NHS
North East and
North Cumbria

North East and North Cumbria Joint Forward Plan 2023/24 – 2028/29

September 2023

Better health and wellbeing for all...

Contents

Foreword – Samantha Allen, ICB Chief Executive

Following the publication of our Integrated Care Strategy in December 2022, we have been working closely with our partner organisations to produce our joint forward plan.

Our Integrated Care Partnership Better Health and Wellbeing for All strategy requires a sustained collaboration across a broad range of partners and stakeholders, beyond the improvements to outcomes that health and care services can deliver in isolation.

Our joint forward plan is complementary to Better health and Wellbeing for All strategy. It is a delivery plan for the parts of the strategy related particularly to NHS delivered or commissioned services, but within the broader partnership context.

Our joint forward plan provides a:

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

As part of our joint forward plan, we have developed detailed action plans for:

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

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

Samantha Allen

Chief Executive

North East and North Cumbria Integrated Care Board

1 Introduction to the Joint Forward Plan

1.1 Background.

1.1.1 The Joint Forward Plan.

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

- Principle 1: Fully aligned with the wider systems ambitions.
- Principle 2: Supporting subsidiarity (meaning making decisions as locally as possible and not relying on central decision making), building on existing local strategies and plans and reflecting universal NHS commitments.
- Principle 3: Delivery focussed, specific objectives, trajectories and milestones.

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

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

1.1.2 Delivery plan for the Integrated Care Partnership (ICP) Better Health and Wellbeing for All Strategy.

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

- Longer, healthier lives: reducing the gap between how long people live in the North East and North Cumbria compared to the rest of England.
- Fairer outcomes: we know that everyone does not have the same opportunities for good health, because of where they live, their income, education, and employment.
- Better health and care services: high quality services no matter where you live and who you are.
- Giving our children the best start in life: enabling them to thrive, have great futures and improve lives for generations to come.

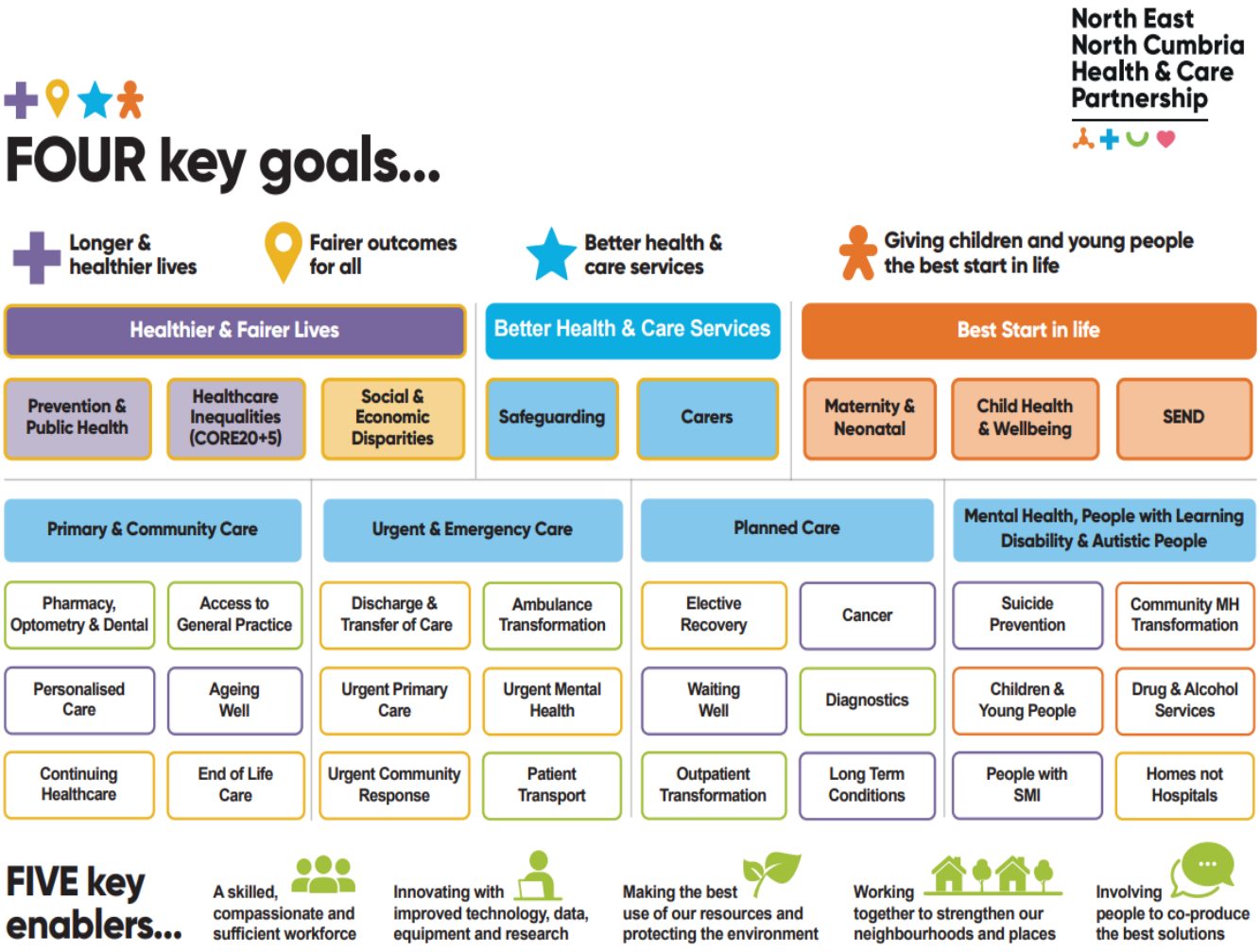
Our joint forward plan is a delivery plan for the parts of the strategy related to NHS delivered or commissioned services.

1.1.3 How the joint forward plan is organised.

Our Joint forward plan is aligned to the Better Health and Wellbeing for All strategy. It covers the strategy:

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

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



Note: The diagram above give a basic indication of our key work programmes. It is difficult to give a good visual representation of all the work programmes and their connections to each other.

1.1.4 Action Plans.

As part of our joint forward plan, we have developed action plans including:

- the integrated care strategy goals
- the integrated care strategy enablers
- key service areas, for example urgent and emergency care.

The action plans are address the immediate priorities and the longer-term transformation priorities. They include key deliverables meaning what we will deliver, and by when, and measures of impact. Where possible the plans have been developed in partnership, often through an existing integrated care system workstream or clinical network or place-based partnership. Our action plans are informed by:

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

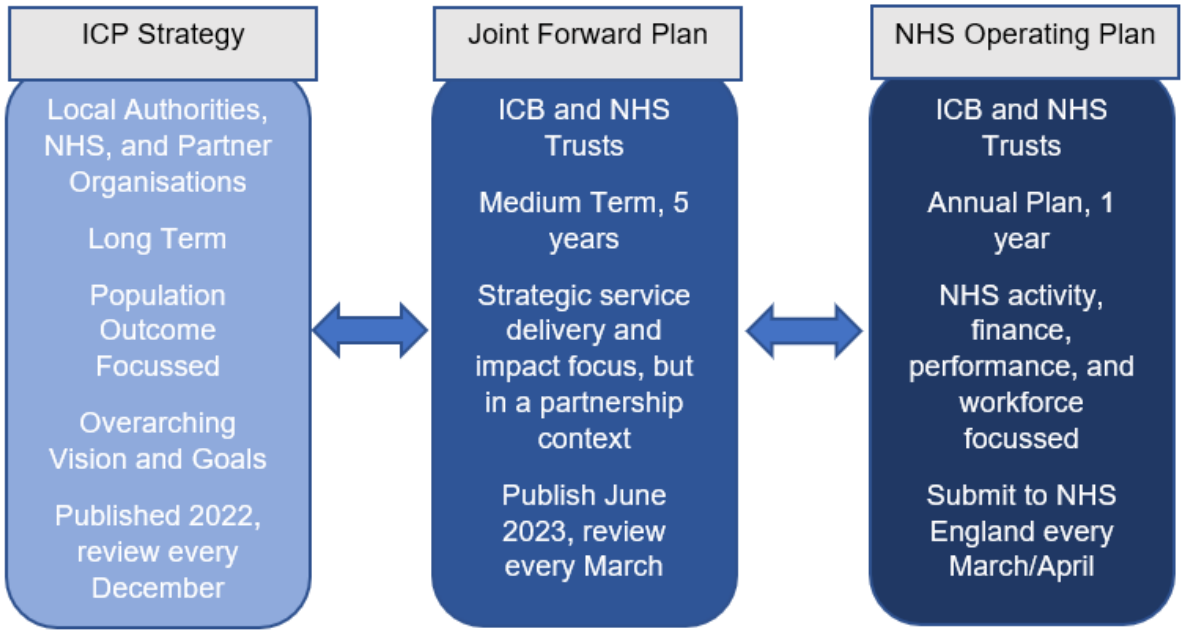
1.1.5 Review and update.

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

- Our implementation over the previous year
- Our maturing partnerships, integration and aligned programmes of work.
- Our learning, as we seek to be the 'best at getting better'.
- Changes in population needs, national policy, good practice, and legislation.
- Confirmation of resource allocations, the funding we have available.
- The views of experts by experience and communities, partners and partnerships including Health and Wellbeing Boards.

1.1.6 How our plans fit together.

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



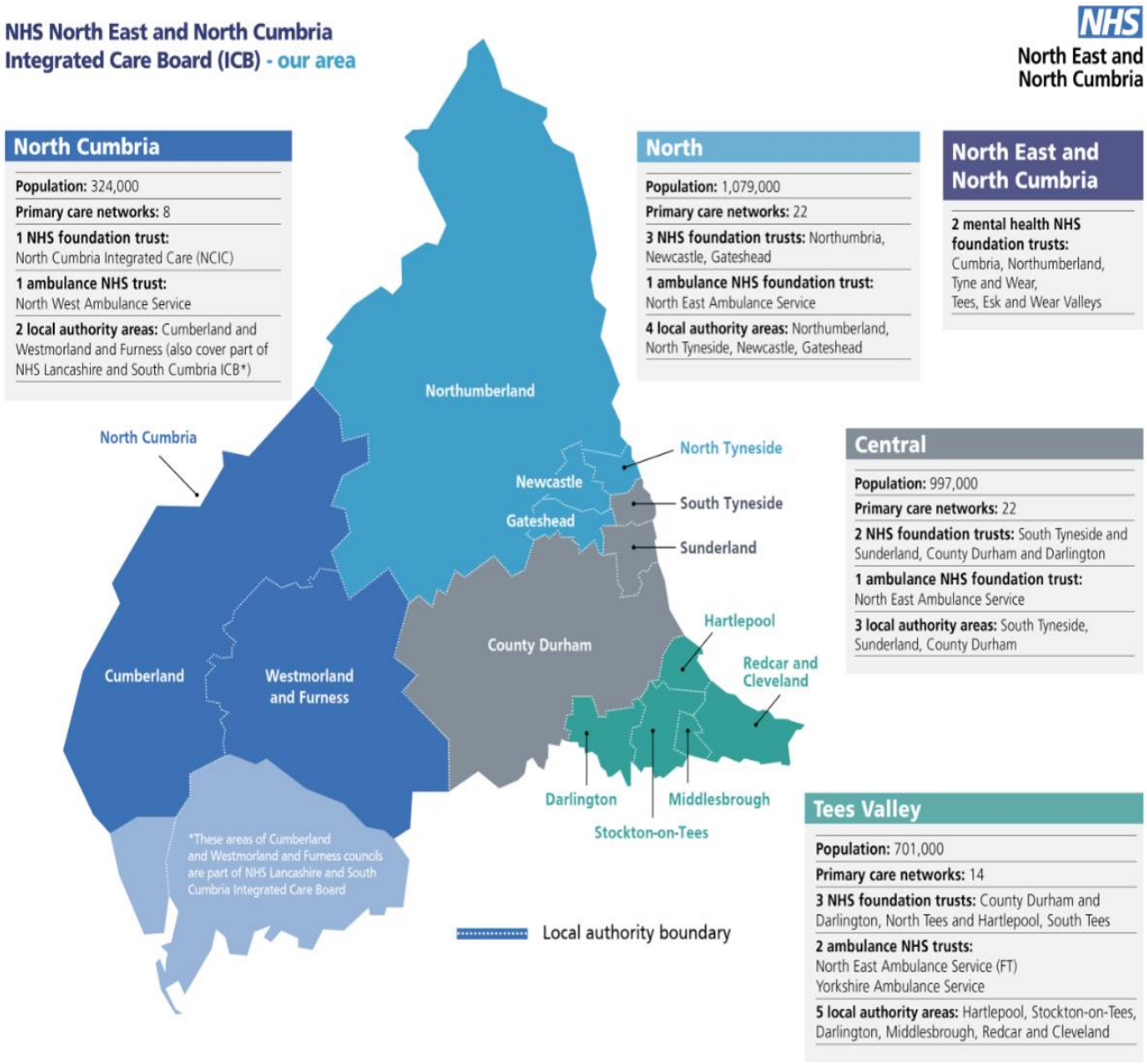
1.2 Our population and healthcare services.

The NHS workforce across the North East and North Cumbria totals nearly 90, 000 full time equivalent staff and includes:

- General Practices, grouping together across 64 primary care networks.
- Community pharmacy, optometry and dental practices.
- Eight NHS Trusts predominantly (though not exclusively) delivering physical health community and hospital-based services.
- Two mental health and learning disability NHS Trusts.
- North East, and North West, Ambulance Services delivering NHS 111, non-emergency patient transport services and 999 paramedic emergency services.
- NHS commissioned, free at the point of delivery community, voluntary and social enterprise and independent sector services.

The North East and North Cumbria ICB covers the largest resident population of c3 million (2021 census). Our population:

- is older, 21% are over 65 compared to 18.6% in England.
- experiences significant socio-economic deprivation. 1 in 3 people live in the most 20% deprived communities in England.
- experiences health inequalities. Life expectancy and healthy life expectancyat birth are significantly worse than the England average.



1.3 How we developed the joint forward plan.

1.3.1 Draft joint forward plan for feedback.

Our ways of engaging and involving people and stakeholders are still developing, but we have actively sought and received feedback to inform the joint forward plan. We have a clear ambition to strengthen our approach to engagement and involvement as a continuous focus for the future.

NHS England requested that ICBs and NHS Trusts publish a final version of the joint forward plan by the end of June 2023. For the North East and North Cumbria, we wanted to take more time. We chose to publish a draft version of the joint forward

plan on the ICB website in the first week in July. We also wrote to a wide range of partner organisations and partnerships in early July seeking their views on the draft document by the end of August. This followed discussion at the North East and North Cumbria Integrated Care Partnership in June.

