Better health and wellbeing for all...

NHS
North East and North Cumbria

Clinical Conditions Strategic Plan

2025 – 2030

Our ambitions...

We have ambitious plans to help people in the North East and North Cumbria live longer and healthier lives. From lower life expectancy to some of England's highest rates of child poverty, our Better health and wellbeing for all strategy highlights our region's health challenges and sets demanding goals to tackle them by 2030.

To make this happen, we need to focus on the areas where we can have the greatest impact. The Department of Health and Social Care's major conditions strategy highlights the six conditions which contribute most towards death and ill health. This has challenged us to think not just about how we meet people's health and care needs, but also about what causes the most ill health and early deaths in our region. With many people living for longer with multiple long-term conditions, the need for this work is greater than ever.

Our priority areas

This clinically-led strategic plan is based on a population health management approach. Using data and intelligence for a detailed understanding of the factors that affect people's health, we can focus our efforts on conditions where we can have the greatest impact.

Our long-term focus must be on prevention and addressing the wider determinants of health, like lifestyle, behaviour, housing, employment and the environment, to achieve the greatest impact.

We have set out 12 priority areas where we want to improve:

Adults:

- Lung cancer
- Cardiovascular health
- Respiratory health
- Lower back pain
- Anxiety and depression

Children:

- Diabetes
- Asthma
- Epilepsy
- Obesity
- Oral health
- Anxiety and mental health
- Autism and learning disabilities

Prevention is key

Prevention must be at the heart of everything we do. By making every contact count we can promote vital lifestyle changes while optimising clinical care. Individual patients are often managing more than one condition, so we need a holistic and person-centred approach. This shift towards preventing ill health can make the best possible use of our resources and achieve the greatest impact for our communities.

Proactive care – also known as anticipatory care – is focused on prevention rather than cure. It means working to improve health and wellbeing by increasing capacity and resilience in patients and the people who support their care.

Tackling inequalities and the wider determinants of health

Our lives are complex, and many factors affect our health and wellbeing throughout the course of everyone's life. Not everyone has the same opportunities to be healthy, often because of where they grow up, live or work.

Some groups in our communities are disproportionately impacted by poor health, so we need both a universal and a targeted approach to tackling these disparities. Using a life course approach across the health and care system, we can focus on initiatives that will have the greatest benefit for our people.

Looking after our staff

It's vitally important that we look after our greatest asset – the 170,000 people who work in health and care in the North East and North Cumbria.

Two of the most common causes of staff sickness – lower back pain, and anxiety and depression – are among the priority areas in this plan. We will build on this to develop a **WorkWell** programme, drawing on what we have learned through the clinical conditions strategic plan process.

Making it happen

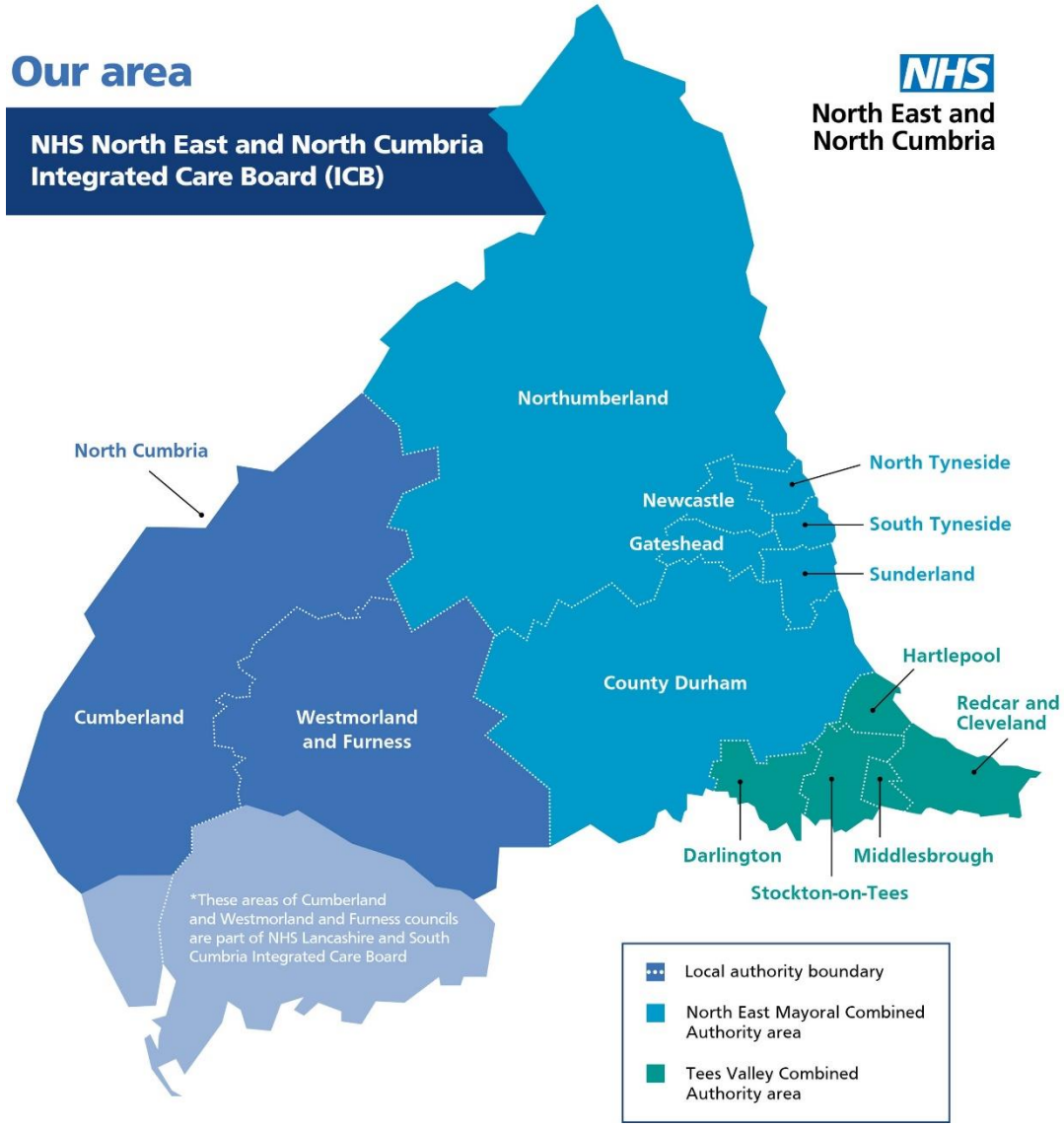
We are England's largest ICB, with a real opportunity to influence policy in areas like poverty, education and employment, using our data and clinical intelligence. As a system leader, we will ensure a continued effort towards achieving our shared ambition of Better Health and Wellbeing for All.

We will work closely with partners like local authorities and the voluntary sector to tackle broader issues impacting people's health, like poverty, housing, education and employment, as well as rural disparities. Our plan also links closely with other key strategies in areas like women's health, data and technology, and housing.

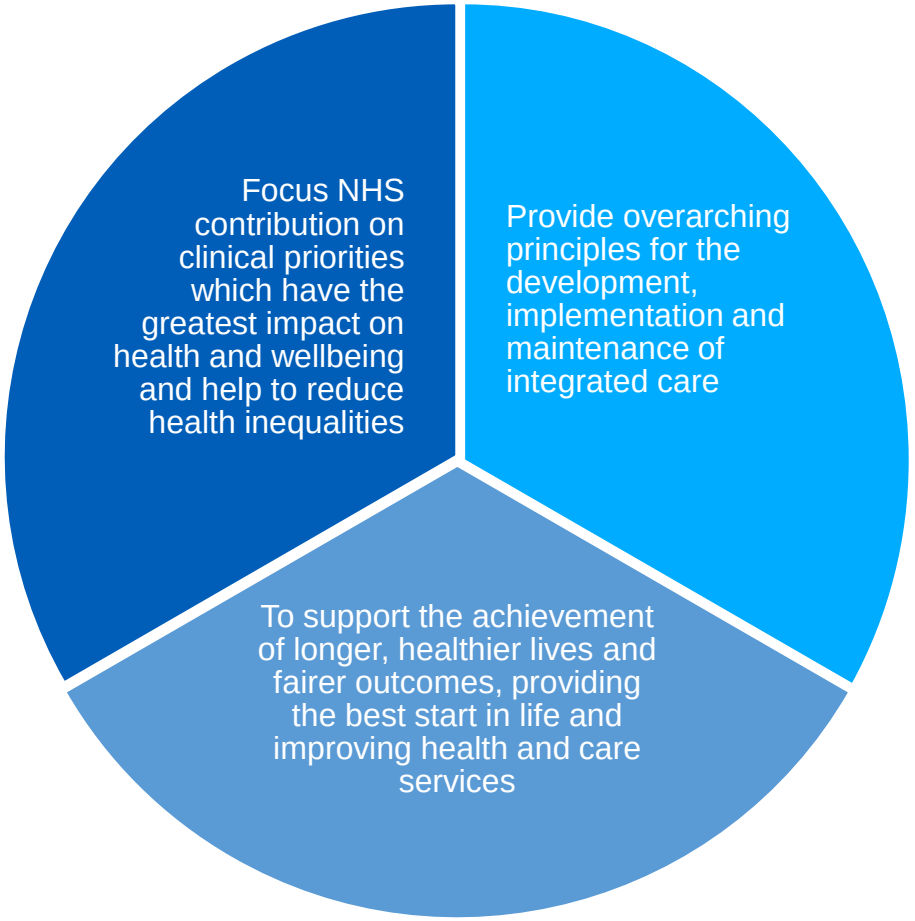
Our thanks go to the many people who have helped to develop this strategy. Taking a clinically led, data-enabled approach, we have been able to identify the best opportunities to improve population health outcomes and tackle health inequalities.

Working with our providers and listening to our patients, we can make a real difference to people's health in the North East and North Cumbria.

Dr Neil O'Brien, Chief Medical Officer
NHS North East and North Cumbria
Integrated Care Board



Our vision: using population health information to get the best outcomes from health services in North East and North Cumbria



- **We will shift** from a reactive hospital-based treatment model to proactive approaches of prevention and early intervention
- **We will address** unwarranted variation in clinical practice and improve inconsistent clinical pathways and outcomes
- **We will focus** on personalised prevention, promoting self-care and management
- **We will develop** new models of care in priority pathways which include continuity of care
- **We will address** healthcare inequalities in access, experience, and outcomes
- **We will improve** the care of people with single and multiple long-term conditions
- **We will promote** value-based healthcare and improve efficiency and value across the system
- **We will ensure** more action on upstream prevention of avoidable illness and its exacerbations
- **We will rapidly adopt** new technology and innovation to improve care

Why do we need a clinical conditions strategic plan?

Throughout our engagement with local clinical leaders, we have often been asked:
why do we need a clinical conditions strategic plan, what are we trying to achieve?

The challenge:

We know there are many challenges facing us as a local health and care system as populations shift, lifestyles change, healthcare become more specialist and innovation grows. Some of these challenges include:

- Wide health inequalities between people of different socio-economic groups and other inclusion groups
- Unwarranted variation in healthcare provision
- Fragmentation and services focused on specific disease pathways
- Lack of focus on prevention
- Demographic changes and multi-morbidity
- Need for care closer to home
- Need to scale up innovative and excellent practice across the region
- Need for sustainable longer-term decision making
- Need to take a population health approach, to understand population health needs and focus on the priorities that will maximise improvements in population health and wellbeing

The aim:

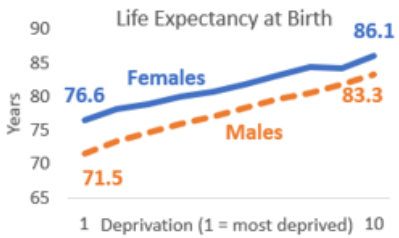
Through the development and implementation of our clinical conditions strategic plan, we aim to:

- Narrow the health inequality gap
- Reduce unwarranted variation and drive quality improvement in our services
- Deliver person-centred care, joining up pathways around people's needs
- Ensure prevention is built into our common narrative, our service delivery and our way of doing things
- Deliver care closer to home wherever possible, improving accessibility
- Ensure we create a learning environment, harnessing innovation and spreading best practice
- Ensure our investment is prioritised to areas of greatest need based on our findings
- See that our hard work and targeted investment ensures **Better Health and Wellbeing for All**

The scale of our population health challenge

Whole Population

Inequalities



Female **+9.5**
Male **+11.8**
Difference in Life Expectancy Between Most and Least Deprived Areas (Years)

20.8%
Gap in School Readiness Between Children Eligible And Not Eligible For Free School Meals

51% of children eligible for free school meals have not achieved a good level of school readiness

Most Prevalent Long Term Conditions (All Ages)

642,900 (21%) Have **Anxiety**

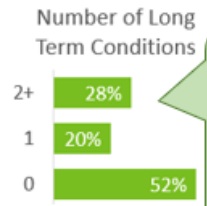
530,900 (17%) Have **Hypertension**

470,700 (15%) Have **Depression**

218,500 (7%) Have **Diabetes**

218,400 (7%) Have **Asthma**

Multi Morbidity



28% of People Live With 2 or More Long Term Conditions

Proportion of people with 2+ LTCs is **higher** in more deprived communities

Most Deprived **29%** Least Deprived **25%**

Risk Factors

16% Are Smokers (Where Smoking Status Recorded)

