NHS
North East and
North Cumbria

Strategic Integrated Care Partnership December 2022

MEETING
15 December 2022 14:30 GMT

PUBLISHED
13 December 2022

Agenda

Location	Date	Time
Durham Centre, Belmont Industrial Estate, Durham, DH1 1TN	15 Dec 2022	14:30

	Item	Owner		Page
1	Welcome and introductions	Sir Liam Donaldson	14:30	3
2	Apologies for absence	Sir Liam Donaldson	14:40	—
3	Declarations of interest	Sir Liam Donaldson	14:45	—
4	Notification of items of any other business	Sir Liam Donaldson	14:50	—
5	Recap of 1st meeting and Purpose of Today	Sir Liam Donaldson	14:55	5
6	Development of the North East and North Cumbria Integrated Care Strategy and feedback following widespread multisectoral engagement	Jacqueline Myers / Peter Rooney	15:05	7
7	Summary of feedback from the Area ICPs and proposed Terms of Reference and ways of working for the North East and North Cumbria Integrated Care Partnerships	Sam Allen / Dan Jackson	16:00	122
8	Options for the formation of an ICP Adult Social Care Providers Forum	Jane Robinson / Dan Jackson	16:30	—
9	Questions submitted by the public in advance	Sir Liam Donaldson	16:40	—
10	Any other business	Sir Liam Donaldson	16:50	—
11	Date of next meeting	Sir Liam Donaldson	16:55	—
12	Close	Sir Liam Donaldson		—

Pemberton House,
Colima Avenue,
Sunderland.
Tyne and Wear.
SR5 3XB

Re: ICP.01 /LD

08 December 2022

Dear Colleague,

North East and North Cumbria Integrated Care Strategy Meeting

I am looking forward to seeing you at the next meeting on Thursday 15th December 2022. Registration and refreshments will be available from 2pm onwards and the meeting will start promptly at 2:30pm. This is a public meeting, and a recording of our proceedings will be uploaded to the ICB website afterwards.

The meeting calendar invitation has been circulated in advance of this meeting and the agenda and papers are attached to this letter.

Please see the details for the meeting venue with contact details and directions for the day.

The meeting Venue:
The Durham Centre
Auditorium Room,
Belmont Industrial Estate.
Durham
DH1 1TN

Venue: Contact Details
Lesley Miller/Manager
Tel No: 0845 4812191
Enquiries@thedurhamcentre.co.uk

Directions to Durham Centre

Purpose of the meeting

The focus of the meeting will be to review some key documents in the development of our Integrated Care Partnership

- The proposed North East and North Cumbria Integrated Care Strategy and a summary of our engagement with partners on this document from the four Integrated Care Partnership Areas
- The proposed Terms of Reference and membership for the Strategic ICP and the Area ICP's with a summary of feedback from discussions in each Area ICP.

Accessibility

Members of the public have had the opportunity to raise questions in advance of our meeting and these will be considered during the meeting.

We have recently received feedback from a range of patient and service user groups that in the interests of accessibility it would be helpful if we could always try to use the clearest language possible in our discussions, avoiding jargon and acronyms wherever possible. I will

raise this point at the start of the meeting and would welcome the views of partners on what more we can do to ensure our meetings our inclusive and accessible to the public.

Thank you for your ongoing support and I look forward to meeting you all next week.

Best Wishes

Professor Sir Liam Donaldson
Chair of NHS North East and North Cumbria ICB

Inaugural Meeting of the North East and North Cumbria Integrated Care Partnership Meeting

Tuesday 20 September 2022 – 10:00am - 2:00pm

Venue: The Auditorium, Durham Centre

Item No:	Notes & Actions from 1st Meeting	Action
	The meeting was attended by partners from the ICB and each of the fourteen local authorities in the North East and North Cumbria	
1.	**Establishing the ICP: statutory requirements and national guidance, and key next steps**	
	Dan Jackson presented an overview of the national guidance in this area and a series of recommendations on the membership and ways of working for our Strategic ICP and Area ICPs. These were to be captured in a revised Terms of Reference which Dan will present today	
2.	**Broader social and economic outlook for the North East and North Cumbria: challenges and opportunities**	
	Rob Hamilton, the Chief Economist for the North of Tyne Combined Authority, and member of the North-East Regional Economic Directors Group, presented a helpful overview of the economic outlook for the North East and North Cumbria. This was followed by observations from the floor, including: • A recognition of our deep-seated challenges in the North East and North Cumbria, but optimism for the future of our region • The barriers to employability caused by poor health • How we can collaborate to boost the skills and employability of our population • How we attract and retain people in our region • How we value the role of all the VCSE sector in our economy	

3.	**Towards a healthier North East and North Cumbria**	
	Sam Allen, ICB Chief Executive, presented a deep dive into our major health and wellbeing challenges, what we can do as a system to focus our collective efforts on improving population health, and how this can be addressed through the development of an Integrated Care Strategy	
4.	**Feedback from the Integrated Care Strategy joint working group**	
	Jacqueline Myers, ICB Executive Director of Strategy and System Oversight, and Jane Robinson, Corporate Director of Adults Services and Health at Durham County Council presented some of the early themes from their multi-sectoral discussions on the development of our strategy. This was followed by a range of comments, including: • How partners can comment further on the emerging strategy • How local Health and Wellbeing Boards can engage with the strategy? • How can we maintain focus on both short-term and long-term goals, e.g., winter pressures and long-term conditions? • How we can continue to engage our residents, service users and communities	
	Next Steps	
	It was agreed to hold a second meeting of the Strategic ICP in December at which we would consider a Terms of Reference for our ICPs and a final draft of our Integrated Care Strategy, and our statutory requirement to publish this document.	
	<u>Next Meeting</u> Date: Thursday 15 December 2022 Time: 14:30-17:00 Venue: The Auditorium, The Durham Centre	

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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

North East and North Cumbria Strategic ICP 15 December 2022	
Report Title:	**North East and North Cumbria Integrated Care Strategy**

Purpose of report

Integrated Care Partnerships (ICPs) are required to publish an Integrated Care Strategy by the end of December 2022. The purpose of the strategy is to show how the ICP will meet the health and care needs of the population served.

The North East and North Cumbria ICP is asked to agree to publish the attached strategy in December 2022.

The ICP is asked to note that an easy read version of the document will also be developed. This will be supported by a summary brochure, an animation and further content to make the strategy more accessible to wider communities and stakeholders.

Key points

Developing the strategy

In July 2022, the Department for Health and Social Care published guidance for the development of integrated care strategies. The North East and North Cumbria ICP established a steering group to oversee the development the strategy, supported by task and finish groups.

A first draft of the strategy was produced in October 2022. The draft was informed by more than 300 needs assessments, plans and strategy documents received by the strategy steering group following a call for evidence during the late summer.

On 26 October, the draft strategy was published on the ICP page of the ICB public website. It was shared across social media and other communications channels and distributed to a wide range of stakeholders asking for their views and comments. During November nearly 400 online survey responses were received, as well more detailed responses from individuals, organisations and partnerships.

During November a standard presentation was used to support discussions with stakeholders, including with ten of the health and wellbeing boards and all four of the local ICPs. An independent report on the feedback received was commissioned. The report is provided as appendix 2.

Final strategy

Based on the feedback, a final version of the strategy has been produced for publication before the end of December. This is attached as appendix 1.

The strategy is based on a case for change, the strengths in our region we can build on, and then the organising principles of our vision, goals and enablers, summarised below:

The strategy set out our goals to improve health and wellbeing in our region for everyone, and to reduce health inequalities. It describes how we will:

- Reduce the gap between how long people live in the North East and North Cumbria compared to the rest of England, so that our communities live longer, healthier and happier lives.
- Ensure fairer health outcomes for people. We know that everyone does not have the same opportunities to be healthy because of the environments where they are born, grow up, live, work, and their age too.
- Ensure our health and care services are high-quality, no-matter where you live and who you are. That they are also joined-up and that people have the same access to the right care.
- Work together to give our children and young people the best start in life.

The strategy also describes the deeply challenging context communities in the North East and North Cumbria are currently facing, as well as the pressures faced by health and care services and our workforce.

In summary, the strategy commits the ICP to a radical transformation of population health and wellbeing outcomes to ensure everyone in our region can experience better health and wellbeing.

Delivering the strategy

Delivering the strategy will require aligning our collective resources at all levels - neighbourhood, local authority place, the four local integrated partnerships and across the whole ICP region.

We will develop specific plans to take forward each key element of the strategy, for example a clear workforce plan. These will support the strengthening of work at a local level, while encouraging local determination and focus depending on local needs and context.

Local authorities, the ICB, and our broader partnership arrangements will need to have regard to the strategy in how they plan, commission, and deliver services. This includes ensuring alignment to the key themes.

We will undertake at least an annual review of the strategy. We will also publish a clear update on our implementation of the strategy including progress against the measurable goals.

Risks and issues

The strategy includes some specific and measurable goals and supporting commitments. There is a risk that these objectives may not be achieved, or indeed may not set a sufficiently high ambition. This risk will be mitigated by regular review of the strategy implementation supported by measurement of the delivery of the objectives.

There is a risk that the strategy is not sufficiently clear about how its ambitions will be delivered. The strategy focusses more on *what* we want to achieve, rather than *how* it will be achieved. This risk will be mitigated by developing more detailed action plans, for example on the workforce, and by asking all partner organisations and partnerships to pay due regard to the strategy.

There is a risk that the strategy does not take proper account of the wide differences in health and care needs between populations, and between local authority places. This will be mitigated by supporting partnerships in local authority places to apply flexibility in how the strategy is delivered in accordance with local context.

Assurances

The strategy has been produced in line with the national guidance from the Department for Health and Social Care, is founded on existing plans and the best available evidence and has been informed by engagement with stakeholders.

Recommendation/Action Required

1. The ICP are requested to approve the strategy for publication by the end of December.

2. To provide a copy of the strategy to NHS England (in their role as a commissioner of services) and to confirm their agreement with the strategy.

3. The ICP are requested to note the intention to commission an independent organisation to develop an easy read version of the document. This will be supported by a summary brochure, an animation and further content to make the strategy more accessible to wider communities and stakeholders.

Sponsor/approving director	Jane Robinson, Corporate Director, Adult and Health Services, Durham County Council and Jacqueline Myers, Executive Director of Strategy and System Oversight, North East and North Cumbria Integrated Care Board.
Report author	Peter Rooney, Director of Strategy and Planning, North East and North Cumbria Integrated Care Board

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**	✓	**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**	✓	**N/A**	

Key implications	
Are additional resources required?	Delivering the strategy will require the optimal use of resources across the ICP, but at this stage there are no explicit resource requirements.
Has there been/does there need to be appropriate clinical involvement?	There has been involvement through the process outlined in the key points above. A commitment to co-production is one of the five key enablers described in the document.
Has there been/does there need to be any patient and public involvement?	
Has there been/does there need to be partner and/or other stakeholder engagement?	

Appendix 1 Integrated Care Strategy

Appendix 2 Engagement Findings Report

Better health and wellbeing for all

a strategy for the
North East and North Cumbria

Final Draft
7 December 2022

Contents

Foreword by Professor Sir Liam Donaldson

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Professor Sir Liam Donaldson

Chair of the North East and North Cumbria Integrated Care Board

1 Introduction

1.1 Our Integrated Care Partnership

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

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

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

These are:

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

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

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

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

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

1.2 Our partnership working

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

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

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

1.3 Our Integrated Care Strategy

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

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

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

1.4 Developing our strategy

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

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

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

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

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

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

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

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

2 Our case for change

2.1 The current position

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

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

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

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

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

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

We would not choose to start from here.

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

2.2 Health and wellbeing outcomes

2.2.1 Measuring health and wellbeing

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

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

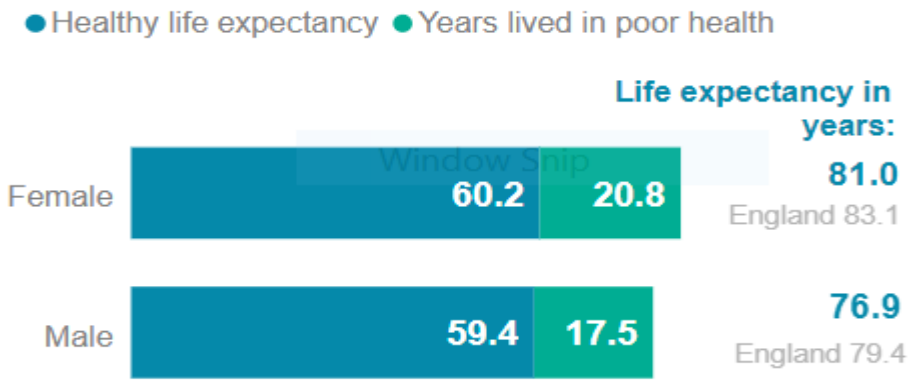
Our key measures are:

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

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

2.2.2 Life expectancy and healthy life expectancy at birth

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



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

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

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

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

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

2.3 Health inequalities

2.3.1 Inequality in health outcomes

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

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

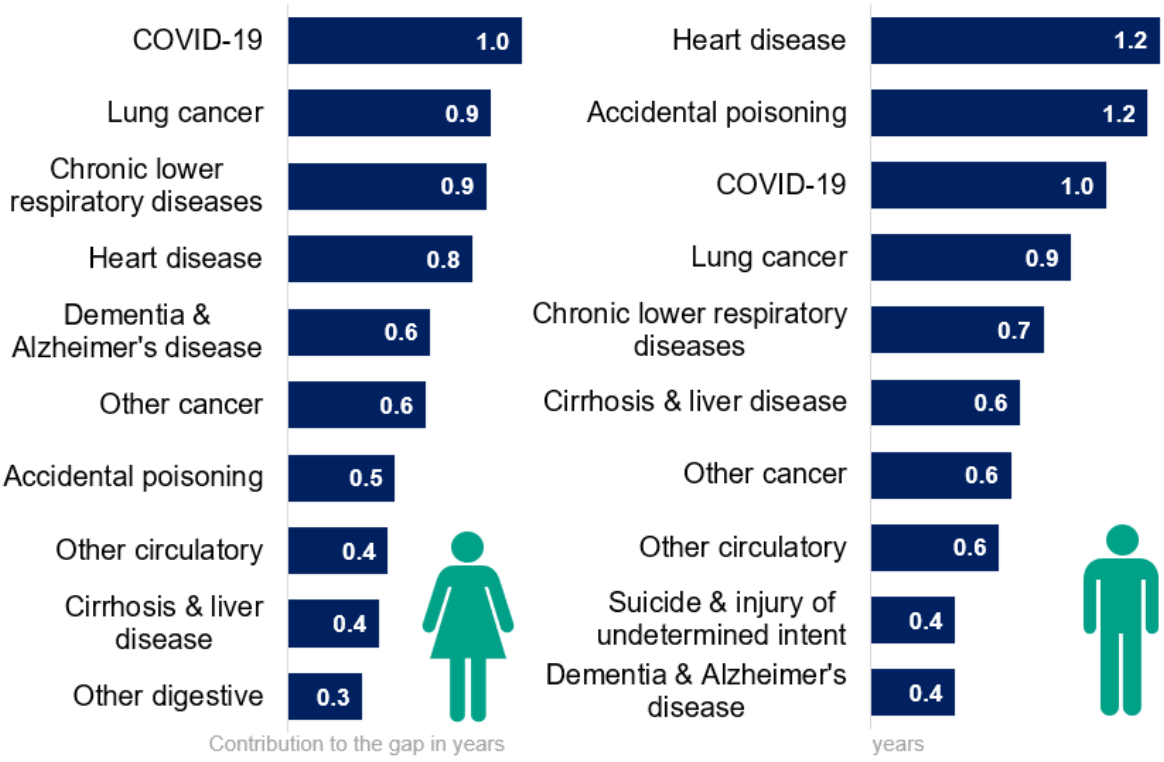
The difference was approximately 8.1 years for women and 10.4 years for men. This difference is much larger than the comparable inequality gap for England.