Developing the joint forward plan:

- We began in March 2024 by developing action plans for each Place (typically a local authority area) and each North East and North Cumbria work stream or clinical network.
- This was based around current work and thinking about a longer-term vision and areas for improvement or transformation.
- The action plans tried to include the priorities requiring focussed work, supported by measurable objectives.
- In some cases, it became clear that our planning processes are not yet sufficiently mature, or our work programmes are still unclear.
- A frequent challenge was the crossover or interdependency between priorities at place, and priorities across the whole North east and North Cumbria.
- We summarised the key points in the action plans to develop a single overarching draft joint forward plan – which inevitably became a high-level document.
- We sought feedback on the draft, used the feedback to inform the final document, and retained feedback to also support the March 2024 refresh document.

During July and August, we received a wide range of feedback from individual members of the public, experts by experience, and members of staff. We also received feedback from partner organisations across the NHS, voluntary community and social enterprise organisations, local authorities and others including academic, research and innovation partners. As far as possible we also sought feedback from each of the Health and Wellbeing Boards, recognising the practical difficulties of doing so in the time available. This was strengthened by an additional discussion with the North East Joint Overview and Scrutiny Committee in September.

Key Questions for partners:
In discussion with partner organisations, we particularly requested feedback around three key questions:

i) whether anything was missing from the draft or needed to be described differently
ii) whether the draft was consistent with key priorities at Place, and,
iii) if the draft is consistent with other key priorities across the North East and North Cumbria.

Most feedback offered constructive suggestions on how the final plan could be improved. Feedback was typically generously offered with 'it would be better if' insights and observations, rather than requests for fundamental changes to the draft. This included suggestions about specific issues which respondents felt were not present in the draft or did not go far enough with clear commitments.

Key areas of feedback included:

- Use of language
- Partnership working compared to an NHS focus.
- Locality/Place focus compared to the whole North East and North Cumbria
- Clarity of objectives
- Key NHS services of concern to experts by experience and stakeholders
- Stakeholder engagement and involvement
- How resources/investments will support the delivery of the plan
- Programme delivery and governance – how programmes link together and who decides what.

Helpful feedback highlighted the need to:

- use accessible language.
- explain technical content.
- explain references to work programmes that may be unfamiliar to people.
- avoid unexplained acronyms and jargon.
- avoid language that could be stigmatising or labelling.

Some respondents felt the draft plan was not clear in terms of its scope, particularly whether it was a plan for the NHS, or a plan for the wider partnerships. They requested a more inclusive approach, with a greater focus on partnership working and integration. Equally, some respondents were concerned that the draft plan gave the impression that the NHS was trying to lead on areas of work it is not primarily responsible for. Those respondents suggested that the plan should focus on what the NHS specifically will do in relation to healthcare services.

Some feedback identified that the objectives in the draft need to be more specific. The content was felt to be principles or broad statements rather than tight and measurable objectives. This was often linked to concerns about how the delivery of the plan would be monitored and reported.

We received feedback that the draft plan was not sufficiently focussed on key areas of NHS service delivery that are of the most concern to citizens and people who use

services. Generally, feedback including from Health Watch reports, raised the following as key issues requiring concerted effort and greater clarity:

- Dentistry – specifically inequalities in access to NHS Dentistry.
- General Practice – specifically the challenges in access to General Practice.
- Mental Health and neurodevelopmental pathways – often but not always in relation to children and young people.
- Access and waiting times, particularly for elective care.
- Long term conditions, including diabetes.
- Health inequalities, specifically how the NHS will work to reduce inequalities in healthcare.
- Prevention, how the NHS will seek to make greater investments in prevention and how this will be funded.

Inevitably the draft did not comprehensively cover all areas of health and health care. Respondents requested a wide range of further service areas to be included. Some of the clearest themes related to:

- Women's health.
- Trauma informed services, sometimes linked to safeguarding and reducing the impact of violence on women and girls.
- Environmental sustainability.
- Collaboration, particularly the role of the Provider Collaborative arrangements.

Several respondents were concerned that there is a risk of losing local focus. They felt that a plan across all the North East and North Cumbria might not give sufficient attention to the particular needs of local populations, how local services work, and how local partnerships have developed. This included a concern that local decision making may be diminished, but also that there needs to be better clarity on how local working interplays with North East and North Cumbria wide approaches.

A recurrent theme in the feedback was a lack of clarity on how the programmes link together. This included several requests for an overarching visual description of all of the key workstreams and clinical networks.

Finally, some respondents were concerned, or at least unclear, about how engagement with experts by experience and stakeholders would be properly built into all of the work described in the draft. Some respondents advocated a greater direct involvement in decision making, and the principles of co-production.

1.3.3 Summary of changes.

We have read and considered all the feedback received. We have not been able to make all the requested changes. In some cases, there were simply different views from respondents. More generally our plans and ways of working are not yet well developed to answer all the issues respondents quite reasonably raised.

We hope that the people who gave feedback will be able to recognise that we have listened. Briefly, some of the key changes we have made include:

- Hopefully, clearer use of language where possible.
- Trying to be clearer about areas where the NHS will seek to be a good partner versus areas where the NHS is responsible or leading work.
- Added new sections for example on women's health.
- Changed the description of objectives to areas of focus.

1.3.4 March 2024 refresh – see section 8.

We recognise that we have not fully addressed the requests for greater clarity on the role of Place/localities, and on the various governance and partnership structures. In part these are under review in the context particularly of changes in the ICB. We anticipate a clearer position for the March 2024 refresh of the joint forward plan.

March 2024 Refresh:

We have not been able to act on all the feedback received for the first joint forward plan. We have kept all the feedback and will use this to inform our work over the coming months to develop the March 2024 refresh of the plan. We have specifically noted:

- The need to be clearer about our partnership and governance arrangements, particularly the role of locality-based work.
- The need for clearer and more specific objectives, including how progress will be measured and how we will align investment or resources to achieve key programmes.
- Some of the areas that really matter to experts by experience and stakeholders, for example a stronger section on improving access to General Practice.

2 Delivering the Joint Forward Plan

2.1 Partnership Working.

Delivering the joint forward plan is dependent on partnership working across the NHS and with our broader partners. Although NHS England require the plan to be focussed on the NHS, we are very mindful of the need to work in partnership. This includes with local authorities, the community, voluntary and social enterprise sector, academic, research and innovation partners and the independent sector, and increasingly experts by experience.

The joint forward plan is intended to support, not diminish, our commitment to partnership working. We strongly recognise the role of Health and Wellbeing Boards. They provide a strong focus on establishing a sense of place, instil a mechanism for joint working and improving the wellbeing of their local population, and set strategic direction to improve health and wellbeing. The ICB is a member of each of the Health and Wellbeing Boards and is fully committed to being an active partner recognising the statutory leadership role of the Boards. They are especially important in giving local leadership to addressing the wider determinants of health, and to the local delivery of the Better Health and Wellbeing For All Integrated Care Strategy.

We are still developing the role of ICB delegations at place/locality level and how they align with the work of health and Wellbeing Boards. This is further described in section 6.2.

The North East and North Cumbria Integrated Care Partnership (ICP) is a statutory committee jointly formed between the Integrated Care Board and all upper-tier local authorities that fall within the ICS area. The ICP brings together a broad alliance of partners concerned with improving the health and wellbeing of the population. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area. We published our ICP strategy, Better Health and Wellbeing For All, in December 2022.

Across the North East and North Cumbria, we have a broad range of workstreams and clinical networks. They perform a vital role in taking forward the delivery of the relevant sections of the joint forward plan.

We want to ensure that all of our partnership arrangements are inclusive of local authorities, the voluntary, community and social enterprise sector, and the independent sector, wherever relevant. We equally want to ensure that experts by experience are strongly included on our arrangements.

The delivery of the plan will require strong collaboration between providers of NHS or NHS commissioned services. The Provider Collaborative arrangements (see section 5.2) will play an increasingly key role in this.

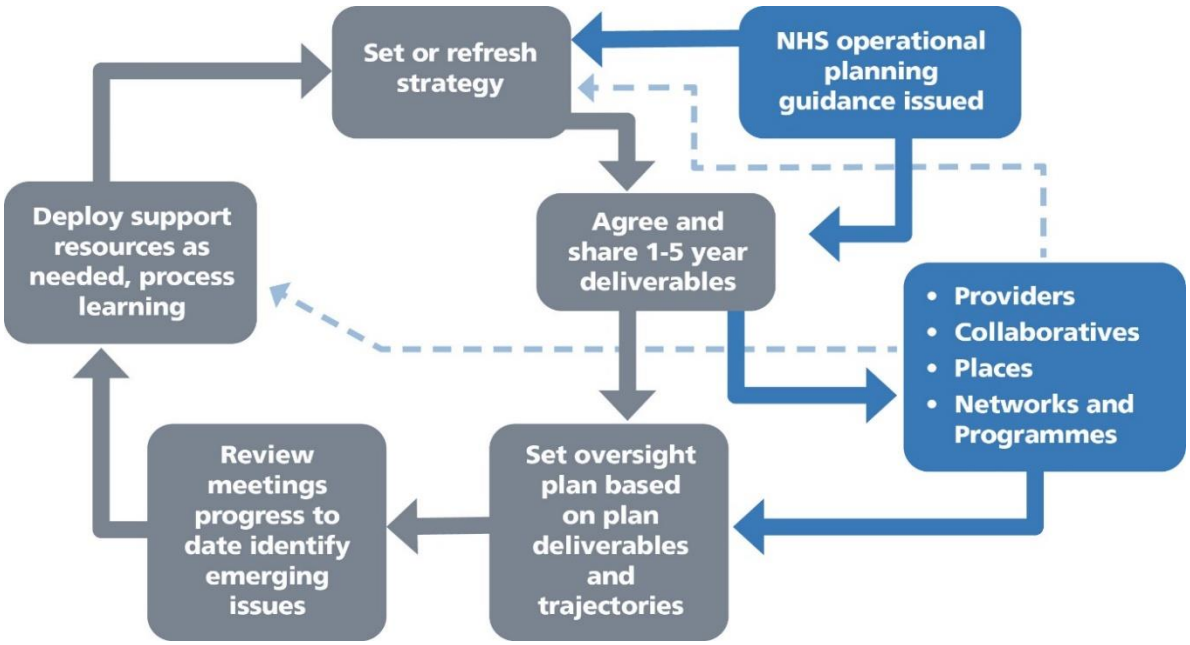
2.2 Delivery.

2.1 Overview.

The overall approach to Strategy deployment is summarised in the graphic below:

Establish mission/vision	→	Purpose of an ICB
Strategy, key priorities objectives	→	Better health and wellbeing for all ICP Strategy
Deploy to teams, plans with metrics	→	Place, service and enabler action plans with measurable goals
Implement plans, track progress	→	Delivery of plans, impact focus
Quarterly review timetable & process Service	→	Oversight Framework Place, and Enabler workstreams
Annual review, reflection, evaluation Plan	→	ICP Strategy and Joint Forward Review and Refresh

Working with our partners, the ICB has developed a robust framework to deliver the Integrated Care Strategy set by the Integrated Care Partnership and this joint forward plan. The ICB Oversight Framework articulates the ICB Cycle of Business, as set out in the figure below:



Each discrete plan that makes up the joint forward plan will have a:

- Delivery plan, with clear actions, milestones, and measurable impacts.

- Lead ICB executive, a lead director, and an identified group within the ICB governance structure responsible for the plan.
- Regular reporting mechanism into the ICB Oversight Framework.
- Regular meeting with those working on the programme and the lead ICB Executive to discuss progress and to tackle any delivery difficulties.
- Facilitated leader forum to share good practice and learn with others.

2.2 Tracking Progress.

The ICB will receive regular reports on the progress in completing the actions identified within the plans. This will take the form of a 'strategy deployment milestone tracker' which will come to the ICB Board twice each year. The ICB Executive Committee has delegated responsibility for the delivery of plans. It will ensure that it has a formal reporting line from all the groups with responsibility of a section of the joint forward plan.

2.3 Taking a learning approach – being 'the best at getting better'.

The ICB has set its Mission as becoming 'The best at getting better'. In 2023/24 the ICB will take its learning system to the next stage of development. This will be a key plank of support underpinning the delivery of our plans. Teams will have access to communities of practice through the learning community, and to training and resources to support them. To achieve this, we will:

- Make learning and improvement the default approach in how we go about tackling our biggest challenges.
- Bring people together from across the system to identify, share learning and collaborate on these challenges.
- Build collective capability in learning and improvement.

2.4 Using data and insight.

The ICB is working with partners to ensure we improve our use of data to drive our decision making and plans. During 2023/24 we will improve our business intelligence and population health management capacity and capability to:

- Have a better understanding of the population health and wellbeing needs, including variation within our places compared to the national picture.
- Have a systematic approach to using population health and other insight to focus our programmes and measure their impact.
- Have a comprehensive, well presented, and accessible set of information reports and programme updates.

2.3 Operating Model.

2.3.1 Workstreams and Clinical Networks.

In the second half of the 2023/24 financial year, we will work with partners to review our workstreams and networks, to ensure that they are clearly aligned to the key programmes in the joint forward plan.

2.3.2 Refining the ICB's operating model.

There is a clear opportunity to refine the ICB operating model to ensure it is set up to deliver its vision and goals. ICBs are required to reduce their running costs by 30% over the next 3 years. During 2023/24, the ICB will develop and deliver its 'ICB 2:0' programme, with the following measures of success:

1. An ICB set up to drive delivery of our Integrated Care Strategy.
2. An intelligence driven organisation that tracks, triangulates and forecasts; is responsive not reactive and truly knows its population and the impact of its interventions.
3. An organisation that develops and maintains excellent relationships and fosters collaboration with and between health and care partners.
4. An operating model that is transparent, reliable, effective, and efficient, does things once and to an excellent standard with a quality management system.
5. Ability to meet our statutory responsibilities and ensure quality and safety is prioritised.
6. Affordable within the running cost envelope.
7. A healthy, engaged, skilled, productive, inclusive, and diverse workforce.
8. Clarity of role and responsibility for all, with clear alignment of clinical and managerial leadership to all elements of the operating model.
9. Continuation of a flexible and hybrid working model, with more sharing of work spaces with partners, optimising the use of technology.
10. An open, honest, equitable and compassionate change process to implement the new arrangements, driven by our values.

3 Longer, Healthier Lives and Fairer Outcomes

3.1 Introduction.

We recognise that health outcomes and health inequalities are caused or influenced by a wide range of socio-economic factors. Those factors are often beyond the control of the NHS. Improving health outcomes and reducing health inequalities requires a long-term approach from all partners. This work is coordinated at a local level by Health and Wellbeing Boards in response to joint strategic needs assessments.