38% Are Obese (Where BMI Recorded)

19% Have Increased or High Alcohol Risk (Where Alcohol Status Recorded)

Children and Young People

Most Prevalent Long Term Conditions (Aged Under 18)

23,000 (4%) Have **Autism**

23,000 (4%) Have **Asthma**

14,200 (2%) Have **Anxiety**

2,900 (0.5%) Have **Learning Disabilities**

2,100 (0.4%) Have **Epilepsy**

1,600 (0.3%) Have **Diabetes**

Obesity

12% of Children in **Reception** Are Obese

25% of Children in **Year 6** Are Obese

(Highest Rate in England)

Year 6 obesity rates are **higher** in more deprived communities

Most Deprived **40%** Least Deprived **15%**

Mental Health

31 Deaths by **Suicide** Aged 7 to 18 in NENC 2018/19 to 2022/23

Adults (figures for all ages)

Lung Cancer

93.6 per 100k Incidence of **Lung Cancer** (England 71.0)

Incidence of Lung Cancer is **higher** in more deprived communities

Most Deprived **142.3** Least Deprived **51.8**

Respiratory

216,300 (9.5%) Have a **Respiratory Disease**

Back Pain

36,400 A&E Attendances For Back Pain In Last 2 Years

Of these:

37% have anxiety
31% have depression

60% of Adults Expected To Experience Back Pain During Lifetime (Nationally)

Anxiety and Depression (Age 18+)

Most Deprived **28%** Least Deprived **21%** Rates of **anxiety** are **higher** in more deprived communities

Most Deprived **23%** Least Deprived **14%** Rates of **depression** are **higher** in more deprived communities

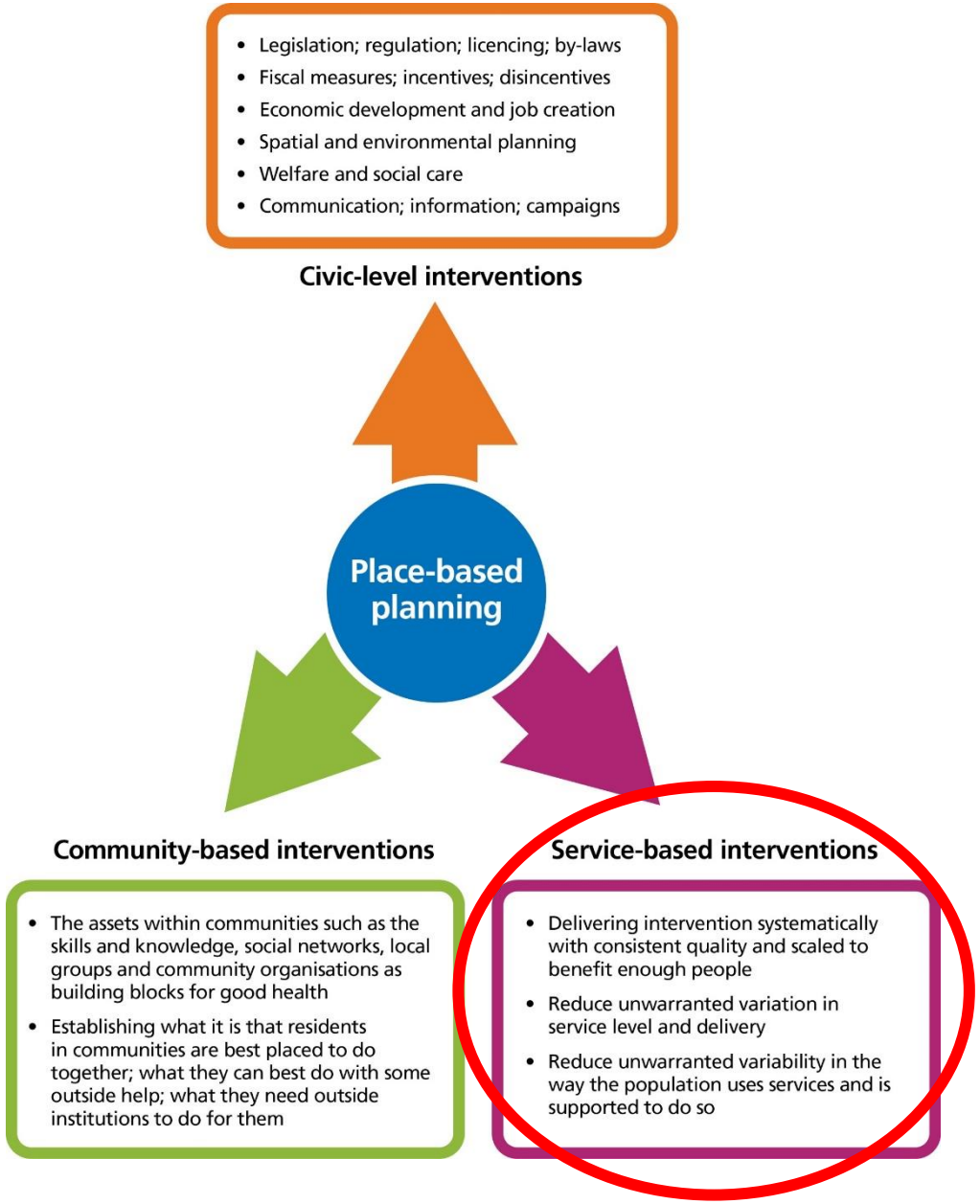
Cardiovascular

616,000 (20%) Have 3+ Risk Factors For Circulatory Disease

NHS contribution to improving population health outcomes

- Achieving improvements in population health outcomes requires system-wide partnership working in delivering civic, community and service-level interventions (Bentley, 2017)
- Across our ICS there are strategies and partnership forums taking forward the different interventions at neighbourhood, place and ICP levels
- This clinical conditions strategic plan is mainly focused on the contribution of healthcare services to improving population health outcomes and addressing healthcare inequalities
- It acknowledges and builds on the Better Health and Wellbeing For All strategy as well as other place-based and neighbourhood/area strategies aimed at improving population health outcomes
- The focus of this strategy is to identify the clinical priorities that will contribute to the ambition set out in our ICP strategy and to reduce healthcare inequalities in access, experience and outcomes for healthcare services

PHE Public Health Data Science based on the original concept created by Chris Bentley, 2017.



Principles for our clinical conditions strategic plan development

- Focus on **clinical services'** unique **contribution** to improving population health and tackling healthcare inequalities across the life course
- Ensuring integrated approaches with **seamless transition** between services for children and young people as well as adults as their needs change
- Ensuring a **balance between current pressures and preventing future needs** by building on the efforts to prevent ill health and the importance of maintaining momentum and investment in the Healthier and Fairer programme
- Impact of **multi-morbidity** (e.g. two or more long term conditions), **poly-pharmacy** (prescribing or taking too many medications) and the need to **avoid a single disease focus** (ensuring a person-centred approach)
- Partnership and system-wide working to tackle **inequalities,** addressing the social determinants of health and acknowledging the complex interaction of factors
- **Inclusion health** and ensuring a health equity approach supported by the Core 20Plus5 frameworks. Gaps in service areas to be levelled up across the region and **variation reduced**
- **Workforce development and training** across the clinical services to progress the priorities identified and improve the effectiveness of clinical services

Approach to developing the clinical conditions strategic plan

- The clinical conditions plan will not sit in isolation but is part of our broader system strategy and plans
- The clinical conditions plan is underpinned by what our local NHS can contribute to support the prevention agenda
- The clinical conditions plan provides a framework for service model development
- The clinical conditions plan provides a greater understanding of our people's needs through population health management
- Our prioritisation approach is evidence-based
- The development of the clinical conditions strategic plan is based on clinical and system engagement
- There is clear alignment with other national and regional policies such as the national major conditions strategy
- Our ICB is working in partnership with provider networks to ensure robust and sustainable services are developed and nurtured
- The clinical conditions plan will support our clinical community in understanding the impact they can have on ensuring the best start in life, healthier lives, fairer outcomes, and ultimately improving health and care services for the people of the North East and North Cumbria

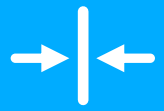
Process of developing the clinical conditions strategic plan

Population health management approach

Using data, intelligence, and outcomes from system clinical engagement to determine condition-specific priorities for development

Clinical curiosity

Presenting assumptions and challenging with clinical leaders from across the system (including clinical networks), based on local intelligence and lived experience



System alignment

Working in partnership with provider collaboratives, community assets and other stakeholders to ensure alignment of service plans to our clinical conditions strategic plan priorities

System implementation

Ensuring an integrated approach to delivery of ambition. Working with communities and the local health system to maximise NHS contribution to the clinical priorities identified

Clinical leadership, network and stakeholder engagement

Prioritisation framework for the clinical conditions strategic plan

Criteria and ranking – adult clinical priorities

Criteria	Weighting %
Premature mortality	**20**
Contributing to life expectancy gap	**20**
Morbidity - global burden of disease (GBD) study estimates	**25**
GBD risk factors	**10**
Highest number of people affected (prevalence)	**20**
Resource utilisation	**5**

- The steering group reviewed criteria and agreed % weighting for each one based on importance
- This was then used to score each health condition presented as part of a collated long list
- The scoring process was undertaken by individuals and then calibrated as a multi-professional group

Criteria and ranking – children and young people clinical priorities

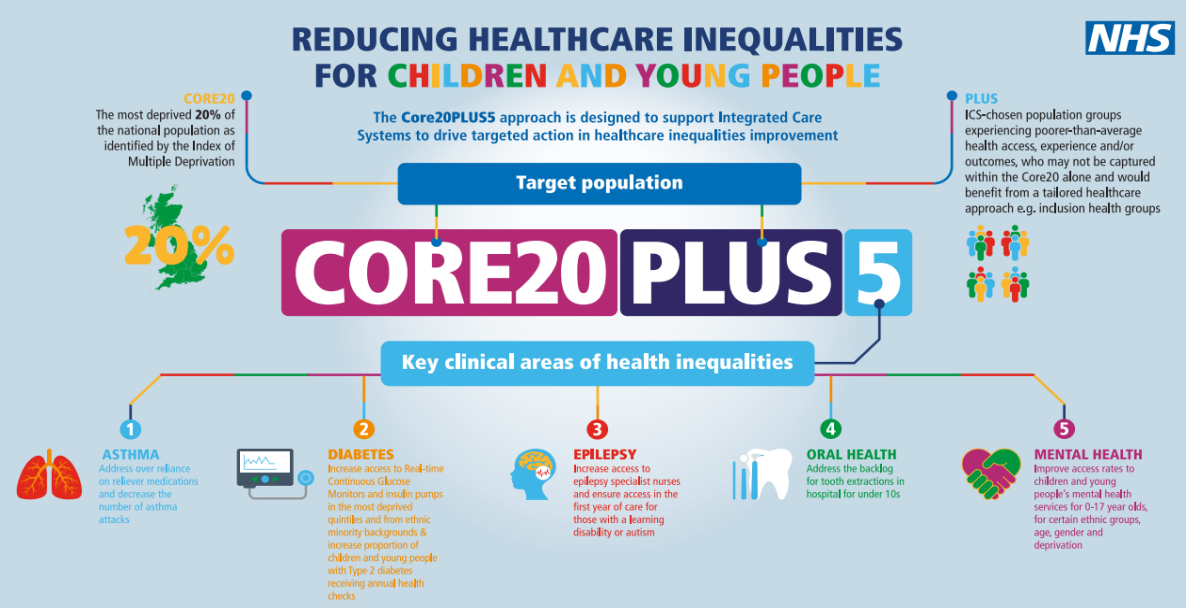
Criteria	Weighting %
Lifetime impact	**20**
Effectiveness of intervention	**10**
The scale of inequalities	**15**
Level of unwarranted variation in the management of conditions	**10**
Highest number of people affected (prevalence)	**20**
Impact of disability and quality of life	**20**
Resource utilisation	**5**

