Northumberland
County Council

Your ref:
Our ref:
Enquiries to: Lesley Bennett
Email: Lesley.Bennett@northmberland.gov.uk
Tel direct: 01670 622613
Date: 5 September 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, 14 SEPTEMBER 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, N Bradley, C Briggs, A Conway, P Ezhilchelvan (Chair), V Jones, S McCartney, V McFarlane-Reid, R Mitcheson, R Murfin, R Nightingale, 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 - 6)

Minutes of the meeting of the Health and Wellbeing Board held on Thursday, 10 August 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. NORTHUMBERLAND AND NORTH TYNESIDE COMMUNITY INFECTION PREVENTION AND CONTROL STRATEGY 2023-28 (Pages 7 - 60)

To present the new Northumberland and North Tyneside Community Infection Prevention and Control Strategy 2023-28 and seek approval for the strategy goals and actions to achieve those goals. The report will be presented by Dr. Jim Brown, Consultant in Public Health.

5. HEALTHY WEIGHT ALLIANCE (Pages 61 - 72)

To receive a report updating the Board on progress with the Health Weight Alliance. The report will be presented by David Turnbull.

6. CUMBRIA, NORTHUMBERLAND, TYNE & WEAR NHS FOUNDATION TRUST'S (CNTW) NEW STRATEGY; 'WITH YOU IN MIND' (Pages 73 - 100)

To receive a report and presentation on CNTW's new strategy 'With You in Mind'. The report will be presented by Sheree McCartney, Group Nurse Director North Locality and Anna Foster, Trust Lead for Strategy and Sustainability.

7. HEALTH AND WELLBEING BOARD – FORWARD PLAN (Pages 101 - 106)

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

8. 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.

9. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 12 October 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, 10 August 2023 at 10.00 a.m.

PRESENT

Councillor P. Ezhilchelvan
(Chair, in the Chair)

BOARD MEMBERS

Binning, G.	Simpson, E.
Conway, A.	Snowdon, H.
Jones, V.	Standfield, P.
Lee, P. (Substitute)	Syers, G.
McFarnlane-Reid, V.	Watson, J.
Murfin, R.	Whittaker, L. (Substitute)
Pattison, W.	Wigham, R. (Substitute)
Rennison, S.	

IN ATTENDANCE

A. Bell	ICB
L.M. Bennett	Senior Democratic Services Officer
A. Everden	Public Health Pharmacy Adviser
K. Lounton	Interim Head of Service
J. Maybury	Public Health
D. Nugent	Healthwatch
L. Robertshaw	Public Health

13. APOLOGIES FOR ABSENCE

Apologies for absence were received from A. Blair, N. Bradley, A. Iceton, S. McCartney, R. Mitcheson, G. O'Neill, G. Reiter, C. Wardlaw, and Councillor Renner-Thompson.

14. MINUTES

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 8 June 2023, as circulated, be confirmed as a true record and signed by the Chair.

15. ANNUAL REPORT OF SENIOR CORONER

Members received an update on the Coroner Service and the Annual Report of the Senior Coroner. The report was presented by Karen Lounten, Interim Head of Service.

Karen Lounten raised the following key issues from the report:-

- **Background**
  - The Coroner was an independent judicial officer appointed by, but not employed, by the County Council. This enabled total impartiality.
  - Four assistant Coroners had been appointed on a sessional basis to provide cover for holidays etc. and provide resilience in the event of a major incident.
  - Excellent accommodation facilities had been provided in County Hall by Northumberland County Council enabling a high level of service to be offered to bereaved families and staff. The Chief Coroner had been very impressed by the facilities available during a recent visit.
  - Four investigative staff were employed by the Police and worked in County Hall.
  - The high level of service was due to a team effort between the Coroner's staff, the Police and Northumberland County Council.
- **Role and Purpose of the Coroner**
  - The role of the Coroner was to investigate and possibly hold an inquest into violent or unnatural deaths, where the cause was unknown or a death which happened in custody or state detention.
  - The purpose of an inquest was not to determine civil or criminal liability but who determine who the person was, where, when and how they died.
  - It was good practice to produce an Annual Report outlining the work, the challenges and achievements.
  - In 2022, 2,023 cases were referred to the Coroner although many cases were discontinued when the death was found to be from natural causes. 270 open inquests had been held and 732 post mortems.
  - Cases took approximately 26.5 weeks to process. There were no cases which had not been concluded within 12 months.
  - There had been a slight increase in the number of deaths since 2019.
  - NSECH at Cramlington received seriously unwell people from all over the region which had led to increased demand for the service as it was the place of death rather than the home address of the deceased which determined where the death was registered.
- **Trends and Patterns**
  - There had been an increase in the number of suicide conclusions. One explanation could be the consequence of a change in the standard of proof from 'beyond reasonable doubt' to 'on the balance of probability'.
  - It was not clear to what extent the COVID 19 pandemic may have affected these figures. The service had operated as near to normally as possible during the Pandemic aided by the excellent facilities and ability to use technology to assist with attendance.

- **Next Steps**
  - There would be dialogue with the Police with a view to increasing resources. Northumberland had the second highest demand in the region in terms of cases but fewer officers.
  - Discussions were ongoing with NHS colleagues regarding non-invasive post mortem facilities and body storage facilities.
  - The provision of a Medical Examiner system was long awaited and although may reduce the case load, the cases referred to the Coroner may become more complex.
  - The Senior Coroner had extended his thanks to Northumberland County Council, NHS and Police colleagues for their contribution towards providing an excellent service for Northumberland.

The following comments were made:-

- The suicide rate had spiked in 2021 and then reduced. It was noted that the number of suicides was small, although the rate was high and the small numbers could skew rates so caution was needed when interpreting these data.
- Where emergency hospitals such as NSECH operated across borders, it would be useful if the figures reflected the reduction in cases elsewhere.
- The inequalities theme was not referred to at all in the report. Karen Lounten agreed to investigate and report back.
- Data regarding demographic changes could also be added to future reports

RESOLVED that the presentation be received.

16. HEALTHWATCH ANNUAL REPORT 2022/23

Members received the Healthwatch Annual Report presented by Derry Nugent.

The following key points were raised:-

- Major work in the last year included
  - Autistic Young People and Mental Health Services
  - Work to improve experience of families and young people accessing mental health services. The report had been welcomed by CNTW and ICB. Plans and strategies would be developed and Healthwatch would follow progress to ensure they were followed through.
  - Engagement with young people - A survey had been developed with assistance from young people and received a fantastic response. Ponteland High School had built this into its lesson plans including young people's voices in a range of areas from democracy to health care and raised the idea of being a citizen.
  - Exploration of A&E attendances by 0-5 year olds living in Blyth. It had been found that in many cases parents took their children to A&E because they were advised to by other respected agencies.

- **What had Healthwatch been told?**
  - **Access to GPs** – this was the most common problem with concerns about telephoning, available appointments and continuity of care. There were increasing numbers of 'Did Not Attends'. Working with GPs and patients to identify the cause.
  - **Pharmacies -** There was concern about pharmacies reducing their opening hours. Greater emphasis on communicating changes to patients was required.
  - **Dentistry** – Concerns about access to dentistry could only be addressed at a national level. It was currently not possible to direct anyone to a Northumberland practice which was accepting NHS patients. Work was ongoing with Healthwatch in other areas to gather further information.
  - Annual Survey which this year had been changed to an Annual Conversation. It had been carried out working with community sector partners and so heard from groups which would not normally engage with Healthwatch.
  - **Priorities for Next Year**
  - Social Care and Health – in Social Care, how the service user voice and involvement was enabled and included
    - Maintaining communications during lockdown conditions in care homes – looking into what worked and what did not.
    - Health – Primary Care, GPs, Pharmacy, Dentistry and Audiology.
    - Northumberland Residents' experiences of using Newcastle Hospitals – particularly experience of travelling from more remote areas.
    - Health Visiting Services – gathering information by talking to parents and Harrogate District NHS Foundation Trust.
  - Other themes would include access to services by those in isolating jobs with additional factors restricting access to services, such as the fishing and agriculture industries.
  - Improvement and Feedback processes within services. People were often uncertain about how to give feedback. Websites were often not updated regularly with appropriate information.
  - The Healthwatch AGM would be on the afternoon of 18 October 2023, and would be a community listening event this year. Strategic partners were invited to attend to listen to the voices and experiences of invited service users.

The following comments were made:-

- With regard to access to Primary Care, it may be useful for Healthwatch to have discussions with the Local Medical Council.
- Armed Forces families could have difficulties registering with a dentist, this issue should be flagged up as strongly as possible.
- Patients awaiting treatment for cancer may experience delays in their treatment if they could not get dental treatment and may not be able to afford private treatment.

- If S.106 funding was generated for additional GPs or dentists capacity as part of a new housing development there was an issue with local surgeries not wanting to take it up.
- Inequality played a role in demand at a local level and it was important to look at what could be fixed or affected at a local level.

RESOLVED that the report be received.

17. BETTER CARE FUND PLAN 2023-25

Members were requested to sign off the Northumberland Better Care Fund (BFC) Plan 2023-25 and to make any proposals about the sign-off process for future BCF plans. The report was presented by Alan Bell, North East and North Cumbria ICB.

The Board was informed that guidance notes for the current year had been received late and had a tight deadline for the submission of the BCF plan. The aim of the plan was to help people stay well, safe and independent in their homes and to encourage integration between health and care services. The main element of the plan was the Discharge Fund which aimed to ensure the successful discharge of patients from hospital into care services within the community. It was hoped that the BCF would be signed off by NHS England in October 2023.

RESOLVED that

(1) the BCF Plan annexed to the report as Annex A (narrative plan) and Annex B (spreadsheet plan) be signed off by the Board.

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

18. NOTIFICATION OF CLOSURE OF 100 HOUR PHARMACY IN CRAMLINGTON

Members received a report updating them on the closure of a 100-hour pharmacy in Cramlington.

Ann Everden, Public Health Pharmacy Adviser, informed the Board that the Cramlington pharmacy had closed before the end of the notice period. The Pharmaceutical Needs Assessment (PNA), approved in September 2022, was now out of date. This could be addressed by way of a supplementary statement referring to a gap in the pharmacy service between 6 and 10 pm Monday-Saturday and Sundays 10 am – 4 pm.

There was also an opportunity to update the PNA to reflect the changes in ownership. A report would be brought back to the November/December meeting outlining the pharmacy situation in Blyth, Prudhoe and Ashington. Ann Everden reported that she had been seconded onto an ICB working group looking at the ICB's processes for communication of these issues.

RESOLVED that

(1) A supplementary statement to the Pharmaceutical Needs Assessment 2022 be agreed declaring that there was a gap in essential, advanced, additional and locally commissioned pharmaceutical services in Cramlington between the hours of 6 pm and 10 pm Monday to Saturday and on Sundays between 10 am and 4 pm.

(2) a second supplementary statement was required to acknowledge the change in ownership of all Lloyds pharmacies in Northumberland.

(3) an update report be submitted to the November/December meeting of the Board.

19. ICB DRAFT JOINT FORWARD PLAN

Members received a copy of the Integrated Care Board Draft Joint Forward Plan.

Graham Syers reported that this was a statutory document that the ICB was required to produce and submit to NHS England by late September 2023. The plan sets out a strategic overview of key priorities and objectives for the medium term, its collaborative work with other bodies and strategic ways of working.

Any comments were welcomed and should be directed to Graham Syers who would forward them on.

RESOLVED that the report be noted.

20. HEALTH AND WELLBEING BOARD – FORWARD PLAN

Members noted details of forthcoming agenda items at future meetings.

An update report on the Safe Haven at Ashington was requested for a future meeting.

21. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 14 September 2023, at 10.00 am in County Hall, Morpeth.

CHAIR ________________________

DATE ________________________

Northumberland
County Council

HEALTH AND WELLBEING BOARD

14TH SEPTEMBER 2023

Northumberland and North Tyneside Community Infection Prevention and Control Strategy 2023-2028

Report of: Councillor Veronica Jones, Portfolio Holder for Improving Public Health and Wellbeing

Lead Officer: Gill O'Neill, Executive Director of Public Health, Inequalities, and Stronger Communities

---

Purpose of report

- To present the new Northumberland and North Tyneside Community Infection Prevention and Control Strategy (2023-28) to the Health and Wellbeing Board; and
- To seek the approval of the Board for the strategy goals and actions to achieve those goals.

Recommendations

Health and Wellbeing Board is recommended:

- To accept the new Northumberland and North Tyneside Community Infection Prevention and Control Strategy; and
- To approve the strategy goals and actions agreed to achieve those goals.

Link to Corporate Plan

The Northumberland and North Tyneside Community Infection Prevention and Control Strategy is relevant to the first two priorities of the Northumberland County Council Corporate Plan:

- **Achieving value for money:** The strategy focuses on building resilience and capacity within community services, teams and settings to implement effective infection prevention and control (IPC) interventions.
- **Tackling inequalities:** There is strong evidence that people in inclusion health groups and those with lower socioeconomic status are consistently at higher risk of infectious diseases, antimicrobial resistance, and incomplete or delayed vaccination.[1] The priority of the community IPC team is care homes because of the large number of vulnerable residents with disabilities. Disability is a protected characteristic in the Equality Act. Therefore, activities to support care home staff are

helping to reduce inequalities. This argument similarly applies to the potential for expansion to protect general practice patients and domiciliary care service users, many of whom will also be vulnerable and have disabilities.

Key issues

- Infection prevention and control (IPC) is about using practical, evidence-based approaches to prevent patients, residents, service users, visitors, and staff from being harmed by avoidable infections.
- The SARS-CoV-2 (COVID-19) pandemic has reinforced the importance of effective IPC measures in community settings.
- The strategy aims: to minimise preventable incidents and outbreaks of harmful infection in community settings in Northumberland and North Tyneside through effective IPC interventions; and to ensure that Northumberland and North Tyneside are as prepared as possible to implement effective IPC measures in community settings in response to new or developing threats or pandemics.
- This strategy covers Northumberland and North Tyneside because they share an acute hospital trust and IPC team. It focuses on IPC in community settings and provider only, and not hospital settings, specifically: care homes; domiciliary care (homecare) including independent supported living; children's residential homes; educational settings; and general practices.
- There are 99 care homes, 58 domiciliary care providers, 221 independent support living settings, 279 early years settings, 174 schools and colleges, 36 general practices, and five children's residential homes in Northumberland.
- The Northumbria Healthcare NHS Foundation Trust IPC team is currently made up of 10.1 whole time equivalent (WTE) nursing staff broken down into 5.3 WTE staff working in the acute and 4.8 WTE staff working in the community (covering Northumberland and North Tyneside). Activities span training, direct support, audit, and collaborative working.
- Current guidance seeks to ensure that organisations and staff have the knowledge, skills, training, behaviours, values, support, monitoring, culture, and leadership to prevent infections.
- A literature review, surveys, stakeholder focus groups, and a prioritisation exercise were undertaken. These identified opportunities for additional training, increased awareness of guidance, and monitoring of IPC behaviours. The surveys also found high levels of 'infectious presenteeism'. A high value is placed on the role of the IPC team, but the resource is stretched between multiple settings and between prevention and control.
- We need to work as a whole system to improve IPC in community settings, and collectively prioritise deployment of the IPC team. There is need not only for additional resource, but also for approaches that build resilience and capacity within settings which are reflected in the strategy goals and how we will achieve them.
- The strategy implementation group will meet quarterly to monitor implementation and report annually to the Health Protection Assurance Board.

Background

Infection prevention and control (IPC) is about using practical, evidence-based approaches to prevent patients, residents, service users, visitors, and staff from being harmed by avoidable infections.

The SARS-CoV-2 (COVID-19) pandemic reminded all of us of the threats that infectious diseases continue to pose. To date, more than 228,000 people in the United Kingdom have died with COVID-19 identified as a cause on their death certificate.[2] An estimated 1.9 million people living in private households in the UK (2.9% of the population) were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first confirmed or suspected COVID-19 infection that were not explained by something else) as of 5 March 2023.[3] By March 2022, it was estimated that the UK Government had spent an additional £310 to £410 billion on measures in response to the pandemic.[4]

A strategy has been developed by a cross-system partnership including: the Northumbria Healthcare NHS Foundation Trust (NHCT) Infection Prevention and Control (IPC) team; Northumberland County Council (NCC) and North Tyneside Council Public Health teams; the NCC Adult Social Care Commissioning, Education, Children's Residential Services, and Health and Safety teams; the North East and North Cumbria (NENC) Integrated Care Board (ICB) Northumberland and North Tyneside 'Place' teams; the Northumberland Local Medical Council; the UK Health Security Agency (UKHSA) North East Health Protection team; and the Cumbria Northumberland and Tyne and Wear NHS Foundation Trust.

The strategy covers Northumberland and North Tyneside because they share an acute hospital trust and IPC team. It focuses on IPC in community settings and providers only, and not hospital settings, specifically: care homes; domiciliary care (homecare) including independent supported living; children's residential homes; educational settings; and general practices.

The strategy seeks not only to maximise and prioritise the resources available within limited budgets for a specialist IPC team to deliver activities in communities, but also to ensure that the wider systems and services across Northumberland and North Tyneside have the knowledge, skills, behaviours, and values to prevent and control harmful infections and be as prepared as possible for future threats.

Aims of the strategy

The aims of the strategy are:

- To minimise preventable incidents and outbreaks of harmful infection in community settings in Northumberland and North Tyneside through effective IPC interventions.
- To ensure that Northumberland and North Tyneside are as prepared as possible to implement effective IPC measures in community settings in response to new or developing threats or pandemics.

Objectives of the strategy

The objectives of the strategy are:

- To understand current IPC provision, activities, behaviours, and need within community settings (*Where are we now?*).

- To understand current guidance for community settings and interventions to influence behaviours.
- To agree and prioritise goals to promote IPC measures in community settings, including additional resources and capacity building approaches (*Where do we want to get to?*)
- To agree how we will achieve the goals (*How will we get there?*).
- To define how we will monitor achievement against the goals (*How we will know we have arrived?*).

Where are we now?

There are a number of key international and national documents underpinning the IPC responsibilities of organisations and staff including:

- World Health Organization Global report on infection prevention and control.[5]
- Health and Social Care Act 2008: Code of practice on the prevention and control of infections outlines ten criteria which care organisations must demonstrate compliance against.[6]
- National Infection Prevention and Control manual for England.[7]
- Infection Prevention Society Competencies Framework.[8]
- National Occupational Standards.[9]
- Infection Prevention Society Competencies Framework.[10]
- NHS England and Public Health England: Supporting excellence in infection prevention and control behaviours IPC implementation toolkit.[11]
- COVID-19 national guidance for health and care professionals.[12]
- Health protection in children and young people settings, including education.[13]
- E-Bug: a health education programme that aims to promote positive behaviour change among children and young people to support IPC efforts.[14]
- IPC guidance for adult social care.[15]
- IPC guidance for adult social care COVID-19 supplement.[16]
- CQC advice on IPC for general practice.[17]

These documents all seek to ensure that organisations and staff have the knowledge, skills, training, behaviours, values, support, monitoring, culture, and leadership to prevent infections.

The scale of the challenge is considerable. There are 98 care homes, 58 domiciliary care providers, 221 independent support living settings, 279 early years settings, 174 schools and colleges, 36 general practices, and five children's residential homes in Northumberland.