However, we also recognise that the NHS can be a good partner in seeking to influence the wider determinants of health and can also take positive action to reduce inequalities in how health care is delivered.

The Healthier and Fairer Programme is a system-wide approach to prevent ill health, reduce healthcare inequalities, and support the NHS to play a greater role in addressing social and economic inequalities. All the work programmes are delivered in partnership through:

- three key workstreams – prevention, healthcare inequalities and the NHS contribution to positively influencing the wider determinants of health.
- three enabling workstreams - population health management, workforce development and community asset-based approaches.

Each workstream is co-chaired by an ICB Medical Director and a Director of Public Health, with membership drawn from across the health and care system.

3.2 Our position now.

Life expectancy at birth and healthy life expectancy at birth in our region are lower than the rest of the country. Using these measures, the North East and North Cumbria has some of the worse health outcomes in England. There are also inequalities in life expectancy at birth between the most deprived 20% and least deprived areas within our region. In 2020/21, the difference in life expectancy was approximately 8.1 years for women and 10.4 years for men. The difference is much larger than the comparable inequality gap for England.

The North East and North Cumbria population has some of the lowest health literacy levels in England. Risk factors for low health literacy include deprivation and having multiple long-term conditions. People who receive the most health information often have the least capacity to benefit from it due to the impact of their health literacy. Low health literacy may accommodate for 3–5% of total healthcare costs.

Definitions:

- **Anchor institutions**: The Health Foundation describes anchor institutions as large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. These organisations are 'rooted in place' and have significant assets and resources which can be used to influence the health and wellbeing of their local community. Anchor institutions can help address local social, economic, and environmental priorities in order to reduce health inequalities.
- **Core20PLUS5** is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.
- **Health care inequalities**: inequalities experienced by people in the delivery of healthcare services. This includes access, uptake, experience and outcomes associated with healthcare services.
- **Health literacy**: is about being able to access, understand, check, and use information to make choices about health.
  Health inequalities: Health inequalities are unfair and avoidable differences in health across the population, and between different groups.
- **Inclusion health groups**: an umbrella term to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.
- **Proportionate universalism**: seeking to reduce health care inequalities by providing universal services that everyone can access but tailored into a scale and intensity that is proportionate to the level of need.
- **Wider determinants of health:** The health of the population is influenced by multiple factors, often referred to as the wider determinants of health, including education, housing, income and the environment.

3.3 Areas of Focus.

3.3.1 Achieving the NHS prevention ambitions.

The NHS has a greater role to play in secondary prevention. Areas of work include:

- Reducing harm from alcohol
- Supporting programmes focussed on healthy weight, exercise and nutrition.
- Reduce the tobacco dependency (smoking) rate to 5% by 2030.
- Improving the detection and management of the 3 high risk conditions for cardiovascular disease (Atrial Fibrillation, Hypertension, and Raised Cholesterol).

3.3.2 Reducing health and healthcare inequalities.

Our key approach to reducing healthcare inequalities is to deliver the Core20PLUS5 programme. This includes delivery to meet the following objectives **for adults**:

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

For **children and young people**:

- Improve asthma care, decrease the number of asthma attacks, and reduce the over reliance on reliever medications (inhalers used when short of breath)
- Improve diabetes type 1 care, increasing access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds.
- Increase the proportion of those with Type 2 diabetes receiving recommended NICE care processes.
- Increase access to epilepsy specialist nurses and ensure access in the first year of care for people with a learning disability and autistic people.
- Improve dental care, recognising the Core20PLUS5 measure to reduce the number of tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under
- Improve access rates to mental health services, for certain ethnic groups, age, gender, and deprivation.

- Embed approaches to smoking prevention and reducing nicotine dependence (smoking) in all appropriate delivery plans.

3.3.3 Health care inequalities.

Delivering Core20PLUS5 as above will have a real impact on health care inequalities. We will ensure that tackling healthcare inequalities in access, experience and outcomes is at the centre of our planning and delivery of healthcare services. This also includes taking steps to apply Proportionate Universalism in their service delivery to address healthcare inequalities. Additionally, we are working to better understand inequalities in how health care is delivered and experienced. A Healthcare Inequalities Toolkit has been developed that will support all parts of the healthcare system in identifying healthcare inequalities. This also includes taking steps to apply Proportionate Universalism in their service delivery to address healthcare inequalities.

Part of our approach will be based on a recognition of health literacy. We want to enable our healthcare services, and where applicable jointly with other partners, to communicate in a way that is accessible and easy to understand by ensuring:

- Health literacy is considered in planning, evaluation measures, quality improvement, and patient safety.
- Health literacy approaches are used in all communications and easy-to-use materials that are easy to access.
- Our population is involved in the design, implementation, and evaluation of health information.
- Effective training, continuing professional development, recruitment and selection with health literacy in mind.

3.3.4 NHS contribution to reducing social & economic inequalities.

Social and economic conditions are influenced by policy choices beyond the NHS's control. The ICB is committed to working collaboratively alongside partners to make a positive change. This includes:

- Health literacy (as above)
- Poverty proofing health settings to removes barriers to improving healthcare access, experience, and outcomes.
- Maximising digital solutions, while guarding against digital exclusion.
- Anchor institutions network to maximise their impact.

3.3.5 Embed Population Health Management.

Our Population Health Management approach is a key *enabler*. Our approach is data driven to help plan and deliver care that maximise health outcomes and reduces health inequalities. This priority is closely aligned the Digital, Data and Technology enabler in section 6. Our areas of work include:

- Developing the critical infrastructure to enable population health management approaches at neighbourhood, place and system levels.
- Develop a full longitudinal dataset across primary, secondary, mental health, social care, community data and blue light services.
- Ensure a stronger cross system intelligence and population health analytics function.
- Embed population health into mainstream decision making.

3.3.6 Pregnancy and postnatal healthcare.

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

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

3.7 Broader Action on Determinants of Health

3.7.1 Housing.

There are strong links between good quality housing and health. The NHS is clearly not the lead organisation responsible for housing. We recognise the statutory duties of local authorities and the leadership role of other organisations. We want to be a good partner in supporting and working with those organisations.

The ICB and broader NHS will work with partners to develop a plan to effect positive change in relation to housing and its impact on health and wellbeing. The intention is for the NHS to complement and contribute to existing work. To support this, an inaugural Housing, Health and Care Conference was held in May 2023. Based on feedback, the key areas of work are:

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

3.7.1 Work and health.

The NHS is not responsible for leading economic regeneration, ensuring good employment opportunities, or for ensuring that workplaces promote good health. However, the NHS should play a supporting role in achieving each of those aims, working alongside our partners. To support this the Department for Health and Social Care and Department for Work and Pensions Joint Work and Health Unit invited the North of Tyne Combined and Local Authorities to explore the development of a work and health strategy with the ICB. This focussed on tackling the health barriers people face in accessing and sustaining good work.

External mapping support from the Institute for Public Policy Research North identified opportunities including:

- Creating more ‘good work’ in the local public and private sector, including through anchor institutions to widen employment pathways.
- Promote the principles of good work through initiatives such as the Better Health at Work Scheme and North of Tyne Combined Authority’s Good Work Pledge
- Explore Community Wealth Building approaches to develop local supply chains, improve employment conditions, and increase the socially productive use of wealth and assets.

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

4 Best Start in Life

4.1 Maternity and Neonatal.

4.1.1 Introduction.

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

4.1.2 Areas of Focus.

<u>Listening to women and families with compassion which promotes safer care.</u>

Listening, understanding, and acting improves maternity outcomes and experiences. Our work in this includes:

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

<u>Supporting our workforce to develop their skills and capacity.</u>

Good models of care and support can only be delivered by skilled teams with sufficient capacity. We will focus on:

- Growing our workforce resulting in sufficient staffing levels across the whole team supported undergraduate training and establishment.
- Valuing and retaining our workforce and investing in skills.

<u>Developing and sustaining a culture of safety to benefit everyone.</u>

A safety culture improves the experience of care for women and babies and supports staff. This will include:

- Developing a positive safety culture: leaders understand ‘how it feels to work here’ and everyone takes responsibility for safer care.
- Ensuring a compassionate approach to learning from safety incidents.

- Support and oversight: identifying where services require support before serious problems arise in line with the Perinatal Quality Surveillance Model.

Meeting standards that underpin our ambition.

Our action plan does not introduce new standards. We are focussed on ensuring existing standards are consistently in place and met. This includes:

- Standards to ensure best practice: implementation of best practice such as Saving Babies Lives, and rationalisation of standards.
- Data to inform learning: improve the timeliness and accuracy of data and implementing the recommendations of the Reading the Signals: maternity and neonatal services in East Kent – the report of the independent investigation.
- Make better use of digital technology: the implementation of electronic patient records to support flows of information and enable women to have digital access to their care records.
- Priority pathways for the key areas that negatively influence health outcomes, particularly alcohol use, substance use and nicotine dependence.

Family Hubs.

Working with partners we will continue to develop family hubs, building on the experience already in place across localities for example in County Durham. Where practicable this will include enabling community midwifery teams to be co-located with health visiting and other professionals in Family Hubs buildings.

4.2 Children and Young People

4.2.1 Introduction.

Children and young people are included in all the service, enabler, and place plans in the later sections of this Plan. Improving health outcomes for children and young people requires a high level of partnership working, particularly with local authorities, including for example education, safeguarding and social care.

Our Child Health and Wellbeing Network plays a valued role in bringing together partners across the system to have a clear focus on children and young people's health and wellbeing. The wide reach of this work connects into other areas of governance at place and in regional work. The involvement of children, young people, and family's needs to take place in ways that are meaningful to them.

4.2.2 Areas of Focus.

Mental Health and Wellbeing.

Mental Health was the highest priority following feedback and is consistently highlighted by professionals and children and young people. Our focus includes:

- Improve access to mental health support in line with the national ambition accessing NHS funded services.
- Reduce the reliance on inpatient care, while improving the quality of inpatient care for those who need it.
- Skill children, young people, and the workforce to support mental health and resilience.
- Improve access to, and uptake of, perinatal mental health services for mothers.
- Support fathers' mental health and wellbeing, including through family hubs.

Long Term Conditions in Children and Young People**.**

Prevention and the effective management of long-term conditions are key to improving population health and curbing the increasing demand for healthcare services. Our approach will be to:

- Locally deliver NHS England's Children and Young People's Transformation Programme relevant to long term conditions including epilepsy, diabetes, asthma, clinics for excessive weight and transitions.
- Take forward the Integration Centre to drive innovations into our most disadvantaged communities including areas relevant to long term conditions.
- Deliver Core20PLUS5 work focused into these areas enhanced by the North East and North Cumbria local application of the framework.

Children and Young People who may be vulnerable or have complex support needs.

The impact of Covid on our children and young people is well documented. Core20PLUS5 is a national approach to reduce health inequalities. Specific consideration should be taken for the inclusion of young carers, inclusion health groups and other socially excluded groups. Our work includes:

- Ensuring that the waiting times for elective care for children and young people improve at least as quickly as they do for adults. We are undertaking an audit of all children and young people's services waiting times and will focus on the pathways with the longest waits.
- Deliver the children and young people's Core20PLUS5 framework.
- Meet the regulatory framework and good practice for Special Educational Needs and Disabilities (SNED) working with our partners.

Best Start in Life, Pre-school Needs, and Perinatal**.**

We will work with partners to deliver the Best Start in Life Vision for 1001 Critical Days. This will include a focus at the lace/locality level, and delivering initiatives that

skill children, young people, and the workforce to support best start in life, preschool needs, and perinatal mental health.

Health Protection.

We will ensure rates of routine vaccination and immunisations are improved as a key foundation for health protection.

5 Improving Health and Care Services

5.1 Overview.

5.1.1 Strategic Principles.

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

Strategic Principles

- Shift towards self-management and care closer to or in the home.
- Better care co-ordination and personalisation
- Step change in prevention and early intervention.
- Evidence base interventions; reduction in unwarranted variation
- Improved sustainability of secondary and tertiary care; hub and spoke models, using technology and pathways to keep care as local as possible but not at expense of best possible outcome.
- More holistic care towards end of life.
- More timely access.
- Fairer outcomes contribution reducing health care inequalities.
- Improving the local integration of services with partners.
- foster a culture of innovation and use the evidence from research and innovation to drive decision making.
- Using resources wisely and living within our financial means.

5.1.2 Clinical Strategy.

The framework above will also support the development of our Clinical Strategy. This work is led by the ICB Executive Medical Director with extensive clinical stakeholder involvement. The aim of the strategy is to ensure focussed effort through a collective response to the priority areas identified.

Data, intelligence, and insight from system clinical engagement will be used to determine some initial, condition specific priorities for the clinical strategy. The criteria we have used to assess our prioritisation of clinical conditions includes:

- Premature mortality.
- Contribution to the life expectancy gap.
- Morbidity.
- Prevalence.
- Resource utilisation.

The approach is underpinned by population health data, to identify interventions that have the greatest impact on healthy life expectancy and reducing health inequalities. The ICB will work in partnership with provider collaboratives and clinical networks to ensure sustainable services, maximising opportunities to develop our highly skilled and committed workforce.

We are currently identifying our key priorities for adults and children and young people. Once we have formalised these, we will be engaging with the wider professional community to discuss the specific impact interventions which we will use to form the strategy and associated delivery plan. Over the coming months there will be a robust communications and engagement plan to ensure stakeholder involvement before the publication of the final strategy by the end of March 2024. This will be included in the refreshed joint forward plan also in March 2024.

5.2 Provider Collaboratives.

5.2.1 Primary Care Collaborative.

We are working with partners to develop a Primary Care Collaborative covering General Practice, pharmacy, optometry, and dentistry. The proposed functions are:

- Relationships across all four primary care contractor groups.
- Representative voice into the Integrated Care System.
- Co-design the Primary Care Strategy as an equal partner.
- Collaborate across the North East and North Cumbria.
- Work with and influence other provider and clinical networks.
- Fuller Stocktake delivery and the transformation and stability of primary care. (Implementing the report Next Steps for integrating primary care: Fuller Stocktake led by Dr Claire Fuller and published in May 2022).

5.2.2 Mental Health, Learning Disability and Autism Provider Collaborative.

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

- Children and Young People Mental Health inpatient services
- Adult Low and Medium Secure Services
- Adult Eating Disorder Services.