Source: Population weighted experimental estimates based on OHID Segment tool

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

2.3.2 Main causes of in inequality by disease groups

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

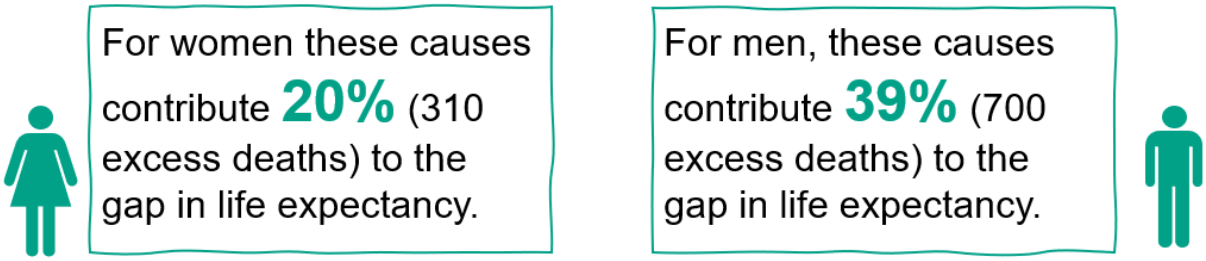


Source: Population weighted experimental estimates based on OHID Segment tool

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

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

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



Source: Population weighted experimental estimates based on OHID Segment tool

2.4 Social determinants of health and wellbeing

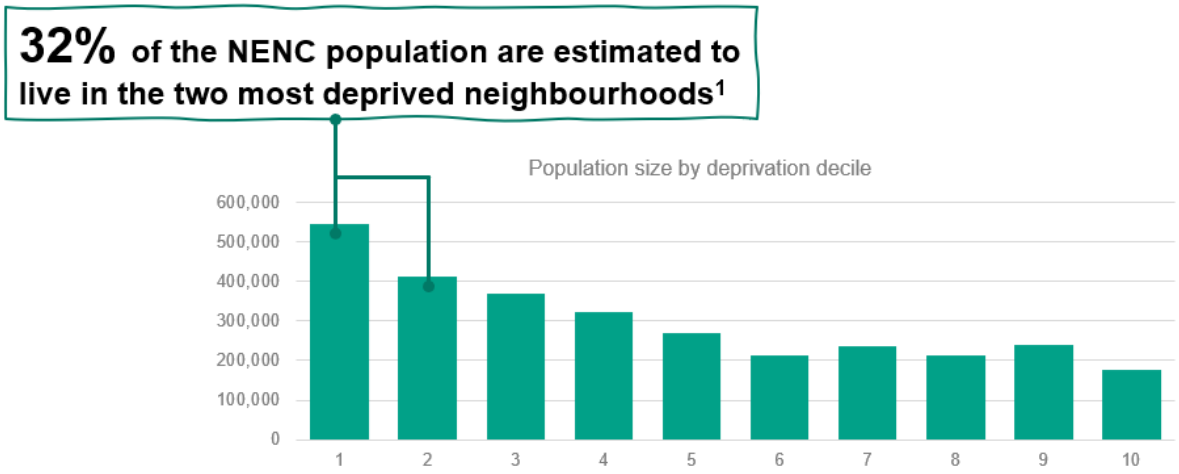
2.4.1 Socio-economic deprivation

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

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

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

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



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

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

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

2.5 Health and care services

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

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

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

3 Strengths to build on

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

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

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

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

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

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

4 Our vision, goals and ambition

4.1 Introduction and overview

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

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

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

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

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

4.2 Longer and heathier lives for all

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

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

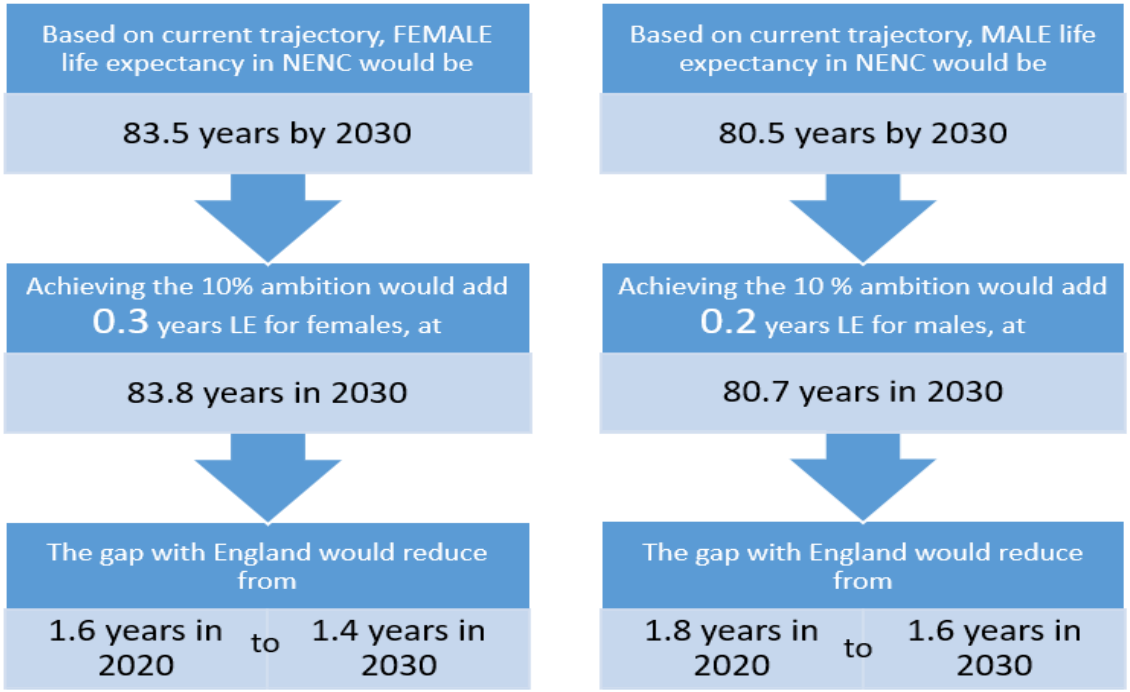
As set out in our case for change, we have lower life expectancy and healthy life expectancy at birth than the England average. In the longer term our ambition is to eliminate this inequality. The people of the North East and North Cumbria deserve at least the same level of health outcomes as people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

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

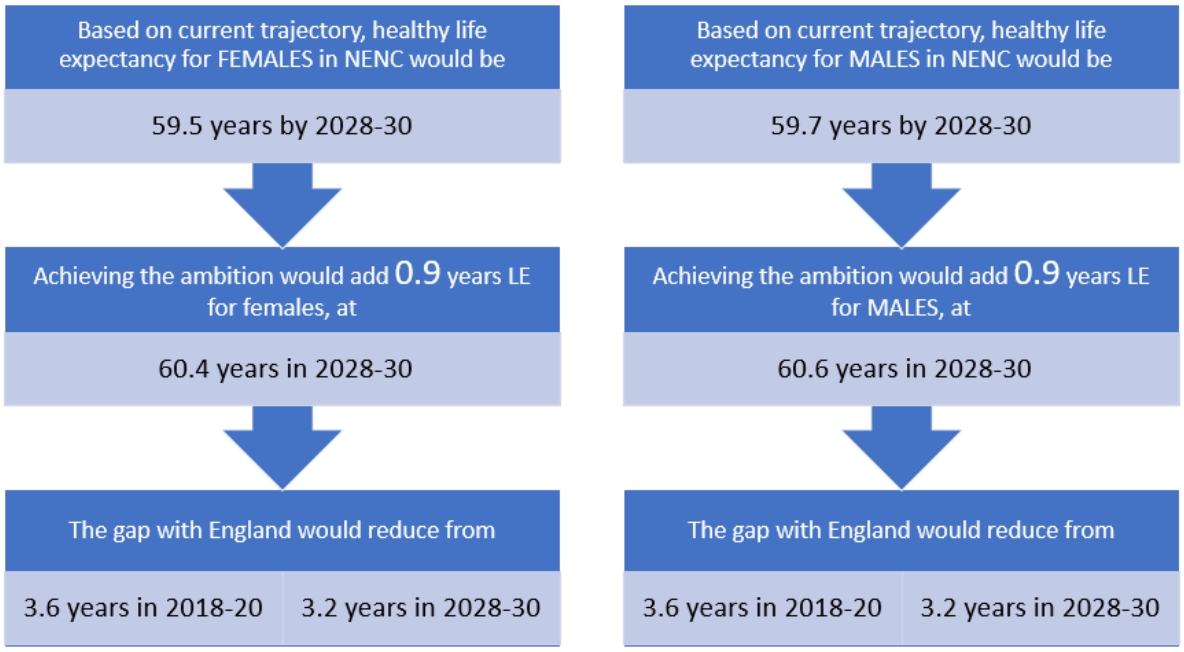
The wording of this goal can be confusing. We cannot know in advance what the England average for life expectancy and healthy life expectancy at birth will be in 2030. We can model the current position, and the current trajectory – meaning the 'if we did nothing different' scenario.

The charts below show the modelling.

Life expectancy at birth



Healthy life expectancy at birth



4.3 Fairer health outcomes for all

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

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

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

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

4.4 Best start in life for our children and young people

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

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

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

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

4.5 Improving health and care services

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

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

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

4.6 Supporting goals

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

By 2030, we aim to:

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

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

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

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

5. Increase the percentage of people diagnosed at the early stages of cancer (stage 1 and 2) to the national target of 85% by 2028.

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

We would like to set further supporting commitments, but as yet have not developed effective baselines or defined a reasonable ambition. During 2023 we will additionally seek to set stretching yet realistic supporting commitments in relation to:

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

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

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

5 Longer and healthier life expectancy

5.1 Supporting economic and social development

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

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

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

5.2 Health and wellbeing related services

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

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

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

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

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

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

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

5.3 Community centred and asset-based approaches

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

5.4 Community wealth and anchor institutions

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

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

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

5.5 Prevention and health promotion

5.5.1 Healthier and Fairer Committee of our ICP

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

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

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

Prevention, including:

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

Core20Plus5 (this is explained in sections 6.2 and 7.4)

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

Broader economic and social benefits, including:

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

5.5.2 Improving nutrition and supporting active lives

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

5.5.2 Smoking and alcohol programmes

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

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

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

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

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

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

5.5.3 Social isolation

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

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

5.5.4 Health literacy

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

6 Fairer health outcomes

6.1 Health inequalities

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

Inequalities:

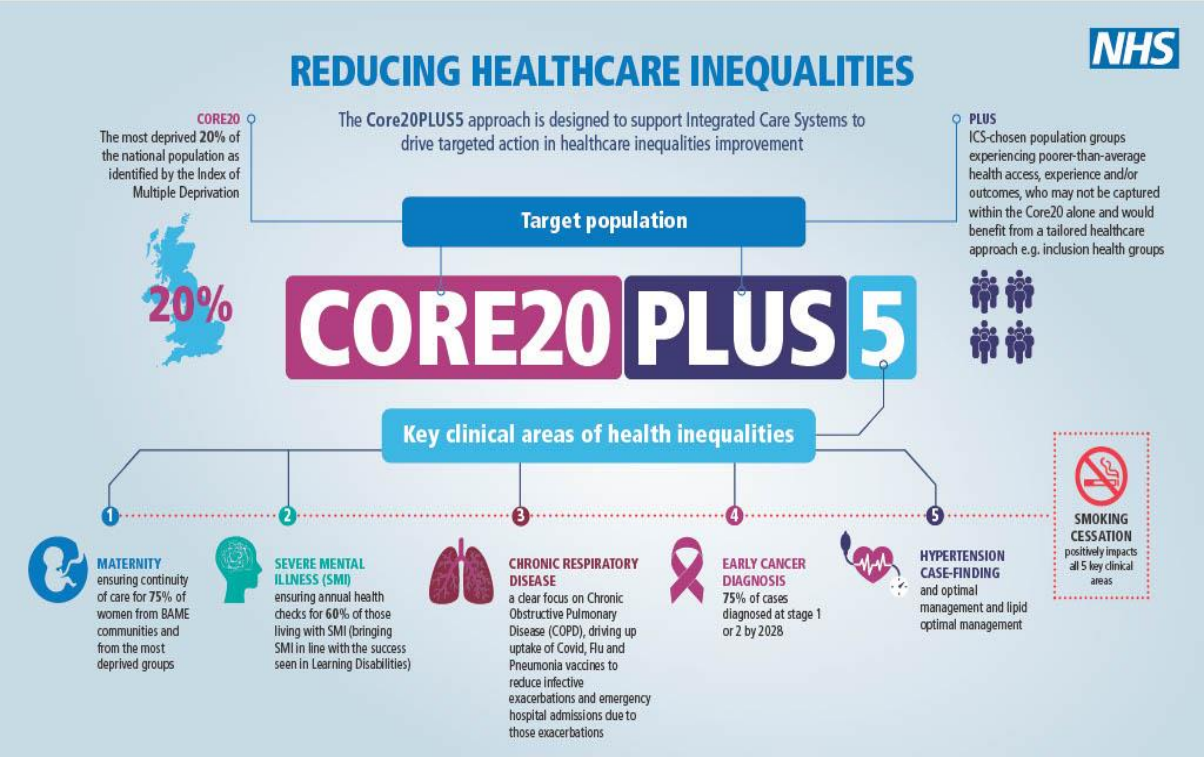
- Are a result of complex interaction between factors to produce differences across population groups
- Occur by socio-economic status, geography, protected characteristics or social exclusion, vulnerability and deprivation
- Are not inevitable and addressing them requires cross sector action by organisations,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

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

6.2 Core20Plus5 for adults

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

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



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

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

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

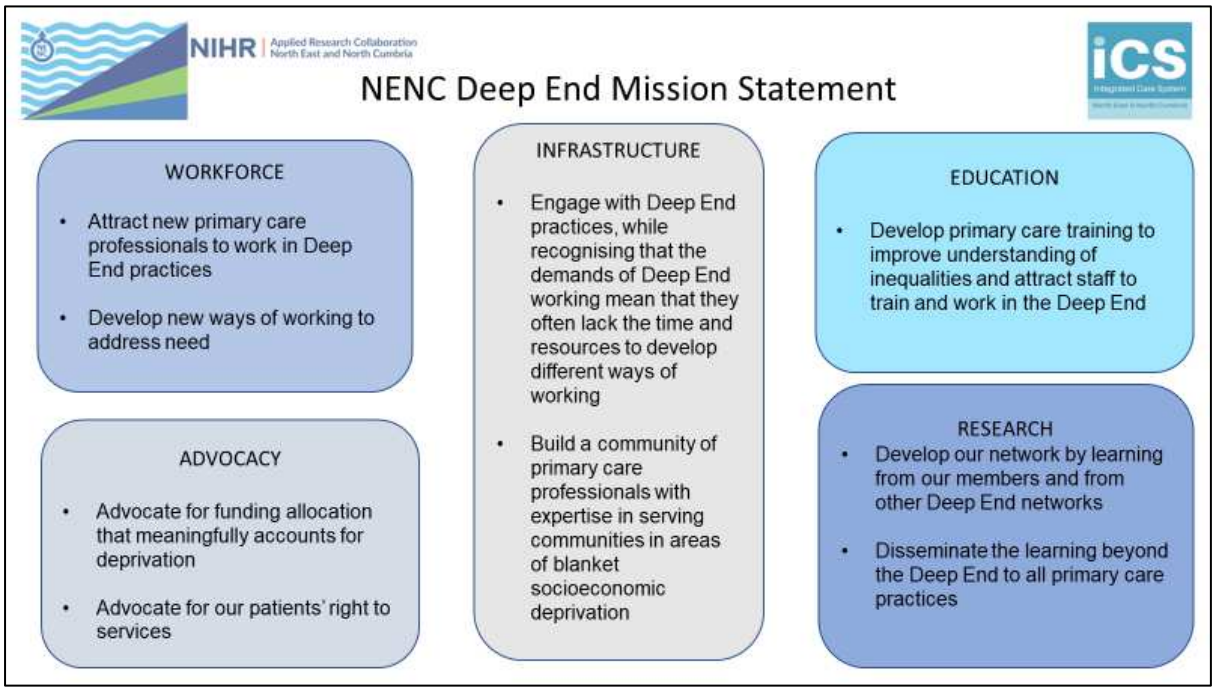
The final part of Core20plus5 sets out five clinical areas of focus:

