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North Tyneside Council

Health and Wellbeing Board

2 November 2022

A meeting of the Health and Wellbeing Board will be held:-

on **Thursday, 10 November 2022**

at **10.00 am**

in **Room 0.02, Quadrant, The Silverlink North, Cobalt Business Park, NE27 0BY**

Agenda Item **Page(s)**

1. **Apologies for Absence**
   To receive apologies for absence from the meeting.

2. **Appointment of Substitute Members**
   To receive a report on the appointment of Substitute Members. Any Member of the Board who is unable to attend the meeting may appoint a substitute member. The Contact Officer must be notified prior to the commencement of the meeting.

3. **Declarations of Interest and Dispensations**
   Voting Members of the Board are invited to declare any registerable and/or non-registerable interests in matters appearing on the agenda, and the nature of that interest. They are also invited to disclose any dispensation in relation to any registerable and/or non-registerable interests that have been granted in respect of any matters appearing on the agenda.

   Non voting members are invited to declare any conflicts of interest in matters appearing on the agenda and the nature of that interest.

Members of the public are welcome to attend this meeting and receive information about it.

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For further information about the meeting please call (0191) 643 5359.

Please complete the Declarations of Interests card available at the meeting and return it to the Democratic Services Officer before leaving the meeting.

4. **Minutes** 5 - 12
To confirm the minutes of the meeting held on 22 September 2022.

5. **Healthy Weight Declaration** 13 - 16
To receive a progress report in relation to the Healthy Weight Declaration and to support its launch on 22 November 2022.

6. **North East and North Cumbria Integrated Care Partnership - Draft Integrated Care Strategy** 17 - 58
To consider the North East and North Cumbria Integrated Care Partnership's Draft Integrated Care Strategy and provide comments and feedback to help further develop the strategy.

7. **North East and North Cumbria Integrated Care Board - North Tyneside Place Arrangements**
To receive an update on the development of the Integrated Care Board's place based governance arrangements in North Tyneside.

8. **Joint Local Health & Wellbeing Strategy - Best Start in Life** 59 - 76
To consider progress made in delivering the ambitions and actions relating to the Best Start in Life theme contained in the Joint Local Health & Wellbeing Strategy "Equally Well: A healthier, fairer future for North Tyneside 2021-25" and implementation plan.

9. **Joint Local Health & Wellbeing Strategy - Ensuring a Healthy Standard of Living for All** 77 - 80
To consider progress made in delivering the ambitions and actions relating to the ensuring a healthy standard of living for all theme contained in the Joint Local Health & Wellbeing Strategy "Equally Well: A healthier, fairer future for North Tyneside 2021-25" and implementation plan.

10. **Review of Membership of the Board** 81 - 84
To review the membership of the Board to ensure that the range of organisations represented at meetings are appropriate in terms of delivering the ambitions set out in the Joint Local Health & Wellbeing Strategy.

Members of the Health and Wellbeing Board:-

Councillor Karen Clark (Chair)
Councillor John O'Shea (Deputy Chair)
Councillor Peter Earley
Councillor Paul Richardson
Councillor Joe Kirwin
Wendy Burke, Director of Public Health
Julie Firth, Interim Director of Childrens Services
Eleanor Binks, Interim Director of Adult Services
Anya Paradis, North East and North Cumbria Integrated Care Board
Mark Adams, North East and North Cumbria Integrated Care Board
Julia Charlton, Healthwatch North Tyneside
Paul Jones, Healthwatch North Tyneside
Christine Briggs, NHS England
Helen Steadman, Newcastle Hospitals NHS Foundation Trust
Birju Bartoli, Northumbria Healthcare NHS Foundation Trust
Sarah Brown, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
Kirstin Richardson, Wallsend Primary Care Network
Alex Kent, North Shields Primary Care Network
Richard Scott, Whitley Bay Primary Care Network
Kathryn Blomfield, North West Primary Care Network
Vacancy, North Tyneside Safeguarding Adults Board
Patricia Whelan-Moss, TyneHealth
Craig Armstrong, North East Ambulance Service
Steven Thomas, Tyne & Wear Fire & Rescue Service
Claire Wheatley, Northumbria Police
Dawn McNally, Age UK North Tyneside
Geraint Morris, North of Tyne Pharmaceutical Committee
Cheryl Gavin, Voluntary and Community Sector Chief Officer Group
Dean Titterton, YMCA North Tyneside

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Health and Wellbeing Board

Thursday, 22 September 2022

Present: Councillor Karen Clark (Chair)
Councillors Peter Earley, Joe Kirwin, John O'Shea and Paul Richardson
Rachel Nicholson, North Tyneside Council
Scott Woodhouse, North Tyneside Council
Anya Paradis, North East and North Cumbria Integrated Care Board
Julia Charlton, Healthwatch North Tyneside
Paul Jones, Healthwatch North Tyneside
Brian Moulder, Newcastle Hospitals NHS Foundation Trust
Ross Wigham, Northumbria Healthcare NHS Foundation Trust
Steven Thomas, Tyne & Wear Fire & Rescue Service
Karen Murray, Northumbria Police
Dawn McNally, Age UK North Tyneside
Ann Gunning, North of Tyne Pharmaceutical Committee
Cheryl Gavin, Voluntary and Community Sector Chief Officer Group
Dean Titterton, YMCA North Tyneside

In attendance: Gemma Pelley, Northumbria Police
Sue Graham, North Tyneside Council
Michael Robson, North Tyneside Council

Apologies: Wendy Burke, Director of Public Health
Jacqui Old, Director of Children's and Adult Services
Jackie Laughton, North Tyneside Council
Mark Adams, North East and North Cumbria Integrated Care Board
Nicola Bailey, North East and North Cumbria Integrated Care Board
Helen Steadman, Newcastle Hospitals NHS Foundation Trust
Birju Bartoli, Northumbria Healthcare NHS Foundation Trust
Claire Wheatley, Northumbria Police
Geraint Morris, North of Tyne Pharmaceutical Committee

HW10/22 Appointment of Substitute Members

Pursuant to the Council's constitution the appointment of the following substitute members was reported:-

Rachel Nicholson for Wendy Burke (Director of Public Health)
Scott Woodhouse for Jacqui Old (Director of Children and Adult Services)
Brian Moulder for Helen Steadman (Newcastle Hospitals)
Karen Murray for Claire Wheatley (Northumbria Police)
Ann Gunning for Geraint Morris (Local Pharmaceutical Committee)
Ross Wigham for Birju Bartoli (Northumbria Healthcare)

HW11/22 Declarations of Interest and Dispensations

Councillor Karen Clark declared a registerable personal interest in relation to Equally Well, the Board's Joint Health & Wellbeing Strategy because she is a Director and Employee of Justice Prince CIC, an organisation concerned with tackling inequalities which has contracts with, and receives funding from, the Council and partners.

Councillor Joe Kirwin declared a registerable personal interest in relation to the North East and North Cumbria Integrated Care Board because his wife is an employee of Newcastle Hospitals NHS Foundation Trust and he is employed by Pancreatic Cancer Action, a national cancer charity engaged in lobbying organisations such as the ICB.

Councillor Peter Earley declared a registerable personal interest in relation to those items on the agenda with a link to the North Tyneside Carers Centre because he is a Trustee of the Centre.

HW12/22 Minutes

Resolved that the minutes of the previous meeting held on 30 June 2022 be confirmed and signed by the Chair.

HW13/22 Pharmaceutical Needs Assessment 2022/25

The Board was responsible for preparing a Pharmaceutical Needs Assessment (PNA) for the area and for reviewing it at least every three years. The purpose of the PNA was to:

a) determine if there were enough community pharmacies to meet the needs of the population of North Tyneside. NHS England uses the PNA to determine applications to open new pharmacies in the area; and
b) act as a commissioning guide for services which could be delivered by community pharmacies to meet the identified health needs of the population.

In November 2021 the Board had agreed a process for reviewing, updating and consulting on a revised version of the PNA. A steering group with representatives from the Integrated Care Board (ICB), NHS North of England Commissioning Support, North of Tyne Local Pharmaceutical Committee, Healthwatch North Tyneside, and North Tyneside Council had overseen the development of the refreshed PNA.

A draft revised PNA had been prepared and this had been subject to a formal 60 day consultation period during July and August 2022 which had enabled stakeholders and members of the public to submit their comments. 13 responses had been received, 7 from members of the public and 6 from organisations working in North Tyneside. 12 respondents thought the PNA was accurate and agreed with the conclusions of the PNA, 4 respondents thought there were aspects missing from the PNA and details of these comments were presented to the Board. Some of the issues raised fell outside the scope of the PNA but it was acknowledged that the Board together with the ICB needed to maximise opportunities to identify additional clinical services to be commissioned and provided through community pharmacies.

The Board considered the additional capacity and resources required in pharmacies to deliver additional clinical services, particularly the option of funding and training Accuracy

Checking Technicians which could free Pharmacists from dispensing duties and enable them to spend more time providing frontline clinical services. It was suggested that the Board may wish to give further consideration to the development of additional services from community pharmacies at a future meeting.

A final version of the revised PNA had been prepared taking into account the comments arising from the consultation exercise. This was presented to the Board for approval prior to publication before the deadline on 1 October 2022. The Board expressed its thanks to all those involved in the steering group for their work in reviewing and updating the PNA.

Resolved that the Pharmaceutical Needs Assessment 2022-25 be approved for publication prior to the deadline on 1 October 2022.

HW14/22 Joint Health & Wellbeing Strategy - Implementation Plan, Consultation Findings and Governance Arrangements

In November 2021 the Board had adopted a revised Joint Local Health & Wellbeing Strategy (JLHWS): Equally Well: A Healthier, Fairer Future for North Tyneside 2021-2025 and subsequently agreed a process of formulating and consulting on an implementation plan to deliver the vision and ambitions contained in the strategy.

As the strategy made clear that attempts to tackle inequalities must be done in collaboration and equal partnership with those affected it was essential that the draft implementation plan should also be agreed by the community. North Tyneside Healthwatch had therefore led an extensive consultation process with a range of local community groups to gather views from residents and organisations about the implementation plan. The Board heard about one example of engagement which had involved an artist in residence working with a focus group to produce an artwork illustrating the key issues to emerge.

The overall findings of the consultation were broadly positive, with consultees agreeing with the approach of the strategy, particularly the need to look at the wider determinants of health to reduce health inequalities. Details of the findings were presented to the Board and particular reference was made to:

a) the cost-of-living crisis which could potentially widen health inequalities and affect many people who were sometimes referred to as ‘just about managing’ and also local businesses;
b) ensuring that the capacity within the voluntary, community & social enterprise sector was maximised and that delivery solutions were truly co-produced;
c) workforce challenges needing to be more explicit in the implementation plan;
d) the challenges and costs associated with transport to work and appointments; and
e) the importance of digital inclusion.

The Board was presented with an implementation plan which set out actions, outcomes and proposed performance indicators based on the 7 impact areas contained within the strategy. The Board were assured from the feedback that the implementation plan reflected the lived experience of communities.

It was acknowledged that tackling health inequalities required a long-term commitment from the Board and its partners and making a difference in relation to poverty and the social determinants of health would take longer than the life of the strategy. The Board also considered the political and economic changes which had occurred during the time taken to

formulate the implementation plan. The plan would therefore need to be flexible to adapt to contextual changes and it needed to be understood that some issues could only be addressed at a national level.

A proposed governance structure was presented to the Board which aimed to provide assurance that each of the 7 impact areas contained within the strategy were being considered by a multi-agency partnership. Each partnership would have responsibility for delivering the actions, monitoring progress, reporting on implementation to the Board and drafting an implementation plan for year 2. The responsible partnerships and the timescales for reporting progress to the Board were proposed as follows:

Impact Area	**Responsible Partnerships**	**Reporting to the Board**
Best start in life	Children and Young People's Partnership	10 Nov 2022
Maximising capabilities of children, young people and adults	Children and Young People's Partnership	12 Jan 2023
Fair Employment and good work for all	Employability Strategy Group	9 Mar 2023
Ensuring a healthy standard of living for all	Poverty Partnership	10 Nov 2022
The places and communities we live in and with	Safer North Tyneside Partnership. Wallsend and North Shields Masterplan. Climate Change Partnership. Culture Partnership.	12 Jan 2023
Our lifestyles and healthy behaviours	Tobacco Alliance Healthy Weight Alliance Drugs Alliance Alcohol Partnership	9 Mar 2023
An integrated health and care system	Integrated Care Board Place Based arrangement for North Tyneside (details to be confirmed)	June 2023

The Chair of the Board would write to the Chairs of the respective partnerships to agree the governance and reporting mechanisms. Key indicators had been selected to measure progress and a dashboard would be developed to monitor progress. An overall annual progress report and a refresh of the implementation plan would be presented to the Board in June 2023.

Resolved that (1) the feedback from the findings of Healthwatch North Tyneside's consultation be noted;
(2) the implementation plan, based on the findings from the consultation, be approved;
(3) a flexible approach be adopted to delivering the plan to adapt to changes in economic and political context;
(4) the proposed governance arrangements to deliver the implementation plan be endorsed; and
(5) the proposed mechanism for reporting back progress of delivery against the implementation plan be endorsed.

HW15/22 Better Care Fund Plan 2022/23

The Board was presented with the Better Care Fund (BCF) Plan for 2022/23. The BCF was a government initiative which had operated since 2015 to improve the integration of health and care services, with an emphasis on keeping people well outside of hospital and facilitating safe and timely discharge from hospital.

The BCF created a local pooled fund, managed jointly by the Council and the North East and North Cumbria Integrated Care Board (ICB), governed by a Section 75 legal agreement. The value of the fund in 2022/23 would be £30.774m which represented an increase of 4.47% on the previous year. The BCF would help fund community based social care services, such as reablement, immediate response home care, CareCall, and loan equipment/adaptations.

The BCF Policy Framework for 2022/23 had been published in July 2022 and it set out two policy objectives: to enable people to stay well, safe and independent at home for longer and to provide the right care in the right place at the right time. BCF Plans had to comply with the following national conditions:

a) to be a jointly agreed plan between local health and social care commissioners, signed off by the Health and Wellbeing Board;
b) NHS contribution to adult social care had to be maintained in line with the uplift to the identified North Tyneside ICB minimum contribution;
c) investment in NHS-commissioned out-of-hospital services; and
d) implementation of the BCF policy objectives.

The performance of the BCF Plan had to be monitored against the following mandatory metrics:

a) effectiveness of reablement;
b) permanent admissions of older people to residential care;
c) unplanned hospitalisations due to chronic ambulatory care sensitive conditions; and
d) hospital discharge, improving the proportion of people discharged from home to their usual place of residence.