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

5.2.3 North East and North Cumbria Provider Collaborative.

The Collaborative was formed in 2021 to create a vehicle for foundation trusts to collaborate to achieve better outcomes than each organisation could deliver on their own. The Collaborative contributes to the delivery of the Better Health and Wellbeing for all strategy goal 'Better Health and Care Services' through:

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

The Collaborative is a key point of collective leadership and has potential to develop further as an important part of our governance structures. It includes all the NHS Trusts in the North East. The North West Ambulance Service is part of the Provider Collaboratives in the North West but has links to the Collaborative.

The Collaborative have agreed ten principles which outline how we will work together to develop an even stronger culture of collaboration.

1. We will support each other and provide mutual aid in times of pressure.
2. We will make shared decisions to speed up transformation and change.
3. We will challenge each other and hold each other to account.
4. We will always act in good faith and in the best interests of the people we serve.
5. We will empower staff to work with other Trust staff to improve care.
6. We will make sure there is strong clinical leadership and governance in all our work.
7. We will actively involve staff, patients, the public and wider stakeholders.
8. We will show solidarity when making decisions for the local population.
9. We will take responsibility for delivering on agreed priorities and manage risks together.
10. We will promote a high performing culture of teamwork, innovation and continuous improvement. To do this we will share information, communicate honestly and respectfully and act ethically with responsible behaviour and decision making.

The Collaborative has identified five key delivery priorities to be delivered via three programmes of work:

Clinical Programmes	**1.** To develop a strategic approach to clinical services encompassing acute, mental health, learning disabilities and community. This will focus on addressing vulnerable services, harnessing and developing our centres of excellence, thinking about a strategic response to clinical networks and associated cross system working arrangements.
	2. To deliver on elective recovery including all service aspects of inpatient, diagnostics and cancer care, as well as mental health and learning disabilities. Our aim is to meet or exceed national benchmarks, standards and targets.
	3. To deliver urgent care standards (including ambulance standards) and requirements across all NENC providers and local systems to reduce variation and improve consistency of response
Clinical Support Programmes	**4.** To build capacity and capability in clinical support services (particularly diagnostic capacity) to ensure appropriate infrastructure is in place to deliver the above clinical priorities.
Corporate Programmes	**5.** To support the wider ICS in sustainable transformation, establishing and delivering appropriate corporate strategies to enhance integration and tackle variation. This will include approaches to collective planning, rationalised and aligned estates/capital processes, the development of underpinning approaches in workforce and a commitment to the North East and North Cumbria green strategy.

The Collaborative will be refreshing its work programme in the Autumn of 2023 and more detail will be included in the March 2024 refresh of the joint forward plan.

5.2.4 Hospice Collaborative.

We will work collaboratively with Hospice Providers as valued partners, including through the developing Hospice Collaborative. This recognises the role of Hospice Providers not just in palliative and end of life care, but also in delivering a range of community services.

Cross Cutting Themes

5.3 Personalised Care Plan.

Personalised Care needs to be embedded throughout all workstreams as an enabler to transformation as part of a whole system approach. Delivery of the ICB's legal responsibility relating to the consistent provision of Personal Health Budgets and Personal Wheelchair Budgets needs to be a priority. Our focus includes:

5.3.1 Embed personalised care approaches across all workstreams.

Our aim is to harness the universal approach to personalised care throughout all workstreams by:

- Engaging with all workstreams to identify where personalised care approaches can be maximised in their service transformation work.
- Workforce development with the ICS Workforce workstream.
- Implementing Schedule 2 of the NHS Standard Contract.

5.3.2 Supporting primary care networks.

We know that social prescribing link workers, care co-ordinators and health and wellbeing coaches are key to the NHS Long Term Plan commitments on personalised care. We will work to ensure that all Primary Care Networks have social prescribing link workers and an expansion of ARRS roles, for example in perinatal mental health and for autistic people. This needs to be implemented carefully recognising the additional leadership and supervision time ARRs roles require from General Practitioners.

5.3.3 Maternity

We will work to ensure all women have personalised and safe care through a personalised care plan and are supported to make informed choices. We will support the Local Maternity and Neonatal System to embed Personalised Care, in line with the Three-Year Delivery Plan for Maternity and Neonatal Services.

5.3.4 Joined up clinical care.

More generally, we know that many people experience disjointed clinical care for themselves and/or their loved ones. We recognise the long term, systemic, challenge to improve the clinical coordination of care and communication with patients and carers.

5.4 Carers.

Family and informal carers, including young carers, often experience significant challenges in accessing the right support for the person they care for and themselves. They also often experience a significant impact on their own health and wellbeing. We need to place people including carers at the centre of our work. This requires partnership working at a local level with communities. In many areas, support for carers is jointly developed and commissioned by health and social care. We recognise the importance of supporting people with a caring role to access health services but equally recognise that the focus should be on supporting carers as a whole person. With partners, we will:

- Embed support for carers in all our work programmes.
- Improve access to support for carers.
- Consider the impact on carers in all of our assessments of service changes.
- Ensure the voice of carers is included in all our engagement programmes.

5.5 Safeguarding and Cared for Children including Care Leavers.

Safeguarding is a key priority across all elements of service provision. We will work closely with partners, particularly local authorities (including as the corporate parents of the looked after children). We have developed a range of key priorities for safeguarding. Each priority will be led by a senior NHS safeguarding lead (denoted as workstreams), will be reviewed with oversight from the Integrated Care System Health Safeguarding Executive, and updated in line with national guidance.

5.5.1 Cared for Children including Care leavers.

The poor physical and mental health outcomes for care leavers and care experienced are stark. Children in care have often experienced significant trauma and face difficulties accessing health support. Children from the poorest 10% of neighbourhoods are 10 times more likely to be in foster or residential care than children from the least poor 10%. Our objectives include:

- To reverse the trend in statutory health care for cared for children.
- To ensure well-coordinated, targeted, proactive, and preventative health provision to ensure equitable access to mental and physical health and care.
- To deliver the NENC ICB commitments in the Care Leavers Covenant.
- To ensure integrated care pathway for cared for children.
- To Align support to care leavers until up to 25 years of age.

5.5.2 Transitional Safeguarding.

Investing in support to address harm and its impacts at this life stage can help reduce the need for more costly intervention later in life. Our objectives include:

- Embed a trauma and psychologically informed approach across all commissioned health services, recognising the lifelong impact of trauma.
- Ensure cared for children experience a smooth transition from child to adult mental health services with appropriate support.

5.5.3 Domestic Abuse.

The Domestic Abuse Act 2021 puts an emphasis on strengthening the response across all agencies and making domestic abuse everyone's business. The ICB is subject to the statutory Serious Violence Duty and must collaborate with other duty holders to prevent and reduce serious violence. The ICB has a particular duty to ensure that the needs of victims of abuse and children and young people are specifically addressed. Experience of violence increases health inequalities. Young females are most likely to experience domestic abuse. Our areas of focus include:

- Ensuring that the ICB wide working environment adopts and promotes the view that domestic abuse is unacceptable and will not be tolerated.
- Embedding the Domestic Abuse Act 2021 principles of prevention, early intervention and multi-agency working for victims and survivors.

5.5.4 Self-Neglect.

Self-neglect poses complex challenges to practitioners and is one of the most common forms of abuse in adults. The prevalence of self-neglect are higher among certain ethnic groups, the elderly and those with lower levels of education and income. Chronic illness and disability increase the risk of self-neglect. Our work will include a focus on:

- Supporting the approach of Making Safeguarding Personal when working with individuals who self-neglect and address the challenges in practice.
- Delivering an CB wide approach to ‘Was Not Brought’ for children and adults.

5.6 Serious Violence.

Integrated Care Boards are one of the five duty holders and as such are required to work together to specified to prevent and reduce serious violence. We will continue to use our established partnership arrangements to response to the requirements of this duty, building on existing work with the aim of further reducing incidents of serious violence. This will be a much stronger area of focus in the March 2024 refresh of the joint forward plan, and links to a range of existing work programmes including safeguarding, trauma informed services and women's health.

5.7 Women's Health.

Although on average Women in the UK live longer than men, they also spend a greater proportion of their lives in ill health or disability than men. Many women endure a poor experience of health care services. The underlying cause of which is that the health system has historically been built by men for men. Consequently, women are often not listened to or believed by the health and care system.

In August 2022 the Department of Health and Social Car published the Women's Health Strategy for England. This document sets out the 10-year ambitions for improving the health and wellbeing of women and girls and how the health and care system listens to women. The strategy encourages the expansion of women's health hubs across the country to improve access to services and health outcomes. The Strategy's 10 Year ambitions are:

- Women and girls have more of their health needs met at one time and in one place, through the development of local pathways that bring together and improve access to services – for example, into women's health hubs.
- That there are clear pathways between primary, community and secondary care settings delivered, for example, through hubs, and women and girls can access secondary care and specialist services.

We are developing our North East and North Cumbria Women's Health Programme to take forward the implementation of the national strategy. In October 2023 we will be holding a North East North Cumbria Women's Health Conference with the Office for Health Improvement and Disparities. The conference will highlight work from across the region and will identify areas for improvement. This will form a key part of our collaborative approach to developing our North East North Cumbria Women's Health Strategy implementation plan. Our implementation plan will be focussed on the strategy's seven priorities.

Seven Priorities:

1. Menstrual health and gynaecological conditions.
2. Fertility, pregnancy, pregnancy loss and post-natal support.
3. Menopause.
4. Mental health and wellbeing.
5. Cancers.
6. The health impacts of violence against women and girls.
7. Healthy ageing and long-term conditions.

In year 1 of the joint forward plan our focus is on getting organised and laying the foundations for success. This will include:

- Establishing a Woman's Health Steering Group.
- Grow and develop a Community of Practice for our whole region to work. together, share learning and models of good practice.

- Carry out a review of current service provision.
- Develop a full implementation plan.

In years 2 – 5 of the joint forward plan we will focus on changing service delivery, including the development of Women' hubs across the region. This will be more fully described in the March 2024/25 refresh of the joint forward plan, including the ICB duty to reduce the impacts of violence against women and girls.

Community Focussed Services.

5.8 Ageing Well Service Plan.

The Ageing Well Programme operates at a system-level but driven by place-based partnerships. Our approach is to foster real change, supporting delivery through relationships, collaboration and sharing of best practice. Our feedback shows that some of the key areas important to ageing well include:

- Access to NHS services
- Good information and advice to allow older people to navigate around services and self-manage; and
- Co-ordination of care, to recognise users as customers on a single journey and not pass them on from one service to another.

We will seek to generally incorporate those principles across all our work. Our further areas of focus include:

5.8.1 Urgent Community Response (UCR).

Providing urgent care to people in their own homes within two-hours if their health suddenly deteriorates. Pour objectives are to:

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

5.8.2 Proactive Care (Formally known as Anticipatory Care).

Proactive, personalised care and support for people living with frailty and/or multiple long-term conditions. Our focus will be to support Integrated Neighbourhood Teams (see the Primary Section) to implement the national Proactive Care model.

5.8.3 Enhanced Health in Care Homes (EHiCH).

Enabling proactive care and support to residents and their families. This includes support for Integrated Neighbourhood Teams to deliver the EHiCH model and to reduce variation in EHiCH outcomes across the North East and North Cumbria.

5.8.4 Community Health Services Digital.

We will drive digital transformation with community health services to improve patient care. This will include:

- Improving the use and quality of data within the Community Service Data Set.
- Increasing the number of community providers utilising the Great North Care Record / Shared Care Record.
- Increase learning and sharing of digitally enabled community care and support.

5.8.5 Supporting the workforce.

To increase the uptake and utilisation of the Enhanced Care for Older People (EnCOP) workforce competency framework through a workforce development programme.

5.9 Palliative and End of Life Care (PEoLC) Service Plan.

The Health and Care Act 2022 places a legal duty on ICBs to commission palliative care services. The duty is intended to ensure that the palliative and end of life care needs of people of all ages, with progressive illness or those nearing the end of their lives, and their loved ones and carers, receive the care and support they need to live and to die well. Palliative and End of Life Care is part of clinical subject areas and workstreams such as Primary Care and Urgent and Emergency Care.

We are currently considering the future governance arrangements for the leadership of Palliative and End of Life Care. The North East and North Cumbria Palliative and End of Life Network and the Paediatric Palliative and End of Life Collaborative currently report via the Northern Cancer Alliance (adults) and via the new Children's Alliance (Children and young people) to the ICB Executive Board. Further work is required to ensure an improved governance framework, including developing an all-age Palliative and End of Life Care Board. The ICB is also committed to working collaboratively with Hospice Providers and the Hospice Alliance as part of our partnership arrangements. Our key work programmes include:

5.9.1 Improving access.

Our aim is to remove the barriers preventing access to PEoLC services including:

- Increasing the number of patients on primary care PEoLC registers including children and young people.
- Ensuring 24/7 generalist PEoLC services and 24/7 remote access to specialist palliative care (SPC) advice for staff and carers, in all places.

- Seven-day face to face SPC services in all places including the use of Virtual Wards or other models.

5.9.2 Improving Quality.

Our aim is to improve the quality of services irrespective of age, condition, or diagnosis, with greatest improvement for locally identified priority groups. To achieve this, we will support:

- A confident workforce across statutory and VCSE sectors with the support and capability to deliver high quality PEoLC.
- Personalised and community focused approaches to improve the PEoLC experience for patients and carers (including Social Prescribing).

5.9.3 Improving Sustainability.

Our aim is for patients of all ages to be able to access a range of PEoLC services, which are equitable and meet diverse needs. This will include:

- Sustainably commissioned all-age PEoLC services.
- PEoLC services for children and young people including in transition.
- Increased use of Virtual Wards.

5.10 Pharmacy and Medicine.

Medicines are the most common and most evidence-based intervention in healthcare. Managing the use medicines well is a statutory responsibility of the ICB. The ICB spends c£560 million on prescribing in primary care each year, nearly 10% of the ICB budget. We have experienced a very high level of growth in our prescribing spend which is a financial pressure. Our long-term ambition is to ensure the optimal use of medication in all pathways. Some of our immediate priorities are:

5.10.1 Decreasing antibiotic prescribing report implementation.

We will reduce the use of Antimicrobial Resistance (AMR). To achieve this, we will:

- Deliver bespoke practice level AMR reports to every practice every two months for three years, supported by Practice engagement.
- A reduction in antibiotic prescribing and variation across the region.

5.10.2 Increasing capacity for point of care (POC) testing.

This is a key focus to support antimicrobial stewardship in primary care and includes providing resources for POC testing capacity and support in primary care and with stakeholders across pathways. We will evaluate the impact of this work.

5.10.3 Community Pharmacy.

We will work with community pharmacies to support the management of common infections, supported by pathways, point of care testing and supply of medicines.