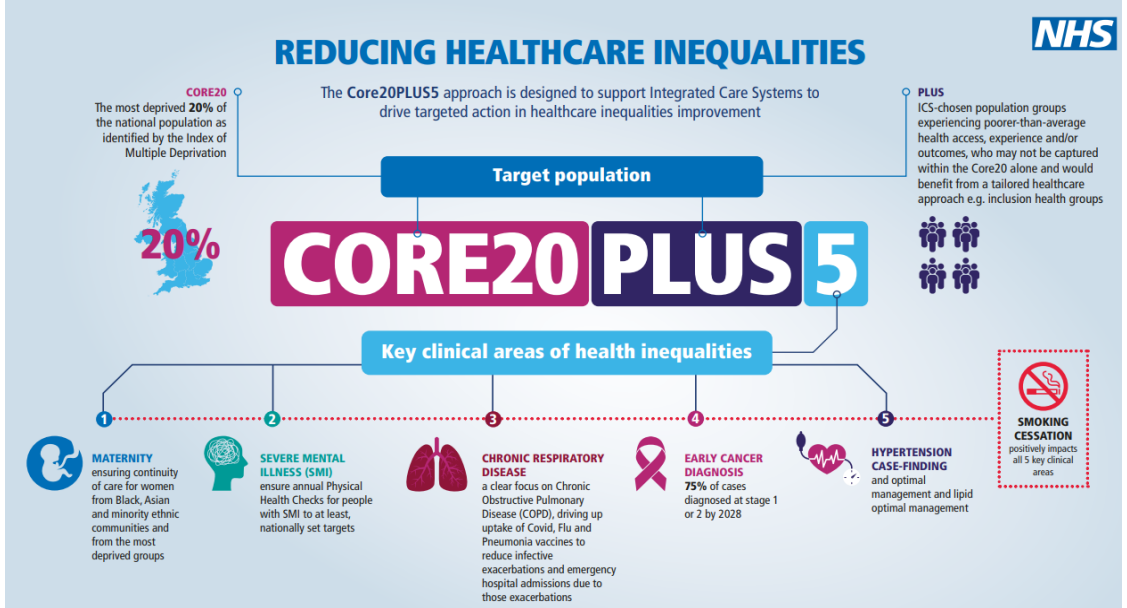
- The Child Health and Wellbeing Network reviewed criteria and ranked each one in terms of relevance
- The network facilitated a series of multi-disciplinary discussions to score the long list of health conditions
- The short list was then debated and signed off by the network as the priority areas for children and young people

Our links to wider strategy and considerations

- Several common themes emerged as part of the strategy development process
- Those in blue relate to an all-age focus; the red shapes relate specifically to considerations affecting children and young people
- We recognise that these are key enablers in the delivery of our ambition
- We will ensure, through implementation, that links are made with other strategies and work programmes

Core 20 PLUS 5 – going further





- Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level
- The **Core 20** element relates to the identification of the 20% most deprived within the national population
- The **PLUS** population groups include ethnic minority communities, inclusion health groups, those with a learning disability and protected characteristic groups

- There are **5** national priorities for children and young people and adults
- Our aim is to further understand our target population and identify the key clinical areas of health inequalities for the people of the North East and North Cumbria
- Using our own data-driven population health management approach, we have identified our condition-specific priorities

Our clinical priorities

Adults

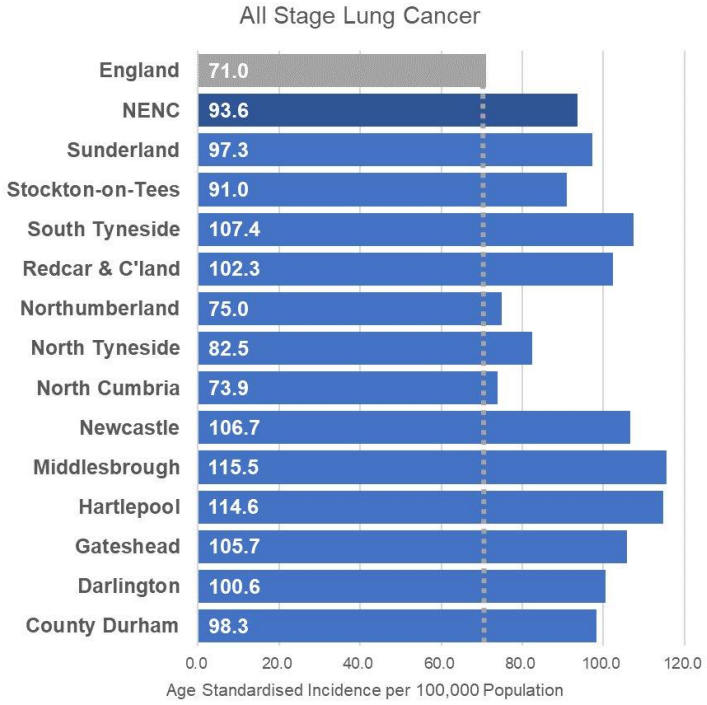
- Lung cancer
- Cardiovascular health
- Respiratory health
- Lower back pain
- Anxiety/depression

Children and young people

- Diabetes
- Asthma
- Epilepsy
- Obesity
- Oral health
- Anxiety and mental health
- Autism and learning disabilities

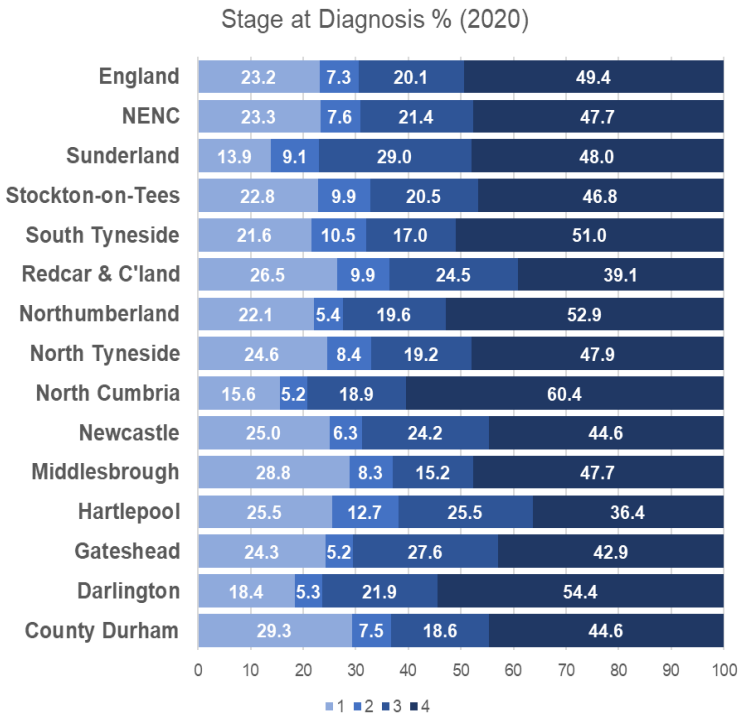
Our priorities for adults

Lung cancer – what the data tells us…



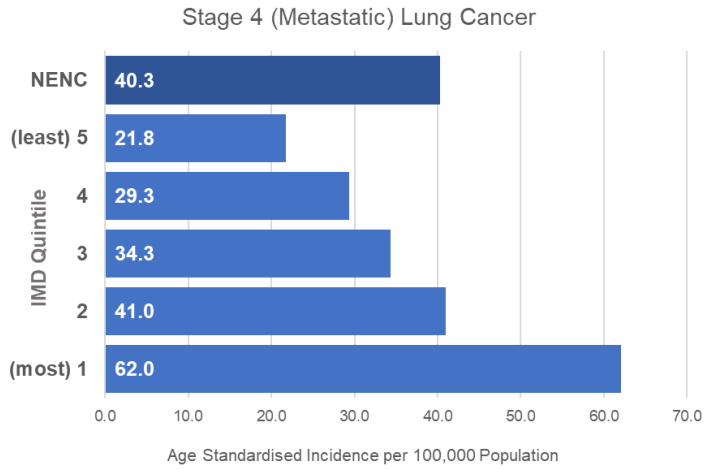
Lung cancer is one of the leading causes of premature mortality and the gap in life expectancy between deprived and affluent areas.

Our lung cancer rates are higher than the England average and all places across North East and North Cumbria NENC have a higher age standardised incidence than England.



Almost half our lung cancer diagnoses are at stage 4 in line with the national average, with North Cumbria having the highest rate.

Recent years have seen an increase in proportions of lung cancers diagnosed at stage 1 and a reduction at stage 4 in NENC.



Around 40% of cases of stage 4 lung cancer occur in areas with IMD Quintile 1.

Stage 4 lung cancer incidence is almost three times higher in the deprived compared to affluent areas.

Lung cancer recommendations

The lung cancer recommendations were developed in collaboration with the Northern Cancer Alliance, who have worked with patients and clinicians to co-produce a regional lung cancer strategy.

Prevention

- We will continue to support the Healthier and Fairer Programme in the rollout of the regional **tobacco control** strategy and the aim to reduce prevalence of smoking to 5% by 2030.

Case finding and diagnostics

- We will scale up **targeted lung health checks** to progress further and faster than the national ambition for 100% coverage by 2030 – creating a ‘stage shift’ at presentation.

Treatment

- We will continue the work on **reducing barriers to accessing services**, designing provision around those with greatest need, broadening referral routes into services and including self-referral access in target groups.

- We will ensure **equity of access to diagnostic tests and effective treatment,** addressing unwarranted variation and matching capacity to rising demand from targeted lung health checks .

Rehabilitation

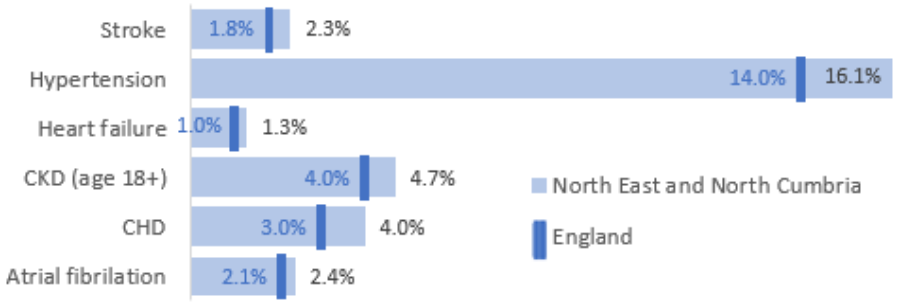
- We will embed a holistic approach to improving fitness and management of co-morbidities so that more patients can be offered treatments and enjoy better quality of life at all disease stages.

Lung cancer outcome indicators

	Indicator	Links to recommendations
Prevention: smoking prevalence and cessation	Proportion of patients aged 15+ who are recorded as current smokers and those with no smoking status ever recorded *(focus on underserved populations)* Proportion of smokers with supported quit attempts recorded	Roll out of regional tobacco control strategy
Case finding and diagnostics	Proportion of eligible patients invited to a Targeted Lung Health Check Proportion of Targeted Lung Health Checks completed based on patients invited	Scale up TLHC to progress further and faster than the national ambition Reduce barriers to accessing services
	All new lung cancer diagnoses by route of presentation and stage at presentation	
Longer term outcomes	<75 years mortality rate from lung cancer (Persons, 1 year range)	Outcomes that reflect the success of the integrated pathway and model of care implemented

Cardiovascular health – what the data tells us…

Rates of cardiovascular conditions are **higher** than the England average



Risk Factors Frequency

Number of Risk Factors	Rate per 10,000 population	% of patients
1	3,400	34%
2	1,922	19%
3	1,114	11%
4	592	6%
5	207	2%
6	35	0%
7	3	0%
8	0	0%
9	0	0%

Circulatory diseases account for

15%

of all emergency admissions

20%

(1,951 per 10,000 population)

have three or more risk factors for circulatory disease

	HyperTension	Smoker	High Cholesterol	Diabetes	Obese	Alcohol Misuse	Male	Asian/Black	>50 years old
HyperTension	12.9%								
Smoker	1.3%	12.1%							
High Cholesterol	4.8%	1.8%	13.4%						
Diabetes	2.8%	0.7%	1.3%	5.0%					
Obese	5.3%	1.7%	4.6%	2.6%	13.6%				
Alcohol Misuse	0.5%	1.1%	0.5%	0.2%	0.5%	2.4%			
Male	6.1%	6.7%	5.2%	2.7%	5.3%	1.5%	45.8%		
Asian/Black	0.2%	0.3%	0.3%	0.2%	0.3%	0.0%	2.3%	4.4%	
>50 years old	11.4%	4.3%	9.9%	4.0%	8.0%	1.0%	15.0%	0.5%	32.6%

15.0% over 50 years old and male

5,345

monthly circulatory disease emergency admissions on average across NENC

Source: SUS Data, August 2022 – July 2023 RAIDR Primary care data collection August 2023; QOF 2021/22

Cardiovascular health recommendations

The cardiovascular health recommendations were developed in collaboration with the long term conditions and physical health clinical networks.