The plan documented the current performance against these metrics, it set ambitions for future performance, and explained how the services funded through the BCF would work alongside other services to impact the metrics. The plan had been aligned with the place-based strategy developed by the Future Care Programme Board, which has representation from across the local health and social care sector.

The Board considered whether there was scope within the Better Care Fund to ensure that care staff employed by care homes were paid the national living wage, rather than the national minimum wage, particularly for young workers. Whilst the Authority could not dictate the terms and conditions of employment it could analyse and assess rates of pay as part of the fair cost of care exercise.

Resolved that (1) the Better Care Fund Plan 2022/23 be approved; and
(2) the Director of Children's and Adult Services in consultation with the Chair of the Health & Wellbeing Board be authorised to determine and agree any further revisions to the submission on behalf of the Board, before the deadline for submission to NHS England on 26 September 2022.

HW16/22 Social Care and Integration White Papers

The Board received a presentation outlining the Government's proposals for adult social care reform and the integration of health and social care services as set out in two separate white papers.

The white paper entitled "*People at the Heart of Care*" set out an ambitious 10-year vision for how the Government intended to transform support and care in England. This vision put people at its heart and revolved around the following 3 objectives:

a) people have choice, control and support to live independent lives.
b) people can access outstanding quality and tailored care and support.
c) people find adult social care fair and accessible.

The Board were presented with details of the proposed reforms and their impact in terms of funding reform, self funders accessing commissioning arrangements for residential and nursing care, market reform including fair cost of care exercise, housing and care, technology, data and intelligence, assurance regime and workforce development. In considering the proposals the Board considered the potential financial implications for the Council and Council Tax payers should the level of Government grants not be sufficient to meet the costs of reform.

The white paper "*Health and social care integration: joining up care for people, places and populations" s*et out the Government's plan to join up care for patients and service users, for staff looking for ways to better support increasing numbers of people with care needs and for organisations delivering these services to the local population. The Board were presented with details of the proposals and their impact in terms of setting local shared outcomes, leadership, accountability and finance, use of digital technology and data and workforce development.

Resolved that the proposals contained in the Government white papers *Health and social care integration: joining up care for people, places and populations* and *People at the Heart of Care* be noted.

HW17/22 North East and North Cumbria Integrated Care Board

The Board received a presentation from Anya Paradis, the Director of Place for North Tyneside of the North East and North Cumbria Integrated Care Board (ICB), to provide an update on the introduction of the ICB's operating model. She described the key priorities for the ICB's development, details of the ICB's leadership team, the proposed role and membership of the North of Tyne and Gateshead Integrated Care Partnership (ICP) and the ICB's approach to continuity of place based working.

The options regarding future place based governance in North Tyneside were under consideration and proposals were likely to be presented to the ICB and local authorities in the Autumn of 2022 ahead of formal adoption in April 2023. The Chair asked that any proposals be submitted to the Board for discussion.

Resolved that the presentation in relation to the development of the North East and North Cumbria Integrated Care Board's operating model be noted.

HW18/22 Review of Membership of the Board

The Board was invited to review its membership in the light of changes to the governance and structure of the National Health Service.

From 1 July 2022 responsibility for commissioning healthcare services in North Tyneside transferred from the North Tyneside Clinical Commissioning Group (CCG) to the North East and North Cumbria Integrated Care Board (ICB). The requirement to appoint a representative of the CCG to Board was replaced by a requirement to appoint a representative from the ICB. It was therefore proposed that two seats be allocated to the ICB and that these be filled by its Executive Director Place Based Delivery, Mark Adams, and its Director of Place for North Tyneside, Anya Paradis.

In North Tyneside there were four Primary Care Networks, groups of GP Practices working together to develop localised healthcare services for their patients. In order to recognise the role of the PCNs in delivering the ambitions contained in the Board's Joint Health & Wellbeing Strategy and developing the actions to be included within the implementation plan, it was proposed that the Clinical Director of each PCN be invited to serve on the Board as members.

It was also proposed that a further review of the Board's membership be undertaken to ensure that the range of organisations represented at meetings are appropriate in terms of delivering the ambitions set out in Equally Well: the Joint Local Health & Wellbeing Strategy.

Resolved that (1) the two seats previously held by the North Tyneside Clinical Commissioning Group be transferred to the North East and North Cumbria Integrated Care Board;
(2) the Clinical Directors of each of the four Primary Care Networks in North Tyneside be appointed as members of the Board; and
(3) the Chair, Deputy Chair and other leading members of the Board be requested to review the membership of the Board to ensure that the range of organisations represented at meetings are appropriate in terms of delivering the ambitions set out in the Joint Local Health & Wellbeing Strategy; and
(4) any recommendations arising from this review for changes to the membership be presented to the Board for consideration at a future meeting.

HW19/22 Chair's Announcements

The Chair acknowledged that Lesley Young Murphy and Jacqui Old, who had both served as longstanding members of the Board in their respective roles as Chief Operating Officer of the North Tyneside Clinical Commissioning Group and the Council's Director of Children's and Adult Services, had now both moved on to different roles and would no longer be attending meetings of the Board. The Chair recognised their significant and valuable contributions to the work of the Board and wished them well in their new roles.

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North Tyneside Health & Wellbeing Board Report Date: 10 November 2022

Title: Healthy Weight Declaration Update

Report from:	North Tyneside Council	
Report Author:	Louise Gray, Consultant in Public Health	(Tel: 0191 264 1613)
Relevant Partnership Board:	North Tyneside Healthy Weight Alliance	

1. Purpose:

The purpose of this report is to provide the Board with an update on progress made with the Local Authority Declaration on Healthy Weight

2. Recommendation(s):

The Board is recommended to:

a) Note the contents of this report
b) Support the launch of the Healthy Weight Declaration on 22 November 2022. Board members may also wish to assure themselves that relevant staff from their own organisation will be in attendance at the launch.
c) Agree to receive a broader update from the Healthy Weight Alliance on 9 March 2023

3. Policy Framework

This item relates to Section 8 of the Joint Health and Wellbeing Strategy, "Equally Well: A healthier, fairer future for North Tyneside 2021- 2025". This item relates to actions to tackle obesity, promote healthy weight and reduce inequalities.

4. Information:

4.1 Overview

Living with obesity can impact on a person's physical and mental health and wellbeing. People living with obesity are more likely to develop high blood pressure (a risk factors for cardiovascular disease), Type 2 diabetes and certain factors. Evidence suggests that children living with obesity are more likely to be overweight as adults and may also experience issues such as bullying, low self-esteem and weight stigma[1,2].

[1] **Simmonds et al (2016).** Predicting adult obesity from childhood obesity: a systematic review and meta-analysis. *Obes Rev. 2016 Feb;17(2):95-107*

[2] **Craigie et al (2011).** Tracking of obesity-related behaviours from childhood to adulthood: A systematic review. *Maturitas. 2011 Nov;70(3):266-84*

It is widely acknowledged that excess weight is not evenly distributed, and some gaps are more likely to have a higher prevalence than other, leading to health inequalities. At a population level, people living in more deprived areas are disproportionately affected by obesity and the associated medical conditions. These inequalities are key drivers of the Joint Health and Wellbeing Strategy and some of the specific actions to support the "our lifestyles and healthy behaviours" ambition.

4.2 The current position in North Tyneside

Population level data is available to provide an understanding of the prevalence of excess weight (e.g., overweight and obesity) in North Tyneside. In 2020-21, 65.9% of adults in North Tyneside were estimated to be living with excess weight, which was the lowest prevalence in the North East but higher than the England value of 63.5%[3]. The National Child Measurement Programme (NCMP) results for the 2021-22 academic year show that over 1 in 4 children in Reception (26.1%) in North Tyneside are living with excess weight, and this increases to over 1 in 3 in Year 6 (38.6%). These results represent an increase on previous years and are higher than provisional national data. As above, local NCMP data shows that children living in or attending schools in more deprived parts of the borough are more likely to be living with excess weight than those from less deprived areas.

The full impact of the COVID-19 pandemic on weight is not yet fully understood, but initial indicators suggest that the prevalence of excess weight has increased at a population level in adults and children. This is supported by local NCMP data. If current trends continue it is predicted that there will be more people who are obese than those who are a healthy weight by 2040, making obesity the most common BMI status.

4.3 Local Authority Declaration on Healthy Weight

Obesity is a complex problem; decisions around food choices and physical activity are not made in a vacuum. There are many individual, environmental and population factors that affect someone's weight and therefore this means that some people find it more difficult to achieve and maintain a healthy weight than others.

The Healthy Weight Declaration is a strategic, system-wide commitment made across all council departments to reduce unhealthy weight in local communities, protect the health and wellbeing of citizens and to make an economic impact on health and social care and the local economy. The Healthy Weight Declaration was developed by Food Active and consists of 16 commitments under the following headings:

- Strategic/system leadership
- Commercial determinants
- Health promoting infrastructure/environment
- Organisational change/culture shift
- Monitoring and evaluation

The North Tyneside Health and Wellbeing Board agreed to adopt the Healthy Weight Declaration on 16 September 2021. The Board agreed to take a lead role, through the work of the Healthy Weight Alliance, in ensuring a whole systems approach to addressing the obesogenic environment and supporting individuals. The Board also agreed to support a joint approach with Northumbria Healthcare NHS Foundation Trust to provide strong

[3] **OHID (2022).** Fingertips: Obesity Profile – Adult prevalence data. Available online *[Accessed 17 October 2022]*

systems leadership across North Tyneside and effective partnership working in relation to tackling the complexities of tackling obesity across the borough.

It was later agreed that the whole system approach would be further strengthened if Northumberland County Council jointly launched their Healthy Weight Declaration at the same time. Therefore, North Tyneside Council, Northumbria Healthcare NHS Foundation Trust and Northumberland County Council will launch their Healthy Weight Declarations on 22 November 2022. It is thought that this will be the first joint launch of this kind in the country.

The Healthy Weight Declaration will launch at an online event on 22 November 2022. There will be presentations from all three organisations to set out some of their proposals to address the relevant commitments and support healthy weight across the system. Members of the Healthy Weight Alliance and other relevant stakeholders in North Tyneside have been invited to attend the launch.

Progress against the commitments of the Healthy Weight Declaration commitments and a broader action plan to reduce inequalities in weight and the food environment in North Tyneside will be overseen by the Healthy Weight Alliance.

5. Decision options:

The Board may either:

a) Note the report and take no further action; or
b) Agree to the recommendations set out in Section 2 of this report

6. Reasons for recommended option:

The Board are recommended to agree option b) to provide a robust and systematic approach to tacking unhealthy weight across North Tyneside and work in line with the Joint Health and Wellbeing Strategy to reduce inequalities.

7. Appendices:

None

8. Contact officers:

Louise Gray, Consultant in Public Health, North Tyneside Council

9. Background information:

The following background documents have been used in the compilation of this report and are available from the author: -

National Child Measurement Programme: Summary of North Tyneside data 2021-2022

North Tyneside Joint Health and Wellbeing Strategy 2021-2025: Equally Well: A healthier, fairer future for North Tyneside

Office for Health Improvement and Disparities (2022). Fingertips – Obesity Profile

COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

10 Finance and other resources

There is a cost of £1950 plus VAT to adopt the Healthy Weight Declaration. This will be paid for through the Public Health Ringfenced Budget. Further actions may be identified by the Healthy Weight Alliance in future which may require a financial commitment from some partners, but there is no work currently ongoing that is beyond the remit of partners' usual activity.

11 Legal

The Board has a duty under Section 195 of the Health & Social Care Act 2012 to encourage partners to work closely together and in an integrated manner for the purpose of advancing the health and wellbeing of the people in the area.

12 Consultation/community engagement

A stakeholder event was held on 27 July 2021 with partners across the system and within North Tyneside Council, and there was further discussion at the Health and Wellbeing Board on 16 September 2021.

13 Human rights

There are no human rights implications directly arising from this report.

14 Equalities and diversity

There are no equality and diversity implications arising directly from this report. Obesity-related health harms are a key indicator of health inequalities. The North Tyneside Healthy Weight Alliance and partner agencies will work to reduce those inequalities.

15 Risk management

No risk assessment has taken place since the last report to the Health and Wellbeing Board. Any risks identified can be managed following the Council and partners' existing risk processes.

16 Crime and disorder

There are no crime and disorder implications directly arising from this report.

SIGN OFF

Chair/Deputy Chair of the Board	X
Director of Public Health	X
Interim Director of Children's Services	X
Interim Director of Adult Services	X
Director of Healthwatch North Tyneside	X
Integrated Care Board Director of Place	X

North Tyneside
Health & Wellbeing Board Report
Date: 10 November 2022

Title: North East and North Cumbria Integrated Care Partnership - Draft Integrated Care Strategy

Report from : **North East and North Cumbria Integrated Care Board**

Report Author: Michael Robson (Tel: 0191 643 5359)
Law and Governance

Relevant Partnership Board: North East and North Cumbria Integrated Care Partnership

1. Purpose:

This report presents details of the North East and North Cumbria Integrated Care Partnership's Draft Integrated Care Strategy and seeks comments and feedback from the Board to help further develop the Strategy.

2. Recommendation(s):

The Board is recommended to:-

a) consider the contents of the Draft Integrated Care Strategy;
b) provide the North East and North Cumbria Integrated Care Partnership with comments and feedback on the draft strategy either collectively as a Board, directly at the meeting or individually by means of the online survey.

3. Policy Framework

This item relates to all aspects of the Joint Local Health and Wellbeing Strategy (JLHWS), "Equally Well: A healthier, fairer future for North Tyneside 2021- 2025".

4. Information:

The Health and Care Act 2022 established the North East and North Cumbria Integrated Care Board (ICB) and the Act requires the ICB and partner local authorities to form a joint committee, termed the Integrated Care Partnership (ICP). The ICP is an equal partnership between Local Government and the NHS, which aims to join-up how health and care is supported across the region. The ICP will also bring together a range of organisations, including voluntary, community and independent organisations to work together to improve the health and wellbeing of people who live in the region.

A key accountability for the ICP is to produce an Integrated Care Strategy, setting out how the assessed needs of the local population will be met, including from Joint Strategic Needs Assessments (JSNAs). This includes social care, primary and secondary care, physical and mental health, and health related service across the whole population regardless of age.

A draft strategy document was published on 26 October 2022 and this is attached as Appendix 1.

Peter Rooney, the Director of Strategy and Planning at the North East and North Cumbria Integrated Care Board, has agreed to attend today's meeting to present details of the Strategy and to receive feedback.