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

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

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

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



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

6.3 Inclusion health

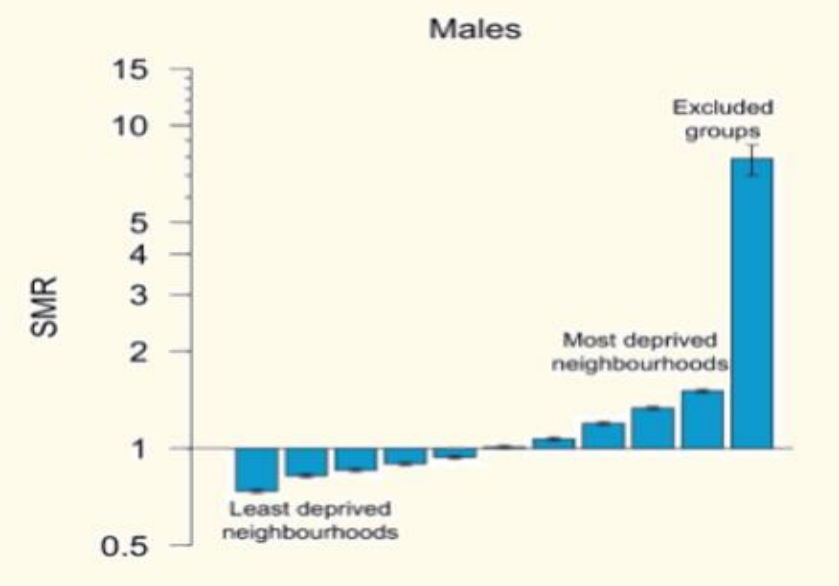
We know that some groups of people are especially disadvantaged and vulnerable. People who are socially excluded, experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), stigma and discrimination and are not consistently accounted for in databases.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

- People experiencing homelessness

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

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

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



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

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

6.4 Inequalities in health and care

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

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

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

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

6.5 Challenges for rural and coastal areas

Rural poverty and economic challenges

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

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

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

Geographical isolation

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

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

7 Best start in life for our children and young people

7.1 Introduction

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

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

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

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

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

7.2 Maternity services

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

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

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

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

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

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

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

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

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

Our areas of focus will include:

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

7.3 Health and care services for children

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

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

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

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

Working in partnership, we will seek to:

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

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

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

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

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

- A focussed improvement in transitions from child, young people and adult services

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

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

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

7.4 Core20Plus5 for children and young people

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

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

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

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

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

Target populations

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

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

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

Clinical areas of focus

The final part sets out five clinical areas of focus:

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

7.5 The voice of children and young people

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

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

8 Improving health and care services

8.1 Core principles and cross cutting services

8.1.1 Improving quality and safety

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

We will do this by

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

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

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

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

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

8.1.2 Sustainable services

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

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

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

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

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

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

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

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

8.1.3 Equal value of mental and physical health services

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

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

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

8.1.4 Personalising health and care

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

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

8.1.5 Supporting unpaid carers

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

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

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

8.1.6 Better integration and co-ordination of care

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

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

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

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

8.1.7 Ageing well

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

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

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

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

8.1.8 Better end of life care

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

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

8.2 Protecting health and wellbeing

8.2.1 Safeguarding

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

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

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

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

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

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

8.2.2 Health protection

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

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

8.2.3 Emergency preparedness, resilience and response (EPRR)

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

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

8.3 Long term conditions and cancer

8.3.1 Cancer

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

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

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

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

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

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

8.3.2 Long term conditions

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

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

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

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

8.4.1 Mental health

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

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

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

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

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

8.4.2 Learning disability and/or autism

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

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

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

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

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

8.4.3 Substance misuse

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

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

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

8.5 Adult social care

8.5.1 Demand for services

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

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

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

8.5.2 Economic contribution

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

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

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

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

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

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

8.5.3 Sustainability

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

8.5.4 Prevention and promoting independence

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

8.5.5 Areas of focus

Some of the key programmes we will deliver include:

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

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

These programmes will be supported through the adult director of social services' networks.

8.6 NHS services

8.6.1 Primary care and community services

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

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

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

8.6.2 Urgent and emergency care

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

- Increase the proportion of urgent care which is delivered in community settings including in the home
- Increase the proportion of 111 and 999 calls that are clinically assessed and maximise hear and treat and see and treat pathways
- Eradicate 12 hour waits in emergency departments, and ambulance handover delays in excess of 30 minutes, and improve ambulance response times
- Expand the range and uptake of 2 hour community response services, to enable people to receive timely care in the right place

- Enable people to return to their permanent place of residence with the right support once they no longer need medical treatment in hospital.

8.6.3 Elective care

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

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

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

8.6.4 NHS England delegation

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

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

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

Working in partnership with the ICB, the NHSE specialised commissioning will explore ways to deliver new service models for advanced place-based arrangements to integrate specialised services into care pathways, focussing on population health for the ICB. We will do this through joint collaborative commissioning approaches as set out in the roadmap for integrating specialised services within Integrated Care Boards, published in May 2022. We will explore opportunities for more advanced integrated arrangements where these will support the delivery of outcomes for our population.

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

9 Enabling strategies

9.1 A skilled, compassionate and sufficient workforce

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

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

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

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

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

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

A key focus will be on developing improved career structures across and between health and social care. This will include better ways to enable people living in in our communities to enter the health and social care workforce, with good training and support, recognising that many talented and committed people currently face barriers to joining our workforce.

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

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

9.1.1 Becoming a learning system

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

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

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

9.2 Working together to strengthen our neighbourhoods and places

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

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

To further support local partnership working we will agree formal of local governance arrangements at local authority place level by March 2023, and encourage local networks and collaboratives across sectors in each local authority area. A key focus will be to implement integrated neighbourhood teams, in line with the Fuller report, bringing together all partners, including the primary care, voluntary sector, social

care and Ambulance services. This will build on existing partnership working, strengthening how teams already work together at locality level.

9.3 Innovating with improved technology, data, equipment and research

9.3.1 Research and innovation

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

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

9.3.2 Digital technology and data

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

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

The health and care system collects a significant amount of data from patients, carers and service users. The majority of this data is not used beyond care delivery, performance management and contract management. Through the advances in computing powers, abilities to link datasets and use this data to develop insights and

deep understanding of the communities we serve. We will develop and implement a complimentary, data, intelligence and insights strategy placing information at the centre of our collective decision making.

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

9.3.3 Estates

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

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

9.4 Making the best use of our resources

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

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

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

9.5 Protecting the Environment

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

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

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

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

9.6 Involving people

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

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

We will work to ensure that people are actively involved in how we take forward the delivery of the strategy. This will include tapping into the extensive community assets

people are already involved in, and sometimes represented by. For example, the voluntary, community and social enterprise sector, pre-existing and potential networks, and trusted institutions such as community centres. We will also recognise and respect the role of elected members in local authorities as community leaders, and we will work closely with the Health Watch organisations and network.

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

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

10 Delivering the strategy

10.1 Partnership working at all levels

Neighbourhoods

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

Place and local authority areas

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

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

Delivering the strategy will require:

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

Local ICPs

The four local ICPs will provide:

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

ICP level

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

- Association of Directors of Adult Social Services (ADASS) network
- Directors of children's services network
- Directors of public health network
- The directors of finance and ADASS group
- Emerging shared fora for housing
- Provider collaboratives covering the whole of the ICP area

- Emerging networks for general practice, including a strong collaboration between primary care networks
- Using the networks across Health Watch and voluntary, community and social enterprise sector to ensure strong partnerships with communities, experts by experience and third sector organisations
- Clinical networks focussed on particular disease groups, for example the Northern Cancer Alliance
- Networks focussed on population groups, for example the Child Health and Wellbeing Network

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

10.2 Delivering the strategy

Delivery plans and measuring progress

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

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

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

Communicating the strategy

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

Reviewing the strategy

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

Integared Care Partnership (ICP) Strategy

Engagement Findings Report

Final report v1.3 (DRAFT)

6th December 2022

Table of Contents

1 Executive summary

1.1 Introduction

The Integrated Care Partnership (ICP) is a statutory joint committee of the Integrated Care Board (ICB) and the thirteen local authorities in the North East and North Cumbria (NENC) and includes partners from the voluntary, community and social enterprise (VCSE) sector. The committee is responsible for setting the priorities for the system through the development and approval of an integrated care strategy.

Based on prior engagement, the ICP developed a draft integrated care strategy which set out the ambitions and goals to improve the health of all communities across NENC, as well as the steps that will be taken to make these ambitions into reality.

To ensure that stakeholders, partners, and members of the public had the opportunity to help shape this evolving strategy – the committee welcomed the views of these individuals through an online survey open from 27th October to 25th November 2022. Additionally, individuals / organisations were able to submit a direct response.

In total, 386 individuals responded to the survey and 45 additional submissions were received.

1.2 Key findings

The table below shows the proportion of survey respondents who were agreeable with different aspects of the strategy; the vision, the goals, the plan to support the goals and the key commitments.

	Proportion of survey respondents who felt this was right (N=386)
The vision	80%
The goals:	
Longer, healthier life expectancy	86%
Fairer health outcomes	84%
Excellent health and care services	86%
The plan to support the goals:	
Workforce	80%
Places and Neighbourhoods	79%
Technology, equipment and facilities	78%
Resources and protecting our environment	77%
The key commitments:	

Reduce the gap in life expectancy	72%
Reduce the smoking prevalence	72%
Reduce the inequality in life expectancy	77%
Reduce the suicide rate	70%
	Proportion of survey respondents who felt the strategy aligned with… (N=92)*
The priorities of their organisation	62%
The priorities of their geographical place	59%
The priorities of work streams across the ICP	52%

**Completed by those responding as an ICP member or on behalf of an organisation only.*

Although some provided favourable comments about the strategy, others provided comment / suggestion as to how the strategy could be further enhanced / strengthened. The following provides a summary of the key themes which stemmed from the feedback gathered.

- **Document accessibility –** the document was felt to contain much terminology / jargon / acronyms that members of the public, including Children and Young People (CYP) as well as partners in non-healthcare settings, would find difficult to understand. It was suggested that the document digresses from its 'NHS style' to a shorter, easier-to-read document. Specific comments made about the language / terminology used within the draft were fed back to the ICP throughout the engagement process, in a separate document.
- **Specific detail -** the document was felt to lack specific detail as to how the vision (including goals and commitments) will be achieved, as well as being measured / evidenced. Additional information was requested with regards to an accountability framework, a roadmap with milestones and concrete deliverables and monitoring structure.
- **The challenge posed -** for some the vision / goals / commitments are felt to be too ambitious within the timescales specified. However, this was not the case for all, with some highlighting areas where specific goals / commitments could be strengthened / more aspirational (e.g., the goal relating to the reduction in suicide rate).
- **Missing focus areas** / **wider areas to consider** – throughout the engagement, specific areas were identified as not being strong enough / absent from the strategy. The key ones being:
    - The underrepresentation / lack of focus on Children and Young People (CYP).

- Communication, engagement, and involvement – recongising the importance of listening to and embedding the voice of patients, members of the public, communities, businesses and VCSE partners / organisations.
- The role of prevention and wider determinants of health and wellbeing, in helping to address health inequalities.
- Recognition and value of the VCSE sector, as key partners within the ICS at both system and place level.
- Improving access to services, including access for those with disabilities / ill health.

A wide variety of other areas were also identified, these included:

- Mental health and access to mental health services
- Obesity
- Substance misuse
- Public education and prevention
- Palliative and End-of-Life (EoL) care
- Loneliness and social isolation
- Elderly care / health of older people
- Social care provision / improving access to social care.

Further comments / queries were raised with regards to financial investment, and whether this will be available to help build resources / services, as well as the workforce, to help achieve the vision.

Concluding points

This document provides an overview of the wealth of feedback collated with regards to the overall strategy and its composing parts. A wide range of suggestions are put forth to help strengthen its approach.

It is evident that members of the public and stakeholders welcomed the opportunity to be involved in this process, with many looking forward to helping to support the ICP going forward with the further development of the strategy, as well as its delivery.

2 Introduction

The Integrated Care Partnership (ICP) is a statutory joint committee of the Integrated Care Board (ICB) and the thirteen local authorities in the North East and North Cumbria (NENC) and includes partners from the voluntary, community and social enterprise (VCSE) sector. The committee is responsible for setting the priorities for the system through the development and approval of an integrated care strategy.

Based on prior engagement, the ICP developed a draft integrated care strategy which sets out the ambitions and goals to improve the health of all communities across NENC, as well as the steps that will be taken to make these ambitions into reality.

2.1 Methodology

To ensure that stakeholders, partners, and members of the public had the opportunity to help shape this evolving strategy – the committee welcomed the views of these individuals through an online survey. The survey was open from 27th October to 25th November 2022.

Additionally, stakeholders, partners, and members of the public were given the opportunity to submit a direct response.

	No. of responses
Online survey	386
Additional submissions (from stakeholders, partners, and members of the public)	45

2.2 Notes on analysis

The report is split into two sections: survey findings and additional responses.

Specific comments in the feedback relating to the wording within the draft strategy (i.e., grammatical errors, typos, terminology) were presented to the ICP in a sperate document.

3 Survey findings

3.1 Demographics

A total of 386 responses were received to the online survey.

Whilst 87% responded on behalf of themselves, 24% answered on behalf of an organisation. A list of these is provided under the table below.

Additionally, 4% responded as an ICP member. It was requested that within this report, the responses of these individuals were presented as part of the whole sample as well as separately (see sections titled 'Feedback from ICP members').

Table: Are you completing this survey…? (N=386)

	% (N)
… on behalf of yourself	87% (285)
… on behalf of someone else	2% (5)
.. as an ICP member	4% (14)
… on behalf of an organisation	24% (78)
No response	1% (4)

Participating organisations:

- Age UK Gateshead
- Bensham Family Practice
- Buddy_Cups
- Catalyst Stockton-on-Tees Ltd
- CLIP
- Connected Voice Haref
- Craig Healthcare
- Cumbria Third Sector Network
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Diabetes UK
- Durham County Council Public Health Healthy Settings Team
- Eden Valley Hospice and Jigsaw Cumbria's Children's Hospice
- ESCAPE Family Support
- Gateshead Health
- Halo Project
- Hartlepool Borough Council
- Hartlepool Local Authority
- Haydon Bridge & Allendale surgery
- HBC
- HC-One
- Healthwatch
- Healthwatch Northumberland Board
- Hospital of God at Greatham
- iCan Health and Fitness CIC
- Journey Enterprises
- Labriut Health Living Centre
- Lets Connect (Teesside and County Durham)
- LilyAnne's C.I.C
- Middlesbrough FC Foundation

- Middlesbrough Food Partnership
- Mind and Sole
- NE NHS Independent Complaints Advocacy
- NENC ICS End of Life Care
- NENC VCSE Ageing Well sub-group (part of the NENC VCSE Partnership Programme)
- NENC VCSE Learning Disability & Autism sub-group (part of the VCSE Partnership Programme)
- NENC VCSE Multiple and Complex Needs sub-group (part of the NENC VCSE Partnership Programme)
- NENC VCSE Women/VAWG sub-group (part of the VCSE Partnership Programme)
- NESCHA
- NHS England
- North Cumbria Integrated Care NHS Foundation Trust
- North of England Activities and Training
- North Tees and Hartlepool NHS trust
- North Tyneside Public Health Team
- Northern Cancer Voices
- Northumberland Community Development Co
- Northumberland County Council
- Northumbria Cancer Patient and Carer Group
- NRASS
- Parkinson's UK
- PC and SIC ODN NENC
- Prospect Surgery A81029
- Prudhoe Medical Group
- Regional Ageing Well Programme
- Rise North East
- Seahouses Development Trust
- Search Newcastle CIO
- South Durham Health Community Interest Company
- South Tees Hospitals NHS Foundation Trust
- South Tees Public Health
- South Tyneside & Sunderland NHS Foundation Trust
- St Cuthbert's Hospice
- Teesdale Day Clubs
- Teesside Hospice and St Teresas Hospice
- The Adderlane Surgery
- Thirteen Housing Group
- Thomas Pocklington Trust
- Thriving Together Northumberland
- Together Middlesbrough & Cleveland
- Vision Northumberland
- YMCA North Tyneside
- You've Got This.

Respondents were asked to indicate where they, or the person / organisation they were responding on behalf of, where from.

Slightly higher proportions were from Durham (18%), Northumberland (13%), other / more than one area (13%) Hartlepool (12%), North Tyneside (10%) and Stockton (9%).