The Northumbria Healthcare NHS Foundation Trust IPC team is currently made up of 10.1 whole time equivalent (WTE) nursing staff broken down into 5.3 WTE staff working in hospital settings and 4.8 WTE staff working in the community (covering Northumberland and North Tyneside). Activities span training, direct support, audit, and collaborative working. Since March 2020, the IPC team has supported care homes experiencing around 700 COVID outbreaks. Although there were fewer outbreaks of other infectious diseases during the first year of the pandemic, there were 30 outbreaks of gastroenteritis in care homes in Northumberland and 6 in North Tyneside between April 2021 and March 2022, increasing to 58 in Northumberland and 23 in North Tyneside between March 2022 and January 2023. There have also been cases and outbreaks of seasonal influenza, group A

streptococcal disease, pneumococcal disease, scabies, and other infectious diseases. The IPC team has provided telephone or face-to-face support for most if not all these incidents.

A rapid review was undertaken of the literature on views, attitudes, experiences, or knowledge of IPC in our target settings, barriers, and facilitators to implementing IPC measures, and interventions to improve adherence.

Surveys were undertaken of staff working in each setting to understand the met and unmet needs of staff to enable effective IPC measures to be in place to prevent harmful infections or outbreaks, and the barriers and facilitators to implementation of effective IPC measures in each setting. The questionnaire was informed by the literature review. Stakeholder focus groups and interviews, and a prioritisation exercise were also undertaken.

Key findings from the surveys were:

- Respondents were generally confident in their IPC knowledge, skills and behaviours, but the survey findings suggest opportunities for additional training, increased awareness of guidance, and monitoring of IPC behaviours through audit and other approaches.
- Many care homes use in-house IPC training but we have no information about its quality. Some staff are unaware of training that is available.
- Cost and time are barriers in education and general practice.
- Many respondents across all sectors said they feel compelled to come into work even if they are unwell with an infection.
- Whilst many staff are aware of an IPC champion or lead in their organisation, in others including domiciliary care and general practice, awareness or existence of such a role is less common. (This question was not asked of education because an IPC lead or champion is not currently common practice, although there is a health and safety lead.)

A previous care home survey and stakeholder interviews reported high levels of satisfaction and value about the involvement of the IPC team. However, the prioritisation exercise demonstrated that the resource is stretched between multiple settings and between prevention and control such that, for some settings such as domiciliary care and primary care (general practice), there is so little time available within existing resource that little can be achieved within that time. This reinforces the need not only for additional resource, but also for approaches that build resilience and capacity within the setting as opposed to direct delivery.

Where do we want to get to and how will we get there?

The strategy sets out a vision for all health and care professionals working in the community to have the capability, opportunity, and motivation to implement infection prevention and control measures in their setting to protect those who use their services or live, work, or study in their settings.

This strategy is guided by the following principles:

- We will work as a whole system to implement IPC measures in community settings.
- Recognising that the specialist community IPC nurse team is a finite resource, we will seek to work as partners to maximise impact by prioritising the deployment of the team.

- With the support of partners, the specialist community IPC team will seek to build resilience and capacity within the community by training and supporting key professionals already working in or with settings.

Thirteen goals were agreed by the strategy development group, and how we will achieve and monitor them. These are outlined in the strategy document. They cover:

- Funding and prioritisation;
- Building IPC capacity in community settings; and
- Preventing infectious presenteeism.

Implications

Policy	This strategy seeks to implement national guidance by the Department of Health and Social Care and NHS England as well as local policy. The strategy has been developed collaboratively by Northumbria Healthcare NHS Foundation Trust, Northumberland County Council, North Tyneside Council, North East and North Cumbria Integrated Care Board in Northumberland and in North Tyneside, UK Health Security Agency, and Cumbria Northumberland and Tyne and Wear NHS Foundation Trust. It reflects the 'whole system approach to health and care' theme of the Joint Health and Wellbeing Strategy.
Finance and value for money	One of the goals is for additional, long-term, sustainable funding to maintain and increase the scope and magnitude of activities of the IPC team to support more settings in the community. The strategy implementation group will work with partners across the system to continue to make the case for equitable, sustainable investment in IPC expertise. Nevertheless, the strategy focuses on using existing resources to build resilience and capacity within community services, teams and settings to implement effective IPC interventions.
Legal	All care organisations must demonstrate compliance against in the Health and Social Care Act 2008: Code of practice on the prevention and control of infections.[18]
Procurement	If funding were identified for additional specialist IPC resource, there may be implications for procurement.
Human Resources	The focus of the strategy is on mobilising existing assets within our communities and systems: upskilling professionals who visit care homes; and linking with Health and Safety teams, head teacher networks, IPC champion roles, and care home and domiciliary care forums. There are therefore implications in terms of training and workforce.

Property	There are no specific implications for property.
Equalities (Impact Assessment attached) Yes ☐ No x N/A ☐	An EIA has not been undertaken for the purposes of this report. People in inclusion health groups and those with lower socioeconomic status are consistently at higher risk of infectious diseases, antimicrobial resistance and incomplete or delayed vaccination. Implementation of this strategy would help to reduce those inequalities. The priority of the community IPC team is care homes because of the large number of vulnerable residents with disabilities. Disability is a protected characteristic in the Equality Act. Therefore, activities to support care home staff are helping to reduce inequalities. This argument similarly applies to the potential for expansion to protect general practice patients and domiciliary care service users, many of whom will also be vulnerable and have disabilities.
Risk Assessment	A formal risk assessment has not been undertaken for this strategy. However, implementation of the strategy would reduce risks related to harmful infectious diseases affecting Northumberland residents and patients.
Crime & Disorder	None identified.
Customer Consideration	One of the aims of the strategy is to minimise preventable incidents and outbreaks of harmful infection in community settings.
Carbon reduction	None identified.
Health and Wellbeing	This strategy seek to protect the health of the population and support preparedness for pandemics and other infectious threats.
Wards	All

Background papers:

- Northumberland and North Tyneside Community Infection Prevention and Control Strategy (2023-2028)
- Appendices 1-4 for the strategy
- References as listed at the end of this report.

Report sign off.

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

	Full Name of Officer
Director of Law and Governance and Monitoring Officer	Stephen Gerrard
Director of Finance & Procurement (Deputy S151 Officer)	Alison Elsdon
Executive Director	Gill O'Neill
Chief Executive	Helen Paterson
Portfolio Holder(s)	Veronica Jones

Author and Contact Details

Dr Jim Brown, Consultant in Public Health
Email: jim.brown@northumberland.gov.uk

References

[1] https://bmjopen.bmj.com/content/13/4/e067429#article-bottom
[2] https://coronavirus.data.gov.uk/details/deaths [Accessed 20th July 2023; data up to 16th June 2023]
[3] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/30march2023
[4] https://commonslibrary.parliament.uk/research-briefings/cbp-9309/
[5] https://apps.who.int/iris/handle/10665/354489.
[6] https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance
[7] https://www.england.nhs.uk/publication/national-infection-prevention-and-control/
[8] https://www.ips.uk.net/resources/file/IPS-R-QMVNQ2HHNX3P9L6
[9] https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/chapter-1-standard-infection-control-precautions-sicps/
[10] https://www.ips.uk.net/ips-competencies-framework
[11] https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/
[12] https://www.gov.uk/guidance/covid-19-information-and-advice-for-health-and-care-professionals
[13] Health protection in children and young people settings, including education - GOV.UK (www.gov.uk)
[14] Home (e-bug.eu)
[15] https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care
[16] https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement/covid-19-supplement-to-the-infection-prevention-and-control-resource-for-adult-social-care
[17] https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-99-infection-prevention-control-general-practice
[18] https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

North East &
North Cumbria

Northumbria Healthcare
NHS Foundation Trust

Northumberland & North Tyneside Community Infection Prevention and Control Strategy (2023 to 2028)

July 2023

North Tyneside Council

Northumberland
County Council

Contents

Acknowledgements 3
Summary 4
1 Introduction 5
2 Aims of the strategy 6
3 Objectives of the strategy 6
4 Scope 6
5 Governance 6
6 Where are we now? 7
6.1 Scale of the challenge 7
6.2 Northumbria Healthcare NHS Foundation Trust IPC team 8
6.3 Guidance and best practice 9
6.4 Barriers, facilitators, and interventions 10
6.5 Surveys of staff in community settings 11
6.6 Stakeholder focus groups and interviews 12
6.7 General Practice audit 13
7 Where do we want to get to, how will we get there, and how will we know we have arrived? 13
7.1 Vision 13
7.2 Mission statement 13
7.3 Prioritisation 14
7.4 Principles 15
7.5 Reporting 15
7.6 Goals, how we will achieve them, and monitoring 16
8 References 20

Acknowledgements

Thank you to the following steering group members who contributed to the development of this strategy:

Dr Jim Brown (Lead author)	Consultant in Public Health, Northumberland County Council
Claire Coyne	Deputy Director of Quality and Patient Safety, NENC Integrated Care Board (Northumberland)
Gemma Cuthbertson	Operational Manager Contracts and Commissioning, Northumberland County Council
John Froud	Corporate Health & Safety Manager, Northumberland County Council
Adam Hall	Children's Services Residential Lead Manager, Northumberland County Council
Liz Hanley	Associate Director Nursing and Quality, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Ruth Henein	Head of Infection Prevention & Control, Northumbria Healthcare NHS Foundation Trust
Aimée Joyce	Infection Prevention & Control Information and Data Co-ordinator, Northumbria Healthcare NHS Foundation Trust
Jon Lawler	Consultant in Public Health, Northumberland County Council
Heather Lawson (Co-author)	Senior Infection Prevention & Control Nurse, Northumbria Healthcare NHS Foundation Trust
Dr Tamsin Oswald	Director of Infection Prevention & Control and Consultant Microbiologist, Northumbria Healthcare NHS Foundation Trust
Chris Piercy	Director of Nursing and Senior Responsible Officer for Infection Prevention & Control, NENC Integrated Care Board
Hilary Snowdon	Executive Officer, Northumberland Local Medical Council
Kelly Stoker	Head of Infection Prevention and Control, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (until June 2023)
David Street	Director of Education, SEND and Skills, Northumberland County Council
Emma Wilson	Senior Health Protection Practitioner, UKHSA
Chris Woodcock (Co-author)	Senior Public Health Manager, North Tyneside Council
Amanda Young	Health & Safety Advisor (Schools), Northumberland County Council

Thank you also to members of the Northumberland County Council Adult Social Care Contracts and Commissioning team and the Northumbria Healthcare NHS Foundation Trust Infection Prevention & Control team for their participation in focus groups.

Summary

Background
The SARS-CoV-2 (COVID) pandemic has reinforced the importance of effective infection prevention and control (IPC) in community settings.

Aims
To minimise preventable incidents and outbreaks of harmful infection in community settings in Northumberland and North Tyneside through effective IPC interventions; and to ensure that Northumberland and North Tyneside are as prepared as possible to implement effective IPC measures in community settings in response to new or developing threats or pandemics.

Scope
Community settings or providers in Northumberland and North Tyneside, specifically: care homes; domiciliary care (homecare) including independent supported living; children's residential homes; educational settings; and general practices.

Where are we now?
The Northumbria Healthcare NHS Foundation Trust IPC team is currently made up of 10.1 whole time equivalent (WTE) nursing staff broken down into 5.3 WTE staff working in the acute and 4.8 WTE staff working in the community (covering Northumberland and North Tyneside). Activities span training, direct support, audit, and collaborative working.

Current guidance seeks to ensure that organisations and staff have the knowledge, skills, training, behaviours, values, support, monitoring, culture, and leadership to prevent infections.

A literature review, surveys, stakeholder focus groups, and a prioritisation exercise were undertaken. These identified opportunities for additional training, increased awareness of guidance, and monitoring of IPC behaviours. The surveys also found high levels of 'infectious presenteeism'. A high value is placed on the role of the IPC team, but the resource is stretched between multiple community settings and between prevention and control.

Where are we going and how will we get there?
We need to work as a whole system to improve IPC in community settings, and collectively prioritise deployment of the IPC team. There is need not only for additional resource, but also for approaches that build resilience and capacity within settings which are reflected in the strategy goals and how we will achieve them.

Our vision is for all health and care professionals working in the community to have the capability, opportunity, and motivation to implement IPC measures in their setting to protect those who use their services or live, work, or study in their settings.

How will we know we have arrived?
The strategy implementation group will meet quarterly to monitor implementation and report annually to the Health Protection Assurance Board.

1 Introduction

> *"Over the last decade, major outbreaks such as those due to the Ebola virus disease and the Middle East respiratory syndrome coronavirus (MERS-CoV), and the coronavirus disease 2019 (COVID-19) pandemic… have exposed the gaps in infection prevention and control (IPC) programmes that exist irrespective of the resources available or the national level of income."*

WHO Global report on infection prevention and control (2022)[1]

Infection prevention and control (IPC) is about using practical, evidence-based approaches to prevent patients, residents, service users, visitors, and staff from being harmed by avoidable infections. Effective IPC must be part of everyday practice and be applied consistently by everyone.

The SARS-CoV-2 (COVID-19) pandemic reminded all of us of the threats that infectious diseases continue to pose. To date, more than 228,000 people in the United Kingdom have died with COVID-19 identified as a cause on their death certificate.[2] An estimated 1.9 million people living in private households in the UK (2.9% of the population) were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first confirmed or suspected COVID-19 infection that were not explained by something else) as of 5 March 2023.[3] By March 2022, it was estimated that the UK Government had spent an additional £310 to £410 billion on measures in response to the pandemic.[4]

In Northumberland and North Tyneside, the Northumbria Healthcare NHS Foundation Trust (NHCT) Infection Prevention and Control (IPC) team was crucial to this effort. As well as working to prevent and control outbreaks within hospital settings, the team supported care homes during hundreds of outbreaks, as well as providing advice and support to domiciliary care and independent supported living providers, schools, colleges, early years settings, children's residential homes, general practices, prisons, and many other settings where they could. They were the eyes and the ears, building relationships and trust with managers and staff, and working in collaboration with colleagues in Council public health, social care, and education teams, Clinical Commissioning Group (CCG) then Integrated Care Board (ICB) teams, and the Public Health England (PHE) then UK Health Security Agency (UKHSA) north east health protection team. They continue to provide training, advice, support, audit, and visits within a limited resource to prevent and control infections and outbreaks.

This strategy seeks not only to maximise and prioritise the resources available within limited budgets for a specialist IPC team to deliver activities in communities, but also to ensure that the wider systems and services across Northumberland and North Tyneside have the knowledge, skills, behaviours, and values to prevent and control harmful infections and be as prepared as possible for future threats.

2 Aims of the strategy

The aims of the strategy are:

- To minimise preventable incidents and outbreaks of harmful infection in community settings in Northumberland and North Tyneside through effective IPC interventions.
- To ensure that Northumberland and North Tyneside are as prepared as possible to implement effective IPC measures in community settings in response to new or developing threats or pandemics.

3 Objectives of the strategy

The objectives of the strategy are:

- To understand current IPC provision, activities, behaviours, and need within community settings (*Where are we now?*).
- To understand current guidance for community settings and interventions to influence behaviours.
- To agree and prioritise goals to promote IPC measures in community settings, including additional resources and capacity building approaches (*Where do we want to get to?*)
- To agree how we will achieve the goals (*How will we get there?*).
- To define how we will monitor achievement against the goals (*How we will know we have arrived?*).

4 Scope

This strategy covers Northumberland and North Tyneside because they share an acute hospital trust and IPC team. It focuses on IPC in community settings and providers only, and not hospital settings, specifically:

- Care homes.
- Domiciliary care (homecare) including independent supported living.
- Children's residential homes.
- Educational settings.
- General practices.

5 Governance

A strategy group was convened to oversee the development of this strategy: membership is described in the Acknowledgements section.

IPC is considered at a regional level by the Antimicrobial Resistance and Healthcare Associated Infection Subcommittee of the North East and North Cumbria (NENC) ICB Quality and Safety Committee. The subcommittee seeks to bring together key stakeholders across health and social care from the NENC Integrated Care System (ICS) to tackle antimicrobial resistance, reduce healthcare associated infections, share information and best practice, and achieve system-level assurance.

6 Where are we now?

6.1 Scale of the challenge

Table 1 outlines the number of potential community settings and providers across Northumberland and North Tyneside in which the NHCT IPC team might play a role.

Table 1. Scale of the challenge: numbers of settings and providers

	Northumberland	North Tyneside
Care sector	• 71 elderly care residential and nursing homes • 28 specialist learning disability/mental health care homes • 58 domiciliary care providers • 221 independent supported living (ISL) settings	• 31 elderly care residential and nursing homes • 14 learning disability/mental health care homes • 30 domiciliary care providers • 27 independent supported living providers with around 400 settings

Education	• Early years provision
	  ○ 174 childminders
	  ○ 95 day nurseries
	• 130 first and primary schools
	• 14 middle schools
	• 15 high and secondary schools
	• 13 special/alternative provision schools
	• One pupil referral unit
	• One further education college
		• Early Years Provision:
		  ○ 108 childminders
		  ○ 48 day nurseries
		• 55 first and primary schools
		• 16 secondary schools
		• 6 special schools
		• 1 further education college and part of a university campus

NHS General Practice	• 36 general practices	• 26 general practices
Children's residential homes	• 5 residential homes	-

6.2 Northumbria Healthcare NHS Foundation Trust IPC team

The NHCT IPC team is currently made up of 10.1 whole time equivalent (WTE) nursing staff broken down into 5.3 WTE staff working in hospital settings and 4.8 WTE staff working in the community (covering Northumberland and North Tyneside).

The activities of the team in the community currently include:

- Training:
  - Care home staff, including face-to-face, webinar, and e-learning training that is regularly updated, and IPC champion training and care home forums.
  - Community services (provided by NHCT).
  - Hand hygiene training in primary schools.
  - Home (domiciliary) care staff: charge may apply and there is no current training programme except for staff employed by NHCT.
  - General practice staff: a charge applies for training.
- Direct support:
  - Outbreak management at Intermediate Care Units. (Note that outbreak management of most community settings is undertaken by the UKHSA Health Protection team.)
  - Care home visits and telephone calls during outbreaks (planning to reduce or cease because of insufficient capacity).
  - Outbreak support for other settings, for example nurseries, at the request of the UKHSA Health Protection Team.
  - Fit testing for FFP 3 masks in care homes and other settings where needed.
- Collaborative working:
  - Care Quality Commission (CQC) monthly information sharing meetings about care homes / home care services, including support where there are safeguarding concerns due to inadequate IPC.
  - Care home provider forum meetings.
  - Link nurse champions meetings.
  - Multi-agency meetings and collaborative working with Adult Social Care Commissioning, ICB, Public Health, and UKHSA.
  - Care home newsletter.
  - Community events e.g. Wooler children's day; IPC week.
- Audit:
  - Community patient hand hygiene satisfaction survey.
  - Hand hygiene audits (validation) of community staff.
  - Care home report on the extent to which IPC measures are being met.
  - General practices: a charge applies to undertake an IPC audit in general practice.
  - Root cause analysis e.g. patients with community-acquired infections (such as *Clostridium difficile*) admitted to hospital.

Since March 2020, the IPC team has supported care homes experiencing around 700 COVID outbreaks. Although there were fewer outbreaks of other infectious diseases during the first year of the pandemic, there were 30 outbreaks of gastroenteritis in care homes in Northumberland and 6 in North Tyneside between April 2021 and March 2022, increasing to 58 in Northumberland and 23 in North Tyneside between March 2022 and January 2023. There have also been cases and outbreaks of seasonal influenza, group A streptococcal disease, pneumococcal disease, scabies, and other infectious diseases. The IPC team has provided telephone or face-to-face support for most if not all these incidents.

Where issues were identified, the themes frequently noted on support visits to care homes were:

- Poor adherence to use of PPE and to guidance.
- Cleanliness.
- Lack of education of staff.
- Leadership.
- Estates issues.