At this stage the ICP are seeking comments and feedback on the draft Strategy from stakeholders and a wide range of partners, including the Health and Wellbeing Boards of the 13 local authorities in the region. Individuals and organisations are also invited to submit their views through an online survey available at https://necs.onlinesurveys.ac.uk/icp_strategy_survey. Anyone can do this before 25 November 2022.

A short summary of the approach taken by the ICP in developing the strategy is attached as Appendix 2.

The draft strategy is very much evolving and will benefit from any feedback. The ICP will develop the strategy further in light of views gathered as part of engagement during November with a view to presenting it at the next ICP meeting in December.

5. Appendices:

Appendix 1 – North East and North Cumbria Integrated Care Partnership's Draft Integrated Care Strategy
Appendix 2 - Developing the Integrated Care Strategy

6. Contact officers:

Peter Rooney, Director of Strategy and Planning, North East and North Cumbria Integrated Care Partnership
Michael Robson, Clerk to the Board, Law and Governance (Tel 643 5359)

7. Background information:

The following background documents have been used in the compilation of this report and are available from the author:-

- North East and North Cumbria Integrated Care Partnership's Draft Integrated Care Strategy
- Health and Care Act 2022

COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

8 Finance and other resources

There are no direct financial implications for the Board arising from this report.

9 Legal

The Board has a duty under Section 195 of the Health & Social Care Act 2012 to encourage partners to work closely together and in an integrated manner for the purpose of advancing the health and wellbeing of the people in the area.

Section 26 of the Health & Care Act 2022 requires the Health & Wellbeing Board to consider revising its Joint Local Health & Wellbeing Strategy (JLHWS) following the development of the Integrated Care Strategy for the area. If, having considered the Integrated Care Strategy, the Board considers its JLHWS to be sufficient, there is no requirement to refresh.

10 Consultation/community engagement

At this stage the ICP are seeking comments and feedback on the draft Strategy from stakeholders and a wide range of partners, including the Health and Wellbeing Boards of the 13 local authorities in the region. Individuals and organisations are also invited to submit their views through an online survey.

11 Human rights

There are no human rights implications directly arising from this report.

12 Equalities and diversity

The ICP will be required to comply with the public sector equality duty in developing its Integrated Care Strategy.

13 Risk management

A risk assessment has not been completed in relation to this item.

14 Crime and disorder

There are no crime and disorder implications directly arising from this report.

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NORTH EAST AND NORTH CUMBRA INTEGRATED CARE PARTNERSHIP

DRAFT INTEGRATED CARE STRATEGY

DRAFT: 21/10/2022

FOREWORD – ICP CHAIR

To be inserted in the final strategy.

EXECUTIVE SUMMARY

To be inserted in the final strategy.

1 INTRODUCTION AND BACKGROUND

1.1 Introduction to the Strategy

The Health and Care Act 2022 enables health and care organisations to improve services and outcomes through stronger joint working, and to take shared responsibility for tackling growing health inequalities. The Act established Integrated Care Boards (ICBs) as statutory NHS organisations. It also requires ICBs and partner local authorities to form a joint committee, termed the Integrated Care Partnership (ICP). A key accountability for the ICP is to produce an Integrated Care Strategy, setting out how the assessed needs of the local population will be met, including from Joint Strategic Needs Assessments (JSNAs).This includes social care, primary and secondary care, physical and mental health, and health related service across the whole population regardless of age.

This document sets out the Integrated Care Strategy for the North East and North Cumbria Integrated Care Partnership (ICP), in the context of our existing partnership working arrangements and the national guidance.

1.2 Our Integrated Care Partnership

The ICP Board is a statutory joint committee between the thirteen Local Authorities from across the North East and North Cumbria (which will become fourteen in 202023/24 as two new unitary authorities begin in Cumbria) and the Integrated Care Board (ICB). It is an equal partnership between Local Government and the NHS, with a key purpose to align the ambition and strategies of partners across the area. The Department for Health and Social Care, NHS England and the Local Government Association have jointly developed five key expectations for Integrated Care Partnerships as follows:

- Be a core part of the Integrated Care System, driving direction and priorities;
- Be rooted in the needs of people, communities and places;
- Create space to develop and oversee population health strategies to improve health outcomes and experiences;
- Support integrated approaches and subsidiarity;
- Take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights

The ICP will bring together not just Local Government and the NHS, but also the diverse Voluntary, Community and Social Enterprise and Independent Sectors to find effective shared solutions to improve the health and wellbeing of our region.

The North East and North Cumbria ICP has the second largest population in England at 3.14 million (Greater Manchester is very slightly larger by around 7, 000 people) across a large and diverse geography. The landscape of the region is characterised by urban and inner city conurbations, coastal areas and rural areas. Whilst this makes for beautiful terrain and serene environments, it also presents a number of unique and specific challenges for the people living in those areas. To maximise the opportunity to work together at scale where beneficial, but balanced with more localised approaches, we have committed to working together through a single overarching ICP alongside four local ICP arrangements covering

the areas in the graphic below.

Local ICPs will develop a strategic picture of health and care needs from their constituent local authority 'places' working with partners including existing health and wellbeing boards. These provide a vital forum for partners to assess the needs of local people and set local priorities for health and care improvement, building on the existing work of health and wellbeing boards in each Place. We will continue to focus at Place, and will:

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

1.3 Strategic Planning Context

The ICP Integrated Care Strategy provides a strategic direction and key commitments at a headline level. This is based on the understanding of health and care needs across the region and at the 13 places, and the nationally mandated functions. It is not a detailed operational plan. Local authorities and the NHS are required to give full attention to the ICP Strategy in considering how they plan, commission or deliver services. The ICB and NHS partners develop more detailed delivery plans to support the anticipated national requirement of a five year NHS Joint Forward Plan for each ICB area.

1.4 The Data

Information in the draft strategy have been calculated taking data published at local authority geographies and applying a population weighted method to generate estimates as actual data is not available for the ICP geographic area. The estimates have been provided by Office for Health Improvement and Disparities (OHID) LKIS. Source data at local authority level is taken from Office for Health Improvement and Disparities (OHID) Fingertips platform and Life Expectancy Segment tool.

2 OUR VISION, LONG TERM GOALS AND ENABLING PROGRAMMES

2.1 Summary Vision, Goals and Enabling Programmes

The graphic below provides a summary of overall vision, long term goals and key enabling actions. We will develop fuller plans under each of these areas to demonstrate how we will deliver our commitments.

2.2 Guiding Strategic Commitments

Our guiding strategic commitments for each of those areas are:

Our Vision: 'Better and Fairer Health for all of our People and Communities'

- Local Authorities, the NHS and Partner Organisations will be clear where they need to lead, collaborate and advocate to work effectively and efficiently together
- We will develop a clear leadership and accountability framework to ensure the delivery of our strategy, with transparent reporting of progress across the ICP
- We will deliver a renewed partnership with experts by experience and the people who use our services, including through stronger partnerships with Health Watch and third sector organisations who know our communities best.

Goal: Longer, Healthier Life Expectancy

- We will reduce the gap in healthy life expectancy between our ICP and the England average by 25% by 2030, and aim to raise the average healthy life expectancy to a minimum of 60 years in every Local Authority by 2030
- We will reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below by 2030.

Goal: Fairer Health Outcomes

- We will reduce the inequality in life expectancy within our ICP between the most deprived and least deprived deciles by at least 25% by 2030

- We will reduce the suicide rate from 13 per 100, 000 population (2019/2021) to below the England average (10.4 per 100, 000 population 2019/2021) by 2030.

Goal: Excellent Health and Care Services

- We will commission and deliver high quality and joined up health and care services, delivering improving outcomes and safety with more equitable access. We will reduce unwarranted variation and healthcare inequalities across all services.

Enabler: Workforce:

- We will ensure a well-supported, sustainable, diverse workforce including ensuring the physical and mental wellbeing of the workforce.

Enabler: Places and Neighbourhoods.

- We will ensure place remains at the forefront of our actions and delivery of this strategy with decisions made at the most appropriate level and deliver integrated neighbourhood teams in all Places by March 2025.

Enabler: Technology, equipment and facilities

- We will deliver a digital, data, intelligence and insights strategy that aligns with our ambitions for placing population health management (PHM) at the centre of our decision making and transformation of health and care services.

Enabler: Resources and protecting our environment.

- We will advocate for our ICP to receive fair financial allocations and will deploy our resources to ensure improvement across the whole area but with the greatest improvement in areas with the poorest outcomes
- We will fully participate and contribute to the cross-sector coalition working to enable our region to become England's greenest region by 2030.

3 OUR STRENGTHS AND ASSETS TO BUILD ON

Across our Integrated Care Partnership are we much to be proud of. We have a broad range of outstanding assets and capabilities, providing a strong foundation for improvement. They also provide a credible source of hope, we will make real improvements with confidence and realistic optimism.

We have strong communities, with hundreds of thousands of people providing unpaid care to support their loved ones, and who freely give their time and skills through volunteering. Our Voluntary, Community and Social Enterprise sector is an amazing asset, and makes a huge contribution to the health and wellbeing of our region and our communities.

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

We have an outstanding health and care workforce, delivering high quality services across the ICP in all sectors, with some of the most accessible primary care services and best

performing emergency care in the country, alongside a record of ground-breaking surgery and pioneering new treatments, world class facilities and national centres of excellence.

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

We are proud too of 'an outstanding record of being outstanding', with high and improving CQC scores across NENC, and a commitment to education and development across all professions. Our medical training is rated as among the best in the UK (scoring first in 17 out of 18 quality indicators in the national GMC training survey). We are home to one of the UK's top ten medical schools at Newcastle, and an innovative new medical school in Sunderland, dedicated to widening access to ensure the profession reflects the communities it serves. By taking the lead in apprenticeships and training we have offered a way into highly skilled and rewarding professions for thousands of young people and our future generations.

Finally, we have a very strong foundation of partnership and collaborative working, across the ICP and at Place level in each of our Local Authority areas. These and our many other strengths and assets provide a fantastic foundation for us to make a real and lasting difference to the health and wellbeing of or population.

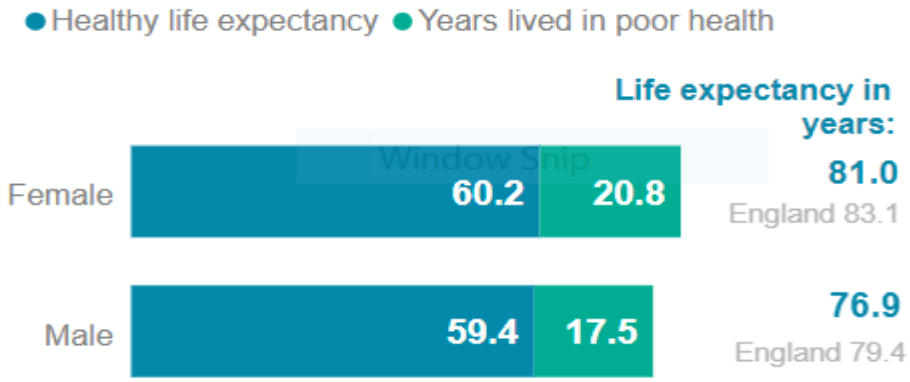
4 OUR ICP HEALTH OUTCOMES

4.1 Introduction

The quality of health and care services in the North East and North Cumbria is consistently rated amongst some of the best in England across a range of metrics. We are realistic about the challenges in sustaining our services, but we have optimism because of a strong track record of innovation and transforming care. There have been many improvements in recent years, for example the number of people dying from cancer or heart disease has decreased, fewer people are smoking and many are living longer. Despite this, overall healthy life expectancy remains amongst the poorest in England, and needs to change.

4.2 Life Expectancy and Healthy Life Expectancy

4.2.1 Life expectancy at birth in our Integrated Care Partnership area was lower than the England average in 2018-20 for both women and men as shown in the graphic below, and people also spend a significant time in living in poor health

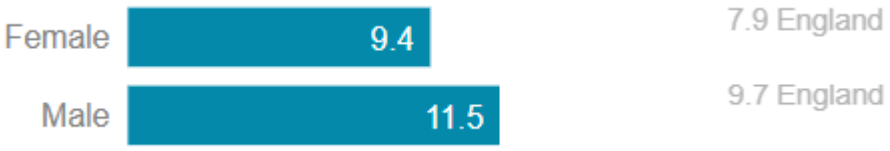


Source: Population weighted estimates (experimental) for NENC via Picture of Health - ICS edition 2022 based on data available from OHID Public Health Profiles 2022.

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

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

4.2.3 The difference in life expectancy at birth between the most and the least deprived areas within our ICP was approximately 9.4 years for women and11.5 years for men in 2018-20 (based on weighted averages, this is an indicative figure only). This difference is much larger than the inequality gap for England as shown below.



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

4.3 Economic Inclusion, Socio-Economic Deprivation and Health Outcomes

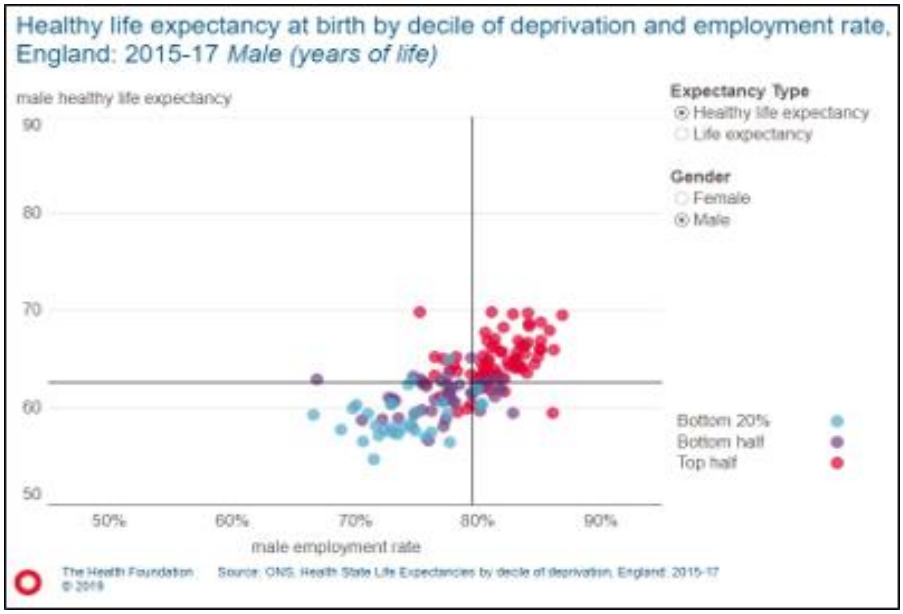
There is a strong two-way relationship between health and economic outcomes. Poor social and economic circumstances affect health throughout life. People living in poverty and multiple disadvantage have greater risks of serious illness and premature death, face increasing health inequalities and spend a greater proportion of their shorter lives living with long term conditions and disabilities.