5.10.4 Proactive medicines optimisation system across all GP practices.

We will continue to ensure broad support to Practices to optimise the use of medicines. Areas of short-term focus will include:

- Roll out of Analyse Rx medicines optimisation system for all 'EMIS' system practices within 2023/24.
- Utilising the dashboards to identify areas for further improvement.

5.10.5 Reduce over medication of people with a learning disability.

We will deliver the national programme reduce the over medication of people with a learning disability. We will develop a comprehensive plan to achieve this, led by a Consultant Pharmacist. This will include education and support to address over and inappropriate prescribing for children and young people with a learning disability.

5.11 Primary Care: Dentistry, General Practice, Pharmacy and Optometry.

Primary Care is the foundation of NHS services. However, we know that there is major pressure across community dentistry, general practices, community pharmacy and optometry. There is a very real workforce and sustainability crisis across many primary care services, and many people experience poor access to primary care.

5.11.1 General Practice.

General Practice is delivering more patient care than ever, often working with patients with higher levels of acuity and dependence than ever before. This is against a backdrop of a very real workforce and sustainability challenge. During the rest of the 2023/25 financial year, we will develop the general practice recovery plan. This is likely to include a key focus on:

- Improving access and reducing the challenge to access appointments.
- Improving the stability and resilience of general practice.
- The opportunities to deliver general practice at scale, and through stronger primary care networks.
- Structural solutions to workforce sufficiency
- Best use of enablers including estates and digital.

Our short-term focus is to ensure the stability of general practice. Our longer-term focus will be to support the transformation of general practice. This will include the broader aim to deliver integrated neighbourhood teams as outlined in the Next Steps for Integrating Primary Care: Fuller Stocktake published in May 2022. This will include:

- Establishing integrated neighbourhood teams to cover the full population with active all community partners. This will include working with partners, including recognising the vital role of the voluntary, community and social enterprise sector and local authority partners.
- Neighbourhood services that address inequalities and support Core20PLUS5 populations.
- Partnership based provision of services leading to improved patient journeys, joined up systems, and patient centred personalised care.

Both the short-term recovery plan, and longer-term transformation plan, will be a key feature in the March 2024 refresh of the joint forward plan.

5.11.2 Dentistry.

The North East and North Cumbria Integrated Care Board received delegation from NHS England for the commissioning of dental services from April 2023. We recognised very quickly that dentistry needed to be a key focus immediately.

Access to NHS primary care dentistry has declined. Some communities have very limited, or even no, access to NHS primary care dentistry within a reasonable traveling distance. This is typically worse in areas with higher rates of socio-economic deprivation, meaning there is a real issue of inequality of healthcare delivery. This can have a very real impact on oral health and implications for broader physical and mental health and wellbeing. It also leads to pressure in other services.

We know that NHS primary care dentistry is of huge concern to communities. It is the main area identified by members of the public to Health Watch and is a main area of complaints made to the NHS. Improving this position is a key objective of the ICB. The ICB is developing an overall oral health strategy with three elements to it:

- An initial dental recovery plan to stabilise services.
- A medium-term strategic plan to transform dentistry services.
- A longer-term oral health improvement plan building on each of the local authority oral health strategies.

The ICB Short-Term Recovery Plan for 2023/24 is aiming to ‘protect, retain and stabilise’ local NHS community dental services. We are particularly focussed on where need and inequality is greatest – typically the CORE20 communities (neighbourhoods which are in the 20% most deprived in England).

In year 1 and 2 of the joint forward plan our short-term actions to date have included additional resources for 2023-24 for:

- the NHS 111 Clinical Assessment Service
- out of hours dental treatment services
- access sessions, to be used by Practices for Patients requiring urgent or emergency dental care treatment and patients presenting with high oral health needs identified as part of the clinical examination undertaken. It is also a requirement that practices participating within this arrangement prioritise looked after children who require oral health support.

We have also agreed an approach to ensure that the financial resources from NHS dentistry contracts which are 'handed back' (effectively the practice choosing to no longer offer NHS dentistry) are quickly made available to other NHS dentistry providers in the same locality where they can demonstrate they have the capacity to deliver. This is quicker, and more effective, than using more traditional formal procurement approaches which have often attracted little or no interest from dental providers.

We are looking to develop further specific incentives for Practices to sustain services. We intend for those incentives to be ahead of or additional to nationally agreed changes to the dental contract. We will use non recurrent approaches so we can continue to direct resources most effectively, and not to duplicate changes in the national contract.

In year 3 – 5 of the joint forward plan we will begin to focus on long term transformational changes, subject to the effectiveness of our recovery plans in sustaining NHS Primary care dentistry and oral health improvement, including supporting water fluoridation.

Our key measures of success are:

- to stabilise, and then increase, the total number of Unit of Dental Activity (UDA) across NHS primary care dentistry. This forms part of the annual operational plan the ICB submits to NHS England. The UDA is a unit of currency for measuring the type of clinical activity expected from a dentist within a 12-month contract for a certified financial value. Essentially our aim is to increase the amount of dentistry activity is provided.
- to have greatest increase in provision in the areas with highest needs and greatest inequalities in healthcare provision.
- To increase the number of and whole-time equivalents of dentists operating on NHS contracts and ensuring an upward trend.

5.11.3 Pharmacy and Optometry.

From April 2023, the ICB also became responsible for the delegated commissioning of pharmacy and optometry. Our immediate focus was to ensure an effective transfer of responsibility. During the rest of 2023/24 we will be developing our plans for both services. This will be more fully developed for the March 2024 refresh of the joint forward plan.

Acute and Secondary Care Focussed Themes.

5.12 Cancer Service Plan.

The Northern Cancer Alliance aim to improve cancer care through collaboration. We do this by bringing together clinical, commissioning, and operational leaders from different hospital trusts and other health and social care organisations, to transform the diagnosis, treatment, and care for cancer patients. The Alliance is committed to involving the public in all its work including joint work with other system workstreams.

We will continue support the increased uptake of breast, bowel and cervical screening and the uptake of the Human papillomavirus vaccines (HPV). HPV vaccines prevent infection by certain types of human papillomavirus. Available HPV vaccines protect against either two, four, or nine types of HPV. All HPV vaccines protect against at least HPV types 16 and 18, which cause the greatest risk of cervical cancer). Our further cancer work programmes include:

5.12.1 Early diagnosis.

Our aim is to increase the number of cancers diagnosed at an early stage. To achieve this, we will:

- Improve timely presentation and access to Primary Care, specifically target 20% most deprived and other communities of health inequality.
- Continue to support both national and local innovation programmes.
- Roll out Targeted Lung Health Checks across the region and ensure the uptake of lung health checks is above 50%.
- Continue to support the clinical trial of NHS-Galleri technology specifically targeting most deprived 20%. Galleri is a new blood test that can detect signs of many different types of cancer in a sample of a person's blood. The NHS-Galleri trial is a research trial to see how well the Galleri blood test works in the NHS. The aim of the trial is to see if using the Galleri test alongside existing cancer screening can help to find cancer early when it is usually easier to treat.
- Support early diagnosis, non-specific symptoms pathways, and the extension of the NHS bowel screening programme to 54-year-olds.

5.12.2 Faster diagnosis framework and waiting times.

We will deliver the new national faster diagnosis framework and improve waiting times, particularly reducing the number of the longest waiting patients on pathways. This will include:

- Meeting cancer waiting time standards, improving year on year.
- Maintaining priority pathway changes for lower gastro-intestinal, skin (tele-dermatology) and prostate cancer.
- Supporting locality based primary care cancer leads to promote and improve the pathways locally for people presenting with non-specific symptoms.
- Combined pathway for upper and lower gastro-intestinal cancers.
- Using robotic data processes to improve data quality and reporting.
- Rolling out the digital patient tracking list dashboard.

5.12.3 Treatment variation and personalised care.

We want to improve the quality and uptake of personalised care, identify gaps in access and address health inequalities to improve patients experience of care. Our work will include:

- Reducing variation in care for breast surgery, prostate radical treatment, and radiotherapy treatment for rectal cancer patients.
- Reducing variation in patient experience, diagnosing cancer within the cancer waiting times standards, and improving access to services.
- Ensuring that personalised care interventions are available for all.
- Delivering the psychosocial support development plan.
- Ensuring personalised, stratified follow up pathways for all suitable patients in breast, prostate, colorectal, and endometrial cancer.
- Embedding a universal offer of prehab for all cancer patients.

5.12.4 Improving experience of care.

Our aim to improve patients experience of cancer care through collaboration. We do this by bringing together clinical, commissioning, and operational leaders from different hospital trusts and other health and social care organisations, to transform the diagnosis, treatment, and care for cancer patients. The Northern Cancer Alliance is committed to involving the public in all its work and joint work with other system workstreams. We know that having sufficient workforce capacity and involving patients in developing services is key to a good experience of care. We will ensure:

- community engagement to enable coproduction throughout
- use of insight and feedback to coproduced (with people with relevant lived experience and staff) quality improvement action plans.
- the best possible skill mix of the workforce.

- a focus on the supply, recruitment, retention and upskilling of the Cancer Clinical Nurse Specialist workforce.
- Continued work with national and regional teams to address the need to expand the cancer workforce, particularly in non-surgical oncology.

5.13 Elective Care & Diagnostics Service Plan.

Currently people often experience significant waiting times for access to diagnostics and elective care. We want to continue to improve waiting times and access. The Strategic Elective Care Board (SECB) has senior representation from the Provider Collaborative, Primary and Secondary Care, the ICB, NHSE, the Northern Cancer Alliance and the Diagnostic Programme Board. The SECB feeds into the Provider Leadership Board which is made up of Chief Executives of the NHS Foundation Trusts including Mental Health and Ambulance providers. Our key work programmes include:

5.13.1 Elimination of long waits and reduction in the overall size waiting lists.

Our aim is to achieve national ambitions and constitutional standards in relation to waiting times. To achieve this, we will:

- Eliminate the longest waits for elective care, achieving the national objectives for 23/24 and future years.
- Eliminate waits of over 65 weeks by March 2024 except when patients choose to wait longer and complex spinal surgery (with reduced waits)
- Deliver the system specific value weighted activity target as agreed through the operational planning process (this relates to a measure of the total amount of elective care delivered)
- Ensure choice at point of referral and at subsequent points in the pathway through a choice programme.
- Provide support to the NHS Trusts with the greatest challenges including collaborative working between Trusts.
- Work with the independent sector to support NHS capacity where needed.
- Develop digital solutions that support patient choice and elective recovery.

As part of this work, we will be delivering a Patient Choice plan in accordance with the NHS England guidance on ensuring patients are able to exercise at the point of referral and across their pathway.

5.13.2 Clinical transformation and reduced unwarranted variation.

We will deliver the Excellence in Basics programme to optimise capacity, and where appropriate consider the potential for centres of excellence. This will include:

- Achieve the national targets for productivity and efficiency.
- Ensuring the delivery of the right procedure in the right place.
- A reduction in outpatient follow-up in line with the national ambition.

5.13.3 Specialty based development work.

We will take forward **s**pecialty-based approaches to improvement, harnessing shared learning through the establishment of clinical alliances. This will include a focus on specialties, for example good eye care and the local delivery of the NHS England framework to reduce community musculoskeletal waits while delivering best outcomes and experience. We will Implement the high volume, low complexity best practice pathways, and continue the focus to ensure the right clinical workforce.

5.13.4 Diagnostic programme.

Our aim is to reduce variation and increase the equity of access to services in all geographical locations. This will include focusing on areas of greatest need using a wide range of metrics including health inequalities. Our key actions are to:

- Increase capacity to meet demand, delivering activity to meet elective and cancer backlogs as well as the diagnostic waiting time ambition.
- A continued focus on the diagnostic workforce supply, retention, skill mix and ways of working.
- Network maturity in Imaging, Pathology and Endoscopy.
- Developing a digital diagnostic roadmap, enabling interoperability.

5.14 Specialised Commissioning Plan

There is a national plan to delegate the commissioning of some specialised services to ICBs from April 2024. During the 2023/24, the ICB and NHS England will work together via a Joint Committee and associated sub-groups. This infrastructure will be used to track progress on transformation priorities such as the 3 included in this thematic plan. Details of how this will run from April 2024 are to be determined.

5.14.1 ICB readiness for delegated specialised commissioning from April 2024.

Our short-term focus is to agree the model for how specialised commissioning will run from April 2024 including ensuring effective due diligence on services due to transfer to the ICB. With NHS England we will develop a robust approach to the transfer of contractual responsibility and the management of any clinical and financial risks.

5.14.2 Priority services.

We will work with NHS England to ensure that treatments and pathways continue to improve across identified priority services, including:

- Non-surgical oncology service delivery, including radiotherapy, genomics and chemotherapy.
- Neuro-rehabilitation services. The pathway spans NHS England and ICB commissioned services providing an opportunity for joint working.
- Gynaecology oncology service provision. This includes developing the Clinical model to reduce variation and fragmentation, improve coordination and the management of patients across the system and provide long-term sustainability of the service workforce and capacity.

5.14.3 Screening and vaccination programmes.

NHS England will keep responsibility for some specialised services, such as the national screening and vaccination programmes until at least 2025. The ICB will support the screening programmes through close liaison with NHS England. The ICB will also support screening and vaccination services to maximise uptake by championing and promoting these services through its commissioned primary and secondary care services.

5.15 Urgent and emergency care service plan.

Improving urgent and emergency care is a kay national and local focus. System leadership is provided through the Urgent and Emergency Care (UEC) Network Board. Its membership includes Trust Chief Executives who chair the five Local Accident and Emergency Delivery Boards (LADBs). Our immediate priorities for urgent care include:

5.15.1 Increasing urgent and emergency care capacity.

We will work to reduce bed occupancy rates, increase the number of staffed hospital beds, and increase ambulance capacity. This will include:

- Reducing adult general and acute bed occupancy to below 92%.
- Increasing ambulance capacity through single points of access for paramedics for specific services
- Increasing clinical assessment in ambulance control centres including those with mental health expertise.
- In the same way that we are working to eliminate the longest waits for elective care, we also will eliminate the longest ambulance handovers waits. This does not mean that we accept any long handover delays. We need to focus on

reducing all handovers, reducing average handover times to under 15 minutes over time.
- Improved ambulance response times for Category 2 incidents, beginning with work to achieve an average response time of 30 minutes in 2023/24. This is both an Ambulance service and a wider system responsibility, requiring a sustained partnership focus.

5.15.2 Improving Discharge.

Once people no longer need hospital care, being at home or in a community setting is the best place for them to continue recovery. To support this, our work includes:

- Improving joint discharge processes building on Home First, Discharge to assess and Transfer of Care Hubs.
- Using digital solutions to ensure accuracy and access to data including 'live' discharge dashboards.
- Implementing a stronger approach to 'own' medically optimised lists
- Scaling Up Intermediate Care.
- Scaling Up Social Care Services, learning from Winter 2022/23.
- Completing a review of neuro rehabilitation pathways.