6.3 Guidance and best practice

There are a number of key international and national documents underpinning the IPC responsibilities of organisations and staff including:

- World Health Organization Global report on infection prevention and control.[1]
- Health and Social Care Act 2008: Code of practice on the prevention and control of infections outlines ten criteria which care organisations must demonstrate compliance against.[5]
- National Infection Prevention and Control manual for England.[6]
- Infection Prevention Society Competencies Framework.[7]
- National Occupational Standards.[8]
- Infection Prevention Society Competencies Framework.[9]
- NHS England and Public Health England: Supporting excellence in infection prevention and control behaviours IPC implementation toolkit.[10]
- COVID-19 national guidance for health and care professionals.[11]
- Health protection in children and young people settings, including education.[12]
- E-Bug: a health education programme that aims to promote positive behaviour change among children and young people to support IPC efforts.[13]
- IPC guidance for adult social care.[14]
- IPC guidance for adult social care COVID-19 supplement.[15]
- CQC advice on IPC for general practice.[16]

Summaries of each are provided in Appendix 1. All of these seek to ensure that organisations and staff have the knowledge, skills, training, behaviours, values, support, monitoring, culture, and leadership to prevent infections. And yet, as the pandemic revealed, these frameworks had not fully embedded in organisations: there were numerous barriers to implementation which the strategy group sought to understand.

6.4 Barriers, facilitators, and interventions

A rapid review was undertaken of the literature on views, attitudes, experiences, or knowledge of IPC in our target settings, barriers, and facilitators to implementing IPC measures, and interventions to improve adherence. Barriers and facilitators are summarised in Table 2, although studies were only available for healthcare and care home settings.

Several interventions have been identified as being effective in improving adherence to IPC measures among healthcare workers including: educational materials combined with educational meetings; local opinion leaders; audit and feedback; reminders; tailored intervention; monitoring the performance of the delivery of health care; educational games; and patient-mediated interventions.[17]

Table 2. Barriers and facilitators to implementing IPC measure in healthcare and care home settings[18] [19] [20] [21]

	Barriers to or associations with lower implementation of IPC measures	**Facilitators or association with higher implementation of IPC measures**
Healthcare settings and staff	• High workload or/ time constraints • More beds or higher patient-to-nurse ratio • Glove overuse • Non-availability of equipment (in particular sinks or hand towels) • Gaps in knowledge of occupational vaccinations, the modes of transmission of infectious diseases, and the risk of infection from needle stick and sharps injuries	• Knowledge, education and training, and experience • Being a nurse as opposed to a doctor • Good hand hygiene is an important predictor of overall IPC level
Care home settings and staff	• IPC seen as outside control of care home • Negative feedback loop of outbreaks on staffing • Staffing skills & education • Low wages, staff shortages, and high staff turnover • High workload (burnout) • IPC not viewed as appropriate to making a 'homely environment' • Isolation of residents creating moral distress among staff	• Staff training • Monitoring • Organisational support (in particular, effective leadership) • Attention to organisational issues (barriers)

During the height of the COVID pandemic, NHS England undertook a research project to understand the drivers of behaviours that influenced compliance with COVID-19 IPC measures. Insight was gathered from frontline staff, patients, professional bodies, and clinical, communication and IPC experts to understand

these drivers, and a suite of co-designed products were developed to address the key themes.[22] The key insights are summarised in Table 3.

Table 3. Key insights and advice from the NHS England and Public Health England Supporting excellence in infection prevention and control behaviours IPC implementation toolkit (March 2021)

- Strong, compassionate leadership and role modelling.
- Enhance the mindset of the workforce about both protecting SELF and OTHERS, creating a culture of kindness where compliance is associated with being kind and caring to all.
- Staff need support to challenge colleagues and patients/visitors on IPC compliance, particularly when speaking to senior staff and medics.
- "Hotspots" are areas where infrastructure issues (mainly space) aren't easily overcome but can be improved with some quick fixes, improved monitoring, and situational comms.
- Training to further enhance awareness and understanding of IPC measures and their purpose.
- Clear messaging for patients and visitors, outlining not just what we want them to do, but how to do it e.g. wearing a mask over nose and mouth. Direct messaging was felt to be more effective than softer messaging for this group.
- Zero-risk approach to sickness will relieve pressure on staff to come in with minor symptoms.

6.5 Surveys of staff in community settings

Surveys were undertaken of staff working in each setting to understand the met and unmet needs of staff to enable effective IPC measures to be in place to prevent harmful infections or outbreaks, and the barriers and facilitators to implementation of effective IPC measures in each setting. The questionnaire was informed by the literature review on barriers, facilitators, and interventions to promote adherence to IPC measures together with the Theoretical Domains Framework (TDF).[23] [24]

The number of responses was quite low in all settings apart from children's residential homes, and no responses were received from staff working in early years settings – see Table 4.

Key findings from the surveys were:

- Respondents were generally confident in their IPC knowledge, skills and behaviours, but the survey findings suggest opportunities for additional training, increased awareness of guidance, and monitoring of IPC behaviours through audit and other approaches.
- Many care homes use in-house IPC training but we have no information about its quality. Some staff are unaware of training that is available.
- Cost and time are barriers in education and general practice.
- Many respondents across all sectors said they feel compelled to come into work even if they are unwell with an infection.

- Whilst many staff are aware of an IPC champion or lead in their organisation, in others including domiciliary care and general practice, awareness or existence of such a role is less common. (This question was not asked of education because an IPC lead or champion is not currently common practice, although there is a health and safety lead.)

Table 4. Number of responses to IPC surveys by location and setting

Setting	Number of responses	Northumberland	North Tyneside	Other
Care homes	64	46 (72%)	17 (27%)	1 (1.6%)
Domiciliary care	57	22 (39%)	27 (47%)	8 (14%)
Education	24	10 (42%)	14 (58%)	0 (0%)
Children's residential homes	44	44 (100%)	0 (0%)	0 (0%)
General practices	36	13 (39%)	22 (61%)	0 (0%)

In a survey in September 2022 of Northumberland and North Tyneside care homes, high levels of satisfaction were reported about the involvement of IPC team in past 2 years, their face-to-face visits, and the monthly webinars the team provided.

Full details on the methods, results, and interpretation of the surveys in each setting can be found in Appendix 2.

6.6 Stakeholder focus groups and interviews

Key findings from stakeholder interviews and focus groups were:

- There is a high value placed on the role of the IPC team, the support they gave during the pandemic, and the relationships that have developed during the pandemic.
- Relationships between system partners, and with providers, improved during the pandemic because of the good communication, collaboration, and support given.
- There is a need for IPC support and training for staff in early years settings.
- There is a need for sustainable, capacity-building solutions in view of the small size of the IPC team. Examples proposed included upskilling of professionals who visit care homes, and the IPC team working with Council Health and Safety teams to support educational settings to implement IPC measures.
- Whilst IPC champion approaches were broadly supported, some caution was expressed about the difficulties for IPC champions in care homes to challenge their colleagues.

Further information can be found in Appendix 3.

6.7 General Practice audit

Currently, not all general practices in Northumberland and North Tyneside have face-to-face IPC training or audit undertaken by the NHCT IPC team because this incurs a financial charge. However, of practices that asked the team to undertake an IPC audit, a number of themes were identified – see Table 5.

Table 5. Common themes and issues identified from IPC audits conducted by IPC Team of General Practices in Northumberland and North Tyneside 2019-2022

Theme	Issue
PPE	• Not stored appropriately, stored in drawers, cupboards and not freely accessible to staff
Furnishings	• Fabric chairs: ripped, stained • Fabric chairs in reception areas unable to be effectively cleaned • Ripped pillow covers
Staffing	• IPC not on agenda for staff meetings • No IPC leads identified • Staff not receiving regular IPC training/updates
Environment	• Heavily cluttered treatment/consultation rooms • Sinks cluttered with extraneous equipment, urinalysis sticks, phlebotomy equipment, gloves, loose paper towels etc… • Sinks not overflow free • Carpeted areas in patient areas
Audit	• No audits formally completed around environmental cleanliness • Hand hygiene audits not routinely completed
Storage	• Lack of storage e.g. couch rolls stored on floor

7 Where do we want to get to, how will we get there, and how will we know we have arrived?

7.1 Vision

Our vision is for all health and care professionals working in the community to have the capability, opportunity, and motivation to implement infection prevention and control measures in their setting to protect those who use their services or live, work, or study in their settings.

7.2 Mission statement

We will work in partnership to build capacity in community settings to minimise preventable incidents and outbreaks of harmful infection and be resilient to new threats of infectious disease.

7.3 Prioritisation

Recognising that the specialist community IPC nurse team is a finite resource of 4.8 whole time equivalent nursing staff, the steering group undertook a prioritisation exercise to explore the balance of resource committed between prevention and control and between each type of setting based on agreed criteria.

After a discussion, the group agreed the focus between types of setting for the specialist IPC team as in Table 6.

Table 6. Prioritisation of specialist IPC resource by setting or sector

Setting or sector (number)	*Percentage of specialist IPC*
Care homes (140+)	60%
Education and early years (700+)	25%
Domiciliary care (100+)	10%
Primary Care (62)	5%
Total	100%

After further discussion, the balance of time spent between prevention and supporting settings with 1-2 cases, a cluster, an outbreak, or frequent incidents was agreed for each type of setting. This was then translated into days per month for each setting based on 4.8 WTE IPC nurses as shown in Table 7.

Table 7. Days per month of focus for specialist IPC resource by setting and phase

Phase	Name	Days per month of specialist IPC resource (4.8 WTE)			
		Care homes	Education	Domiciliary care	Primary care
1	Prevention	18.9	11.3	7.2	3.6
2	1-2 cases	2.7	2.3	0	0.2
3	Cluster	13.5	3.4	0.5	0.2
4	Outbreak	10.8	4.5	0.5	0.2
5	Frequent incidents	8.1	1.1	0.1	0.2
	Total	54	22.5	9	4.5

This prioritisation demonstrates that the specialist IPC resource is stretched between multiple settings and between prevention and control such that, for some settings or sectors such as domiciliary care and primary care (general practice), there is so little time available within existing resource that little can be achieved within that time. This reinforces the need not only for additional resource, but also for approaches that build resilience and capacity within the setting as opposed to direct delivery.

Further details of the prioritisation exercise can be found in Appendix 4.

7.4 Principles

This strategy is guided by the following principles:

- We will work as a whole system to implement IPC measures in community settings.
- Recognising that the specialist community IPC nurse team is a finite resource, we will seek to work as partners to maximise impact by prioritising the deployment of the team.
- With the support of partners, the specialist community IPC team will seek to build resilience and capacity within the community by training and supporting key professionals already working in or with settings.

7.5 Reporting

The Northumberland and North Tyneside community IPC strategy steering group will meet twice yearly to update on progress against the goals and monitoring framework below, and report to the Health Protection Assurance Board in each of Northumberland and North Tyneside on an annual basis, or more frequently if needed or requested to do so.

7.6 Goals, how we will achieve them, and monitoring

Goal	*How will we achieve it?*	*Indicator*
Funding and prioritisation		
Goal 1: The NHCT IPC team has additional, long-term, sustainable funding to maintain and increase the scope and magnitude of activities of the IPC team to support more settings/providers in the community, including care homes, general practices, domiciliary care, educational establishments, and children's residential care.	• We will work with partners across the system to continue to make the case for equitable, sustainable investment in IPC expertise to support community settings in Northumberland and North Tyneside.	• Increased number of whole-time equivalent specialist IPC nurses working to support community settings
Goal 2: Where resources are limited, priorities for work within community settings will be agreed with system partners.	• We will work as system partners to ensure that we are able to maximise impact of limited resources through agreed priorities and principles.	• Annual review of priorities
Building IPC capacity in community settings		
• *All community settings*		
Goal 3: Managers and staff will be aware of training that is available.	• Together with and via system partners, the NHCT IPC team will share a list of quality assured training opportunities to care home providers, domiciliary care providers, educational settings, general practices, and children's residential homes.	• Annual survey of community settings / providers
Goal 4: All training, whether external or in-house, is of high quality and updated to reflect current guidance.	• Where training is provided in-house, system partners will work with providers to quality assure training. • Where training is provided by the NHCT team or system partners, the content will be regularly reviewed to ensure its accuracy.	• Record of annual review of webinar and module training provided by NHCT • Surveys of staff attending training • Number of care home providers sharing their

		training package for quality assurance purposes
• *Care homes*		
Goal 5: All professional staff visiting care homes from all sectors have had training in IPC to identify good practice, recognise when standards of IPC are not being met, provide IPC advice, and link easily to additional specialist support when needed.	• The IPC team will engage with staff who visit care homes to offer additional IPC training, assess competence if appropriate, and maintain a network to enable sharing of best practice and updated guidance, answer questions, and provide specialist support.	• Record of IPC training provided to professional staff visiting care homes • Number of professional staff visiting care homes who have had training in past 1 year
Goal 6: All care homes have an IPC champion who receives additional IPC training, is given time for training and linking with other IPC champions via a network, is empowered to support colleagues, and can link easily to additional IPC support when needed.	• System partners who have existing relationships or contracts with care home providers will promote the need for a named IPC champion in each care home. • NHCT will continue to provide training and support to IPC champions in care homes.	• Record of IPC champions held by IPC team • Annual survey of IPC champions
Goal 7: All agency staff will be trained in IPC.	• Make contact with larger agencies to understand training requirements and explore with regional partners regional approaches to providing and assuring training. • Include a question about training of agency staff in the quality assurance checklist used by the IPC team during care home visits.	• Record of number of agency staff trained in IPC by NHCT • Annual survey of care home managers to determine number of agency staff trained in IPC
• *Educational settings*		
Goal 8: Leaders in educational settings continue to recognise the importance of effective IPC measures to protect the health of their students and staff, minimise student and staff absences, and contribute to	• Strategy group members will offer to join headteacher meetings to promote the benefits of IPC measures and the use a 'making every contact count' approach with all educational staff to promote IPC.	• Record of IPC team input to Headteacher meetings

preventing wider spread of infections within the community.		
Goal 9: Staff in educational settings have a basic knowledge of common infections and IPC measures.	• Build links between the NHCT IPC team and the local authority Health and Safety (H&S) teams who already work with schools, including opportunities for additional IPC training for H&S teams and access to specialist advice when needed. • H&S teams in both local authorities will work with the IPC team and system partners to regularly update the IPC policy or guidance within the Health and Safety guidance for use by educational settings. • The IPC team will offer virtual training to H&S leads within educational settings on an annual basis to update knowledge of IPC. • Undertake a specific piece of work to understand issues for early years providers, from whom we had no responses in the survey.	• Record of additional IPC training for H&S teams and access to specialist advice. • Record of IPC team input into Health and Safety guidance for use by educational settings. • Number of H&S leads within educational settings receiving training in IPC. • Report on project with early years settings.
Goal 10: Children and young people aged 3-16 years will have age-appropriate knowledge of hygiene, microbes, vaccinations, and antimicrobial resistance and are supported to play their role in prevention outbreaks and using antimicrobials appropriately.	• We will promote and support educators, community leaders, parents, and caregivers to use E-Bug to educate children and young people and promote positive behaviour change.	• Survey of educational settings on use of E-Bug to educate children and young people and promote positive behaviour change.
• *General practice*		
Goal 11: There is an IPC champion in every general practice who receives additional IPC training, is linked to a wider network of IPC	• System partners who have existing relationships with general practice will	• Number of general practices with an IPC champion.

champions, is empowered to support colleagues, and can link easily to additional IPC support when needed.	promote the need for a named IPC champion in each practice • NHCT will continue to provide training and support to IPC champions in practices.	• Number of IPC champions trained by IPC team.
Goal 12: All practice staff receive regular quality-assured IPC training and audit.	• Work with general practice colleagues to understand demand and willingness to participate in, and promote, regular training. • Work with system partners to secure funding for face-to-face training and audit in general practice.	• Funding secured for face-to-face training and audit in general practice. • Number of general practices who receive face-to-face training.
Preventing infectious presenteeism		
Goal 13: Systems are in place to discourage staff from attending work if they are unwell with an infection ('infectious presenteeism').	• We will use existing communications channels with providers and the general public to discourage infectious presenteeism. • All commissioners will ask providers to include in their business continuity plans how they will manage in the event of staff absence due to sickness. • We will include the discouragement of infectious presenteeism in all training provided. • Commissioners will encourage providers to include mitigations within their risk assessment for when infectious presenteeism is unavoidable, for example use of face masks, enhanced ventilation, and cleaning, or avoiding care of people who are immunosuppressed or otherwise at high risk from the infection.	• Record of communications to providers and the general public to discourage infectious presenteeism. • Record of how providers will manage in the event of staff absence due to sickness in their business continuity plans. • Record of discouragement of infectious presenteeism in all training provided e.g. learning modules.

8 References

[1] World Health Organization. (2022). Global report on infection prevention and control. World Health Organization. https://apps.who.int/iris/handle/10665/354489.

[2] https://coronavirus.data.gov.uk/details/deaths [Accessed 20th July 2023; data up to 16th June 2023]

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/30march2023

[4] https://commonslibrary.parliament.uk/research-briefings/cbp-9309/

[5] https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

[6] https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

[7] https://www.ips.uk.net/resources/file/IPS-R-QMVNQ2HHNX3P9L6

[8] https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/chapter-1-standard-infection-control-precautions-sicps/

[9] https://www.ips.uk.net/ips-competencies-framework

[10] https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

[11] https://www.gov.uk/guidance/covid-19-information-and-advice-for-health-and-care-professionals

[12] Health protection in children and young people settings, including education - GOV.UK (www.gov.uk)

[13] Home (e-bug.eu)

[14] https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care

[15] https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement/covid-19-supplement-to-the-infection-prevention-and-control-resource-for-adult-social-care

[16] https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-99-infection-prevention-control-general-practice

[17] Silva, M.T., Galvao, T.F., Chapman, E. et al. Dissemination interventions to improve healthcare workers' adherence with infection prevention and control guidelines: a systematic review and meta-analysis. Implementation Sci 16, 92 (2021). https://doi.org/10.1186/s13012-021-01164-6

[18] Alhumaid, S., Al Mutair, A., Al Alawi, Z. et al. Knowledge of infection prevention and control among healthcare workers and factors influencing compliance: a systematic review. Antimicrob Resist Infect Control 10, 86 (2021). https://doi.org/10.1186/s13756-021-00957-0

[19] Daker-White, G, Panagioti, M, Giles, S, et al. Beyond the control of the care home: A meta-ethnography of qualitative studies of Infection Prevention and Control in residential and nursing homes for older people. Health Expect. 2021; 25: 2095- 2106. https://doi.org/10.1111/hex.13349

[20] Iaboni, A., Quirt, H., Engell, K. et al. Barriers and facilitators to person-centred infection prevention and control: results of a survey about the Dementia Isolation Toolkit. BMC Geriatr 22, 74 (2022). https://doi.org/10.1186/s12877-022-02759-4

[21] Tomczyk S, Twyman A, de Kraker ME, Rehse APC, Tartari E, Toledo JP, et al. The first WHO global survey on infection prevention and control in health-care facilities. Lancet Infect Dis. 2022. https://doi.org/10.1016/S1473-3099(21)00809-4

[22] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/03/C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf

[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4370908/#:~:text=The%20TDF%20domains%20and%20their,%2C%20and%20decision%20processes%2C%2011

[24] https://implementationscience.biomedcentral.com/articles/10.1186/s13012-017-0605-9

Northumberland & North Tyneside Community Infection Prevention and Control Strategy (July 2023): Appendices 1-4

Appendix 1 – IPC guidance and best practice

WHO Global report on infection prevention and control (IPC)

The World Health Organization (WHO) has identified that there are significant gaps in IPC that were amplified by the COVID pandemic and other major outbreaks:[1]

> *"Over the last decade, major outbreaks such as those due to the Ebola virus disease and the Middle East respiratory syndrome coronavirus (MERS-CoV), and the coronavirus disease 2019 (COVID-19) pandemic, have demonstrated how epidemic-prone pathogens can spread rapidly through health care settings. These events have exposed the gaps in infection prevention and control (IPC) programmes that exist irrespective of the resources available or the national level of income.*
>
> *Furthermore, other less-visible health emergencies are also a compelling reason to address gaps in IPC, such as the silent endemic burden of health care-associated infections (HAIs) and antimicrobial resistance (AMR), which harm patients every day across all health care systems."*

The WHO has reinforced the need for well-funded IPC provision both to address existing infections and to be better prepared for new threats or pandemics. It has identified three priorities to accelerate progress:

1. Political commitment and policies to scale up and enforce the core components of IPC programmes and the related minimum requirements, including through sustained financing, legal frameworks and accreditation systems.
2. IPC capacity-building and creation of IPC expertise.
3. Development of systems to monitor, report, and act on key indicator data.