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

Our ICP population faces a particular challenge in the context of the current cost of living crisis, for example:

- Average pay growth is currently 6%, but significantly less for many workers, and well below the current rate of inflation
- Throughout the next year we are anticipating the largest fall in real incomes since records began and will have a disproportionate impact on more deprived households.

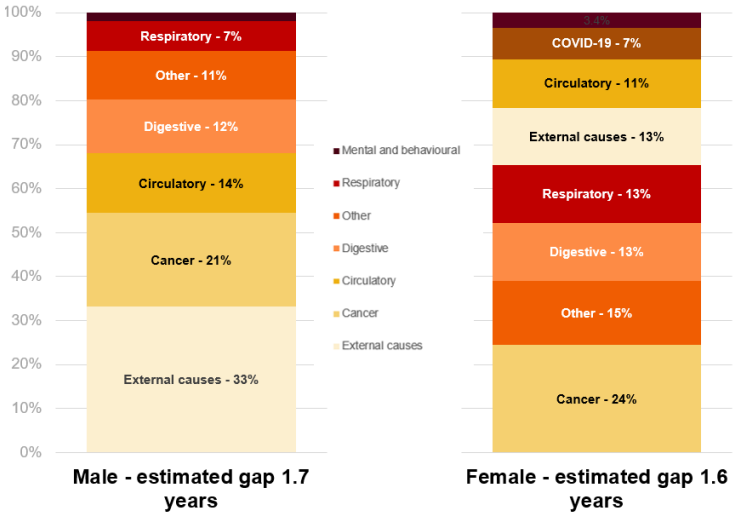
The chart below illustrates the relationship between healthy life expectancy at birth for men (the picture is very similar for women) and deprivation and employment.



4.4 Inequality in health outcomes

The graphic below shows the main causes of inequality in health outcomes between our ICP and England by disease groups for 2020 – 21. External causes, which include suicide and accidental poisoning, are particularly significant for men, the single biggest cause for women is cancer.

Causes of death that drive inequalities in life expectancy between England and NENC (experimental estimates NENC 2020 to 2021)



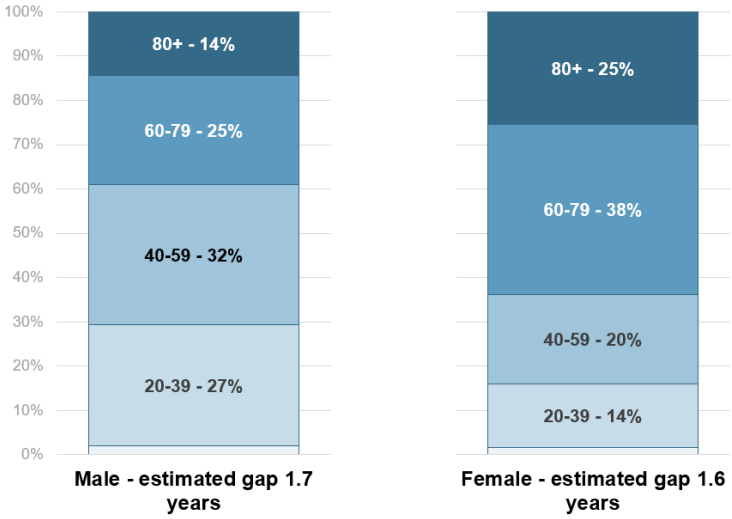
Main cause for the life expectancy gap between the area and England in females is cancer, whereas in males it is external causes which includes deaths from injury, poisoning and suicide

Figures for breast cancer are only displayed for females. Deaths from breast cancer occurring in males are included in the Other cancer category. Circulatory includes heart disease and stroke. Respiratory includes flu, pneumonia, and chronic lower respiratory disease. Digestive includes alcohol-related conditions such as chronic liver disease and cirrhosis. External includes deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease.

Source: Population weighted estimates for NENC (unpublished) based on data from OHID Segment tool.

There are differences between women and men age groups that drive the inequality in life expectancy between out ICP and England. For women, a higher percentage of the life expectancy gap is associated with excess deaths at an older age than for men.

Causes of death that drive inequalities in life expectancy between England and NENC by age group
(experimental estimates NENC 2020 to 2021)



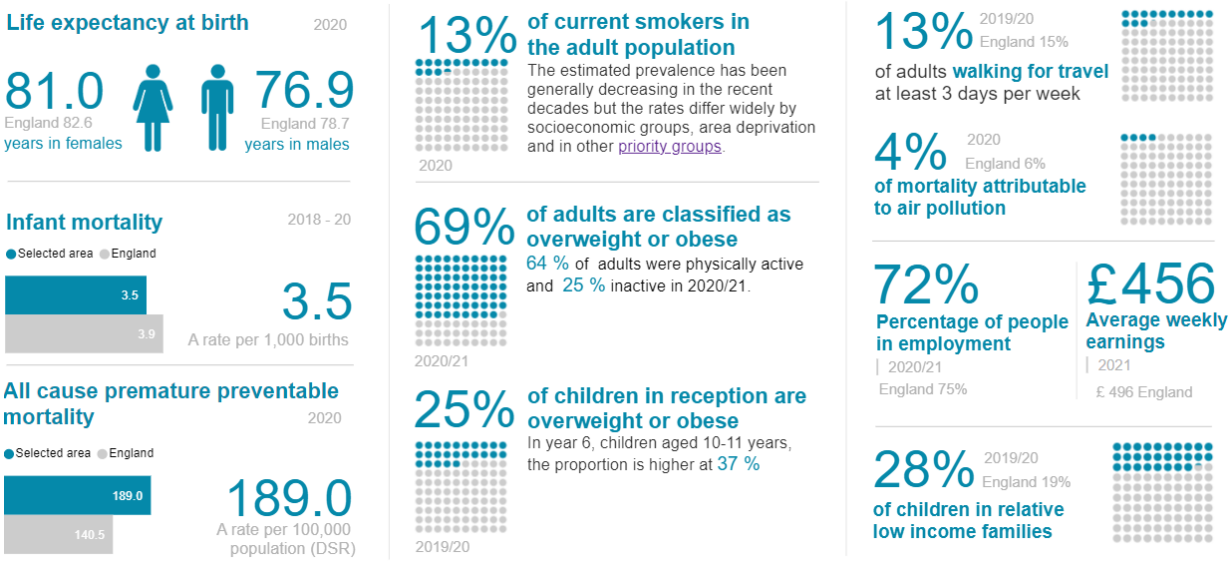
The life expectancy gap is mostly due to excess deaths in ages 60-79 in females whereas in males it is age group 40-59, an age group which makes the biggest proportion of the gap in life expectancy between England and the ICS.

Source: Population weighted estimates for NENC (unpublished) based on data from OHID Segment tool.

5 LONGER AND HEALTHIER LIFE EXPECTANCY

5.1 The Current Position

Health outcomes are not as good as they should be, we need to achieve a real improvement. The graphic below summarises some of the key factors influencing healthy life expectancy in our ICP.



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

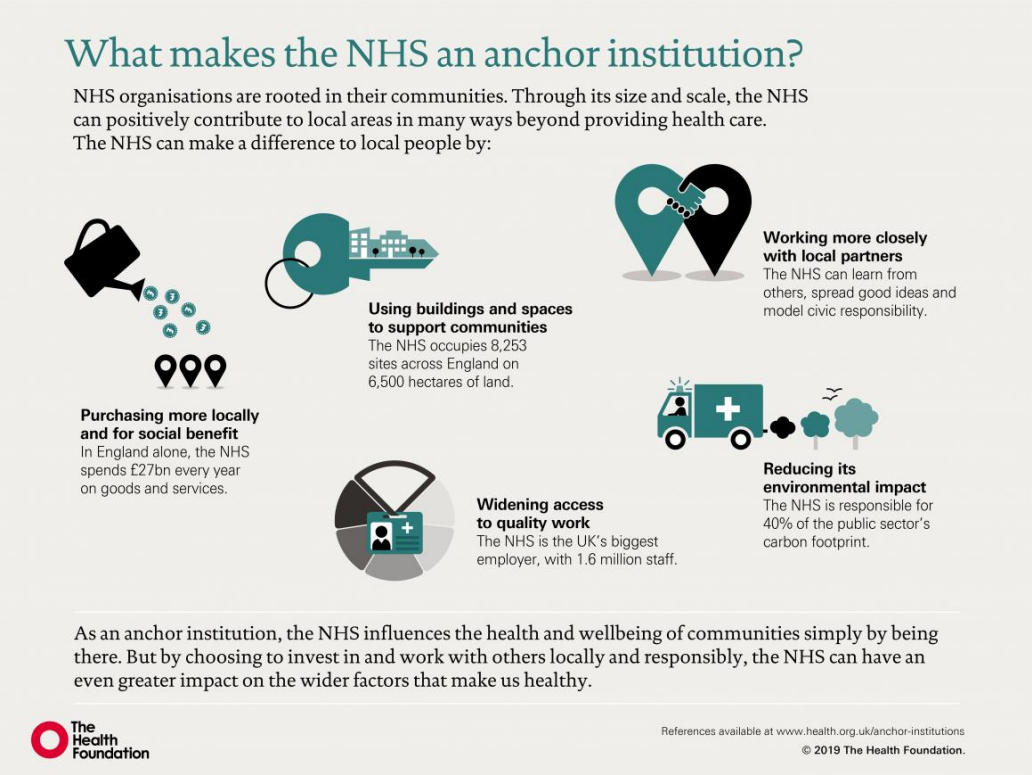
5.2 Our Key Commitments to achieve longer, healthier life expectancy are:

- We will reduce the gap in healthy life expectancy between the North East and North Cumbria and England average by 25% by 2030, and aim to raise the average healthy life expectancy to a minimum of 60 years in every Local Authority by 2030
- We will reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below by 2030.

5.3 To achieve our Key Commitments we will:

5.3.1 Greatest improvement where most needed: Many of our key work programmes to work towards longer, healthier expectancy will also have a positive impact on achieving fairer health outcomes (see section 6). We will raise overall levels of health at the same time as flattening the gradient in health by improving the health and wellbeing at pace where the need is higher. In technical language this approach is called Proportionate Universalism.

5.3.2 Anchor Institutions**:** Large partner organisations, rooted in their local communities, can make a big difference to social determinants by acting as Anchor Institutions. The term anchor institutions refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities. The Health Foundation and other partners have developed the graphic below to show how NHS organisations act as anchor institutions in their local communities. Although the graphic refers to the NHS, the same principle applies to a partners, including Local Authorities, Universities and large employers.



5.3.3 Community Centred and Asset Based Approaches: Asset-based approaches emphasise the need to redress the balance between meeting needs and nurturing the strengths and resources of people and communities. We will use asset-based approaches

to address health inequalities in access, experience and outcomes building on the knowledge, skills, experience, resilience, and expertise that lie within the communities we serve. We will build on the learning from the covid-19 pandemic in which community centred approaches across the region played a key role in a number of the key strands for the pandemic response.

5.3.4 Prevention and Health Promotion: We will continue to implement evidence-based programmes of preventive interventions that are effective across the social gradient – for example, proven smoking cessation, alcohol reduction, and excess weight reduction programmes. We will build on this to make the prevention efforts more targeted including supporting and empowering patients to manage their health and well-being where appropriate.

5.3.5 Embedding prevention across health and care services**:** Across our ICP we will contribute to the wider systems that support people to enjoy good education and employment, fair pay and incomes, and good quality homes and neighbourhoods.

5.3.6 Health Protection: The experience of the Covid 19 Pandemic brought to the fore the vital importance of effective Health Protection Programmes. We will work with partners, including the UK Health Security Agency (UKHSA) to:

- Maximise routine adult and childhood vaccination programmes
- Ensure effective delivery of the Covid and seasonal flu vaccination programmes
- Adopt effective practices to protect the population from new and emergent threats
- Reduce iatrogenic harms, by which we mean harms caused by health and care services, for example the transmission of viruses in Hospitals and Care Homes.

5.3.7 Partnership Working: Partnership working at a place level is key to the achievement of our ambition. We will use evidence-based tools including opportunities for co-production, and understanding lived experience to deliver better health and wellbeing outcomes in a way that meets the different needs of all local people. Importantly, we will be attentive at all levels to ensuring that we acts as good partners, recognising the strengths and challenges of all partner organisations and stakeholders.

6 FAIRER HEALTH OUTCOMES

Health inequalities arise because of variations in the conditions in which we are born, grow, live, work and age; this means that not everyone has the same opportunities to be healthy. We are committed to delivering fairer health outcomes by reducing health inequalities across the entire population. Health Inequalities are defined as the systematic differences in health between groups of people. Inequalities in life expectancy, the difference in how long groups of people in they live average, are one of the key measures of health inequality.

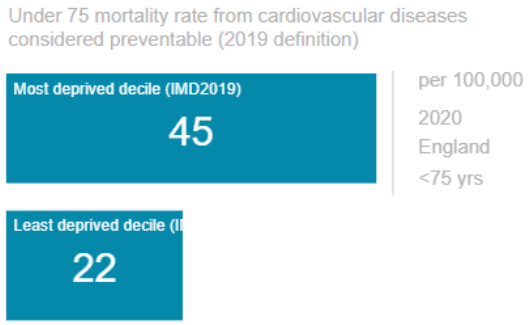
6.1 The Current Position

6.1.1 Health inequalities within our ICP, and between our ICP and the rest of the country, remain stubbornly high. We have high levels of unemployment (and poorly paid or insecure employment), low levels of decent housing, and significant areas of deprivation. These contribute to some of the starkest health inequalities, early death rates and highest sickness levels in England.

