients and carers and asked for NHS England/North East and North Cumbria ICB commissioners to carry out an Equalities Impact Assessment to determine the effect on patients with protected characteristics. We asked how people who would be affected due to their mental capacity, sensory loss and ability to travel to different locations and for whom English is an additional language, including those whose first language is BSL, would be made aware of the change.

Hearing from the local community

The Healthwatch Northumberland Board agreed a series of visits to the pharmacy using our Enter and View powers so that we could hear directly from people currently using the service. We focused on weekend and out of hours times using a short survey. We heard from over 230 people. Nearly half said they had used the pharmacy outside of core hours in the last 12 months. The main concerns were that not having a pharmacy with extended hours would bring complications and considerable inconvenience to people who are already under pressure from long term conditions and disabilities. People were also concerned that the closure would add more pressure on the already overstretched alternative services.

"We often have to pick up medication after 6pm but will no longer be able to do so which means my daughter will be left in pain until the next morning which isn't nice. There are no other pharmacies open late in Cramlington."

"Massive queues at Boots to add to the already big queues."

What difference will this make?

As a result of our work the commissioners are developing a plan for what happens next which will be informed by patients' needs. In addition, the Chair of the Northumberland Health and Wellbeing Board has written to the Secretary of State for Health asking for a review of the community pharmacy funding model which was part of the underlying issue.

How we have made a difference for the community

Throughout our work we gather information about health inequalities by speaking to people whose experiences aren't often heard.

Annual Conversation

Each year we run an annual survey to hear about people's experiences of health and social care. This year we wanted to get more detailed feedback from those we may not usually hear from, and who may not always respond to surveys about their experiences, through our 'Annual Conversation'.

We worked with community partners across Northumberland to ensure we heard a range of experiences, either during conversations within a group setting or as in individual one-to-one conversation.

We heard from people affected by their loved one's drug and alcohol misuse, and this feedback was used during Northumberland County Council's recommissioning of drug and alcohol services.

Specific needs around access to, and awareness of, adult social care services were raised by ethnically and culturally diverse communities. None of the group appeared to be aware of home care services or care homes or help for carers and where to seek help should it be required in future, so better promotion of services could be needed. There were concerns raised around whether services would 'take over' and consider cultural practices when providing care so it was felt reassurance around this would be needed in the event of seeking help. We were hearing that the best way to promote and raise awareness of services in ethnically and culturally diverse communities would be to have both online and hard copy documents or leaflets available in different community languages, with Kurdish, Sorani, Arabic, Turkish, Spanish and Bangladeshi given as examples. We have shared what we heard about the need to for better and specific communications by those commissioning the services.

We ran a general online public survey alongside these detailed conversations. Whether positive or negative, the theme of access to services dominated the feedback we received.

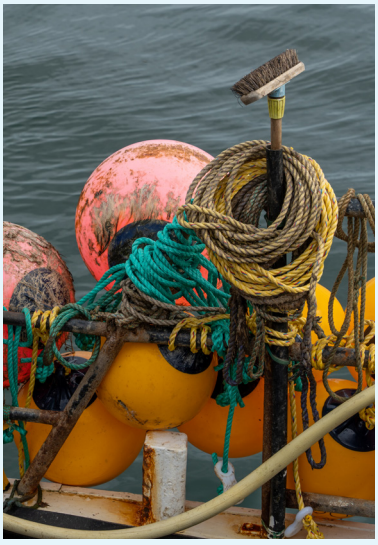
Hearing from all communities

Over the past year we have worked hard to make sure we hear from everyone within our local area. We consider it important to reach out to the communities we hear from less frequently, to gather their feedback and make sure their voice is heard and services meet their needs.

This year we have reached different communities by:

- Regularly visiting a local fishing community to hear from fishermen and their families
- Listening to people who don't often have their say through our Annual Conversation
- Working with schools to hear more from young people in Northumberland
- Holding monthly face-to-face drop-in sessions across the county

Better care for fishermen



We are part of a bi-monthly health initiative bringing healthcare and support services to fishermen and their families at Amble Quayside. 'Health at the Quayside' is an initiative with Seafit - run by the Fishermen's Mission - and Well Up North Primary Care Network. Because of the nature of their work, fishermen can find it difficult to access health services.

The initiative will run throughout 2023, providing a range of free services such as health checks, physiotherapy and mental health support. We have been on hand to listen to people's experiences of services and to provide our Information and Signposting Service, alongside charitable organisations such as Prostate Cancer UK. This is an important piece of work which recognises the health inequalities fishermen face and could lead to similar initiatives with other isolated professions such as the farming industry.

> "I could do with going to the GP about my elbow. But nowadays the GP wants you to call at 8.30am. I just can't call at that time. By the time I'm back on shore, all the appointments have been taken."
>
> **Local fisherman**

Here to Hear drop-in sessions

Our Here to Hear drop-in sessions take place every month in all five local council areas across the county. These sessions are a way of hearing from more people across our vast and diverse county. The drop-ins ensure our services are accessible to more people in more communities and by reviewing and changing the location of our sessions when necessary, we can meet and hear from people from different areas, both rural and urban.

Coming to a Here to Hear drop-in works. One visitor told us about the difficulties they had trying to access NHS dental care for their young child. We signposted them to a dental practice which we knew had additional capacity for appointments.

> "I contacted the dental practice the following day after receiving your message and they saw our son the next day. Thank you so much. It has taken 15 months to find him somewhere."
>
> **Morpeth resident**

‘How are you feeling?’ young people’s campaign

We wanted to hear from more young people living in Northumberland about how they are feeling and their experiences of healthcare services in the county. We also wanted to provide information about local services and support to this age group, around both physical and mental health. With a group of volunteers including three of our student volunteers, we developed an online form for under 25s, an animation explaining the campaign, and printed materials to support the campaign.

With the help of local schools and groups we heard from 650 young people living in Northumberland. Some of the themes that came out were that young people would like quicker access to services, more mental health provision and to be listened to by health and care professionals.

“I’d like NHS services to be more easily accessible for more people to use and not have such a long wait to speak to someone.”

“Let us say what we need without letting our parents or school know. We need more support for children in making their own appointments without parental supervision.”

“When people do need help the NHS do the best they can and they put all their hard work into what happens.”

Young people in Northumberland

Advice and information

If you feel lost and don't know where to turn, Healthwatch Northumberland is here for you. In times of worry or stress, we can provide confidential support and free information to help you understand your options and get the help you need. Whether it's finding a GP surgery, how to make a complaint or choosing a good care home for a loved one – you can count on us.

This year we've helped people by:

- Providing up-to-date information people can trust
- Helping people access the services they need
- Hosting monthly online information sessions about a range of conditions
- Supporting people to look after their health during the cost of living crisis

Online information sessions

We continued to hold our monthly online events where we invite a guest speaker from a health charity or support organisation.

We aim to feature health conditions that don't always have a lot of public exposure and ask that presenters focus on what support and services they can offer people living in Northumberland. The sessions are attended by a mixture of health professionals and members of the public.

This year almost 150 people came along to the ten sessions we hosted, and 50 of them went on to subscribe to our newsletter. Organisations who presented for us this year include the National Autistic Society, Diabetes UK, Kooth and the Limbless Association.

Providing this service not only helps individuals directly, but helps professionals give advice to people and they in turn get the help they need.

> "Personally, I find your online sessions really helpful at getting to know different organisations and the support they offer, and I always share the resources after with my team."
>
> **Lisa Baker, Social Prescriber**

Access to flu vaccinations

We heard from someone who had recently arrived in the country who was having difficulties booking flu vaccinations for their children. Due to the timing of their arrival into the UK they had missed the school flu vaccination programme.

They told us they had contacted their local GP who advised them to ask school, and school had in turn asked them to go back to their GP. They were left with no understanding of how to access this service for their children. After looking into this further we managed to contact the childhood immunisations team to book a community clinic appointment.

After having initial difficulty in finding the right department to contact and then being asked to complete online forms to access an appointment which unfortunately did not work, we eventually arranged an appointment by telephone for them for the following day. Whilst the staff were friendly and helpful the process itself appeared to be complex and difficult to navigate and would be even more so for someone whose first language was not English. The person was very pleased with the result.

> "Really you did very well with us I am so thankful for what you did."
>
> **South East Northumberland resident**

Support with communication issues

We were contacted by someone looking for information following a delay in communication after having an MRI scan. We were able to refer them to the Patient Advice and Liaison Service (PALS) for help with getting answers and support.

> "In these difficult times there must be many other patients who are as anxious as I was, and they probably don't know about Healthwatch Northumberland and PALS who can come to the rescue."
>
> **Alnwick resident**

Signposting to local activities

During one of our Here to Hear sessions a local resident asked if we could help them find social groups in the area. We signposted them to several groups including Northumberland Recovery College. A peer support worker agreed to give them a call to discuss their needs further and book them on to suitable activities.

> "Today is my lucky day."
>
> **Blyth resident**

Volunteering

We're supported by a team of amazing volunteers who are at the heart of what we do. Thanks to their efforts in the community, we're able to understand what is working and what needs improving.

This year our volunteers:

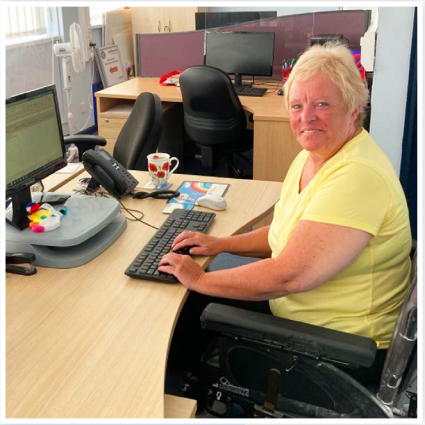
- Visited communities as part of our Here to Hear drop-in sessions
- Collected experiences and supported their communities to share their views
- Carried out Enter and View visits to a pharmacy which is closing
- Created a campaign to help us hear more from young people
- Supported us in the office with data entry, research and administration

Colin

"I like volunteering with Healthwatch Northumberland as it gives me a chance to give something back to the community. I have had my own health problems so I can understand and appreciate other people's experiences. I regularly help at engagement events and enjoy speaking to the public and hearing their views. I also enjoy raising awareness of Healthwatch Northumberland and the work we do."

Karen

"I love being a volunteer in the Healthwatch Northumberland office, as there is always different and interesting work to do. I think volunteering with Healthwatch is important, to get our name out there so the public can have their say about the health and social care services they use."



Hearing from young people

Our volunteers have attended Freshers Fairs to hear from young people, raise awareness of our services and promote our volunteering opportunities.

This served as a pilot for our county-wide 'How are you feeling?' young people's campaign which was developed by a team of staff members and volunteers including Jess, Ann and Molly, pictured here with Volunteer Officer Emma at Queen Elizabeth High School, Hexham.

Do you feel inspired?

We are always on the lookout for new volunteers, so please get in touch.

healthwatchnorthumberland.co.uk
03332 408468
info@healthwatchnorthumberland.co.uk

Finance and future priorities

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure

Income		Expenditure	
Annual grant from Government	£200,000	Expenditure on pay	£157,591
Additional income	£29,971	Non-pay expenditure	£30,848
		Office and management fee	£20,000
Total income	**£229,971**	**Total expenditure**	**£208,439**

Additional funding is broken down by:

£20,377 - brought forward from 2021/22
£1,500 - Healthwatch England for Power BI training
£1,000 - Northumbria Healthcare for outpatient engagement project
£2,594 - NHS England for Healthier Together project
£4,500 - North East and North Cumbria ICS Healthwatch Network grant

Next steps

In the ten years since Healthwatch was launched, we've demonstrated the power of public feedback in helping the health and care system understand what is working, spot issues and think about how things can be better in the future. Services are currently facing unprecedented challenges and tackling the backlog needs to be a key priority for the NHS to ensure everyone gets the care they need.

Over the next year we will continue our role in collecting feedback from everyone in our local community and giving them a voice to help shape improvements to services. We will also continue our work to tackle inequalities that exist and work to reduce the barriers you face when accessing care.

Top three priorities for 2023-24

1. Social Care: We will gather the experience of those residing in care homes using our Enter and View powers. We will work with Northumberland County Council as it develops its Adult Social Care Plan ensuring our communities' views are heard.

2. Health: We will focus on how people access services, especially where there are specific barriers, for instance due to the job they do or where they live. We will continue to gather experiences of primary care services.

3. Volunteering, Communications and Engagement: We will increase the number of volunteers and the diversity of people involved with Healthwatch Northumberland. We will build on our 2022 experience by using more targeted focus group 'conversations' to gather the experiences of Northumberland residents.

Statutory statements

Healthwatch Northumberland
Adapt (NE)
Burn Lane
Hexham
Northumberland
NE46 3HN

Healthwatch Northumberland uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making

The Healthwatch Northumberland Board consists of 11 members who work on a voluntary basis to provide direction, oversight and scrutiny to our activities. Our board ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local communities. In 2022/23 the board met five times and made decisions on matters such as agreeing an Operational Plan and priorities to guide our work, and agreeing to use our Enter and View powers to gather patient experience of a community pharmacy closure. Our volunteers were involved in recruitment of our new Board Chair.

We ensure wider public involvement in deciding our work priorities, by using the feedback people give us about their experiences, conducting focus groups and an Annual Survey to highlight areas where we can make a difference.

Methods and systems used across the year to obtain peoples experiences

We use a wide range of approaches to ensure that as many people as possible have the opportunity to provide us with insight about their experience of health and care services.

During 2022/23 we have been available by phone, text and email, provided a webform on our website and attended virtual and face-to-face meetings of community groups and forums. We hold five drop-in sessions per month in community locations plus a monthly online forum and we engage with the public through social media.

We are committed to taking additional steps to ensure we obtain the views of people from diverse backgrounds who are often not heard by health and care decision-makers. This year we have done this by holding focus groups with black women, carers of people with drug and alcohol addiction, learning disabled people and people in the fishing industry. We worked with schools to hear from young people aged 13+. We ensure that this Annual Report is made available to as many members of the public and partner organisations as possible. We publish it on our website, across our social media platforms and produce hard copies for our stakeholders.

Responses to recommendations

This year we made 42 recommendations through reports, discussions and presentations. We had no providers who did not respond to requests for information or recommendations. There were no issues or recommendations escalated by us to the Healthwatch England Committee, so no resulting reviews or investigations.

Taking people's experiences to decision-makers

We ensure that people who can make decisions about services hear about the insight and experiences that have been shared with us.

In our local authority area, for example, we take information to the Health and Wellbeing Overview and Scrutiny Committee, Equalities Plan System Planning Steering Group, Primary Care Applications Working Party, Carers Board, Community Mental Health Transformation Leadership Forum and the Older Persons Pathway Group.

We also take insight and experiences to decision makers in the North East and North Cumbria ICB at 'place' level; this is through our attendance at the Northumberland System Transformation Board. We also provide insight by working with other Local Healthwatch in the North of Tyne Integrated Care Partnership and to the Integrated Care Board and System Quality Group with Healthwatch across the North East and North Cumbria ICB area.

We share our data with Healthwatch England to help address health and care issues at a national level.

Enter and view

We carried out four Enter and View visits this year. This was to one site - Lloyds pharmacy within Sainsbury's in Cramlington.

Our visits highlighted the impact closing the pharmacy would have for vulnerable people. Our recommendations to Northumberland Health and Wellbeing Board were that NHS England/North East and North Cumbria ICS community pharmacy commissioners in considering the imminent closure and for the future service should:

1. Ensure direct communication be made to patients at the point the prescription is made (e.g. at the GP surgery) as to where an electronic prescription is being sent

2. Ensure direct communications be made to patients and carers who have repeat prescriptions at this pharmacy

3. Ensure an Equalities Impact Assessment be done by NHS England and/or North East and North Cumbria ICB to determine the effect on patients with protected characteristicsThese recommendations have been taken up by NHS England and/or North East and North Cumbria ICB.

Health and Wellbeing Board

Healthwatch Northumberland is represented on the Northumberland Health and Wellbeing Board by our Chair, David Thompson. During 2022/23 our representative has effectively carried out this role by providing contributions based on feedback and evidence gathered from service users on issues such as access to dentists.

David Thompson also represented Healthwatch Northumberland on the North East and North Cumbria ICS Place System Transformation Board and the Healthwatch Network at the Integrated Care Board.

healthwatch Northumberland

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Healthwatch Northumberland

Northumberland
County Council

HEALTH AND WELLBEING BOARD

Date: 10 August 2023

Better Care Fund Plan 2023-2025

Report of Councillor Wendy Pattison, Adult Wellbeing

Executive Director: Neil Bradley – Adults, Ageing and Wellbeing

Purpose of report

To request the Board formally to sign off the Northumberland Better Care Fund (BCF) Plan 2023-25, and to make proposals about the sign-off process for future BCF plans.

Recommendations

The Board is recommended:

1. **To sign off the BCF Plan annexed to this report as Annex A (narrative plan) and Annex B (spreadsheet plan)**

2. **To delegate to the Council's statutory Director of Adult Social Services (currently the Executive Director for Adults, Ageing and Wellbeing) the authority to sign off any future BCF planning submissions, if the nationally-set timetable makes it impracticable for the Board to do so before the submission date, provided that a draft of the submission has been circulated to all Board members for comment, and no issues have been raised which require fuller discussion at a Board meeting before sign-off.**

Link to Corporate Plan

The BCF supports the Tackling Inequalities objective in the Corporate Plan 2023-2026 of all adults living well, regardless of age, background, illness or disability.

Key issues

1. The Better Care Fund is a funding mechanism introduced from 2015/16, whose original objective was to require local authorities and NHS bodies in each area to develop joint plans for a substantial element of their funding to support an integrated approach to services at the interface between the community and acute hospitals. Initially its

intended objective was to reduce growth in emergency admissions; over time the main focus has shifted to reducing delayed discharges from hospital.

2. Over time, a number of further elements of funding have been added to the sums originally required to be covered by BCF plans. Over the years the Fund has supported some new initiatives in Northumberland, but most of the available funding is committed to maintain existing core community health and social care services.

3. The main new funding element this year is a specific Discharge Funding grant, consisting of an NHS element and a local authority element. Schemes planned to be funded from the NHS element include additional intermediate care capacity during the winter and additional funding for NEAS. The local authority element will be used flexibly to support costs associated with hospital discharge, and to fund the costs of a block contract for specialist care home support for older people whose dementia is causing them to behave in ways which mainstream care homes for older people find difficult to accommodate because of risks to the person themselves, other residents or staff. Older people in this category are among the hardest to find suitable accommodation for after acute hospital treatment.

Better Care Fund Plan 2023-2025

BACKGROUND

1. Background

1.1 For a number of years, local authorities and local NHS commissioners have received details of the conditions they are required to meet in their plan for the use of the Better Care Fund after the beginning of the financial year to which the plan relates, and have received confirmation of approval of this plan some months later. Plans for 2023/24 were only formally approved in January this year, and additional BCF funding to support discharges from hospital was confirmed in mid-November 2022 with a separate plan required by mid-December.

1.2 In practice, since the funding supports core community health and social care services, both the local NHS and the Council have largely continued with previous patterns of expenditure in each year, without waiting for formal approval of the BCF plan.

1.3 Planning requirements for the current financial year were published considerably earlier than in recent years, though still slightly after the start of the financial year, on 4 April 2023. However we did not until 19 May receive details of the reporting which is required about the use of the main new element of the grant – funding specifically for support to enable early discharges from hospital. It was therefore not possible to present a draft BCF plan to the 8 June meeting of the Board before the submission date of 28 June, so an oral report was provided to the Board on what were expected to be the main points of the plan, and a draft report was circulated to all Board members for comment before the submission date.

1.4 All comments received from Board members were supportive, with a few detailed comments about specific presentational points which have been reflected in the final submitted versions accompanying this report.

1.5 After submitting the plan on 28 June, we received some comments from the regional panel established by NHS England to assure the plans. These requested further detail on some points. The attached version includes this further detail, which does not change the substance of the plan or the planned allocation of expenditure. NHS England expect to issue letters confirming approval of plans by 8 September.

1.6 The submitted plans are in principle two-year plans, though some of the financial allocations to local areas are said to be provisional, so the expenditure plans for the second year are at this stage only indicative. Planning guidance also states that the Department of Health and Social Care may revise the conditions attached to the Discharge Fund for 2023/24 after analysing information about the use of discharge funding allocated in 2022/23. It is not clear what (if any) further planning documents may be required during the two-year period.

2. The process for Board sign-off

2.1 Planning guidance for the BCF requires that plans are signed off by or on behalf of the Health and Wellbeing Board. However in practice timetabling issues have generally meant that it has not been practicable to present a near final version of the BCF plan to the Board for sign off – and NHS England's BCF planning template reflects this by asking whether the Plan has been signed off yet at the date of submission, and requiring confirmation that it has received Board sign-off afterwards if not. Slightly different approaches have in practice been adopted in different years, depending in part on whether there are any substantially new elements in the Plan. In some years plans have been signed off by the Chair of the Board or by the responsible Executive Director; in other years a Board meeting has been asked to sign them off.

2.2 The second recommendation in this report is intended to formalise the position and ensure that the Board has adequate oversight of our joint plans.

IMPLICATIONS ARISING OUT OF THE REPORT

Policy	The plan support the council's long-standing policy of aiming to ensure that people do not have to stay in hospital when they no longer need to be there because no suitable community support is available for them.
Finance and value for money	BCF income and expenditure formed part of the Council's budget adopted in February.
Legal	There is a formal partnership agreement between the Council and the ICB under Section 75 of the NHS Act 2006 covering the joint arrangements for the use of BCF funding, which will be updated as necessary.
Procurement	Most Council expenditure on commissioned services included in the BCF plan will be within the terms of existing contracts. Any commissioned services outside those terms will be procured in line with the Council's usual processes.
Human Resources	No direct implications have been identified.
Property	No implications.
Equalities (Impact Assessment attached) Yes ☐ No ☒ N/A ☐	Equality issues will be considered as part of individual assessments when arranging care and support services.

Risk Assessment	No risks specifically linked to the use of BCF funding have been identified.
Crime & Disorder	No implications have been identified.
Customer Considerations	Services funded through the BCF provide vital support for ill and disabled people.
Carbon reduction	No direct implications have been identified.
Health and wellbeing	Services funded through the BCF support ill and disabled people to live well.
Wards	All

BACKGROUND PAPERS

There are no background documents for this report within the meaning of the Local Government (Access to Information) Act 1985.

Report sign off.

Authors must ensure that officers and members have agreed the content of the report.

	Full name of officer
Monitoring Officer/Legal	Stephen Gerrard
Executive Director of Finance & S151 Officer	Jan Willis
Executive Director	Neil Bradley
Chief Executive	
Portfolio Holder(s)	Wendy Pattison

Author and contact details

Report Author: Stephen Corlett – Senior Manager (Policy)
Phone: (01670) 62 3637
Email: Stephen.Corlett@northumberland.gov.uk

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BCF narrative plan – Northumberland

Cover

Health and Wellbeing Board(s).

Northumberland.

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

Via our System Transformation Board, partners from the social care, local acute trust, mental health care trust, ambulance services, Healthwatch (VCS) and primary care.

How have you gone about involving these stakeholders?

The key stakeholders are directly involved in planning the health and social care for our Northumberland system through our System Transformation Board (STB).

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Our System Transformation Board (STB) acts as the main vehicle to monitor the performance of key metrics including those set by the BCF and ensures delivery of the objectives. Through the close working relationships between health and care partners, our integration plans are put in place and delivered. To monitor newly identified metrics, agreement has been reached with system partners to meet on a quarterly basis to monitor and put in place corrective action where required. Ultimately the STB holds stakeholders to account for delivery and transformation. The integrated working relationships are key to ensuring successful delivery of our plans. The STB reports to the Northumberland Health & Wellbeing Board.

Executive summary

The priorities for Better Care Fund have been to jointly agree a plan between local health and social care commissioners which ensures NHS contributions to adult social care is maintained in line with ICB allocations, continue the investment in NHS commissioned out of hospital services and continue to improve outcomes for those people being discharged from hospital.

In line with national guidance, our local focus now includes ensuring continued ring fenced investment in NHS commissioned out of hospital services. Northumberland continues to meet the requirement to invest over and above the required minimum contribution to support care in the community. This investment supports discharge pathways and admission avoidance through community facing assets.

The Northumberland system is addressing inequalities through targeted work looking to address inequalities across the system. The work is looking to address both the underlying inequalities in the area and the ways in which those have been exacerbated by the COVID19 pandemic. A comprehensive action plan is in place and works in conjunction with the BCF planning requirements.

Development of the plan has included the close working and involvement through priority setting work with local partners, including providers, VCS representatives, and locality authority leads (including house and DFG leads).

This plan continues to build on the integration approach the Northumberland has followed with previous iterations of the BCF plan.