Table: Where you, the person, or the organisation you are responding on behalf, of is from?* (N=372)

	% (N)
Durham	18% (58)
Northumberland	13% (42)
Other / more than one area	13% (43)
Hartlepool	12% (39)
North Tyneside	10% (32)
Stockton	9% (28)
Gateshead	7% (21)
Newcastle	7% (21)
No response	6% (18)
Darlington	5% (16)
Redcar & Cleveland	5% (15)
Sunderland	5% (15)
Allerdale / Carlisle / Copeland / Eden District	4% (13)
Middlesbrough	2% (5)
South Tyneside	2% (6)

**Those that responded to the survey as an ICP member did not answer this question.*

3.2 The vision

The ICP's vision is for 'Better Health for all of our People and Communities' and to improve health and wellbeing for everyone across the North East and North Cumbria.

Respondents were asked if they felt this vision was right; to which 80% felt it was, 10% said it wasn't and 26% were unsure.

Table: Do you think we got this vision right? (N=386)

	% (N)
Yes	80% (264)
No	10% (32)
Not sure	26% (85)
No response	2% (5)

Respondents were given the opportunity to comment upon the vision. As for all open questions within this survey, to provide a quantifiable representation of the feedback – each response was coded, with codes being grouped into themes.

The range of themes identified were grouped under the following categories and are presented in the table below:

- Support for the vision / positive comments
- Missing focus area / wider areas to consider
- Achieving the vision
- Funding / resources
- Partnerships
- Wording / information
- Other.

Notably, some of the key themes in response to this question related to:

- Missing focus area / wider areas to consider – respondents identified numerous areas that they felt were absent and/or required more focus within the vision / strategy, these included obesity, substance misuse, mental health, care for the elderly, and End-of-Life (EoL) care.

  With similar areas being identified in each of the open questions within the survey, a summary of these is provided in Section 2.7.

  However, specifically in response to this question, a high number of responses were noted in relation to the following. These were therefore presented as discrete themes:

  - Improving access to services / appointments, including access for those with disabilities / ill health.
  - Reducing / tackling health inequalities / ensuring equal access for all.
  - Under-representation of Children and Young People (CYP).

- Query / uncertainty as to how the vision will be measured / evidenced / delivered, and further whether it is achievable.
- Query / comment about financial investment, with a feeling that this is integral to the delivery of the strategy, including investment in resources / services, and the workforce.
- Comment / suggestion about greater integration / partnership work needed with members of the public and patients (i.e., Patient and Public Involvement - PPI), communities, schools / education, VCSE sector, local food partnerships and community pharmacies.
- Comment relating to the vision being meaningless / too generic / broad.

Specific comments included:

"Concern is that there are a lot of words but not clear how organisations and individuals will be able to tell the difference in 1- and 5-years time. A bit woolly"

"Very adult focused and fails to recognise the unique health needs of children and young people and the importance of improving their health to improve the health/outcomes as adults. Less than half a page on CYP is disappointing"

"Access - is missing from the vision, people need to be able to access services simply and easily".

Table: Please share any thoughts on the vision or if you think anything is missing (N=187)

Support for the vision / positive comments	No. of responses
Good / perfect vision / aligns with our organisation's vision	14
Working together as one system / joint health and social care is imperative	10
Missing focus area / wider areas to consider	
Missing focus area / wider areas to consider (See Section 2.7)	54
*Improved access to services / appointments	23
*Too focused on adults / needs more focus on CYP	12
*Equal access for all / tackling and reducing health inequalities	11
Achieving the vision	
How will this be measured / achieved? Is it achievable?	27
Strategy should not replace local strategies / make it clear that the vision aligns with local strategies	2
How does the strategy differ from previous visions / strategies?	2
Other comment, including: - Success dependent on every organisation being fully committed - How will the public be informed of this? - Who will monitor the process / results?	4
Funding / resources	
Funding required / key to strategy delivery	22
Partnerships	
Need to work more with public / patients / communities	9
Need to work with schools / education	6
Need to work with VSCE sector	7
Need to work with local food partnerships	1
Need to work with community pharmacies	1
Other comment re: integrated care / partnerships and information sharing	3
Vision wording / information	
A bit meaningless / generic / broad	25
Specific reference to 'wellbeing' needed	8
Specific reference to 'care' needed	8
'People and communities' not needed / what is the difference between them?	3
Other comment / suggestion, including: - Second part reads better - Seems haphazard / rushed - Data sounds fictitious	5
Other	
Other comment	24
Other comment relating to access to / improving healthcare services including barriers to accessing digital services	15

**Identified as a discrete theme, due to the number of respondents who referenced this specifically.*

3.2.1 Feedback from ICP members

The following summarises the feedback received specifically by ICP members in terms of the vision.

Table: Do you think we got this vision right? (N=14)

	No.
Yes	10
No	2
Not sure	2
No response	0

Table: Please share any thoughts on the vision or if you think anything is missing (N=5)

Key points
• Need to better understand how the money will follow the person. • How will this be achieved? • What about prevention and rehabilitation services? • Suggestion of 'Prevent, educate, and provide better health to all people and communities.' • Vision not wide enough – focus should be on better life outcomes (education, housing etc.). • Lack of focus on CYP.

3.3 The goals

To support this vision, there are three key goals. These are:

- **Longer, healthier life expectancy** – this means reducing the gap between how long people live in the North East and North Cumbria, compared to the rest of England, so that people live longer, healthier lives.

- **Fairer health outcomes** – people may experience a difference with their health because of different environments where they are born, grow up, live, work, and age. This means not everyone has the same opportunities to be healthy. This is known as health inequalities, and we want to reduce this across the entire population.

- **Excellent health and care services** – we want to make sure the health and care services in the North East and North Cumbria region is high-quality, the same quality no-matter where you live, joined-up, and that people have the same access to the right care.

Similar proportions felt each of these goals were appropriate, specifically:

- 86% perceived 'longer, healthier life expectancy' was right
- 86% perceived 'excellent health and care services' was right
- 84% perceived 'fairer health outcomes' was right.

Table: Do you think we got these goals right? (N=386)

	Yes	No	Not sure	No response
	% (N)	% (N)	% (N)	% (N)
Longer, healthier life expectancy	86% (331)	5% (19)	8% (30)	2% (6)
Fairer health outcomes	84% (326)	6% (24)	7% (27)	2% (9)
Excellent health and care services	86% (331)	5% (21)	6% (24)	3% (10)

Respondents were given the opportunity to provide any further comments on the goals. Responses were grouped into themes and are presented in the table below under the following categories:

- Support for the goals / positive comments
- Partnerships
- Missing focus area / wider areas to consider
- Achieving the vision
- Funding / resources
- Wording / information
- Other.

Notably, some of the key themes in response to this question related to:

- Missing focus area / wider areas to consider – numerous additional areas were felt to be absent from the goals / require more focus. An overview of these is provided in Section 2.7.

  The following areas were however presented as discrete categories, due to the number who referred to each:

  - Tackling / reducing health inequalities / ensuring equal access for all.
  - Improving access to services / appointments (including primary care).
  - Under-representation of CYP.

- Query / uncertainty as to how will these goals be achieved, including proposed timescales, and how these goals will be measured / evidenced.

- Query / comment about financial investment, with a feeling that this is integral to the achievement of these goals, including stronger / greater workforce and better management of, and more resources.

- In terms of the wording of the goals, there was feeling that emphasis should be on 'healthier life' not 'longer life', whilst others considered them to be meaningless / vague and/or state the obvious.

Specific comments included:

"I agree reduction in health inequalities by ensuring clear education to our parents. Supporting our children with better healthcare and stronger transition and educating our future population would be the way forward"

"All 3 goals are difficult to argue against, but systemic health inequity is going to a huge challenge to overcome"

"Just getting to see a GP would be an ambitious goal"

"I think the goals are focused on health and care and there needs to be consideration given to wider social, environmental and economical factors which will improve people's lives e.g., access to leisure, community services, good jobs etc"

Table: Please share any thoughts on these goals or if you think anything is missing (N=167)

Support for the goals / positive comments	No. of responses
Good / admirable goals / support these commitments	6
Partnerships	
Cannot be done alone / need to work in partnership (public / patients / communities / VCSE sector)	9
Missing focus area / wider areas to consider	
Missing focus area / wider areas to consider (See Section 2.7)	56
*Need to tackle health inequalities	30
*Improve access to services	15
*Too focused on adults / under-representation of CYP	13
Achieving the vision	
How / when will you achieve these goals? Including measurement and evidence	24
Fear no change / how will it be done differently?	5
Much commitment / hard work needed to achieve	3
Too ambitious	2
Other, including: - How will this be communicated to the public? - Plan needs to be flexible	2
Funding / resources	
Financial support / investment required to achieve the vision	14
Other comment relating to funding / resources, including: - Need to stop putting profits before humanity - Investment in VCSE sector	5
Wording / information	
Emphasis should be on 'healthier life' not 'longer life'	14
Meaningless / vague / old phrases / stating obvious	9
'Excellent health and care services' is important/should be placed first	6
Goals need more detail	6
What is the measurement of 'fairness'?	5
Grammatical error	2
Should increase life expectancy to match the best in England	2
Other	
Other comment	30
Comment relating to access to / improving healthcare services	13
Concern about the size of the ICB / need for separate visions (ICS / ICB / ICP)	3
Improving quality of care must not reduce quality in other areas	2

**Identified as a discrete theme, due to the number of respondents who referenced this specifically*

3.3.1 Feedback from ICP members

The following summarises the feedback received specifically by ICP members about the goals.

Table: Do you think we got these goals right? (N=14)

	Yes	No	Not sure	No response
	No.	No.	No.	No.
Longer, healthier life expectancy	13	1		
Fairer health outcomes	12	2		
Excellent health and care services	13	1		

Table: Please share any thoughts on these goals or if you think anything is missing (N=6)

Key points
• Too health focused – greater focus on wellbeing needed. • Acknowledgement needed of societal pressures as well as social care. • Not wide enough – should focus on better life outcomes (education, housing etc.). • Lack of focus on improving outcomes for CYP. • How will this be achieved? • What about prevention and rehabilitation services? • Clear education needed for parents supporting their children with better healthcare (educating our future population).

3.4 The plan to support the goals

There are four ways these goals can be supported. These are:

- **Workforce** – we want a well-supported, sustainable, diverse workforce, which supports the physical and mental wellbeing of our employees.

- **Places and Neighbourhoods** – we want to make sure that local areas and neighbourhoods are considered at the start when we are delivering actions from this strategy, with decisions made at the most appropriate level.

- **Technology, equipment and facilities** – We will deliver a digital, data, intelligence, and insights strategy to help us manage the health of the population, based on research and information.

- **Resources and protecting our environment** – We will support this ICP to receive a fair budget to provide health care services across the region. We will make sure there is improvement across the whole area, with the greatest improvement in areas which need it most.

In terms of the plan to support the goals, there was high and very similar agreement for each. Uncertainty was slightly greater for 'resources and protecting our environment' with 77% perceiving this was right, 6% that it wasn't, whilst 15% were unsure.

Table: Do you think we got these right? (N=386)

	Yes	No	Not sure	No response
	% (N)	% (N)	% (N)	% (N)
Workforce	80% (309)	8% (29)	11% (41)	2% (7)
Places and neighbourhoods	79% (306)	7% (27)	12% (45)	2% (8)
Technology, equipment and facilities	78% (302)	7% (26)	13% (50)	2% (8)
Resources and protecting our environment	77% (298)	6% (23)	15% (57)	2% (8)

Respondents were given the opportunity to comment on this plan. Responses are presented in the table below under the following categories:

- Missing focus area / wider areas to consider
- Enablers
- Achieving the vision
- Wording / information (general)
- Other.

Again, many felt that specific areas were absent / needed more focus within the goals / strategy, particularly improving access and providing equality for all. See Section 2.7 for more information.

Additionally, numerous comments were made with regards to how the vision / goals will be achieved, and the importance of working in partnership / adopting a co-productive approach.

In terms of the plan (enablers), a summary of the key themes for each is provided here:

- **Workforce** – respondents highlighted the challenges faced in terms of recruitment and retention, with considerable effort / major changes felt to be needed to address this. This included consideration of career pathways / prospects, fair wage and working conditions and greater support / recognition of employees.

- **Places and Neighbourhoods** – reflecting on the wording used, respondents highlighted the importance of 'working with / listening to' local people / groups / communities / neighbourhoods. Furthermore, questions were raised over the specific terminology used (i.e., 'Places', 'Neighbourhoods' and 'appropriate-level').

- **Technology, equipment, and facilities** – concern was raised about the barriers that some people face in terms of accessing technology / online services, consideration of this was felt to be needed due to the risk of digital exclusion and further exacerbation of health inequalities. Additionally, some commented upon the need to improve data integration / record sharing across the system, whilst others felt this should be at the 'bottom of the list'.

- **Resources and protecting our environment** – to achieve the vision, financial support was felt integral. Furthermore, the omission / lack of detail about how the environment will be protected was questioned, as was the meaning of 'fair budget'.

Specific comments included:

"More detail on the meaning of place - this varies so a definition may strengthen this element"

"In partnership we need to recruit and train many people. Do we have ring fenced money otherwise it won't get off the ground?"

"It is very difficult at present to recruit staff, both nursing and medical. This may need a lot more thought"

"Places and local neighbourhoods - local neighbourhoods are involved - their voice is heard, feedback system. Co-creation"

"Health inequalities and outcomes vary even in the same localities, e.g., Newcastle. How will we achieve greater improvements in areas which need it most?"

Table: Please share any thoughts you have on how we can support these goals or if you think anything is missing (N=189)

Missing focus area / wider areas to consider	No. of responses
Missing focus area / wider areas to consider (Section 2.7)	25
*Improved access to health services / GPs / dental services / community services for all / healthcare equality	18
Enabler: Workforce	
Focus on recruitment and retention	36
More support / recognition for healthcare providers / volunteers (including support wellbeing / mental health of employees)	9
Major changes required to address the workforce / need a clear plan	6
Need to consider fair wage and working conditions	6
'Diversity' less important	4
Consider career pathways / prospects	2
Enabler: Places and Neighbourhoods	
Importance of 'working with and listening to' local people / groups / communities / neighbourhoods	16
Query over terminology; Places, Neighbourhoods, appropriate level	8
Importance of community-centred approaches / place-based services	3
Other comment, including: - Need to get away from 'places' working in silos - Should include public planning - ICP needs to understand services in local communities	4
Enabler: Technology, equipment, and facilities	
Technology / online services not an option for all	17
Record sharing should be easier / data integration needs to improve	11
Technology should be bottom of the list / too much emphasis	7
Inadequate safeguarding of data protection / selling of information	4
Other comment, including: - Intelligence/insights also need to include lived experiences / literature - Ensure everyone has access to technology - IT causes stress / increased workload - Technology can never be a suitable replacement for face-to-face interaction - Should include innovation	6
Enabler: Resources and protecting our environment	
Financial support needed to achieve the vision / investment in services	14
No / lack of detail on how to protect the environment / more needed	7
Query about spending - what is a 'fair budget'?	4
Sustainability needs to be included	3
Too much focus on urban areas / leave rural areas behind	3
No mention of facilities	2

Funding needed for VSCE sector	1
Achieving the vision	
Good in theory / how will this be achieved?	18
Needs to be realistic / need robust plan	6
Other comment, including: - Dependent on national policy - Keeping system working is key - Streamlining of services could tackle all the above - Will take too long	5
Wording / information (general)	
Too generic / simplistic view	7
Stating the obvious / unable to disagree	2
Other	
Other comment	42
More focus about working in partnership / co-production	16
Comment relating to access to / improving healthcare	15

**Identified as a discrete theme, due to the number of respondents who referenced this specifically.*

3.4.1 Feedback from ICP members

The following summarises the feedback received specifically by ICP members about the plan.

Table: Do you think we got these right? (N=14)

	Yes	No	Not sure	No response
	No.	No.	No.	No.
Workforce	12	1	1	
Places and neighbourhoods	13			0
Technology, equipment and facilities	11	1	1	1
Resources and protecting our environment	12	1	1	

Table: Please share any thoughts you have on how we can support these goals or if you think anything is missing (N=7)

Key points
• Need to think different about how best we attract a new kind of worker • Leading the system to provide solutions for workforce issues. • Better information sharing across the ICP is needed (i.e., between systems, professionals and services without living in fear of GDPR or Information Governance). • Prevention is the way forward. • Aspirations to level up and lead from the North East (rather than London-centric NHS). • Consideration of housing and other social determinants of health. • Importance of investing time and efforts on building a strong society / healthcare system. • Right treatment at the right time in the right place. • Ensuring good mental health provision is available. • Strong emphasis on education and teaching not only our healthcare teams but also the public and future leaders. • Identifying areas of need such as mental health and chronic illness and ensuring clear similar pathways are present for all children and families reaching out for healthcare.