5.15.3 Expanding care outside hospital.

We will ensure care closer to, or at home, to avoid the deconditioning and prolonged recovery that can accompany a hospital stay. This will include:

- Expanding new types of care outside hospital including virtual ward pathways, urgent community response, same day emergency care, acute respiratory infection hubs and unscheduled care across systems.
- Sustainable services with defined criteria to admit patients onto virtual wards whilst supporting patients at home and in the community.
- Expanding virtual ward provision for step-up and step-down care, increasing utilisation, and extending access into additional specialties.

5.15.4 Making It easier to access the right care.

We will ensure that the urgent and emergency care system is responsive to the needs of patients. To achieve this, we will:

- Deliver a further expansion of 111 online and clinical assessment models.
- Increase direct booking into primary care.
- Improve access for people needing mental health support including 24/7 urgent mental health helplines accessible via the 111.
- Develop alternative offers to 999 and A&E for urgent care.
- Implement 24/7 co-located urgent treatment centres (UTC) in emergency departments maximising the "see and treat" approach.
- Expand same day emergency care services (SDEC) to at least 12 hours a day, 7 days a week.

- Develop greater integration with GP out of hours services and greater clinical support for community-based teams.

5.15.5 Health Protection.

The ICB will work with providers to help maximise coverage of key vaccinations for both patients and staff, which help prevent peak A&E and other service pressures, such as flu, Covid 19, pertussis and MMR.

Mental health, people with a learning disability and autistic people.

5.16 Neurodevelopmental Service Plan.

The ICB and partners are developing a broad and inclusive Mental Health, Learning Disability and Autism Collaborative. Inclusive groups will be co-designed and form part of the overall governance structure. There will be a specific group focused on autism. Our areas of focus include:

5.16.1 Improved autism and other neurodevelopmental pathways.

Children, young people, and adults wait too long to be assessed in neurodevelopmental diagnostic pathways, delays to assessment can delay the implementation of Education, Health, and Care Plans. Commissioners, providers, and delivery partners will listen and learn from people who have a lived experience and their families and supporters. We will:

- Develop increased capacity to meet the current demand, and the forecast increased demand for autism and attention deficit and hyperactivity disorder (ADHD) services – recognising the current long waiting times and access challenges that people face.
- Work with partners to provide better support to school-based staff in making referrals to the right pathways.
- Improve our early help and support offer, including for people who do not have a diagnosis.
- Work with partners and lived experience experts to design a new ‘needs led’ pathway to help support children, young people, adults, parents, and carers.
- Improve the diagnostic pathway our post diagnostic support offer.
- Work with partners to develop stronger early support and intervention within education and communities for families and children.
- Use appropriate risk stratification to influence prompt access to specialist assessments and treatment.
- Develop appropriate shared care arrangements with primary care for medication and physical health monitoring.

5.16.2 Improving outcomes for autistic people and people with other neurodiversity.

In the broader partnership context, we will:

- Address stigma.
- Enhance access to support and ensure person led care.
- Improve education and employment opportunities, fostering acceptance, and
- Provide appropriate healthcare. This will include tackling health and care inequalities for autistic people and ensuring the right support in the community and in inpatient care.
- Ensure the rollout of the mandatory Oliver McGowan training on Learning Disability and Autism.

Oliver McGowan training:

This is the standardised training developed 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.

5.17 People with a learning disability.

We are developing a broad and inclusive Mental Health, Learning Disability and Autism Collaborative. We will improve quality by giving people, their families, and supporters a strong voice through co-production. We will keep people at the centre of their own care and treatment. This section is interdependent with the Autistic People section 5.3. Our overall aim is to reduce the inequality in health outcomes and inequality in health care services for people with a learning disability. Some of our key programmes include:

5.17.1 Support for General Practice.

We will support General Practice to increase the number of people on Learning Disability registers and to increase the number of people on registers who receive an annual health check. This is important in enabling reasonable adjustments to be made in health care and will support improving the uptake of screening and immunisation programmes for people with a learning disability.

5.17.2 Improving the quality of care and support.

We will ensure people receive high-quality care and support that respects their rights, promotes their well-being, and enables them to lead fulfilling lives as valued members of society. This will include taking action to ensure the quality of services, for example:

- Undertaking host commissioner oversight visits to all specialist inpatient services.
- Ensuring the quality and type of advocacy is improved.
- Acting on lessons from reviews into failings in health care, for example the Whorlton Hall Safeguarding Adults Review. (This review set out the systemic failures that enabled people with learning disabilities to be subjected to abuse and ill treatment in specialist care and support services at Whorlton Hall).

5.17.3 Improving health outcomes.

Health care can make a significant difference to the health outcomes of people with a learning disability. We will work to ensure that all services make reasonable adjustments and that learning from Learning Disabilities Mortality Reviews (LeDeR) leads to service improvements. Our focus includes:

- Use learning from LeDeR to prevent avoidable deaths and ill health.
- Increase the uptake of vaccinations to prevent serious illness.
- Ensure all health and care pathways are reasonably adjusted, particularly of immediate focus cancer and long-term conditions due to their major impact on health outcomes.

5.17.4 Reduce reliance on inpatient care.

We will work with partners to reduce the reliance on inpatient care and enabling people to live healthy and positive lives in the community. This will include:

- Increased community-based support options and investment in community models.
- Improving the use of dynamic support registers
- Ensuring appropriate Hospital length of stay reflecting the treatment needed, including ensuring discharge planning begins on admission using tools such as the 12 Point Discharge Plan.
- Reducing the number of patients in long term segregation and seclusion through application of the Independent Care (Education) and Treatment Review process.

5.18 Mental Health Plan

Improving mental health and mental wellbeing is a key priority. Our work is led by the Mental Health, Learning Disabilities and Autism Sub-Committee. This provides leadership for the delivery and commissioning of NHS services across the life course, including children, young people, adults and older adults. It is a decision-making body with executive representation and delegated authority from the ICB. This is supported by our two Partnership Boards which are co-terminus with the Cumbria, Northumbria, Tyne and Wear and Tees, Esk, Wear Valley NHS Foundation Trusts (within the North East, we recognise the Trust delivers services outside our geography). There are also a range of place-based partnerships forming a link between places and entire system. Some of our improvement programmes include:

NHS Long term plan commitments:

We recognise the key mental health priorities in the NHS Long Term Plan, and will continue to focus on each of these alongside the work programmes further described in this section:

a) Total access to improving access to psychological therapies (IAPT) services.
b) Estimated diagnosis rate for people with dementia.
c) Women Accessing Specialist Community Perinatal Mental Health Services
d) Access to Community Mental Health Services for Adults and Older Adults with sever and enduring mental illness.
e) Access to Children and Young People's Mental Health Services.

5.18.1 Community transformation and improving access to services.

We will deliver integrated primary and community care for adults and older adults with severe mental illnesses (SMI) and more common mental health problems, such as anxiety and depression. This includes:

- Delivering on the principles of access to support close to home and personalised specialist care early enough to make a difference.
- Increasing the number of people on the General Practice Sever Mental Illness registers who have received a physical health in line with national standards.
- Ensuring people will be able to call NHS 111 and speak directly to a mental health crisis service. Mental health clinicians will work alongside ambulance colleagues so that people do not have to go to hospital unnecessarily for treatment and/or support.
- People with common mental health problems will have quicker access to NHS Talking Therapies and will benefit from a wider range of integrated community support based around primary care.

5.18.2 Preventing Suicide.

Suicide is a leading cause of premature mortality. The North East and North Cumbria also has the highest rate of suicide of any region in England.

Our ambition is to halve the difference in the suicide rate between our ICP and England in 2019/2021 (three year rolling average) by 2029/31. To achieve this, we will work with partners including local authority public health teams to deliver effective suicide prevention interventions including:

- Improved access to services for people who express suicidal ideation. This will require a real partnership focus, recognising that many people at risk of suicide are not currently, and may never have been, in contact with mental health services.
- Public information campaigns to raise awareness of ways to support people experiencing mental health difficulties.
- Use of data to inform targeted interventions to prevent suicide clusters.

5.18.3 Children and Young Peoples' Mental Health.

Access to children and young people's mental health services is consistently one of the most urgent areas of improvement members of the public, experts by experience and stakeholders want to see. It is a key priority for the local NHS. Our aim is to ensure much better access to specialist mental health care based around children and young people's needs. This will be in the context of the NHS long term plan commitments. This includes:

- Increasing the coverage of mental health support teams for schools.
- Working in partnership to deliver new models of care.
- Commissioning early-intervention "getting help" services - particularly those with reach into underserved communities.
- Seamless working between primary care, paediatric inpatient units, and mental health providers to improve the eating disorder pathways.
- Improving crisis/intensive home treatment teams to minimise inpatient admissions, through better pathways and considering options for investment and increased capacity.
- Improvements in the inpatient pathway to ensure high quality provision as close to home as possible.
- Increase access to perinatal services and move towards offering 2-year support across as investment and workforce challenges allow.

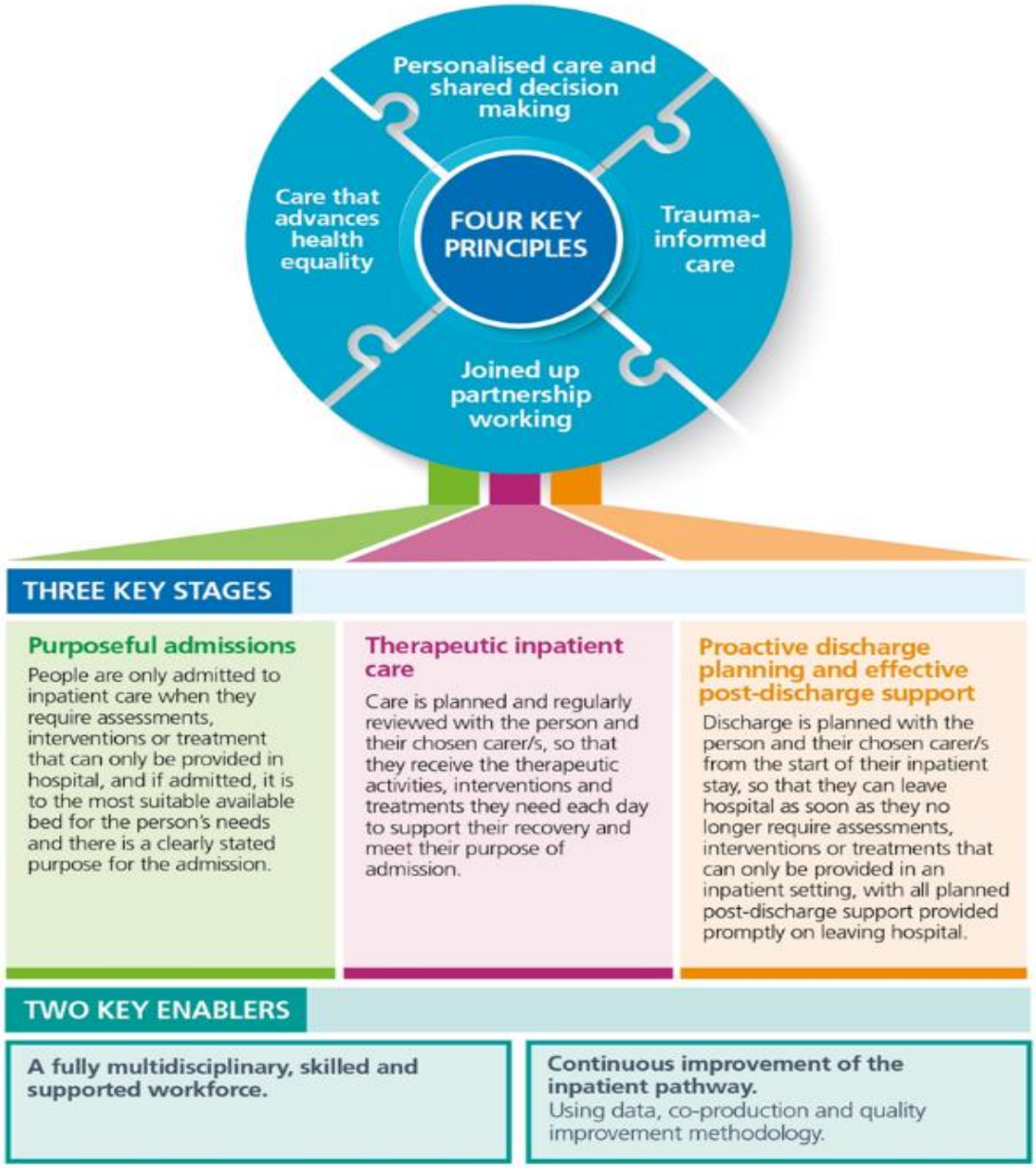
This work needs to be set in a broader partnership context. The scale of poor mental wellbeing, and mental illness, amongst children and young people is a challenge requiring broad partnership action.

5.18.4 Developing a safe, therapeutic, rights-based approach to in-patient care.

We will co-produce the model for trauma and autism informed therapeutic inpatient care with experts by experience and staff working in services. Some of our key principles for this work are:

- Ensuring a culture within inpatient care that is safe, personalised and enables patients and staff to flourish.
- Oversight and support structure that identifies issues early. Challenged services will have timely, effective, and coordinated recovery support.
- Working to eliminate out of area admissions in mental health pathways. This will require significant partnership work, and many of the solutions to achieving this commitment lie in the transformation of community services.

This work will be underpinned by the NHS England commissioning guidance published in July 2023.



5.19 Trauma Informed Services

We have a growing understanding of the impact of traumatic experiences on people, including the negative impacts on physical and mental wellbeing. Many people are exposed to trauma in their lifetime, and this can significantly affect how an individual can live their life. We recognise that cumulative trauma across the lifespan is associated with multiple health consequences. There is a considerable evidence base on understanding the impact of multiple adverse childhood experiences (sometimes referred to as ACEs) and similarly the recognition and incidence of trauma for adults. This is a complex area, we will work with experts by experience and all our partner organisations to develop a fuller plan, with an ambition to develop trauma informed NHS services. Our work will initially focus on:

Trauma Informed:

Being 'Trauma Informed' means being able to recognise when someone may be affected by trauma, collaboratively adjusting how we work to take this into account and responding in a way that supports recovery, does no harm, and recognises and supports people's resilience. One of the most commonly used definitions is the 4 Rs of Trauma-informed care (Substance Abuse and Mental Health Services Administration, 2014):

- **Realise** the widespread impact of trauma and understand potential paths to recovery.
- **Recognise** the signs and symptoms of trauma.
- **Respond** by fully integrating knowledge about trauma into policies, procedures and practices.
- **Resist Re-traumatisation** – seek to actively resist re-traumatisation.