Health and Social Care Act 2008: Code of practice on the prevention and control of infections

All registered care providers must demonstrate compliance with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections[2] which outlines ten criteria which care organisations must demonstrate compliance against (see Table 1).

[1] World Health Organization. (2022). Global report on infection prevention and control. World Health Organization. https://apps.who.int/iris/handle/10665/354489.

[2] https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Table 1. Criteria that all care organisations must demonstrate compliance against in the Health and Social Care Act 2008: Code of practice on the prevention and control of infections

Criteria
Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
Criterion 2: The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Criterion 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Criterion 4: The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
Criterion 5: That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
Criterion 6: Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7: The provision or ability to secure adequate isolation facilities.
Criterion 8: The ability to secure adequate access to laboratory support as appropriate.
Criterion 9: That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
Criterion 10: That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection prevention and control.

National Infection Prevention and Control manual

This provides an evidence-based practice manual for use by all those involved in care provision in England and should be adopted as guidance in NHS settings or settings where NHS services are delivered, including general practice.[3]

In all non-NHS care settings, to support with health and social care integration, the content of this manual is considered best practice.

The manual states that managers/employers of all services must ensure that staff:

- Are aware of and have access to IPC guidance, including the measures required to protect themselves and their employees from infection risk.
- Have had instruction/education on infection prevention and control by attending events and/or completing training.

[3] https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

- Have adequate support and resources to implement, monitor and take corrective action to comply with IPC guidance; and a risk assessment is undertaken and approved through local governance procedures.
- Who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.
- Who have had an occupational exposure are referred promptly to the relevant agency (e.g. GP, occupational health or accident and emergency), and understand immediate actions (e.g. first aid) following an occupational exposure including process for reporting.
- Have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).
- Include infection prevention and control as an objective in their personal development plans (or equivalent).
- Refer to infection prevention and control in all job descriptions.

Infection Prevention Society Competencies Framework

Although the Infection Prevention Society Competencies Framework[4] is aimed at IPC practitioners, several competencies are relevant to all those working in community settings.

In particular, staff in community settings should be able to

- Apply the relevant IPC principles design and implement strategies to prevent and control infection.
- Recognise gaps in knowledge, skills and competence of self and others in relation to IPC and develops improvement strategies.
- Communicate IPC information effectively in a verbal and/or written form at an appropriate level for their target audience.
- Ensure key services supporting the IPC agenda e.g., cleaning and waste management are meeting the needs, requirements and specification of the service, assessing and identifying any risks or gaps in provision.

Standard infection control precautions (SICPs)

Standard infection control precautions (SICPs) should be used by all staff, in all health, care and education settings, at all times, for all patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment.[5]

There are ten elements of SICPs and five may be applicable to all settings.

1. Assessment of infection risk.
2. Hand hygiene.
3. Respiratory and cough hygiene.

[4] https://www.ips.uk.net/resources/file/IPS-R-QMVNQ2HHNX3P9L6
[5] https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/chapter-1-standard-infection-control-precautions-sicps/

4. Personal protective equipment (where required).
5. Safe management of the environment and managing prevention of exposure (including sharps).

Setting-specific national guidance and resources

The following setting-specific national guidance are currently available and should be followed:

- COVID-19 national guidance for health and care professionals.[6]
- Health protection in children and young people settings, including education,[7] which includes sections on:
    - What infections are, how they are transmitted and those of higher risk of infection.
    - Preventing and controlling infections.
    - Supporting immunisations programmes.
    - Managing outbreaks and incidents.
    - Managing specific infectious diseases.
    - Specific settings and populations: additional health protection considerations.
    - Children and young people settings: tools and resources.
- E-Bug is a health education programme that aims to promote positive behaviour change among children and young people to support IPC efforts, and to respond to the global threat of antimicrobial resistance.[8]
- IPC guidance for adult social care.[9]
- IPC guidance for adult social care COVID-19 supplement.[10]
- CQC advice on IPC for general practice.[11]

IPC Education framework

NHS England published the IPC Education Framework in March 2023.[12] It sets out a vision for the design and delivery of IPC education for staff working in NHS and adult social care. Whilst it is not directed at other settings, many of the principles will be relevant to education and children's social care.

The framework encourages organisations to commit to demonstrating:

- a culture of ongoing IPC learning and development
- strong IPC leadership at board/executive level, supported by visible IPC role models

---

[6] https://www.gov.uk/guidance/covid-19-information-and-advice-for-health-and-care-professionals
[7] Health protection in children and young people settings, including education - GOV.UK (www.gov.uk)
[8] Home (e-bug.eu)
[9] https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care
[10] https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement/covid-19-supplement-to-the-infection-prevention-and-control-resource-for-adult-social-care
[11] https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-99-infection-prevention-control-general-practice
[12] https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

- that IPC education and training is developed by and with IPC experts, using the expertise of the multidisciplinary team to promote delivery, which is tailored to all staff needs, focusing on behaviour as well as developing knowledge and skills.

The framework outlines both standards for organisations who develop and deliver IPC educational programmes for health and social care, and standards to ensure health and social care systems and providers maintain a learning environment for IPC. It identifies three tiers based on staff role, and or each tier lists the knowledge and understanding needed, as well as behaviours to demonstrate knowledge and understanding. Tier 1 is “everyone working in health and social care settings”.

Behaviours expected by people at Tier 1:

- Staff ensure good IPC practice is appropriately embedded into their work.
- Staff ensure their actions minimise risks to health and safety and contribute to positive and safe practice.

Individuals demonstrate these behaviours (Learning outcomes for people at Tier 1) by being able to:

1. Perform appropriate, effective hand hygiene and glove use to prevent the spread of infection.
2. Use a range of PPE which is relevant to their role and know how and when to use it.
3. Contribute to the cleanliness of the work environment as relevant to their role
4. Dispose of waste immediately in the correct waste stream as close to the point of generation as possible.
5. Use antibiotics appropriately, personally and professionally as relevant to their role.
6. Engage in vaccination programmes, personally and professionally as relevant to their role.
7. Cover their nose and mouth with a disposable tissue when sneezing, coughing, wiping, and blowing their nose, where this is not possible to at least sneeze into their elbow/sleeve.

The behaviours and learning outcomes for Tier 1 are relevant to staff in all of the target settings for this strategy.

National Occupational Standards

National Occupational Standards (NOS) are statements of the standards of performance for individuals when carrying out functions in the workplace, together with specifications of the underpinning knowledge and understanding.

NOS are developed for employers by employers through the relevant sector skills council or standards setting organisation.

NOS for IPC were developed in 2012 and revised in 2021[13]:

[13] https://www.skillsforhealth.org.uk/info-hub/national-occupational-standards-overview/?from=20

- IPC1.2012 – Minimise the risk of spreading infection by cleaning, disinfecting and maintaining environments
- IPC2.2012 – Perform hand hygiene to prevent the spread of infection
- IPC3.2012 – Clean, disinfect and remove spillages of blood and other body fluids to minimise the risk of infection
- IPC5.2012 – Minimise the risk of exposure to blood and body fluids while providing care
- IPC6.2012 – Use personal protective equipment to prevent the spread of infection
- IPC7.2012 – Safely dispose of healthcare waste, including sharps, to prevent the spread of infection
- IPC8.2012 – Minimise the risk of spreading infection when transporting and storing health and social care related waste
- IPC10.2012 – Minimise the risk of spreading infection when transporting clean and used linen
- IPC11.2012 – Minimise the risk of spreading infection when laundering used linen
- IPC12.2012 – Minimise the risk of spreading infection when storing and using clean linen
- IPC13.2012 – Provide guidance, resources and support to enable staff to minimise the risk of spreading infection

Appendix 2 – Stakeholder surveys

Methods

Surveys of staff were undertaken using Microsoft Forms across five settings in Northumberland North Tyneside, including:

- Care homes.
- Domiciliary care.
- Residential children's homes.
- Educational settings.
- General practices.

The questionnaire was informed by the literature review on barriers, facilitators, and interventions to promote adherence to IPC measures (see Section **Error! Reference source not found.**) together with the Theoretical Domains Framework (TDF). The TDF is "an integrative framework developed from a synthesis of psychological theories as a vehicle to help apply theoretical approaches to interventions aimed at behavio[u]r change".[14] It identifies 14 domains that cover the determinants of behaviours. These include: knowledge; skills; social/professional role and identity; beliefs about capabilities; optimism; beliefs about consequences; reinforcement; intentions; goals; memory, attention, and decision processes; environmental context and resources; social influences; emotion; and behavioural regulation.[15] Of note, TDF underpins the COM-B model that is used to understand what needs to be altered to facilitate behaviour change, identifying three factors that need to be present for any behaviour to occur:

- Capability: having the psychological capacity and physical ability to enact the desired behaviour.
- Opportunity: the environment that enables the behaviour.
- Motivation: the desire to carry out the behaviour over other behaviours.

The COM-B model is advocated in the recently published Infection prevention and control education framework.[16]

The objectives of the surveys were:

- To understand the met and unmet needs of staff to enable effective IPC measures to be in place to prevent harmful infections or outbreak either between or during pandemics.
- To understand the barriers and facilitators to implementation of effective IPC measures in each setting.

---

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4370908/#:~:text=The%20TDF%20domains%20and%20their,%2C%20and%20decision%20processes%2C%2011

[15] https://implementationscience.biomedcentral.com/articles/10.1186/s13012-017-0605-9

[16] https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

Results

The number of responses by location and setting are shown in Table 1.

Table 1. Number of responses to IPC surveys by location and setting

Setting	Number of responses	Northumberland	North Tyneside	Other
Care homes	64	46 (72%)	17 (27%)	1 (1.6%)
Domiciliary care	57	22 (39%)	27 (47%)	8 (14%)
Education	24	10 (42%)	14 (58%)	0 (0%)
Children's residential homes	44	44 (100%)	0 (0%)	0 (0%)
General practices	36	13 (39%)	22 (61%)	0 (0%)

Results – Care homes

Out of a total of 64 responses, 17 (27%) were from people working in North Tyneside, 46 (72%) from Northumberland, and one (1.6%) respondent who stated they worked in Newcastle. Most areas of Northumberland were represented, and there were most from the Alnwick area (18; 28% of all responses). Most respondents (56; 87.5%) were either care home managers or care workers or assistants.

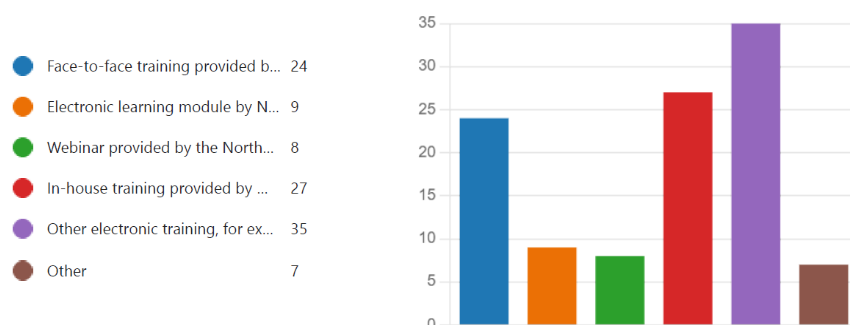
Many of the responses implied confidence or good practice:

- 91% said they have an IPC champion or lead in their care home.
- 86% said they have had IPC training in past 12 months.
- 86% said their organisation has a policy of being bare below the elbow when delivering direct care.
- Few respondents identified any barriers to training.
- Respondents completely or somewhat agreed that:
    - IPC is everyone's responsibility.
    - They had sufficient knowledge of guidance, skills, training (including in managing residents with challenging behaviours), time, access to handwashing facilities and alcohol handrub, personal protection equipment (PPE), organisational support, monitoring, space, and reminders to implement IPC measures.
    - They were confident to intervene if they witnessed a breach in guidance.
    - Visitors are happy to follow guidance.
- In questions about hand hygiene, they were more likely to report being over-cautious.

Findings suggesting opportunities for development included:

- The most common training in the past 12 months was e-learning or in-house training (not provided by the Northumbria Healthcare IPC team) – see Figure 1. There may be an opportunity to quality assure the training delivered.
- Less than half of staff will contact IPC team or UKHSA about IPC issues, but most will contact line manager; they are unlikely to contact local authority about IPC issues.
- 16% of respondents stated they are expected to come into work if unwell with an infection.

Figure 1. Responses from care home staff (n=64) about type of training received



Results – Domiciliary care (home care)

Of a total of 57 responses, 22 (39%) reported that they worked in Northumberland, and 27 (47%) that they worked in North Tyneside. Of the remainder, one worked in both Northumberland and North Tyneside, one indicated the North East, and five stated other areas in the North East including Newcastle, Gateshead, and Hartlepool. Because this may indicate the site of the office, these results were included but a sensitivity analysis undertaken to exclude these with results reported if it changes the conclusions. Most respondents (49; 86%) were homecare or supported living managers, deputy managers, directors, or care coordinators. Seven (12%) were homecare workers and one was an infection control admin.

As with care home staff, many of the responses implied confidence or good practice:

- 95% said they have had IPC training in past 12 months.
- 86% said their organisation has a policy of being bare below the elbow when delivering direct care.
- Respondents completely or somewhat agreed that:
    - IPC is everyone's responsibility.
    - They had sufficient knowledge of guidance, skills, training, time, access to handwashing facilities and alcohol handrub, personal protection

equipment (PPE), organisational support, and monitoring to implement IPC measures.
    - They were confident to intervene if they witnessed a breach in guidance.
- In questions about hand hygiene, they were more likely to report being over-cautious.

Findings suggesting opportunities for development included:

- 65% of respondents reported having an IPC champion or lead in their workplace – see Figure 2.
- 18% identified barriers to training, including cost, not knowing what is available, and time – see Figure 3. One respondent said:

  "Access to IPC training for staff is no longer available, new staff do not have access to the training previously available to staff during the pandemic".
- The most common training in the past 12 months was e-learning or in-house training (not provided by the Northumbria Healthcare IPC team) – see
- Figure4. There may also be an opportunity to quality assure the training delivered.
- 9% state they are expected to come into work if unwell with an infection.

Figure 2. Responses from domiciliary care staff about IPC champion or lead

Do you have an Infection Prevention and Control Champion or Lead within your workplace?

Figure 3. Responses from domiciliary care staff (n=57) about barriers to accessing training

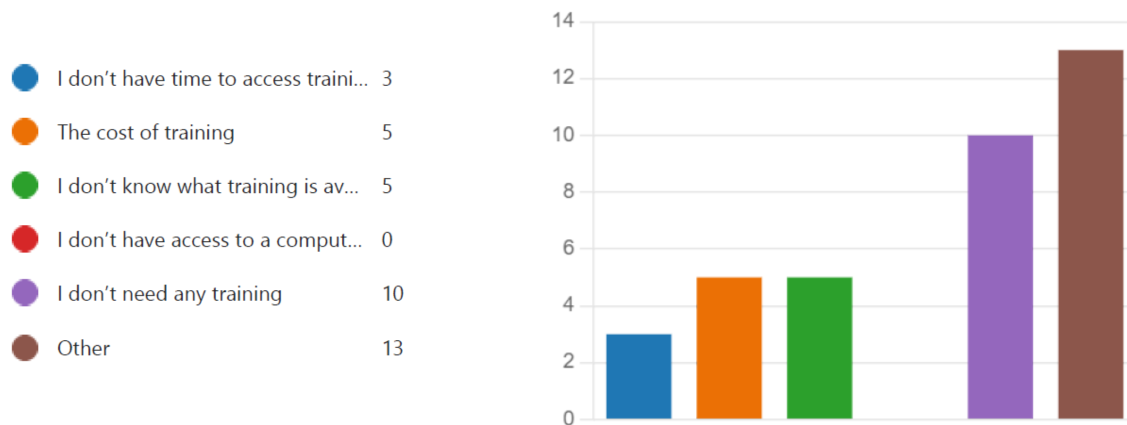
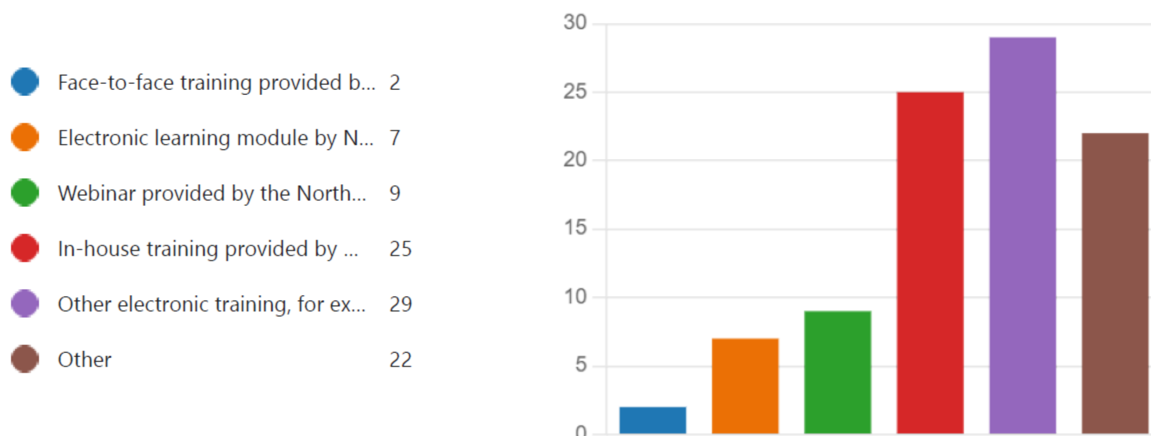


Figure 4. Responses from domiciliary care staff (n=74) about type of training received



Results – Educational settings

There were 24 responses, of which 14 (58%) were from North Tyneside and 10 (42%) from Northumberland. There were no responses from early years settings, and 18 out of 22 responses were from primary or middle schools. A total of 19 responses were from head teachers (including one executive head teacher). The remaining responses were from business managers or an administrator.

There was strong agreement that IPC is everyone's responsibility, and 87% stated that arrangements to manage outbreaks are recorded in their organisation's

Emergency Plan. Most respondents thought they had sufficient knowledge and skills, access to handwashing facilities and PPE, and organisational support.

There are several findings suggesting opportunities for development (see Figures 5 and 6):

- Only 29% of respondents completely agreed that they have had sufficient training in IPC, with 29% somewhat agreeing, and 25% completely or somewhat disagreeing. All identified barriers to training including not knowing what is available, cost, and time (in that order).
- There was considerable variation in terms of whether respondents reported having sufficient time to implement IPC measures: 12.5% completely agreed; 50% somewhat agreed; 8% neither agreed nor disagreed; 25% somewhat disagreed; and 4% completely disagreed.
- 13% stated they are expected to come into work if they were unwell with an infection.