3.5 The key commitments

To measure progress, there are four key commitments:

- Reduce the gap in healthy life expectancy between our ICP and the England average by 25% by 2030 and aim to raise the average healthy life expectancy to a minimum of 60 years in every Local Authority by 2030.
- Reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below by 2030.
- Reduce the inequality in life expectancy within our ICP between the most deprived and least deprived deciles by at least 25% by 2030.
- Reduce the suicide rate from 13 per 100, 000 population (2019/2021) to below the England average (10.4 per 100, 000 population 2019/2021) by 2030.

The majority thought each of these commitments were right, with highest agreement for 'reducing the inequality in life expectancy' (77%) and lowest for 'reducing the suicide rate' (70%).

Table: Do you think we got these commitments right? (N=386)

	Yes	No	Not sure	No response
	% (N)	% (N)	% (N)	% (N)
Reduce the gap in healthy life expectancy	72% (278)	6% (24)	18% (71)	3% (13)
Reduce smoking prevalence	72% (277)	9% (34)	17% (64)	3% (11)
Reduce the inequality in life expectancy	77% (297)	6% (23)	13% (52)	4% (14)
Reduce the suicide rate	70% (272)	8% (31)	18% (71)	3% (12)

Respondents were asked to provide any comments they had about these commitments. Responses were grouped into the following categories and are shown in the table below:

- General comments
- Missing focus area / wider areas to consider
- Commitments
- Funding / resource
- Other.

In terms of missing focus area / wider areas to consider, numerous individuals cited areas that they would like the ICP to show commitment to, with many comments being made to mental health / access to mental health services, CYP, substance misuse and obesity. A summary of these can be seen in Section 2.7.

Furthermore, many questioned how these will be achieved and evidenced, with others feeling that given the timeframe, these are not realistic / too ambitious.

In terms of the different commitments, a summary of the key themes relating to each is provided here:

- **Healthy life expectancy / inequality in life expectancy** – the general feeling about these commitments was that the average healthy life expectancy should be higher than 60 (i.e., 65), whilst a smaller number questioned whether life expectancy should be a key commitment, and others that the emphasis should be on 'healthier life' not 'longer life'.

- **Smoking** – there was a feeling amongst some that this should not be seen as a priority over other health areas, whilst some queried whether this included vaping recongising the rising prevalence of this, particularly among young people. Furthermore, whilst some felt this target was too unrealistic, others felt it was not ambitious enough.

- **Suicide** – whilst several individuals felt the commitment could be more ambitious, others questioned how this will be achieved, particularly with the difficulties faced in terms of access to mental health services. Acknowledging the complexity of suicide / mental health, some further stressed that this is not something the ICP can tackle alone.

Specific comments included:

"Does the smoking prevalence relate only to cigarettes, or does it include vaping, which has seen significant increases, particularly in the younger population who never smoked?

"Reducing suicide is questionable task when one of the MH service providers is in dire straits. lack of face-to-face counselling services and extra pressure on economy"

"Where is the outcome for CYP?"

"Work to provide better access/services for mental health support which will then contribute to your goals"

Table: Please share any thoughts on these key commitments (N=191)

General comments	No. of responses
Not achievable / realistic within timeframe	34
Good / commendable commitments	30
How are you going to achieve / implement / evidence them?	25
Not ambitious enough	8

Just words/meaningless / needs more information	6
Suggestion to change from 'we will' to 'we aim to'	3
Other, including: - Query over evidence to support these figures - Commitments shouldn't be made - Query over alignment of commitments with national levels - Development plan will be key to achieving these - Needs to be communicated widely	14
Missing focus area / wider areas to consider	
Missing focus area / wider areas to consider (see Section 2.7)	31
*Commitment to reducing mental health / improve mental health services	20
*Commitment for CYP	13
*Commitment to tackle substance misuse	11
*Commitment to tackle obesity	9
Commitment(s): Healthy life expectancy / inequality of life expectancy	
Age should be higher / 60 too low	14
Life expectancy is important but should not be a key commitment	3
Emphasis should be on 'healthier life' not 'longer life'	2
Reduce inequality in life expectancy for those who suffer with long term illness/disability	1
Commitment: Smoking	
Smoking should not be a priority / not as important	9
Query of inclusion of vaping / vaping prevalence	7
Target too unrealistic / difficult to stop people	6
Target should be strengthened	4
Education / support needed to reduce smoking	3
How will this be measured / evidenced?	2
Commitment: Suicide	
Suicide target should be less / zero / more ambitious	10
How will suicide be reduced, especially with no mental health services?	7
Suicide is complex / specific / not just health related (cannot be reduced by ICP alone)	6
Other, including: - Suicide rate is important - Treatment of disabled has increased suicide rates	4
Funding / resource	
Doubt there will be funding / will need funding to achieve	8
More resources needed to reach the goals, including staffing	7
Not right to take investment from best performing for the most deprived	2
Other	
Other comment	29

**Identified as a discrete theme, due to the number of respondents who referenced this specifically*

3.5.1 Feedback from ICP members

The following summarises the feedback received specifically by ICP members about the commitments.

Table: Do you think we got these commitments right? (N=14)

	Yes	No	Not sure	No response
	No.	No.	No.	No.
Reduce the gap in healthy life expectancy	11		3	
Reduce smoking prevalence	13		1	
Reduce the inequality in life expectancy	13		1	
Reduce the suicide rate	11	1	2	

Table: Please share any thoughts on these key commitments (N=4)

Key points
• Fully support • Are these targets all achievable and practical? Is the plan to increase life expectancy in every Local Authority area or increase the ICS average? • How will this be achieved? • What about prevention and rehabilitation services? • Investment needed – both from a time and effort perspective, and financial • Importance of having the right leaders in place, with similar views and visions for the future.

3.6 The ICP draft strategy

Respondents were given the opportunity to add any further comments about the strategy.

There was a feeling amongst some that the strategy is challenging, ambitious and on the right track.

"Sounds ambitious hope it works"

"Difficult journey ahead, but definitely on the right track to improve all aspects of your vision"

Furthermore, some identified specific benefits that the strategy will bring / aspects that they were satisfied to see included within the report:

- Good emphasis on specific elements e.g., mental health, learning disabilities and parity of esteem.
- Organisations coming together / opportunity to strengthen how statutory services work in partnership with VCSE organisations in the delivery of community-based approaches.
- Opportunity to work with people / communities to promote and empower them to be active participants in their care.
- Alignment of primary and secondary care.
- Opportunity to share best practice and lessons learnt.

In contrast, more negative comments and/or suggestions as to what they would like to see incorporated into / changed within the document, included:

- Missing focus area / wider area to consider - see Section 2.7 for more detail.
- Improved accessibility of the document i.e., a shorter, easy-to-read document with less jargon and acronyms.
- More tangible information about how the vision / goals will be measured and achieved.
- Greater co-production / integration of the patient and public voice. *(This is presented as a discrete category from 'missing focus area / wider areas to consider', due to the number of respondents who referred to this specifically)*.
- Under representation of CYP / too greater focus on adults with the section on Children's Services feeling too brief with vague commitments. Additionally, the omission of Looked After Children was noted. *(This is presented as a discrete category from 'missing focus area / wider areas to consider', due to the number of respondents who referred to this specifically)*.
- Lack of reference of how to plan / involve / resource the VCSE sector.
- Frustration that these issues have continually failed to be addressed with fear that their will be no change and/or the strategy duplicates that of Health and Wellbeing Board plans.

Specific comments included:

"I am concerned that due to the language used within the strategy and reading age around the accessibility and whether there is a true emphasis on the underserved"

"Again, the omission of PPI is a huge worry as it needs to be a key element of policy, strategy and development".

"Ambitious and challenging but with the right motivations. Patient and public voices need to be loud and listened to promote and support aims of integrated care".

"This mentions nothing at all about how you plan to involve and resource the voluntary and community sector. You have an obligation to involve the VCS but there is a history - in Northumberland at least - that any involvement and resource to the VCS is token at best. Your commitment to this needs to be spelt out".

Table: Please share any other thoughts you have on the ICP draft strategy document (N=167)

Positive comments	No. of responses
Strategy on the right track / challenging and ambitious	15
Specific benefit of the strategy identified	5
Negative / neutral / other comments	
Missing focus area / wider areas to consider 2.7	42
Accessibility of the document must be considered	27
Limited tangible information about how this will be achieved, measured and/or evidenced	19
Lack of co-production / patient and public involvement; including engagement at the strategy development level	18
Under representation of CYP / too greater focus on adults	14
No mention of how to plan / involve / resource the VCSE sector	11
Issues have continually failed to be addressed / fear no change	9
Challenges of providing equitable access to care across the ICP, for example: - Access to specialist / emergency care - Access for rural areas (particularly Allerdale & Copeland) - Levelling between diseases	7
Query / concern regarding structure, size and leadership of the ICB, including: - Confusion as to why ICS / ICB / ICP all need separate strategies - Concern the ICP is too large / unmanageable - Query about representation of the ICP / ICB - Lack of acknowledgement of ICP leadership - Purpose of sub-regional ICPs (not felt to be an enabler for place-based solutions)	5
Consider technology / access for older people / living in rural areas	3
To be achieved funding is a must / consider a move over time to the new national fair shared funding formula	3
Strategy too ambitious	3

NHS must be recongised as the default provider of health / less private medicine	2
Strategy not ambitious enough (more integration required to deliver change / think about the future 40 years from now)	2
Data sharing needs to improve across the system	2
Other, including: - Consider differing needs / priorities of different communities - Consider approach to working in deprived communities - Strategy slightly skewed to secondary care - No mention of inclusion health groups - Some services require significant overhaul to even approach the 18-week constitutional commitment - Greater honesty needed about the current issues being faced (e.g., workforce shortage, cost of living crisis) - No mention of Health and Wellbeing Boards - Communication is paramount (sharing visions across NENC).	27

Those who responded on behalf of an ICP member or on behalf of an organisation, were asked whether they felt the strategy fits well with the priorities of their organisation, of their geographical place and the work streams across the ICP.

There was greatest agreement the strategy fits well with the priorities of their organisation (62%), compared to priorities of work streams across the ICP (52%).

Table: Do you think the draft strategy fits well with…?* (N=92)

	Yes	No	Not sure	No response
	% (N)	% (N)	% (N)	% (N)
The priorities of your organisation	62% (57)	11% (10)	20% (18)	8% (7)
The priorities of your geographical place	59% (54)	8% (7)	24% (22)	10% (9)
The priorities of work streams across the ICP	52% (48)	4% (4)	36% (33)	8% (7)

**Completed by those responding as an ICP member or on behalf of an organisation only.*

3.6.1 Feedback from ICP members

The following summarises the feedback received specifically by ICP members in relation to the overall draft strategy.

Table: Please share any other thoughts you have on the ICP draft strategy document (N=8)

Key points

General comments
 	
• Very health focussed.
• Which documents have these statistics been taken from and where is the corresponding evidence?
• Concern about the development of the strategy and ICP domination.
• Strategy lacks detail, too general and uses too much jargon / system language.
• Strategy seems focussed on extending life-expectancy as opposed to creating a more joined-up approach between health, education, and voluntary services, to support an improved quality of life and overall patient experience.
 	
Achieving the vision
 	
• What is going to be done differently this time to achieve this?
• Concern about the implementation of the strategy in terms of whether the outcomes are achievable, or as to whether a March 2023 deadline for putting together joint financial and estates plans is practical, particularly if local authorities are to be part of this process.
 	
Workforce
 	
• The significance of how important the workforce is, is not strong enough. Key to everything the ICP delivers is having the right workforce in place. There are gaps in workforce that potentially cannot be solved in the short term which is a risk to patient care and to the health and wellbeing of staff.
• Need to work across the systems to improve the recruitment workforce crisis and ensure the longevity of the NHS i.e., looking at alternative career pathways (post-16).
• No connection about anchor institutions to the workforce and the opportunities this brings.
 	
Children and Young People (CYP)
 	
• Section on CYP is too brief with vague commitments.
• No mention of one of the most disadvantaged cohorts - Looked After Children (LAC).
• Lack of reference to:
  ○ Special Educational Needs and Disabilities (SEND).
  ○ Impact of the pandemic on childhood obesity.
  ○ The long-term impact investment in Early Years can have.

- Children's Social Care.
- Auditing the sub-contracting of services and lack of joined-up approach between 0-5 services, Local Authorities and the NHS.
- The Department for Education's initiatives around Early Years.

ICP leadership and representation

- No mention of leadership – details needed to provide assurance that it is being led by competent people with the correct values.
- Board must have adequate representation of CYP (at least 25%).

Other comments

- Lack of reference to:
  - Prevention and rehabilitation services.
  - Outcomes referenced in the long-term plan.
  - Maintaining NENC's major trauma centres, cancer and organ transplantation centres.
  - Estates maintenance / suggestions to maintain and improve NHS facilities.
  - The importance of social prescribers.
  - The importance of high-quality speech and language output.
  - Action research or working with local authorities to improve therapies.

- Engagement initiatives and better communication paramount to ensuring consistency in the vision across the whole of the ICP region.

Table: Do you think the draft strategy fits well with…? (N=14)

	Yes	No	Not sure	No response
	No.	No.	No.	No.
The priorities of your organisation	7	3	4	
The priorities of your geographical place	9	2	3	
The priorities of work streams across the ICP	7	2	5	

3.7 Missing focus areas / wider areas to consider

This section summarises the areas that were thought to be absent from the strategy and/or require more focus.

- Public education and prevention
    - Health literacy
    - Educating and informing patients (i.e., self-care)
    - Encouraging healthy living in the 50+ age range
    - Prevention for long-term health improvement.

- Access to services
    - Improved access to services (including GPs and dentists) / more services
    - Supporting, maintaining, and encouraging growth of primary care
    - Reduced waiting times
    - Better emergency care provision/access to same day emergency care (SDEC)
    - Support for those with learning disability to access services.

- Public and Patient Involvement (PPI)
    - Voice integral to promote and support the aims of integrated care, particularly around personalised care
    - Connect to the self-care agenda
    - Required at all levels, not just after decisions have been made
    - Need to work with VCSE sector / work with local organisations.

- Children & young people (CYP)
    - Maternity care - improving care for families within infants under 1 year of age, in the antenatal and postnatal period, including sudden unexpected death in
    - Early intervention – giving children a better start / intervention from birth (i.e., Best Start in Life / 1001 days)
    - Mental health (including suicide and self-harm) and access to mental health services
    - Smoking / vaping
    - Consideration of Looked After Children (LAC) and those with care experience, and young carers
    - Supporting CYP with SEND in a preventative way (in and through schools)
    - Support for CYP transitioning from children's to adult's services
    - Central role of health services in:
        - Delivering Best Start in Life / first 1001 days
        - Safeguarding children
        - Preventing escalation of mental health issues.

- Health inequalities
    - Providing equal access to help close gaps
    - Reaching those who need it most / underserved population
    - Reducing poverty levels.

- Mental health;
    - Addressing the burgeoning mental health issues within society
    - Better access to mental health services for all e.g., those with disabilities, autism, neurodivergence and veterans, including crisis support
    - Reducing waiting times for counselling
    - Dementia.

- Healthy living / lifestyles – food / diet / nutrition / physical activity
    - Targets for obesity
    - Changing attitudes / lifestyles
    - Importance of access to good, nutritious, and sustainable food
    - Food system change.

- Palliative and End-of-Life (EoL) care
    - Dying is a condition the entire population face
    - Strategy for a good death
    - Including patients with life limiting illness.

- Loneliness and social isolation
    - Consider impact on wellbeing and quality of life
    - Particularly for older people.

- Support for carers
    - Support / better outcomes for unpaid caregivers
    - Particularly those supporting people with dementia – a growing, challenging group.

- Elderly care / health of older people
    - Elderly care in the community
    - Enhanced Health in Care Homes programme.

- Other, including:
    - Wider determinants i.e., education, housing, employment
    - Drug and alcohol misuse / related deaths
    - Social care provision / improving access to social care
    - Cost of living crisis
    - Emergency planning
    - Violence Against Women and Girls (VAWG)
    - Multi-morbidities
    - Anticipatory care
    - Advanced care planning
    - Cancer diagnosis / outcomes
    - Care for disabled
    - Chronic pain.

4 Additional responses

Forty-five additional responses were received from representatives from the NHS, council, VCSOs, partner organisations, members of the public, and other stakeholders.