6.1.2 Positive health outcomes strongly correlate with a social factors, including strong communities, access to preventative and responsive health services, healthy and varied and diet and regular exercise, well-paid employment and secure accommodation and a

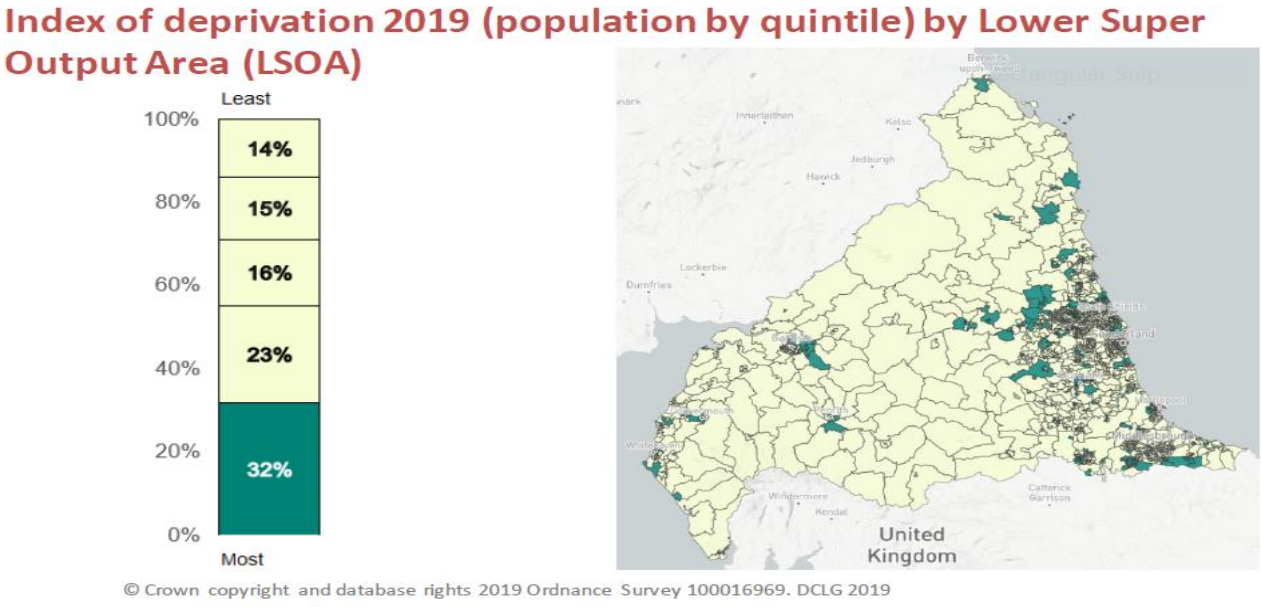
financially secure and supported childhood. Equally, poor health outcomes strongly correlate with relative levels of deprivation, a major challenge for the North East and North Cumbria.

6.1.3 Equally, poor health outcomes strongly correlate with relative levels of deprivation, a major challenge for the North East and North Cumbria. The graphic below shows that premature mortality from cardiovascular diseases (under 75 mortality) considered to be preventable in 2020 in England was double in the most deprived decile of the population compared to the least deprived.



Source: Picture of Health - ICS edition 2022. Data available via OHID Public Health Profiles.

6.1.4 The graphic below shows that a far higher percentage of our population live in the most deprived quintile and second quintile than the national average for England. We also know that there is a significant amount of rural poverty and disadvantage which is often not recorded through official data sets.



6.1.5 The way health and care services are delivered can contribute to health inequalities. Some groups of the population have lower participation in routine screening programmes or present at a later stage of disease progression, due to the barriers people need to overcome in order to engage with services. These barriers include the cost of travel to health services, convenience, health literacy, unconscious bias, diagnostic overshadowing and lack of agency and advocacy support. A key part of our work is to ensure that we eradicate, and at least minimise, those inequalities.

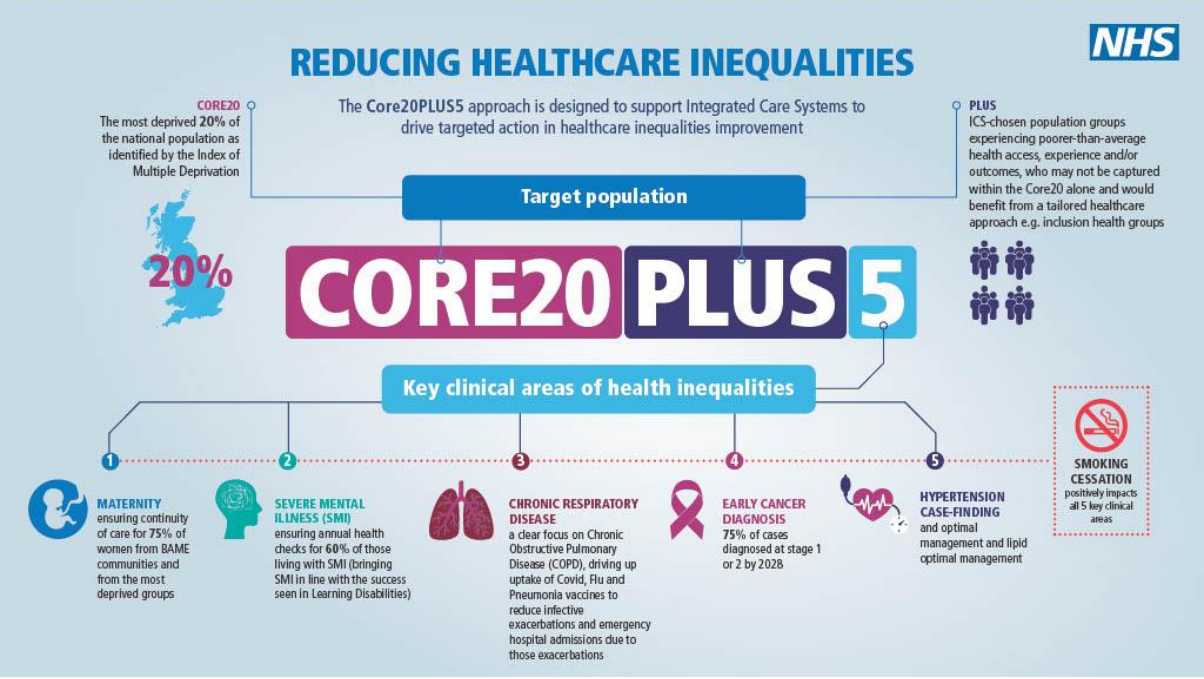
6.2 **Our Key Commitments** to achieve fairer outcomes are:

- We will reduce the inequality life expectancy between the most deprived and least deprived deciles within our ICP by 25% by 2030
- We will reduce the suicide rate from 13 per 100, 000 population (2019/2021) to below the England average (10.4 per 100, 000 population 2019/2021) by 2030.

6.3 **To achieve our Key Commitments** we will deliver Core 20Plus5:

Core 20 PLUS 5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. Focusing resources on the Core20PLUS5 approach across the ICP, working in partnership with local authorities, communities, and the voluntary and community sector, healthcare systems have the potential to have the greatest impact in narrowing the inequalities gap.

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



The most deprived 20 per cent of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health. Across the North East and North Cumbria a third of the population lives in the 20% most deprived areas of the country. This is not uniformly distributed with some of the local authority areas having much higher proportions of their populations living in the most deprived 20% nationally.

The PLUS population groups within the Core20Plus5 include a number of groups where the outcomes are poorer compared to the rest of the population. These include people from Black Asian and Minority Ethnic groups, people with a learning disability and autism, coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller

communities, sex workers, people in the justice system, victims of modern slavery and other socially excluded groups.

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

1. Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
5. Hypertension case-finding and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

7 EXCELLENT HEALTH AND CARE SERVICES

7.1 Introduction to Health and Care Services in the North East and North Cumbria

The NHS and Social Care workforce across the North east and North Cumbria totals around 180, 000 full time equivalent staff. This includes around 74, 000 full time equivalent people working in NHS Secondary care roles alone, and a General practice workforce of around 9, 500 full time equivalents. Within the NHS our ICP includes:

- General Practices, grouping together to deliver services jointly across 64 Primary Care Networks
- Community Pharmacies and Dental Practices
- Eight NHS Foundation Trusts predominantly (though not exclusively) delivering physical health community and hospital based services
- Two Mental Health and learning Disability NHS Foundation Trusts delivering community and in-patient services
- North East Ambulance Service, covering most of the region, and North West Ambulance Service covering North Cumbria, delivering NHS 111, Patient Transport Services and paramedic Emergency Services
- A range of Independent Sector organisations providing NHS commissioned, free at the point of delivery services

Similarly, within Social Care there is a huge service infrastructure, across:

- Over 1, 900 care establishments and more than 550 regulated care providers
- Nearly 90, 000 jobs, with more than 125, 000 unpaid carers providing more than 20 hours a week support to a family member, friend or loved one
- Organisations providing home care to enable people with long term care needs
- Reablement and rehabilitation services to enable people to regain the skills and confidence to live as independently as possible through asset based, rather than deficit based approaches
- Services supporting people with Learning Disabilities and/or Autism and long term Mental Health conditions

- Social Care work to assess need and plan care packages to meet need, and vital interventions to ensure the safeguarding of vulnerable and at risk adults and children
- Joint care, education and health packages for children with complex needs.

There are 120,000 registered carers across our ICP providing at least 20 hours a week of (unpaid) care for family members, friends and loved ones. The total number is likely to be much larger. Many of the people being supported in this way are living with long term, often life long, care and support needs. Without the amazing commitment and dedication of unpaid carers the health and care system would quickly come to a standstill. We need to collectively find better ways to support carers across the North East and North Cumbria.

Similarly, the diverse Voluntary, Community and Social Enterprise (VSCE) sector makes an enormous contribution to the wellbeing of our region. This includes established charitable organisations, and none profit making organisations with charitable aims delivering valued services, but also the vital work of thousands of informal self-help and community groups which often rely entirely on volunteers freely giving their time and voluntary contributions.

7.2 Overarching Strategy

This section of the Integrated Care Strategy is the overarching quality and clinical and care services strategy for the ICP. It does not seek to set out a comprehensive strategic plan for each and every service provided. It does provide a framework by identifying the high-level strategic priorities for the system as a whole and for each of the provider sectors.

The major causes of mortality and morbidity in our ICP are preventable diseases and much of this disease burden is driven by social circumstances. The approach to service provision is nonetheless a key factor in people's health and wellbeing and is more directly influenced by the partners within the ICP.

The health and care services in our ICP have a proud record of excellence; delivery of timely, safe and effective interventions and high rates of patient and service user satisfaction with the care received. In recent years, however, we have seen a growing gap between the need for services and the capacity to provide them. This is most clearly seen in the lengthening waits to access services across all parts of the health and care system.

We will ensure the care service users experience is evidence based, person centred, and uses all of our resources thoughtfully, to achieve the best possible outcomes for people across the North East and North Cumbria. There will be a relentless focus on supporting staff to design and operate models of care that transcend organisational barriers and remove duplication and unwarranted variation. The ICP will support work with the provider sectors to learn from the best and where there are service sustainability issues, to foster collaboration to overcome them.

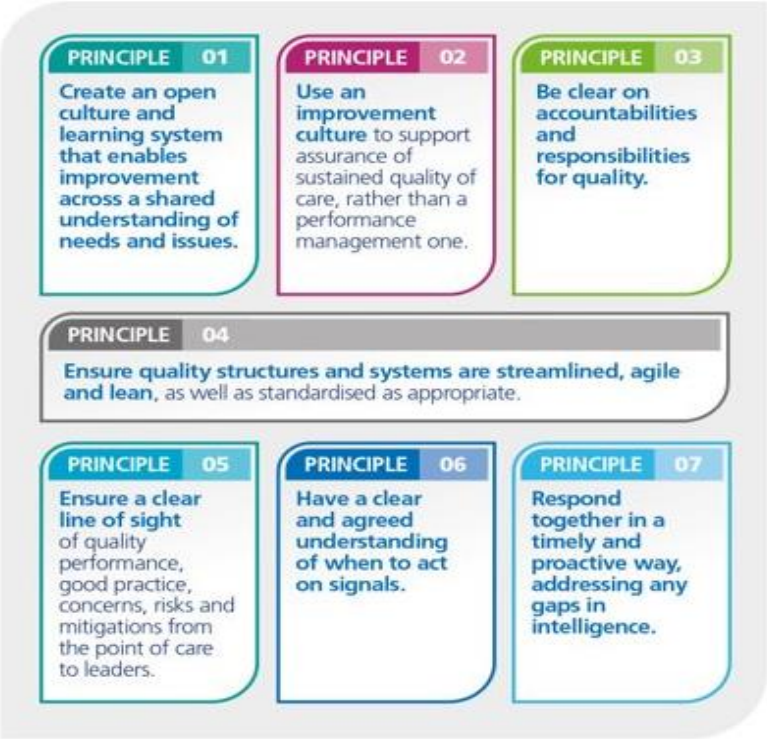
7.3 Quality and Assurance and Improvement

The ICP recognises the vital role that partners have in providing oversight of the quality of care provided, and in creating and sustaining a culture of openness, learning and continuous improvement. Through its quality assurance and improvement arrangements, the ICP partners will deliver ambitious and significant improvements in the quality of care, focussing on the areas our patients, service users, staff and regulators highlight as of concern. We will share learning from our best performing providers; reducing the variability of the service

offer, increasing the reliability and consistency of the care we give and ensuring our staff members are supported to be kind and compassionate.

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

The ICP Quality System Group will provide a strategic forum across health and social care, to support the formal quality governance processes within each part of the system. Within this forum the partners will share intelligence, consider new ways to promulgate learning and develop approaches to support improvement in the most challenged parts of the system where there may be quality concerns across a number of providers, for example in places where there are severe workforce shortages.



The System Quality Group will use the principles developed by the National Patient Safety Improvement Programme, shown here.

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

7.4 Sustainability of Services

Across our ICP partner organisations are facing major challenges regarding clinical, operational and financial sustainability. Many of these challenges are long standing but have also been compounded by the impact of the Covid-19 pandemic. In some parts of our system, there are particularly intractable difficulties in providing stable and high quality services. In some cases there have been repeated efforts to address these difficulties, with limited success. The ICP partners will work together, using the opportunity that convening

health and social care organisation together at scale brings, to improve sustainability in the most fragile places and services. We will apply a multi-pronged approach to this endeavour:

- Intensive support and improvement resource provision, including drawing in learning;
- Supporting local teams to implement new models of care where they see the opportunity to improve;
- Implementing networked and collaborative models of care from the wider North East and North Cumbia system where local solutions cannot deliver sustainability.

To deliver sustainable service provision form should follow function. As care models evolve, some organisational change may need to follow, for example in GP practices or groups of hospitals. There will also need be active management of the social care market, with all partners in the ICP working together to ensure sustainable social care.

Our enabling strategies, set out in section 8 of this document, will complement the work we undertake with specific partners or places, by focussing on sustainability, for example through a comprehensive workforce plan that addresses the areas of greatest challenge, or the prioritisation of digital investment. We will be mindful of avoiding adverse unintended consequences in our future service design work and will consider sustainability alongside reducing inequalities.

7.5 Parity of Esteem and integration of mental and physical health services

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

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

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

7.6 Personalising Health and Care

Personalised Care is the practice of enabling people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences. We will deliver a Personalised Care Programme across the ICP, which invests in meeting health and wellbeing needs, using the Universal

Personalised Care model. Our key guiding principle will be 'what matters to me', enabling service users to have greater control.