Prevention

- We will **proactively manage risk factors** within primary care such as atrial fibrillation, hypertension, hyperlipidemia, stroke, diabetes and chronic kidney disease management

Case finding and diagnostics

- We will proactively **case find** for hypertension, atrial fibrillation, diabetes, hyperlipidemia, chronic kidney disease, stroke and heart failure and deliver **access to timely diagnostics and effective treatment,** addressing unwarranted variation, ensuring capacity for diagnostic and treatment services

Treatment

- We will commission and deliver high quality nationally agreed **models of care**

Rehabilitation

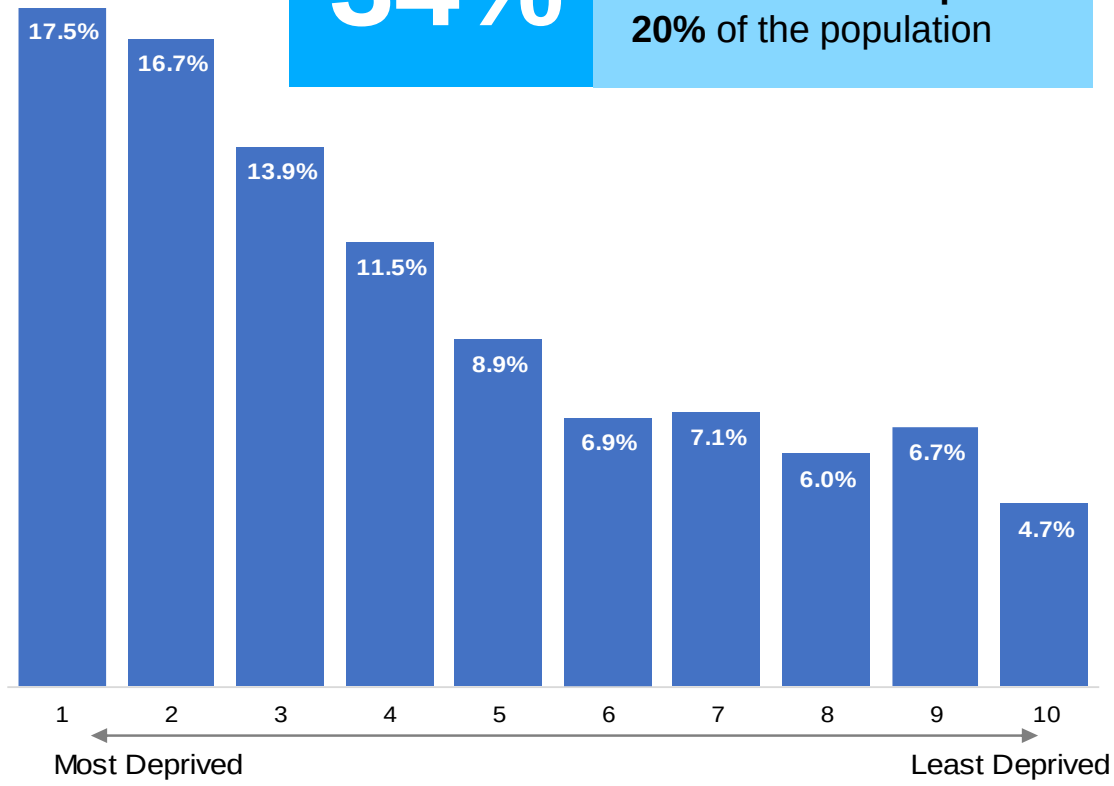
- We will ensure **secondary prevention and optimisation are embedded** in our care pathways and at each contact point to target atrial fibrillation, hypertension, stroke, hyperlipidemia, diabetes and CKD management

Cardiovascular health outcome indicators

	Indicator	Links to recommendations
Prevention and case finding	Disease prevalence (compared to expected levels or models) for: **Hypertension** **Diabetes** **Atrial fibrillation** **Chronic kidney disease (CKD)** **Familial hypercholesterolaemia (genetically confirmed)**	Proactively case find and deliver access to timely diagnostics and effective treatment
Condition management and treatment	Percentage of patients with CVD who are currently prescribed a statin or other lipid lowering therapy (last 12 months)	Deliver high quality nationally agreed models of care Ensure secondary prevention / optimisation is embedded in care pathways
	Percentage of patients with CKD (i) with blood pressure treated to target level, (ii) who have had a urine albumin-creatinine ratio test (last 12 months), (iii) with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists (last 12 months)	
	Percentage of patients with hypertension where the latest blood pressure reading is below the age-appropriate threshold	
	Percentage of patients with atrial fibrillation and a CHA2DS2-VASc score of 2+, treated with anticoagulation drug therapy (last 12 months)	
	Percentage of people with Type 1 and Type 2 diabetes who have received all care processes (last 12 months)	
Longer term outcomes	Adults with CKD who require kidney replacement therapy (dialysis and transplantation)	Outcomes that reflect the success of the integrated pathway and model of care implemented
	Percentage of people with diabetes having major amputation within 6 months of first expert assessment	
	Rate of non-elective admissions for stroke (per 100,000 age sex standardised)	
	Rate of non-elective admissions for myocardial infarction (per 100,000 age sex standardised)	
	Under 75 mortality rate from all circulatory diseases (1 year range)	

Respiratory health – scale of the challenge…

34% with a respiratory disease are in the **most deprived 20%** of the population

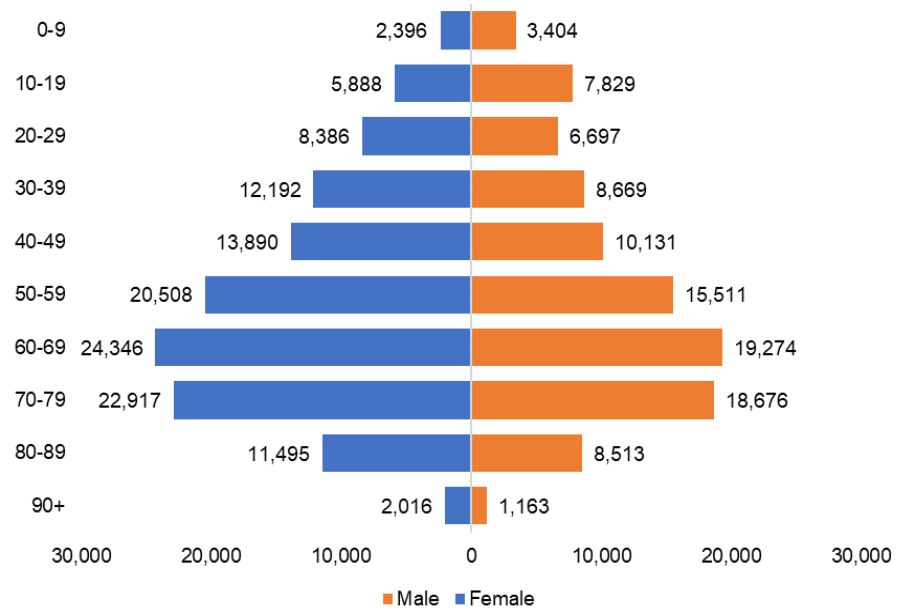


9.5% of our population have **at least one** of the following respiratory diseases:

COPD, asthma, bronchiectasis

Of **223,906** people in the respiratory disease cohort:

- **18% Current smokers**
- **35% Ex-smokers**
- **51% Overweight or obese**
- **65% Over 50**



Source: Raidr primary care data collection: September 2023

Respiratory health recommendations

These respiratory health recommendations were developed in collaboration with the long term conditions and physical health clinical networks.

Prevention

- We will continue to support the Healthier and Fairer programme in the rollout of the regional **tobacco control** strategy and the aim to reach 5% prevalence by 2030.

Case finding and diagnostics

- We will ensure symptomatic patients have equitable access to **spirometry and fractional exhaled nitric oxide (FeNO)** testing. We will ensure **targeted lung health checks** are rolled out and **proactive case finding** is in place for those who aren't included in the specific clinical criteria.

Treatment

- We will ensure diagnosis is based on appropriate testing (as outlined) with **timely access to treatment and management of conditions.**

Rehabilitation

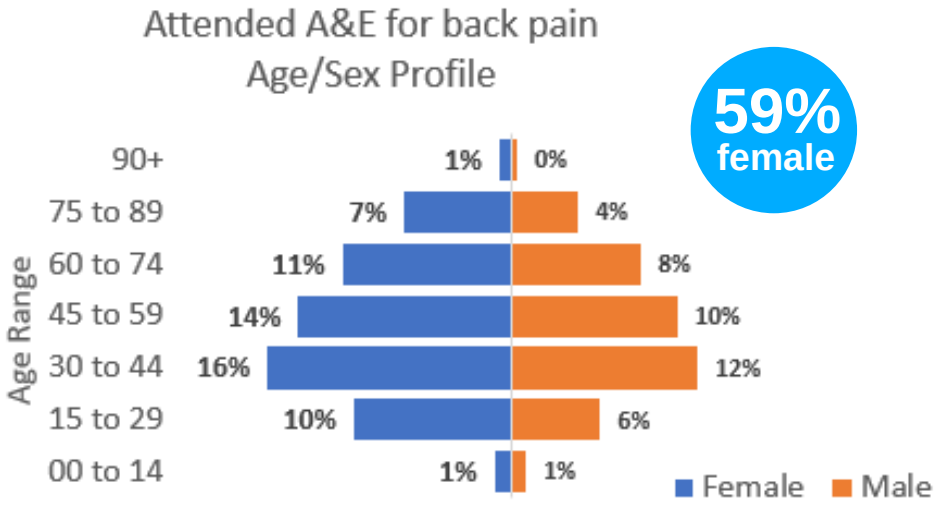
- We will ensure a holistic approach to managing risk factors and co-morbidities, as well as optimising respiratory health with appropriate pharmacological intervention. Equitable access to symptom-led prehabilitation and rehabilitation.

Respiratory health outcome indicators

	Indicator	Links to recommendations
Case finding and diagnostics	Proportion of patients aged 18+ with asthma with the diagnosis confirmed via objective tests (between 3 months before or 6 months after diagnosis)	Equitable access to spirometry and FeNO testing
	Proportion of patients with COPD with the diagnosis confirmed via spirometry (between 3 months before or 6 months after diagnosis)	
Condition management and treatment interventions	Percentage of patients aged 18+ with asthma with a review in the last 12 months Percentage of patients with COPD with a review in the last 12 months	Timely access to treatment and management of conditions Holistic approach to managing risk factors and co-morbidities
	Proportion of respiratory hospital admissions where smoking status is confirmed, and smoking cessation is initiated	
Longer term outcomes	Rate of emergency hospital admissions for respiratory disease in last 12 months	Outcomes that reflect the success of the integrated pathway and model of care implemented
	<75 mortality rate from respiratory diseases (Persons, 1 year range)	

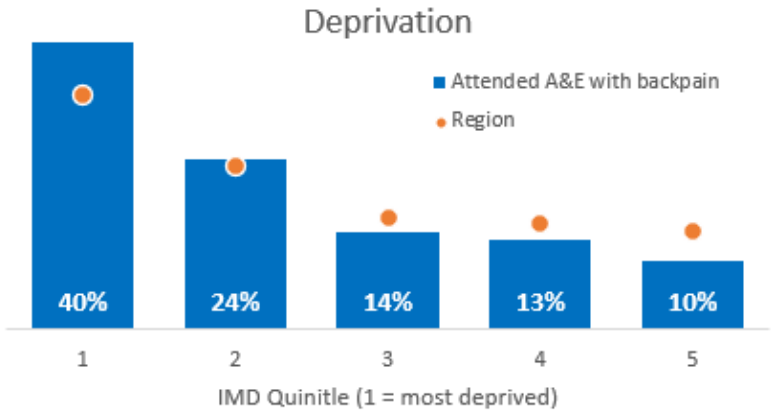
Lower back pain – scale of the challenge…

36,380 people attended **A&E for back pain** in last two years (Nov 21 to Oct 23)



60% of the national adult population can expect to have a **back problem** at some time in their life*

40% live in the **most deprived** areas (vs 33% total NENC population)



1,250
(per 100,000 population)

The estimated rate of musculoskeletal disorders **caused or made worse** by work (employed in last 12 months). England = 1,440

People attending A&E for back pain were more likely than those attending for other reasons to have **anxiety** (37% vs 24%) and **depression** (31% vs 18%)

Source: SUS; RAIDR Primary care data collection; Labour Force Survey 2020/21 – 2022/23

* Campbell, J. and Colvin, L.A. (2013) Management of low back pain. BMJ 347.

Lower back pain recommendations

The lower back pain recommendations were developed in collaboration with the regional spinal clinical network and are aligned to the national back pain pathway.

We will implement the national back pain pathway which includes:

Access

- We will develop a **Single Point of Access** to MSK interface services with referrals by professionals or via self-referral.

Multi-disciplinary triage

- We will develop **interface services** to include imaging and management of red flag referrals. GPs will no longer refer directly for MRI or X-ray. We will ensure that interface services refer all cases to secondary care via a **virtual Multi-Disciplinary Team (MDT)** to include spinal surgeons and pain management service.

Rehabilitation

- We will develop a range of Combined Physical and Psychological Programmes (CPPP) across the North East and North Cumbria to support people in their recovery.