The submissions varied greatly in terms of content, with some being very specific about certain aspects / sections of the report, and others making more general comments. To reflect this, views have been presented as follows:

- General comments
- Comments made in relation to specific sections of the strategy.

As with the survey feedback, comments made specifically about the wording / language of the strategy were taken out and presented separately to the ICP Board.

4.1 General comments

Some responses contained positive comments about the strategy, with it perceived to provide challenge and aim high, as well as being much welcomed and 'feeling different'. Furthermore, specific aspects included within the strategy were welcomed i.e., the inclusion of unpaid carers, the recognition of the VCSE sector as assets, and the focus on parity of esteem and health inequalities.

"The goals, vision, plans and commitments are strong and ambitious"

Support was further expressed by several organisations / Boards who felt the strategy aligned with their aims and objectives.

In contrast, various comments / suggestions were made about the draft, and ways it could be strengthened.

Improving accessibility of the strategy

There was a feeling that the strategy reads too much like an NHS document, aimed towards people in the healthcare sector. It is suggested that the document is made much more accessible / applicable by addressing the language / terminology used and distilling parts of the strategy into enabling strategies (e.g., detail on CORE20PLUS5).

"Is there a plan to have an easy-read / multi language / braille / audio version of the final strategy"

Furthermore, it was recommended that including more references to NENC's unique strengths, as well as its legitimate shortcomings, would help to make it feel more like a strategy for NENC, as opposed to one that could represent any deprived region in England.

Role of the ICP / breadth of the strategy

Query was raised by some as to the authority / remit / mandate of the ICP, and further the breadth and scope of the strategy.

For example, one response felt the document reads like a strategy for the ICB setting out its operational targets, including statements which could be interpreted that the ICP will deliver some of the proposals.

"For example, in Section 2.1 it states …we will develop fuller plans under each of these areas to demonstrate how we will deliver our commitments… The ICP is not a delivery body"

Furthermore, it was questioned as to whether the focus of the strategy should be broader than health, so it is more like a Health and Wellbeing Board strategy for the whole of the ICS, just without the mandated authority of Health and Wellbeing Boards at place level.

Detail within the strategy

There was a strong feeling that the strategy lacks specific detail as to how the vision will be achieved, including partnership working and decision making, as well as concerns that the 'high level' nature of the report makes it difficult for partners to apply it at a local level. There was query as to what is the local flexibility for implementing the strategy as well as the join-up between the regional strategy, sub-regional working, and place-based working and how this will lead to change on the ground.

"The strategy refers to equal partnership between local authority and health but there is no detail on how this will be achieved"

Additional information / further detail was requested including an accountability framework, a roadmap with milestones and concrete deliverables, a monitoring structure, and identification of what policies / interventions are required at scale.

"Clearer about responsibilities delegated to place, including budget responsibilities, and how places can best interface with the ICB as a key delivery vehicle"

Providing this detail was felt to be particularly important, particularly as the timescales to achieve these ambitions were perceived by some to be very ambitious, and further to support stakeholders to see where they might take some ownership in it. It was additionally suggested that including examples of where breakthroughs have been achieved, would help to provide a more optimistic outlook.

"The document is very clear on what the areas of concern are and has the data to back it all up but doesn't clearly explain how they are going to be tackled"

"The audience and communications strategy needs to be carefully considered so that everyone within the ICB understands how they can contribute and why, from individuals to organisations"

Evidencing data used to develop the commitments / targets was felt integral by some, who questioned the credibleness of such and whether these can be achieved.

"Some commitments don't feel credible – can we be clearer about the data, assumptions and construct of such in order to demonstrate how they are credible and achievable?"

"An ask to reconsider targets to ensure they are realistic and deliverable i.e., on health life expectancy"

Furthermore, there were concerns that the strategy fails to adequately address the problems that now confront today's society, including the health and social care system. It was therefore suggested that within the strategy, that there is stronger acknowledgement of the challenges that the NENC population are facing, including the harmful effects and predicted longevity of the current cost of living crisis.

"Do we need to say early on that we recognise our population is experiencing some of the most significant challenges of anywhere in country – poverty, unemployment etc."

Development of the strategy and enthusiasm of organisations / Boards / Federations

There was great enthusiasm among responding organisations / Boards / Federations in supporting the ICP in the next stages of the development of the strategy, as well as its delivery.

"We are ready to participate in both designing and delivering new ways of working and we are absolutely committed to addressing the inequalities of health rightly emphasised in the draft strategy"

Responses highlighted the value their input would have for the ICP in terms of better understanding needs / priorities / research and engagement undertaken / work being undertaken, as well as improving alignment with existing strategies.

Many of these organisations noted how their involvement (as well as that of the VCSE sector / organisations, communities, patients and members of the public) at an earlier stage of the development of this strategy, would have been more beneficial. The 'tight' deadlines for the development of the strategy were perceived to have prevented sufficient engagement and co-production opportunities.

"Incorporating the VCSE voice at an earlier stage would have really helped to have strengthened the sector's feel that they are 'an equal partner within the system instead of an afterthought', which has historically been the case"

"It is crucial that the Board are sighted on and involved in its development to reflect place-based issues, need and assets and understand how it interacts with the Joint Health and Wellbeing Strategy and partners organisational strategies"

Embedding communication, engagement, and involvement

In line with the above, there was a strong feeling that the strategy lacks commitment / focus on communication, engagement, and involvement - specifically listening to, and embedding, the voice of patients, members of the public, communities, businesses and VCSE partners / organisations.

It was therefore suggested that a more person-centric view should sit at the heart of the vision, with patient / public engagement being considered as an additional enabling programme.

"Involving patients and communities in the design and delivery of care, is essential if healthcare is to become more responsive, personalised, valued and efficient"

It is anticipated that embedding engagement / involvement would help the vision to be achieved, whilst providing assurance that the ten principles of engagement have not been forgotten.

Further details on specific sections where it is felt engagement / involvement should be incorporated is provided in Section 4.2.

"A significant contributor to making such comprehensive and lasting progress rests with applying meaningful communication and engagement across the whole public spectrum"

"Limited reference to actual patient / service user involvement except for 8.3.1 – developing inclusive frameworks and approaches for involving service users and staff in identifying and articulating system wide unmet needs".

"We would strongly advocate that where possible; development of the Integrated Care Partnership Strategy involves residents, communities and businesses in actions and decisions that will affect them so they can be part of the support and feel that we are doing with, and not doing to, them and that we are listening to them about what success looks like".

Recognition and value of the VCSE sector

Whilst references to working with the VCSE sector were welcomed, there was a feeling amongst some that there could be greater emphasis on the role of VCSE organisations as key partners within the ICS, at both system and place level. More specifically, the opportunities that this would bring were highlighted:

- To share intelligence and experience to inform priorities and commissioning.
- To work with statutory partners and local people to co-design innovative service delivery models unlocking the huge potential that exists in local communities.

It was noted how having greater focus on the involvement and value of the VCSE sector would provide benefit in terms of meeting some of the targets.

More detail as how this partnership working can be achieved, was requested.

Wider determinants / prevention

Acknowledging the lack of progress in tackling health inequalities over the years, it was felt strongly that a greater emphasis is needed on prevention and the wider determinants of health and wellbeing. Changes to healthcare alone, were stressed to not be enough to achieve the ambitions set out within the strategy.

Where reference is made to health inequalities, it was felt that tangible commitments need to be incorporated, as well as consideration of an additional enabling programme - 'importance of prevention and early intervention in increasing life expectancy or to free up capacity for health and care services to become excellent' (i.e., "stop avoidable illness and intervene early").

"The public health and equality message is absolutely to the fore of your strategy but none of it is new and none of it reflects the relative lack of progress in recent years – if anything the system failures are making inequalities worse whilst also making access to care depressingly difficult for everyone"

To see the wider determinants of health considered early and up front would feel like this was more than a traditional NHS strategy"

In terms of health inequalities, it was acknowledged how some areas have much more work to do than others, and how this requires disproportionate effort and resources in those areas (this was felt to be needed to be recongised in terms of financing, governance, and performance).

Under-representation of Children and Young People (CYP)

There was very strong feeling that there is too little focus on CYP, with it felt that the strategy primarily focuses on adults. It was repeatedly emphasised that a commitment needs to made to CYP, and this included upfront within the document in the guiding strategic commitments.

Areas felt to be particularly important included 'best start in life' in terms of securing better health and wellbeing outcomes throughout the life course, and mental health and emotional wellbeing.

"A broader focus on children in terms of prevention would be advantageous in the development of the strategy and its subsequent action plans. There doesn't appear to be a focus for tackling children's health and in particular the advantages that can be accrues through focusing on giving children the best start in life".

Furthermore, it was thought that the section on children's services needs to better reflect the needs of all CYP living within the region. Further detail on this is provided in Section 4.2.

Missing focus area / wider areas to consider

- Palliative and End-of-Life (EoL) care, including for children and young adults.
- Disease prevention, including some targeted strategies to reduce some of the high disease prevalence in the region.
- Substance misuse; acknowledging the region's highest rate of drug misuse deaths in 2021 and for the last 9 years.
- Health literacy; with a suggested focus on accessibility agendas.
- Neurology; specifically defining a care pathway.
- Paediatric acute inpatient services; with NENC noted to have the lowest number of paediatric acute inpatient beds nationally
- Addressing waste within the system
- Transport and transport links; highlighted to have a significant impact on local people and their ability to access services and community support.
- Commitment to equality, diversity, and inclusion
- Commitment that the ICS will maintain a comprehensive health service, free at the point of need, accessible to anyone residing in the area, including homeless people and migrants.

4.2 Comments made in relation to specific sections of the strategy

Section 1.2 – Our Integrated Partnership

- Suggested commitment that NHS providers are the default providers of health services, care and treatment; and that as contracts with private sector companies come up for renewal the default position is that they be awarded to NHS providers.
- Suggested commitment that if any contracts do continue to be awarded to the private sector, there must be vigorous scrutiny to ensure that this is conducted in a transparent and accountable manner.
- Suggested inclusion of the meaning 'co-production'.

Section 2.1 – Summary Vision, Goals and Enabling Programmes

- Concern that the diagram does not make it clear which boxes are vision, goals or enabling programmes.
- Suggested inclusion of CYP to make the vision / commitments more balanced up front.

Section 2.2 – Guiding Strategic Commitments

Our Vision

- Feeling that it is not compelling enough.
- Feeling that 'fairer and better' are not fully reflected in the bullet points.
- Suggestion to articulate what the added value is of the ICP.
- Suggested inclusion of reference to reducing health inequalities.
- Suggested commitment to 'ensure that no one in our population is overlooked or left behind' / 'we take accountability to adapt the way that we work and deliver services to meet the needs of local people and communities'.

Goals (general)

- How will these be differentiated from place-based strategies?

Goal (Longer, healthier life expectancy)

- Feeling that the 25% target for healthy life expectancy is not ambitious enough.
- Suggested that the commitment to 'reducing the mortality gap for people with a Learning Disability, Autism or on the SMI register' should be included here.
- Goal means nothing to North Cumbria, where the average is already higher than the target proposed – a more granular approach is suggested.

Goal (Fairer health outcomes)

- Feeling that the commitment to reducing the suicide rate is too ambitious – important for ICS to seek assurance that its partners are fully committed to radical action on this, and that those partners understand that the majority of people who take their lives are not in contact with mental health services.
- Query as to whether the focus on suicide prevention is appropriate in this context, and whether focus needs to be on other health conditions that affect many more people and are significant contributors to ill health.
- If suicide target essential – consider drug related deaths and deaths related to alcohol within the measure.

Goal (Excellent health and care services)

- Acknowledgement needed that current structures may contribute to widening the inequality gap.
- Suggested greater emphasis on the need for health and care services to integrate and collaborate to deliver these services.
- Scope to strengthen this by referencing healthcare inequalities around access to services, health literacy etc and how this forms part of overall work to reduce the health inequalities gap.
- Suggestion to make it explicit that this includes social care.

Enablers:

- Suggested wording change:
    - '…diverse health and care workforce'
    - '…decisions made as close to communities as possible'

Section 3 – Our Strengths and Assets to Build on

- No mention of Academic Health Science Network, or references to mental health / autism / learning disability.
- Suggested inclusion of a description of regional infrastructure and assets.
- Suggested reference to the comprehensive range of important, and supportive, community partners whose pro-active partnership work would undoubtedly contribute towards health and care improvements.

Section 4.2 – Life Expectancy and Healthy Life Expectancy

- No mention of mental health, alcohol or obesity – key drivers of poor health and inequalities.
- Suggested revision of the associated targets to reflect the increasingly difficult financial context.
- Need to consider the differences in the prevalence of mental illness, learning disabilities and autism between NENC and England as a whole, and any research into what is driving higher levels of prevalence.

Section 5.2 – Our Key Commitments

- Feeling that the commitments are a mix of themes, principles, and actions.
- No mention of vaping, which is massively rising within the younger population.
- Absence of emphasis on substance misuse, mental health and wellbeing, alcohol and those with multiple and complex needs.

Section 5.3.2 – Anchor Institutions

- Consideration of schools / colleges as such, given their 'rooting in communities'.
- Detail required in terms of the ICP's expectations of organisations as anchor institutions to support direction setting.

Section 5.3.3 - Community Centred and Asset Based Approaches

- Uncertainty as to the effectiveness of asset-based approaches.
- Suggested inclusion of the meaning 'asset based approaches'

Section 5.3.4 – Prevention and Health Promotion and **Section 5.3.5 – Embedding Prevention Across Health and Care Services**

- Suggested inclusion of Making Every Contact Count (MECC) and Better Health at Work Award (BHAWA) - as a driver / facilitator framework for the wider Public Health workforce.

Section 6 - Fairer Health Outcomes

- Concern that the map (page 12) only highlights rural areas in the worst quintile.
- With regards to the commitment relating to suicide rate – noted that this does not specifically address the underlying issues which contribute to suicide rates, including alcohol and substance misuse, suicides linked to multiple and complex needs etc.
- Suggestion that the important role of local government in suicide prevention could be made more explicit.
- Suggested inclusion of a commitment to meaningful communication and engagement with the identified groups.

Section 6.3 – Core20PLUS5

- Concern about the inherent drawbacks of the Core20PLUS5 model in terms of addressing health inequalities.
- No mention of smoking, despite smoking now being included as a sixth consideration.
- Absence of care leavers in the 'PLUS' population.
- Suggested inclusion of 'maternity care' (including perinatal mental health services) as part of Core20PLUS5.
- Suggested reference to the CYP's National Framework for Core20PLUS5.

Section 7 – Excellent Health and Care Services

- Perception that this section has been written in isolation from previous chapters and not fully driven by the priorities in earlier chapters.

Section 7.1 – Introduction to Health and Care Services in the NENC

- Concern raised about the 'range of independent sector organisations', many of which are private businesses.
- Good to recognise the range of organisations working in Adult Social Care as well as the roles of the at-scale GP Federations / Alliances.
- Suggested greater clarity around the VCSE organisations working directly with the NHS to provide services that support medical, social and wellbeing outcomes to further demonstrate the historic partnership working between sectors.

Section 7.3 – Quality and Assurance and Improvement

- Questioned whether this should be a function of the ICP, or instead sit with the ICB where there are already quality structures.
- Lack of reference to patient outcomes or experience (patient safety mentioned only briefly) - suggested inclusion of an eighth principle focusing on engagement.
- Suggested amend from BAME (which is no longer considered appropriate) to Black and Minoritised Communities (with no acronyms).

Section 7.4 – Sustainability

- Questioned whether this should be a function of the ICP.

Section 7.5 – Parity of Esteem and Integration of Mental and Physical Health Services

- Highlights the absence of mental health in the earlier parts of the document.
- Concern about public understanding of the term 'parity of esteem'.

Section 7.6 – Personalising Health and Care

- Section highlights the absence of service user and carer engagement, involvement, and co-production earlier in the document.

Section 7.7 – Supporting Carers

- Concern that there is an implication of greater reliance on unpaid carers.
- Feeling that the section lacks detail as to how, and what will be achieved - the reasons why previous strategies have continually failed to improve support for unpaid carers were felt to be 'shining out' of the draft strategy.