Figure 5. Responses from education staff (n=24) asking 'Please state how much you agree or disagree with the following statements about preventing infections'.

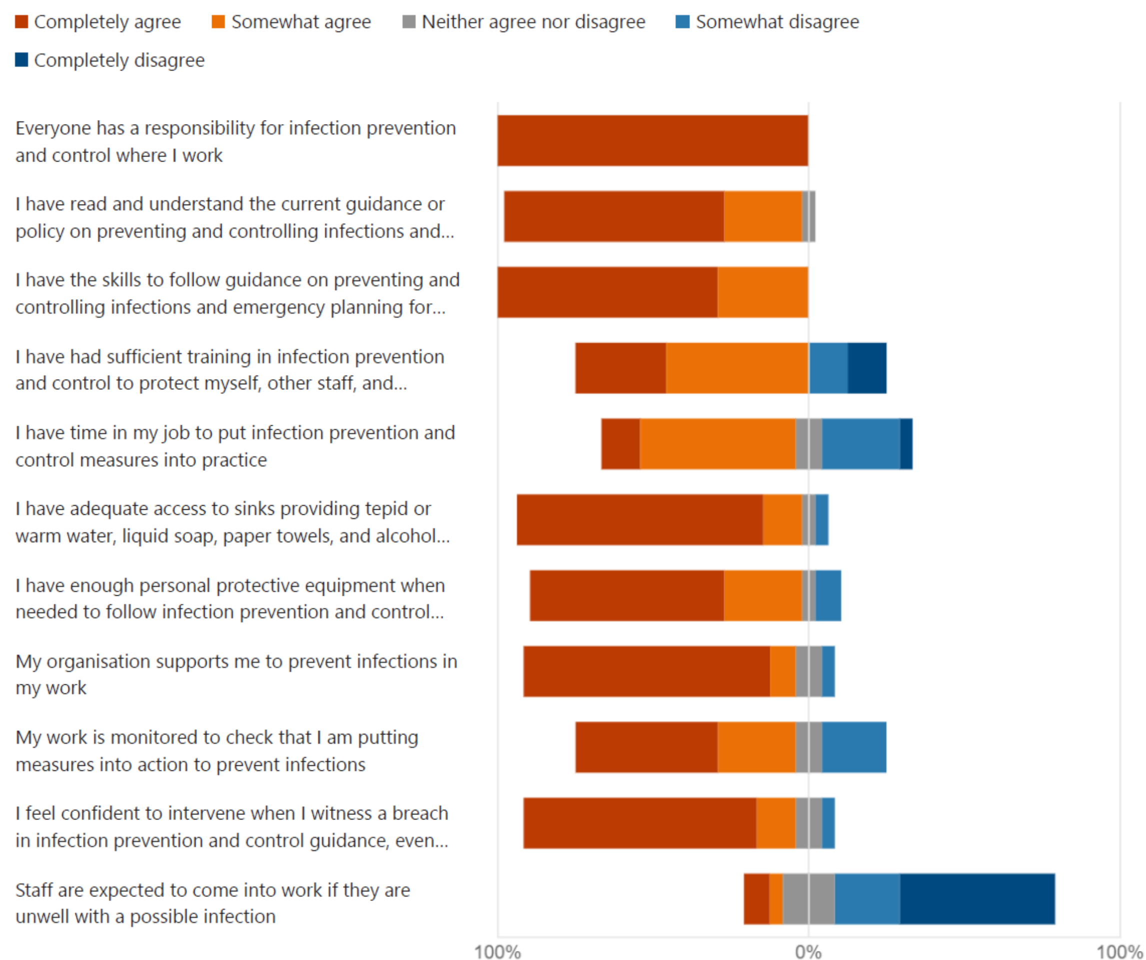
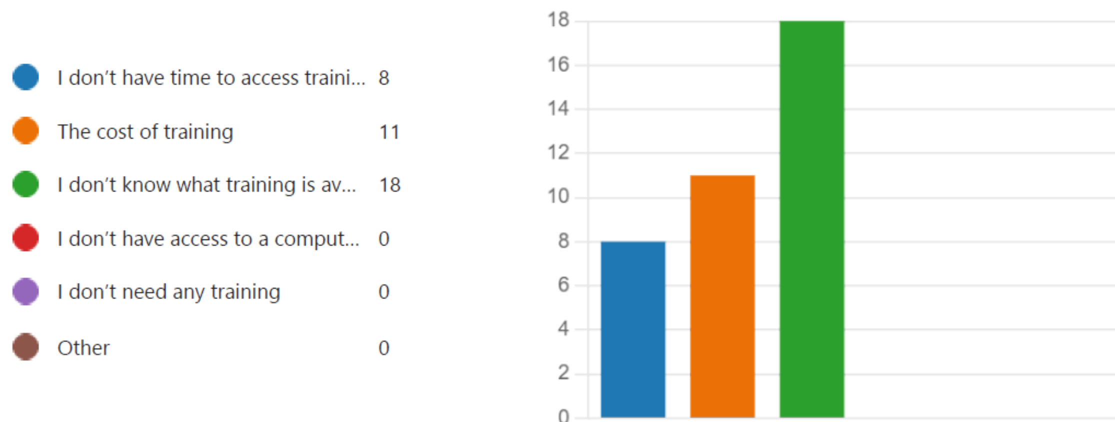


Figure 6. Responses from education staff (n=24) about barriers to accessing training



One headteacher for North Tyneside said:

> *"An understanding of what training is available for my staff would be much appreciated. Also sometimes consistency in information given across Health Care professionals can vary."*

Another headteacher from Northumberland expressed a sense of helplessness at the series of infections affecting students and staff:

> *"One can try ones best and expect everyone else to try [their] best. But pre Christmas and post Christmas it does not seem to make a difference re the illnesses in my school… We have gone from one to the next and then reinfection airborne or not. Tonsillit[i]s, influenza, hand foot and mouth, slapped cheek, chicken pox, scarlet fever, vomiting… [T]he two week break at Christmas seems to have made no difference. Our attendance will be shocking as the children are just not recovering quickly and they are moving from one to the next as I say. Along with staff ."*

One business manager from North Tyneside identified issues accessing PPE or implementing a deep clean during an outbreak:

> *"Whilst we have plenty of PPE now, during the Covid pandemic it was not as easy to get hold of and the DfE were too slow to respond on centralised distribution. It would help to know where any centralised stocks are readily available if another infection outbreak should occur. Additional cleaning in some schools is difficult to get when staff have set hours and responsibilities and can't do or the school can't afford the additional hours for deeper cleans during outbreaks."*

Results – Residential children's homes

All 44 responses were from staff working in Northumberland children's homes. All staff groups responded, with the highest numbers being shift coordinators or support workers.

Many of the responses implied confidence or good practice:

- 82% staff have had IPC training in past 12 months and few respondents identified any barriers to training. Most training has been electronic with around half reporting they have accessed the e-learning developed by Northumbria Healthcare IPC team on the Learning Together portal.
- Most respondents completely or somewhat agreed that:
  - IPC is everyone's responsibility
  - They have sufficient knowledge of guidance, skills, training, time, access to handwashing facilities and alcohol handrub, personal protection equipment (PPE), organisational support, monitoring, space, and reminders to implement IPC measures.
  - They were confident to intervene if they observed a breach in IPC guidance.

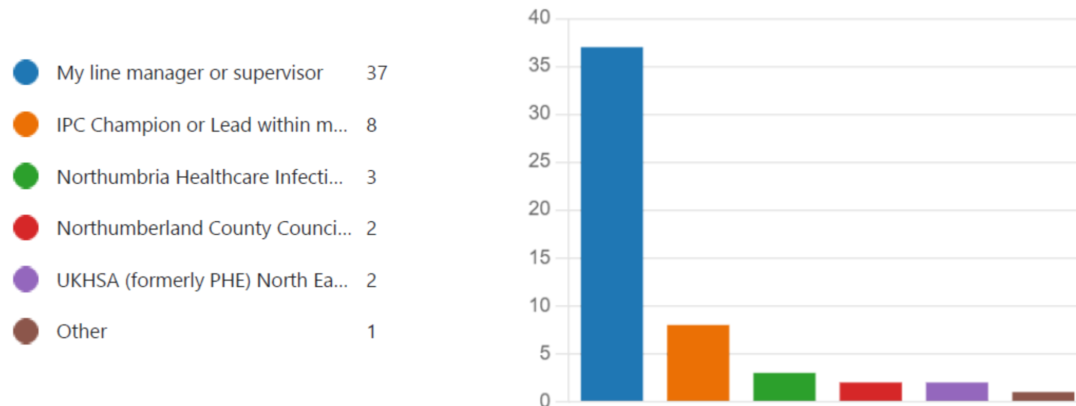
Findings suggesting opportunities for development were:

- Only 25% respondents said they have an IPC champion or lead in their workplace (see Figure 7).
- Most will contact their line manager if they have an IPC issue, which is appropriate but may suggest lack of awareness of wider support (Figure 8).
- 18% of respondents said that they are expected to come into work if they are unwell with an infection.

Figure 7. Responses from children's residential home staff (n=44) asking if they have an IPC champion or lead

Do you have an Infection Prevention and Control Champion or Lead within your workplace?

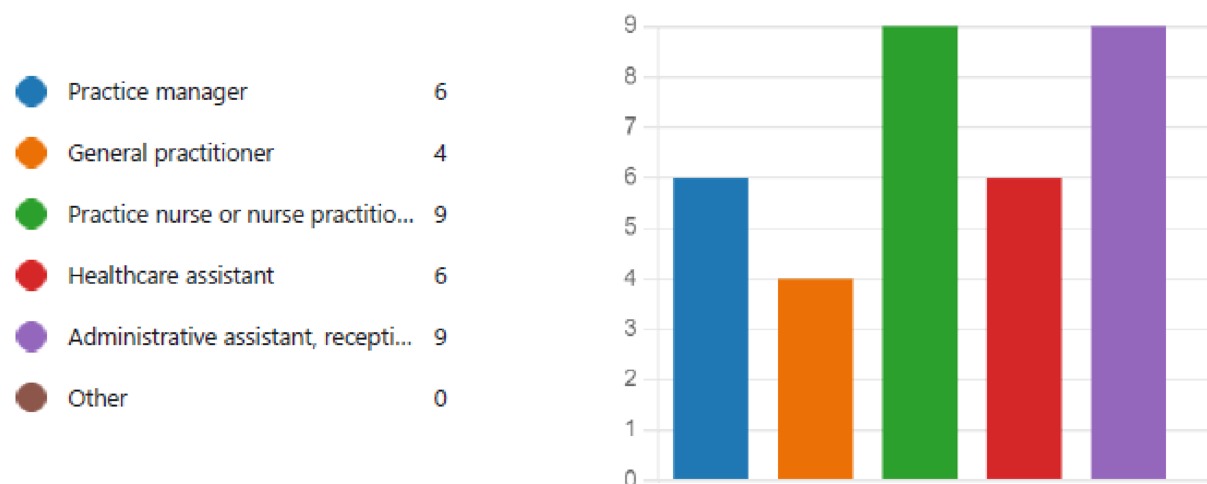
Figure 8. Responses from children's residential home staff (n=44) asking who they contact if concerned about IPC



Results – General practice

Out of a total of 36 responses, 22 (69%) were from North Tyneside general practices, and 14 (31%) from Northumberland. There were no responses from Bedlington, Haltwhistle, Ponteland, or Prudhoe. There was quite an equal spread between different clinical and administrative job roles – see Figure 9.

Figure 9. Responses to IPC survey of general practice by job role



Many of the responses implied confidence or good practice (see Figure 10):

- Most respondents completely or somewhat agreed that:
    - IPC is everyone's responsibility

    - They have sufficient knowledge and understanding of guidance, skills, training, access to handwashing facilities and alcohol handrub, personal protection equipment (PPE), and organisational support to implement IPC measures.
    - They were confident to intervene if they observed a breach in IPC guidance/
- There was a high level of knowledge in relation to hand hygiene.

Findings suggesting opportunities for development were (see Figure 10):

- There was some variation in responses for questions about time, monitoring, and confidence to intervene if witnessing a breach in IPC guidance.
- A total of 64% of respondents have had IPC training in past 12 months. Most training has been electronic, not provided by Northumbria Healthcare. A third of respondents stated they did not need any training. One Northumberland GP said:

  > *"We are too busy for frequent repetitive training, more geared to hospital environments."*

  However, there were several comments suggesting that training is needed, with one respondent saying they needed training tailored to general practice:

  > *"When the changes were made to IPC last April, it was initially stated that it only applied to hospital settings and not GP Practices. This was then changed at the last minute which meant that GP Practices were denied the help, guidance and training that had been given to Trusts. The new guidelines are onerous and there is no information, central training, help or documentation in order to help GP Practices achieve these standards."* (Practice manager, North Tyneside)
  >
  > *"I don't believe enough training and evaluation happens in primary care to maintain adequate infection control and patient safety." (Practice nurse or nurse practitioner, Northumberland)*
  >
  > *"Training specific to primary care rather than hospital would be useful."* (Practice manager, Northumberland)

- Barriers to training (see Figure 11) were not knowing what training was available (12 respondents) and time (10), with cost less of a barrier (5). Time was also a barrier for some in implementing IPC measures. One respondent said:

  > *"Time is a precious resource and training often done in my own time."* (GP, Northumberland)

- Two-thirds of respondents (24 out of 36) report that they do not have an IPC champion or lead, or don't know – see Figure 12.

- 11% of respondents said that they are expected to come into work if they are unwell with an infection.

Figure 10. Responses from general practice staff (n=36) asking 'Please state how much you agree or disagree with the following statements about preventing infections'.

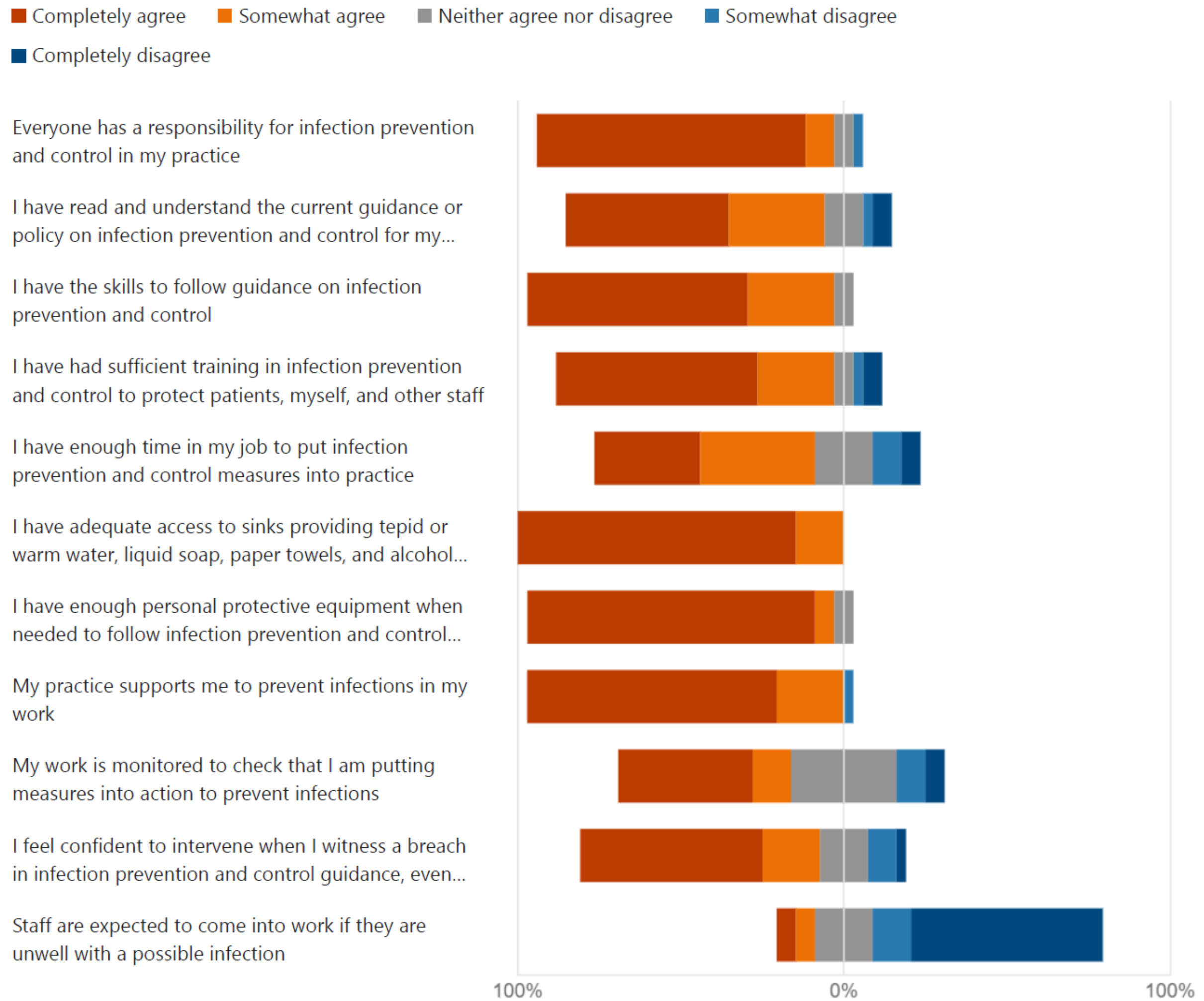


Figure 11. Responses from general practice staff (n=36) about barriers to accessing training

Are there any barriers to accessing training in infection prevention and control? Please tick all that apply.

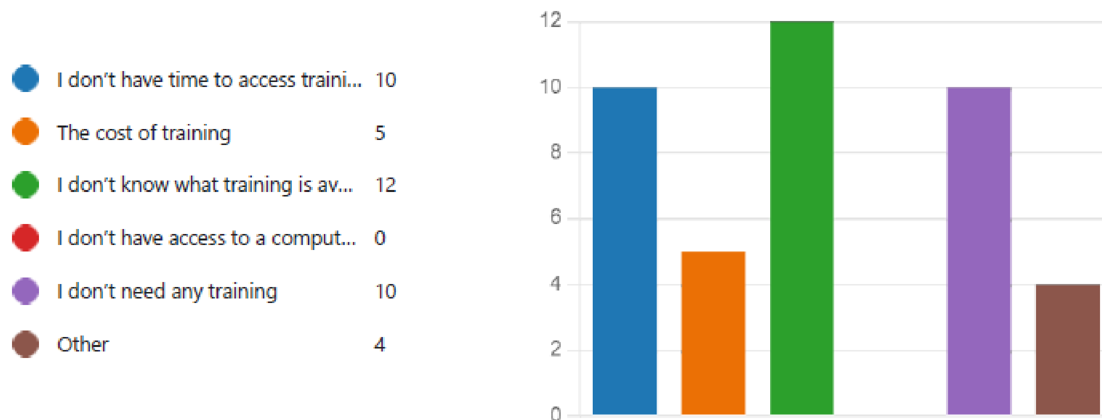
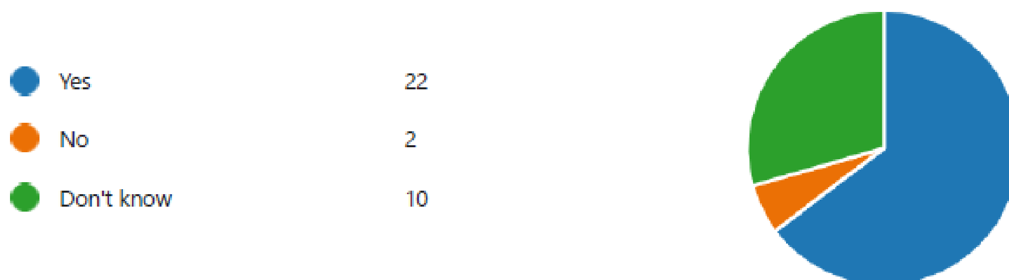


Figure 12. Responses from general practice staff (n=36) about IPC champion or lead

Do you have an Infection Prevention and Control Champion or Lead within your practice?