We will embed personalised care approaches (Shared Decision Making, Personalised Care and Support Planning, Supported Self-Management, Personal Health Budgets, Choice, Community based support) in all programmes and pathways.

7.7 Supporting Carers

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

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

We will create a widespread movement at all levels of the system based on 'Thinks Carer'.

- Engage unpaid carers and Carer Organisations as partners in an approach to improve outcomes, and to co-produce a shared vision of 'what good looks like'

- Engage all of the ICP partners in setting out a clear case for change for supporting carers more effectively
- Identify and share best practices, supported by practical tools to enable all partner organisations to positive actions

We will become better at identifying carers and provide more support to them in terms of their own health and wellbeing, and to the person or people for whom they care. In particular, we will improve access to respite care, fund local networks of peer support and ensure access to social prescribing and benefit advice.

7.8 Better integration and co-ordination of care

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

- Health and Social Care
- Primary Care and Secondary Care
- Mental and Physical Health

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

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

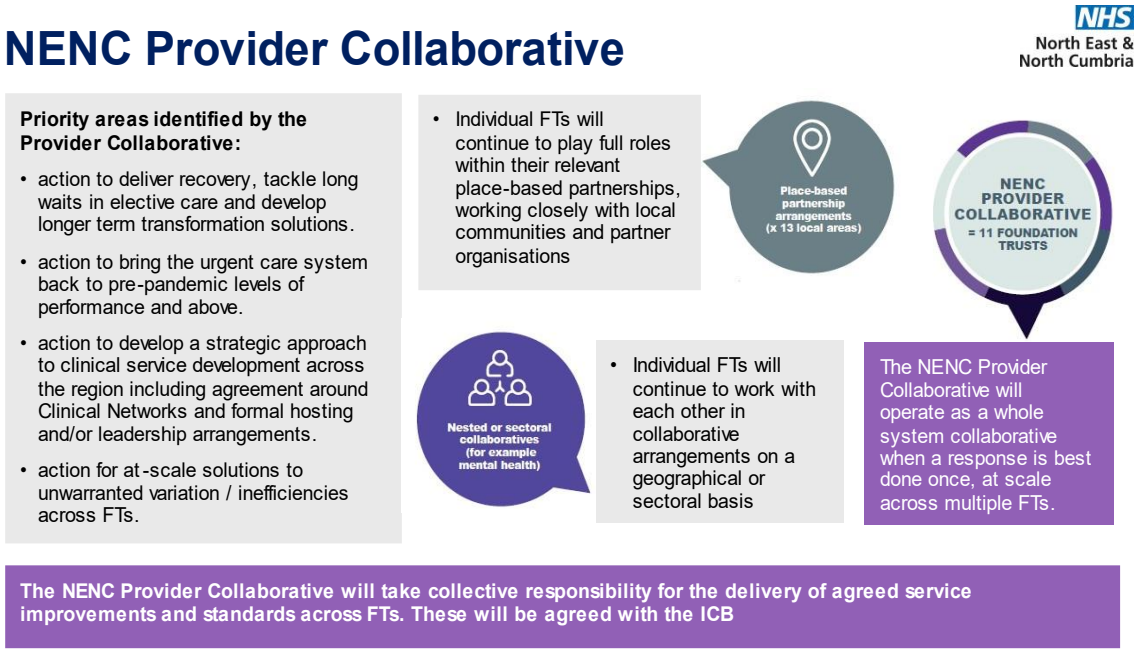
At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations. This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

We will strengthen the impact of our clinical networks and strategic programmes so they are a powerful force driving improvement the quality and sustainability of services and reducing inequalities.

7.9 Provider collaboration

Organisations across the ICP will build effective collaborative arrangements. This will include networks of Primary Care Networks and General Practice Federations working together at scale, supported by the Primary Care Collaborative, the Mental Health Collaborative responsible for some specialist services under delegation from NHS England, and the NHS Foundation Trust (FT) Provider Collaborative. The latter will play a key role in enabling improved Urgent and Emergency, Elective and Cancer Care particularly, and in ensuring sustainable services through networks of care provided across NHS Foundation Trusts.

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



7.10 Our overarching commitments for excellent health and care services are:

- Providers that are regulated by the CQC will achieve a 'Good' or 'Outstanding' rating
- Measurable improvement in the sustainability of the most challenged parts of our system, in relation to quality indicators, workforce and finance – we will define the specific target areas of this work in our forward plan.
- We apply the waiting times standards in the NHS constitution to all mental health, learning disability and autism services and achieve parity with physical health waits
- Personal Health Budget or Personal Wheelchair budget assessments and offers will be made to all those who are eligible.
- We will increase the number of unpaid carers and accessing an array of strengthen support offers
- We will support the development of provider collaboration, through the 3 linked collaboratives for primary care, FTs and mental health, learning disabilities and Autism

7.11 KEY ISSUES FOR HEALTH AND CARE SERVICE SECTORS

7.11.1 Primary Care and Community Services

The majority of NHS patient interactions are delivered in primary care, through general practice, dentistry, optometry and community pharmacy. The ICP recognises that ensuring the provision of high quality and sustainable primary care is a critical factor in the health and wellbeing of the population. Whilst we are fortunate to have relatively strong primary care services in our area, they have been stretched by the ongoing impact of the Covid 19

pandemic. There are some parts of our geography that are struggling to maintain their primary care services due to severe workforce shortages, particularly of general practitioners (GPs) and dentists.

Within general practice, shortages are being partially mitigated by the recruitment of other types of clinicians and practitioners and through the use of new pathways and technologies, with opportunities to introduce more innovation in the future.

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

The Fuller Report, published by NHS England earlier this year, makes a range of recommendations for the improvement of primary care. One of its most significant recommendations is the creation of multi-disciplinary neighbourhood teams, with a focus on caring for people with the most complex needs, for example frail older people or those living with long-term conditions. The ICB will make implementing the Fuller Report recommendations a priority, working closely with the primary care networks (PCNs) that have been set up to support primary care development. This will build on the neighbourhood and locality teams that already exist and are delivering real improvements already, rather than a tip down imposition of a new model.

The ICB will further develop primary care collaboration, in partnership with the PCNs to develop models of care and cross-patch working to support sustainability and resilience in the places where staffing levels are lowest in relation to population served.

From April 2023, the ICB will take on the commissioning of pharmacy, optometry and dentistry. The ICP recognises there are significant challenges with timely access to dentistry in parts of the region and that this is a matter of significant public concern. The ICB will work with the dentistry sector to improve access, through a combination of new models of care and a concerted effort on recruitment. The ICP will also work with NHS England to press for improvement to the national dentistry contract.

Our enabling People Strategy will include specific measures to support the development and maintenance of the primary care workforce to ensure that we are able to deliver our ambitious plans to invest in our primary and community services.

Our key commitments for Primary Care are:

- Multi-disciplinary neighbourhood teams will created to cover all of our population and we will align secondary care specialist to these teams
- We will implement integrated care models for frail older people, those living with long term conditions and those approaching the end of life and in doing so, reduce admissions to hospital for these groups
- The arrangements for same day urgent care in primary care will be aligned with the overall urgent and emergency care strategy

7.11.2 Children's Services

The ICP includes areas with some of the highest child poverty rates in the country. There has been a sustained increase in demand for a wide range of children's services including:

- Emotional wellbeing and mental health services

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

Across our ICP local Place systems are addressing multiple operational challenges simultaneously in order to meet the needs of children.

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

Our key commitments in children's services are:

- We will improve access to effective services and for the NHS services achieve parity with waiting times to access physical health services
- We will increase the numbers of children learning disabilities and Autism who are safely supported to live at home
- We will ensure measures to tackle the wider determinants of health include a focus on children and in particular those from our poorest communities.

7.11.3 Adult Social care

Adult Social Care experienced extremely difficult challenges through the peaks of the Covid 19 Pandemic, which exposed the longstanding and underlying fragility in many social care services. Additionally, Adult Social Care is experiencing significant pressure from:

- Increased referrals because of mental health issues, domestic abuse, safeguarding concerns and the breakdown of unpaid carer arrangements
- Supporting service users to access the right care in the right place, including supporting people who need to be discharged from Hospital
- Increased complexity of need
- Challenges in sustaining the independent sector care market in both the residential and nursing home sector and for home care provision
- The implementation of social care reforms including charging and funding

Adult Social Care is often talked about as a burden on public finances, but it is important to note the enormous contribution to the local economy and social infrastructure from Adult Social Care. Across our ICP Social Care is well over £1billion annually, with over £200 million of self-funded care, and a much higher value-added contribution (at least in excess of £2.5 billion and probably over £3 billion per year) to local economies.

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

Across our ICP partners are committed to working together to transform adult social care and in doing so engage the widest possible coalition of partners to develop new ways of supporting people to live well within their communities. This has never been more important as the escalating cost of living in the UK is causing ever more people to struggle to afford the

basic needs to sustain their health and wellbeing. The wide range of challenges faced by people with insufficient resources can include:

- Difficulty maintaining a warm home
- Inadequate amounts of food and/or of a balanced diet
- Mental health difficulties as a result of the stress caused

Within the NHS there has been a sustained focus on the difficulties discharging patients from hospital who no longer require inpatient care but who cannot go home without a package of home care or who need to move into a nursing or care home for their needs to be met.
It is also recognised that some people are not accessing support at home at an early enough juncture and if they were able to access earlier support, whether from adult social care or primary and community health services, many hospital admissions could be avoided altogether. This would result in a better experience for the people concerned and reserving hospital for care and treatment of those for whom an inpatient stay is essential.

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

Beyond the focus on the workforce, the ICP members will work together to innovate in the field of community health and social care, investing in technology and building partnerships to tackle the wider determinants of health, for example working with the housing sector to support the building of well insulated affordable homes in places people will enjoy living. Communities with access to green spaces and places to exercise, and community spaces that allow the VCSE sector to support the development of community resilience and support and combat loneliness and isolation that many older people experience.

We will work in partnership with the Voluntary, Community and Social Enterprise sector, and our NHS partners, to deliver a much stronger prevention offer to the population, so that vital capacity in the regulated care sector is reserved for the people who most need it

Our key commitments for Adult Social Care are:

- We will strengthen the provision on Home Care and Extra Care Housing, and reduce the reliance on Residential and Nursing Homes
- We will work with the care market and increase capacity and sustainability
- We will reduce the time spent in hospital by people awaiting access to social care
- We will expand the adult social care workforce
- We will develop shared solutions alongside Housing, and maximise the opportunities of digital and technology

7.11.4 Urgent and Emergency Care

Urgent and emergency care (UEC) services across our ICP are facing significant pressure. Demand has returned to, and is now often exceeding, pre-pandemic levels. At the same time NHS organisations are struggling to clear a backlog of planned work. This includes pressure in primary care and community services, as well as within our emergency departments and

acute hospitals, within mental health crisis response services and also our ambulance services. It will take all parts of the system working together to ensure strong sustainable urgent and emergency care services.

Although the performance of the ICB exceeds the national average against the various national standards for urgent and emergency care (UEC), we know that we need to substantially improve it, so we can confidently meet the needs of our population and cope with surges of demand at times of pressure.

The partners within the ICB will work together to deliver an ambitious redesign of the provision of urgent and emergency care. The system will use senior clinical decision making as close to the start of patients' pathways – expanding and enhancing our staffing for the 999 and 111 services so they can better assess patients and connect them into the most appropriate service for their needs. We will invest in additional ambulance call handlers, clinical assessors (from a range of clinical disciplines) and vehicles, to ensure we can improve and sustain our call response times to within the national standards.

We will invest in community based urgent care services, making sure that all communities benefit from access on the day primary care, urgent treatment centres (UTCs) and a 2 hour urgent care community response service. We will develop the clinical support offer to care and nursing homes, providing a tailored array of primary and community services and to a single point of contact to access them.

The development of integrated neighbourhood teams as described in the primary care section above, will be connected to speciality teams to facilitate the care of frail older people and those with long term conditions. People will be supported to shape their own care plan and those nearing the end of life to make an advanced care plan. Virtual wards will be available to support patients with an exacerbating or deteriorating condition that is amenable to home care with specialist input.

We will further develop our community mental health crisis response and explore the opportunity to establish community safe havens.

The Northern Care Record will be further developed to facilitate the sharing of care plan and patient preferences across organisational boundaries. Through these measures we will reduce the number of patients we convey to acute hospitals.

Within Emergency Departments (EDs) we will ensure access to an alongside UTC with access to urgent GP appointments and which meet the extended specification for UTCs in terms of the injuries and ailments they treat.

We will ensure all acute hospitals develop same day emergency care services and have provide clear arrangements for both GPs and the ambulance services to access them without recourse to the ED.

The combined impact of all the system pressures outlined in the sections above leads to delays in patients who are no longer requiring hospital care leaving their hospital beds, if they require a package of care or a community, care or nursing home bed to do so. It is well known that an extended stay in hospital brings unnecessary risk of harm to patients, as well as causing delays for patients awaiting admission. It is expected that the redesign of the UEC pathways and services, as outlined above, will reduce or at least slow the growth of urgent admissions to hospitals.

In addition to the action outlined to support the expansion and sustainability of social care, ICP partners will collaborate to plan and commission sufficient provision to meet the needs

of patients requiring support to be discharge, applying the home first and discharge to assess approaches. We will work with the VCSE sector to provide additional support and deploy technology to provide real time understanding of capacity and demand.

We will develop the escalation processes and surge response arrangements within places and at system level to ensure any mounting delays are tackled as effectively as possible.

Our key commitments for urgent and emergency care are:

- We will increase the proportion of urgent care which is delivered in community settings including in the home
- We will increase the proportion of 111 and 999 calls that are clinically assessed and reduce the proportion the result in a conveyance to an ED
- We will eradicate 12 hour waits in ED departments
- We will eradicate ambulance handover delays in excess of 30 minutes

7.11.5 Elective Care

The Covid-19 pandemic has created pressure within Elective services across the North East and North Cumbria (NENC) geography. The nationally directed suspension of elective activity during the first wave of Covid 19 and the impact of infection control measures for the majority of 2020 and 2021, resulted in a large growth in the number of patients waiting for elective care and the time they wait. The position improved during 2022 for the very longest waits, but the overall list continued to grow, both nationally and locally.

Reducing elective waiting times will be a significant challenge for the NHS given the array of pressures in the system. It will demand a mix of increasing capacity to diagnose and treat patients and a redesign of patient pathways and service delivery models to ensure clinical capacity is optimally utilised.