National Condition 1: Overall BCF plan and approach to integration

Northumberland has a long history of close integration between health and social care, though the organisational framework for this has changed a number of times over the past three decades in response to national reorganisations of the NHS, mergers of local NHS organisations, and changes in the preferred models for joint working adopted by NHS organisations. Currently, in addition to the mandated BCF partnership arrangement between the council and the ICB there is a separate section 75 partnership between the Council and the ICB (originally entered into with Northumberland Clinical Commissioning Group) under which the Council has operational responsibility for commissioning of continuing healthcare (CHC) and mental health after-care services from independent sector providers, and for case management and financial processing for CHC. Benefits of this partnership include seamless transitions when people's eligibility changes to a different funding source, and economies of scale in commissioning, financial processing and the arrangement and monitoring of personal health budgets and personal budgets for social care.

Since 2021, there have been no formal partnership agreements between the Council and NHS providers. But following the ending in October 2021 of the previous partnership between Council and Northumbria Healthcare NHS FT, under which most operational statutory adult social care functions of the Council were performed by staff employed by Northumbria, the Council has been focusing on developing closer joint working arrangements with GP practices and primary care networks, and with mental health services operated by the Cumbria, Northumberland Tyne and Wear (CNTW) NHS FT, as well as aiming to maintain joint arrangements with Northumbria Healthcare, particularly to support hospital discharge.

In line with this change of focus, the adult social care community teams responsible for assessment and care coordination were reorganised in April 2022 into "care and support" teams, which work with people whose main contact with NHS community services is likely to be with primary care and community nursing; and specialist teams, which work with people whose primary contact with NHS professionals is likely to be with CNTW specialist services, such as community mental health teams, learning disability services, or substance misuse services. The Council continues to operate a "HomeSafe" team based in Northumbria Healthcare's acute hospitals, whose primary function is to ensure that urgent arrangements are in place to enable people to leave hospital once they are medically fit.

These changes have been made working closely with the "Place" team for Northumberland in the ICB, to ensure that the commissioning of community NHS services supports the integration of operational activity.

Because of our broader joint relationship, we see the Better Care Fund as one element in the wider financial framework within which we operate, rather than as funding for a distinct

set of joint programme. Our shared priorities for our "Place" for 2023-25 therefore extend beyond the schemes specifically funded through the BCF. They are:

- To review the impact of the creation of "care and support" teams, and explore the potential for further steps towards closer integration between these teams and primary care
- To continue discussions between the Council, CNTW and the ICB about closer integration of community mental health and learning disability services, including improvements to after-care planning under section 117 of the Mental Health Act
- To address current workforce capacity issues in home care services as a result of which we are currently not always able to make timely arrangements to support people in their own homes
- To continue to work together to address issues for care homes with nursing arising from current capacity issues in the nursing workforce
- To improve the availability of care home accommodation which offers skilled and person-centred support for older people who, as a consequence of dementia, are behaving in ways which create potential risks to other residents and to care staff
- To work together to further develop models for urgent community response which will provide alternatives to hospital admission, aiming to achieve the national target of two-hour urgent response. Because of the geography of Northumberland, it is unlikely that the best solution will be to adopt a standard model across the County.
- To support the development of a range of attractive housing options for older people with potential care and support needs, designed and located with the aim of maximising their independence
- To continue to develop the network of public sector initiatives working to support the many local community and voluntary organisations which support the health and well-being of the county's residents, and to guide individuals towards local organisations that can help them
- To work together across all services and with as wide as possible a range of other partners to take forward the commitments set out in the Northumberland Inequalities Plan 2022-2032

With regard to funding elements to support the initiatives, investment is expected to support improvements within the identified metrics. The further detail includes:

- Spending on the 2 Hour Urgent Community Response - which will increase the resources available to the existing services. This will support the capacity in our system to avoid the unnecessary conveyance to hospital for a range of issues including falls. It is expected this will in part support improvement in the falls metric.
- A scheme set up to support the Voluntary and Care Sector – allowing organisations to submit bids for additional fund which support Population Health Management and address health inequality issues. This process is already underway and organisations across Northumberland have submitted a variety of bids which will look to positively support our communities.
- Support to Primary Care Population Health Management projects – support to allow projects which address locally identified population health management projects via our Primary Care Networks is in place. This is now in the second year of running with significant positive feedback received and a variety of projects which look to support the integration agenda.
- Support to the community nursing service – this scheme funds part of the nursing service which is an integral part in delivering both proactive and reactive care to support our residents to remain at home for longer.

- Pulmonary rehabilitation service support – this is a key part of focus to support our residents with respiratory issues. It delivers both virtual and face to face support programmes in a group setting. It continues to receive positive feedback from those who have accessed the service. This is an example of supporting the delivery of the Core20Plus5 agenda.
- Supporting Community Hospitals – our community hospitals which are located across Haltwhistle, Alnwick, Berwick and Blyth are seen as an essential part of supporting flow across our system. They support rehabilitation in community bed setting. The community hospitals support the discharge process. Due to the geographical nature of Northumberland, the community hospital sites are placed in areas which allow placement closer to patient homes and support timely discharge.

Most of the BCF funding available in 2023-2025 is already committed to maintaining the core social care and community health services which are the essential foundation on which all of these priorities depend. New developments will primarily be funded through the Discharge Support Fund, the Market Sustainability and Improvement Grant which the Council has been allocated by the Government and core NHS and local authority budgets. Volumes of activity funded from the main BCF programme will in general be lower in 2023/24 than in the previous year, because unit costs have risen by more than the 5.66% increase in BCF funding, as a result of increases to minimum wage levels and other cost inflation, and the maintenance of these core services will have to be further supported from other revenue.

National Condition 2: Enabling people to stay well, safe and independent at home for longer

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home.

Our overall approach is described above. Our plans in relation to the specific issues about which the template asks for further information are as follows.

Personalised care and "asset based" approaches

Arrangements for personal health budgets and personal budgets for social care have been harmonised in Northumberland. A standard assessment format used across all funding streams (CHC, section 117 after-care, and social care) includes an indicative personal budget/personal health budget to give the person a starting point for considering whether they would prefer to make their own care and support arrangements independently (but can be adjusted by agreement if it becomes apparent that the actual costs of support are good reasons higher than the indicative budget).

A single direct payments support team based in the Council provides advice and practical assistance to people who choose to manage the money themselves through a direct payment, regardless of the funding stream. Clinical advice about proposed plans can be accessed through the ICB, which is also able under the partnership agreement between the ICB and the Council to audit the clinical appropriateness and value for money of all individual arrangements, including arrangements where the personal health budget is "notional" or is held by a third party. The Council's corporate improvement plans for this year include a review of direct payment arrangements, which will also involve the ICB.

The Council teams which coordinate care planning are expected always to start from the outcomes which the person wants to achieve in their daily life, and to consider how all of the resources available to them in their family and social networks and their local community could contribute to achieving those outcomes, rather than framing assessments as a

mechanism for assessing eligibility for a defined list of formal health and social care services. We are currently considering how to offer staff further support in developing the skills and confidence to work in this way routinely.

Population health management, and proactive care

The Northumberland system has a collaborative approach to ensuring proactive care is delivered to our residents using a Population Health Management (PHM) approach. Northumberland has developed the PHM approach using a three step process; developing the correct Infrastructure, ensuring the Intelligence is available to make informed decisions, and building evidence based Interventions which are locally tailored.

This approach has been adopted after several successful pilot projects including the development of a comprehensive update to the Northumberland Palliative and End of Life strategy. This demonstrated the value in ensuring stakeholders are involved at the beginning of pathway developments or changes, involvement of the analytical capacity, ensuring that all data is considered as part development including engagement with local populations by working with independent agencies such as Healthwatch, and reaching a consensus on appropriate evidence-based interventions.

Northumberland has now several subgroups of STB which use the PHM approach to ensuring proactive care is at the forefront of service development. This includes the Community Collaborative Group (CCG) which performs a vital role in discussing and progressing issues surrounding our community services across our Northumberland integrated Neighbourhoods. This includes development of vital services to prevent hospital admission and ensure care is proactively administered to residents. The CCG group includes a range of stakeholders from across the health and care system with appropriately level of decision making ability. To date they have supported development of the 2 hour urgent community response service, the virtual ward introduction and operation of community services.

The virtual ward programme is continuing to progress well with an expansion inline with the national requirements. A project management structure has been implemented with regular reporting to all stakeholders and has support implementation processes. This includes share learning with our regional partner organisations. The virtual ward programme covers several specialty areas including Respiratory, Frailty, Surgery, Cardiology and General Medicine. The learning from specialties further ahead with virtual ward implementation such as respiratory has been used to support colleagues all clinical areas. Further significant increases in capacity are planned for December 2023 which is expected to support patients to remain at home in the busy winter period.

Another good example of the proactive PHM approach Northumberland utilises is through the Care Home Collaborative. This group was initiated during COVID pandemic and now meets on a regular basis to discuss and proactively improve care provision for our most vulnerable groups in a care home setting. This group ensures that national policy is adhered to including the Enhanced Care in Care Home Framework which is a key component to ensuring high quality care. This is a multidisciplinary group who come together to share expertise and learn across our system. A recent example of a piece of work was the pilot of a falls check list to capture care home views by self-assessment and provide additional support for falls prevention where required.

Multidisciplinary teams at place or neighbourhood level

The Council's approach to aligning its frontline staff with primary health care teams and specialist community teams in areas such as mental health and learning disability is described above. The Council's expectation since this approach was adopted in 2019 has been that where opportunities are available these frontline teams will be co-located with the

health professionals who work with the same people, which might include placing social care staff in primary care premises or in office accommodation shared with CNTW. We intend to explore further during 2023 the extent to which changes in working practices stimulated or accelerated by the pandemic may affect either the benefits of co-location or the opportunities to achieve it.

PCNs in Northumberland have a more complex geography than originally envisaged, and the model for developing integrated working will incorporate some adjustments to the Fuller Stocktake model to take account of the fact that some PCNs do not cover a single geographical neighbourhood, and that the diverse geography of Northumberland requires differing arrangements in different parts of the county. Our aim is to align the Council's care and support teams as closely as possible with the patient lists of an identifiable group of GP practices, to maximise the opportunities to develop close relationships between professionals working to support the same people. For the same reasons, CNTW have not found it practicable to align all mental health services with PCNs, and the council is currently considering whether its community mental health teams should be aligned with the localities around which CNTW organises services. However the general principles of the Fuller recommendations will shape future arrangements.

Our approach to support for unpaid carers, and to housing adaptations, and other housing initiatives is explained elsewhere in this plan.

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community.

Estimates are based on recent experience. As with capacity to support discharge, the key current issue is workforce capacity in home care, which we hope will improve during the year as a result of initiatives described below.

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- **unplanned admissions to hospital for chronic ambulatory care sensitive conditions**
- **emergency hospital admissions following a fall for people over the age of 65**
- **the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

Unplanned admissions for chronic ambulatory-care sensitive conditions

Northumberland continues to develop a state of the art response to emergency medicines using the Northumbria Specialist Emergency Care Hospital, Base Sites and Community hospitals to provide a consistent, robust approach to supporting chronic ambulatory care sensitive conditions. The use of integrated teams across the community and acute sector enables this approach to support patients in the most appropriate setting.

Admissions following a fall

Northumberland continues to focus on falls for those over the age of 65. This takes the form of reactive and proactive services to ensure residents are supported appropriately in relation to falls. A mapping exercise is currently underway to understand the way each supporting service approaches falls and to ensure consistency across services in response to a fall. This includes working with partner organisations who may come into contact with individuals at risk of falls to ensure appropriate measures are put in place to prevent falls. The 2 hour urgent community response service is seen as the centre piece to reactive model once a

falls has occurred. This service, where possible, will avoid residents unnecessarily being taken to hospital as a result of a fall and instead, being supported to remain in the community. Due to Northumberland's geography, response to falls is something which is challenging and the approach taken is to develop existing services rather than develop new services which may struggle to recruit due to the limited workforce available across the patch.

Long-term admissions of older people to care homes

It remains the Council's objective to explore alternatives to care home admission wherever those are reasonably available. In recent years patterns of admissions have been affected by Covid, and it is still not entirely clear whether that continues to affect the numbers. There is also some risk that current capacity issues in home care could lead to an increase in the number of older people who become permanent care home residents, and this is one reason for the Council's proposal to invest substantially in improved terms and conditions for home care workers from the Market Sustainability and Improvement Fund.

Given the reasons for uncertainty, the short-term target in the plan is based on maintaining the existing level of admissions to care homes, which would imply a modest reduction in the rate per head of population. However it remains our objective to further develop both community services and housing options which reduce the need for older people to move into a care home.

National Condition 3: Provide the right care in the right place at the right time

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge

In Northumberland a substantial proportion of available BCF funding has always been allocated to maintaining the level of core community-based services, and this will continue. Under a partnership arrangement agreed with the former Clinical Commissioning Group in 2013, and now transferred to the ICB, all commissioning of independent sector care services to support people eligible for NHS continuing healthcare or for after-care under section 117 of the Mental Health Act has been delegated to the Council, simplifying relationships with providers and ensuring a consistent approach across the local system.

A significant current obstacle to providing the right care in the right place at the right time is that since summer 2021 there have consistently at any one time been around 200 people who have been assessed as needing care and support, with care in their own homes as the right way to provide that, but who are currently not receiving home care because there is insufficient capacity in homecare providers. Regrettably, in some cases, it has been necessary to arrange short-term care home placements until a home care service can be sourced. In some cases, this is also leading to delays in arranging discharge from hospital, though overall levels of discharge delay remain low by national standards.

The Council will be using separate grant funding to further increase the fees paid to home care providers, and improve the terms and conditions of home care workers, with the aim of addressing the recruitment and retention issues which are causing current capacity problems. Some care providers in Northumberland are also now making use of care staff recruited from overseas using the Government's visa scheme, and there are early signs that this is leading to some reduction in the number of care packages which cannot immediately be sourced.

Our plans for the use of discharge funding prioritise flexible responses to the obstacles which can stand in the way of patients leaving hospital to return home or to find care home accommodation which can meet their needs.

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital.

Estimates of demand are primarily based on experience over the past year. Currently the major capacity issue we are facing is in the home care workforce – since summer 2021 we have had an unprecedented number of people for whom we are unable immediately to arrange the home care which they have been assessed as needing – the figure has fluctuated but generally been of the order of 200 people, including patients in hospital. The Council is planning to invest substantially in home care during 2023/24 and 2024/25 from the Market Sustainability and Improvement Fund, with the aim of making employment in the sector more attractive, and the capacity projections incorporate an estimate of the impact that we hope this will have on discharge capacity by the winter months. While the Council's initiatives are being not being funded through the BCF, they form part of an integrated overall approach to addressing the key priorities for heath and social care. The main elements of the Council's plans for the home care workforce are:

- A scheme introduced from the beginning of winter 2023/24 offering additional funding to home care providers in return for a commitment to pay home care workers at least the maximum tax-free rate of mileage payments approved by HMRC of 45p per mile. This was developed in response to feedback from providers that, because of increases in fuel costs, home care workers who are required to drive to visit clients, particularly in rural areas, were finding that the increased costs of this were leaving them out of pocket
- A further scheme implemented from July 2023, offering homecare providers funding to pay home care workers a minimum rate of £12 per hour – 10% above the "Real Living Wage", and more than 20% above the mandatory National Living Wage
- Another initiative scheduled to be introduced from October 2023, which will extend additional financial support further, linked to commitments to address some of the other key concerns of home care workers, such as fluctuating income.

Capacity in bed-based intermediate care will also be increased with support from the ICB element of the Discharge Fund. Over the winter period, additional intermediate care beds will be opened to support the expected increase in demand over this more pressured time. This will complement the existing intermediate bed capacity already available in the system. It will support hospital discharge and wrap around support from community teams. The capacity and demand tab with in the planning template reflects this with increasing Pathway 2 Demand and associated capacity from December 2023 onwards.

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metric: Discharge to usual place of residence

The local authority element of the Discharge Fund will be used to support a range of schemes aimed at ensuring that people receive the right care in the right place at the right time.

The majority of the local authority element will be used to ensure that funding is available to support rapid discharge on each of the key discharge pathways. We have shown this in the expenditure plan as four separate schemes based on our current estimate of how the funding will be allocated between different forms of support, but these schemes will be managed together to ensure that the overall funding available is used in the most effective way to achieve the underlying objective.

Some of the funding will be used to meet the costs of individual care packages to support patients after discharge, and to continue innovative models for home care introduced during winter 2022/23 with funding from the Adult Social Care Discharge Fund (though we will review during the year how well those new models are working, and how they relate to the wider changes in our home care commissioning arrangements). We are also exploring with providers a number of further initiatives potentially funded from these budgets, which we would expect to introduce in advance of the period of maximum winter pressures, including:

- Further exploration of ways in which we can support care homes to adjust their staffing rapidly to enable them to accept at short notice a patient ready for discharge from hospital. A pilot scheme established using the winter 2022/23 Discharge Fund was less successful than we hoped; we are discussing with care home operators suggestions they have made about why this was and what might work better. One issue raised by care homes is the disruption and cost caused when they bring in extra staff at short notice to be able to accommodate a discharged patient but the discharge is then delayed because of issues arising in the hospital or patient transport issues. We are discussing with them whether there is a case for guaranteeing reimbursement of extra costs in that situation.
- Changes to an existing scheme under which premium fees are paid for care home residents whose dementia is resulting in behaviour which care homes find difficult to manage without some additional staffing.

Finding appropriate discharge arrangements is often particularly difficult for those patients whose dementia causes them to have episodes of extreme confusion or anxiety during which their behaviour becomes a risk to themselves, other patients, or staff. In addition to exploring changes to the scheme providing additional financial support to any care home accommodating residents in that category, an element of the Discharge Fund will be used to support a separate scheme based on a block booking of 12 beds in a care home with specific expertise in supporting older people in this category. The intention is that this care home will be able to accept patients at the point of discharge, working with them to reduce their anxiety and establish effective plans for managing their behaviour, with the expectation that they will then be able to move on to a care home closer to their family or local community.

More generally, we expect there to be some improvement in the discharge to usual place of residence metric over time as a consequence of the enhancements to the terms and conditions of home care workers which are being funded from the Market Sustainability and Improvement Fund. Because inflationary increases to the cost of care services are this year greater than the increase in the NHS minimum contribution to the local authority, we will not be able to fund increased activity from the BCF, except for activity supported through the Discharge Fund element.

As the BCF team in NHS England is aware, the metric in use is interpreted differently by different NHS trusts, because of ambiguities in the definition of what counts as a person's "usual place of residence". The interpretation of this metric by Northumbria healthcare, the main acute trust serving Northumberland, which appears to us to be a reasonable interpretation of the specification in the NHS data dictionary, *excludes* from this category discharges of a patient who was already a care home resident before admission and who returns to the same care home on discharge. Our understanding is that the majority of NHS trusts nationally code discharges of this kind as being to the person's usual place of residence. As a result Northumberland's measured performance on this indicator is expected to remain significantly below average unless national steps are taken to ensure more consistent interpretation of the definition, but we do not think that this reflects below average performance,

though for reasons explained above we are currently less able than we would wish to be to arrange homecare services as soon as a patient is medically ready to leave hospital.

Set out progress in COVID is showing that seven-day working, weekend working and extended hours for services across health and social care can deliver improved flow of people through the system. This is successful, however, only if it is applied to all services including clinical decision-making and practical support services, including innovative use of virtual delivery. **implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.**

Since the ICB inception, a state of the art model has been developed to ensure delivery of the High Impact Change Model is in place. This uses a whole system approach to ensure best practice is shared and we achieve a resilient system across the NENC region. The nine core elements of the model are what leads this model including early discharge planning, monitoring demand & capacity, MDT working, using a home first approach, trusted assessor model, engagement and choice, ensuring effective care home discharge.

A ICB Director for System Resilience is now in place who plays a coordination role across the NENC system. Alongside this, there is now a well established data hub which receives daily updates from all community and acute providers across NENC, and compiles this in central repository which can be viewed via an iPhone App. This gives an almost real time view of system activity and allows the Resilience leads alongside Place leads to consider how to support organisations across the system, for example by organising mutual aid or diverting activity where necessary.

During the extremely busy winter period 22/23, daily discharge meetings were stepped up with a lead from each Place area taking part. This allowed each Place to highlight the issues they were experiencing and quickly develop pragmatic system solutions. For Northumberland, this highlighted the strength we have in having individuals with shared health and care roles in being able to pin point data and quickly put in place local solutions developed by the operational leads on the ground. The operational leads who are committed to making our system work with health and care worker are what continues to make the Northumberland system successful. The discharge meetings continue to be held but on a less frequent basis, this gives the opportunity to touch base and ensures that pressures are swiftly known and able to be resolved.

A Discharge Summit event was held with all stakeholders from across the system invited. It gave an opportunity to learn from across the wider system with both national and international models explored. This event was well attended and allowed stakeholders to come together to reflect on the recent system pressures and develop new ways of working. Although the summit was virtual, Northumberland stakeholders all convened at a central Northumberland location and this gave an opportunity to further develop relationships at local level. This continued strive to work in partnership, regardless of organisational structure and boundaries, is something which Northumberland is significantly proud of.

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The minimum BCF transfer to the local authority from the ICB and the iBCF funding continue to be used primarily to support core social care services, which are required in order to meet the local authority's duties under the Care Act. Since the Care Act maintains the principles of the previous statutory framework, in which the primary statutory duty of the local authority is to meet individual needs on the basis of personalised assessments, BCF funding is used to ensure, so far as possible, that there continues to be adequate capacity in social care services to meet all the eligible assessed needs of both people with care and support needs and carers.

In 2023/24, the capacity and sustainability of services will also be supported by expenditure from the Market Sustainability and Improvement Fund, the largest part of which is being used in Northumberland to support a substantial increase in the rates paid to home care providers, linked to increased expectations about the rates of pay and other terms and conditions of home care workers, aiming to put an end to the situation which has existed since summer 2021 where at any one time there have been of the order of 200 people who have been assessed as having eligible needs which would best be met by arranging care in their own homes, but whose needs no available home care provider immediately has the capacity to be able to meet.

The Discharge Fund will also enable us to adopt flexible ways to meet the local authority's Care Act duties towards people leaving hospital.

Supporting unpaid carers:

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Within the partnership arrangements between the ICB (formerly the Clinical Commissioning Group) and the Council for NHS CHC, a consistent approach has been adopted to supporting carers, whichever funding stream is involved. Carers' needs are considered as an integral part of needs assessments and care and support planning, and whichever funding stream supports the person with care needs also covers support for the person's carer(s), with the principles in the Care Act being used as guidance when considering the needs of the carer(s) of people funded through CHC. The ICB's financial commitment to this is reflected in the BCF plan. This ensures that that the needs of the person and their carer(s) can be considered as a whole, recognising that in most cases the form of support that matters most to carers is a plan for the person they care for which takes full account of their own need to be able to balance caring with other aspects of their lives.

Services provided to the cared-for person which are particularly important for carers, whatever the funding stream, include

- short breaks, including traditional short stays in a care home and more flexible arrangements, often supported through direct payments
- day services and support to enable the person to engage in activities outside the home without their carer (we estimate that in about half of all cases the primary reason for these services is to provide relief for a carer)
- sitting services to ensure that the person is safe at home so that their carer can do other things

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

The grant funding to support DFGs which is incorporated within the Better Care Fund will continue to be used primarily to meet the costs of the statutory DFG scheme, now augmented by a discretionary scheme introduced in December 2020, which focuses in particular on making funding equivalent to DFGs available to support a move to more suitable accommodation, where this is a better solution; meeting additional costs where necessary adaptations cost more than £30,000; and providing additional financial support in circumstances where the statutory means test produces unacceptable outcomes. Surplus

grant funding not required for these purposes will continue to be used mainly to support other capital expenditure on accommodation for disabled people, though by agreement with the Place Director for Northumberland in the ICB it may also be used for some other social care capital schemes.

In recent years, there has consistently been funding from the grant available to support schemes over and above meeting all mandatory DFG applications. Since we do not yet know how the additional DFG funding announced for 2023/24 and 2024/25 will be allocated, and inflation has increased construction and related costs, we cannot be certain what the position will be in those years, but our planning assumption is that we will continue to have some scope for investment in other schemes. There are no waits for DFGs related to funding availability, and we have no reason to think that DFGs are significantly under-publicised.

The operation of DFGs and policy on use of the DFG grant element to support accessible accommodation outside the statutory scheme both sit within the adult social care directorate in Northumberland, which is a unitary authority, and the senior manager responsible for the operation of the DFG system is part of the adult social care senior management team which shapes the advice about strategic developments given to the Council. The Council's housing function has worked closely with adult social care and the ICB to develop extra care and supported housing schemes.