Summary and discussion of survey findings

First, caution is needed in interpreting the findings of some of the surveys owing to the number of responses, and likelihood that people who did not respond are systematically different from those who did respond (non-response bias).[17] With the exception of the survey of staff working in children's residential care, the number of responses was quite low. This was particularly true of general practice and education. Indeed, there were no responses from staff working in early years settings: further work may be needed to gain insights in this sector.

It is also worth recognising that there may also have been factors related to the survey questionnaires themselves that lead respondents to answer falsely or

[17] https://www.sciencedirect.com/topics/nursing-and-health-professions/nonresponse-bias

inaccurately (response biases), for example the tendency to agree with a statement particularly if it is more socially acceptable.

Indeed, many of the responses suggested that respondents were confident in their IPC knowledge, skills and behaviours. Given the common themes that are noted on care home visits or during risk assessments, this may not be the case universally. Despite the high confidence, the survey findings still suggest opportunities for training, increased awareness of guidance, and monitoring of IPC behaviours through audit and other approaches.

Many staff use in-house training for which the quality may or may not be high. Some staff are unaware of training that is available. And for some, cost and time are barriers, particularly in education and general practice.

A worrying number of staff across all sectors feel compelled to come into work even if they are unwell with an infection. The reasons for this may be varied, due to attitudes and values of the organisation, manager, and employee.

Whilst many staff are aware of an IPC champion or lead in their organisation, in others including domiciliary care and general practice, awareness or existence of such a role is less common. This question was not asked of education because an IPC lead or champion is not currently common practice, although there is a health and safety lead.

Many staff report that they do not contact the local authority if they are concerned about IPC, which is somewhat at odds with perceptions within both local authorities.

Finally, the surveys do not identify the many structural barriers to implementing good IPC measures that were identified during the pandemic, such as inability to recruit and retain staff in social care, use of agency staff, the state of repair of some settings, and the importance of effective leadership.

Previous local survey findings

In a survey in September 2022 of Northumberland and North Tyneside care homes, high levels of satisfaction were reported about the involvement of IPC team in past 2 years, their face-to-face visits, and the monthly webinars the team provided – see Figure 13-15. The number of responses were limited to 50, but this provides an important snapshot of how valued the team was during the pandemic by care home managers and staff.

Free text responses were very positive about the role of the IPC team:

- *“I think that the team have been great with advice and support.”*
- *“The team have always supported us during covid answering questions and advising us on certain things. The training has been delivered to a very high standard and our staff team have learnt and retained information given so as to put it into practice.”*
- *“Keep doing what you are already doing really well!”*

- *“We have had training recently and that has been most effective. It didn't stop us from having an outbreak but these have been small. I have only been at the home for a few months but am very happy with the input that we receive.”*
- *“The support has been fantastic.”*
- *“I believe that the IPC has been very helpful with all their advice and training especially the Donning and Doffing training. I am mindful that there is always someone to speak to over the telephone if we have any queries or concerns.”*
- *“They are a phone call away if needed for advice.”*

Figure 13. Satisfaction with IPC team (September 2022)

How satisfied is your home with the involvement from the IPC Team over the past 2 years

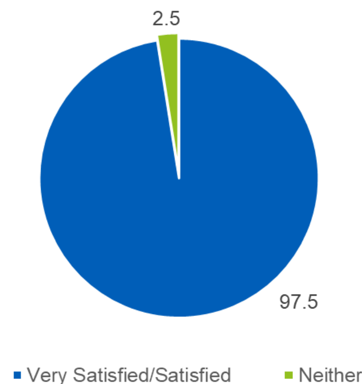


Figure 14. Satisfaction with monthly webinars by the IPC team (n=50; September 2022)

How satisfied were you with the Monthly Care Home Webinars?

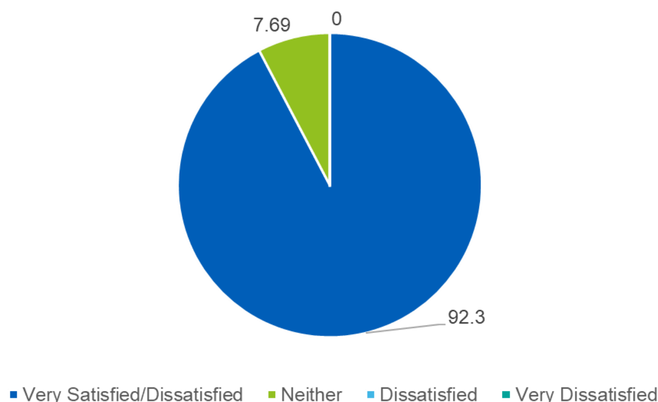
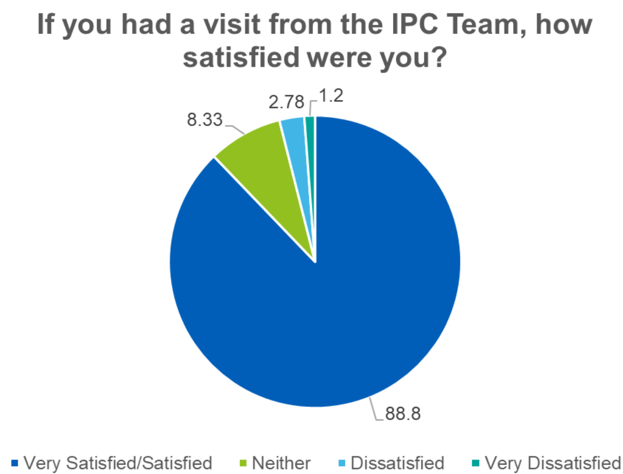


Figure 15. Satisfaction with face-to-face visits by the IPC team



In a separate survey of Northumberland care home managers earlier in the pandemic in November 2020 by the care sector outbreak prevention and control team, they were asked about the training their staff had received. Responses were received from 34 care homes indicating that, for a third of care homes that responded, one third had had in-house training only. Together with other data sources, this survey helped to target offers of support.

Appendix 3 – Stakeholder focus groups and interviews

Stakeholder focus groups or interviews were undertaken with IPC strategy group members, the Northumbria Healthcare IPC team and the Northumberland County Council Adult Social Care Commissioning and Contracts team. At the sessions, the survey findings were shared, and the participants were asked:

- What are your reflections on these findings?
- What aspects of IPC went well during the pandemic?
- What didn't go so well? What gaps were and are there?
- What are or were the barriers and facilitators?
- What difference would an expanded IPC team make, or have made?
- What else should we be doing as a system to increase the effectiveness of IPC measures?

Several key themes emerged from the discussions that are summarised below.

There is a high value placed on the role of the IPC team, the support they gave during the pandemic, and the relationships that have developed during the pandemic.

In both surveys and focus groups, many people praised the role of the IPC team particularly during the pandemic, and expressed concern if there were to be any reduction in resource:

> *"I would say that the links with the infection control team were fantastic and I think they've always been strong there, but they really came into their own and I suppose touching on a point about the size of that team, it is a bit worrying if the if they've shrunk a little bit."* [Adult social care commissioning manager, Northumberland]

Relationships between system partners, and with providers, improved during the pandemic because of the good communication, collaboration, and support given:

> *"I think the way we all linked in, you know, IPC team, [Public health] and contracts team, I think that was really beneficial. That was really good…*
>
> *And we have quite a good relationship with the providers, I think that's strengthened throughout the pandemic."* [Adult social care commissioning manager, Northumberland]

There is a need for IPC support and training for staff in early years settings

Several participants identified the challenge but also opportunity in ensuring implementation of effective IPC measures within early years settings, because of the high risk of transmission of infection, the challenges in controlling outbreaks in these settings, and the impact on parents being able to work, and the health of the wider community:

“We got very involved with early years settings early in the pandemic... People were attending work sick because they didn’t get paid otherwise... We did training for Early Years managers and practitioners that was well received, leading them to change their guidance from work we had done.” [IPC nurse]

The need for sustainable, capacity-building solutions in view of the small size of the IPC team

There was consistent agreement that, whilst face-to-face support by the IPC team was always appreciated and expansion of the IPC team would be preferable, the IPC team would need to prioritise and could not provide training and support to all providers in all sectors. Models that require training and support of IPC champions, professionals who visit the setting or have existing relationships with the setting, were likely to be more sustainable:

“I think also [it would be good if] the small number of us that do go out and about [were] to have some additional training as well because we've been the people that have been advising. So I think if CQC are looking at what we do, we need to keep our skills up... So any additional training we can have would be beneficial that we can be passing on the right information basically.” [Adult social care commissioner, Northumberland]

A ‘hub and spoke’ model was suggested. In particular, upskilling professionals who visit care homes, such as community nurses, frailty nurses, care home nurse practitioners, adult social care commissioning teams, care managers, and safeguarding teams (as well as CQC inspectors), would enable staff to identify good or bad practice, provide immediate advice, and share findings so that additional support can be offered, whether IPC training or wider support for the manager around staffing or environmental issues. This would also reduce duplication, promote greater collaboration, and increase system preparedness for future threats.

Whilst IPC champion approaches were broadly supported, some caution about the challenges for IPC champions in care homes was expressed:

“I do wonder how well [having an infection control champion] actually works in in practice. You know, how much challenge there is there from those champions to their colleagues, because I think that's tough. I think that's a really tough thing to do.” [Adult social care commissioning manager, Northumberland]

It was not thought to be feasible to ensure that all educational settings had an IPC champion, and other approaches would be needed. Health and safety teams already have relationships with schools and would be in a good position to support them, particularly if they built links with the IPC teams and received additional support to build on their already considerable knowledge of IPC. Other suggestions were trying to build IPC into the PHSE curriculum.

Appendix 4 – Prioritisation

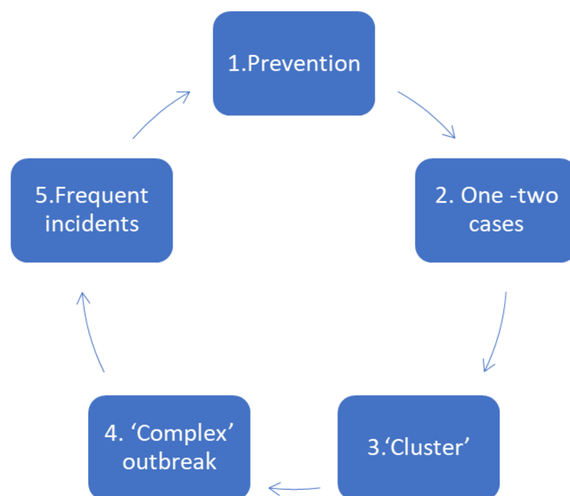
Recognising that the specialist community IPC nurse team is a finite resource of 4.8 whole time equivalent nursing staff, the steering group undertook a prioritisation exercise to explore the balance of resource committed between prevention and control for the specialist resource across and between each type of setting. Settings were split into four:

- Care homes
- Education and early years (including children's residential homes)
- Domiciliary care
- Primary care (general practice)

Phases in the IPC 'cycle' were split as in Figure 1 and steering group members were asked to prioritise each setting and each phase using the following criteria:

- Vulnerability of resident or service user
- Number of settings
- Risk of infection
- Types of infection
- Infection spread
- Wider community impact
- Frequency and complexity of outbreaks

Figure 1. Suggested phases in the IPC cycle to inform prioritisation

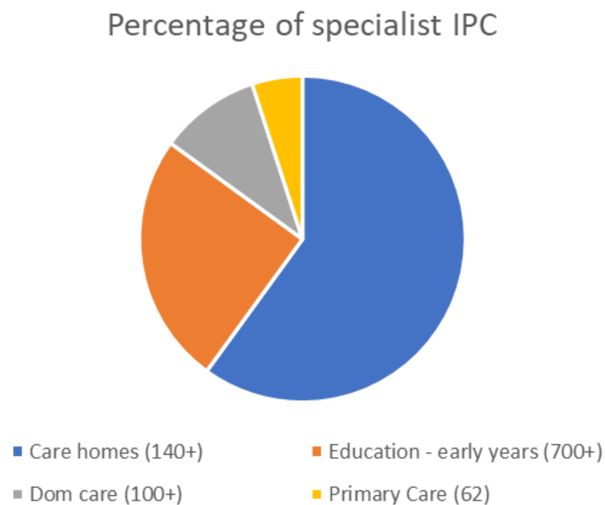


After a discussion the group agreed the focus between types of setting for the specialist IPC team as in Table 1 and Figure 2.

Table 1. Prioritisation of specialist IPC resource by setting

Setting	Percentage of specialist IPC
Care homes (140+)	60
Education and early years (700+)	25
Dom care (100+)	10
Primary Care (62)	5
Total	100

Figure 2. Prioritisation of specialist IPC resource by setting



After further discussion, the balance of time spent on each phase was agreed for each type of setting as in Table 2.

Table 2. Distribution of specialist IPC resource by phase for each setting

		Percentage of specialist resource			
Phase	Name	Care homes	Education	Domiciliary care	Primary care
1	Prevention	35	50	80	80
2	1-2 cases	5	10	0	5
3	Cluster	25	15	5	5
4	Outbreak	20	20	5	5
5	Frequent incidents	15	5	10	5
	Total	100	100	100	100

This was then translated into days per month for each setting based on 4.8 WTE IPC nurses as shown in Table 3.

Table 3. Days per month of focus for specialist IPC resource by setting and phase

		Days per month of specialist IPC resource (4.8 WTE)			
Phase	Name	Care homes	Education	Domiciliary care	Primary care
1	Prevention	18.9	11.3	7.2	3.6
2	1-2 cases	2.7	2.3	0	0.2
3	Cluster	13.5	3.4	0.5	0.2
4	Outbreak	10.8	4.5	0.5	0.2
5	Frequent incidents	8.1	1.1	0.1	0.2
	Total	54	22.5	9	4.5

This prioritisation demonstrates that the specialist IPC resource is stretched between multiple settings and between prevention and control such that, for some settings like domiciliary care and primary care (general practice), there is so little time available within existing resource that little can be achieved within that time. This reinforces the need not only for additional resource, but also for approaches that build resilience and capacity within the setting as opposed to direct delivery.

Northumberland
County Council

Health and Wellbeing Board

14th September 2023

Northumberland Healthy Weight Alliance

Report of: Councillor Veronica Jones, Portfolio Holder for Public Health, Inequalities and Stronger Communities

Responsible Officer(s): Gill O'Neill. Executive Director – Public Health, Inequalities and Stronger Communities

1. Link to Key Priorities of the Corporate Plan

Northumberland Healthy Weight Alliance (HWA) will support the NCC Corporate Plan 2023-2026 priorities:

Tackling inequalities; Children and young people have the best start in life and grow up well. Residents have the building blocks of a good life. Empowered and resilient communities.

Driving Economic Growth; Skilled and aspirational people. A connected county.

The establishment of a HWA was a recommendation in the 2021/22 Director of Public Health (DPH) Annual Report: Healthy Weight for all Children

The Joint Health and Wellbeing Strategy is being refreshed to reflect the Marmot policy areas (listed below) and help deliver the inequalities plan.

1. Give every child the best start in life
2. Enable all children and young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities Strengthen the role and impact of ill health prevention
6. Strengthen the role and impact of ill health prevention
7. Pursue environmental sustainability and health equity together
8. Tackle racism, discrimination and their outcomes

How healthy weight supports these principles is shown below in the report.

2. Purpose of report

- To update board members on progress regarding Northumberland HWA.
- To feedback on the HWA workshop, May 2023, including suggested priority areas for action, key stakeholders and monitoring of impact arrangements.
- To inform board members of the appointment of a HWA 'Champion' / Chair.
- To seek agreement that Northumberland HWA reports to the Health and Wellbeing Board.

3. Recommendations

It is recommended that the Health and Wellbeing Board:

- approves the establishment of Northumberland HWA, to bring agencies and communities together to ensure a coordinated approach to healthy weight.
- agree that Northumberland HWA reports to the Health and Wellbeing Board.
- delegate responsibility to the HWA to deliver the Healthy Weight Declaration (signed November 2022).

4. Forward plan date and reason for urgency if applicable

Not Applicable

5. Background

The 2021/22 Director of Public Health Annual Report outlines the complexities associated with public health challenges such as obesity. The DPH report makes a series of recommendations which aim to make healthy weight, specifically for children and young people, a priority for Northumberland. One of the recommendations in the DPH report is the formation of a HWA. This paper outlines the role of the HWA and updates members on progress to date.

Why Action is Needed Across Northumberland

Previous Health and Wellbeing Board reports have outlined the picture of unhealthy weight in Northumberland and the health, social and economic burden of unhealthy weight as well as the compounding impacts of the recent COVID-19 pandemic and the current cost of living crisis. In Summary;

- nearly a third of children aged 2 to 15 are overweight or obese and younger generations are becoming obese earlier and staying obese for longer *(JHWB Strategy – Best Start in Life theme)*

- almost two thirds of adults in Northumberland are overweight or obese, with those from lower income households much more likely to fall into this category compared to people from higher income households *(JHWB Strategy – Living and Ageing Well)*

- excess weight is a significant health issue for all ages, contributing to both physical and mental ill health, a reduced number of years spent in good health and reduced life chances *(Marmot principle – Strengthen the role and impact of ill health prevention)*

- in light of COVID-19 and the association between health inequalities, chronic disease and obesity as risk factors, it is important for Northumberland to build back better, providing healthier places, reducing inequalities and building resilience into recovery plans as part of the prevention agenda. *(Marmot principle – create and develop healthy and sustainable places and communities)*

- the current cost of living crisis is placing additional strain on household budgets as prices of essentials such as food & fuel increase. Low-income families may turn to purchasing cheaper foods, often with little nutritional value with less access to a range of healthy and affordable foods resulting in diet-related inequalities and further widening health disparities. *(Marmot principle – ensure a healthy standard of living for all)*

- promoting healthy weight is even more important amidst the cost-of-living crisis to reduce pressure on the health and social care system, promote well-being and quality of life, and ensure a productive workforce and healthy economy. *(Marmot principle – create fair employment and good work for all)*
- Northumberland County Council has the potential to impact positively on the drivers that influence behaviours, including access and availability of food and drink options. The Local Authority Declaration on Healthy Weight presents an opportunity to tackle some of these drivers.

Northumberland's Healthy Weight Alliance

There is no single cause of overweight and obesity. The causes exist in the places we live, work and play with a multitude of complex factors including access to healthy food, proximity to fast food outlets, advertising and the marketing of calorie dense food and drinks and opportunities to be physically active. Establishment of Northumberland HWA aims to make healthy weight everybody's business with all stakeholders having an important role to play, including our residents. The goal is to ensure consideration and support for healthy weight is included in all our policies and practices.

Healthy Weight Alliance Workshop

In May 2023, the council's Public Health Team coordinated the first HWA workshop. Forty-five delegates from various organisations with a range of strategic roles attended. The aim of the workshop was to revisit the positive work which had been progressed pre covid pandemic. The workshop used the strategic themes from the Local Authority Healthy Weight Declaration to initiate conversations around healthy weight and collect insight from colleagues. The five strategic themes are:

a) **System Leadership** – Adopting a long term, system-wide approach to healthy weight.

b) **Commercial Determinants** – Promoting healthy food and drink options, while protecting our residents against the harmful effects of inappropriate marketing by the food and drink industry.

c) **Health Promoting Environments** – Ensuring where we live has a positive impact on physical activity, active travel, the food environment and food security.

d) **System and Cultural Change** – How our Anchor institutes (and partners) work to create a culture and ethos promoting an understanding of healthy weight.

e) **Healthy Weight across the Life course** – A life course approach that supports healthy weight of both the current and future generations.