Lower back pain outcome indicators

	Indicator	Links to recommendations
Access to services	Number of referrals for lower back pain seen by MSK interface services And % seen within 6 weeks of referral	Single point of access to MSK interface services
Condition management and treatment interventions	Waiting times for outpatient appointment for spinal related activity	Develop interface services (including imaging) For these services to refer to secondary care via MDT
	Elective surgical hospital admissions for back and radicular pain (activity and length of stay)	
	Community-requested MRI scans of the spine	
Longer term outcomes	Proportion of patients who report improved outcomes at discharge from MSK interface services	Outcomes that reflect the success of the integrated pathway and model of care implemented
	Non-elective hospital admissions for back and radicular pain (activity and length of stay)	
	111 calls for lower back pain (no recent injury)	

Anxiety and depression – scale of the challenge…

Of people in our region aged 18+…
1 in 5 have had a record of **depression** (19% 469k)
1 in 4 have had a record of **anxiety** (25% 625k)

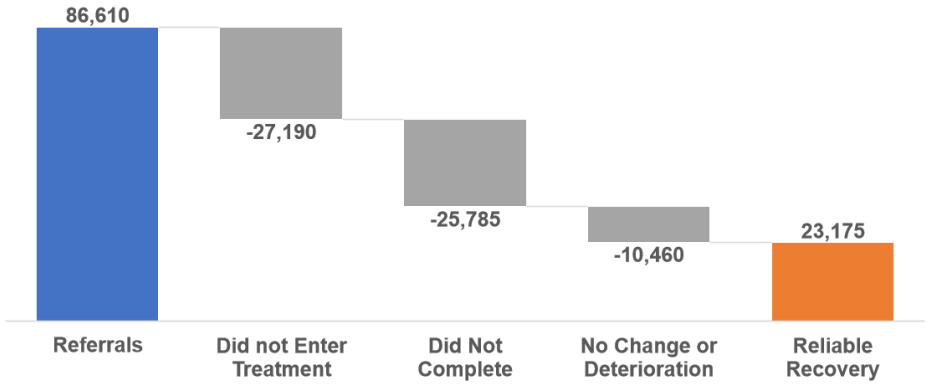
Talking therapies in our region (2022-23)

- 86,610 referrals
- 59,420 entered treatment (69% of referrals, England 69%)
- 33,635 completed (57% entered treatment, England 55%)

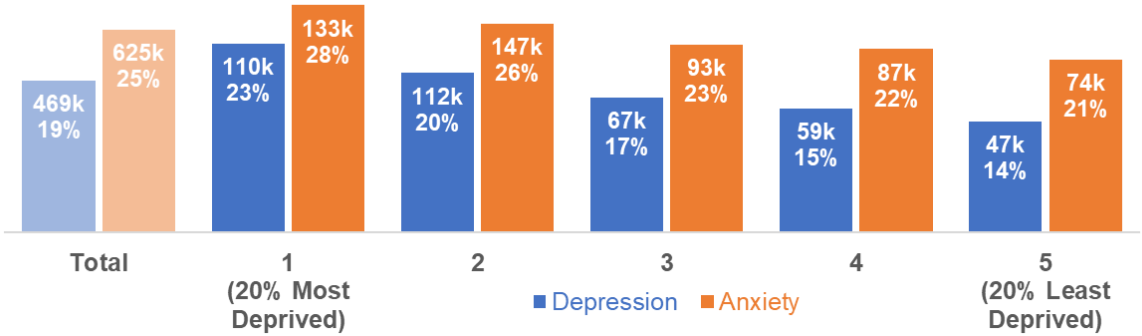
Mean waits:

1st treatment **15.7 days** (England 19.8 days)
1st to 2nd treatment **58.8 days** (England 46.1 days)

Talking therapies 2022-23:



Prevalence of depression and anxiety by deprivation quintile:



39% of **referrals** received are from IMD 20% **most deprived** areas, of those that accessed services **50% completed** a course of treatment compared to **65%** of those in the **least deprived** 20%

Outcome measures, finishing treatment 2022-23:

65% of people from IMD 20% **most deprived** areas who completed treatment had **reliable improvement** compared to **71%** of those in the **least deprived** 20%

Anxiety and depression recommendations

The anxiety and depression recommendations were developed in collaboration with the mental health and learning disabilities network.

Prevention

- We will ensure **targeted prevention** and implementation of effective, easily accessible community support networks with **access to early help and support.** We will target the most at risk groups to maximise **prevention** opportunities.

Treatment

- We will ensure timely access to **talking therapies** and other psychological treatments, with **optimised prescribing of supportive medication.**

Rehabilitation

- We will promote community mental health transformation and the **integrated community model of care**, ensuring comprehensive assessment, access to therapies and standardisation of care pathways.

Anxiety and depression outcome indicators

	Indicator	Links to recommendations
Incidence and prevalence of anxiety and depression	Incidence: Proportion of patients aged 18+ with a new diagnosis of anxiety or depression* (in the last 12 months) and no prior diagnosis ever recorded Prevalence: Proportion of patients aged 18+ with a diagnosis of anxiety or depression* recorded in the last 10 years **Identified via a combination of relevant condition and prescribed medication codes*	Describes burden of these conditions in the population Ensure targeted prevention and implementation of support networks
Treatment and interventions	Proportion of patients referred to NHS Talking Therapies who completed a course of treatment and moved to recovery Proportion of patients referred to NHS Talking Therapies who entered treatment but did not complete the course of treatment	Timely access to talking therapies and other psychological treatments
	Prescribing rates of antidepressants and anxiolytics in people aged 18+	Optimised prescribing of supportive medication
Longer term outcomes	Emergency hospital admissions for intentional self-harm	Outcomes that reflect the success of the integrated pathway and model of care implemented
	Suicide rate (in persons aged 10+ years) crude rate	

Our priorities for children and young people

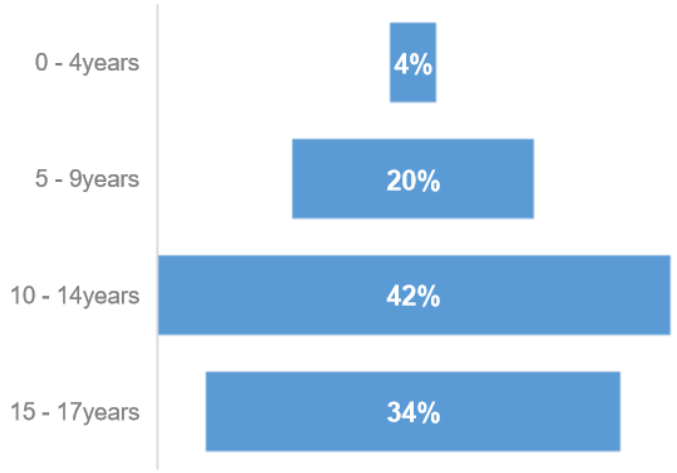
Diabetes in children and young people – scale of the challenge

54% Male

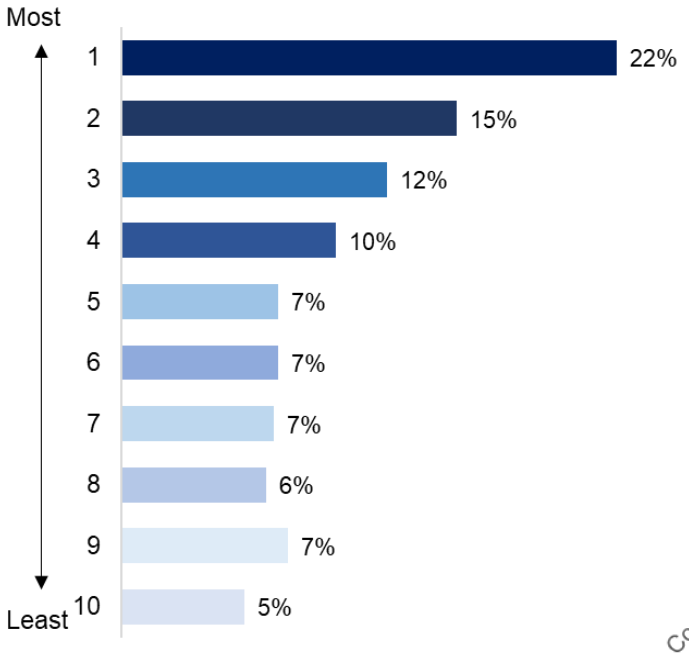
46% Female

1,590 (0.3%) of under-18s have diabetes

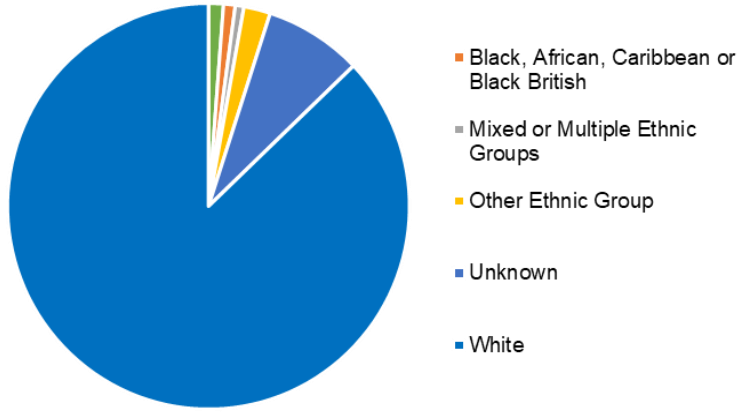
Age:



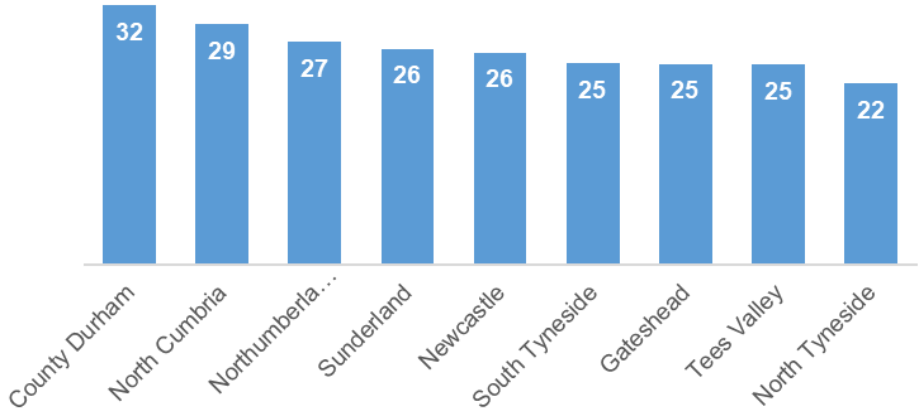
Deprivation Levels
(Most – Least Deprived)



Ethnicity:



Type 1 Diabetes by place
rate per 10,000 population of under 18s



Children and young people's diabetes recommendations

The CYP diabetes recommendations were developed in collaboration with the Child Health and Wellbeing Network.

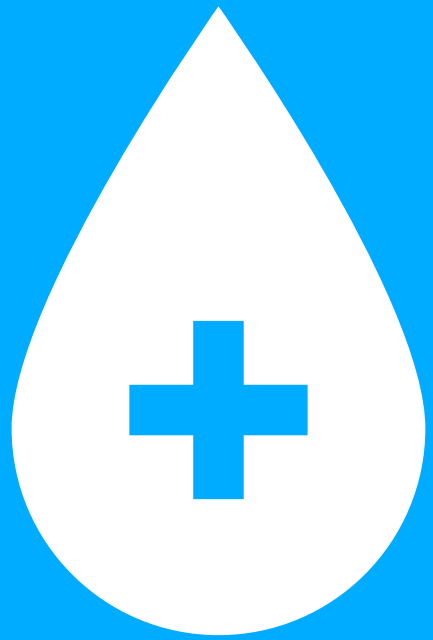
Access

- We will ensure all diabetes services/ trusts are commissioned and delivered in line with **best practice** model of care criteria including ensuring all CYP have access to a **diabetes MDT**

Treatment

- We will ensure fair and better access to new diabetic advances including treatment and technology and we will implement learning from the **GLP-1 agonist prescribing pilot**

- We will address **inequalities in access to technology** and ensuring the right technology is available for children and young people

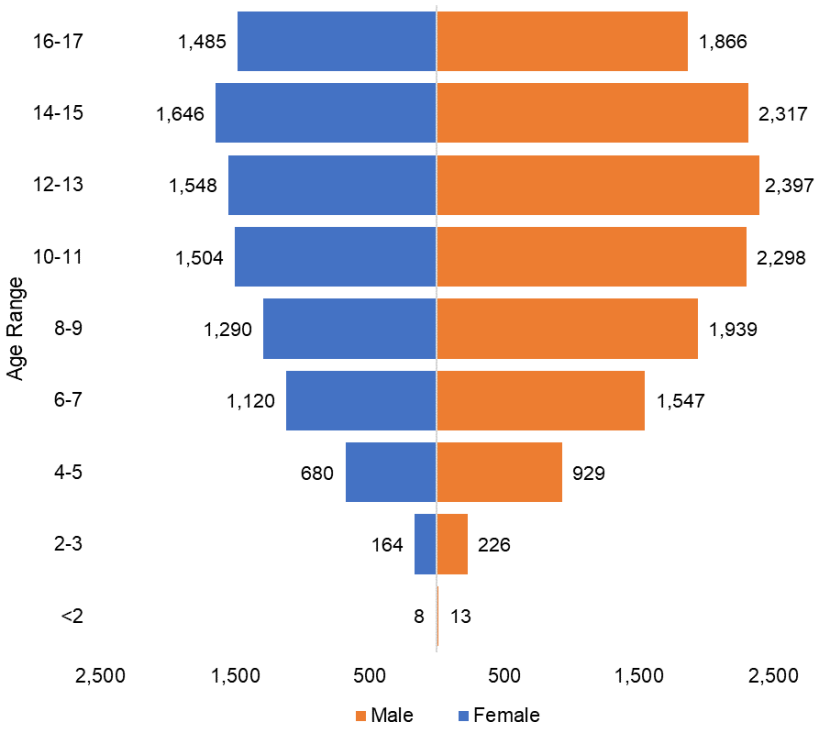


Children and young people's diabetes outcome indicators

	Indicator	Links to recommendations
Access	Percentage of children and young people with Type 1 diabetes receiving all recommended 'key' annual health checks Percentage of children and young people with Type 2 diabetes receiving all recommended 'key' annual health checks	All services are delivered in line with best practice including access to a diabetes MDT
	Percentage of children and young people with Type 1 diabetes whose HbA1c is: • Less than or equal to 48mmol/mol • Greater than 80mmol/mol	
Treatment	Percentage of children and young people with Type 1 diabetes from minority ethnic groups using continuous glucose monitors	Address inequalities in access to technology, ensuring the right technology is available
	Percentage of children and young people with Type 1 diabetes from most deprived 2 quintiles using an insulin pump	
Longer term outcomes	Percentage of children and young people with Type 1 diabetes with one or more diabetic ketoacidosis-related admissions not associated with diagnosis	Outcomes that reflect the success of the integrated pathway and model of care implemented