There is an existing joint strategy for extra care housing and supported accommodation, and the development of schemes within the strategy is jointly supported by housing, social care and health. Funding from the DFG grant not required to meet statutory DFG obligations and eligible needs and the local discretionary scheme has been used to create a fund which is available to provide support with the development of extra care and other accommodation based schemes. The Council's Market Position Statement covers housing and supported accommodation schemes funded both through social care and NHS funding streams, and has been developed in consultation with the Council's housing service. The Council provides an in-house telecare service.

Supporting the development of housing suitable for older people and others with disabling health conditions is a critical component in developing a community infrastructure which enables patients to return home from hospital safely and without delays.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

The discretionary policy is available if any of the situations described in the policy arises, funded from the same budget as mandatory DFGs; to date there has been no need to create a separate budget limit. The policy sets out three circumstances in which grants can be paid:

- to support someone to move to alternative more suitable housing, in cases where adapting the person's existing home would not be the best way to meet the person's needs, or would be impractical or unreasonably expensive

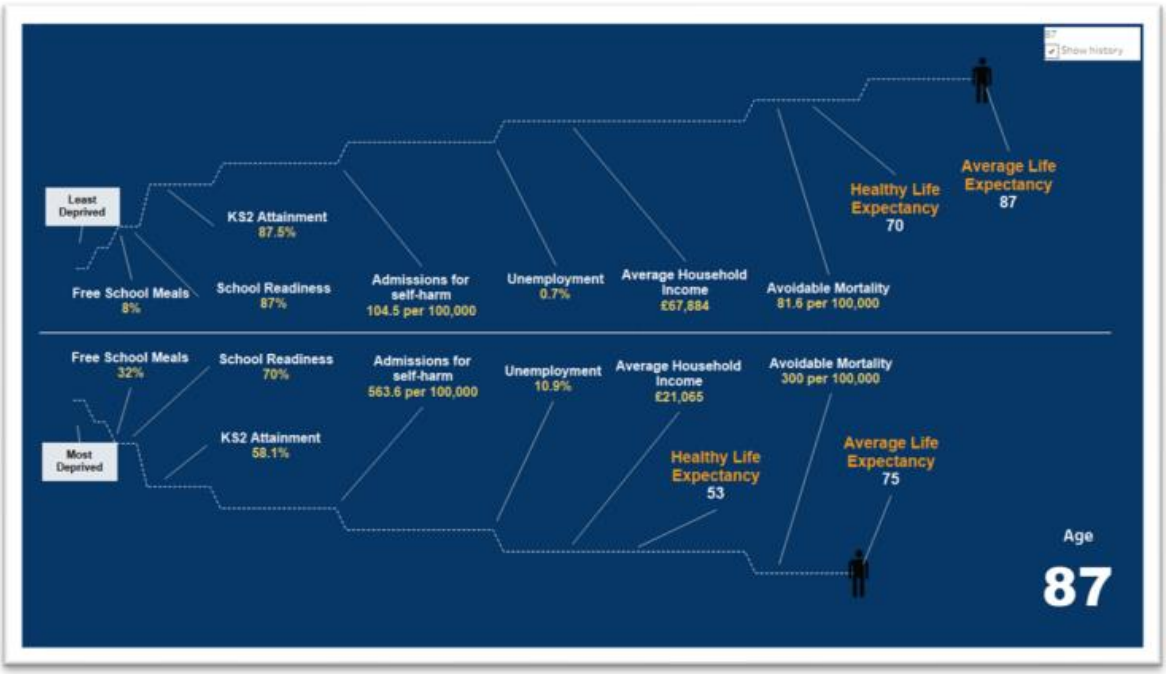
- to cover the extra cost of adaptations that a person needs which are more expensive than the nationally set limit on DFGs
- to provide additional support in special circumstances where the means test for a DFG would otherwise make it difficult or impossible for someone to afford adaptations which they need

Northumberland is a unitary local authority, so there is no district council structure in the area.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics?

Residents in our most deprived communities have an average life expectancy of 75 years compared to 87 years in the least deprived; 12 years more of life if you have the benefits that come with the lowest levels of deprivation. There is a 17-year age gap in good health (healthy life expectancy) between those living in the least deprived areas and those living in the most deprived communities; 70 years of living in good health compared to 53 years. Figure below shows the level of inequalities which exist across the life course for a range of indicators across Northumberland communities.



The context for our BCF Plan is set by the Northumberland Inequalities Plan, endorsed by the Health and Wellbeing Board and adopted by the Council in September 2022, which is available at www.tinyurl.com/Inequalities22. The Plan sets out a common purpose and ambition to reduce health, social and economic inequalities in Northumberland, based on a system-wide commitment to focus on a few key enablers which will support an improvement in a focused collection of short, medium and longer-term indicators which will demonstrate that inequalities are narrowing and outcomes for our residents are improving.

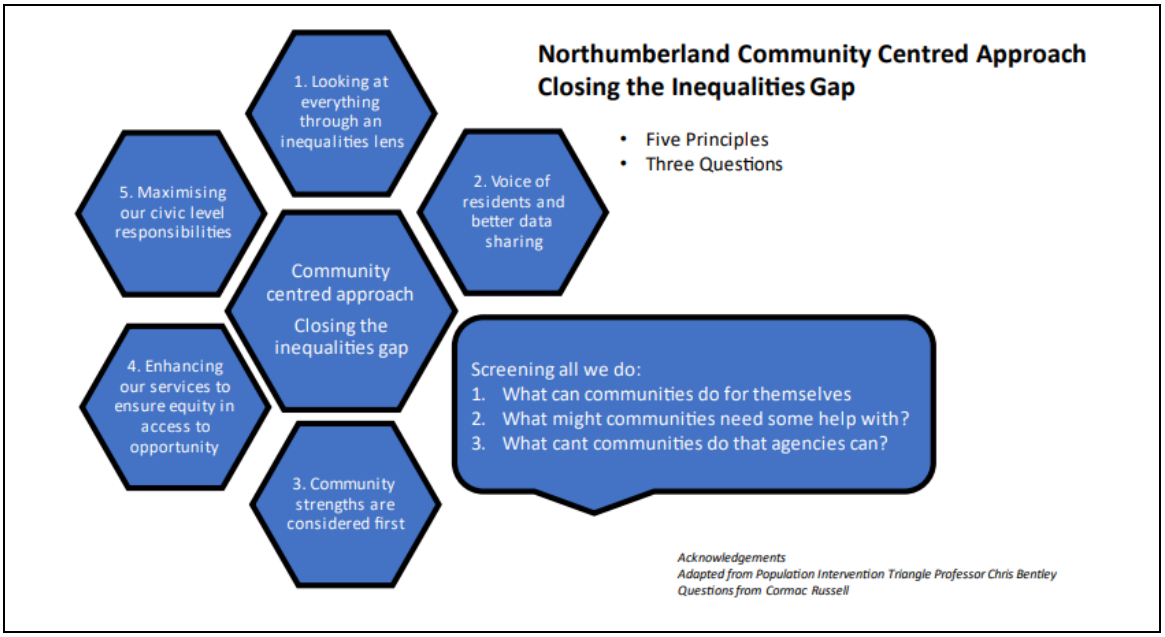
The plan drew on locality conversations in which almost 400 stakeholders such as VCSE, local staff from public sector, private sector (senior officers to front line) town and parish councils and, elected members participated.

The plan is based on five principles:

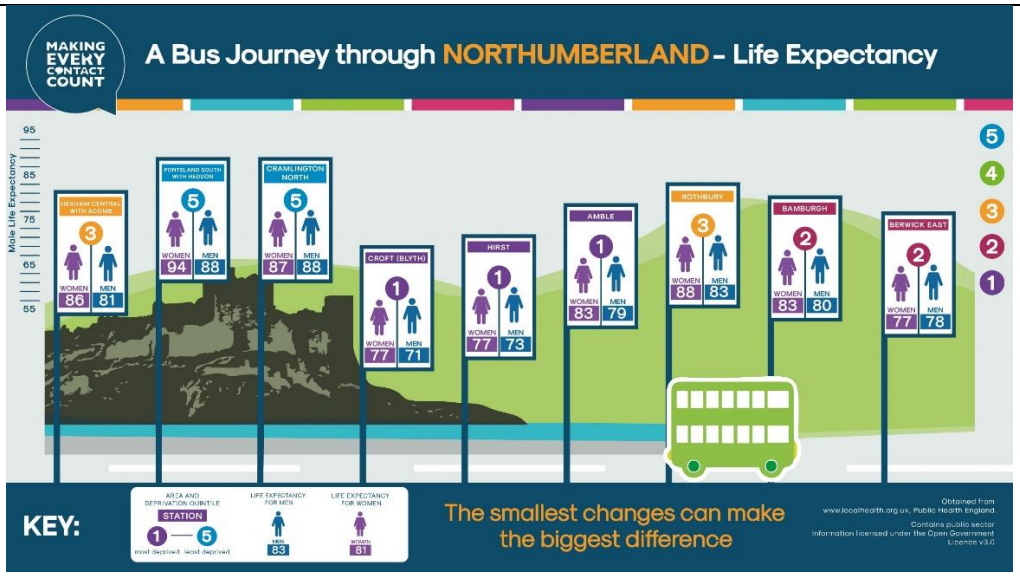
- Look at everything through an inequalities lens
- Voice of residents and better data sharing
- Community strengths are considered first
- Enhancing our services to ensure equity in access to opportunity
- Maximising our civic level responsibilities

All participating organisations have agreed to ask three screening questions in all we do:

- What can communities do for themselves?
- What do communities need some help with?
- What can't communities do (even with help from outside agencies) that agencies/institutions can do.



As the Northumberland Inequalities Plan was created from the ground up, it was not specifically developed using the NHS Core20Plus5 model however the general concept of focusing on the most deprived communities remains the same. The Northumberland Inequalities Plan is about reducing the inequalities for those who are at most need, namely the most deprived 20% of our communities. The bus journey map of life expectancy is reality check of the work we still have to do to address the inequalities work in the most deprived communities.



Equally, through the System Transformation Board, the 5 key clinical areas are something which the Board very much are the day to day focus in terms of addressing the inequalities. This includes comprehensive workplans for Maternity, Several Mental Illness, Respiratory Disease, Cancer Diagnosis and Hypertension Case Finding.

An example of some of the focused work includes:

- A Respiratory Collaborative group – this includes clinical colleagues, public health and commissioners who come together monthly to share national and local guidance, develop action plans and address the issues. This group has met for a number of years following development from the RightCare national focused group. The collaboration stretches across both Northumberland and North Tyneside areas which makes sense given sharing the same Acute trust. A recent example of working includes a specific communication developed by partners to support those patients at most risk of emergency admission during the winter period.
- Cancer Joint Working Group – system group has a comprehensive action plan and meets regular with a range of system partners including strong engagement with the voluntary and community sector partners.
- Smoking Cessation – working with regional colleagues, a comprehensive strategy is in place to support reduction in smoking cessation.
- Cardiology Collaborative – a group meets regularly with system partners including clinicians from primary and secondary care. This group includes focused working on projects to support lipid management.

Changes to the BCF plans have been screened for equality impacts. In most cases, funding will continue to be allocated to the same services as previously, and no new issues about differential impact based on protected characteristics are expected to arise. In general, almost all of the funding is expected to support disabled people.

Because most funding will be allocated to individuals based on individual assessments, it is expected that specific issues relating to protected characteristics will be taken into account during the assessments.

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Complete:
Health and Wellbeing Board:	Northumberland		Yes
Completed by:	Alan Bell		Yes
E-mail:	alanbell@nhs.net		Yes
Contact number:	1670335153		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Thu 10/08/2023	<< Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Paul	Ezhilchelvan	Paul.Ezhilchelvan@northumberland.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Levi	Buckley	levi.buckley@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Rachel	Mitcheson	r.mitcheson@nhs.net	Yes
	Local Authority Chief Executive		Helen	Paterson	Helen.Paterson@northumberland.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Neil	Bradley	neil.bradley@northumberland.gov.uk	Yes
	Better Care Fund Lead Official		Alan	Bell	alanbell@nhs.net	Yes
	LA Section 151 Officer		Jan	Willis	Jan.Willis@northumberland.gov.uk	Yes
Please add further area contacts that you would wish to be included in official correspondence e.g. housing						

or trusts that have been part of the process -->				

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Northumberland

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£3,328,942	£3,328,942	£3,328,942	£3,328,942	£0
Minimum NHS Contribution	£29,816,747	£31,504,374	£29,816,747	£31,504,374	£0
iBCF	£12,495,752	£12,495,752	£12,495,752	£12,495,752	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,751,885	£2,908,129	£1,751,885	£2,908,129	£0
ICB Discharge Funding	£1,126,691	£1,870,308	£1,126,690	£1,870,308	£1
Total	**£48,520,016**	**£52,107,505**	**£48,520,016**	**£52,107,505**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£8,473,074	£8,952,650
Planned spend	£10,326,026	£10,910,478

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£18,583,415	£19,635,236
Planned spend	£18,583,415	£19,635,236

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	240.0	238.0	283.0	249.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,891.0	2,763.1
	Count	2272	2248
	Population	82281	83799

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	86.9%	86.6%	87.0%	90.3%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	601	640

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Northumberland

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	We have given below the best indication that we can in this format of the current relationship between demand and capacity, but both the geography of Northumberland and the flexible way in which services operate mean that the kinds of calculation suggested in the guidance would not produce a meaningful picture, so we have supplied figures based on current activity levels. There is also currently an issue about the balance between home care capacity and care home capacity, which we hope to address by using most of this year's MSIF grant to fund a step change to home care workers' terms and conditions. At present some short-term care home placements are used to support people after discharge because home care cannot immediately be arranged. The 2UCR service is in the process of setting up a single	Complete:
		Yes
		Yes
		Yes
		Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	#	##	Sep-23	Oct-23
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	0	0	0	0	0
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	Reablement at home (pathway 1)	44	#	42	42	42
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		16	#	15	15	15
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	243	#	##	264	264

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	90	#	97	97	97
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		45	#	45	50	50
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	20	#	20	20	20
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		42	#	42	42	42
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	15	#	15	15	15
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		12	#	12	12	12
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	4	4	4	4	4
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		10	#	10	10	10
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		4	4	4	4	4
Totals	**Total:**	545	#	##	575	575

3.2 Demand - Community

Demand - Intermediate Care					
Service Type	**Apr-23**	**#**	**##**	**Sep-23**	**Oct-23**
Social support (including VCS)	0	0	0	0	0
Urgent Community Response	187	#	##	197	200
Reablement at home	59	#	57	57	57
Rehabilitation at home	325	#	##	342	342
Reablement in a bedded setting	0	0	0	0	0
Rehabilitation in a bedded setting	0	0	0	0	0
Other short-term social care	162	#	##	162	162

3.3 Capacity - Hospital Discharge

	Capacity - Hospital Discharge					
Service Area	**Metric**	**Apr-23**	**#**	**##**	**Sep-23**	**Oct-23**
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0
Reablement at Home	Monthly capacity. Number of new clients.	63	#	60	60	60
Rehabilitation at home	Monthly capacity. Number of new clients.	350	#	##	380	380
Short term domiciliary care	Monthly capacity. Number of new clients.	50	#	55	55	55
Reablement in a bedded setting	Monthly capacity. Number of new clients.	60	#	60	60	60
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	17	#	17	17	17
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	15	#	15	15	15

3.4 Capacity - Community

Capacity - Community						
Service Area	Metric	Apr-23	#	##	Sep-23	Oct-23
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0
Urgent Community Response	Monthly capacity. Number of new clients.	178	#	##	187	190
Reablement at Home	Monthly capacity. Number of new clients.	62	#	60	60	60
Rehabilitation at home	Monthly capacity. Number of new clients.	342	#	##	360	360
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0
Other short-term social care	Monthly capacity. Number of new clients.	170	#	##	170	170

Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	0	0	0	0
0	0	0	0	0
42	42	42	42	42
15	15	15	15	15
264	264	264	264	264

97	97	97	97	97
50	55	55	55	55
20	20	20	20	20
42	42	42	42	42
15	15	15	15	15
12	26	26	26	26
4	9	9	9	9
10	10	10	10	10
4	4	4	4	4
575	599	599	599	599

Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	0	0	0	0
200	310	320	320	320
57	57	57	57	57
342	342	342	342	342
0	0	0	0	0
0	20	20	20	20
162	162	162	162	162

Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	0	0	0	0
60	60	60	60	60
380	380	380	380	380
55	60	65	70	75
60	80	80	80	80
17	37	37	37	37
15	15	15	15	15

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint

Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	0	0	0	0
190	295	304	304	304
60	60	60	60	60
360	360	360	360	360
0	0	0	0	0
0	20	20	20	20
170	170	170	170	170

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint

97	97	97	97	97	97	97	97	97
47	47	50	50	50	55	55	55	55
20	20	20	20	20	20	20	20	20
42	42	42	42	42	42	42	42	42
15	15	15	15	15	15	15	15	15
12	12	12	12	12	26	26	26	26
4	4	4	4	4	9	9	9	9
10	10	10	10	10	10	10	10	10
4	4	4	4	4	4	4	4	4
572	572	575	575	575	599	599	599	599

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	0	0	0	0	0	0	0	0
197	197	197	200	200	310	320	320	320
57	57	57	57	57	57	57	57	57
342	342	342	342	342	342	342	342	342
0	0	0	0	0	0	0	0	0
0	0	0	0	0	20	20	20	20
162	162	162	162	162	162	162	162	162

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	0	0	0	0	0	0	0	0
60	60	60	60	60	60	60	60	60
380	380	380	380	380	380	380	380	380
55	55	55	55	55	60	65	70	75
60	60	60	60	60	80	80	80	80
17	17	17	17	17	37	37	37	37
15	15	15	15	15	15	15	15	15

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	0	0	0	0	0	0	0	0
187	187	187	190	190	295	304	304	304
60	60	60	60	60	60	60	60	60
360	360	360	360	360	360	360	360	360
0	0	0	0	0	0	0	0	0
0	0	0	0	0	20	20	20	20
170	170	170	170	170	170	170	170	170

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Northumberland

Complete:

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Northumberland	£3,328,942	£3,328,942
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£3,328,942**	**£3,328,942**

Yes

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Northumberland	£1,751,885	£2,908,129

Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS North East and North Cumbria ICB	£1,126,691	£1,870,308
Total ICB Discharge Fund Contribution	£1,126,691	£1,870,308

Yes

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Northumberland	£12,495,752	£12,495,752
Total iBCF Contribution	**£12,495,752**	**£12,495,752**

Yes

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding

Yes

Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North East and North Cumbria ICB	£29,816,747	£31,504,374
Total NHS Minimum Contribution	**£29,816,747**	**£31,504,374**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£29,816,747**	**£31,504,374**	

Yes

	2023-24	2024-25
Total BCF Pooled Budget	**£48,520,016**	**£52,107,505**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Northumberland

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£3,328,942	£3,328,942	£0	£3,328,942	£3,328,942	£0
Minimum NHS Contribution	£29,816,747	£29,816,747	£0	£31,504,374	£31,504,374	£0
iBCF	£12,495,752	£12,495,752	£0	£12,495,752	£12,495,752	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,751,885	£1,751,885	£0	£2,908,129	£2,908,129	£0
ICB Discharge Funding	£1,126,691	£1,126,690		£1,870,308	£1,870,308	£0
Total	**£48,520,016**	**£48,520,016**	**£0**	**£52,107,505**	**£52,107,505**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,473,074	£10,326,026	£0	£8,952,650	£10,910,478	£0
Adult Social Care services spend from the minimum ICB allocations	£18,583,415	£18,583,415	£0	£19,635,236	£19,635,236	£0

Checklist

Column complete:

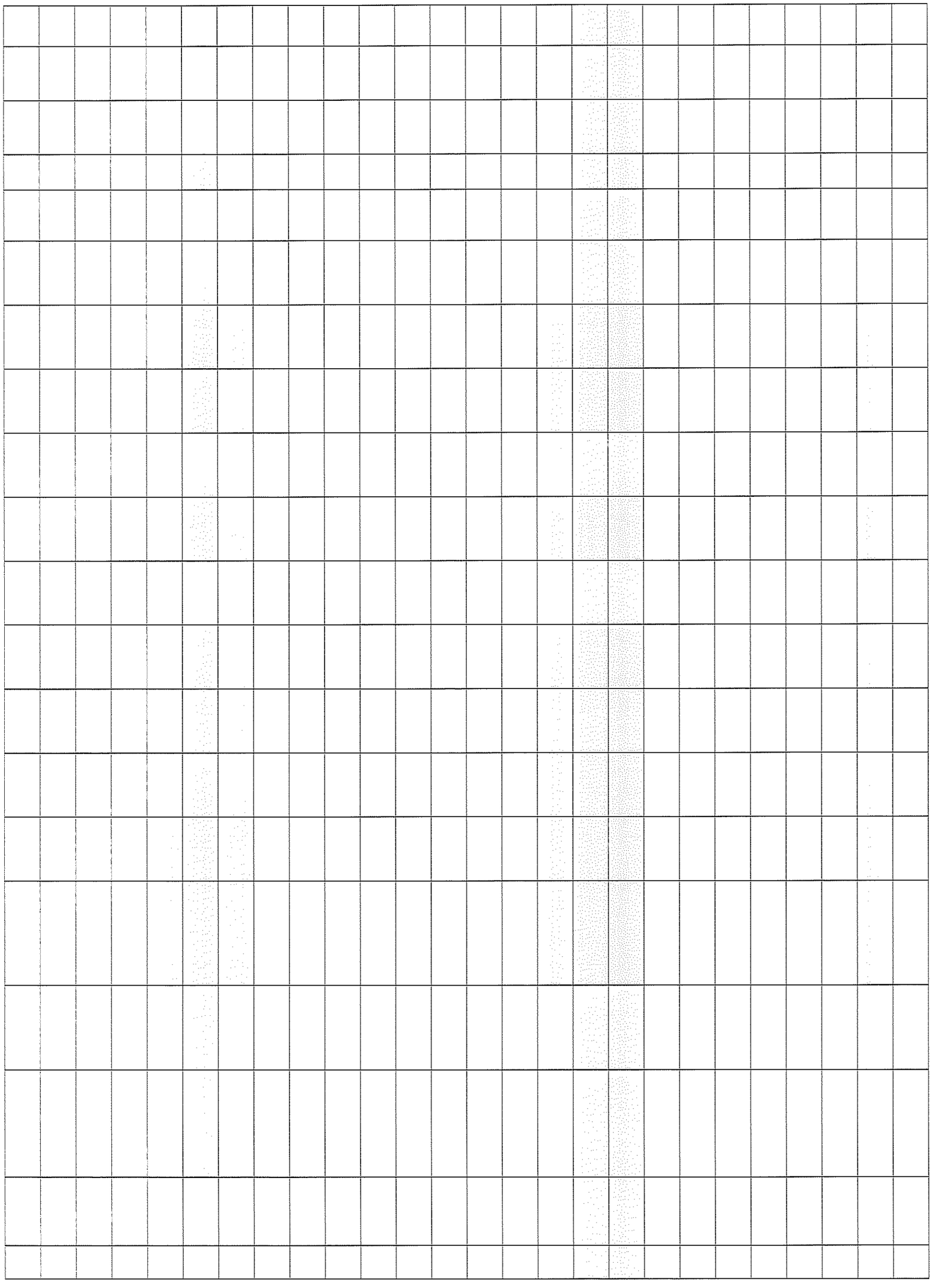
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