Workshop feedback was framed around 3 key questions (see appendix one)

1. What might our key areas of focus look like and why.
2. How will we know what success looks like (and how will we measure success).
3. Who are the key organisations / people that need to be involved.

From the 5 facilitated table discussions a range of key priority areas were identified across each of the key strategic themes. Feedback was broad and diverse, however, overarching themes included:

- development of a food strategy for Northumberland,
- design and development of where we live to maximise access to healthy foods and be physically active,
- giving every child the best start in life – utilising assets e.g. family hubs to promote good nutrition in the early years e.g. breastfeeding and infant feeding.

Another workshop will be held shortly to present feedback to delegates and agree priorities. The National Obesity Health Alliance, advocates 3 priority areas for action. Following this workshop, terms of reference will be prepared for approval by the Health and Wellbeing Board. The HWA will be chaired by Paul Jones, Director of Environment and Transport and include senior staff from organisations across the county.

Next Steps

Another workshop will be held shortly to present feedback to delegates and agree priorities. The National Obesity Health Alliance, advocates 3 priority areas for action. Following this workshop, terms of reference will be prepared for approval by the Health and Wellbeing Board. The HWA will be chaired by Paul Jones, Director of Environment and Transport and include senior staff from organisations across the county. .

6. Options open to the Council and reasons for the recommendations

Options open to the Council include:

i. Adopting the recommendations outlined in section 3 of this report.

ii. Consider the governance and delegated responsibilities for the HWA and suggest alternative arrangements.

iii. Reject the recommendations with a clear rationale for non-adoption of the recommendations.

To progress work to create a Healthy Weight environment for all, it is recommended that the board agree to option i. outlined above.

7. Implications

Policy	Establishment of the HWA will support key policy priorities and themes within the Corporate Plan. It will also support the North East and North Cumbria (NENC) Integrated Care System health and prevention workstream and the Marmot principle of strengthening the role and impact of ill health prevention
Finance and value for money	Funding for a Local Authority approach will come from the Public Health ringfenced grant. NCC has already paid to work with Food Active to support Northumberland County Council's HWD £1950 + VAT. Within this 'fee', Food Active will support Northumberland with access to HWD PR, ongoing support within the Food Active team (which includes nutritionists), access to the HWD support pack, use of artwork and logo upon successful adoption and support with monitoring and evaluation.
Legal	No implications identified
Procurement	The HWD encourages the review of contracts and provision at public events, in all public buildings and facilities. This supports the Marmot principle of creating and developing healthy and sustainable places and communities.
Human resources	There are no implications for HR
Property	No specific implications for property

Equalities Act: is a full impact assessment required and attached?	No - not required at this point All of this work will be through inequalities lens adopted by the inequalities plan, using the three screening questions: what can communities do for themselves; what communities need help with and what can't communities do which agencies need to do
Risk assessment	There is a risk to the implementation of HWD 16 commitments within the context of the cost-of-living crisis which will be monitored closely over the first year as lower income families would need to spend 47% of their disposable income on food to meet the Government's healthy diet recommendations.
Crime and disorder	N/A
Customer considerations	Voice of residents will be actively sought as we progress implementation.
Carbon reduction	It is anticipated that the HWA will support the council's carbon reduction plans. This supports the Marmot principle of pursuing environmental and health equity together
Health and wellbeing	Establishment of the HWA supports the joint health and wellbeing strategy and action plan

Wards	All Wards

8. Background papers

- Local Authority Declaration on Healthy Weight. Why a local authority declaration on healthy weight is needed. 2020, Health Inequalities Group evidence briefing.
- Northumberland Declaration on Healthy Weight
- Obesity Health Alliance
- Northumberland Director of Public Health Annual Report 2021/22 - Healthy Weight for all Children

9. Links to other key reports already published

N/A

10. Author and Contact Details

David Turnbull - Public Health Senior Manager
Email: david.turnbull@northumberland.gov.uk

Report sign off.

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

	Full Name of Officer

Monitoring Officer/Legal	Neil Masson obo Stephen Gerrard
Executive Director of Finance & S151 Officer	Jan Willis
Relevant Executive Director	Gill O'Neill
Chief Executive	Helen Paterson
Portfolio Holder(s)	Veronica Jones

Appendix 1. Feedback From Initial Healthy Weight Alliance Workshop: May 2023

System Leadership – Adopting a long term, system-wide approach to healthy weight.

Strategic System Leadership
What Key Areas of Work Should We Focus on?
• Align healthy weight into our key policies, plans and strategies • Use our procurement powers to explore opportunities around healthier foods • Explore pulling our expertise and knowledge together to develop a local food strategy – which considers, growing foods, food production, sales, sustainability
How Will we Measure Success?
• Healthy Weight featuring in all Policies • Relationships with Anchor Institutes e.g. how many anchor organisations are active members of the HWA
Who Should be Involved?
• Commercial Partners • Schools and other education institutions • NHS & Partners • North of Tyne Combined Authority • VCSE Organisations

Commercial Determinants – Promoting healthy food and drink options, while protecting our residents against the harmful effects of inappropriate marketing by the food and drink industry.

Commercial Determinants
What Key Areas of Work Should We Focus on?
• What is in our control? – Breakfast Clubs, Events, Advertising, Cafés, Restaurants, Take-Aways, Vending Machines, Menu Options • How we could work with Delivery Companies (of fast food) to encourage promotion of healthier foods / alternatives • Procuring Healthy Ingredients – To use in staff restaurants / schools / hospitals
How Will we Measure Success?
• Number of commercial organisations working with us?

• Changes in LA and partner restaurants etc?
Who Should be Involved?
• Northumberland Communities Together – Nourish Northumberland • Licencing • Procurement

Health Promoting Environments – Ensuring where we live has a positive impact on physical activity, active travel, the food environment and food security.

Health Promoting Environments
Key Areas
• Accessible Environments – Parks, Green Spaces and Local Amenities • Design of Built Urban Developments – How do we address current unusable / inadequate infrastructure (retrofit)? • Environments / Assets with multiple benefits i.e. Allotments • Addressing Transport Issues
How Will we Measure Success?
• Money leveraged into the county e.g. via North of Tyne • % of the population walking / cycling / scooting • What is our measure of good design? – Set of shared design principals • Vibrant high streets – Relationships with local businesses / producers
Who Should be Involved?
• Elected Members • Town and Parish Cllrs • VCS • Various L.A. Departments • Chamber of Commerce • Residents

System and Cultural Change – How our Anchor institutes (and partners) work to create a culture and ethos promoting an understanding of healthy weight.

System and Cultural Change
Key Areas

- Creation of a Northumberland Food Strategy (to include / consider)

  Procurement
  Reducing Food Poverty
  Climate Change

- Supporting Local Businesses to compete with big industry / large scale providers

  Revised commissioning framework

- How we use our collective powers to change culture and support the economy and improve health

  NCC - Organising events for local producers, share local resources
  Active Northumberland - Review of catering offer, review of food suppliers
  NHFT - Review vending provision, food labelling patients and staff
  ICB - Review of systemwide tool for patients living with obesity

How Will We Measure Success?

- Staff H&WB Surveys – with an agreed framework / set of questions to compare
- Analysis / Audit of our Making Every Contact Count (MECC) impact
- Procurement Policies – That include (even prioritise) local producers

Who Should be Involved?

- Northumbrian water
- Farmers – NFU
- VCS – Food Banks
- Residents / Community Groups
- Workforce Health Leads / Reps

Healthy Weight across the Life course – A life course approach that supports healthy weight of both the current and future generations.

Healthy Weight across the Life course

Key Areas

- Starting Well (Starting Early)

  Addressing Maternal Obesity
  Utilising Family Hubs – Breastfeeding, Infant Feeding (weaning), health literacy

- School Food and Physical Activity Environment

Adopting an Active Schools approach • Improving cooking knowledge and skills (including equipment) • Clear consistent messaging across the life course
How Will We Measure Success?
• School Food Plans (?) • Progress tracked against the Core 20 Plus 5 offer (Adults and CYP)
Who Should be Involved?
• Education – School Governors • Early Years – Midwives, Health Visitors, Infant Feeding Teams • Food Banks

This page is intentionally left blank

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Northumberland Health and Wellbeing Board
14 September 2023

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust's new strategy; 'With you in mind'

Background

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is a health organisation made up of 9,000 people across our region. We spend more than £500 million each year, providing healthcare across North Cumbria, Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland for:

- People with mental ill-health
- Children and young people
- People with a learning disability
- People with neurodevelopmental conditions
- People who need support from secure services
- People with neurodisabilities
- People with problematic substance use or addictive behaviours

We also provide specialist support such as perinatal, mental health for Deaf people and gender dysphoria services.

This paper introduces the Trust's new strategy, 'With you in mind'. An electronic copy of this strategy can be found here alongside an easy read version of the document.

Strategy Summary

The strategy sets out our strategic direction. It does not tell us in detail how we will deliver, but sets out our ambition, what we aim to be. It is supported by an operational Annual Plan.

We know that we need to change. Over the years our health and care systems have become competitive, divided and in many ways disjointed. We have also seen funding levels slow and in some sectors decline. And the pandemic has opened great holes where there were gaps in care. This has hit the most vulnerable in our communities harder, at the same time as the gap between rich and poor is growing. Our opportunity now is to think differently, to be bold and radical in our thinking. We

have integrated care systems that bind us together rather than a competitive world that sets us apart. Now is the time for us to build relationships with our partners in primary care, the charitable and voluntary sector, with local authorities and other health providers.

Through this strategy, we intend to work better, simpler, and create time to focus on the things that matter to people. We know that we cannot do this alone, and effective partnership working is the key to change.

To develop this strategy, we asked service users, carers, their families, our staff and organisational partners to describe what matters to them. This extended engagement was called ‘CNTW2030’, taking place in 2021 and 2022 to develop a set of long-term commitments which form the heart of the strategy. This engagement must continue in the form of partnership working at all levels of the health and social care system.

The strategy includes commitments to:

- Service users
- Carers
- Staff
- Partners and communities

We know that we are not currently achieving these commitments – but we want them to be our guide. We want these commitments to be our inspiration for how we work and how we change over the years ahead. Our aim is to deliver on these commitments every day, in every contact. To develop the strategy, we set out five strategic ambitions, a vision and values to describe how we intend to meet these commitments.

Our five strategic ambitions are:

1. Quality care, every day – We want to deliver expert, compassionate, person-led care in every team, every day.
2. Person-led care, when and where it is needed – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals.
3. A great place to work – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.
4. Sustainable for the long term, innovating every day – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.
5. Working with and for our communities – We will create trusted, long-term partnerships that work together to help people and communities.

Recommendations

It is recommended that the Health and Wellbeing Board notes the ethos and ambition of the Trust's new strategy, in particular, the commitment to partnership working across the Health and Social Care system.

Anna Foster
Trust Lead for Strategy and Sustainability
September 2023

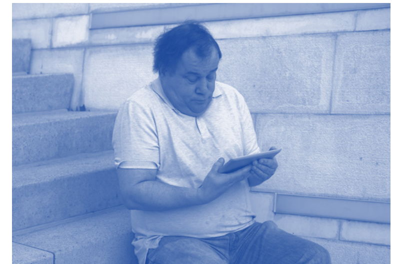
This page is intentionally left blank

NHS

Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

With you in mind

Our strategy from 2023



Contents

Welcome to our strategy 3
About us 5
Our commitments 6
Commitment to our service users: 6
Commitment to our families and carers (also known as our 'Carer Promise'): 7
Commitment to our staff: 7
Commitment to our partners and communities: 7
Our vision: 8
Our values: 8
Our five ambitions 8
Ambition 1: Quality care, every day 9
Ambition 2: Person-led care, when and where it is needed 10
Community based care for adults and older people with mental ill-health 11
Inpatient care for adults and older people with mental ill-health 12
Children and young people 14
People with a learning disability 15
People with neurodevelopmental conditions 16
People who need support from secure services 17
People with neurodisabilities 17
People with problematic substance use or addictive behaviours 18
Ambition 3: A great place to work 19
Ambition 4: Sustainable for the long term, innovating every day 20
Ambition 5: Working with and for our communities 21
How will we deliver this strategy? 23

Welcome to our strategy

What is our strategy?

It is something that binds us together, that sets out what is important to us, the things that we want to achieve together, the path that we want to take.

This is about what it is to be Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, sometimes called 'CNTW', and our hopes, aspirations and ambitions to support the people and communities that we serve.

We have called it With you in mind. Because we work together, we have empathy and care for each other, and we will work tirelessly to improve mental wellbeing for the people and communities we serve.

Who is it for?

It is for us together. CNTW is not a faceless organisation, it is not a group of services, and it not defined by its buildings or its status.

We are CNTW. Together, we shape, drive and make CNTW what it is and what it can be.

How is this strategy different?

We asked people what they want from us.

The result is not rocket science. It is not unexpected. It tells us that what we all want is to be treated with humanity, with respect and with care.

When we need help, we want to be listened to, to be understood, and to be involved in making things right. We want to be safe, healthy and happy in our communities, with the people we care about and the people we love. We want people to respect our rights.

But systems, processes and yes, even organisations can get in the way.

We have looked at what people have asked from us and turned it into a set of commitments. A set of commitments that we will look to live by every day. And that in turn drives our ambitions for our future. What we aspire to be.

What will it mean?

Our world feels very challenged. We are recovering from a global pandemic. We are living through a cost of living crisis, which makes it hard for a lot of people to make ends meet. And we feel the impact of war in Europe and other parts of the globe. Health and care services are stretched to limits as demand for help grows. We can feel threatened, and we certainly understand the impact that this has on our mental wellbeing. This is a time of struggle. But it is also a time of great opportunity.

We need to change. Over the years our health and care systems have become competitive, divided and in many ways disjointed. We have also seen funding levels slow and in some sectors decline. And the pandemic has opened great holes where there were gaps in care. And this has hit the most vulnerable in our communities harder, at the same time as the gap between rich and poor is growing.

Our opportunity now is to think differently, to be bold and radical in our thinking. We have integrated care systems that bind us together rather than a competitive world that sets us apart. Now is the time for us to build relationships with our partners in primary care, the charitable and voluntary sector, with local authorities and other health providers. Together we can work better, simpler, and create time to focus on the things that matter to the people and communities we serve. This strategy set out our vision for what this can look like.

How will we deliver this?

This document is our guide; it sets out our strategic direction.

It does not tell us in detail how we will deliver, but sets out our ambition, what we aim to be.

Every year we will set out an operational plan which will describe how we will take our strategy forward in that year, what we will deliver and what we expect the impact to be. We will also set out a small number of supporting strategies, which will describe in more detail some of our key milestones and deliverables for the next five years. But perhaps, most importantly, we want this to be a living and breathing document, that we all play our part in delivering every day, with every contact... with you in mind.

Ken Jarrold CBE
Chair

James Duncan
Chief Executive

About us

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is a health organisation made up of 9,000 people across our region.

We spend more than £500 million each year, providing healthcare across North Cumbria, Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. Along with partners, we support people in their own homes, in their communities and in our hospitals. We help:

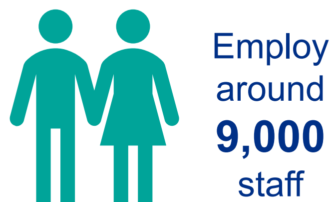
- People with mental ill-health
- Children and young people
- People with a learning disability
- People with neurodevelopmental conditions
- People who need support from secure services
- People with neurodisabilities
- People with problematic substance use or addictive behaviours

We also provide specialist support such as perinatal, mental health for Deaf people and gender dysphoria services.

About the Trust

Mental Health and Disability Foundation Trust

Local population of **1.7** million



Employ around **9,000** staff

Local catchment area of **3,350** mi²

We work from over **70** sites across

Cumbria, Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland

We also provide a number of regional and national specialist services to England, Ireland, Scotland and Wales

Working across **8** local authorities and a partner member of the North East and North Cumbria Integrated Care Board

Turnover of around **£537m** million

Page 81

Developing this strategy to reflect what's important

To develop our strategy, we asked service users, carers, their families, our staff and partners to describe what matters to them.

They asked us to work together, with them in mind, with compassion, humanity and care. This is at the heart of this strategy.

We have developed long-term commitments in response to these asks, which will guide everything we do. We know that we are not currently achieving these commitments – but we want them to be our guide. We want these commitments to be our inspiration for how we work and how we change over the years ahead.

Our aim is to deliver on these commitments every day, in every contact. In this document we set out how we will meet these commitments, through our vision, our values, and the ambitions that we are setting ourselves.

Our commitments

Commitment to our service users:

- Understand me, my story, my strengths, needs and risks. Work with me and others, so I can keep healthy and safe;
- Protect my rights, choices and freedom;
- Respect me and earn my trust by being honest, helpful and explaining things clearly;
- Support me, my family and carers in an effective, joined-up way that considers all my needs, and
- Respond quickly if I am unwell or in crisis, arranging support from people with the right expertise. Make sure I don't have to keep repeating my story.

Commitment to our families and carers (also known as our 'Carer Promise'):

- Recognise, value and involve me;
- Work with me to ensure you're aware of my needs as a carer;
- Listen to me, share information with me, and be honest with me when there is information you can't share;
- Talk with me about where I can get further help and information, and about what I can expect from you.

Commitment to our staff:

- Respect me for who I am, trust me, value me and treat me fairly;
- Allow me freedom to act, to use my judgement and innovate in line with our shared values;
- Protect my time by making systems and processes as simple as possible so I can deliver the work I aspire to, learn, progress and get a balance between work and home;
- Offer me safe, meaningful work and give me a voice, working as part of a team that includes other professions and services, and
- Support me with compassionate managers who communicate clearly and understand what it's like to do my job.

Commitment to our partners and communities:

- Explain what to expect from CNTW;
- Help us to fight illness, unfairness and stigma;
- Make sure that organisations talk to each other and put the needs of people's before their own. Share responsibility for getting things right;
- Get to know local communities. Respect their wisdom and history;
- Be responsible with public funds;
- Share our buildings, grounds and land; and
- Protect the planet.

Our vision:

To work together, with compassion and care, to keep you well over the whole of your life.

Our values:

Our values are what bind us. We have considered these in the light of what people have asked of us. We believe that these are the values that we share together, and that we need to uphold if we are to meet our commitments:

We are caring and compassionate…

because that is how we'd want others to treat those we love.

We are respectful…

because everyone is of equal value, is born with equal rights and is entitled to be treated with dignity. We want to protect the rights of future generations and the planet that sustains us all.

We are honest and transparent…

because we want to be fair and open, and to help people make informed decisions.

Our five ambitions

To deliver our commitments and the care that we want to achieve, we have five ambitions in this strategy:

1. **Quality care, every day** – We want to deliver expert, compassionate, person-led care in every team, every day.
2. **Person-led care, when and where it is needed** – We will work with partners and communities to support the changing needs of people over their whole lives. We know that we need to make big, radical changes. We want to transfer power from organisations to individuals.
3. **A great place to work** – We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.
4. **Sustainable for the long term, innovating every day** – We will be a sustainable, high performing organisation, use our resources well and be digitally enabled.
5. **Working with and for our communities** – We will create trusted, long-term partnerships that work together to help people and communities.

Ambition 1: Quality care, every day

We will aspire to deliver expert, compassionate, person-led care every day, in every team. We will value research and learning.

We will act fairly and with compassion. We will uphold people’s rights to live safe, meaningful lives in their communities. We want people to live their best lives.