5.19.1 Children and young people pilots.

Learning from the existing pilot programmes on trauma informed services for children and young people. For example, as part of the National NHS England Vanguard of the Integrated Care Framework, Gateshead and Newcastle place have a team each that will work to embed a trauma informed approach across the system which are embedded in the local authorities to integrate working. The 2-year pilot services will be available for 5–25-year-olds who are at high risk, high vulnerability or experiencing high harm. Similar pilots are ongoing in other Places including Durham and Tees Valley and include a real focus on evaluation with the potential to lead to clear models and frameworks.

5.19.2 Adult Service pilots.

We will also implement learning from the current pilot programmes on trauma informed services for adults with severe and enduring mental illness. This work has been developed in the priorities of community mental health transformation. Learning and implementing learning from the pilot programmes will be our key focus in year 1.

5.19.3 All service framework.

More broadly, our real ambition is to develop and implement practice frameworks and a delivery model to embed a system wide approach to trauma informed care in every interaction across all NHS services. This will be a huge undertaking and will require a long-term approach to developing skills and capacity across the whole NHS, with appropriate competencies for all our workforce. Developing the longer-term framework will take time and will be our key focus for year 2 – 5.

6 Our Enablers

6.1 Skilled, Sufficient and Empowered Workforce

We are working with partners to develop a shared People and Culture Plan. The North East and North Cumbria will be a better place to live and work, supporting our ambition of becoming the employer of choice and increasing our job fill rate across health and social care services by 50% by 2029. The plan requires commitment and collaboration from all our partners, led by our system wide People Board.

The following approaches are inclusive of joint work with local authority, voluntary, community and social enterprise sector and independent sector partners.

6.1.1 Workforce supply across the system, including a key focus on retention.

Workforce sustainability is a major challenge across all services. We recognise for example that some services are reliant on small numbers of key, highly specialised staff, who have scarce training and skills and take a long time to train and replace. We aim to ensure safe staffing levels across all our services and sectors. This will require work to widen participation to allow people to join the NHS and Social Care, and effective partnership work with higher educational institutions. We will deliver campaigns highlighting opportunities of working in health and social care, and work to ensure we recruit from all communities, so our workforce looks like the communities we serve.

6.1.2 Workforce health and wellbeing across the system.

There is wide variation in staff experience in our system, with examples of good practice to build on. We will:

- Work to develop a wellbeing culture that improves equitable access to health and wellbeing support regardless of employer.
- Collaborate to develop a system approach to health and wellbeing where it makes sense to work together.
- Maximise the terms and conditions of staff across sectors, wherever possible ensuring that people are appropriately rewarded.
- Improve our staff engagement and morale by sharing the outputs of our staff engagement surveys.

6.1.3 System leadership and talent.

Good leadership is at the centre of our model for ensuring that we work beyond organisational and professional boundaries. To support this, we will:

- Develop a proactive and inclusive talent management approach that increases our leadership supply pipeline.
- Develop compassionate and inclusive leaders that represent our diverse communities and amplify our strength as a system.
- Create a system of leadership development focusing on sharing best practice for integrated working.

6.1.4 Equality, Diversity, and Inclusion (EDI).

In the long-term our ambition is to become the most equitable and inclusive place to work in the health and social care sector. To achieve this, we will:

- Improve the EDI capability and knowledge of our workforce.
- Always ensure legal compliance as an absolute minimum and work to and exceed good practice expectations.
- Listen to people to build psychological safety, improve their lived experience, to create the best workplace environment.

A particular focus will be to tackle workforce health inequalities including:

- Developing a Healthier and Fairer academy approach to ensure that staff are equipped with the right skills, information, and networking opportunities to see real change.
- Creating an approach to appropriate, relevant, and timely intelligence and insights through the creation of a North East and North Cumbria performance dashboard for workforce health inequalities.
- Supporting the development of an approach to workforce priorities within the Anchor Institutions approach

6.1.5 Retention.

Valued members of staff choose to leave our services every year, often with good reason. We want this to change, and will:

- Develop support offers so we are an employer of choice.
- Review human resources pathways and induction, so staff have the best start.
- Value our workforce, enabling them to make their best contribution.
- Develop career structures with partners across and between health and social care, removing barriers preventing people to entering the workforce.

6.1.6 New Ways of Working.

We will support staff to adapt to technological advances and role development. This will include reviewing role functions to allow for different workforce models, and as technology progresses, including incorporating artificial intelligence.

6.2 Working Together at Place and in Neighbourhoods

6.2.1 Partnership working at place.

By place we typically mean on local authority footprints. We will further strengthen our partnerships with governance and decision arrangements. The context for place-based partnerships includes:

- Keeping well-established place-based working arrangements involving partners from health, local authorities and the voluntary, community and social enterprise (VCSE) sectors.
- Place-based partnerships are not statutory bodies. The 2022 Health and Care Act did not create a legal requirement for Place-Based Partnerships. It does allow for ICBs to delegate some functions and budgets to local committees as part of place-based partnerships. NHS England statutory guidance requires ICBs to properly allow for delegation at Place and is generally permissive giving a wide degree of latitude in developing Place based partnerships.

Place-based partnerships focus on joining up and co-ordinating services, addressing the social and economic factors that influence health and wellbeing, and supporting the quality and sustainability of local services. Place-based arrangements will fulfil three interdependent functions:

a) Place partnerships - consultative fora with delivery focus, usually without delegated authority.
b) Place based delivery groups (PBDG) - ICB internal decision making.
c) Joint governance arrangements between ICB and Local Authority - to oversee the Better Care Fund and Section 75/256 agreements (and potentially further functions).

6.2.2 Strengthening our Partnerships – Timeline.

From April 2023:

- ICB place committees – the ‘Part b’ element of place-based partnerships. This involves the ICB, local authorities, NHS trusts, primary care, VCSE partners and others in decision making on delegated ICB functions.
- The ‘Part b’/ICB Place Committee would remain accountable to the ICB.
- Further development on managing financial delegations locally.
- Alignment of the place partnership and Section 75 governance meetings.
- The relationship with their local health and wellbeing board.

Longer term development: Maximise joint working at place, building on our collective learning, as place-based arrangements continue to mature and strengthen.

Openness to stronger joint arrangements.

In some places partners want to go much further and wish to work towards jointly exercising statutory functions. The ICB will collaborate with partners, particularly local authorities, to find ways of meeting shared ambitions for joint working.

6.3 Involving People to Co-produce the Best Solutions

Triangulation of intelligence and stakeholder feedback is a key enabler to delivering our commitments. This is coupled with proactive engagement to gain the very best understanding of service users, partners, and stakeholders. We cultivate partnership working across our Integrated Care Partnership and support partners to flourish and build relationships at system and place.

We recognise and value the statutory function of Health Watch ensure the patient voice is heard and influences strategic decisions, and as an independent source of patient and resident feedback. We are committed to working not just with Health Watch, but with all stakeholders and organisations who are able to support the voice of experts by experience to be heard.

6.3.1 Work Programme

Our key work programmes to support improved involvement include:

- Raising the profile of involvement across the ICB and ICP, bringing together involvement, building on existing assets and strengths. We will also develop a formal subcommittee of the Quality and Safety Committee focussed on insights from experts by experience.
- Develop ways to listen, with mechanisms to collect lived experience. This will include establishing a citizens' panel and developing an Involvement toolkit to support engagement across the ICB.
- Deliver a programme of communications to establish strong relationships with internal and external stakeholders. This includes campaign programmes on access, prevention, and population health.
- Supporting partnership development, including across the ICP, Area ICPs, system leadership groups, networks with local authority professional forums and the independent care provider sector.
- Effective stakeholder management including complaints and compliments.
- Improving partnership working including with scrutiny committees, health and wellbeing boards and the voluntary, community and social enterprise sector to ensure their voice is heard.

6.3.2 Citizens' Panel.

During the second half of the 2023/24 financial year, we will take forward the development of the Citizens' Panel. This will be based on learning from independent

research the ICB commissioned on citizen engagement. This research aimed to explore the benefits, drawbacks, and resource requirements of differing models of citizen engagement, and provide recommendations on an approach that will meet the needs of the ICB on an ongoing and enduring basis. The key conclusion from phase one of the research is that citizens' panels are a method of engagement that has proven effectiveness within the health care setting generally, and within ICS /ICB structures specifically. Themes from the research included:

1. The importance of engagement
2. There was mixed experience in engagement, with varying knowledge about citizens' panels.
3. Lessons learned from involvement in engagement - The key issues raised concerned inclusivity and methodologies employed. There was a powerful sense that engagement needed to reach a wide audience, in particular the voices of traditionally lesser heard groups.
4. How citizen engagement may work across the ICB - Effective engagement across the ICB was discussed in terms of geography and people. Many of the stakeholders suggested that engagement needed to begin at ‘place’ level, before being combined into regional level.
5. There was also discussion of the need to embed engagement as a normal way of working in the ICB.
6. Respondents discussed the need to ensure that engagement activities consist of a ‘feedback loop’, all involved should know what happened because of engagement and why. There was also the need to ensure the language used within engagement is accessible to all, avoiding jargon.
7. Stakeholders expressed a desire for the ICB to engage in a ‘mixed method’ programme of engagement, it was felt that it wouldn’t be possible to engage with a representative sample using only one method.

Citizens' panels:

A Citizens' panel is a large, demographically representative group of citizens who help to regularly assess public preferences and opinions. Participants are generally recruited through random sampling of the electoral roll or postcode address file. Panels can range in size, for example from 500 to several thousand members. Once citizens agree to participate, they are invited to a rolling programme of research and consultation – typically involving regular surveys and, where appropriate, further in-depth research tools such as focus groups and workshops. Engagement can be online or in person, however methods of recruitment and engagement within citizens' panels can also minimise the risk of digital exclusion, an issue inherent to online communities.

6.4 Best use of Resources and Protecting the Environment Financial Plan.

Unique and longstanding challenges mean our healthcare system is dealing with a 'quadruple whammy', resulting in a vicious circle of ill health.

The 'quadruple whammy':

1. Greater health and care need – chronic ill health and health inequalities impacting our communities' ability to live healthier lives.
2. A position made worse because of the pandemic – our region was hit harder than other areas.
3. Our large and complex geography makes it more expensive to provide accessible services and population growth remains fairly static.
4. Our funding infrastructure does not target those who need it most.

The national funding formula considers the North East and North Cumbria to be over-funded, so funding growth will be lower than other areas. There is also an NHS plan to reprofile funding based on population projections that also reduces growth funding in future years. Our priority now is to develop a sustainable medium and long-term financial recovery plan over the next three to five years. This work is being undertaken in the context of a planned combined NHS deficit of around £50 million for 2023/24 across the North east and North Cumbria and a recognition that the underlying is significantly higher. We will need to work together to ensure we can live within the resources allocated in the short and medium term.

Our key financial principles are:

6.4.1 Financial Sustainability - Living within our means:

- Move the ICS into financial balance - a break-even/surplus position from the current deficit position.
- Move the ICB into underlying financial balance – improving from an underlying deficit position of c£60million combined across NHS organisations.
- Move the NHS provider sector into underlying financial balance.
- Partners – ensuring ICB actions do not unfairly or unreasonably put at risk the financial position of third sector partners, other commissioned providers (e.g., primary care organisations) or local authorities.

6.4.2 Financial Fairness - Investing in health equity:

- Allocating resources within the ICB to address inequalities.

- Allocating resources within places to address inequalities.
- Exceeding national aim to spend 1% of the ICB budget on prevention.
- Directing discretionary resources where they can have biggest impact.
- Poverty-proofing our services to remove barriers to access for our population.

6.4.3 Allocative Efficiency - Allocating resources effectively:

- Secondary care sustainability, securing best value working efficiently across Providers, and fair investment into 111, non-emergency patient transport services and paramedic emergency services.
- Invest in primary and community services and early intervention services.
- Fair investment in mental health, learning disability and autistic people.
- Information technology to maximise the benefits of service integration.

6.4.4 Maximising Value with Partners.

- Aligned investments with social care at place, and to improve the sustainability of the care sector.
- Work with public health teams to ensure best value from the "1%" spend on prevention and targeted in the places to have the most impact.
- Work with the voluntary, community and social enterprise sector to develop framework arrangements to deliver value in a financially sustainable way.

Protecting the Environment.

Environmental sustainability requires action and collective leadership from all partners, including the NHS. Failing to reduce our environmental impact will have serious implications for both the physical and mental health of our communities. Within the partnership context, the issues and challenges for the NHS include:

- The NHS is responsible for 40 per cent of the public sector's carbon footprint.
- Environmental sustainability is an important driver of health. Air pollution for example is the biggest environmental threat to health in the UK, with between 28,000 and 36,000 deaths a year attributed to long-term exposure.
- Keeping people healthy also has a lower impact on the environment, as they need less treatment and fewer medicines.
- Health inequalities are linked to environmental issues, such as poor air quality, lack of access to green spaces and access to nutritious foods.

We have published our North East and North Cumbria Green plan covering 2022 – 2025, with an ambitious goal to become the greenest NHS region by 2030. The plan highlights existing good practice to build on, focussed initially on eight key areas.

North East and North Cumbria Green plan:

1.Our People: Our staff are key to delivering our green ambitions, the size of our workforce means minor changes will soon add up to make a big difference.

2.Sustainable healthcare: We'll work to develop low carbon, sustainable models of care that improve health outcomes while cutting our carbon and waste footprint. We've already identified many areas where we can make a rapid difference.

3. Low Carbon Travel: The NHS generates a lot of road travel. About 3.5 per cent (9.5 billion miles) of all road travel in England relates to patients, visitors, staff and suppliers to the NHS, contributing around 14 per cent of the system's total emissions. We will ensure every NHS organisation has a green travel plan in place to reduce the amount of road travel.

4. Energy: Buildings and estates represent 10 per cent of the NHS carbon footprint. Improving energy efficiency is one of the most cost-effective methods of cutting carbon.

5. Reducing Waste: We'll work to reduce waste everywhere we can with a target of zero waste to landfill across the region by 2030. We'll aim to reduce the volume of clinical waste by 50 per cent by 2030 and for all remaining non-recyclable clinical waste to be treated through energy recovery by 2030.

6.Supply Chain and Procurement: The people and organisations who supply the NHS with everything we need (the NHS supply chain) accounts for 62 per cent of our carbon footprint. Our ambition is to make this network carbon free by 2040 – five years earlier than the national target.