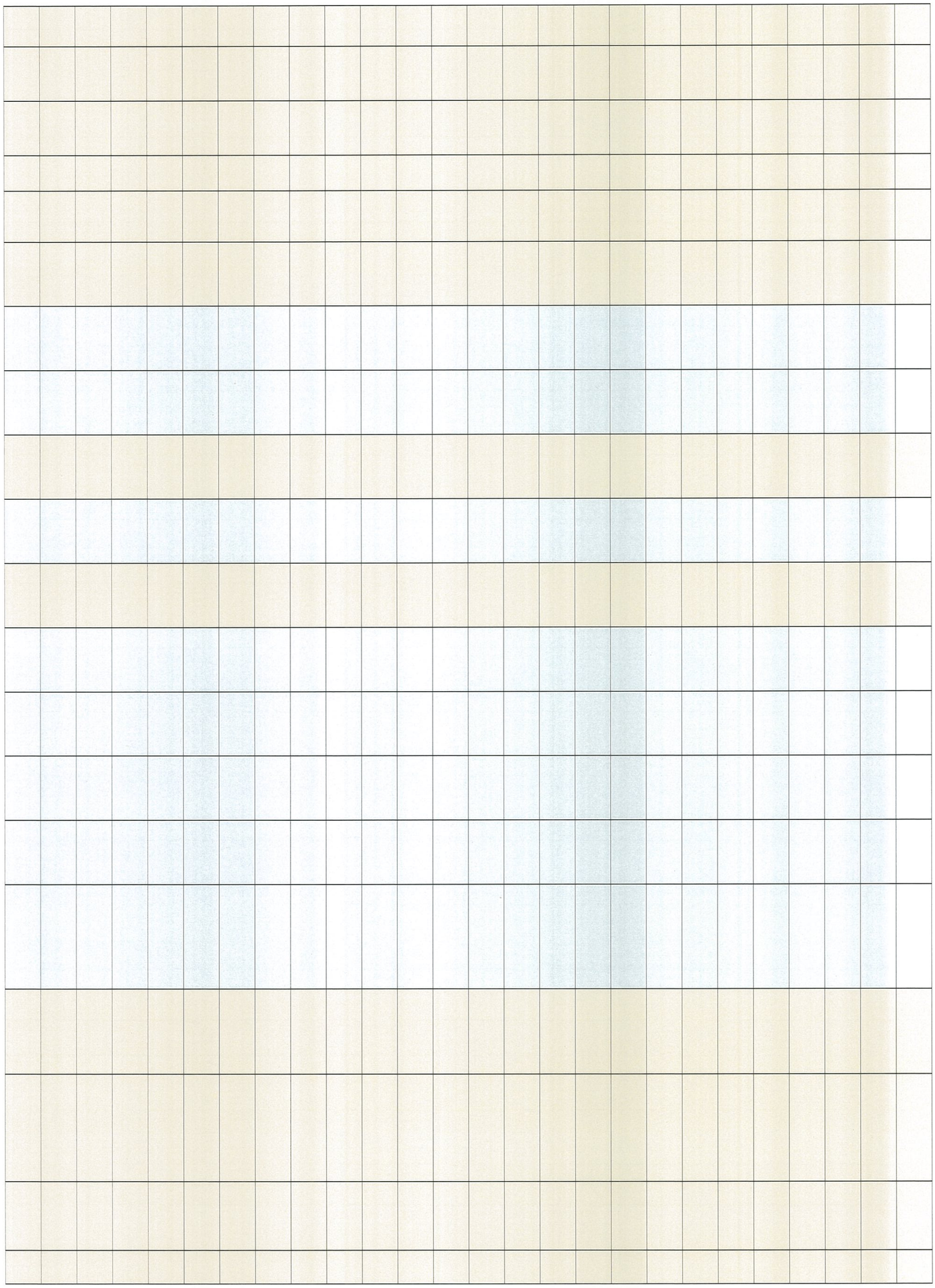
>> Incomplete fields on row number(s):

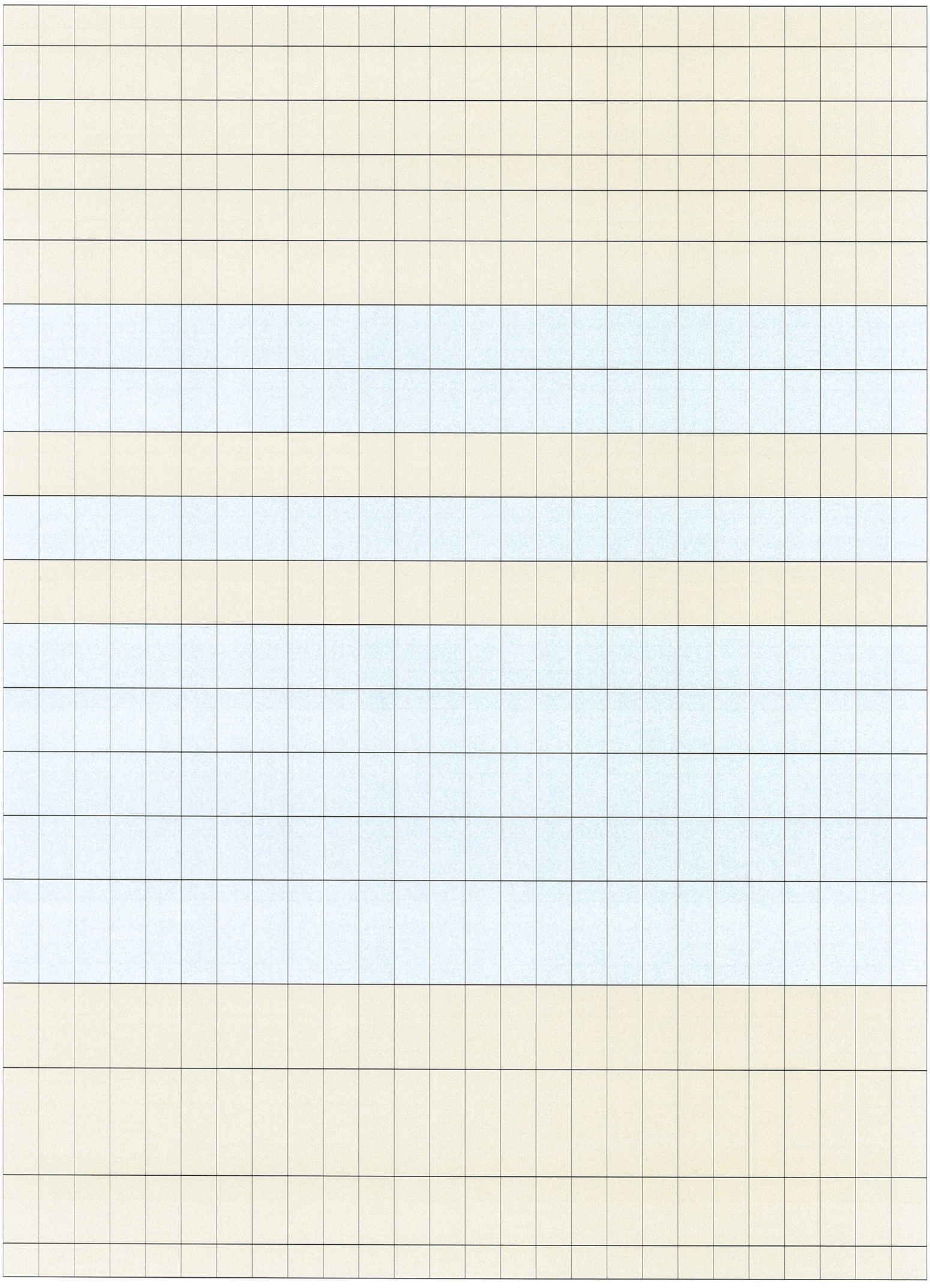
58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 78, 80, 82, 83, 84, 85, 87, 88, 89

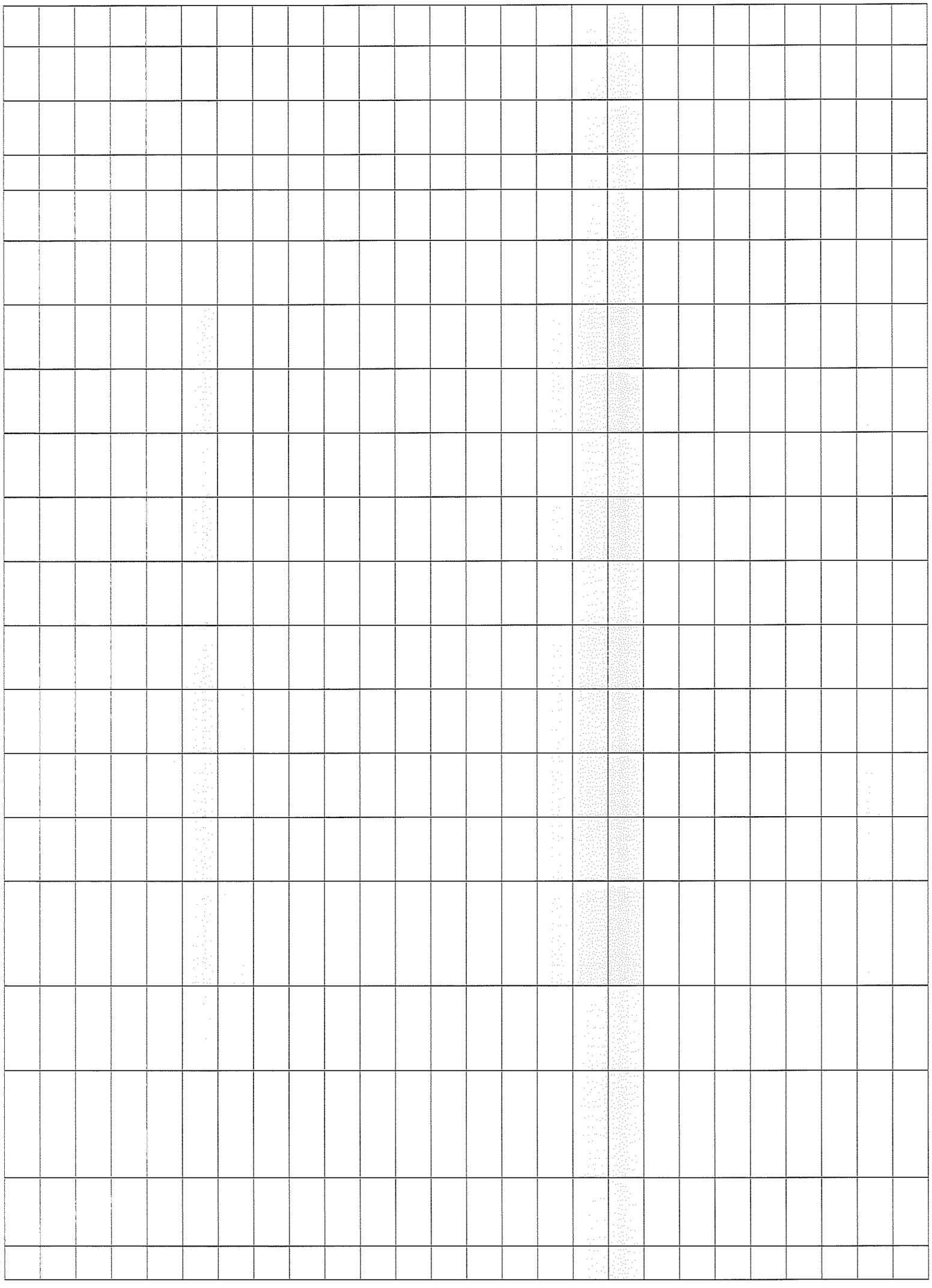
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Planned Expenditure: Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Rehabilitation and Community hospital beds	Community Based Scheme	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)	Share of community hospital beds	22	22	Number of Placements	Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£2,697,041	£2,849,693	26%
2	Local Integrated Networks (LINS)	Community Based Scheme	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£37,472	£38,484	100%
3	Cardiac Rehab Heart Failure	Community Based Scheme	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£586,425	£602,259	100%
4	Pulmonary Rehabilitation	Community Based Scheme	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£105,390	£108,235	100%
5	Short Term Support Team	Community Based Scheme	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£1,302,757	£1,337,932	100%
6	Share of District Nursing including matron	Community Based Scheme	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£5,007,469	£5,351,039	34%
7	Carers	Carers Services	Carers Services	Respite services		270	270	Beneficiaries	Continuing Care		LA			Local Authority	Minimum NHS Contribution	Existing	£907,306	£958,660	100%
8	Local Enhanced Service Out of Hospital	Community Based Scheme	Community Based Schemes	Integrated neighbourhood services					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£589,472	£622,836	100%
9	Preventative services	Support for multiple preventative services	Prevention / Early Intervention	Other	Grant aid to the countywide carer support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£551,658	£582,882	59%

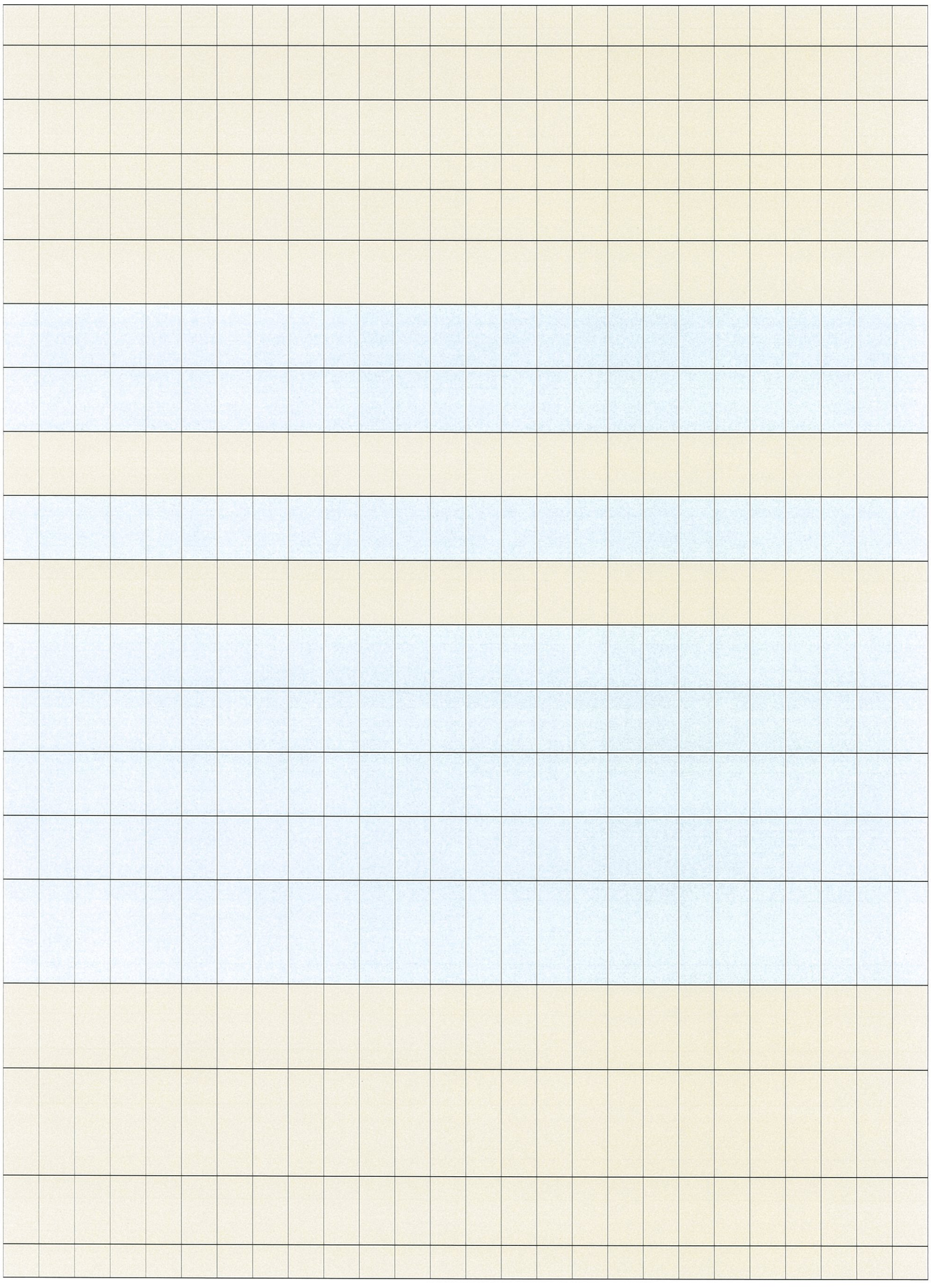
10	Short-term support service (reablement)	Reablement home care service, providing short-term support following discharge	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		1,028	1,028	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,000,000	£3,169,800	66%
11	Short-term support service (therapy)	Occupational therapists working in integrated service with reablement home care	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		2,991	2,991	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£427,158	£451,335	40%
12	Long-term home care (independent sector)	Contribution towards the cost of the long-term home care services supporting	Home Care or Domiciliary Care	Domiciliary care packages		347,350	338,258	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£8,728,906	£9,222,962	28%
13	Long-term home care (independent sector)	Contribution towards the cost of long-term home care services	Home Care or Domiciliary Care	Domiciliary care packages		298,448	275,067	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£7,500,000	£7,500,000	23%
14	Dementia care in care homes	Contribution towards the costs of care home placements for older people	Residential Placements	Care home		128	125	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£5,266,813	£5,564,914	16%
15	Other care home placements	Contribution towards the costs of care home placements for older people	Residential Placements	Care home		131	121	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£4,995,752	£4,995,752	8%
16	HomeSafe discharge support service	Hospital-based social care teams supporting discharge.	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£608,881	£643,343	24%
17	DFG Grant	Mandatory DFG, discretionary grants, and other social care capital	DFG Related Schemes	Other	See column D	200	200	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£3,328,942	£3,328,942	100%
18	Winter Intermediate Care Community	ICB Discharge Fund scheme	Residential Placements	Nursing home		20	20	Number of beds/Placements	Acute		NHS			Private Sector	ICB Discharge Funding	New	£340,391	£340,391	100%
19	Winter Complex Mental Health support	ICB Discharge Fund scheme	Community Based Schemes	Integrated neighbourhood services					Mental Health		NHS			Private Sector	ICB Discharge Funding	New	£129,854	£129,854	100%
		Scheme 20 disaggregated to schemes below labelled 20a, 20b, 20c																	
21	Winter Ambulance Patient Transport	ICB Discharge Fund scheme	Community Based Schemes	Integrated neighbourhood services					Other	Patient Transport	NHS			NHS	ICB Discharge Funding	New	£112,669	£112,669	100%
		Scheme 22 disaggregated to schemes below labelled 22a, 22b, 22c, 22d																	
23	Challenging behaviour dementia service	Block-booked beds in care home specialising in supporting one of the	Residential Placements	Nursing home		12	12	Number of beds/Placements	Social Care		Joint	60.0%	40.0%	Charity / Voluntary Sector	Local Authority Discharge	New	£308,877	£449,180	40%
22a	Home care (pathway 1)	Additional budget for home care following discharge (Pathway 1)	Home Care or Domiciliary Care	Domiciliary care packages		25,865	44,011	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge	New	£650,000	£1,200,000	100%
22b	Short-term care home placements (pathway 2)	Additional budget for short-term bed based services following discharge (Pathway	Residential Placements	Care home		12	12	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge	New	£450,000	£487,699	100%
22c	Long-term care home placements (pathway 3)	Additional budget to reduce delays in making long-term care home placements in	Residential Placements	Care home		7	7	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge	New	£250,000	£271,250	100%
22d	Flexible additional support for early discharge	Other schemes available to be stood up at times of high pressure on hospitals,	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Private Sector	Local Authority Discharge	New	£93,008	£500,000	100%
20a	Winter packages of care support (P1)	ICB Discharge Fund Scheme	Home Care or Domiciliary Care	Domiciliary care packages		7406	17533	Hours of care	Continuing Care		NHS			Private Sector	ICB Discharge Funding	New	£173,296	£410,280	100%
20b	Winter packages of care support (P2)	ICB Discharge Fund Scheme	Residential Placements	Care home		6	11	Number of beds/Placements	Continuing Care		NHS			Private Sector	ICB Discharge Funding	New	£231,292	£547,585	100%
20c	Winter packages of care support (P3)	ICB Discharge Fund Scheme	Residential Placements	Care home		3	6	Number of beds/Placements	Continuing Care		NHS			Private Sector	ICB Discharge Funding	New	£139,189	£329,529	100%

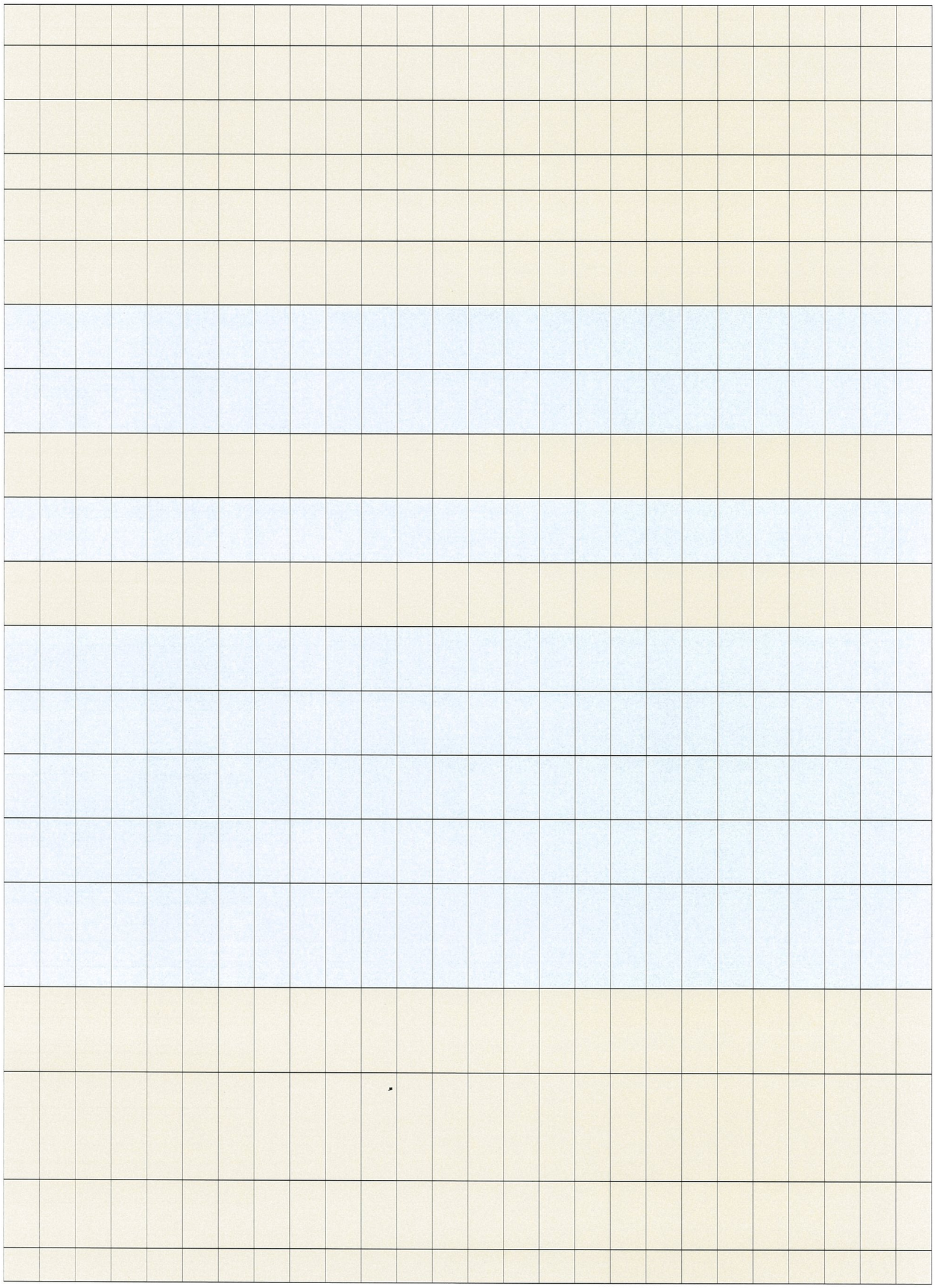


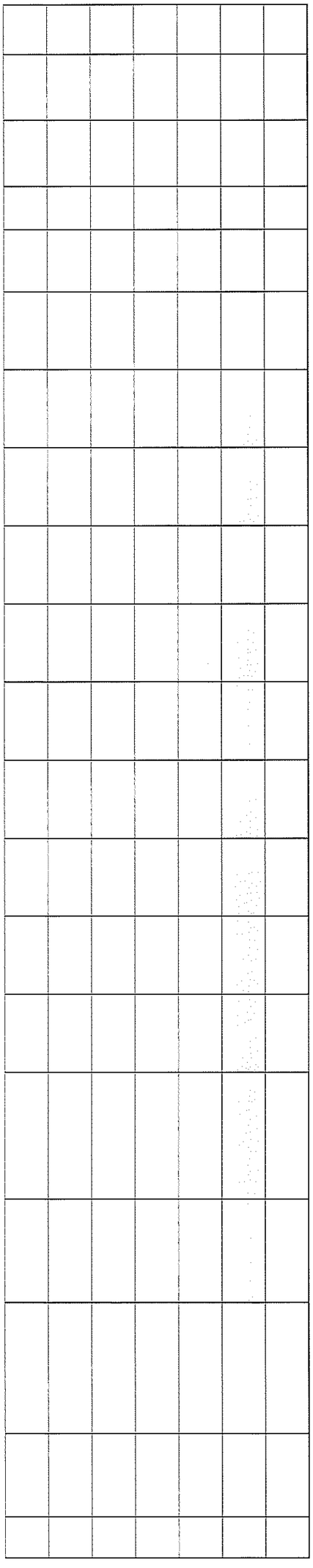












Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other

5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other
9	Housing Related Schemes	

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other
13	Urgent Community Response	

14	Personalised Budgeting and Commissioning	
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other
19	Other	

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained

Carers Services	Beneficiaries

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.

Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Northumberland

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	241.2	239.1	284.0	250.0	This has been a challenging indicator for the area to reduce in recent years, with trend continuing to increase. Realistically, it is aimed that a small reduction in previous year is achieved given the trend over the previous 3 years.	Working with partners through the system transformation board, the performance will be regularly review and actions put in place which address the underlying issues.	Yes
	Number of Admissions	1,026	1,017	1,208	-			
	Population	320,274	320,274	320,274	320,274			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	240	238	283	249			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,797.5	2,891.0	2,763.1	Again, this area continues to be challenging with a worrying upwards trend over the past 8 years. There is now an increased focus on this metric therefore it is hoped that developed plans will support reductions in this area.	A number of actions to support fall reduction including both reactive and proactive models. A great understanding of the underlying reasons behind the increases are required. A lead and manager are assigned to follow up and put the action plan in place.	Yes
	Count	2,195	2272	2248			Yes
	Population	82,281	82281	83799			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	86.8%	86.5%	86.7%	90.0%	This metric continues to be tricky to show true picture given the variation in how interpretation of the data dictionary definition by acute trust colleagues across the country. An increase in this metric is hoped, however we would encourage national colleagues to send out clear guidance to all acute trust colleagues to support consistent interpretation of the definition.	Using the system transformation board, this metric will be monitored and plans will be put in place where deviation from plan is identified. The home first model will continue to be used to support this.	Yes
	Numerator	6,989	7,291	7,225	6,875			
	Denominator	8,055	8,432	8,338	7,639			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	86.9%	86.6%	87.0%	90.3%			
	Numerator	7,000	7,300	7,250	6,900			Yes
	Denominator	8,055	8,432	8,338	7,639			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	601.0	654.9	651.3	639.8	Based on past experience. The principal current obstacle to improvement is workforce capacity in home care services.	Substantial investment in home care services, aiming for a step change in the attractiveness in the terms and conditions of home care workers (funded from the Market Sustainability and Improvement Fund).	Yes
	Numerator	489	554	551	554			Yes
	Denominator	81,368	84,597	84,597	86,583			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.6%	85.0%	89.6%	85.0%	Based on past experience. This indicator is being dropped nationally, and may not be a reliable indicator of performance when compared across LA areas or over time, since its significance may be affected by the detail of service models.	Current plan is to maintain existing services and review as the impact of changes in other parts of the system becomes clear.	Yes
	Numerator	346	340	346	340			Yes
	Denominator	409	400	386	400			Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Northumberland

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes				Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes				Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes				Yes

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend?*Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions?*Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet?*Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes				Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date?*Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes				Yes

Northumberland
County Council

HEALTH AND WELL BEING BOARD

11TH AUGUST 2023

NOTIFICATION OF CLOSURE OF 100-HOUR PHARMACY IN CRAMLINGTON

Report of Councillor Veronica Jones - Improving Public Health and Wellbeing

Lead Officer Pam Lee, Public Health Consultant

Purpose of report

NHS England has notified the Health and Wellbeing Board of the closure of the 100-hour pharmacy, located in Sainsburys supermarket, Manor Walk, Cramlington. This pharmacy closed on 13th June 2023.

Lloyds PLC operated the pharmacy as part of a national franchise within Sainsburys supermarket, with extended opening hours between 7am and 11pm Monday to Saturday, and between 10am and 4pm on Sundays. This pharmacy formed part of the emergency and out of hours hub, which ensured that patients, medical staff and the general population knew where accessible pharmacy services could be found outside normal hours, across the whole of Northumberland.

Recommendations

The Executive Director of Public Health recommends that the Health and Wellbeing Board agrees to an update to the Pharmaceutical Needs Assessment 2022, by means of a supplementary statement. This statement (draft attached) declares that there is a gap in essential, advanced, additional and locally commissioned pharmaceutical services in Cramlington between the hours of 6pm and 10pm Monday to Saturday, and on Sundays between 10am and 4pm. A second supplementary statement is required to acknowledge the change of ownership of all Lloyds pharmacies in Northumberland.

Link to Corporate Plan

This links to the Corporate Plan 2023-26, supporting the priority everybody to live their best lives.

All adults living well, regardless of age, background, illness or disability – we need to find ways to help people to remain independent whatever their disability or condition. We must

support people to live healthier lives and provide good quality equitable services for those who need extra support to maintain health, wellbeing and independence.

Key issues

The closure of a 100-hour pharmacy in Cramlington leaves a gap for patients, public and healthcare professionals between 6 and 9 pm on weekdays, when GP practices in the area are providing extra hours and the public are being encouraged to use pharmacies to relief pressure on other primary care services.

Background

Cramlington (population30,778) is a bustling “new town” built onto a former mining village. It continues to expand in planned, sector developments. It has three GP surgeries and had 4 pharmacies in January 2023. GPs offer extended hours services from the hub at The Village medical centre in Cramlington for practices in Ponteland and Cramlington during weekday evenings, and additionally for practices from further afield at the weekends and bank holidays.

A new Health and Wellbeing Campus on the site of Northumbria Specialist Emergency Care Hospital (NSECH) in Cramlington is currently under construction. Part of the project involves the relocation of Brockwell Medical centre, currently located on Northumbrian Road, into the ground floor of this new building. Other community-based health services will be co-located in this facility. An application to open a new pharmacy as part of this project has been approved, following an appeal.

The report of the appeal panel was published in March 2023, and noted that there was the need for additional pharmaceutical services in Cramlington at that time. This followed a site visit to Cramlington by the appeal panel in February 2023. The panel noted the long queues at pharmacy counters in each of the four pharmacies they visited across Cramlington. They also noted the high prescription volumes being dispensed by the pharmacies and the lack of accessibility to Boots after the shopping centre closes, and the fact that the Village pharmacy was in the entrance to the GP surgery and was only accessible when the surgery was open.

Engagement undertaken by Healthwatch Northumberland following notification of the impending closure of the pharmacy found that residents valued the easy accessibility of the pharmacy, its proximity to bus stops, long opening hours and easy parking. The range of concerns led Healthwatch to ask for an Equalities Impact Assessment to be carried out to understand the effect of the closure on people with Protected Characteristics and who are vulnerable because of other life circumstances.

The conclusions of the Equalities Impact assessment undertaken by NHS England were

- Patients and carers will not be able to access pharmaceutical services in Cramlington after 6 pm and will need to travel 4.2 miles (to Blyth) should they wish to obtain medication or advice between 6 and 9 pm. Consideration may need to be given as to the communication for patients requiring access to urgent prescriptions after 6pm.
- There will continue to be choice of provider within the town.
- Patients who accessed the closed branch by car, bus or on foot will continue to be able to access the other pharmacies in town during usual opening hours;
- Services which patients obtained from the closed branch are available from at least one of the remaining three pharmacies.

Following the closure of Lloyds in Sainsburys there will be a need for pharmacy services to replace those provided from that pharmacy. Although approval has been granted for a new pharmacy at the Health and Wellbeing Campus it is not going to happen quickly and legally has until March 2025 to open.

The current funding of community pharmacy means that a replacement 100-hour pharmacy is unlikely to be commercially viable and is unlikely to attract a new pharmacy business. As the pharmacy regulations have changed, new 100-hour contracts are no longer awarded, with 40hour contracts being given to applicants who offer to fill identified gaps in services. To try to ensure that any applicant includes evenings as part of their core hours, we recommend identifying the evenings as a gap in pharmacy services in Cramlington, although it must be recognised that with the current funding crisis this gap may not attract any applicants. Appendix 1 is the draft supplementary statement number 1 giving notice of a gap in pharmacy services in Cramlington between the hours of 6pm and 10pm.

The current funding crisis in community pharmacy is resulting in numerous pharmacy closures both nationally and regionally. Lloyds have closed all their pharmacies in Sainsburys supermarkets across the country. Other companies such as Boots, Asda and Tesco have also given notice to close some of their 100 hour pharmacies. To try to protect out of hours services, changes were made to pharmacy regulations in May 2023, which allow 100 hour pharmacies to reduce their hours to a minimum of 72 hours per week. The reduced opening hours must include opening until 9pm in the evening and retention of their current Sunday opening hours. Boots in Blyth has requested a reduction in hours until 9pm Monday to Saturday, which may affect Cramlington residents who need to access pharmacy services in the evening.

Lloyds are also in the process of selling their entire national network of community pharmacies. All of Lloyds pharmacies in Northumberland are in the process of being sold to new owners and this should not affect the network of pharmacies across the county.

Appendix 2 is the draft supplementary statement giving the names of the new owners of Lloyds pharmacies.

Implications

Policy	Consideration must be given to how this closure will impact the residents of Cramlington and South East Northumberland
Finance and value for money	There are no direct financial implications for the council.
Legal	The council has a duty to inform NHS England if any changes to pharmacy arrangements will create a gap in pharmacy services. The duties and responsibilities of a Health and Wellbeing Board as set out in the Health and Social Care Act 2012. The Local Authorities (Functions and Responsibilities) (England) Regulations 2000 confirm that the matters within this report are not functions of the Executive
Procurement	N/A
Human Resources	There are no specific implications for human resources,
Property	N/A
Equalities (Impact Assessment attached) Yes ☐ No ☐ N/A ☐	Closure of a centrally located pharmacy which is open for extended hours may impact the ability of disadvantaged members of the community to access pharmacy services. The EIA was undertaken by the Integrated Care Board.
Risk Assessment	The council is obligated to update the PNA on a regular basis and when there are significant changes to pharmacy services.
Crime & Disorder	Commissioned services for opiate substitution provided by community pharmacies reduce the crime associated with illegal substance misuse
Customer Consideration	The fundamental aim is to ensure that pharmacy services are available to Northumberland residents.
Carbon reduction	N/A

Health and Wellbeing	The fundamental aim is to ensure that pharmacy services are available to Northumberland residents.
Wards	All

Background papers:

Report sign off.

Authors must ensure that officers and members have agreed the content of the report:

	Full Name of Officer
Interim Director of Law and Governance and Monitoring Officer	Stephen Gerrard
Executive Director of Resources and Transformation (S151 Officer)	Jan Willis
Executive Director	Gill O'Neill
Chief Executive	Helen Paterson
Portfolio Holder(s)	Cllr Veronica Jones

Author and Contact Details

Anne Everden
Pharmacy Consultant to Public Health
anneeverden@googlemail.com
Mobile 07787 192049

APPENDIX 1: Supplementary Statement 1

This supplementary statement has been prepared and issued by the Director of Public Health on behalf of the Health and Wellbeing Board of Northumberland County Council, and forms part of the Pharmaceutical Needs Assessment.

Since the publication of Northumberland's Pharmaceutical Needs Assessment (PNA) on 30th September 2022, the following change in pharmaceutical services has occurred:

PNA Details

PNA Published	30th September 2022
Date of Supplementary Statement	12th August 2023
Supplementary Statement Number	1

Type of Change

New Opening	
Pharmacy Closure	Pharmacy Closure
Change in Hours	
Change in Ownership	
Pharmacy Relocation	

Details of Change

Lloyds pharmacy which was based in Sainsbury supermarket in Cramlington provided 100 hours of pharmacy services per week, between 7am and 11pm Monday to Saturday and between 10am and 4pm each Sunday. Notice was given in January that Lloyds would cease trading within all Sainsbury stores nationally. Services ceased in Cramlington on 13th June 2023.

A gap in essential, additional, advanced and locally commissioned, pharmaceutical services between the hours of 6pm and 10pm Monday to Saturday and 10am until 4pm on Sunday has been left following this closure.

This supplementary statement to Northumberland's Pharmaceutical Needs Assessment is issued in accordance with paragraph 3D (3) in Part 1A of the NHS (Pharmaceutical Services) Regulations 2005. If you require further information please contact Pamela.forster@northumberland.gov.uk

Prepared by Anne Everden, Pharmacy Consultant to Public Health

APPENDIX 2 Supplementary Statement 2

This supplementary statement has been prepared and issued by the Director of Public Health on behalf of the Health and Wellbeing Board of Northumberland County Council, and forms part of the Pharmaceutical Needs Assessment.

Since the publication of Northumberland's Pharmaceutical Needs Assessment (PNA) on 30th September 2022, the following change in pharmaceutical services has occurred:

PNA Details

PNA Published	30th September 2022
Date of Supplementary Statement	12th August 2023
Supplementary Statement Number	2

Type of Change

New Opening	
Pharmacy Closure	Changes in Ownership
Change in Hours	
Change in Ownership	
Pharmacy Relocation	

Details of Change

Lloyds pharmacy has transferred ownership of the following pharmacies

(7) Brockwell Centre, Cramlington to tbc

(14) 4, Delaval Terrace, Blyth to Seaton Healthcare Ltd

(22) Leadgate House, Glebe Rd, Bedlington to Welcome Health Pharmacies Ltd

(34) Seaton Hirst Medical Centre, Ashington to tbc

(56) Well Close, Castlegate, Berwick on Tweed to LP SD Two Ltd

(57) Union Brae, Tweedmouth to tbc

(67) Hexham General Hospital to tbc

AP Booth has transferred ownership of

(53) Belford Pharmacy, 22 West St Belford to Alphega Pharmacy Ltd

This supplementary statement to Northumberland's Pharmaceutical Needs Assessment is issued in accordance with paragraph 3D (3) in Part 1A of the NHS (Pharmaceutical Services) Regulations 2005. If you require further information please contact Pamela.forster@northumberland.gov.uk

Prepared by Anne Everden, Pharmacy Consultant to Public Health

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North East and North Cumbria

Pemberton House
Colima Avenue
Sunderland
SR5 3XB

www.northeastnorthcumbria.nhs.uk

Ref: 109/SA

05 July 2023

Dear colleague,

North East and North Cumbria Joint Forward Plan

Following the publication of our Integrated Care Strategy in December 2022, we have been working closely with our partner organisations to produce our Joint Forward Plan.

The integrated care strategy requires a sustained collaboration across a broad range of partners and stakeholders, beyond the improvements to outcomes that health and care services can deliver in isolation.

Our draft Joint Forward Plan is complementary to the Integrated Care Partnership Strategy. It is a delivery plan for the parts of our strategy related particularly to NHS delivered or commissioned services, but within the broader partnership context.

Publication of this plan is a national requirement for all Integrated Care Boards (ICBs) and partner Foundation Trusts covering the period 2023/24 – 2028/29.

Our Joint Forward Plan provides:

- A strategic overview of our key priorities and objectives for the medium term.
- A high-level summary of our priorities and objectives.
- A summary of the work programmes we will deliver to achieve our medium-term objectives.

As part of our Joint Forward Plan, we have developed detailed action plans for each of:

- The integrated care strategy goals.
- The integrated care strategy enablers.
- Our local authority place.
- Our service areas, e.g. urgent and emergency care and mental health.

In the same spirit as we have engaged with our system partners to create our integrated care strategy, we are seeking feedback and views from you on the plans that will now deliver these ambitions.

Professor Sir Liam Donaldson
Chair

Samantha Allen
Chief Executive

Please see below link to the Joint Forward Plan on the North East and North Cumbria ICB website draft-joint-forward-plan-202324-202829.pdf (northeastnorthcumbria.nhs.uk)

Could we please ask for your assistance in returning any comments by **31 August 2023**, sending all feedback to our ICP Planning mailbox necsu.icbplanning@nhs.net

Once we have received all feedback, it is our intention to re-publish in September. We will also continue review and update our Joint Forward Plan each year going forward and will publish a revised version every March in line with the national guidance.

Yours sincerely,

Samantha Allen
Chief Executive

NHS
North East and
North Cumbria

Draft:

Joint Forward Plan 2023/24 – 2028/29

Version: 3 July 2023

Better health and wellbeing for all

Contents

Foreword – Samantha Allen

Following the publication of our Integrated Care Strategy, Better Health and Wellbeing for All, in December 2022, we have been working closely with our partner organisations to produce our Joint Forward Plan.

The Integrated Care Strategy, developed with the Integrated Care Partnership (ICP), requires a sustained collaboration across a broad range of partners and stakeholders, beyond the improvements to outcomes that health and care services can deliver in isolation.

Our draft Joint Forward Plan is complementary to this Strategy. It is a delivery plan for the parts of our strategy related particularly to NHS delivered or commissioned services, but within the broader partnership context.

Publication of this plan is a national requirement for all Integrated Care Boards (ICBs) and partner Foundation Trusts covering the period 2023/24 – 2028/29.

Our Joint Forward Plan provides a:

- strategic overview of our key priorities and objectives for the medium term.
- high-level summary of our priorities and objectives
- summary of the work programmes we will deliver to achieve our medium-term objectives.

As part of our Joint Forward Plan, we have developed detailed action plans for:

- the integrated care strategy goals
- the integrated care strategy enablers
- each local authority Place or groups of Places
- our service areas.

In the same spirit as we have engaged with our system partners to create our integrated care strategy, we are seeking feedback and views on the Plan to deliver the ambitions agreed.

We look forward to working with all our NHS and system partners to deliver the commitments in the Joint Forward Plan, and together making a lasting contribution to improve the health and wellbeing of our population.

Samantha Allen

Chief Executive

North East and North Cumbria Integrated Care Board

1 Introduction to the Joint Forward Plan

What is the Joint Forward Plan?

The Joint Forward Plan is a national requirement for all Integrated Care Boards (ICBs) and partner NHS Trusts covering the period 2023/24 – 2028/29. NHS England published national guidance on developing Joint Forward Plans in December 2022 and January 2023. The guidance includes three key principles:

- Principle 1: Fully aligned with the wider systems ambitions
- Principle 2: Supporting subsidiarity, building on existing local strategies and plans and reflecting universal NHS commitments
- Principle 3: Delivery focussed, specific objectives, trajectories and milestones

The national guidance gives flexibility on how Joint Forward Plans are structured, but should as a minimum demonstrate how the ICB and its partner NHS Trusts:

- intend to arrange and/or provide NHS services to meet their population's physical and mental health needs
- will deliver of the NHS Mandate and NHS Long Term Plan in the area
- will meet the legal requirements for ICBs

Is this different to the Integrated Care Partnership (ICP) Strategy?

The North East and North Cumbria ICP is a statutory committee of fourteen local authorities and the Integrated Care Board (ICB). The ICP published the North East and North Cumbria integrated care strategy, Better Health and Wellbeing For All, in December 2022. It is an ambitious strategy organised around four key goals:

Longer and healthier lives
Reducing the gap between how long people live in the North East and North Cumbria compared to the rest of England.

Fairer outcomes
As we know not everyone has the same opportunities to be healthy because of where they live, their income, education and employment.

Better health and care services
Not just high-quality services but the same quality no-matter where you live and who you are.

Giving our children the best start in life
Enabling them to thrive, have great futures and improve lives for generations to come.

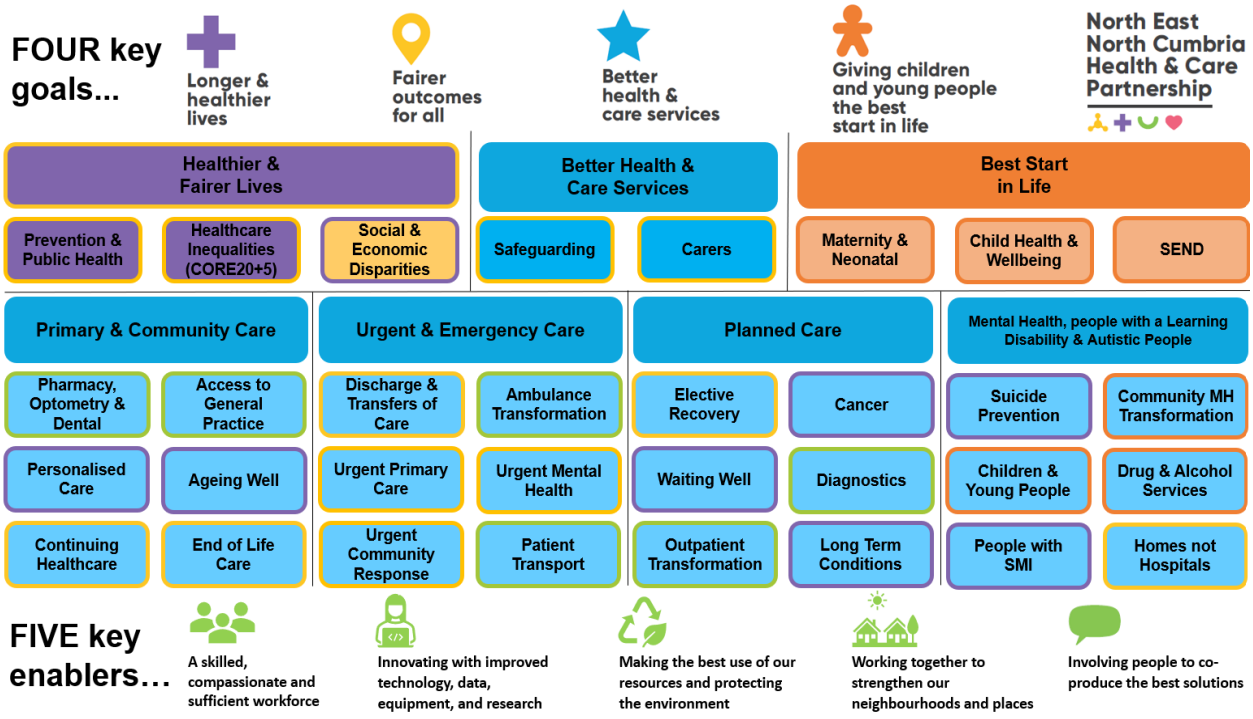
Our joint forward plan is complementary to the ICP Strategy. It is a delivery plan for the parts of our strategy related to NHS delivered or commissioned services, but in the broader partnership context.

What does the Joint Forward Plan cover?

Our Joint Forward Plan is aligned to ICP Strategy. It covers:

- Integrated Care Partnership Strategy **Goals**: to support the delivery of each goal, focussed on NHS delivery as a good partner.
- Integrated Care Partnership Strategy **Enabler Delivery Plans**: An NHS plan for each enabler, in the context of partnership working.
- **Service Delivery Plans**: A Plan for NHS services, such as mental health and primary care, across the North East and North Cumbria.
- A summary of the key work programmes included in each of our **Place Delivery Plans.**

Each of these sections of the Plan are interdependent. A key challenge is to ensure links between the different elements of the Plan, summarised in the graphic below.



Are there any more detailed plans to support the Joint Forward plan?

As part of our Joint Forward Plan, we have developed action plans including:

- the integrated care strategy goals
- the integrated care strategy enablers
- each local authority Place or groups of Places
- key service areas, e.g., urgent and emergency care

The action plans are intended to address the immediate priorities and key deliverables, but also the longer-term transformation/development priorities. Our action plans include key deliverables – what we will deliver, and by when, and Measures of impact. Wherever possible the plans have been developed in

partnership, often through an existing integrated care system wide workstream or clinical network. Our action plans are informed by:

- Health and Wellbeing Plans, Joint Strategic Needs Assessments and the ICP integrated care strategy
- NHS National Operating Plan ambitions 2023/24, NHS Long-Term Plan and relevant National guidance.

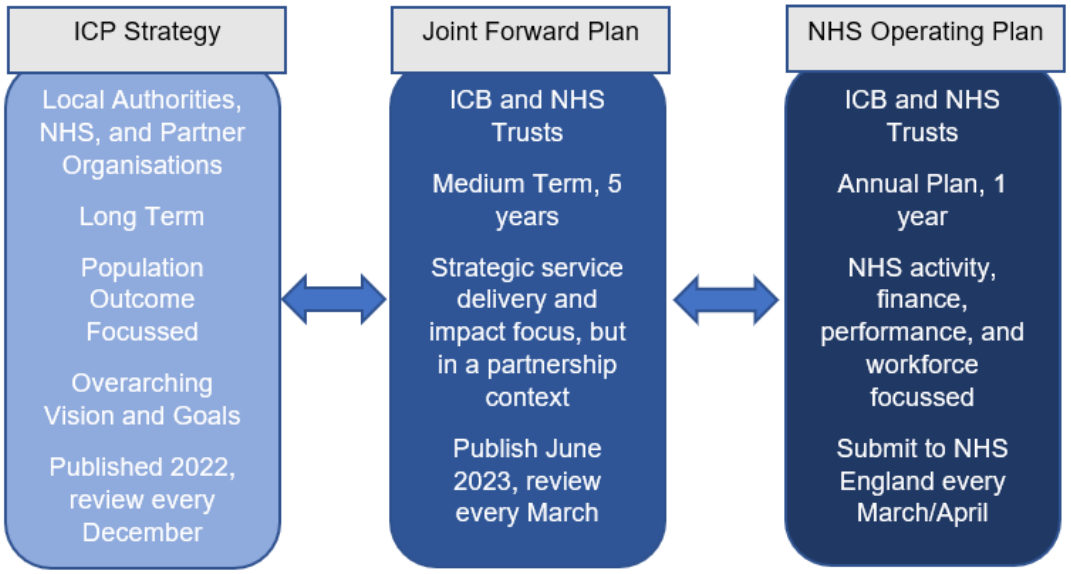
Will the Joint Forward Plan be Reviewed and Updated?