Asthma in children and young people – scale of the challenge

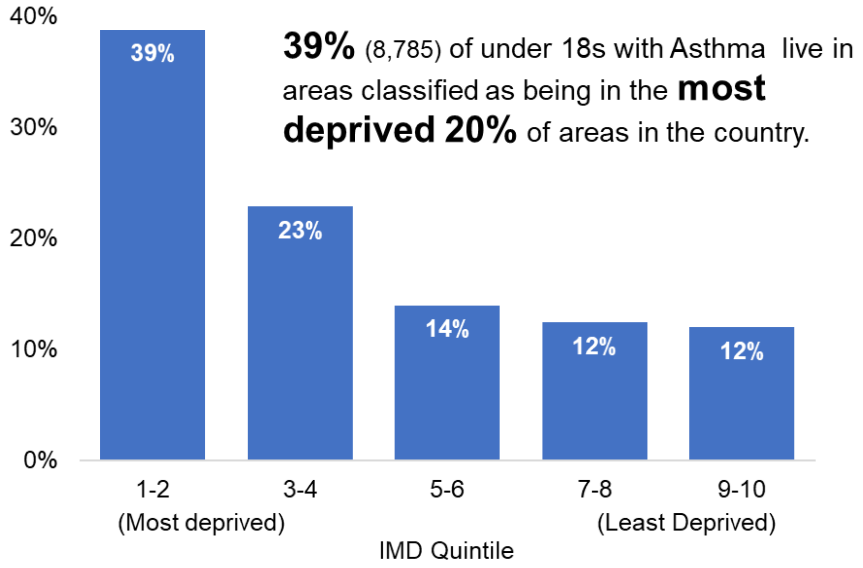
3.9% **(22,997)** of under 18s have **asthma**



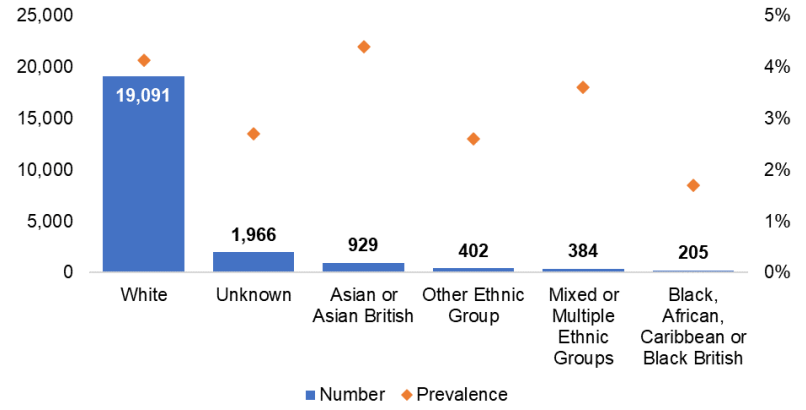
59% **Male**

59% **(13,532)** of under 18s with asthma are **male**

Asian or Asian British people have the highest prevalence of asthma in under 18s at **4.4%**



39% (8,785) of under 18s with Asthma live in areas classified as being in the **most deprived 20%** of areas in the country.



Source: Raidr primary care data collection: November 2023

Children and young people's asthma recommendations

These recommendations have been developed with the Asthma Leadership Group with the aim of addressing over-reliance on reliever medications and decreasing the number of asthma attacks.

Prevention

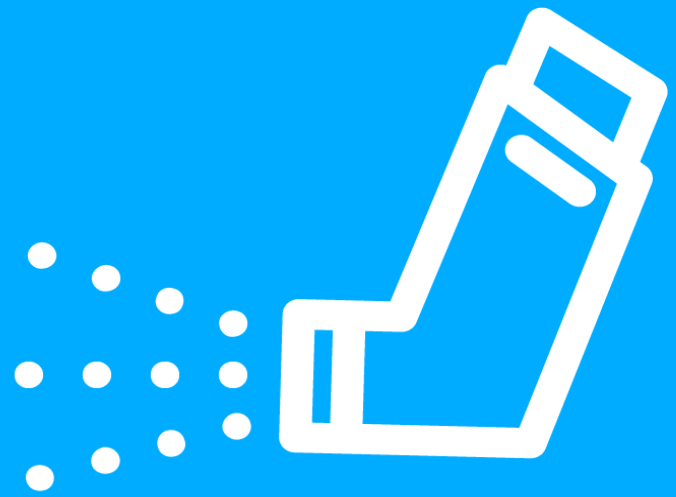
- We will continue to support the Healthier and Fairer programme in the rollout of the regional tobacco control strategy and the aim to reach 5% prevalence by 2030, aiming to reduce smoking in households.

Case finding and diagnostics

- We will ensure fair and equitable access to diagnostic testing including spirometry and FeNO (fractional exhaled nitric oxide). We will enable MDT training and development across the system to ensure an equitable skill set of professionals in line with the standards identified within the **national care bundle** and guided by the **core20 PLUS 5 principles and priorities.**

Treatment

- We will ensure implementation of agreed standards within the national asthma care bundle.



Children and young people's asthma outcome indicators

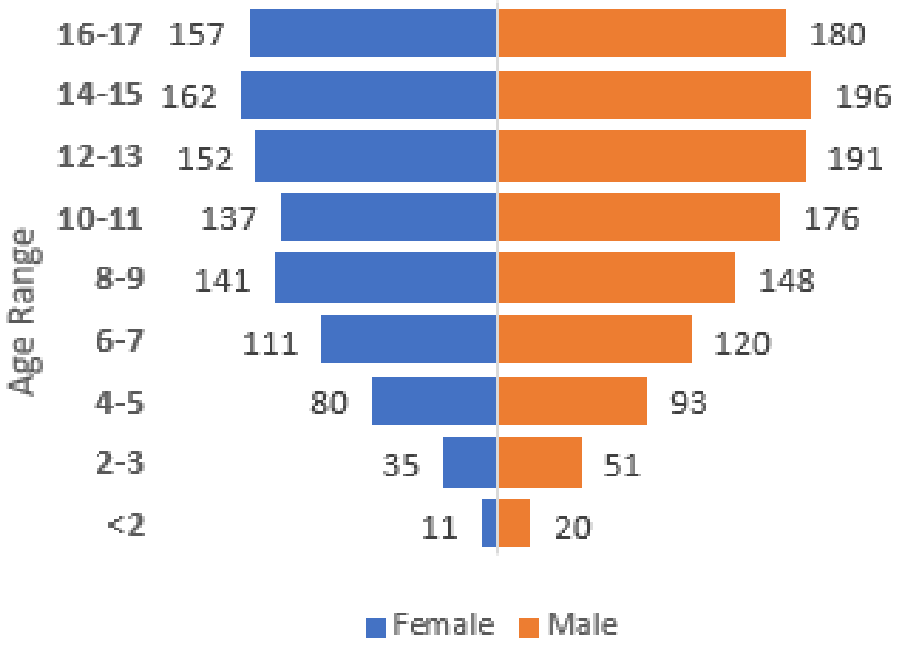
	Indicator	Links to recommendations
Case finding	Proportion of patients aged under 18 years with asthma, on the GP register	To understand prevalence of condition in the CYP population
Condition management and treatment interventions	Percentage of patients <18 with asthma, on the register, who have had an asthma review in the last 12 months • Proportion with a personalised action plan in place • Proportion with inhaler technique checked (last 12 months)	Implementation of agreed standards within the national asthma care bundle
	Proportion of child patients with 5 or fewer inhaled corticosteroids (ICS) products in the last 12 months	CORE20 metrics
Longer term outcomes	Emergency department attendances for asthma Emergency hospital admissions relating to asthma	Outcomes that reflect the success of the integrated pathway and model of care implemented
	Percentage of child patients who were prescribed 6 or more SABA inhalers in the last 12 months	CORE20 metrics
Training	Uptake of tiered training via the National Capabilities Framework for professionals who care for children and young people with asthma	Enable MDT training and development for professionals

Epilepsy in children and young people – scale of the challenge

2,130 people aged under 18 have **epilepsy**

54% Male

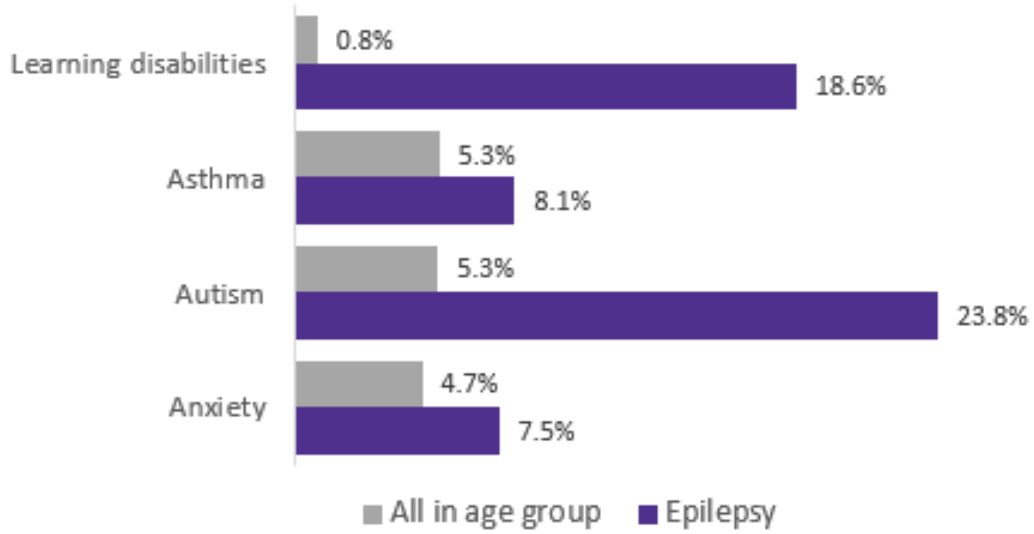
90.2 **emergency admissions for epilepsy** (under 19 years) per 100,000 population in the North East region – **the highest rate in England**. Average is 73.6



Source: Office for Health Improvement and Disparities; RAIDR Primary care data collection

Young people aged 10 to 17

with epilepsy **have higher rates of other long term conditions** compared to others in their age group



Children and young people's epilepsy recommendations

These recommendations were developed in collaboration with the Child Health and Wellbeing Network.

Access

- We will **ensure more equitable access** to epilepsy specialist nurses and MDTs (multi-disciplinary teams).

Treatment

- We will deliver on the **four priority areas identified within the national bundle of care** and support the **sustainability of services** to ensure compliance against the **best practice model of care.**

- We will maintain our collective focus on the '**epilepsy 12 lines of enquiry'** (RCPCH Epilepsy 12 Audit programme)

Children and young people's epilepsy outcome indicators

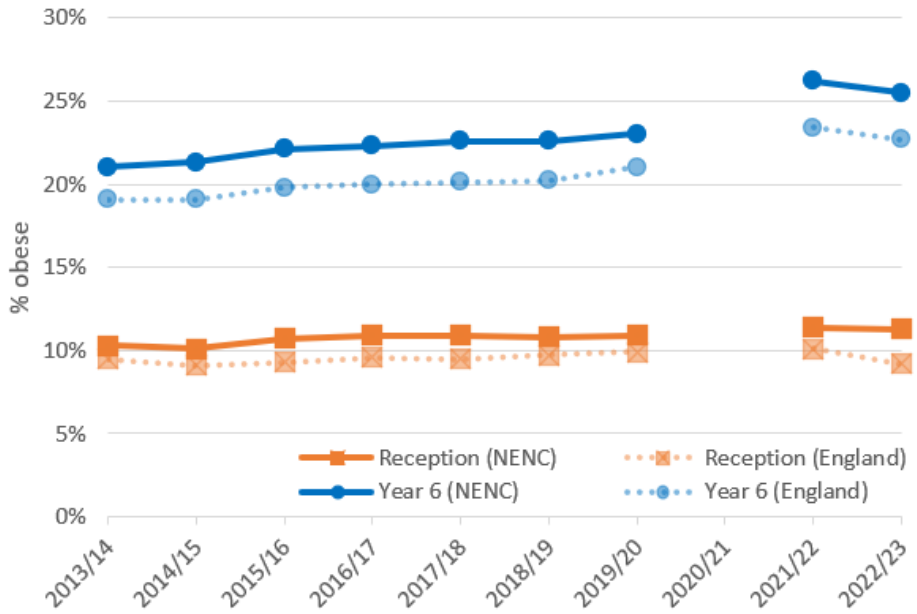
	Indicator	Links to recommendations
Access	Percentage of children and young people with suspected epilepsy with input by a 'consultant paediatrician with expertise in epilepsies' within 2 weeks of a referral from first paediatric assessment	Equitable access to epilepsy specialist nurses and epilepsy MDT CORE20
	% CYP with epilepsy, with input by epilepsy specialist nurse within first year of care And to ensure access in the first year of care for those with a learning disability or autism	
Treatment	Percentage of children and young people indicated as meeting defined criteria for paediatric neurology referral, with input of tertiary care and/or Children's Epilepsy Surgery Service referral by first year	Deliver on the 4 priority areas in the national bundle of care
	Proportion of Trusts where mental health provision is facilitated within epilepsy clinics	
	Proportion of Trusts with outpatient services for epilepsy where there is a presence of both adult and paediatric professionals	
Epilepsy 12 audit participation	Proportion of Trusts who are participating in the Epilepsy 12 audit	Maintain focus on the Epilepsy 12 lines of enquiry
Longer term outcomes	Emergency department attendances for epilepsy (for those with a diagnosis recorded in primary care) Emergency hospital admissions for children and young people where the admission has a primary diagnosis of epilepsy	Outcomes that reflect the success of the integrated pathway and model of care implemented

Obesity in children and young people – scale of the challenge

The North East has highest rates of obesity in Reception and Year 6 of any region in England.