Section 7.8 – Better Integration and Co-ordination of Care

- Concern there is too much focus on the Fuller Report – danger of disengaging partners.
- Query as to whether VCSE sector will be involved in the planning of the neighbourhood teams, as well as being included as part of them, due to their integral role in cohesive neighbourhood working.
- Felt surprising that local voluntary groups and Patient Participation Groups (PPGs) aren't included in the list of teams responsible for 'improving the health and wellbeing of a local community'.
- Suggested inclusion of community mental health transformation in the context of integrated neighbourhood teams.
- Suggested inclusion around the importance of the 'subsidiarity' principle – with NENC being geographically the largest and 2nd most populous ICS in England.

Section 7.9 – Provider Collaboration

- Uncertainty as to whether the Foundation Trust Provider Collaborative will include Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust given its proposed focus.

Section 7.11 – Key Issues for Health and Social Care Service Sectors

- The omission of North East Ambulance Service (NEAS) was questioned - given its significant staffing concerns and the below target ambulance response times.

Section 7.11.1 – Primary Care and Community Services

- Suggested reference to the Deep End Network of GP surgeries.
- Opportunity to include (as a minimum) – pathways of care, workforce, premises, diagnostics, transport, care home, digital connectivity, and digital use.
- Evident gaps – virtual wards and prescribed medicines.

Section 7.11.2 – Children's Services

- Suggested inclusion of a commitment focusing on CYP, within the strategic guiding commitments.
- Suggested inclusion of a commitment to the Best Start in Life Agenda – identifying and meeting need at the earliest point.
- Feeling that the section does not:
    - represent the majority of CYP living within the region (i.e., focusing on those with complex needs only)
    - reflect the significance of the challenges faced by almost all agencies when dealing with CYP with complex presentations.
    - recognise the role of families in supporting the wellbeing of CYP.
- Feeling that the aims / priorities need to demonstrate alignment with feedback from CYP about what is important to them.
- CYP would like more detailed information as well as financial commitment.
- Noted omission of;
    - Maternity and neo-natal services
    - Children's social care
    - Safeguarding
    - Mental health, and access to mental health services
    - Looked After Children (LAC) and those with care experience
    - Transition from children to adult services.
    - Education and learning (key determinant of health and wellbeing).

Section 7.11.3 – Adult Social Care (ASC)

- Feeling that this should not be addressed by the ICP.
- Need to fully encompass the specific challenges relating to securing sustainable social care.
- Feeling the section provides a limited overview of ASC – ASC has a much broader scope and range of responsibilities.
- No mention of parity of esteem between NHS services and social care – despite this being a joint strategy.

Section 7.11.4 – Urgent and Emergency Care

- Concern was raised about Cramlington Emergency Care Hospital not being physically accessible to many people across the North East.
- Consideration felt to be needed in terms of the 'redesign of the provision of urgent and emergency care' with alignment to the North West Regional footprint.
- Suggested commitment to ensuring that anyone who needs emergency or urgent services while present in the ICSs geographical footprint will receive the necessary treatment, whether or not they are registered with, or permanently reside within, the ICS area (considering the needs of homeless people, refugees, and asylum-seekers).
- Suggested commitment to ensure that before a patient is discharged from hospital, that it is safe to do so and that any unpaid carers expected to look after the patient are both willing and capable to do so, and that the operation of the discharge policy will be audited.

Section 7.11.7 – Mental Health

- Access to care in relation to mental health services was felt to be as bad as other acute care needs.
- Reassurance was felt to be needed that mental health services will be provided locally.
- Feeling that the commitments are too specific and do not adequately reflect the narrative provided in the preceding paragraphs.
- Suggested commitment to CYP (an issue routinely cited by CYP as important to them) - specifically, in relation to early intervention and prevention alongside strategies to address how young people with complex mental health needs can be best supported within local communities, including the design and development of new approaches for those young people with the most complex needs.
- Lack of suggestion that the specialist Mental Health Collaborative could expand to include the full range of mental health services.
- Section refers to a different target for health checks, than Section 6.
- Suggested inclusion of I-Thrive model.

Section 7.11.9 – Learning Disability and/or Autism

- Suggested rephrasing of the sentence on annual health checks to reflect the research that is ongoing in the region about the autism check (there is no annual health check for autistic people with no learning disability).
- Suggested inclusion of a commitment to improving outcomes, experiences, and safety of inpatient provision for people who require admission to assessment and treatment wards.
- Consideration to be given the detail / delivery of the commitment to increasing the number of children with learning disabilities living at home, in terms of cost and impact of such strategies.

Section 8 – Enabling Strategies

- Lack of reference to engagement with the wider community, despite this being referred to in the third visionary statement / suggestion to add community engagement as an enabler.
- Feeling that the targets are unachievable (i.e., Collective Estates plan, Five Year ICP Financial Plan).
- Suggested consideration of the different financial, legislative and regulatory regimes that partners operate under.

Section 8.1 - A Skilled, Compassionate and Sufficient Workforce

- Felt the section lacks a level of ambition around system workforce challenges.
- Suggested inclusion of a reference to the benefits that the ICP brings in terms of being able to do things at scale.
- Clarity needed as to whether this includes the local authority social care workforce as well as the NHS.
- Suggested commitment / focus to tackle the workforce issues currently experienced in health and social care, specifically:
    - Creating and promoting opportunities for local people by offering good employment and reducing barriers to get into health and social care careers.
    - Exploring the role of willing universities within the ICP.
    - To follow nationally agreed pay, terms and conditions (including pensions) as negotiated with the NHS staff unions (applicable to all staff employed by any NHS provider within the ICS area).
    - To work alongside NHS staff unions, particularly following safe staffing levels and understanding what is needed to ensure they can be implemented.
    - To ensuring social workers, especially care workers, are put onto the correct pay scale.

Section 8.2 – Working Together to Strengthen our Neighbourhoods and Places

- Suggested commitment to ensure that all meeting of ICBs, ICP bodies, place-based bodies, committees, and sub-committees will be held in public - papers must be available in advance and observers – from the public, trade unions, patients' groups – must be allowed to ask questions and be entitled to written answers to those questions.
- Query as to how the new arrangements being developed through community mental health transformation will link to non-mental health community services.

Section 8.3.1 – Research and Innovation

- The Research and Innovation Steering Group, which will operate across the ICP level will develop a shared research and innovation plan by March 2023. The group will be inclusive,, diverse and representative of the ICP community. This steering group will provide strategic leadership to key priorities including:
    - knowledge management systems to support decision makers, researchers and innovators, and the services which could benefit from adopting research and innovation.
    - incentives to support idea development and the testing of small-scale innovation.
    - communication systems to support learning from the adoption of research and innovation.
    - leadership and accountability to foster implementation science.
    - increasing accessibility and opportunity to participate in research and innovation opportunities across the region as a way to help tackle inequality.
    - closer working relationship with health determinant research infrastructures.

Section 8.3.2 – Digital

- Consideration needed of the potential exclusion of thousands of patients and the consequent risk of increasing health inequalities.
- Concern that the increase in digital services may lead to a reduction in the quality of assessments and treatment.
- Suggestion to incorporate a fifth theme for the illustrative graphic 'support / advise / help those people in society who are digitally disadvantaged'.
- The Good Things Foundation and Positive Transformation Group were put forth as organisations that can support the levelling up of digital awareness and capability.
- Suggestion to develop a new ICS Digital Strategy during 2023, which would go live in 2024 – to ensure it better reflects the merging priorities of the ICS/ICP.

Section 8.4.1 – Finance and Resources

- Importance of guarding against cuts and lobbying for funding.
- Suggestion that the ICS should challenge the current funding formula and show there is a clear justification of why per head funding should be higher here than in the Southeast.

Section 8.4.2 – Protecting Our Environment

- Suggestion of greater emphasis on the geographical challenges for an ICS with many sparsely populated rural areas, and a commitment to try to influence regulators to give more weight to these issues and to support service reconfigurations that have zero carbon benefits.
- Contradiction in intention to commit the ICS to being net zero by 2030 (declaring a climate emergency) and the stated key commitment to be net zero by 2040.

Section 8.5.3 – Our Estates

- Lack of reference to the need to increase physical accessibility and have a presence in local communities.
- Suggestion that a higher-quality estates plan might emerge if more time was taken to consider the implications of the NENC Strategy and to ascertain what the settled post-covid service delivery and working patterns are likely to be.

Section 9 – Communication and Involvement

- Felt important that the ICS communications team implement a modern communication approach going froward.

Section 9.1 – Collaborative Design

- Feeling that a more comprehensive approach could have been used to develop the draft strategy (i.e., co-production with CYP, community / partner organisations, and members of the public).
- Lack of reference to those organisations which represent the views of patients or community groups - suggestion to map out / recognise personal community assets as both local and regional contributors i.e., people represented by voluntary activity; pre-existing and potential networks; trusted institutions such as schools and community centres.

Section 10 – Delivering the Strategy

- Concern about how the results of the survey will be interpreted.
- Query as to whether the feedback received during this engagement process will be made available to members of the public, as well as whether individual submissions will be responded to directly and taken into account.
- Query / challenge as the degree to which communities / VCSE networks will be involved – suggestion to utilise a dashboard to measure and report progress on the whole communication and engagement agenda.
- The intended interaction between ‘place and the ICB must be considered and articulated.

Section 10.1 – Data and Intelligence

- Feeling that more emphasis should be on the collection of assurance data from NSHE neighbourhoods / places / systems rather than from individual providers.
- Importance of developing infrastructure and capacity supporting data flows, and information systems that can talk to each other, between partner organisations – to ensure a strong foundation for population health management work.

Section 10.2 – North East and North Cumbria Learning and Improvement Collaborative

- Agreement that this could be useful, as long as it is focussed holistically on population health and is genuinely cross sector and cross ICS.
- Concern about the duplication with the mutual learning element of the proposed Provider Collaboratives for Foundation Trusts and Primary Care.

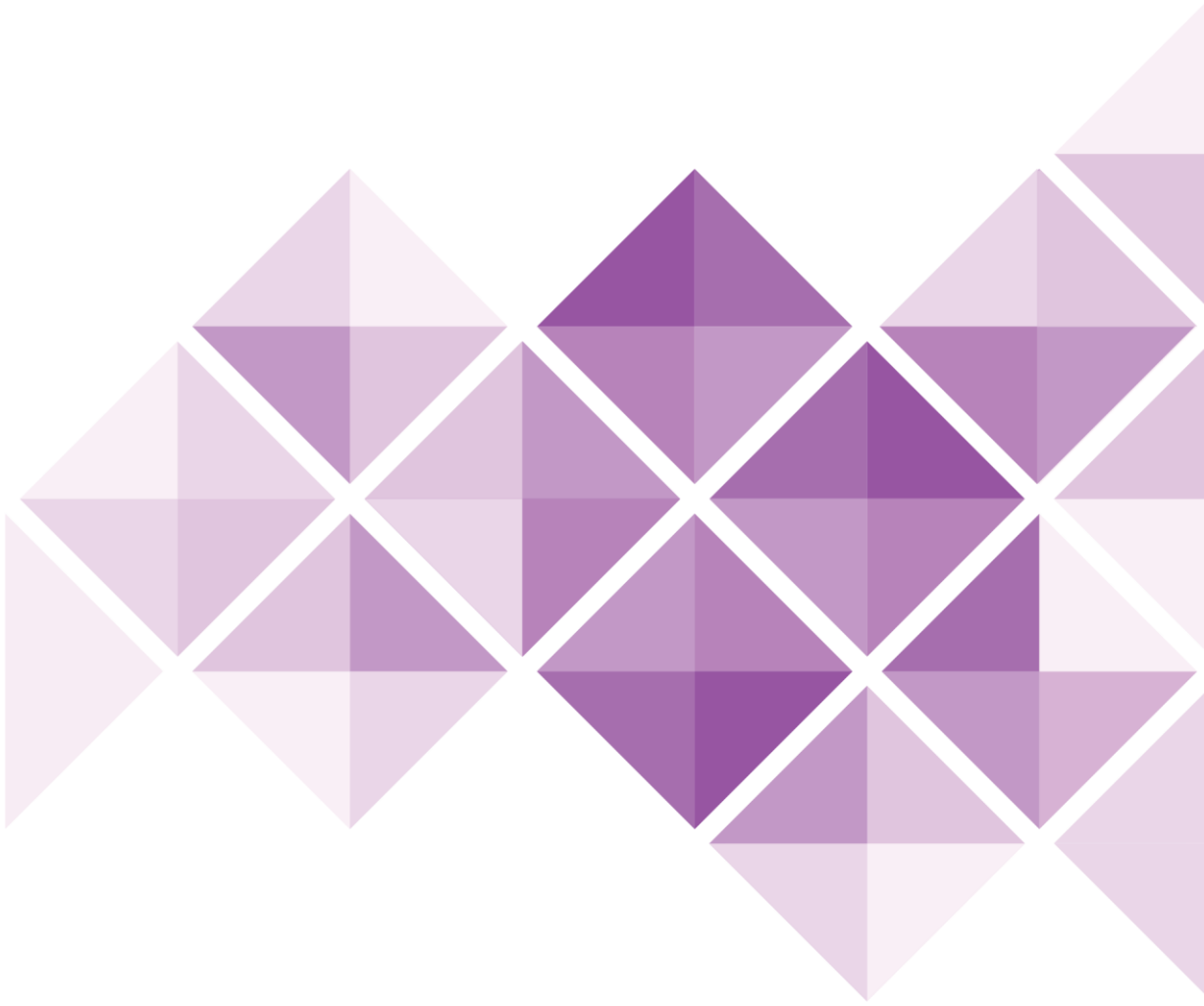
Section 10.3 – Partnership Structures

- Suggested clarity with regards to who is the 'Provide Collaborative'.
- Suggested inclusion of NENC VCSE Partnership Programme as a partnership structure.
- Strong feeling that the ICS should not include private sector representatives on any ICS boards or committees or any bodies with delegated powers from the ICB.
- Suggested inclusion of two commitments:
  - The ICP must include representatives from Mental Health, Community Health, Maternity, Primacy Care and Public Health, as well as from Acute services.
  - ICBs, ICP body, place-based bodies, committees and sub-committees will include representatives of patients' groups and of NHS staff trade unions.

- Suggested governance approach whereby the system is governed through proportionate rather than traditional means of performance management, quality, and risk assurance etc.) in a way that reflects the priorities we commit to (i.e., including data on health inequalities).

Section 10.4 – Implementation and Delivery Plans and Measuring Progress

- Suggestion that the relevant 'tier' of the ICB present their annual commissioning intentions and annual report, in the same way that CCGs were required to do the same to Health and Wellbeing Boards.
- Concern about the risk of the ICB developing a myriad of over-detailed plans which could unintentionally demotivate people at Place / in providers and curtail innovation.
- Noted that the dashboard must include mental health measures, and that there must be understanding of which measures will lead / lag due to the likely delay between intervention and changes in outcome common to many public health related measures.



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NHS
North East and North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

North East and North Cumbria Strategic ICP 15 December 2022	
Report Title:	**Proposed Terms of Reference for the Strategic ICP and Area ICPs**

Purpose of report

To propose Terms of Reference, membership, and ways of working for the Strategic ICP and Area ICPs.

Key points

The proposed Terms of Reference and membership build on both national guidance and feedback from multi-sectorial engagement via the four Area ICPs on preserving our existing partnerships and ways of working.

Risks and issues

None identified

Assurances

N/A

Recommendation/Action Required

These must match the recommendations in the paper itself, use bullet points if there is more than one recommendation.

Sponsor/approving director	Claire Riley, ICB Executive Director of Corporate Governance, Communications and Involvement
Report author	Dan Jackson, Director of Policy, Public Affairs and Stakeholder Affairs

Link to ICB corporate aims (please tick all that apply)

CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓

CA3: Enhance productivity and value for money						
CA4: Help the NHS support broader social and economic development						✓
Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	It was agreed at the Strategic ICP meeting in September 2022 that the ICB would provide a secretariat to support the Strategic ICP and Area ICPs
Has there been/does there need to be appropriate clinical involvement?	This is reflected in the membership of the Strategic ICP and Area ICPs
Has there been/does there need to be any patient and public involvement?	This is reflected in the membership of the Strategic ICP and Area ICPs through the involvement of Healthwatch.
Has there been/does there need to be partner and/or other stakeholder engagement?	These TOR were developed following extensive stakeholder engagement.