Like all ICBs and partner NHS Trusts across England, this is our first Joint Forward Plan. It will be reviewed and updated annually. The first updated version will be published in March 2024, and then updated again every subsequent March. The updated plan each year will be informed by:

- Our implementation over the previous year and our maturing partnerships, integration and/or aligned programmes of work.
- Our learning, as we seek to be the 'best at getting better'.
- Changes in population needs, national policy, good practice, and legislation.
- The views of service users and communities, partners and partnerships including Health and Wellbeing Boards.

How do the different Plans fit together?

We know NHS and broader partnership structures can be confusing. For the NHS, our three key documents are summarised below:



Our Healthcare Services

The NHS workforce across the North East and North Cumbria totals nearly 90, 000 full time equivalent. **Within the NHS our system includes:**

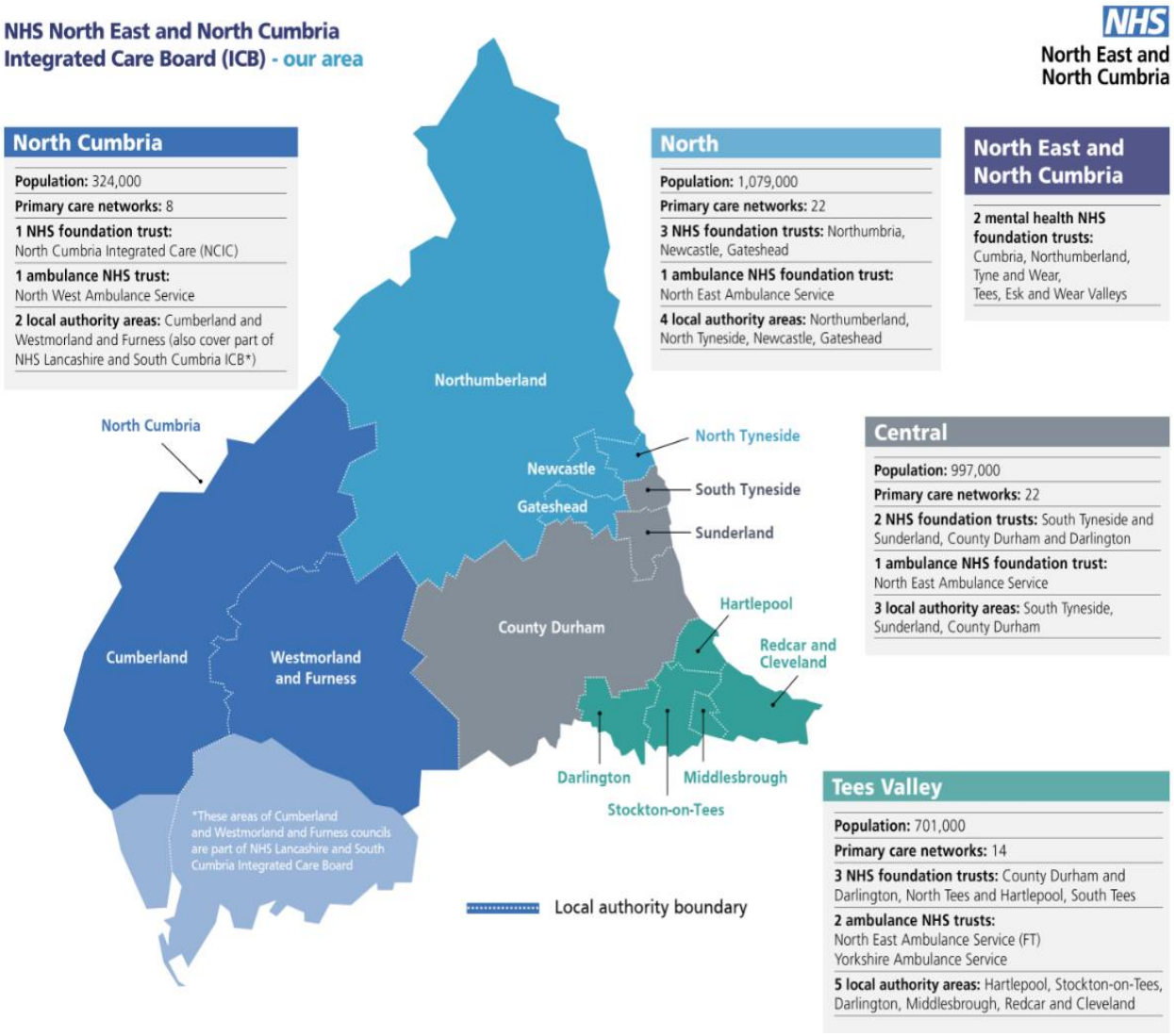
- General Practices, grouping together across 64 Primary Care Networks

- Community Pharmacies and Dental Practices
- Eight NHS Trusts predominantly (though not exclusively) delivering physical health community and hospital-based services
- Two mental health and learning disability NHS Trusts
- North East, and North West, Ambulance Services delivering NHS 111, non-emergency patient transport services and 999 paramedic emergency services
- NHS commissioned independent sector free at the point of delivery services.

Our Population

The North East and North Cumbria ICB includes a large and diverse geography, from cities and towns to rural and coastal communities:

- Our ICB covers the **largest resident population** of c3 million (2021 census)
- Our population is **older**, 21% are over 65 compared to 18.6% in England
- Our population experiences significant **socio-economic deprivation** - 1 in 3 people live in the most 20% deprived communities in England
- Our population experiences **health inequalities**. Life expectancy and healthy life expectancy at birth are significantly worse than the England average.



3 Longer, Healthier Lives and Fairer Outcomes

&

3.1 Partnership Working

The Healthier Lives, Fairer Outcomes Programme is a system-wide approach to prevent ill health, reduce healthcare inequalities and support the NHS to play a greater role in addressing social and economic inequalities. The Healthier and Fairer Advisory Group is a sub-committee of the ICB Executive and provides oversight of three thematic workstreams, and three enabling workstreams, shown below:

Three **Workstreams**

- Prevention
- Healthcare Inequalities
- NHS Contribution to reducing Social and Economic inequalities

Three **Enabling** Workstreams

- Prevention
- Healthcare Inequalities
- NHS Contribution to reducing Social and Economic inequalities

All the Healthier and Fairer work programmes are delivered in partnership:

Healthier and Fairer partnership membership:

Each workstream is co-chaired by an ICB Medical Director and a Director of Public Health, with membership drawn from across the health and care system, including local government, Office for Health Inequalities and Disparities (OHID), VCSE, academia, Healthwatch, local government, ICB

3.2 Achieving the NHS prevention ambitions

We know that life expectancy and healthy life expectancy at birth in our region are lower than the rest of the country. Using these measures, the North east and North Cumbria has some of the worse health outcomes in England. There are also inequalities in life expectancy at birth between the most deprived 20% and least deprived areas within our region. In 2020/21, the difference in life expectancy was

approximately 8.1 years for women and 10.4 years for men. The difference is much larger than the comparable inequality gap for England. The NHS has a greater role in secondary prevention.

Objectives:

- Reduce harm from alcohol
- Increase the rate of 'Healthy weight'
- Reduce the smoking rate to 5% by 2030
- Improve the detection and management of the 3 high risk conditions for cardiovascular disease (Atrial Fibrillation, Hypertension, and Raised Cholesterol).
- To contribute to the development of a sustainable VCSE sector and strengthening of communities at place

3.3 Reducing Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups. The health of the population is influenced by multiple factors, often referred to as the wider determinants of health. Healthcare inequality refers to inequalities experienced by people and groups within the population regarding the access to, uptake and experience of, and outcomes associated with, the delivery of healthcare services.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The CORE20 are the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD), with one third of the NENC population falls within the 20% of the national population which is the most deprived.

Adults Objectives:

- Ensure annual health checks for 60% of adults living with a serious mental illness (SMI)
- Increase uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations for adults with Chronic Obstructive Pulmonary Disease (COPD)
- Ensure that 75% of cancers are diagnosed at stage 1 or 2 by 2030
- Increase the identification and treatment of hypertension and hyperlipidaemia to minimise the risk of myocardial infarction and stroke
- Embed smoking cessation in all appropriate delivery plans

Children and Young People Objectives:

- Reduce the over reliance on reliver medications and decrease the number of asthma attacks.
- Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase the proportion of those with Type 2 diabetes receiving recommended NICE care processes.
- Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
- Reduce the number of tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under
- Improve access rates to mental health services, for certain ethnic groups, age, gender, and deprivation.
- Embed smoking cessation in all appropriate delivery plans.

3.4 NHS contribution to reducing social & economic inequalities - Social and economic conditions are influenced by policy choices beyond the NHS's control. The ICB is committed to working collaboratively alongside partners to make change.

Objectives:

- Health literacy approach improving the way we communicate.
- Poverty proofing health settings to removes barriers to improving healthcare access, experience, and outcomes.
- Maximising digital solutions, while guarding against digital exclusion.
- Anchor institutions network to maximise their impact.

3.5 Embed Population Health Management - Our Population Health Management approach is a key *enabler*. Our approach is data driven to help plan and deliver care that maximise health outcomes and reduces health inequalities.

Note: This priority is closely aligned the **Digital** enabler in section 6.

Objectives:

- Create a full longitudinal dataset (primary, secondary, mental health, social care, community data, blue light services)
- Multi partner intelligence function and population health analytics
- Support culture change, behaviour and develop skills across the system to embed population health into mainstream decision making.

3.6 Pregnancy and postnatal healthcare.

Most babies and children in England are born healthy but children born into poorer families and vulnerable groups are more likely to have poorer outcomes. Giving every child the best start in life is key to reducing health inequalities, maternity care gives the first key opportunity for positive change. **Note:** This priority is aligned to the **Maternity** section 4.

Objectives:

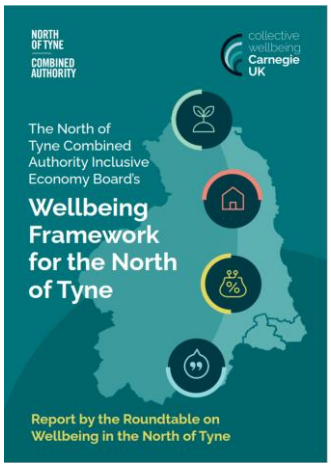
- Focusing on the Core20+ maternity framework, work with pregnant women to improve access and care for them and their support systems in the 20% most deprived deciles, with Black, Asian or Minority Ethnicities and/or with complex social factors.
- Anticipatory care for groups at highest risk of health inequalities.
- Resources to aid service delivery in relation to tobacco dependency, infant feeding, pre-conceptive health, and substance use.

3.7 Housing

We are working with partners to develop a plan, linked to the Healthier and Fairer programme, to effect positive change in relation to housing and its impact on health and wellbeing. An inaugural Housing, Health and Care Conference was held in May 2023. Based on feedback, the proposed that the key areas of work for this plan are:

- An increase in the number of older people, including those who are frail, have dementia and or complex health needs, who are able to live independently, especially in our most deprived communities
- An increase in the provision of extra care housing, for adults with complex physical health needs and for those with learning disabilities, and a reduction in admissions to hospital
- A framework for joint working across the housing, health and care sectors that improves the identification and reduction of cold and dampness in homes

3.8 Work and Health



The Department for Health and Social Care and Department for Work and Pensions Joint Work and Health Unit invited the North of Tyne Combined and Local Authorities to explore the development of a work and health strategy with the ICB. This focussed on tackling the health barriers people face in accessing and sustaining good work.

We will work with partners across the North East and North Cumbria, building on our shared learning from programmes like the Wellbeing Framework for the North of Tyne, while respecting local variation in delivery.

External mapping support from IPPR North identified:

- the opportunity of devolution to develop a shared programme to address inequalities in health and wellbeing outcomes
- Focusing on what works to inform the investment principles
- Co-designing a formal work and health system, connecting frontline services in our places
- Creating more 'good work' in the local public and private sector, including through anchor institutions to widen employment pathways
- Promote the principles of good work through initiatives such as the Better Health at Work Scheme and North of Tyne Combined Authority's Good Work Pledge
- Explore Community Wealth Building approaches to develop local supply chains, improve employment conditions, and increase the socially productive use of wealth and assets

3.9 **Carers and Volunteers –** Family and informal carers, including young carers, often experience significant challenges in accessing the right support for the person they care for and for themselves, and often experience a significant impact on their own health and wellbeing. We need to place carers at the centre of our work, including to improve their own health outcomes. Developing programmes for volunteers is a huge opportunity, building on the high levels of civic engagement across the North east and North Cumbria.

Objectives:

- Embed support for carers in all of our work programmes, improve access for support for carers, and consider the impact on carers in all of our assessments of service changes.
- Ensure the voice of carers is included in all of our engagement programmes.
- Maximise the opportunities to support volunteers and strengthen formal programmes for people who generously give their time and skills to support our services in voluntary roles.

4 Best Start in Life

4.1 Maternity and Neonatal

Partnership Working

Our ambition is to be the safest place to be pregnant, give birth and transition into parenthood. Our commitment to reducing health inequalities and unwarranted variation will be crucial. Mothers and babies from a Black, Asian, or mixed ethnicity background and those living in more deprived communities are more likely to experience serious complications during pregnancy and birth. The NENC Local Maternity and Neonatal System (LMNS) Board leads our work programme working with clinical networks, NHS England and the 10 Maternity Voices Partnerships. We will develop a Maternity and Neonatal Alliance which will bring all partners together under new revised governance arrangements.

Listening to women and families with compassion which promotes safer care - Listening, understanding, and acting improves maternity outcomes and experiences

Objectives

- Personalised Care: Women experience informed choice, an ongoing dialogue, personalised planning, and specialist care when needed.
- Listening to women from diverse backgrounds and targeted local action.
- Involvement through Maternity and Neonatal Voice Partnerships.

Supporting our workforce to develop their skills and capacity - good models of care can only be delivered by skilled teams with sufficient capacity.

Objectives

- Grow our workforce: sufficient staffing levels across the whole team supported undergraduate training and establishment.
- Value and retain our workforce and Invest in skills

Developing and sustaining a culture of safety to benefit everyone - a safety culture improves the experience of care for women and babies and supports staff.

Objectives

- Develop a positive safety culture: leaders understand 'how it feels to work here' and everyone takes responsibility for safer care.
- A compassionate approach to learning from safety incidents.
- Support and oversight: services receive support before serious problems arise, in line with the Perinatal Quality Surveillance Model.

Meeting standards that underpin our ambition - this plan does not introduce new standards but ensures that these enablers are consistently in place to support care.

Objectives

- Standards to ensure best practice: implementation of best practice such as Saving Babies Lives, and rationalisation of standards.
- Data to inform learning: improve the timeliness and accuracy of data and implement the Kirkup report to "read the signals."
- Make better use of digital technology: the implementation of electronic patient records supports flows of information and women to have digital access to their care records.

4.2 Children and Young People

Note: Children and Young People are included in all the service, enabler, and place plans in the later sections of this Plan.

Partnership Working

Our Child Health and Wellbeing Network provides a valued role in bringing together partners across the system to have a clear focus on children and young people's health and wellbeing. The wide reach of this work connects into other areas of governance both at place and in other regional work – for example in the Mental Health ICB workstream, and Local Authority LAC or First 1001 Days. Involvement of children, young people, and families, needs to take place in earnest, including media that is engaging to and initiatives addressing areas of importance to young people.

Mental Health and Wellbeing in Children and Young People and Mothers in the Perinatal and Maternal Health Phases - Mental Health was the highest priority following feedback, highlighted by professionals and the children and young people.
Note: This section is aligned to the objective in **section 5**.

Objectives:

- Improve access to mental health support in line with the national ambition accessing NHS funded services.
- Reduce reliance on inpatient care, while improving the quality of inpatient care for those who need it.
- Skill children, young people, and the workforce to support mental health and resilience.

Long Term Conditions in Children and Young People - Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever-increasing demand for healthcare services.

Objectives:

- NHS England's Children and Young People's Transformation Programme relevant to long term conditions including Epilepsy, Diabetes, Asthma, Clinics for Excessive Weight, and Transitions.
- Integration Centre to drive innovations into our most disadvantaged communities including areas relevant to long term conditions.
- Deliver Core20PLUS5 work focused into these areas enhanced by the NENC local application of the framework.

Complex and vulnerable and special educational needs, health inequalities and the impact of Covid – The impact of Covid on our children and young people is well documented. Core20PLUS5 is a national approach to reduce health inequalities. Specific consideration should be taken for the inclusion of young carers, inclusion health groups and other socially excluded groups.

Objectives:

- Equitable recovery of elective waiting for children and young people
- Deliver the children and young people's Core20PLUS5 framework
- Meet the regulatory framework and good practice for SEND.

Best Start in Life, Pre-school Needs, and Perinatal - Best Start in Life Vision for 1001 Critical Days.

Objectives:

- Connect especially with place and local authority partners.
- Initiatives that skill children, young people, and the workforce to support best start in life, preschool needs, and perinatal mental health.

5 Improving Health and Care Services

5.1 Overview

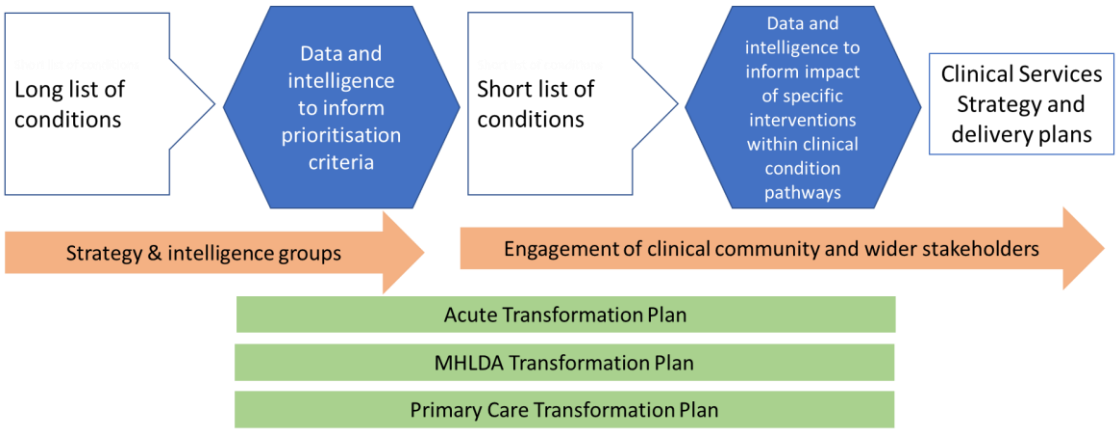
Health and care services in the North East and North Cumbria have a strong foundation to build on. Our integrated care strategy included the key goal to ensure that our providers in our Integrated Care System are rated as 'good' or 'outstanding' by the Care Quality Commission (CQC). To support our work across all the service plans outlined in this section we are developing an overarching framework.

Strategic Principles

- Shift towards self-management and care closer to or in the home
- Better care co-ordination and personalisation
- Step change in prevention and early intervention
- Evidence base interventions; reduction in unwarranted variation
- Improved sustainability of secondary and tertiary care; hub and spoke models, using technology and pathways to keep care as local as possible but not at expense of best possible outcome
- More holistic care towards end of life
- More timely access
- Fairer outcomes contribution reducing health care inequalities
- Improving the local integration of services with partners

The framework above will also support the development of our **Clinical Services Plan** led by the **Provider Collaborative** ICB Executive Medical Director with extensive clinical stakeholder involvement. This work is at an early stage.

Data, intelligence, and insight from system clinical engagement will be used to determine some initial, condition specific priorities for the clinical strategy. The approach is underpinned by population health data, to identify interventions that have the greatest impact on healthy life expectancy and reducing health inequalities.



The ICB will work in partnership with provider collaboratives and clinical networks to ensure sustainable services, maximising opportunities to develop our our highly skilled and committed workforce. The clinical services strategy will support our clinical community in understanding the impact they can have on ensuring the best start in life, healthier lives, fairer outcomes, and ultimately improving health and care services for the people of the North East and North Cumbria.

5.2 Provider Collaboratives

North East and North Cumbria
Primary Care Collaborative

We are working with partners to develop a Primary Care Collaborative covering General Practice, Pharmacy, Optometry and Dentistry. The proposed functions are:

- relationships across all four primary care contractor groups.
- representative voice into the Integrated Care System.
- co-design the Primary Care Strategy as an equal partner.
- collaborate across the North East and North Cumbria where beneficial.
- work with and influence other provider and clinical networks.
- Fuller Stocktake delivery and the transformation and stability of primary care.

Mental Health, Learning Disability and Autism Provider Collaborative

The Collaborative is a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population. This includes delegation from NHS England for some elements of the budget and pathway, beginning with:

- Children and Young People Mental Health inpatient services

- Adult Low and Medium Secure Services
- Adult Eating Disorder Services.

Over time there is potential for the Collaborative to develop to fulfil a leadership function over a broader range of services.

North East and North Cumbria Provider Collaborative

The Collaborative was formed in 2021 to create a vehicle for foundation trusts to collaborate to achieve better outcomes than each provider could deliver on their own. Th Collaborative contributes to the delivery of the NENC Integrated Care Strategy, in particular its long-term goal of 'Better Health and Care Services' by:

- improving the quality and sustainability of health services, towards a goal of all statutory organisations regulated by the Care Quality Commission being rated either 'Good' or 'Outstanding'.
- efficient and effective use of resources, with a focus to collaborate and/or share resources and to identify and reduce unwarranted variation.
- strategic workforce planning in collaboration with national and regional teams.
- opportunities to act as 'anchor institutions', including supporting economic development by leveraging their power as large employers and purchasers.

The Collaborative is a key point of collective leadership and has potential to develop further as an important part of our governance structures.

NENC Provider Collaborative Members:

- Northumbria Healthcare NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust

- South Tyneside and Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

- North Cumbria Integrated Care NHS Foundation Trust

- North East Ambulance Service NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust

5.3 Ageing Well Service Plan

Partnership Working:

The Ageing Well programme operates at a system-level but driven by place-based partnerships. Our approach is to foster real change, supporting delivery through relationships, collaboration and sharing of best practice.

Urgent Community Response - Providing urgent care to people in their own homes within two-hours if their health suddenly deteriorates.

Objectives:

- Increase the number of people accessing UCR services within 2-hours.
- Increase the number of UCR referrals from all key routes, including step-down recovery (when needed).
- Increase the number of UCR services that offer all 9 clinical conditions/needs including a 24/7 falls.
- Improve patient access (equitable), safety, experience, and staff satisfaction within UCR services.

Proactive Care (Formally known as Anticipatory Care) – proactive, personalised care and support for people living with frailty and/or multiple long-term conditions.

Objective: Improve support for Integrated Neighbourhood Teams (INTs) to implement the national Proactive Care model.

Enhanced Health in Care Homes (EHiCH) - Enabling proactive care and support to residents and their families.

Objectives:

- Support Integrated Neighbourhood Teams on the EHiCH model.
- Reduce variation in EHiCH outcomes across the ICB.

Community Health Services Digital - Driving forward digital transformation with community health services to improve patient care.

Objectives

- Improve the use and quality of data within the Community Service Data Set (CSDS)
- Increase the number of community providers utilising the Great North Care Record (GNCR) / Shared Care Record
- Increase learning and sharing of digitally enabled community care and support across the ICB

Supporting the workforce - the Enhanced Care for Older People (EnCOP) workforce competency framework

Objective: Increase the uptake and utilisation of EnCoP as a workforce development programme across the ICB.

5.4 Autism & Neurodevelopmental Service Plan

Note: This section is interdependent with the **Learning Disability** section 5.6.

Partnership Working: ICB and partners are developing a broad and inclusive Mental Health, Learning Disability and Autism Collaborative. Inclusive groups will be codesigned and form part of the overall governance structure for the learning disability and autism programme. There will be a separate group focused on autism.

Improved autism and neurodevelopmental pathways - Commissioners, providers, and delivery partners across all pathways will listen and learn from people who have a lived experience and their families and supporters.

Objectives

- Improve our early help and support offer so that people do not have a diagnosis to receive help and support.
- Work with partners and lived experience experts to design a new 'needs led' pathway to help support children, young people, adults, parents, and carers where a person has a need associated with autism or a neurodevelopmental difference
- Improve the diagnostic element of the service to ensure people do not have to undergo unnecessary assessments over a long period of time
- Improve our post diagnostic support offer

Improving outcomes for autistic people and people with neurodiversity - by addressing stigma, enhancing access to support, improving education and employment opportunities, fostering acceptance, and providing appropriate healthcare, we can work towards a more equitable future.

Objectives

- Tackling health and care inequalities for autistic people
- Right support in the community and supporting people in inpatient care

5.5 Cancer Service Plan

Partnership Working

The Northern Cancer Alliance aim to improve cancer care through collaboration. We do this by bringing together clinical, commissioning, and operational leaders from different hospital trusts and other health and social care organisations, to transform the diagnosis, treatment, and care for cancer patients. The Alliance is committed to involving the public in all of its work and joint work with other system workstreams.

Early Diagnosis - Increase cancers diagnosed at an early stage.