1 in 4 (25.5%) children in Year 6 are obese, a slight decrease from the previous year

Obesity at Reception and Year 6

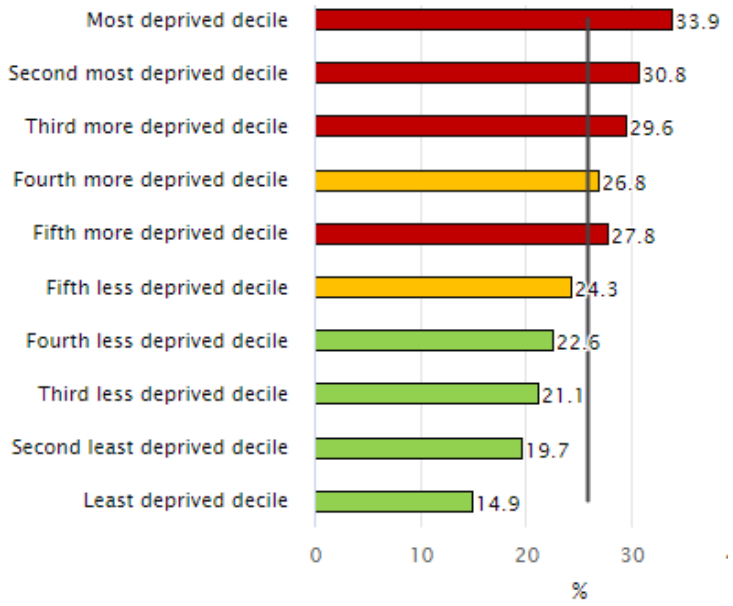


Data available for the North East region shows a clear relationship between deprivation and obesity. **1 in 3** Year 6 children from the **most deprived** areas are obese compared to **1 in 6** from the least deprived.

Boys in Year 6 are more likely than girls to be obese (28.4% vs 23.0%). The genders are closer together in Reception (11.7% boys vs 10.9% girls).

Nationally, children of **Black, Bangladeshi and Pakistani ethnicity** are more likely to be obese than their white counterparts.

Year 6 Obesity by deprivation, 2022/23 (North East Region)



Children and young people's obesity recommendations

We need to develop services for overweight and obese children, to ensure we tackle the lifelong impact of obesity. These recommendations were developed in collaboration with the Child Health and Wellbeing Network.

Prevention

- We will support the development of a **regional whole systems approach for healthy weight and treating obesity.**
- We will take a **family approach**, utilising **Making Every Contact Count (MECC)** and offering opportunistic interventions.

Case finding and diagnostics

- We will deliver actions to improve the **recording of weight/BMI in primary care**.

Treatment and rehabilitation

- We will ensure children and young people have **access to weight management services** including dietetic services and healthy psychology services for weight management for those who need it.
- We will ensure that the **tertiary centres** are sustainable in the long term for regional referrals, advice and shared care.

Children and young people's obesity outcome indicators

	Indicator	Links to recommendations
Prevention	Percentage of physically active children and young people	Regional whole systems approach for healthy weight and treating obesity
Case finding and diagnostics	Percentage of primary care records for children which have a valid height and weight recorded	Improve the recording of weight/BMI in primary care
Treatment and rehabilitation	Number of weight management services available to children and young people in and across NENC, by service tier	Ensure CYP have access to weight management services
	Activity relating to children and young people seen by the Complications from Excess Weight clinics in the region	
Outcomes	Prevalence of obesity in the North East (including inequalities gap relating to deprivation) and uptake levels for those in Reception class and in Year 6	Outcomes that reflect the success of the integrated pathway and model of care implemented

Oral health in children and young people – scale of the challenge

Poor oral health impacts on children's health and well-being, has implications for their physical and emotional well-being, social interactions, mental health and can lead to days missed at school while receiving care.

The rate of tooth extracts with caries as primary diagnosis for children and young people across the North East is more than **double the national rate** for children under 10. The rate is higher than the England average for children and young people between 10 and 19 years.

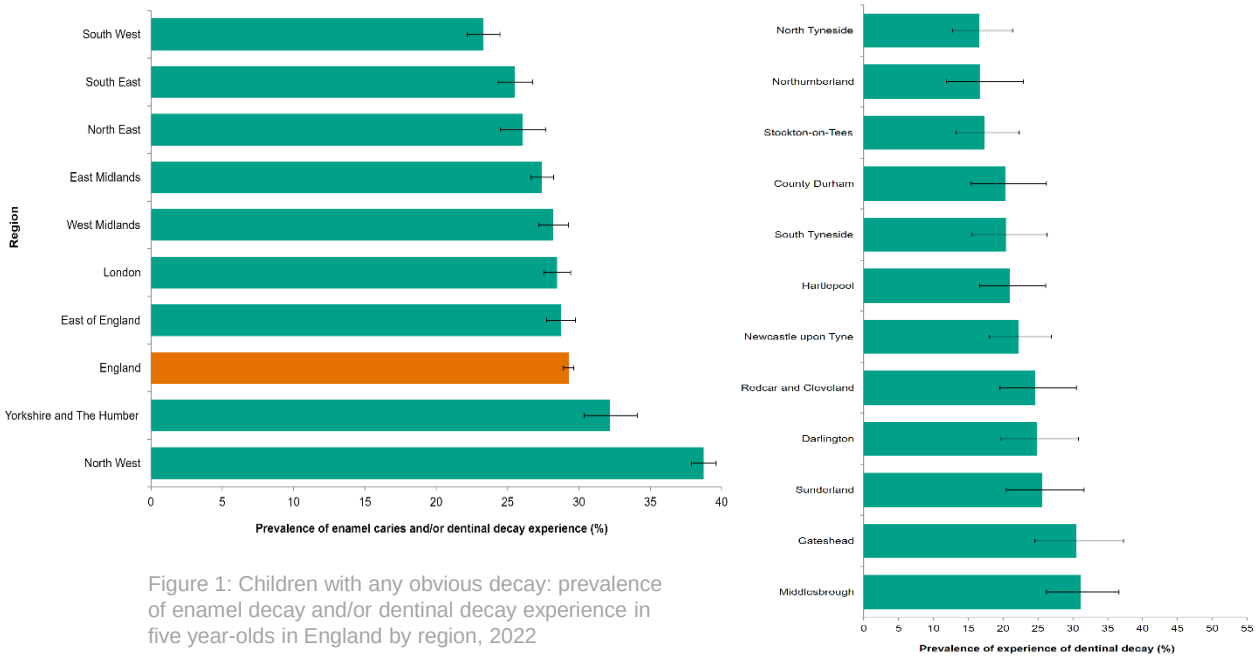


Figure 1: Children with any obvious decay: prevalence of enamel decay and/or dentinal decay experience in five year-olds in England by region, 2022

Nationally, children living in the most deprived areas of the country were almost three times as likely to have experience of dentinal decay (35.1%) as those living in the least deprived areas (13.5%). The prevalence of five year-olds with dental decay experience has continued to fall year on year and in line with national reductions.

While the regional prevalence of children with enamel and/or dentinal decay is lower than the England average of (29.3%), there are variations at a local authority level. Middlesbrough and Gateshead have higher prevalence of five year-old children with dental decay experience than the regional and national averages.

Table 5: FCE tooth extraction rate with caries as primary diagnosis per 100,000 target population

Region	Region Code	Age 0-5yrs	Age 6-10yrs	Age 11-14yrs	Age 15-19yrs	Total 0-19yrs
North East	E12000001	279.3	469.7	85.4	51.2	232.6
North West	E12000002	167.2	300.5	97.0	42.8	158.5
Yorkshire and The Humber	E12000003	231.3	441.3	95.3	36.6	212.2
East Midlands	E12000004	26.5	64.0	28.2	18.1	34.2
West Midlands	E12000005	35.5	80.0	23.7	16.0	40.2
East of England	E12000006	40.9	70.0	29.3	19.4	41.8
London	E12000007	135.3	257.7	76.7	42.2	137.2
South East	E12000008	57.8	108.4	35.9	19.4	57.7
South West	E12000009	142.7	315.5	85.5	28.1	148.8
ENGLAND (unrounded)	**E92000001**	**113.0**	**214.7**	**60.3**	**29.7**	**109.9**

Children and young people's oral health recommendations

These recommendations were developed in collaboration with the Child Health and Wellbeing Network.

Prevention

- We will ensure a targeted approach to the commissioning of dental services in those areas with higher prevalence of dentinal decay and deprivation.
- We will continue to support water fluoridation across the North East and North Cumbria.

Treatment

- We will ensure that all children and young people have access to primary care dental services to ensure proactive treatment and preventive care.
- We will ensure that those who need it are offered fluoride varnish as part of their primary care dental check.
- We will ensure appropriate access to secondary care dental services where required.

Children and young people's oral health outcome indicators

	Indicator	Links to recommendations
Prevention	Number of schools signed up to supervised toothbrushing scheme	Prevention
Treatment	Percentage of children who have recently accessed a dentist (last 12 months) Also to report the subset of children who have had a dental check by the age of 1 (Dental Check by One)	Treatment - ensure that all CYP have access to primary care dental services
	Rates of fluoride varnish in primary care	Treatment- offer of fluoride varnish
Longer term outcomes	Children and young people aged 0-19 years undergoing tooth extraction *[placeholder until robust dataset is developed]*	Outcomes that reflect the success of the integrated pathway and model of care implemented
	Waiting times for tooth extractions relating to Community Dental Services	
	Prevalence of untreated dental decay in 5-year-olds using pufa index scores	

Anxiety and mental health in children and young people – scale of the challenge

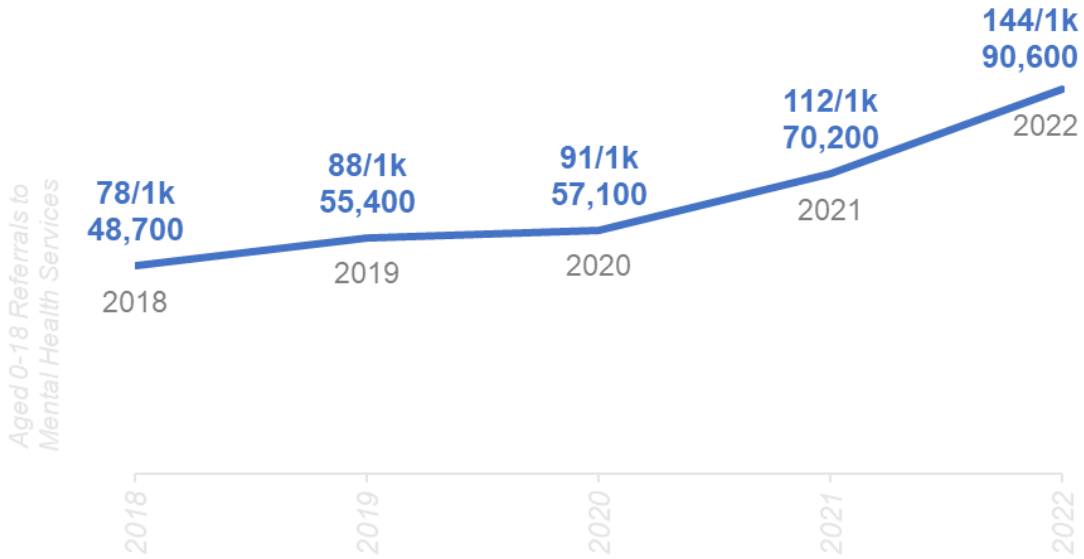
4%

of children aged 7-17 in our region (14k)

have had a record of anxiety

However - due to recording, this is likely an **underestimate.** Based on the mental health of children and young people in England in 2022, approximately **19%** have a **probable mental health disorder**

From national percentages apportioned by age and gender of GP population



31

Deaths by **suicide** were recorded for people aged **7-18** in our region between 2018/19 and 2022/23

Data likely to be **incomplete for 2023** for cases awaiting coroner's verdict

Between 2018 and 2022, there were

322,000

referrals to **mental health services** for young people **aged 0-18**

That's 117,000 distinct patients,

OR

1 referral* per 10 0-18 year olds

*Number of referrals made to **NHS funded mental health services** for patients aged 0-18 made in the years **2018 to 2022.**

Referrals include mental health, eating disorders, learning disability, and autism & other neurodevelopmental conditions.