Together, we will work to understand the needs, goals and risks of each person. This will help us to provide joined-up, long-term care and support. We will work to ‘Triangle of Care’ principles across all services, to build trusted relationships between staff, service users and their carers/families. Evidence-based treatment will be provided by skilled staff to deliver the goals that people want for themselves. The care we provide will be therapeutic, person-led and trauma-informed.

We value learning and we will be informed by research. We will develop the skills of our staff so they can thrive. We will learn from each other, and from others. We will use our curiosity and courage to try new things.

We will be a leader in research, using our expertise to test, learn and embed new technologies and new ways of working. These will bring proven benefit to the people and communities we serve.

We will be open and honest if things go wrong. Every day we will challenge ourselves to learn, improve and do better. We will communicate effectively and simply, in a way that we can all understand.

Ambition 2: Person-led care, when and where it is needed

We will work with partners and communities to support the changing needs of people over their whole lives.

We know that we need to make big, radical changes. We want to transfer power from organisations to individuals. The focus of services is often about managing crisis. We want to shift towards a focus on people keeping themselves well.

Community based care for adults and older people with mental ill-health

We want to remove things that make current services difficult for people to understand. People should be able to reach the support they need when they need it. We are committed to making a radical shift in our approach.

GPs, primary care and community organisations are at the heart of supporting people all through their lives. Each community has its own support and care networks, which we want to work alongside. This will wrap care around the person that needs it. We want to make sure that each person has one story that is understood by all. At any time, people should have access to care and support that is right for their needs. This care and support should be from the organisation that is best placed to meet those needs.

We will work with our partners to create new models of care and support which are simple, easy to access and built on strong, trusted relationships.

Together we will work with people and families to help them to live well in their communities. Together, we will prevent crisis and act early when extra support is needed.

Sometimes people need very specialist support and therapeutic care. We will make sure that we have well trained, skilled people who can respond quickly to provide the right support when it is needed.

We want people get the right care from the right service at the right time. This could be from their GP, social care, community groups, charities, or mental health services.

We will take a radical approach in how we deliver community based care which will:

- Consist of services and teams working together and rooted in our communities;
- Move away from a confusing system of referrals, assessments and treatment, to one of constant support and easy access to the right support at the right time;
- Enable expert advice, support and skilled clinical help is available from our teams when they are needed;
- Make sure that there is support available for people all day, every day, within their communities, to meet their needs and enable them to keep well;
- Provide intensive wrap around support for people who need it most;
- Develop our services with our partners to address the areas of greatest need and health inequality;
- Develop real alternatives to inpatient care with our partners across our places so that where possible, we can support people in crisis within their own communities.

Inpatient care for adults and older people with mental ill-health

We want to make big changes to inpatient services for adults and older people with mental ill-health.

When people are in hospital, we will protect their human rights every day. We will make sure our inpatient wards are welcoming and support healing. We will make sure staff have the right skills to support effective treatment.

When people are ready to go home or need to move to a different ward, we will make sure this goes smoothly. We will work with social care, housing providers, GPs and primary care so people stay well after their hospital stay. We will also design services that avoid hospital stays.

We will listen to service users, carers and families, to make care personal and improve things for all inpatients.

We will protect rights and be open. We will create safety for people to talk about their concerns. An open culture and rights-based approach will mean that:

- people will only be admitted to inpatient care if and when they need it;
- we will always clear on the reason and benefit of admission;
- people will not need to wait to be admitted;
- people will not be admitted to hospitals that are very far away from home;
- inpatient care will be personalised, therapeutic and effective;
- staff will have the specialist skills needed to provide personalise, therapeutic effective care;
- inpatient care will be safe;
- there will be no avoidable long term segregation or seclusion. People will not be kept on their own for a long time;
- we will support people to return home to their communities as soon as they are able; and
- people will not stay in hospital longer than they need to.

Children and young people

Children and young people, their families and carers should get the support they need.

Good physical and emotional wellbeing can prevent long-term problems and help people live healthy, happy lives.

We support children and young people:

- with their emotional wellbeing,
- with mental ill-health, and
- after big life events.

Support will be linked across GPs, paediatrics, schools, colleges and community groups to wrap around families. We will improve our services for children and young people who need a stay in hospital.

We will support services to be very different so that children and young people can receive the support that is best for them. We will work with other organisations to:

- provide the right help and support to young people and families when it is needed;
- make sure that there are no long waiting times for help;
- make sure that the needs, risks and challenges of the child/young person are understood as soon as possible;
- make sure that help and support is available while waiting for a diagnosis or without a diagnosis;
- make sure that help is based on the needs of the child/young person and their family;
- create spaces that children and young people feel safe to go to;
- safeguard the rights of children and young people at all times;
- support families in everything we do;
- work with other organisations to offer better support for children and young people with complex needs, and their families, so they can live well in their own communities; and
- make sure support doesn't stop when a young person turns 18 and help them adapt to services for adults.

People with a learning disability

People with a learning disability should be treated with humanity, dignity and respect.

People with a learning disability should receive healthcare just like everyone else. If they need extra support to stay well and have a good life, they should receive it. Sometimes support will be provided by a service that is only for people with a learning disability. Services that help everyone will make changes so that their support is suitable for someone with a learning disability.

People with a learning disability should only go to hospital when they really need to. This should be close to where they live. When someone with a learning disability is in hospital, we will always protect their rights. We will work with other organisations so that people in hospital can go home as soon as it is right for them.

We will work with other organisations so people with a learning disability stay healthy and live well in their communities. We will:

- support people in their own homes;
- think about how we use medicines, so we don't give people medicine they don't need;
- meet people's physical and mental health needs at the same time;
- make sure staff understand the needs of people with a learning disability, and
- communicate in a way that works so we understand each other.

People with neurodevelopmental conditions

Neurodevelopmental conditions include:

- Autism;
- Attention Deficit Hyperactivity Disorder (ADHD);
- Dyslexia;
- Dyspraxia;
- Dyscalculia; and
- Tourette Syndrome.

People with these conditions are sometimes described as 'neurodivergent.'

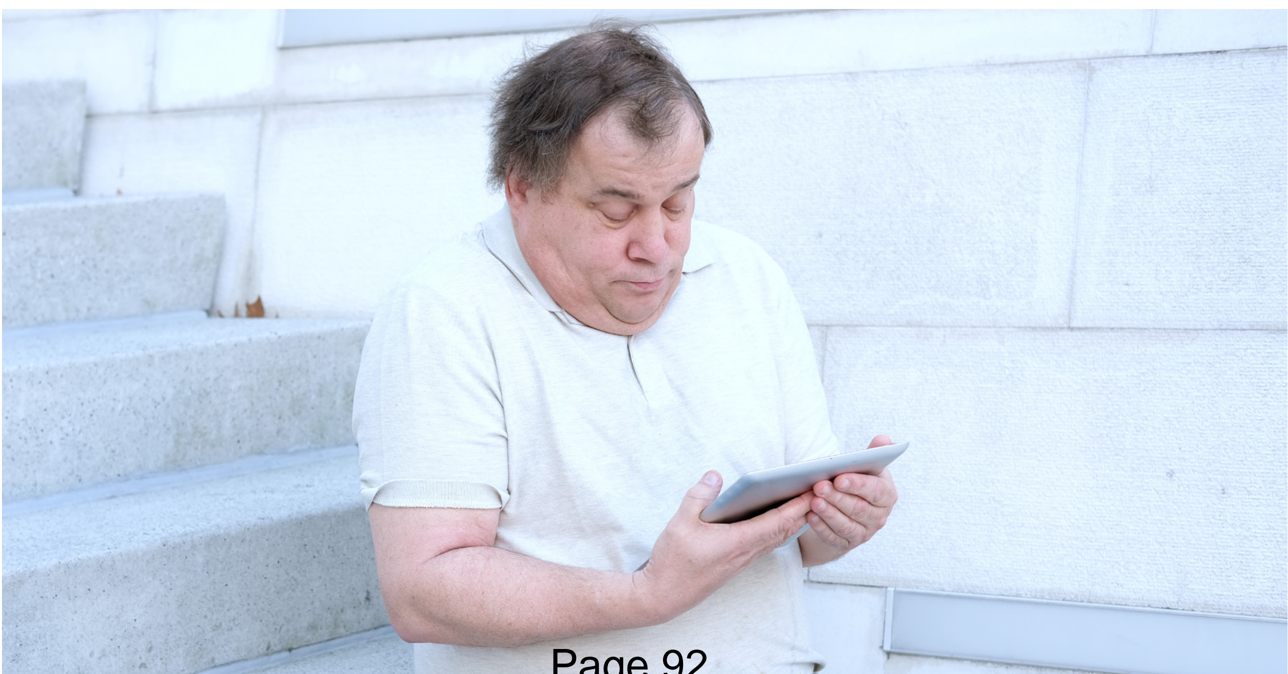
Neurodivergent people are entitled to the same healthcare as everyone else. Making services suitable for neurodivergent people makes them better for everyone. This includes services that are not specifically for autistic people, for example, mental health wards. We will work with other organisations to make sure people only stay in hospital if they really need to.

We will improve our understanding of neurodiversity, neurodivergence and the increased risk of suicide in autistic people.

We will make sure staff have the training to support people effectively. We will make sure there is early support to diagnose and identify the needs of autistic people, people with ADHD and their families.

We will review how we use medicine with people because of their neurodivergence or behaviours of concern. We will make sure that we don't give people medicine they don't need.

We will make things easier for people to understand and we will respect their communication preferences.



People who need support from secure services

Secure services provide safety and real change for a better life.

Secure services provide treatment for people with complex mental disorders linked to offending or seriously harmful behaviour. Some will be involved with the criminal justice system (CJS), courts and prison. Secure services help people gain a deep understanding of themselves and their history.

The Secure Care Provider Collaborative is a partnership with Tees, Esk and Wear Valley NHS Foundation Trust and other organisations.

We will help service users gain new skills, understanding and ways of responding to things they find difficult. This will help people move on from secure settings and have more freedom, choice, and control in their lives. We will do this by focusing on:

- mental health;
- dealing with strong feelings;
- addictive behaviours;
- risk to others;
- physical health;
- social skills;
- relationships;
- meaningful activities; and
- trust and hope.

People with neurodisabilities

We help people with brain diseases or injuries to be as independent as they can in their everyday activities.

We will work with GPs, other hospitals, social services and other organisations to:

- tackle issues that stop people from being admitted to inpatient care;
- tackle issues that stop people from being discharged when they are ready;
- make sure therapy services are available every day (including weekends);
- shorten the time that people wait for outpatient care or community care, and
- make it easier for people to come to appointments.

People with problematic substance use or addictive behaviours

People can recover from their problems with substance use or addictive behaviours.

We will help people get well and stay well by working with them, their families or carers and charities.

We will make sure that services are joined-up and that there are services available for everyone.

If people have mental health problems alongside their problematic substance use or addictive behaviours, we will help them with both.

We will improve services based on changing needs, for example problematic gaming and gambling behaviours.

We will work to the principles of:

- ‘everyone’s job’ (services will work together to meet the needs of people), and
- ‘no wrong door’ (however people come into contact with services, they will be offered care and support that is personalised to meet their needs).

Ambition 3: A great place to work

We want to be a great place to work. We will make sure that our workforce has the right values, skills, diversity and experience to meet the changing needs of our service users and carers.

We cannot deliver our commitments without meeting the needs of our staff and enabling them to thrive. We will invest in staff wellbeing, supporting our workforce to feel valued and safe, to meet their potential and support delivery of high quality care.

Quality of care is improved by having a workforce that represents our communities. We will build a culture of respect, trust and psychological safety, celebrating diversity and making sure staff feel safe to raise concerns.

We will work with partner organisations, including universities, to recruit, develop and retain our people.

We will simplify the way that we work. We will create time for staff to care and learn, be open to new ideas and encourage innovation and research.

Ambition 4: Sustainable for the long term, innovating every day

We will be a sustainable, high performing organisation, use our resources well and be digitally enabled. We will be accountable for the money we spend; we will live within our means, and we will work in a way that is kind to the planet.

We have an opportunity to change. To be sustainable and innovative, we will support people to adapt, to be flexible and to try new ways of working.

To be truly innovative, we must be courageous and willing to learn by trying new approaches. We must work in a way that frees people and teams to improve every day and meet our commitments.

We will be a digital leader. We want to use technology in a way that empowers our people and teams to have the time and information they need to do their job.

We will make best use of our buildings and grounds, ensuring that they are fit for purpose and a resource for our communities. We will test, develop and grow new ventures and opportunities that help us meet our commitments.

Ambition 5: Working with and for our communities

We will create trusted, long-term partnerships that work well together to help people and communities.

Integrated Care Systems (ICSs) are partnerships of organisations. They come together to make sure that health and care services are well planned and joined-up. ICSs have been created to improve the lives of people who live and work in their area.

We are part of the North East and North Cumbria Integrated Care System (ICS). To meet our ambitions, we cannot work alone. To support our people and places, we must work together with the public and our partners in:

- Health;
- Education;
- Housing;
- Industry;
- Charities and volunteers.

Together, we will address the wide inequalities that contribute to ill-health across our region.

The North East and North Cumbria regional healthcare plan is called “Better Health and Wellbeing for All”. The plan seeks to improve health and care for all of us. All organisations in the North East and North Cumbria ICS agree that we want:

- **Better, high quality health and social care services,** no matter where you live or who you are;
- **Fairer health outcomes.** We know that some people have worse health because of where they live, their income, their education or their employment. We will take these factors into account to make good health more equal;
- **Longer and healthier lives.** We want to reduce the gap between how long people in our region live compared to the rest of England;
- **Our children to have the best start in life, so they thrive and have great futures.** This will have a long-term impact, improving lives for generations of children to come.

We are happy to work with our partners to achieve this regional plan. This strategy explains how we will work with them to provide care and support that is rooted in our communities.

Our strength is providing expert, evidence-based advice, support and care for people with complex needs. We provide this when it is needed. We also know that people want constant care and support close to home at all stages of their lives. For this to happen, we must work as a collective with partners in the interests of those we serve. We must work particularly well with primary care. We have lots to offer in support of the regional plan to improve the health and wellbeing of the population. We believe we can be a great partner in delivering care and a great partner to our communities.

- We will work with communities and value their strengths. GPs and primary care are at the heart of healthcare in each community. Also important are the volunteers, charities and self-help groups that do so much to bind a community together;
- With partners, we will teach, train, advise and help people and communities to support their own wellbeing;
- We will make every contact count, to tackle the causes of ill health and shortened lives. This means thinking about someone's physical, emotional and social wellbeing each time we work with them.
- We will reach out and serve all communities, particularly those that are disadvantaged, to reduce inequalities and achieve fairer outcomes;
- We will use our power as an employer, as a purchaser and as a landlord to reduce inequalities.
- We will work every day to reduce suicides;
- With partners, we will radically change our offer to children, young people and their families to provide joined-up care and support; and
- We will support our communities by meeting their local needs.

How will we deliver this strategy?

This strategy is our guide.

We must all own it and consider it in everything that we do. Each year we will develop an annual plan, which will explain what we will do that year to deliver this strategy. The annual plan will consider national policies and priorities but will always be guided by the commitments and ambitions set out in this strategy. It will set out specific actions for each area of this strategy, how we will achieve them and what we expect to see as a result.

We will also develop a number of enabling strategies to support our ambitions, which will set out the key things we need to do over the next five years. We will publish these strategies and hold ourselves to account for their delivery.

Perhaps most importantly, we will build this strategy into the work of every person and every team across the organisation. This strategy will not be delivered without us all playing our part, through the decisions we make and the behaviours we demonstrate every day. This is a document to enable devolution, to guide decision making and to bind us together in the way we work and the goals we aspire to. We will work to make it a reality every day, in everything we do.

This report is available on request in other formats; we will do our best to provide a version of this report in a format that meets your needs.

For other versions telephone 0191 246 6877
or email us at communications@cntw.nhs.uk

Further copies can be obtained by contacting:
communications@cntw.nhs.uk
Telephone: 0191 245 6877

NORTHUMBERLAND COUNTY COUNCIL

HEALTH & WELLBEING BOARD

FORWARD PLAN 2023 - 2024

Lesley Bennett, Senior Democratic Services Officer
Tel: 01670 622613
E-mail Lesley.Bennett@northumberland.gov.uk

Updated : 15 August 2023

FORTHCOMING ITEMS

ISSUE	OFFICER CONTACT
14 September 2023	
• Infection, Prevention and Control (ICP Strategy) • Healthy Weight Alliance • CNTW Transformation Programme	Jim Brown David Turnbull Sheree McCartney
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
• Aging Well
	Gill O'Neill
	Graham Reiter/Jon Lawler
	Rachel Mitcheson/Jim Brown
	Rachel Mitcheson
	Emma Richardson
	Abi Conway
	Pam Lee/Luke Robertshaw

9 November 2023	

• Tobacco Control Partnership Annual Update
• Public Mental Health Annual Update
• Family Hubs
• Healthy Families Partnership Board Update/0-19 Service Annual Review
• 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

Updated : 15 August 2023

14 December 2023	
• Housing and Health • JSNAA Update • Sexual Health Strategy • Health Protection Assurance and Partnership Board	Rob Murfin/Anne Lawson Pam Lee/Pam Forster John Liddell/Clare Elliott/Gill O'Neil Jon Lawler

MEETING DATE TO BE CONFIRMED

• Urgent and Emergency Care - Strategic Care • Child and Adolescent Mental Health • Pharmacy Update Blyth, Prudhoe, Ashington – NOV/DEC • Safe Haven, Ashington • Aging Well	 Ann Everden Pam Lee/Luke Robertshaw

REGULAR REPORTS

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

● Public Health Annual Report ● Child Death Overview Panel Annual Report ● Healthwatch Annual Report ● Northumberland Safeguarding Children Board (NSCB) Annual Report and Update of Issues Identified ● Safeguarding Adults Annual Report and Strategy Refresh ● Annual Health Protection Report ● Northumberland Cancer Strategy and Action Plan ● Tobacco Control ● Healthy Families Partnership Board Annual Report ● Annual Report of Senior Coroner	Gill O'Neill (FEB) Paula Mead/Alison Johnson (JAN) Peter Standfield/Derry Nugent (JULY) Paula Mead (JAN) Paula Mead (JAN) Liz Morgan (OCT) Robin Hudson (DEC/JAN) Kerry Lynch (DEC) Jon Lawler (SEP) Andrew Hetherington/Karen Lounten (JAN)
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.	
7	10.8.23	Annual Report of Senior Coroner	Report received	
8	10.8.23	Healthwatch Annual Report 2022/23	Report received	
9	10.8.23	Better Care Fund Plan 2023-25	(1) the BCF Plan annexed to the report as Annex A (narrative plan) and Annex B (spreadsheet plan) be signed off by the Board. (2) the Council's statutory Director of Adult Social Services (currently the Executive Director for Adults, Ageing and Wellbeing) be delegated the authority to sign off any future BCF planning submissions, if the nationally-set timetable made it	

			impracticable for the Board to do so before the submission date, provided that a draft of the submission had been circulated to all Board members for comment, and no issues had been raised which required fuller discussion at a Board meeting before sign-off.	
10	10.8.23	Notification of Closure of 100 Hour Pharmacy in Cramlington	(1) A supplementary statement to the Pharmaceutical Needs Assessment 2022 be agreed declaring that there was a gap in essential, advanced, additional and locally commissioned pharmaceutical services in Cramlington between the hours of 6 pm and 10 pm Monday to Saturday and on Sundays between 10 am and 4 pm. (2) a second supplementary statement was required to acknowledge the change in ownership of all Lloyds pharmacies in Northumberland. (3) an update report be submitted to the November/December meeting of the Board.	
11	10.8.23	ICB Draft Joint Forward Plan	Report noted	