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

- Development of additional elective diagnostic and treatment capacity, utilising the investments available from the Elective Targeted Investment Fund and the Community Diagnostic Centres
- System-wide joint working to ensure the longest waiters are treated in line with national targets, including use of available independent sector capacity and mutual aid (offering patients from other Trusts earlier treatment dates if waiting times are shorter in some providers)
- Implementation of an Outpatient Transformation Programme, including increased use of advice and guidance services, personalised follow up pathway and virtual clinics, and the redesign of diagnostic pathways
- To implement best practice pathways across the high volume low complexity pathways identified by the Getting It Right First Time Programme
- A 'waiting well' programme to support patients experiencing long waiting times patients to be a fit as possible for their treatment, especially those in our most deprived communities

Our key commitments for elective care are:

- To eliminate waiting times over 1 year by April 2025 (and to all but eliminate 78 week waiters by April 2023)

- To achieve the 6 week wait target for routine diagnostic

7.11.6 Cancer

Cancer Research UK estimates that 38% of cancers are preventable (2015). It is therefore important that we all try to reduce our risk of developing cancer for ourselves, families, friends and the communities in which we live.

Cancer screening and treatment referral rates in NENC are generally higher than the national average but the outcomes (mortality) for the population are worse. 2020/21 data does show a large reduction in screening activity nationally and NENC have followed a similar trend. Public Health analysis highlights the inequalities in the cancer mortality by area of deprivation. It is estimated for every 1000 people aged 65+ with cancer, 142 within the most deprived areas will die compared with 88 in the least deprived.

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

Within the 'Healthier Life Expectancy' section of this strategy, the ICP commits to large scale population programmes relating to reducing smoking and alcohol use and obesity, the ICP will increase uptake in screening programmes; particularly in communities where uptake is relatively low. We will use population data to deliver targeted case finding and surveillance to enable people to access diagnostics, assessment and treatment earlier.

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

The improvements in cancer care have led to major pressures on the specialist cancer workforce, both locally and nationally. In order to be able to deliver our ambitious programme for cancer care, we will deliver a transformation plan for the specialist cancer workforce; extending the roles of the members of multidisciplinary teams such as therapy radiographers and pharmacists and developing new innovative and emerging roles for future medical and clinical staff

Our commitments for cancer care are:

- To make progress towards the early diagnosis national target
- To achieve and sustain the national faster diagnosis target
- To exceed the national standards for screening uptake for all population segments
- To reduce avoidable new cases of cancer
- Improve Experience and Care and Quality of Life for people living with and beyond cancer as measured by the National Cancer Patient Survey

7.11.7 Mental Health

The Covid pandemic significantly impacted the mental wellbeing of the whole population, including for example direct effects such as experiencing bereavement and illness, social isolation, anxiety about personal finances and employment, and an increase in domestic violence. This has exacerbated already high levels of poor mental wellbeing and mental illness. The demand for both children's and adult mental health services has risen

significantly, and many services are currently operating with long waiting lists and operational pressures.

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

The ICP will develop a comprehensive plan for improving the mental health of its population, building up from the services provided at neighbourhood and place, with close working with the VCSE sector as a full and valued partner. In particular, the plan will set out the approaches to:

- Strengthening core community, in-patient and crisis services, including peri-natal mental health services and psychiatric liaison services
- Delivering the Mental Health Community Transformation programmes, which focus on enabling patients in long term hospital care to move into a community setting with a package of support
- A particular improvement in all tiers of Child and Adolescent Mental Health Services, delivering and learning from the CAMHS Whole Pathway Commissioning 'pilot' (one of only four successful pilot sites across the country). Half of all mental health problems are established by the age of 14 and 75% by 24 years,
- Moving towards trauma informed, and psychologically informed services across all of health and car services, recognising the often life-long impact of trauma (for example Adverse Childhood Experiences)
- A concerted and universal suicide prevention programme
- Improving the physical health of people with severe and enduring mental illness, including targeted prevention and health programmes and participation in screening programmes
- An improved service offer for people with a substance misuse and mental illness

Our commitments for mental health are**:**

- We will reduce the gap in life expectancy for people with a severe and enduring mental illness compared to the general population by at least 25% by 2030
- To increase the percentage of people with severe and enduring mental illness who receive an annual health-check to at least 85% by 2030.

7.11.9 Learning Disability and/or Autism

Compared to the whole population, people with a learning disability, and autistic people, on average die at a much younger age. This makes it crucial that as an ICP we tackle the long waits people can experience accessing a diagnosis and treatment for their learning disability or autism and we take specific action to tackle health inequalities that exist in access to physical health care.

The plan we develop will include the delivery of training across health and social care services including the Oliver McGowan Mandatory Training. We will implement the new learning from death reviews (LeDeR) policy to review the deaths of people with a learning

disability and identify learning, opportunities to improve, and good practice. We will redesign pathways to reduce waiting times for autism assessment and diagnosis.

Our key commitments for learning disability and autism are:

- We will reduce the gap in life expectancy for people with a learning disability and/or autism compared to the general population by at least 25% by 2030
- To increase the percentage of people with a learning disability and/or autism or who receive an annual health-check to at least 85% by 2030.
- Ensure people receive services in appropriate environments by reducing the number of people in specialist in-patient services to no more than 30 adults and 15 people under 18 per million of the population by March 2024
- To reduce emergency admissions to hospital through provision of strengthened community services by March 2025
- Develop stronger joint commissioning frameworks across health and social care to improve community provision.

8 ENABLING STRATEGIES

8.1 A Skilled, Compassionate and Sufficient Workforce

People are at the heart of our health and care services and are our biggest strength. We have a highly skilled, dedicated and committed workforce across ICP area. Our workforce showed exceptional resilience throughout the covid pandemic, including adopting new practices to sustain services for the benefit of the population. But our workforce is stretched:

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

Our ICP area is not exempt from those challenges. Some organisations are experiencing severe challenge in the recruitment and retention of staff.

Our Key Commitments are:

We will reduce the vacancy rate across health and social care services by 50% by 2029. The North East and North Cumbria will be the best place to work in health and care, becoming the employer of choice.

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

- Workforce supply
- Workforce health and wellbeing
- Health Inequalities System Leadership and Talent
- Equity, Inclusion and Belonging

- The development of the learning and improvement community
- Build on existing workforce plans, e.g. the North East ADASS Workforce Strategy

8.2 Working Together to Strengthen our Neighbourhoods and Places

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

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

Our Key Commitments are:

- we will agree formal of local governance arrangements at Place level by March 2023
- we will work with local partners to develop a plan for place based governance, to be improved over time, and for place based plans to address shared local priorities
- we will implement integrated neighbourhood teams, by March 2025, and will typically align to Primary Care Network areas.. This will build on existing partnership working, strengthening how teams already work together at neighbourhood and locality level.

8.3 Innovating with Improved Technology, Equipment and Research

8.3.1 Research and Innovation

A large number of highly successful healthcare research and innovation infrastructures, institutes and organisations are operating across our ICP. Some of our opportunities for improvement across the system include:

- Increasing the pace of adoption and spread of impactful innovation, and our risk appetite for trying new ideas
- Developing inclusive frameworks and approaches for involving service users and staff in identifying and articulating system wide unmet needs
- Making the use of data, research evidence and insights more accessible to support researchers, commissioners and innovators
- Reducing obstacles for innovators and SMEs with potentially impactful solutions for the health & care sector to gain traction across the system
- Increasing investment in innovation and research in the primary and social care sectors and exploring new opportunities at the intersection of acute, community, primary and social care
- Increasing socially focused research on challenges experienced across our communities, clinical practice and the wider determinants of health.

Our Key Commitments are:

To establish a culture of innovation, with a higher risk appetite for testing out new ideas and disseminating knowledge and good practice. We will develop an Innovation & Research steering group across the ICP level, and develop a shared research and innovation plan, by

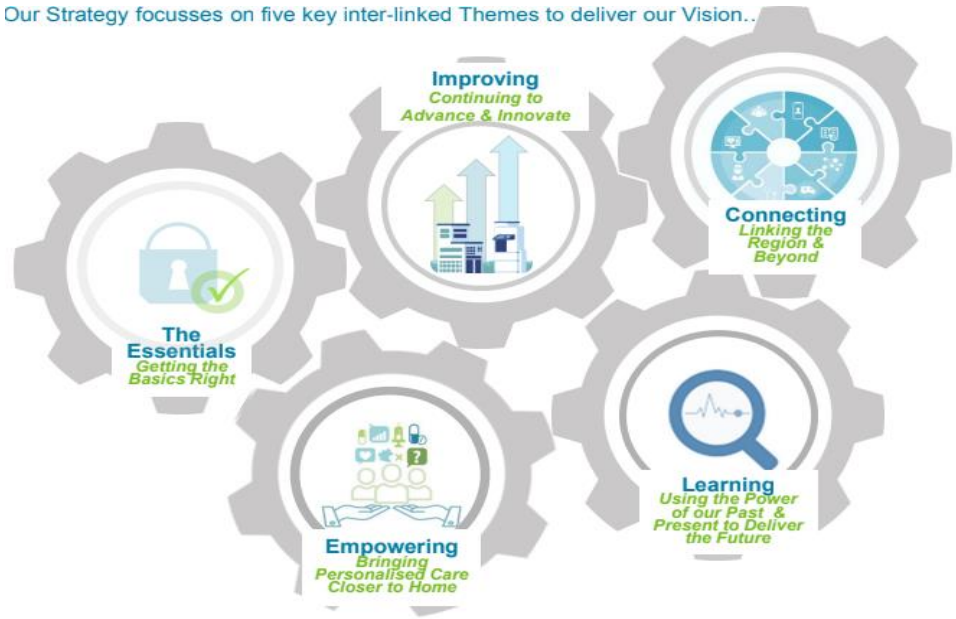
March 2023. This will bring together the National Institute for Health and Care Research, academic partners and organisations delivering services to provide strategic leadership to key priorities including:

- knowledge management systems to support decision makers, researchers and innovators, and the services which could benefit from adopting innovation
- incentives to support idea development and the testing of small scale innovation
- communication systems to support learning from the adoption of innovation
- leadership and accountability to foster implementation science
- closer working relationships with health determinant research infrastructures.

8.3.2 Digital

Digital technology has changed our lives beyond recognition in the last twenty years. Whilst we frequently manage our financial affairs, retail and leisure time online, we have yet to fully exploit the benefits digital technology can bring to the health and care system. We have been laying down the solid foundations on which to build digital services, for example to help meet the technical challenge of linking complex systems together, putting in the right infrastructure, standards and security measures. With the emergence of new digital systems and services we will support and equip our workforce to be ready to embrace these digital opportunities.

We have already developed an Integrated Care System Digital Strategy for 2020 – 24, and have made real progress in our shared work programme, which includes the five interlinked themes in the graphic below:



Our Key Commitments are:

We will deliver the commitments in our existing ICS Digital Strategy, and review and revise that Strategy by March 2023 to support the delivery of the ICP Integrated Care Strategy.

8.4 Making Best Use of our Resources and Protecting our Environment

8.4.1 Finance and Resources

The North East and North Cumbria ICB received £6.5bn of funding in 2022/23 equating to roughly £1,800 per head of population. This is the highest level of funding per head of population but it is over-funded using a national formula and we expect to receive the lower levels of funding growth than other parts of the country in future years, with much reduced additional central support for individual NHS organisations inherent financial challenges.

Nationally and in our ICP, local authorities are facing financial pressures in Adult and Children's Social Care, Public Health and the broader services that impact health and wellbeing outcomes.

At the same time the Health and Care system faces further activity, workforce and financial challenges going forward across the NHS, local authorities and the voluntary sector in an area with high levels of deprivation and health inequalities. It is evident that as a system we need absolute focus on system transformation and efficiency. We will need to work together on system level responses where needed, and not just within individual across the partner organisations.

Our Key Commitments are:

Our system ambition is to achieve Best Value for Money, making effective use of resources together to ensure a financially sustainable health and care. We will collectively develop a balanced Five Year ICP Financial Plan addressing system sustainability by March 2023. As part of our financial plan we will:

- work with partners to tackle areas of inefficiency and inequity, recognising touch points between services and collective ambition and challenges
- commit to improving funding arrangements for VCSE, creating innovative solutions that enable the sector to deliver outcomes that support our shared aims
- harness the strength of integrated working at place to drive transformation and efficiency across health and care.

8.4.2 Protecting Our Environment

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

Our Key Commitments are:

We will have to cut our collective carbon footprint at a faster rate than the NHS national targets of 2040/2045. As an ICP we will publicly declare a Climate Emergency and commit to fast-track the decarbonisation of our regional health and care services, as part of a broader strategy to become the greenest region in England by 2023.

The NHS has committed to reaching carbon net zero. The Health and Care Act 2022 placed new duties on NHS to contribute towards statutory emissions and environmental targets. We will meet the following for carbon emissions in our ICP area:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

8.5.3 Our Estates

Our Health and Care Services are delivered across a huge number and range of buildings. For example this includes over 490 Primary care sites alone. Maintaining high quality estates is a significant challenge, in some cases our estate is undersized for the population, or has significant backlog maintenance or even surplus space in the wrong place.

Our Key Commitments are:

We will develop a collective Estates plan by March 2023, focussed on providing contemporary, sustainable, fit for purpose estate that is accessible and capable of reacting to changes in population size and demand. Where beneficial, this will include:

- consolidating services onto fewer sites to maximise the use of existing infrastructure and to promote joint working where it is in the best interests of service users
- adopt 'one public estate' principles at Place level, including the potential to use shared estates to deliver jointed up clinical and care services
- prioritising capital investment to effectively meet need
- promoting opportunities to reduce cost within the estate and maximises capital
- working from the ground up at neighbourhood, Place and local ICP level
- support to Primary Care Networks and provider collaboratives to ensure well planned and prioritised capital investments.

9 COMMUNICATION AND INVOLVEMENT

9.1 Collaborative Design

We have developed the draft strategy based on:

- a multi-agency steering group, supported by subject matter experts including an intelligence and analytics group
- our call for evidence, we received and considered over 300 documents including joint strategic needs assessments and organisational strategies
- input from each of the ICS work streams
- our pre-existing ICS strategy

9.2 Review of the draft strategy

During November 2022 we will:

- publish the strategy, and invite feedback from the public and stakeholders
- work with Health Watch and the voluntary, community and social enterprise sector to gain feedback from experts by experience
- engage with our partner organisations and place based partnerships, including Health and Wellbeing Boards

We will then consider all of the feedback to inform the final strategy for publication in December 2022.