Objectives:

- Improve timely presentation and access to Primary Care, specifically target 20% most deprived and other communities of health inequality.
- Continue to support both national and local innovation programmes.
- Targeted Lung Health Checks (TLHC rolled out across the region.
- Delivery of expansion plans for TLHCs in 2023 – 2027.
- Ensure uptake of lung health checks is above 50%
- Continue to support the clinical trial of NHS Galleri technology (specifically targeting most deprived 20%)
- Support early diagnosis, non specific symptoms pathways, and the extension of the NHS bowel screening programme to 54-year-olds.

Faster Diagnosis Standard and Operational Performance - Faster Diagnosis standard and reducing the number of the longest waiting patients on pathways.

Objectives:

- Statutory cancer waiting time standards, improving year on year.
- Maintain priority pathway changes for lower GI, skin (tele-dermatology) and prostate cancer.
- Place based primary care cancer leads to promote and improve the pathways locally for people presenting with non-specific symptoms.
- Combined pathway for upper and lower Gastro-intestinal cancers.
- Robotic data processes to improve data quality and reporting.
- Rollout of the Digital patient tracking list dashboard.
- Capacity and demand in patient pathways against waiting times.

Treatment variation and Personalised Care - Improving the quality and uptake of personalised care, identify gaps in access and address health inequalities.

Objectives:

- Address variation in care for breast surgery, prostate radical treatment, and radiotherapy treatment for rectal cancer patients.
- Reduce variation in patient experience, diagnosing cancer within the cancer waiting times standards, and improving access to services.
- Ensure the personalised care interventions are available for all.
- Deliver the psychosocial support development plan.
- Personalised, stratified follow up pathways for all suitable patients in breast, prostate, colorectal, and endometrial cancer.
- Embed a universal offer of prehab for all cancer patients.

Improving Experience of Care - capacity within the workforce and involving patients in developing services is key to a good experience of care.

Objectives:

- Community engagement structure to enable Coproduction throughout
- Use insight and feedback to coproduced (with people with relevant lived experience and staff) quality improvement action plans.
- Enable skill mix and maximise the productivity of the current workforce
- Ensure supply, recruitment and retention and upskilling of the Cancer Clinical Nurse Specialist workforce.
- Work with national and regional teams to address the need to expand the cancer workforce, particularly in non-surgical oncology.

5.6 Elective Care & Diagnostics Service Plan

Partnership Working:

The Strategic Elective Care Board (SECB) has senior representation from the Provider Collaborative, Primary and Secondary Care, the ICB, NHSE, the Northern Cancer Alliance and the Diagnostic Programme Board. The SECB feeds into the Provider Leadership Board which is made up of Chief Executives of all 11 FTs in the system including Mental Health and Ambulance providers. Chief Operating Officers from the 8 acute Trusts also meet regularly with specific focus on Elective Recovery.

Elimination of long waits and reduction in the overall size of the waiting list - Achieve national ambitions and constitutional.

Objectives

- To eliminate long waits for elective care, achieving the national objectives for 23/24 and future years
- Eliminate waits of over 65 weeks by March 2024 except when patients choose to wait longer and complex spinal surgery (with reduced waits)
- Deliver the system specific value weighted activity target as agreed through the operational planning process
- Choice at point of referral and at subsequent points in the pathway
- To support Trusts with the greatest challenges
- Digital solutions that support patient choice and elective recovery.

Clinical Transformation and reduced unwarranted variation - Excellence in Basics programme to optimise capacity with potential for centres of excellence.

Objectives:

- To achieve national targets for productivity and efficiency
- Deliver Right Procedure, Right Place
- Reduction in outpatient follow-up in line with the national ambition

Specialty Based Development Work - Specialty-based approach to improvement harnessing shared learning through the establishment of Clinical Alliances.

Objectives

- Implement the high volume, low complexity best practice pathways
- To have choice for patients where appropriate
- To have the right clinical workforce

Diagnostic programme - Reduce variation and therefore increasing equity of access to services in all geographical locations. Focusing on areas of greatest need using a wide range of metrics including health inequalities.

Objectives:

- Increase capacity to meet demand, delivering activity to meet elective and cancer backlogs as well as the diagnostic waiting time ambition.
- Diagnostic workforce supply, retention, skill mix and ways of working.
- Network maturity in Imaging, Pathology and Endoscopy.
- Digital diagnostic roadmap, developing interoperability.

5.7 Learning Disabilities Service Plan

Partnership Working

We are developing a broad and inclusive Mental Health, Learning Disability and Autism Collaborative. We will improve quality by giving people, their families and supporters a strong voice in through co-production. We will keep people at the centre of their own care and treatment. **Note**: This section is interdependent with the Autistic People section 5.3.

Reduce reliance on inpatient care - reducing reliance on inpatient care and developing the housing care and support (based on each person's needs and preferences) to enable people to live healthy and positive lives in the community.

Objectives:

- Increase community-based support options.
- Dynamic Support Registers at Place and community model investment.
- Appropriate Hospital length of stay reflecting the treatment needed.
- Discharge planning begins on admission using tools such as the 12 Point Discharge Plan.
- Reduce the number of patients in long term segregation and seclusion through application of the Independent C(E)TR process.

Improving the quality of care and support - Ensure people receive high-quality care and support that respects their rights, promotes their well-being, and enables them to lead fulfilling lives as valued members of society.

Objectives:

- Host commissioner oversight visits to all specialist inpatient services.
- Ensure the quality of advocacy is improved.
- Ensure lessons from the Whorlton Hall Safeguarding Adults Review.

Improving health outcomes - Making reasonable adjustments standard across services, carrying out more annual health checks and vaccinations, and adopting the learning from Learning Disabilities Mortality Reviews (LeDeR.

Objectives:

- Use learning from LeDeR to prevent avoidable deaths and ill health.
- Influenza and Covid -19 vaccinations to prevent serious illness.
- Ensure cancer pathways are reasonably adjusted.
- Ensure treatment for long term conditions is reasonably adjusted.

5.8 Mental Health Plan

Partnership Working:

Mental Health, Learning Disabilities and Autism Sub-Committee - The sub-committee provides leadership for the delivery and commissioning of NHS mental health and learning disability services across the life course, including Children, Young People, Adults and Older adults. It is a decision-making body with executive representation and delegated authority from the ICB.

North and South Partnerships - Our Partnership Boards are responsible for providing leadership across their allocated geographies of NENC ICB, which are co-terminus with CNTW and TEWV.

Place based Partnerships - Our place-based partnerships form a link between places and whole system.

Community Transformation and Improving Access to Services - integrated primary and community care for adults and older adults with severe mental illnesses (SMI) and more common mental health problems, such as anxiety and depression.

Objectives:

- Access to support close to home.
- Personalised specialist care early enough to make a difference.
- Increase the number of people on the General Practice SMI registers who have received a physical health in line with national standards
- People will be able to call NHS 111 and speak directly to a mental health crisis service. Mental health clinicians will work alongside ambulance colleagues so that people do not have to go to hospital unnecessarily for treatment and / or support.
- People with common mental health problems will have quicker access to NHS Talking Therapies and will benefit from a wider range of integrated community support based around primary care.

Preventing Suicide- increasing knowledge and skills to include prevention and work with partners including local authority public health teams.

Objective

- Halve the difference in the suicide rate between our ICP and England in 2019/2021 (three year rolling average) by 2029/31.
- Improve access to services for people who express suicidal ideation.
- Develop and deliver public information campaigns to raise awareness of ways to support people experiencing mental health difficulties.
- Use data to inform targeted interventions to prevent suicide clusters.

Transformed Neurodevelopmental Pathways - Children, young people and Adults wait too long to be assessed in neurodevelopmental diagnostic pathways, delays to assessment can delay the implementation of Education, Health, and Care Plans.

Objectives

- Improve our early help and support offer so that people do not have to be diagnosed with a neurodevelopmental disorder to receive help.
- Work together to design a new 'needs led' pathway to help support children, young people, adults, parents, and carers where a person has a need associated with a neurodevelopmental difference.
- Improve the diagnostic element so people do not have unnecessary assessments over an elongated period to receive a diagnosis.
- Improve our post diagnostic support offer.

Children and Young Peoples' Mental Health- access closer to home, reduce unnecessary delays, and specialist mental health care based young people's needs.

Objectives

- Coverage of mental health support teams for schools as national funding / workforce development allows.
- Work in partnership to deliver new models of care.
- Commission early-intervention "getting help" services particularly those with reach into underserved communities.
- Seamless working between primary care, paediatric inpatient units, and mental health providers to improve the eating disorder pathways.
- Crisis/intensive home treatment teams to minimise inpatient admissions, but where necessary, beds as near to home as possible.
- Increase access to perinatal services and move towards offering 2-year support across as investment and workforce challenges allow.

Developing safe, therapeutic, rights-based approach to in-patient care - co-produce the model for trauma and autism informed therapeutic inpatient care.

Objectives

- A culture within inpatient care that is safe, personalised and enables patients and staff to flourish.
- Oversight and support structure that identifies issues early. Challenged services will have timely, effective, and coordinated recovery support.
- Line of sight into the mental health inpatient pathways with the same parity as physical health.
- Eliminate out of area admissions in mental health pathways.

5.9 Palliative and End of Life Care (PEoLC) Service Plan

Partnership Working:

Palliative and End of Life Care is part of clinical subject areas and workstreams such as Primary Care and Urgent and Emergency Care. The PEoLC Network reports to the National PEoLC Team via the North East and Yorkshire PEoLC Strategic Clinical Network (SCN) and sits within the Northern Cancer Alliance. Further work is required to ensure that this is the best governance framework for this NENC Network.

Improving access - remove the barriers preventing access to PEoLC services.

Objectives:

- Increase the number of patients captured on primary care PEoLC registers including children and young people
- 24/7 generalist PEoLC services provided across all places
- 24/7 remote access to specialist palliative care (SPC) advice for staff and carers across all places
- 7-day face to face SPC services provided across all places including the use of Virtual Wards or other models for PEoLC

Improving Quality – using data to address variation in PEoLC service provision.

Objectives

- Improve the quality of services for locally identified priority groups
- A confident workforce across statutory and VCSE sectors with the support and capability to deliver high quality PEoLC.
- Personalised and community focused approaches to improve the PEoLC experience for patients and carers (including Social Prescribing).
- High quality PEoLC for all, irrespective of age, condition, or diagnosis.

Improving Sustainability - patients of all-ages will be able to access a range of PEoLC services, which are equitable and meet diverse needs.

Objectives

- All-age PEoLC services that are sustainably commissioned.
- PEoLC services for children and young people including in transition.
- Increase the use of Virtual Wards for this population
- Ensure commissioning and clinical leadership at place for PEoLC.

5.10 Personalised Care Plan

Partnership Working:

Personalised Care needs to be embedded throughout all workstreams as an enabler to transformation. Delivery of the ICB's legal responsibility relating to the consistent provision of Personal Health Budgets and Personal Wheelchair Budgets needs to be a priority. Personalised care needs to take a whole system approach.

Embed personalised care approaches across all workstreams – Harness the universal approach to personalised care throughout all workstreams.

Objectives:

- Engage with all workstream to identify where personalised care approaches can be maximised in their service transformation work.
- Workforce development with the ICS Workforce workstream.
- Implement Schedule 2 of the NHS Standard Contract.

Support PCNs to recruit Additional Roles Reimbursement Scheme (ARRS) - social prescribing link workers, care co-ordinators and health and wellbeing coaches are key to the NHS Long Term Plan commitments on personalised care.

Objectives

- Ensure all PCNs have social prescribing link workers.
- Expansion of ARRS roles, for example in perinatal mental health and for autistic people.

Maternity - ensure all women have personalised and safe care through a personalised care plan and are supported to make informed choices.

Objectives

- Support LMNS colleagues in embedding Personalised Care, in line with the Three-Year Delivery Plan for Maternity and Neonatal Services.

5.11 Pharmacy and Medicine

Partnership Working

Medicines are the most common and most evidence-based intervention in healthcare. Managing the use medicines well is a statutory responsibility of the ICB

and contributes to the goals within its Integrated Care Strategy. The ICB spends £560 million on prescribing in primary care each year, nearly 10% of the ICB budget.

Decreasing Antibiotic Prescribing Report implementation - The reduction and appropriate use of Antimicrobial Resistance (AMR).

Objectives

- Delivery of bespoke practice level AMR reports to every practice in the ICB every 2-months for three years
- Practice engagement with the reports to affect behavioural change.
- A reduction in antibiotic prescribing and variation across the region

Increasing capacity for Point of Care (POC) Testing - to support antimicrobial stewardship in primary care

Objectives

- Resources for POC testing capacity and support to effectively utilise POC testing in primary care.
- Support stakeholders to undertake POC testing within the pathways
- Evaluate impact of the pathways

Point of care testing service in community pharmacies.

Objectives:

- Increase use of community pharmacies to manage common infections, supported by pathways, point of care testing and supply of medicines.

Proactive medicines optimisation system across all GP practices

Objectives:

- Roll out of Analyse Rx medicines optimisation system for all 'EMIS' system practices within 2023/24.
- Utilising the dashboards to identify areas for further improvement.

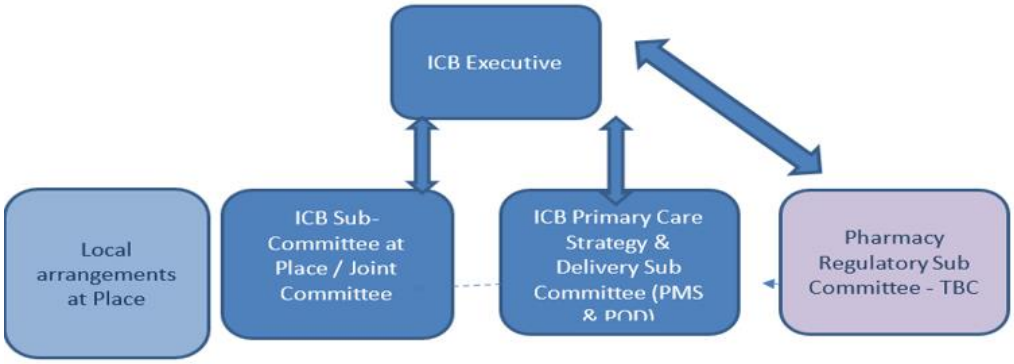
Deliver the national programme to **reduce over medication of people with a learning disability (STOMP/STAMP)**

Objectives:

- Recruit Consultant Pharmacist in employed to deliver change ICB wide.
- Reduction in inappropriate prescribing across the ICB.
- Education and support to address over and inappropriate prescribing for children and young people with a learning disability.
- Comprehensive ICB plans to address STOMP/STAMP.

5.12 Primary Care

Partnership Working - the chart below summarises the governance arrangements supporting Primary Care, which continue to be under review.



Access - Eliminate the challenge to access appointments.

Objectives:

- Ensure equitable and good access to general practice services to meet future demand.

Integrated Neighbourhood Teams - The Fuller Stocktake vision for integrating primary care, bringing together teams to improve care for whole populations.

Objectives:

- Establish integrated neighbourhood teams to cover the full population.
- Neighbourhood services that address inequalities and support Core20PLUS5 populations.
- Integrated neighbourhood teams with active all community partners.
- The collaborative provision of services leading to improved patient journeys, joined up systems, and patient centred personalised care

Stability & Resilience - Improve the delivery of general practice services and understand how to deal with the growing patient demand and complexity.

Objectives:

- A stable and resilient General Practice
- Provider change with minimum negative impact for patients
- Primary care voice is represented at place and system level
- Establish a NENC ICB wide Primary Care Provider Collaborative

Workforce / Estates / Digital - There is a need to upgrade Practice telephony to support patient communication with Practices.

Objectives:

- Sufficient and diverse workforce that provide high quality services
- A fit for purpose estate that meets the needs of practice and PCNs
- IT solutions that support the transformation including telephony systems

Pharmacy / Optometry / Dentistry – From April 2023, the ICB became responsible for the pharmacy, optometry and dental services enabling partnership working.

Objectives:

- Ensure pharmacy, optometry, and dental responsibility transfer well.
- Support pharmacy, optometry, and dentistry transformation
- Provision of high quality, accessible services to all, improving access.

5.13 Safeguarding and Cared for Children (including Care Leavers)

Partnership Working:

Each priority will be led by a senior NHS safeguarding lead (denoted as workstreams), will be reviewed with oversight from the Integrated Care System Health Safeguarding Executive, and updated in line with national guidance.

Cared for Children including Care leavers - The poor physical and mental health outcomes for care leavers and care experienced are stark. Children in care have often experienced significant trauma and face difficulties accessing health support. Children from the poorest 10% of neighbourhoods are 10 times more likely to be in foster or residential care than children from the least poor 10%.

Objectives:

- Reverse the trend in statutory health care for cared for children.
- Well-coordinated, targeted, proactive, and preventative health provision to ensure equitable access to mental and physical health and care.
- Deliver the NENC ICB commitments in the Care Leavers Covenant.
- Integrated care pathway for cared for children.
- Align support to care leavers until up to 25 years of age.

Transitional Safeguarding - Investing in support to address harm and its impacts at this life stage can help reduce the need for more costly intervention later in life.

Objectives

- Embed a trauma and psychologically informed approach across all commissioned health services, recognising the lifelong impact of trauma
- Ensure cared for children experience a smooth transition from child to adult mental health services with appropriate support.

Domestic Abuse - The Domestic Abuse Act 2021 puts an emphasis on strengthening the response across all agencies and making domestic abuse everyone's business. The ICB is subject to the statutory Serious Violence Duty and must collaborate with other duty holders to prevent and reduce serious violence. The ICB has a particular duty to ensure that the needs of victims of abuse and children and young people are specifically addressed. Experience of violence increases health inequalities. Young females are most likely to experience domestic abuse.

Objective

- Ensure that the ICB wide working environment adopts and promotes the view that domestic abuse is unacceptable and will not be tolerated.
- Domestic Abuse Act 2021 principles of prevention, early intervention and multi-agency working for victims and survivors are embedded.

Self-Neglect - Self-neglect poses complex challenges to practitioners and is one of the most common forms of abuse in adults. The prevalence of self-neglect are higher among certain ethnic groups, the elderly and those with lower levels of education and income. Chronic illness and disability increase the risk of self-neglect.

Objectives:

- Support the approach of Making Safeguarding Personal when working with individuals who self-neglect and address the challenges in practice
- ICB wide approach to 'Was Not Brought' for children and adults

5.14 Specialised Commissioning Plan

Partnership Working: Specialised Commissioning

There is a national plan to delegate the commissioning of some specialised services to ICBs from April 2024. During the 2023/24, the ICB and NHS England will work together via a Joint Committee and associated sub-groups. This infrastructure will be used to track progress on transformation priorities such as the 3 included in this thematic plan. Details of how this will operate from April 2024 are to be determined.

Ensure the ICB is ready for the delegation of specialised commissioning from April 2024 - delegation of specialised commissioning is anticipated from April 2024.

Objectives:

- Model for how specialised commissioning will operate from April 2024.
- Conduct due diligence on services due to transfer to the ICB.

Transform non-surgical oncology service delivery - Treatments and pathways across radiotherapy, genomics and chemotherapy continue to advance.

Objectives:

- Provide long term sustainability of the service (workforce and capacity)
- Reduce clinical risk and variation.
- Contracting and finance model to facilitate a new commissioning model.
- Improve digital connectivity across provider systems.

Transform Gynaecology Oncology service provision

Objectives:

- Clinical model making to reduce variation and fragmentation.
- Improve coordination and management of patients across the system
- Provide long term sustainability of the service (workforce and capacity.
- Commissioning model with contracting and finance agreements in place.

Transform Neuro-rehabilitation services - The pathway spans NHS England and ICB commissioned services providing an opportunity for joint-working.

Objectives:

- Improve patient flow in and out of in-patient provision.
- Ensure appropriate and timely referrals into in-patient provision.
- Ensure appropriate pathways and care closest to home where possible.
- Improve data reporting and review in line with targets.

5.15 Urgent & Emergency Care Service Plan

Partnership Working:

System leadership is provided through the Urgent and Emergency Care (UEC) Network Board. Its membership includes Trust Chief Executives who chair the five Local Accident and Emergency Delivery Boards (LADBs).

Increasing urgent and emergency care capacity - Reduce bed occupancy rates, increase the number of staffed hospital beds, and increase ambulance capacity.

Objectives:

- Reducing adult general and acute bed occupancy to below 92%.
- Increasing ambulance capacity through single points of access for paramedics for specific services; increasing clinical assessment in ambulance control centres and mental health expertise
- Eliminate ambulance handovers over 59 minutes
- Improved ambulance response times for Category 2 incidents

Improving Discharge - Once people no longer need hospital care, being at home or in a community setting is the best place for them to continue recovery.

Objectives:

- Joint discharge processes building on Home First, Discharge to assess and Transfer of Care Hubs.
- Digital solutions to ensure accuracy and access to data including 'live' discharge dashboards.
- Implement a stronger approach to 'own' medically optimised lists
- Scaling Up Intermediate Care
- Scaling Up Social Care Services, learning from Winter 2022/23
- Review of neuro rehabilitation

Expanding care outside hospital - Care closer to, or at, home to avoid the deconditioning and prolonged recovery that can accompany a hospital stay.

Objectives:

- Expanding new types of care outside hospital including virtual ward pathways, urgent community response, same day emergency care, acute respiratory infection hubs and unscheduled care across systems.
- Sustainable services with defined criteria to admit patients onto virtual wards whilst supporting patients at home and in the community.
- Expanding virtual ward provision for step-up and step-down care, increasing utilisation, and extending access into additional specialties.

Making It Easier to Access the Right Care - Ensure that the urgent and emergency care system is responsive to the needs of patients.

Objectives:

- Further expansion of 111 online and clinical assessment models.
- Increase direct booking into primary care.
- Improve access for people needing mental health support including 24/7 urgent mental health helplines accessible via the 111.
- Alternative offers to 999 and A&E for urgent care.
- Implement 24/7 co-located urgent treatment centres (UTC) in emergency departments maximising the "see and treat" approach.
- Expand Same day Emergency Care services (SDEC) to at least 12 hours a day, 7 days a week
- Greater integration with GP out of hours services and greater clinical support for community-based teams.

6 Our Enablers

6.1 Skilled, Sufficient and Empowered Workforce

Note: This section will be reviewed when the National People Plan is published.

We are working with partners to develop a shared People and Culture Plan. The North East and North Cumbria will be a better place to live and work, supporting our ambition of becoming the employer of choice and increasing our job fill rate across health and social care services by 50% by 2029. The plan requires commitment and collaboration from all our partners, led by our system wide People Board.

Workforce supply across the system, including a key focus on retention - Covid recovery depends on a healthy, supported and engaged workforce.

Objectives

- Ensure safe staffing levels across all our services and sectors.
- Widen participation to allow people to join the NHS and Social Care.
- Work effectively with Higher Educational Institutions.
- Campaign highlighting opportunities of working in health and social care.

Workforce health and wellbeing across the system - There is wide variation in staff experience in our system, with examples of good practice to build on.

Objectives:

- Wellbeing culture that improves equitable access to health and wellbeing support regardless of employer
- Collaborate to develop a system approach to health and wellbeing where it makes sense to work together
- Maximising the terms and conditions of staff across sectors, wherever possible ensuring that people are appropriately rewarded
- To improve our staff engagement and morale by sharing the outputs of our staff engagement surveys.

System Leadership and Talent - integration is dependent on how we work and learn together. Good leadership is at the centre of our model for ensuring that we work beyond organisational and professional boundaries.

Objectives

- We will develop a proactive and inclusive talent management approach that increases our leadership supply pipeline
- We will develop compassionate and inclusive leaders that represent our diverse communities and amplify our strength as a system.
- We will create a system of leadership development focusing on sharing best practice for integrated working.

Equality, Diversity, and Inclusion (EDI) - a long-term plan to become the most equitable and inclusive place to work in the health and social care sector.

Objectives:

- Improved EDI capability and knowledge.
- Legal compliance and exceeding expectations.
- Listen to people to build psychological safety, improve their lived experience, to create the best workplace environment.

Retention - Support offers so we are an employer of choice. Listening to our people we will review human resources pathways and induction, so staff have the best start.

Objectives

- Valuing our workforce, enabling them to make their best contribution.
- Career structures across and between health and social care, removing barriers preventing people to entering the workforce.

New Ways of Working - adapt to technological advances and role development.

Objective:

Review role functions to allow for different workforce models, and as technology progresses, including incorporating artificial intelligence.

The development of the learning and improvement community - Our aim is to be **'the best at getting better',** embedding learning and improvement at every layer.

Objectives

- To make learning and improvement the default approach in how we go about tackling our biggest challenges as an ICS.
- Bring people together from across the system to identify, share learning and collaborate on these challenges.
- Build collective capability in learning and improvement.