Children and young people's anxiety and mental health recommendations

These recommendations were developed in collaboration with the Child Health and Wellbeing Network.

Prevention

- We will work in partnership on emotional wellbeing and mental health with public health, schools and children's services, continuing to roll out and expand the **Mental Health Support Teams (MHST) in Schools** across NENC. Models of care will be based on the **iThrive** model.

Case finding and diagnosis

- We will focus on providing **proportionate advice and support** to avoid unnecessary medicalisation and diagnostic labelling, while ensuring timely assessment and treatment.

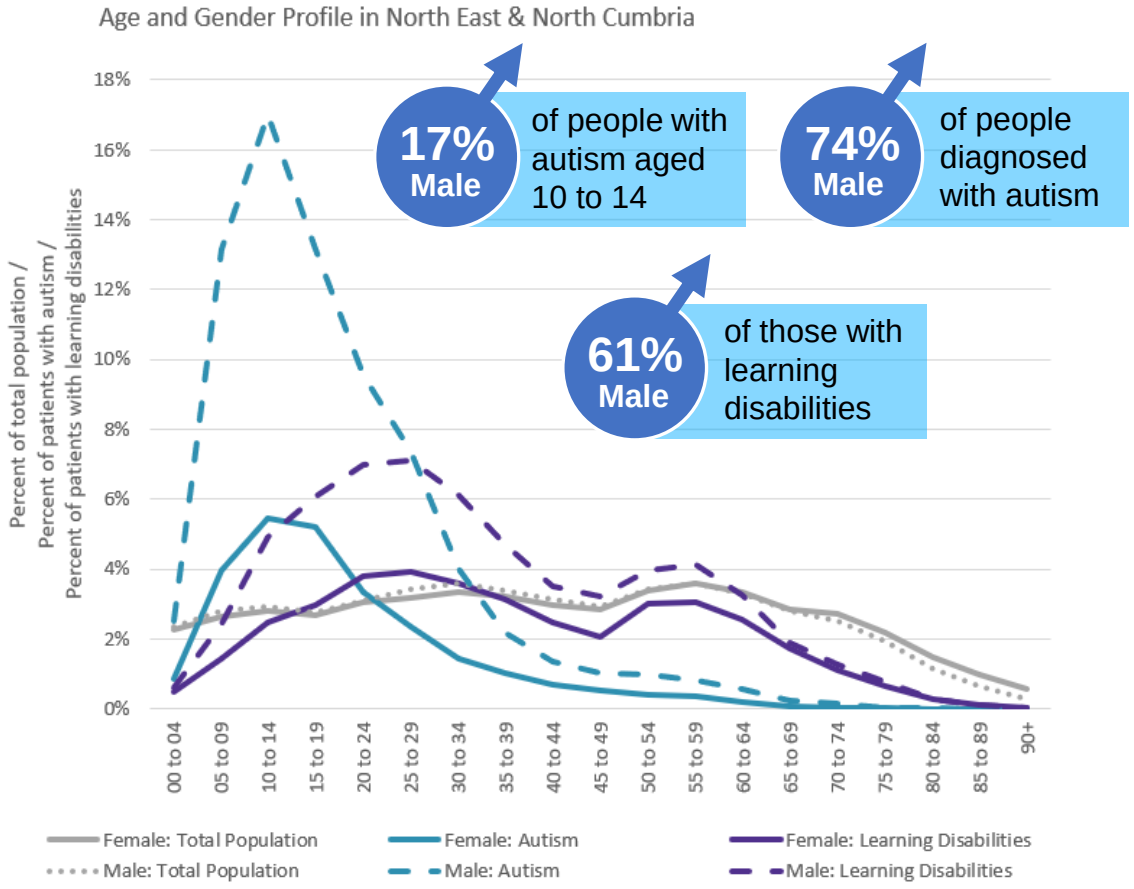
Treatment and rehabilitation

- We will develop a service model for **first episode mental health conditions**.
- We will ensure equitable access to **health psychology** for children with long term conditions.
- We will embed **trauma awareness and trauma-informed practice,** focusing on preventing and limiting the impact of Adverse Childhood Events (ACEs) including adjustments for neurodevelopmental needs.
- We will ensure a **joined-up approach** to children's health, mental health and the neurodevelopmental strategy, commissioning and delivery (including FASD or foetal alcohol spectrum disorders).

Children and young people's anxiety and mental health outcome indicators

	Indicator	Links to recommendations
Prevention	Mental Health Support Teams (MHST) coverage across ICB: • Percentage of pupils / learners in MHST programme • Percentage of settings in MHST programme	Roll out and expand the Mental Health Support Teams in Schools
Case finding and diagnosis	Persistent absentees from school: • Primary school indicator • Secondary school indicator	Provide proportionate advice and support Also links to treatment – equitable access to health psychology
	Number of children and young people with anxiety and physical health comorbidities (and identification of those who are neurodivergent)	
Treatment, rehabilitation and outcomes	Waiting times for specialist CAMHS services **AND** Total number of children and young people accessing services (with subset of these which relate to neurodivergent / neurodevelopmental referrals)	Outcomes that reflect the success of the integrated pathway and model of care implemented
	Hospital admissions for mental health conditions (for those aged <18 years) *To include analysis of patient subgroups*	

Autism and learning disabilities in children and young people – scale of the challenge



17% Male of people with autism aged 10 to 14

74% Male of people diagnosed with autism

61% Male of those with learning disabilities

Source: RAIDR GP data

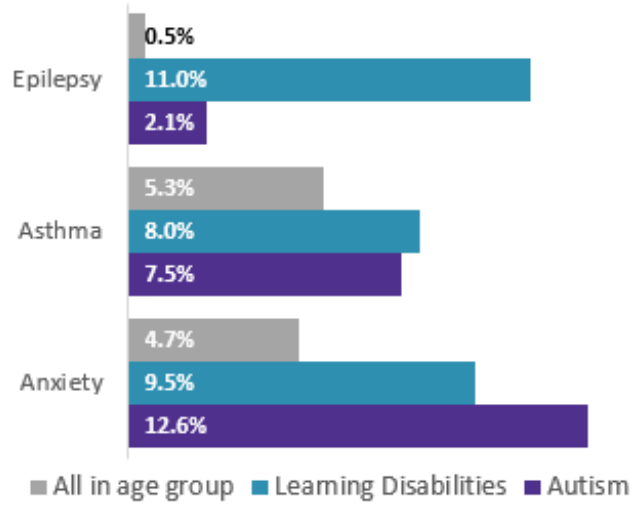
People aged under 18

22,990 (3.9%) have autism

2,870 (0.5%) have learning disabilities

Young people aged 10 to 17

with autism or learning disabilities are **more likely to have other long term conditions** than others in their age group



1 in 4 people were diagnosed with autism after their **15th birthday**

Children and young people's autism and learning disabilities recommendations

These recommendations were developed in collaboration with the Child Health and Wellbeing Network.

Prevention and case finding

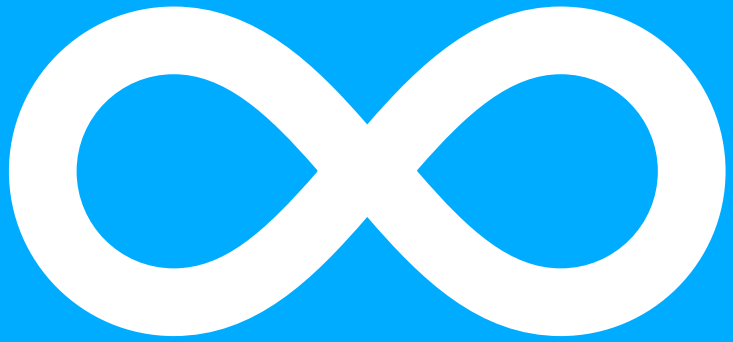
- We will increase the number of **annual health checks and co-morbidities checks** that are carried out in a single appointment.
- We will support the national **digital reasonable adjustments** work throughout the system and ensure a range of sensory support is available.

Diagnosis

- We will support the **timely diagnosis of autism** to enable appropriate support from the voluntary sector and education. We will ensure **pre and post diagnostic autism support** aligned to place autism strategies.

Transition

- We will ensure robust pathways for **transition** into adult services.



Children and young people's autism and learning disabilities outcome indicators

	Indicator	Links to recommendations
Prevention and case finding	Percentage of children and young people with a record (in primary care) of learning disability and / or autism *To include analysis of patient subgroups*	Increase number of annual health checks
	Percentage of children and young people with a learning disability who have had an annual healthcheck **And** who have a completed health action plan in place	
	Percentage of school age pupils with special educational needs (SEN)	
Diagnosis	Waiting times for autism diagnosis	Timely diagnosis of autism and pre and post diagnostic autism support
Outcomes	Emergency hospital admissions for children and young people with a diagnosis of learning disability and / or autism (in primary care) *To include analysis of patient subgroups*	Outcomes that reflect the success of the integrated pathway and model of care implemented
	Avoidable deaths of children and young people with a learning disability	
Transition	Percentage of children and young people with a learning disability and / or autism with a personalised transition plan in place *[placeholder until robust dataset is developed]*	Robust pathways for transition into adult services

Summary of recommendations for adult priorities

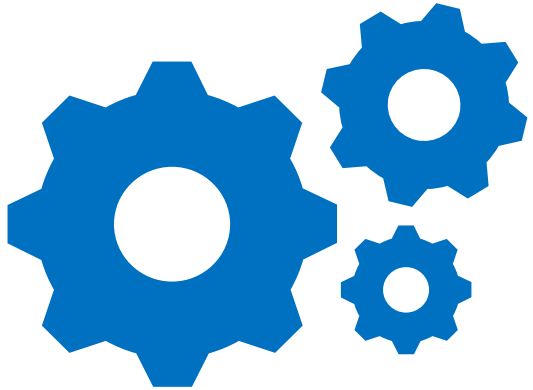
Priority Condition	Condition specific recommendations	Themed recommendations
Lung cancer	• Targeted lung health checks • Timely access to diagnostics and effective treatment	• **Prioritising primary prevention of risk factors** such as the roll out of the tobacco control strategy, alcohol prevention, whole system obesity approach. • **Proactive case finding** • **Secondary prevention** of risk factors • **Making Every Contact Count (MECC)** • Delivering nationally agreed **models of care** • **Optimising use of medication and therapy**
Cardiovascular health	• Proactive case finding in primary care e.g. AF, hypertension, lipids. • Optimising these risk factors	
Respiratory health	• Targeted lung health checks • Spirometry and FeNO • Symptom-led prehab and rehab	
Lower back pain	• Single point of access for MSK • Following national back pain pathway	
Anxiety/depression	• Roll out of integrated community model of care	

Summary of recommendations for children and young people priorities

Priority Condition	Condition specific recommendations	Themed recommendations
Diabetes	• Access to diabetes **MDT** • Access to **technology**	• **Primary prevention** • **Secondary prevention** • **Making Every Contact County (MECC)** • Delivering nationally agreed **models of care** • **Optimising use of medication and therapy** • Ensuring targeted approaches to **reduce health inequalities** • Meet **Core20 PLUS 5** requirements • Ensuring compliance with national **models of care** • **Strengthened clinical leadership** • Facilitating **effective transition**
Asthma	• Access to **diagnostic hubs**	
Epilepsy	• Access to epilepsy **MDT**	
Obesity	• Ensuring **whole system approach** to obesity and weight management	
Oral health	• Improved access to primary dental services to reduce number of extractions due to tooth decay	
Anxiety and mental health	• **MHST in schools** • Embed **trauma informed practice** • Access to **health psychology** for those with a LTC	
Autism and learning disabilities	• Development and rollout of **neurodevelopmental pathways** • Increase number of **learning disability health checks**	

Implementation, performance management, monitoring and evaluation approaches

- **We will use** an outcomes framework for each priority condition, monitor progress and adjust our plans to ensure impact
- **We will monitor** the local NHS contribution to the improvement of outcomes in those priority conditions through robust implementation plans
- **We will ensure** that our implementation plans are person centred
- **Each condition** will have focused management, clinical leadership and governance aligned to its delivery
- **We will work** with system partners to ensure action taken is innovative, maximises the use of technology, develops our workforce and maximises our assets
- **Plans will be costed**, and delivery will be evaluated to demonstrate high impact change
- **Our actions will be taken** on a whole population and targeted intervention approach to reduce health inequalities



Better Health and
Wellbeing for All

NHS
North East and
North Cumbria

Clinical Conditions Strategic Plan 2025-2030

Produced by the North East and
North Cumbria Integrated Care Board
June 2024