7. Greener NHS Sites: Having green spaces and access to nature are known to support patient recovery and have therapeutic benefits. Every NHS organisation will work to ensure green spaces and we will together on the best green space and biodiversity measures we can take.

8. Clean Air: Our first step is to develop a clean air framework for NHS organisations across our region to support them to take actions to reduce air pollution as part of their own green plans.

6.5 Innovating with Improved Technology, Equipment and Estates

Research and Innovation.

In November 2022, the ICB organised a regional Research & Innovation Partnerships Forum. The Forum was supported by the Academic Health Science Network for the North East and North Cumbria, and brought together regional leadership from all six universities, the foundation trusts, research active primary care providers, local authorities, voluntary sector organisations, regionally based National Institute for Health and Care Research (NIHR) infrastructure, as well as those involved in regional economic development initiatives. This Forum helped to co-create the framework for our priorities, which include:

Newcastle Health Innovation Partners (NHIP) is the designated Academic Health Science Centre (AHSC) for our region, comprising a wide range of partners. The NHIP is instrumental in driving forward research and innovation directly aligned to the Better Health and Wellbeing for all strategy and the joint forward plan. For example, this includes:

- expansion of a unique outreach health check initiative delivered by student pharmacists from Newcastle University. This initiative supports the education of the future pharmacy workforce whilst supporting preventative healthcare for underserved citizens in our region.
- An emergent project on the application of a systems engineering approach to redesigning healthcare for adolescents with long term conditions.
- A cross-AHSC project is also being scoped in relation to dental and oral care
- a project, supported by the National Innovation Centre for Data, to understand our current health and care workforce data, to inform future workforce initiatives and assess secondary community health impacts.

6.5.1 Increase inward investment in research funding and innovation.

Our ambitions include:

- Gaining national and global recognition for our unique research and innovation infrastructure
- Supporting the development and adoption of new ideas through the Innovation Pathway
- Facilitating and stimulating the co-production of innovation between the NHS, industry, other sectors, academia, patients, and third sector

- Supporting economic growth through the opportunities formed between NHS, local authorities, and other “anchor” organisations.

6.5.2 Make research evidence more accessible to decision makers and relevant to the needs of the system.

To support this, we will work to increase the overall regional research funding and to attract external investment for innovation. We will develop an inclusive research culture reflective of the needs of the full diversity of the North East and North Cumbria population. A key focus will be to improve mechanisms for research dissemination and support.

6.5.3 Foster a culture of innovation across the system.

Our focus here is to:

- Make research and innovation pivotal to addressing our greatest challenges.
- Support early-stage innovation and the adoption of evidence-based solutions.
- Encourage collaborative innovation and knowledge sharing (particularly with other sectors outside of health) and supporting horizon scanning.
- Highlight promising innovations and celebrating our successes.

Estates.

We are working to develop our longer-term estate plan. This will include:

- Work with the Provider Collaborative to prioritise and optimise our investment in estates across health care services. The NHS demand for capital finance to maintain and update our estates, equipment and facilities is much higher than the funding available.
- Maximising opportunities from national funding programmes, for example the recent development of community diagnostic centres.
- Work with Primary Care to support local estate plans.
- Internal work within the ICB to provide appropriate work places across fewer office bases.
- Review vacant estate to ensure efficiencies can be delivered (where appropriate) and space can be used to support frontline care.
- Acting as an Anchor Institution and working with communities on the use of disposal of buildings to support capacity building.

Digital, Data and Technology.

We continue to develop our ambitious plans to maximise the benefits of digital technology. This work is led by our Digital Partnership Council, supported by the Digital Strategy and Innovation Group and Digital Delivery Group. The partnership structures are supported by the ICB Digital and Information Directorate and are connected to each of our workstreams as an enabling function. Our priorities include:

6.5.4 Supporting System Recovery.

We will support the NHS and partners to recover access and waiting times through the expansion and adoption of digital, data and technology solutions and services, information sharing and interoperability. This includes:

- Digitally enabled recovery of secondary care services, to reduce waiting times for elective and cancer care.
- Digitally enabled access to primary care services.
- Faster access to and sharing of digital diagnostics.
- Enabling patients to contribute to their health and care.

6.5.5 Digital First Primary Care.

We will make sure the right digital tools are available to support general practices and primary care networks to adapt to demand and capacity challenges. This will include:

- Digital tools to allow patients to access GP practices digitally.
- Optimising the use of digital tools to modernise general practice access.
- Empowering patients to manage their own health and ensure digital inclusion.

6.5.6 Digitising Social Care (adult care homes and domiciliary care).

We are working with local authorities, the independent sector, and further partners to support the expanded use of digital within adult social care. This includes:

- Digital social care records in care homes and domiciliary care.
- Network of digital social care champions to build on and promote success amongst the harder to reach care providers.

6.5.7 Frontline Digitisation of Foundation Trusts.

Our key aim is to ensure every NHS Trust has an electronic patient record system to meet key capabilities by March 2026. Achieving this will be dependent on:

- Levelling up the digital maturity of Electronic Patient Records (EPRs) across organisations.
- Achieving the Minimum Viable Product (MVP) functionality for every EPR, as outlined by NHS England, across all Trusts (this means a core standard level of how electronic patient records work).

6.5.8 Data driven decision capabilities to support the whole system.

Our ambition is to have the best Business Intelligence (BI) service in the NHS. To achieve this, we will focus on:

- Improving the intelligence and analytic function for population health management.
- Increasing access to reports including through self-service (meaning that people can access data sets to produce the reports they need to inform service improvements).
- Predictive analytics to move from a model of hindsight (what happened in the past) and insight (what is happening now) reporting to foresight (better modelling of what will happen in the future).

6.5.9 Digital inclusion in all settings.

We want to make sure that everyone benefits from the opportunities of digital, data and technology. We are very mindful that many people are excluded from the benefits of digital currently, and we do not want to make this worse. We will:

- Continue to take direction from our regional Digital Inclusion Steering Group including finalising our Digital Inclusion Strategy.
- Continue to adopt the NHS Digital Design Principles, ensuring services are designed with inclusion in mind from the beginning.
- Continue to work with partners to develop a detailed picture of the current and evolving picture across our region.
- Work to better understand the scale of the problems and contributing factors.
- Develop and agree a further digital inclusion plan.
- Improve access to services through digital tools, options, and resources.

7 Working Locally

7.1 Introduction.

Each local authority place has its own action plan, which forms part of the joint forward plan. The Place plans are important to ensure that the ICB has a local focus across its footprint. This is underpinned by close working and engagement with Local Authorities, health and social care providers, local communities, and voluntary, community and social enterprise sector organisations. Plans have been developed with partners and delivery will be monitored with them, through Place Committees, pre-existing system wide partnership meetings, and/or the Health and Wellbeing Boards depending on local arrangements.

Some Place plans cover more than one local authority area. The North Cumbria plan covers the parts of both Cumberland and Westmoreland and Furness unitary authorities which are within the ICB boundary. The Tees Valley covers Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton on Tees local authority areas. They have developed a joint plan recognising the strength and maturity of partnership arrangements across Tees Valley.

7.2 Place and North East and North Cumbria wide Plans.

The active involvement of Place will span beyond the local priorities described in each place plan. Place is vitally important to the delivery of the goal and enabler thematic plans. Place will inform and influence the development and delivery of the North east and North Cumbria wide action plans, recognising the differences in population need and health and care partnership working at local level.

Health and Wellbeing Boards and Scrutiny Committees.

In each local authority place the respective role of Health and Wellbeing Boards and Health Oversight and Scrutiny Committees are vital in enabling entire system approaches. For example, this includes the wider determinants of good health, primary, community and acute services, the voluntary, community and social enterprise sector, public health, stakeholder involvement and integrated commissioning.

7.3 Focus of Place Plans.

Place plans cover immediate priorities for 2023/24, and longer-term transformation and development plans until 2028/29. Place plans respond to local context and the

needs of the area's population. The plans also all cover consistent themes from the ICP strategy that are best delivered through working at place. These areas of focus are summarised below, noting that the way they are delivered will appropriately vary between and across Places.

7.4 Healthier and Fairer.

Improving population health and reducing health inequalities is clearly a key focus. This includes supporting the implementation of the Healthier and Fairer programme at a local level, but with a heavy focus on priorities from:

- the Health and Wellbeing Board
- the Joint Strategic Needs Assessment
- Joint Health and Wellbeing Plans.

Examples:

- Delivery of the adult and children and young people's CORE20plus5
- Focussed support on 'Deep End' General Practice and health inclusion groups, for example the street homeless.
- Smoking cessation, alcohol, and substance misuse related harms.
- Healthy weight, nutrition, and exercise.
- Addressing the impacts of the cost-of-living crisis in partnership.
- Partnership working on housing, employment, and broader social determinants of health, including Anchor Institution approaches.
- Case finding and early intervention for long-term conditions.

7.5 Best Start in Life.

All of the Place Plans include a broad set of actions to support children and young people, some of which are summarised below. These are often a focus of joint working with local authority and other partners.

Examples:

- Joint approaches to meeting needs which services often find complex, including jointly commissioned packages of care.
- Special Educational Needs and Disabilities.
- Safeguarding, and improving health outcomes for children in our care and those leaving care.
- Entire system approaches to mental and emotional wellbeing, and mental health services, support for people with a learning disability and improving neuro-developmental pathways.
- Specific pathways, for example speech and language therapies, and breastfeeding and reducing tobacco dependence in pregnancy and the postnatal period.

7.6 Improving Health and Care Services.

All Place Plans support the delivery of the North East and North Cumbria wide service Plans; areas of focus include:

7.6.1 Integrated Neighbourhood Teams, Primary Care and Community Services.

Examples

- Service models supporting the sustainability of primary care and improving access to primary care.
- Delivering the local model for integrated neighbourhood teams, and for the development of Primary care Networks.
- Integration between Primary Care and Community services.
- Personalisation programme, for example maximising the value of the additional role reimbursement scheme roles.
- Community based urgent care (see urgent care below).
- Medicines optimisation and partnerships with community pharmacy.

7.6.2 Urgent and Emergency Care.

Examples

- Community based urgent care pathways, including virtual wards, urgent treatment centres, and alternatives to hospital admission.
- Urgent 2-hour community response, for example falls pathways.
- Improvement to hospital discharge processes.
- Services to reduce the reliance on residential care.
- Community based palliative and end of life care.
- Partnership approaches to support people who are high frequent users of emergency services, including accident and emergency.

7.6.3 Mental health, people with a learning disability and autistic people.

Examples

- Delivering the community transformation programme.
- Local programmes supporting suicide prevention.
- Increasing the dementia diagnosis rate and support pathways.
- Reducing reliance on in-patient services, through improved discharge and community pathways.
- Improvements in peri-natal mental health pathways.
- Children and young people (as above in best start in life).
- Focus on improving the physical health of people with a severe and enduring mental illness, people with a learning disability, and autistic people, for example through annual health checks and access to screening programmes.

7.7 Enabling Plans.

All Place Plans address each of the enabling Plans in section 6. Working together to strengthen our neighbourhoods and places is a particular focus. We recognise the strong history of joint and integrated working in local authority Places. We want to work with partners develop the best possible approaches going forward building on our current arrangements.

Examples

- Overarching focus on system integration, transformation, and partnership working, including partnership governance.
- Opportunities to develop shared solutions to workforce, digital, environmental sustainability and aligned approaches to maximising our resources and financial efficiency, including aligned approaches to commissioning services.

8 Focus for the March 2024 refresh.

This is our first joint forward plan. While developing the plan we recognised that there are some gaps in our current service planning, partnership, and delivery arrangements. We also recognise that our NHS Integrated Care Board is still a new organisation. We will be making changes to the ICB internal operating model and how the ICB can best work with partners.

We also received constructive feedback to the draft joint forward plan that there are real gaps in describing the approach to some key services. We have not been able to address all these gaps in the first version of our joint forward plan.

8.1 Continuous development of our plans.

We are committed to continually our joint forward plan and welcome a continued conversation with stakeholders on how we can make improvements for the March 2024 refresh of the plan.

We welcome all feedback to this version of the plan, and suggestions for the refresh, through our involvement approaches, our place-based partnerships and workstreams, as well as from experts by experience. Additionally, feedback can be provided to the ICB Planning email **necsu.icbplanning@nhs.net**. All feedback will be kept on file and considered. Some of the areas (not exhaustive) already identified for improvement include:

8.2 Ways of working.

We know that we need to set out much clearer ways of working, and to co-produce ways of working with our partners. This includes:

8.2.1 Working with the voluntary, community and social enterprise sector.

Our joint forward plan is not well developed in terms of how we will seek to work with the sector as a valued partner.

8.2.2 Working with the independent sector.

We also need to develop clearer approaches to working with the independent sector as a major provider of NHS funded care and jointly funded care with local authorities.

8.2.3 Partnership Working.

Our partnership working, particularly at Place, is deeply important to us. We know that partners, including local authorities, and through statutory arrangements including Health and Wellbeing Boards, want to develop stronger and clearer ways of working with the NHS. We need to agree some clearer partnership frameworks, including for Place based arrangements.

8.2.4 Governance.

We have valued workstreams and clinical networks, but we are not always clear about the purpose, scope, responsibility, and accountability of these. We will develop clearer approaches over the coming months.

8.2.5 Quality.

Our overarching approach to ensuring quality, meaning patient experience, safety, and clinical outcomes, including the delivery of the NHS Patient Safety Incident Response Framework (PSIRF). This sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

8.3 Services.

Some of the key gaps identified in the plan included:

8.3.1 Long term condition management.

Our approach to common long-term conditions, including diabetes, are very underdeveloped in this version of the plan. We anticipate that this will be addressed through our developing Clinical Strategy work.

8.3.2 Dementia and organic mental health.

We are currently developing our approach to dementia / organic mental health in the document, beyond seeking to increase dementia diagnosis rate and in line with the NHS long term plan. This will connect with our developing work on managing long term conditions.

8.3.3 Gender dysphoria services.

We recognise that there has been an increase in demand for gender dysphoria services, and that there are challenges in the current service pathway. As part of our work towards the March 2024 refresh, we intend to develop planned improvements

to the commissioning and provision of services which meet demand and are in line with national guidelines and best practice.

8.3.4 General Practice, pharmacy and optometry recovery plans.

We need to set out a much clearer approach to supporting primary care services, and their broader positioning within community services including those delivered in partnership.

8.3.5 Individual care packages.

NHS funded nursing care, continuing healthcare and children's continuing healthcare, section 117 arrangements and other jointly funded packages are important in providing the support that people need through individual care packages. We are currently working to strengthen our approaches to those areas, including through joint work with partners.