6.2 Working Together at Place and in Neighbourhoods

Partnership Working at Place

We will further strengthen our partnerships with governance and decision arrangements. The context for place-based partnerships includes:

- The preservation of well-established place-based working arrangements involving partners from health, local authorities and the voluntary, community and social enterprise (VCSE) sectors.
- Place-based partnerships are not statutory bodies. The 2022 Health and Care Act did not create a legal requirement for Place-Based Partnerships. It does allow for ICBs to delegate some functions and budgets to local committees as part of place-based partnerships.

Place-based partnerships focus on joining up and co-ordinating services, addressing the social and economic factors that influence health and wellbeing, and supporting the quality and sustainability of local services. Priorities vary depending on the vision and goals agreed locally through Health and Wellbeing Boards. Place-based arrangements will fulfil three interdependent functions:

a) Place partnerships - consultative fora with delivery focus, usually without delegated authority.
b) Place based delivery groups (PBDG) - ICB internal decision making.
c) Joint governance arrangements between ICB and Local Authority - to oversee the Better Care Fund and Section 75/256 agreements.

Strengthening our Partnerships - Timeline

From April 2023:

- ICB place committees – the ‘Part b’ element of place-based partnerships. This involves the ICB, local authorities, NHS trusts, primary care, VCSE partners and others in decision making on delegated ICB functions.
- The ‘Part b’/ICB Place Committee would remain accountable to the ICB.
- Further development on managing financial delegations locally.
- Alignment of the place partnership and Section 75 governance meetings.
- The relationship with their local health and wellbeing board..

Longer term development: Maximise joint working at place, building on our collective learning, as place-based arrangements continue to mature and strengthen.

6.3 Involving People to Co-produce the Best Solutions

Partnership Working

Triangulation of intelligence and stakeholder feedback is a key enabler to delivering our commitments. This is coupled with proactive engagement to gain the very best

understanding of service users, partners, and stakeholders. We cultivate partnership working across our Integrated Care Partnership and support our VCSE sector to flourish and build relationships at system and place.

Raise the profile of involvement across the ICB and ICP

Objectives

- Bring together involvement, building on existing assets and strengths.
- Forward plan for involvement and evaluating impact linking with community networks and research organisations.
- Priorities identified with our communities and partners.
- Develop a formal subcommittee of the Quality and Safety Committee.

Develop ways to **listen**, with mechanisms to collect **lived experience.**

Objectives:

- Establish a Citizens Panel to support engagement
- Involvement toolkit to support engagement across the ICB
- Demonstrate impact of the lived experience stories

Deliver a programme of **communications** to establish strong relationships with **internal and external stakeholders**.

Objectives

- Campaign programmes on access, prevention, and population health.
- Identity for the Partnership, ICB and 'Better health and wellbeing for all'.

Model for **communications delivery** for the organisation and system

Objectives

- Delivery unit with networks and communications system leadership
- Creative hub to deliver digital communications and campaigns
- Interactive web and digital presence for the Partnership and ICB

Effective **partnership** development.

Objectives

- Support the Strategic ICP, Area ICPs and system leadership groups.
- Networks with local authority professional forums
- Engagement mechanisms with the independent care provider sector.
- Support for health initiatives with the Combined and Local Authorities.

Deliver effective **stakeholder management**.

Objectives

- Stakeholder feedback processes including complaints and compliments, triangulating and analysing trends.
- Work with Scrutiny Committees and Health and Wellbeing Boards.
- Support the VCSE sector, ensuring their voice is heard.

6.4 Best use of Resources and Protecting the Environment

Financial Plan

Summary: Unique and longstanding challenges mean our healthcare system is dealing with a 'quadruple whammy', resulting in a vicious circle of ill health.

1. Greater health and care need – chronic ill health and health inequalities impacting our communities' ability to live healthier lives.
2. A position made worse because of the pandemic – our region was hit harder than other areas.
3. Our large and complex geography makes it more expensive to provide accessible services and population growth remains fairly static.
4. Our funding infrastructure does not target those who need it most.

The national funding formula considers the North East and North Cumbria to be over-funded, so funding growth will be lower than other areas. Convergence also reduces growth funding on a glide path to a level of funding that is reduced post-covid. Our priority now is to develop a sustainable medium and long-term financial recovery plan over the next three to five years.

Financial Sustainability - Living Within our Means

Objectives

- Move the ICS into financial balance - a break-even/surplus position
- Move the ICB into underlying financial balance
- Move the NHS provider sector into underlying financial
- Partners – ensuring ICB actions do not unfairly or unreasonably put at risk the financial position of third sector partners, other commissioned providers (e.g., primary care organisations) or local authorities

Financial Fairness - Investing in Health Equity

Objectives

- Allocating resources within the ICB to address inequalities
- Allocating resources within places to address inequalities
- Exceeding national aim to spend 1% of the ICB budget on prevention
- Directing discretionary resources where they can have biggest impact

Priority 3 - Allocative Efficiency - Allocating resources effectively

Objectives

- Secondary care sustainability, securing best value working efficiently across Providers
- Invest in primary and community services and early intervention services
- Fair investment in mental health, learning disability and autistic people
- Information technology to maximise the benefits of service integration.

Priority 4 - Maximising Value with Partners

Objectives

- Aligned investments with social care at place, and to improve the sustainability of the care sector.
- Work with public health teams to ensure best value from the "1%" spend on prevention and targeted in the places to have the most impact.
- Work with the 3rd sector to develop framework arrangements to deliver best value from the sector in a financially sustainable way.

Estates Service Plan

Partnership Working: Local Place based Strategic Estate Groups (SEGs) support the delivery of the ICB Estates Strategy. These groups include representation from: place based ICB teams, local Authorities, acute and mental health trusts, community services as well as wider estates partners NHS Property Services and Community Health Partnerships. All PCNs across the ICB supported the development of place-based estate plans.

Work with the **Provider Collaborative to prioritise and optimise our investment in estates** across health care services **is under development.**

Appropriate and integrated workplace - staff working in a more agile way.

Objectives:

- A range of workspaces with a high-quality and inclusive environment
- Create financial savings that can be recycled back into other services.

Reduction in the void budget – Review vacant estate to ensure efficiencies can be delivered (where appropriate) and space can be used to support frontline care. Our objective is to reduce cost of void estate by 1% per annum

6.5 Innovating with Improved Technology, Equipment and Estates

Research and Innovation

Partnership Working: In November 2022, the ICB organised a regional Research & Innovation Partnerships Forum. The forum brought together leadership from all six universities in the region, the foundation trusts, research active primary care providers, local authorities, voluntary sector organisations, regionally based National Institute for Health and Care Research (NIHR) bodies and those involved in regional economic development initiatives and set the framework for our priorities.

Increase **inward investment** in research funding and innovation

Objectives

- Regional, national, and international recognition of our research and innovation assets
- Support the development of new collaborations
- Increase overall research funding and innovation investment

Make research evidence **more accessible to decision makers** and increase research and innovation **directly relevant to the needs of the system**.

Objectives:

- Optimise research resources across the system
- Develop an inclusive research culture reflective of the needs of the full diversity of the North East & North Cumbria population
- Improve mechanisms for research dissemination and support

Stimulate a **culture of innovation** across the system and sectors

Objectives

- Enhance support for both early-stage innovation and for the adoption of evidence backed solutions
- Encourage collaborative innovation and knowledge sharing
- Concentrate efforts on key ICB priorities and system wide unmet needs
- Showcase and promote promising innovation

Digital Enabler Plan

Partnership Working - our governance for the Digital Care Programme include our Digital Planning Council, supported by the Digital Strategy and Innovation Group and the Digital Delivery Group. The partnership structures are supported by the ICB Digital Directorate and are connected to each of our workstreams as an enabling function.

Digital First Primary Care: Make sure the right digital tools are available to support Practices and PCNs to adapt to demand and capacity challenges.

Objectives

- Digital tools to allow patients to access GP practices digitally.
- Optimise the use of digital tools to modernise general practice access.
- Empower patients to manage their own health and ensure digital inclusion.

Supporting System Recovery: Through the expansion and adoption of digital, data and technology solutions and services, information sharing and interoperability.

Objectives

- Digitally enabled recovery of secondary care services, to reduce waiting times for elective and cancer care
- Digitally enabled access to primary care services
- Faster access to and sharing of digital diagnostics.
- Build on current interoperability capabilities and empower patients to contribute to their health and care.

Digitising Social Care (adult care homes and domiciliary care) – support the expanded use of digital social care records within adult social care.

Objectives

- Digital social care records in care homes and domiciliary care.
- Network of digital social care champions to build on and promote success amongst the harder to reach care providers.
- Identify resources for future care technology.
- Communication plan, to promote the opportunities and achievements.

Frontline Digitisation - Aim to ensure every trust has an electronic patient record system in place meeting key capabilities by March 2026.

Objectives

- To level up digital maturity of Electronic Patient Records (EPRs) across the ICS in secondary care provider organisations.
- Achieve the Minimum Viable Product (MVP) functionality for every EPR, as outlined by NHS England, across all Trusts.

Data Driven Decision Capabilities - To have the very best Business Intelligence (BI) service in the NHS, exploiting the digital and data assets available.

Objectives

- Intelligence functionality and population health management analytics.
- Longitudinal dataset (primary, secondary, mental health, social care, community data, blue light services)
- Increase access to reports & insight using self-service technologies
- Predictive analytics to move from a model of Hindsight (past) and Insight (present) reporting to Foresight (future)

Digital Inclusion - Aim to address and respond to mitigating against digital inequalities, for the residents with fair access for all.

Objectives

- Understand the scale of the problems and contributing factors.
- Develop and agree NENC ICS digital inclusion and strategy.
- Enhance access to services through digital tools, options, and resources.

7 Place

Introduction

Each local authority place has its own action plan, which forms part of the Joint Forward Plan. The Place plans are important to ensure that the ICB has a local focus across its footprint. This is underpinned by close working and engagement with Local Authorities, health and social care providers, local communities, and voluntary, community and social enterprise sector organisations. Plans have been developed with partners and delivery will be monitored with them, through Place Committees, pre-existing system wide partnership meetings, and/or the Health and Wellbeing Boards depending on local arrangements.

Some Place plans cover more than one local authority area. The North Cumbria plan covers the parts of both Cumberland and Westmoreland and Furness unitary authorities which are within the ICB boundary. The Tees Valley covers Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton on Tees local authority areas, recognising the strength and maturity of partnership arrangements across Tees Valley.

Place and North East and North Cumbria wide Plans

The active involvement of Place will span beyond the local priorities described in each place plan. Place is vitally important to the delivery of the goal and enabler thematic plans. Place will inform and influence the development and delivery of the North east and North Cumbria wide action plans, recognising the differences in population need and health and care partnership working at local level.

Focus of Place Plans

Place plans cover immediate priorities for 2023/24, and longer-term transformation and development plans until 2028/29. Place plans respond to local context and the needs of the area's population. The Plans also all cover consistent themes from the ICP strategy that are best delivered through working at Place. These areas of focus are summarised below, noting that the way they are delivered will appropriately vary between and across Places.

Healthier and Fairer – Improving population health and reducing health inequalities is clearly a key focus. This includes supporting the implementation of the Healthier and Fairer programme at a local level, but with a heavy focus on priorities from:

- the Health and Wellbeing Board
- the Joint Strategic Needs Assessment
- Joint Health and Wellbeing Plans.

Examples:

- Delivery of the adult and children and young people's CORE20plus5
- Focussed support on 'Deep End' General Practice and health inclusion groups, for example the street homeless.
- Smoking cessation, alcohol, and substance misuse related harms.
- Healthy weight, nutrition, and exercise.
- Addressing the impacts of the cost-of-living crisis in partnership.
- Partnership working on housing, employment, and broader social determinants of health, including Anchor Institution approaches.
- Case finding and early intervention for long-term conditions.

Best Start in Life – All of the Place Plans include a broad set of actions to support children and young people, some of which are summarised below. These are often a focus of joint working with local authority and other partners.

Examples:

- Joint approaches to meeting needs which services often find complex, including jointly commissioned packages of care
- Special Educational Needs and Disabilities.
- Safeguarding, and improving health outcomes for children in our care and those leaving care.
- Whole system approaches to mental and emotional wellbeing, and mental health services, support for people with a learning disability and improving neuro-developmental pathways.
- Specific pathways, for example speech and language therapies.

Improving Health and Care Services – All Place Plans support the delivery of the North East and North Cumbria wide service Plans; areas of focus include:

Integrated Neighbourhood Teams, Primary Care and Community Services

Examples

- Service models supporting the sustainability of primary care and improving access to primary care.
- Delivering the local model for integrated neighbourhood teams, and for the development of Primary care Networks.
- Integration between Primary Care and Community services.
- Personalisation programme, for example maximising the value of the additional role reimbursement scheme roles.
- Community based urgent care (see urgent care below).
- Medicines optimisation and partnerships with community pharmacy.

Urgent and Emergency Care

Examples

- Community based urgent care pathways, including virtual wards, urgent treatment centres, and alternatives to hospital admission.
- Urgent 2-hour community response, for example falls pathways.
- Improvement to hospital discharge processes.
- Services to reduce the reliance on residential care.
- Community based palliative and end of life care.
- Partnership approaches to support people who are high frequent users of emergency services, including accident and emergency.

Mental Health, Learning Disability and Autistic People

Examples

- Delivering the Community Transformation Programme.
- Local programmes supporting suicide prevention.
- Increasing the dementia diagnosis rate and support pathways.
- Reducing reliance on in-patient services, through improved discharge and community pathways.
- Improvements in peri-natal mental health pathways.
- Children and young people (as above in best start in life).
- Focus on improving the physical health of people with a severe and enduring mental illness, people with a learning disability, and autistic people, for example through annual health checks and access to screening programmes.

Enabling Plans – All Place Plans address each of the enabling Plans in section 6. Working together to strengthen our neighbourhoods and places is a particular focus.

Examples

- Overarching focus on **system integration, transformation, and partnership working,** including **partnership governance.**
- Opportunities to develop shared solutions to workforce, digital, environmental sustainability and aligned approaches to maximising our resources and financial efficiency, including aligned approaches to commissioning services.

8 Delivering the Joint Forward Plan

The overall approach to Strategy deployment is summarised in the graphic below:

Timetable and Engagement

NHE England requires ICBs, and their partner NHS trusts to publish their first Joint Forward Plan (JFP) by 30 June 2023 and share the plans with their Integrated Care Partnership (ICP) and Health and Well-being Boards. In March 2023, the ICB set out its approach to use the Joint Forward Plan as its delivery plan for the Integrated Care Strategy, and to work with its existing strategic programme and place-based teams and leads for the key enabling strategies to develop the plan content.

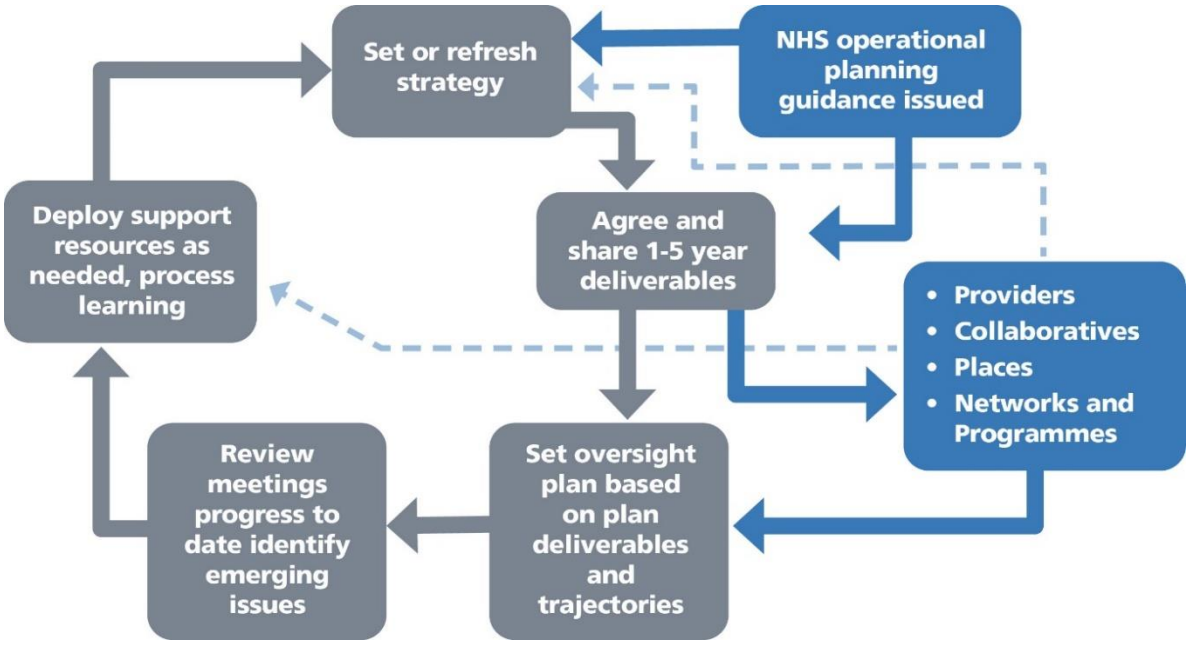
Collectively the ICP ensured a broad engagement approach to the development of the ICP Strategy 'Better Health and Wellbeing for all'. This included publishing an early draft to support stakeholder feedback. To maintain the commitment to stakeholder engagement, during July – August, stakeholders will be encouraged to provide feedback on the JFP and the associated action plans. This will specifically include the Integrated Care Partnership, NHS Trusts, Health Watch and Health and Wellbeing Boards. Endorsement of the Plan will be requested from those stakeholders as appropriate.

A revised version of the Joint Forward plan will be published in September 2023 Subsequently, ICBs and their partner NHS Trusts will be required to publish an annual update of the Joint Forward Plan, beginning in March 2024.

Deployment

Working with our partners, the ICB has developed a robust framework to deliver the Integrated Care Strategy set by the Integrated Care Partnership and this Joint

Forward Plan. The ICB Oversight Framework articulates the ICB Cycle of Business, as set out in the figure below:



Programme support

Each discrete plan that makes up the Joint Forward Plan will have a:

- Delivery plan, with clear actions, milestones, and measurable impacts.
- Lead ICB executive, a lead director, and an identified group within the ICB governance structure responsible for the plan.
- Regular reporting mechanism into the ICB Oversight Framework.
- Regular meeting with those working on the programme and the lead ICB Executive to discuss progress and to tackle any delivery difficulties.
- Facilitated leader forum to share good practice and learn with others.

Governance

In line with the national guidance the approach to the final approval of the Joint Forward Plan will be agreed by the ICB and partner NHS Trusts. The ICB will then receive regular reports on the progress in completing the actions identified within the plans. This will take the form of a 'strategy deployment milestone tracker' which will come to the Board twice each year. The Executive Committee has delegated responsibility for the delivery of plans and will ensure that it has a formal reporting line from all the groups with responsibility of a section of the Joint Forward Plan.

Taking a learning approach – being 'the best at getting better'

As set out in the workforce section, the ICB has set its Mission as becoming 'The best at getting better'. In 2023/24 the ICB will take its learning system to the next stage of development, and access to the resources within this system will be a key plank of support underpinning the delivery of our plans. Teams will have access to communities of practice through the learning community, and to training and resources to support them.

Using data and insight

The ICB is working with partners to ensure we maximise our capability to use data to drive our decision making and plans in line with the furtherance of our integrated care strategy. During 2023/24 we will reform our business intelligence and population health management capacity and capability to:

- Optimise our understanding of the population health and wellbeing needs, including variation within our places compared to the national picture.
- Have a systematic approach to using population health and other insight to shape the focus of our programmes and measure their impact.
- Have a comprehensive, well presented, and accessible architecture of information reports and programme updates.

Refining the ICB's operating model

There is a clear opportunity to refine the ICB operating model to ensure it is set up to deliver its vision and goals. In addition, ICBs are required to reduce their running costs by 30% over the next 3 years. During 2023/24, the ICB will develop and deliver its 'ICB 2:0 Programme, with the following measures of success:

1. An ICB set up to drive delivery of our Integrated Care Strategy.
2. An intelligence driven organisation that tracks, triangulates and forecasts; is responsive not reactive and truly knows its population and the impact of its interventions.
3. An organisation that develops and maintains excellent relationships and fosters collaboration with and between health and care partners.
4. An operating model that is transparent, reliable, effective, and efficient, does things once and to an excellent standard with a quality management system.
5. Ability to meet our statutory responsibilities and ensure quality and safety is prioritised.
6. Affordable within the running cost envelope.
7. A healthy, engaged, skilled, productive, inclusive, and diverse workforce
8. Clarity of role and responsibility for all, with clear alignment of clinical and managerial leadership to all elements of the operating model.
9. Continuation of a flexible and hybrid working model, with more sharing of work spaces with partners, optimising the use of technology.
10. An open, honest, equitable and compassionate change process to implement the new arrangements, driven by our values.

NORTHUMBERLAND COUNTY COUNCIL

HEALTH & WELLBEING BOARD

FORWARD PLAN 2023 - 2024

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Updated : 27 July 2023

FORTHCOMING ITEMS

ISSUE	OFFICER CONTACT
10 August 2023	
• CNTW Transformation Programme • Coroner's Report • Healthwatch Annual Report • Better Care Fund Plan • Closure of 100 Hour Pharmacy in Cramlington	Sheree McCartney Andrew Heatherington Derry Nugent Neil Bradley/Rachel Mitcheson Ann Everden
14 September 2023	
• Health Protection Assurance and Partnership Board • Infection, Prevention and Control (ICP Strategy) • Aging Well • Healthy Weight Alliance	Jon Lawler Jim Brown Pam Lee/Luke Robertshaw David Turnbull
12 October 2023	

• Joint Health and Wellbeing Strategy – Position Statement Report
  • Best Start in Life
  • System Integration
• ICB Place Based Board
• Poverty and Hardship Plan – System Working
• Thriving Together/VCSE Sector Update
	Gill O'Neill
	Graham Reiter/Jon Lawler
	Rachel Mitcheson/Jim Brown
	Rachel Mitcheson
	Emma Richardson
	Abi Conway

Updated : 27 July 2023

9 November 2023	

• Tobacco Control Partnership Annual Update
• Public Mental Health Annual Update
• Family Hubs
• Healthy Family Partnership Board Update
• Joint Health and Wellbeing Strategy
  • Wider Determinants
  • Empowering People and Communities
	Kerry Lynch
	Pam Lee/Yvonne Hush
	Graham Reiter
	Jon Lawler
	
	Rob Murfin/Liz Robinson
	Abi Conway/Karen McCabe

14 December 2023	
• Housing and Health • JSNAA Update • Sexual Health Strategy	Rob Murfin/Anne Lawson Pam Lee/Pam Forster John Liddell/Clare Elliott/Gill O'Neil

MEETING DATE TO BE CONFIRMED

• Urgent and Emergency Care - Strategic Care • Child and Adolescent Mental Health	

REGULAR REPORTS

Regular Reports	
● Joint Health & Wellbeing Strategy Refresh Thematic Groups – Update (Quarterly – Apr/July/Oct/Jan)	
● System Transformation Board Update	Sir Jim Mackey/Siobhan Brown
● SEND Written Statement Update - progress reports	??
● Population Health Management - (Oct/Jan/Apr/July)	Rachel Mitcheson
Annual Reports	
● Public Health Annual Report	Gill O'Neill (APR)
● Child Death Overview Panel Annual Report	Paula Mead/Alison Johnson (JAN)
● Healthwatch Annual Report	Peter Standfield/Derry Nugent (JULY)
● Northumberland Safeguarding Children Board (NSCB) Annual Report and Update of Issues Identified	Paula Mead (JAN)
● Safeguarding Adults Annual Report and Strategy Refresh	Paula Mead (JAN)
● Annual Health Protection Report	Liz Morgan (OCT)
● Northumberland Cancer Strategy and Action Plan	Robin Hudson (DEC/JAN)
● Tobacco Control	Kerry Lynch (DEC)
● Healthy Families Partnership Board Annual Report	Jon Lawler (SEP)
2 Yearly Report	
● Pharmaceutical Needs Assessment Update	(MAY 2024)

NORTHUMBERLAND COUNTY COUNCIL
HEALTH AND WELLBEING MONITORING REPORT 2023-2024

Ref	Date	Report	Decision	Outcome
1	8.6.23	The Community Promise Update	Presentation received.	
2	8.6.23	Health Inequalities – Northumbria Healthcare NHS Foundation Trust	Presentations received	
3	8.6.23	Towards a Collaborative Approach to Reducing Inequalities in Employment Outcomes for our Population.	(1) Presentation received (2) Health & Wellbeing Board survey to be recirculated to Members	
4	8.6.23	Joint Health & Wellbeing Strategy	(1) Report received (2) Summary report to be provided for October meeting	
5	8.6.23	Integrated Care Board – Update	Update noted	
6	8.6.23	Better Care Fund	Retrospective report to be reported to August meeting.	

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