Appendix 1

North East and North Cumbria Integrated Care Partnerships Terms of Reference

North East and North Cumbria Integrated Care Partnership (ICP)

Terms of Reference and Membership for the Strategic ICP and Area ICPs

Background

1. The North East and North Cumbria Integrated Care Partnership (herein referred to as the Strategic ICP) is a joint committee established by the North East and North Cumbria Integrated Care Board and the soon to be fourteen upper tier local authorities in the North East and North Cumbria as equal partners:

2. The local authorities of the North East and North Cumbria ICP are:
   - County Durham
   - Cumberland
   - Darlington
   - Gateshead
   - Hartlepool
   - Middlesbrough
   - Newcastle upon Tyne
   - North Tyneside
   - Northumberland
   - Redcar and Cleveland
   - South Tyneside
   - Stockton-on-Tees
   - Sunderland
   - Westmorland and Furness

3. Together, the North East and North Cumbria Integrated Care Board (ICB) and the North East and North Cumbria Integrated Care Partnership (Strategic ICP) forms the new statutory North East and North Cumbria Integrated Care System (ICS).

4. While acknowledging the diversity of organisations and partners in our integrated care system there are a number of responsibilities placed on the ICB and local authorities as statutory co-owners and equal partners to formally engage with stakeholders and establish an effective and broad-based ICP. These requirements have guided the establishment of an inclusive ICP for the North East and North Cumbria that builds on existing partnership structures to galvanise the partnership behind some common aims and set the culture of the system that we all work in.

Purpose

5. The Strategic ICP will facilitate joint action to improve health and care outcomes and work together to influence the wider determinants of health as well as the broader social and economic development of the North East and North Cumbria

6. Our ICP will create the space for partners to develop joint strategies that better serve local populations, based on population health management approaches. They will enable partners to plan for the future and develop strategies for using available resources creatively to address the longer-term challenges which cannot be addressed by a single sector or organisation alone.

7. National guidance states that ICPs will highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to:
   - helping people live more independent, healthier lives for longer
   - taking a holistic view of people's interactions with services across the system and the different pathways within it
   - addressing inequalities in health and wellbeing outcomes, experiences and access to health services
   - improving the wider social determinants that drive these inequalities, including employment, housing, education, environment, and reducing offending
   - improving the life chances and health outcomes of babies, children and young people
   - improving people's overall wellbeing and preventing ill-health

8. In meeting these challenges, the Strategic ICP has a specific responsibility for developing the **North East and North Cumbria Integrated Care Strategy** for the whole population. This strategy will build on the Joint Local Health and Wellbeing Strategies from all of the Health and Wellbeing Boards in our ICS area, use the best available evidence and data, covering health and social care (both children's and adult's social care), and seek to address the wider determinants of health and wellbeing. The strategy will be built bottom-up from local assessments of needs and assets and the strategy will be focused on improving health and care outcomes, reducing inequalities, ensuring inclusion, and addressing the consequences of the pandemic for our communities.

9. While the Strategic ICP has no formal delegated powers from its constituent organisations, it will provide leadership, oversight, and support for system-wide activities, playing a key role in ensuring joint accountability to our population. The Strategic ICP will also continue to evolve in the way it works in response to the changing priorities of the partnership.

Responsibilities of the Strategic ICP

10. The Strategic ICP's responsibilities are to:
    - Develop and approve an Integrated Care Strategy for the population of North East and North Cumbria – which the ICB and local authorities will be required by law to have regard to the ICP's strategy when making decisions, and commissioning and delivering services.
    - Ensure the Integrated Care Strategy:
      - is focused on reducing health inequalities
      - uses the best available evidence and information
      - takes account of local challenges, assets and resources
      - expands the range of organisations and partners involved in strategy development and delivery,
      - is underpinned by insights gained from our communities,
      - benefits from strong clinical and professional input and advice.
      - Focuses on those issues where ICP partners need to take joint action in relation to managing collective issues and challenges
    - Design and oversee a joint accountability framework to ensure the delivery of the Integrated Care Strategy.

11. In addition to these responsibilities, the Strategic ICP will:
    - Consider recommendations from partners and reach agreement on priority work programmes and workstreams that would benefit from a cross-partnership approach
    - Commission specific advice from established groups, including but not limited to the multi-agency Healthier and Fairer Advisory Group, to obtain subject matter expertise, in setting the direction of the Strategic ICP.
    - Provide active support to the development of four Area ICPs across the North East and North Cumbria, enabling local partnership arrangements, engagement and co-production, bringing together Local Authorities, voluntary and community groups, and other key partners.
    - Facilitate and support cross-area working and sharing of best practice where this would benefit the population or provide efficiencies in our approach.
    - Ensure that the ICP has a greater focus on population health improvement, integration of health and care services around the needs of residents, and a focus on care provided in primary and community settings.

12. For the avoidance of doubt, it is not a function of the Strategic ICP to duplicate the statutory functions of its constituent organisations. The Strategic ICP will not perform a health scrutiny function and will itself be subject to scrutiny by the Health Scrutiny Committees as appropriate of the fourteen local authorities in the ICS area.

Membership

13. The statutory membership of the Strategic ICP will comprise the Chair and Chief Executive of the Integrated Care Board and an elected member and senior officer from each of the fourteen local authorities. Subject to the agreement of the Strategic ICP, an additional initial range of members will be as set out in Appendix 1.

14. In addition to the membership outlined in Appendix 1, the Strategic ICP may appoint such additional persons as it sees fit, either as co-opted voting members or as observers who shall be entitled to participate in discussion at its meetings but shall not be entitled to vote.

15. At the discretion of the Chair, additional ICB directors and other representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

Deputies

16. If a member is unable to attend a meeting of the Strategic ICP, they will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and understanding of the issues to be considered to represent their organisation effectively. Deputies will be eligible to vote if required. The Chair of the Strategic ICP must be informed in advance of the relevant meeting of the identity of a substitute

Chairing

17. Until a substantive chair of the ICP is appointed in 2023, meetings will be convened and chaired by the chair of the ICB on an interim basis.

Frequency of Strategic ICP Meetings

18. The Strategic ICP will meet at least biannually to instigate and then sign off the Integrated Care Strategy development process. As a formal joint committee of the ICB and the local authorities the Strategic ICP will be required to meet in public, and its meetings will be recorded and made available on the ICB website.

Operating Model and Area ICPs

19. Whilst there is a legislative basis for Integrated Care Partnerships, and extensive national guidance on the formation of Integrated Care Systems, there is, in addition, considerable flexibility for the Integrated Care Partnership's members to determine its operating model.

20. Therefore, the statutory members of the ICP have agreed a "one plus four" model, with one Strategic ICP (with a core membership of the ICB and all the local authorities in the ICS) which will be built up from the four existing and well-established partnership forums within North East and North Cumbria. These are based on geographical groupings that created valuable forums to think through how we better coordinate care and create new opportunities for wider access to services. NHS chairs and local authority leaders, as well as their chief executives and senior officers, have already been meeting together informally in this way for several years, building the relationships and trust that are helping to deliver increasing levels of integration and joint planning.

21. Therefore, our Area ICPs will be based on these existing geographies within our ICS:
    - **North**: Gateshead, Newcastle upon Tyne, North Tyneside, and Northumberland.
    - **Central**: County Durham, South Tyneside, and Sunderland.
    - **Tees Valley**: Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland, and Stockton-on-Tees.
    - **North Cumbria**: Cumberland, and Westmorland & Furness (given part of the latter authority is within the North East and North Cumbria ICS area). It was agreed to establish this as a separate Area ICP given the unique challenges of geographical isolation and service fragility within North Cumbria, and their need to collaborate on these challenges with the neighbouring ICP for Lancashire and South Cumbria, as well as its neighbours to the east.

Complimentary role of the Strategic ICP and Area ICPs

22. The Strategic ICP will:
    - oversee and approve the ICS-wide Integrated Care Strategy, built up from an analysis of need from the four Area ICPs led by the Joint Strategy Development Group.
    - promote a multi-agency approach to improving population health and wellbeing and tackling the wider social and economic determinants of health for our population of over 3 million people
    - consider and suggest ways forward to tackle health inequalities, and improve experiences and access to health services at this same population level
    - champion initiatives involving the contribution of the NHS and wider health and care organisations to large scale social and economic development

23. The Area ICPs will:
    - Develop and strengthen relationships between professional, clinical, political and community leaders
    - Analyse needs from each of the constituent places within that Area (based on the HWBB-led Joint Strategic Needs Assessment process) to feed into the Integrated Care Strategy setting process
    - Agree how to deliver the priorities set out in the Integrated Care Strategy within their Area
    - Provide a regular forum for system partners to share intelligence, identify common challenges, agree joint objectives and share learning
    - Ensure the evolving needs of their local population are well understood

24. The membership of the Area ICPs will be diverse and drawn from a range of organisations as set out in Appendix 2 – including the Integrated Care Board, local

authorities, foundation trusts, primary care networks, the voluntary sector and HealthWatch, and other partners.

Chairing of Area ICPs

25. This will be for local determination between Area ICP partners, but typically this will be undertaken by a non-executive chair, such as the chair of a local Health and Wellbeing Board.

Relationship of ICPs to place through Health and Wellbeing Boards

26. In recognition of the importance of place, Department of Health Social Care guidance issued on 22 November 2022 recognises the important ongoing role of Health and Wellbeing Boards (HWBs), and expects as a minimum that all partners – the HWBs, ICBs and ICPs – will adopt a set of principles in developing relationships, including:
    - building from the bottom up
    - following the principles of subsidiarity
    - having clear governance, with clarity at all times on which statutory duties are being discharged
    - ensuring that leadership is collaborative
    - avoiding duplication of existing governance mechanisms
    - being led by a focus on population health and health inequalities

27. ICP need to have regard for and build on the work of HWBs to maximise the value of place-based collaboration and integration, and reduce the risk of duplication. They should ensure that action at system-wide level adds value to the action at place level, and they are all aligned in understanding what is best for their population.

28. ICB and ICP strategies and priorities should not detract from or undermine the local collaboration at place level. In an effective health and care system the ICP should build upon the existing work by HWBs and any place-based partnerships to integrate services. Working together at system level is helpful for issues that benefit from being tackled at scale.

29. HWBs will remain legally distinct from Integrated Care Partnerships but the latter's strategic priorities should be informed by local population health data as expressed through Joint Strategic Needs Assessments, and Joint Local Health and Wellbeing Strategies (JLHWS). The JLHWS sets out the vision, priorities and action agreed by the HWB to meet the needs identified within the JSNA and to improve the health, care and wellbeing of local communities and reduce health inequalities. The JLHWS is for the footprint of the local authority (with children's and adult social care and public health responsibilities).

30. HWBs will need to consider the integrated care strategies when preparing their own strategy (JLHWS) to ensure that they are complementary. Conversely, HWBs should be active participants in the development of the integrated care strategy as this may also be useful for HWBs to consider in their development of their strategy. When the HWB receives an integrated care strategy from the ICP, it does not need to refresh JLHWS if it considers that the existing JLHWS is sufficient

31. The integrated care strategy should build on and complement JLHWSs, identifying where needs could be better addressed at the system level. It should also bring learning from across the system to drive improvement and innovation. Our Area ICPs will

therefore facilitate opportunities to share innovation and expertise in how to deliver integrated approaches in the context of local circumstances – but they should not seek to overrule or replace existing place-based plans.

Frequency of Area ICP Meetings

32. Meetings of the Area ICP will be held be held on a quarterly basis as a minimum. As these are not formal joint committees of public bodies their meetings are not required to be made public, but Area ICPs can hold meetings in public if they wish, and their minutes will be published on the ICB website.

Reporting arrangements

33. Area ICPs will provide regular updates to the Strategic ICP via the minutes from each meeting. These minutes will be agreed by the Chair and circulated to representatives for approval and ratification (with the exception of any elements of any minutes need to be redacted due to conflicts of interest or withheld for reasons of commercial or personnel confidentiality).

Administrative Support

34. The ICB's Corporate Governance, Communications and Involvement team will provide a secretariat to the Strategic and Area ICPs to ensure the effective administration of the partnership, including the publication of meeting details on the ICB's website and the recording of meetings. The agenda and papers for meetings of the Strategic ICP and Area ICPs will be distributed no less than five working days in advance of the meeting unless agreed with the chair.

Conflicts of Interest

35. It is imperative that members ensure complete transparency in any discussions and/or subsequent recommendations by declaring any interests, both actual and/or perceived. The matter must always be resolved in favour of the public interest rather than the individual member or related organisation.

36. Members of the ICP are responsible for declaring any conflicts of interest in relation to the agenda items of the Partnership's meetings. Where any representative has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair shall use their discretion to decide, having regard to the nature of the potential or actual conflict of interest, whether or not that representative may participate in that part, or any other parts of the meeting, in which the relevant matter is discussed. Each representative must abide by all policies of the organisation he/she represents in relation to conflicts of interest.

Conduct of the ICPs

37. Each representative and those in attendance at ICP meetings will abide by the 'Principles of Public Life' and the NHS Code of Conduct, and the Standards for members of NHS boards and governing bodies, Principles of the Citizen's Charter and the Code of Practice on Access to Government Information together with all other applicable guidance, statutory guidance and/or requirements applying from time to time.

Date of review

38. The Partnership will review its own effectiveness, membership and terms of reference annually, however an initial review will take place after a period of six months following its establishment. Recommendations for amendment of the terms of reference will be submitted to the Board for approval.

Approved by the members of the Strategic ICP:
December 2022

Appendix 1:

Strategic ICP Membership

Members from statutory partner organisations:

Integrated Care Board
- Chair: Professor Sir Liam Donaldson
- Chief Executive: Samantha Allen

County Durham
- Cllr Chris Hood, Lead Member for Adults Services
- Jane Robinson, Corporate Director, Adult and Health Services

Cumbria (interim position pending the council reorganisation in 2023)
- Cllr Martin Harris, Lead Member for Adults (Cumberland)
- Cllr Patricia Bell, Lead Member (Westmorland & Furness)
- Colin Cox, Director of Public Health

Darlington
- Cllr Kevin Nicholson, Cabinet Member for Health & Housing
- James Stroyan, Group Director of People

Gateshead
- Cllr Lynne Caffrey, Chair of the Health and Wellbeing Board
- Alice Wiseman, Director of Public Health

Hartlepool
- Cllr Shane Moore, Leader of the Council
- Craig Blundred, Director of Public Health

Middlesbrough
- Cllr David Coupe, Chair of the Health and Wellbeing Board
- Erik Scollay, Director of Adults Services

Newcastle upon Tyne
- Cllr Karen Kilgour, Deputy Leader of the Council
- Matt Wilton, Assistant Chief Executive

North Tyneside
- Cllr Karen Clark, Chair of the Health and Wellbeing Board and the Cabinet Member for Public Health
- Wendy Burke, Director of Public Health

Northumberland
- Cllr Wendy Pattison, lead member for Adult Wellbeing
- Liz Morgan, Director of Public Health

Redcar & Cleveland
- Mary Lanigan, Leader of the Council
- Patrick Rice, Corporate Director Adults and Communities

South Tyneside
- Cllr Anne Hetherington, Lead Member for adults, health and independence
- Tom Hall, Director of Public Health

Stockton-on-Tees
- Cllr Bob Cook, Leader of the Council & Chair of the Health and Wellbeing Board
- Ann Workman, Director Adults & Health Services

Sunderland
- Cllr Kelly Chequer, Healthy City Portfolio Holder
- Gerry Taylor, Director of Public Health

Members from non-statutory partner organisations:

ICS VCSE Partnership
- Jane Hartley, Social Prescribing and Health Partnerships Strategic Manager (and ICB Participant)
- Lisa Taylor, Health and Wellbeing Programme Director

ICS HealthWatch Network
- Christopher Akers-Belcher, Chief Executive, Healthwatch Hartlepool

Housing Sector
- Tracy Harrison, Chief Executive of the Northern Housing Consortium
- Chris Smith, Chief Executive of Thirteen Housing Group

Social Care Provider Sector
- (Member TBC)

Regional Hospice Network
- (Member TBC)

University Sector
- (Member TBC)

Police and Fire & Rescue Services
- (Members TBC)

At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

Appendix 2:

Area ICP Membership
This will be for local determination, but it is expected that each Area ICP will have members drawn from the following organisations and sectors:

- **NHS North East and North Cumbria Integrated Care Board**
- **Foundation Trusts (Acute, Mental Health and Ambulance)**
- **Local Authorities (e.g., Health and Wellbeing Board Chairs and Directors of Adult's Services, Children's Services & Public Health)**
- **Primary Care Networks**
- **Healthwatch**
- **Housing Sector**
- **Police and Fire & Rescue Services**
- **University and Education sector**
- **VCSE providers and local infrastructure organisations**