10 DELIVERING THE STRATEGY

10.1 Data and Intelligence

To improve health outcomes and reduce inequalities it is important to understand population health for groups and areas. We have a strong foundation including:

- Health and Wellbeing Board Joint Strategic Needs Assessments
- Health assessments for particular population and service user groups
- Service utilisation data across sectors
- Comparative data from other areas, including through tools from the Office of Health Improvement and Disparities
- Insight work with particular population groups

Our Ambitions is to develop an integrated data and analytic system across the ICP, and wherever possible at local Place and Neighbourhood. We will continue to draw on the best evidence and listening to what communities tell us about the services they need. We will support partner organisations to improve data systems by ethnicity, accessibility and the communication needs of their populations in records. We will provide 'actionable insights' from the data at all levels, and across service sectors

10.2 North East and North Cumbria Learning and Improvement Collaborative

To achieve our goal of 'being the best at getting better' we created the Learning and Improvement Collaborative to mobilise people from across the region. This will include:

- Enable "boundary-less" learning across the region; making connections and sharing data and learning - across geographical, system, organisational and sector boundaries.
- Acknowledge and celebrate the existing strengths and assets of our system for learning and improvement.
- Create energy, build insight and work together as a system.
- Agree actions to co-create the future.

10.3 Partnership Structures

As outlined in section 8.2 we will develop strong governance arrangements across partner organisations in each Place, including a clear interface with Health and Wellbeing Boards. This will be supported by the formation of four Local ICPs, and an overarching strategic leadership role across the whole region through our ICP. This formal governance will be enhanced by partnership arrangements across the whole ICP, including for example:

- Association of Directors of Adult Social Services (ADASS) Network
- Directors of Children's Services Network
- Directors of Public Health Network
- The Directors of Finance and ADASS group
- Emerging shared forums for Housing

- The Provider Collaborative
- Emerging networks for General Practice, including a strong collaboration between Primary Care Networks
- Using the networks across Health Watch and Voluntary, Community and Social Enterprise Sectors ensure strong partnerships with communities, experts by experience and third sector organisations

10.4 Implementation and Delivery Plans and Measuring Progress

To support the delivery of this Strategy we will develop Delivery plans for each of our key work programmes across the ICP, including frameworks to support delivery at place level where appropriate. We will also develop a clear dashboard to measure and report progress in our delivery of our strategy on a quarterly and annual basis. This will be publicly available to ensure transparency and promote accountability.

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Developing the Integrated Care Strategy

National Requirement

All Integrated Care Partnerships (ICPs) are required to publish an Integrated care Strategy by December 2022. On 29 July 2022 the Department for Health and Social Care published guidance for the development of the Integrated Care Strategies.

Steering Group

In anticipation of the national guidance we established a steering group to oversee the development the strategy. The steering group is jointly chaired by Jane Robinson, Corporate Director, Adult and Health Services, Durham County Council and Jacqueline Myers, Executive Director of Strategy and System Oversight, North East and North Cumbria ICB. The steering group includes representatives from local government, the NHS, and the Office for Health Improvement and Disparities (OHID, previously Public Health England). The steering group is supported by task and finish groups, for example a data and intelligence group.

Call for Evidence and Data

In July the steering group issued a 'call for evidence', requesting key documents including Joint Strategic Needs Assessments (JSNAs) from a wide range of partners. In total over 300 documents were received. The call for evidence has strongly informed the content of the draft strategy, alongside the population health data, which can be viewed through the link: Picture of Health - ICS edition 2022.

Draft Document Engagement Phase

During September and October we began to draft the strategy. On 26 October we will publish the draft through the ICP page on the ICB website as a public facing document. We have developed a short survey to enable members of the public and stakeholders to give feedback throughout late October until 25 November. The feedback will be used to inform the final strategy. We will also take the opportunity, wherever practically possible, to speak with key stakeholders during this phase, for example through Health and Wellbeing Board meetings.

Integrated Care Partnership

On 20 September the joint chairs of the steering group gave an update presentation to the ICP, including on the process to develop the strategy. The ICP will be asked to approve the final strategy in mid-December, informed the feedback from all stakeholders across the ICP geography, public and partner organisations.

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North Tyneside Health & Wellbeing Board Report Date: 10 November 2022

Title: Equally Well Progress update: Best Start in Life

Report Author:	Rachel Nicholson, Senior Public Health Manager, North Tyneside Council	*(*Tel: 0191 643 8073*)*
Responsible Leads:	Wendy Burke, Director of Public Health, North Tyneside Council Janet Arris, Deputy Director of Commissioning, NHS North East and North Cumbria Jill Harland, Public Health Consultant, Northumbria Healthcare NHS Foundation Trust	
Report From: Relevant Partnership Board:	North Tyneside Children and Young People Partnership	

1. Purpose: Progress Update, Equally Well: Best Start in Life

This item relates to the Best Start in Life theme of the Joint Health and Wellbeing Strategy, “Equally Well: A healthier, fairer future for North Tyneside 2021- 2025”.

As outlined in Equally Well this means that every child in North Tyneside will be given the best start in life supported by families, communities, and high-quality integrated services.

2. Recommendation(s):

The Board is recommended to: -

a) Note the progress in delivering the Best Start in Life by the Children and Young Person’s Partnership.

b) Endorse the approach to develop and deliver Family Hubs in North Tyneside as set out in the separate briefing paper and presentation.

3. Progress update: Best Start in Life

The Children and Young People’s Partnership (CYPP) is responsible for the leadership and governance of this theme. The progress against actions in the implementation to achieve the Best Start in Life is set out in **Appendix 1.**

Highlights of progress against the implementation plan and achievements include:

- Northumbria Healthcare NHS Foundation Trust has a Best Start in Life Team and every pregnant smoker in North Tyneside is referred to an Advisor (opt out referral) who works with the woman for her entire pregnancy and into the postnatal period. The goal of the service is to enable a woman to achieve a successful smoking quit, however they provide holistic care for a wide variety of issues during pregnancy, including signposting and referring to wider services to promote a healthier pregnancy. The team offers home visits and clinic appointments from Cedarwood Trust and Howdon Children's Centre to target the areas of greatest need.
- Launched the Baby Breathe Pilot aimed at helping women who have quit smoking during pregnancy to stay smoke-free. Trained colleagues in the 0-19 Children's Public Health service will help to identify women interested in taking part in the research and when signed up, residents will receive BabyBreathe™ support through the antenatal period and beyond, to encourage them to stay smoke-free
- Implemented a new breastfeeding strategy to focus on increasing breastfeeding in our most deprived communities. One of the actions in the strategy included the recruitment of peer supporters and launch of Best Start peer support groups which were established with the support of VODA to enhance early relationships and increase initiation and sustainability of breastfeeding.
- Northumbria Healthcare NHS Foundation Trust developed a specialist breastfeeding clinic to support women with complex feeding issues. The Trust also run a monthly breastfeeding antenatal session, which is attended by circa 60 women, plus partners every month. The Infant Feeding Co-ordinator sees women and babies in the Tongue Tie Clinic to provide assessment and support pre and post procedure.
- Conducted a review of the uptake of the supply of Healthy Start vitamins and the national Healthy Start Scheme, which provides eligible families with food and milk. Access and uptake to vitamins and the healthy start scheme have improved significantly following concerted effort to raise awareness by the 0-19 Children's Public Health team. A notable success was support for a family experiencing severe financial hardship to claim a large back payment from the national Healthy Start scheme.
- The '2 Matters' award has been developed in North Tyneside and is being widely promoted across settings working with our most vulnerable children. The award aims to ensure that wherever 2-year-old children access their funded provision in North Tyneside, they receive the same high quality of care and education, and Practitioners consider the whole family and any identified needs. This approach supports children to be Ready for School.
- Reducing Parental Conflict training has been rolled out to 360 frontline practitioners across North Tyneside to help increase skills and confidence to work with, or refer, parents in conflict to appropriate support. The practitioners are from a variety of settings including schools, young carers, residential, Early Help, 0-19 Children's Public Health service, housing and leisure teams. The training will in turn support children's early emotional and social development and improve their chances to lead fulfilling, happy lives.
- Delivery of an enhanced multi-agency Family Hub offer in North Tyneside is also a current focus to achieving a Best Start in Life. Family hubs should offer non-stigmatising support to families from conception and two, and to

those with children of all ages, which is 0-19 or up to 25 for those with special educational needs and disabilities (SEND), with a great Start for Life offer at their core. For further detail on the work to develop Family Hubs see the attached separate briefing paper, **Appendix 2.**

4. Performance indicators

It is important to understand if our approach and strategic ambition is making a difference to reducing health inequalities.

Appendix 3 gives an overview of the direction of travel indicators for achieving a Best Start in Life. As noted in the strategy major change to reduce health inequalities will not happen overnight, so we will be seeking gradual improvements in these indicators and a reduction in inequalities between different localities across North Tyneside.

4.1. Smoking status at the time of delivery

The Smoking Status at Time of Delivery **(**SATOD**)** collection covers information on the number of women smoking and not smoking at time of delivery (child birth).

9.9% of pregnant women smoked at the time of delivery in North Tyneside which is the lowest rate in the North East. The trend data shows a positive reduction since 2010/11 when 17% of women were smoking at the time of child birth in North Tyneside, which also reflects national trends.

Unfortunately, we know that women from our most deprived communities are more likely to smoke at the time of child birth and we are seeking data from our local NHS Trusts to analyse and understand if there is more targeted work that could be carried out to support women to stop smoking.

4.2. Breastfeeding prevalence at 6-8 weeks after birth

North Tyneside's rate of breastfeeding 6-8 weeks after birth is 42.1%, compared with the regional rate of 35.4% and England rate of 47.6%. The trend data shows a small increase in the rates of breastfeeding at 6-8 weeks since 2015/16 when it was 38% in North Tyneside.

While North Tyneside's current overall rate is the second best in the region when the rates for different localities in North Tyneside are analysed there are stark inequalities. The South West locality has the lowest rate of breastfeeding at 6-8 weeks with 36%, compared with the Coast locality rate of 64%

4.3. Good level of development at 2 to 2 ½ years of age

The indicators for children achieving their milestones at 2 to 2 ½ years of age show that 91% of North Tyneside's children are meeting them. This is a higher percentage than the North East, 88% and England, 83%. However, when we consider the different localities in North Tyneside it is children from our most deprived areas who are not achieving a good level of development; only 74% of children from the Central locality are meeting the milestones, compared with 95% of the children living in the Coastal locality.

4.4 School Readiness

The indicators for children being ready for school show that 72% of North Tyneside's children achieve the knowledge, skills and behaviours that enable children to participate and succeed in school by the end of reception, which is similar to the North East and England figures.

Again, when the data is analysed for those children who are eligible for free school meals and therefore living in more economically deprived families, it shows that only 54% of these children in North Tyneside are ready for school.

4.5 National Child Measurement Programme – end of reception

The National Child Measurement Programme (NCMP) is a nationally mandated public health programme that provides high quality Body Mass Indicator (BMI) data on all children in state-supported schools in England in reception (age 4-5 years) and Year 6 (age 10-11 years) and is part of the government's approach to tackling child obesity.

The overall NCMP data across North Tyneside for children having excess weight at the end of reception (26%) is slightly higher than the England figures (24%). In addition, there are areas within North Tyneside that have significantly higher rates of excess weight including 40% of children in Riverside ward having excess weight at the end of reception.

The trend in NCMP data is also concerning as it shows an increase in North Tyneside children with excess weight since the COVID-19 pandemic, which is also reflected nationally. This is an issue that the North Tyneside Healthy Weight Alliance is aware of and is considering in their plans.

4.6. Cost of living considerations

All the indicators above demonstrate there are unacceptable inequalities across North Tyneside meaning some children do not experience the Best Start in Life.

It is also important to note that the current cost of living rises will impact on a large cohort of people across North Tyneside. The cumulative impact of rising costs is likely to push more families into poverty which will have lasting impacts for our younger generation. Growing up in poverty can affect every area of a child's development and future life chances.

These challenges reinforce the need for concerted effort to ensure every child no matter where they live in North Tyneside has the same opportunities for experiencing the Best Start in Life.

5. Community engagement

4.1 Response to Healthwatch findings

The Children and Young People's Partnership will be meeting on 19 December 2022 and will fully consider the Healthwatch findings that are pertinent to achieving the Best Start in Life.

4.2. Family Hub Consultation

Initial consultation with families has been carried out with local families to help shape the further development of the Family Hub model. It is essential our approach to Family Hubs focuses on how to identify, reach and support our most vulnerable families and communities, including those who do not usually engage.

Our VCSE will be a critical conduit for supporting further consultation, disseminating information and promoting the Family Hubs to our local families using their networks and associations.

Community consultation will be continual process and is essential to ensure that Family Hubs improve outcomes most effectively for babies, children and families in North Tyneside.

6. Appendices:

Appendix 1 – Implementation plan: Best Start in Life progress report
Appendix 2 – Family Hub Briefing
Appendix 3 – Performance indicators

7. Contact officers:

Jo Connolly, Head of Service, 0-19 Children's Public Health Service, 0191 643 4364
Lesley Davies, Senior Manager, Prevention Early Help, 0191 643 6462
Kirsty McLanders, Public Health Manager, 0191 643 4364
Rachel Nicholson, Senior Public Health Manager, 0191 643 8073

9. Background information:

The following background documents have been used in the compilation of this report to the Health and Wellbeing Board:

A Family Hub and Start for Life Programme Guide

COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

10 Finance and other resources

Any financial implications arising from the delivery of the implementation plan to delivery Equally Well, North Tyneside's Health and Well Being Strategy will be met from existing budgets.

11 Legal

The Authority is required to prepare a joint Health and Wellbeing Strategy for the Borough through the Health and Wellbeing Board, under section 116A of the Local Government and Public Involvement in Health Act 2007.

Delivering the Joint Health and Wellbeing Strategy supports the Board's duty under Section 195 of the Health & Social Care Act 2012 to encourage partners to work closely together and in an integrated manner for the purpose of advancing the health and wellbeing of the people in the area.

13 Human rights

There are no human rights implications directly arising from this report.

14 Equalities and diversity

In undertaking the development of the Joint Health and Well Being Strategy and implementation plan, the aim has been to secure compliance with responsibilities under the Equality Act 2010 and the Public Sector Equality Duty under that Act.

An Equality Impact Assessment was carried out on the engagement approach. The aim was to remove or minimise any disadvantage for people wishing to take part in the engagement activity. Direct contact was made with specific groups representing people with protected characteristics under the Equality Act 2010 to encourage participation and provide engagement in a manner that will meet their needs

15 Risk management

Relevant risks have been identified regarding this report, they are currently held on the Authority's corporate, strategic risk registers, they are being reviewed and managed as part of the Authority's normal risk management process.

16 Crime and disorder

There are no crime and disorder implications directly arising from this report.

Appendix 1. Equally Well: Best Start in Life

Progress report to HWBB – November 2022

Leads: Wendy Burke, Janet Arris, Jill Harland. Governance: Children and Young People's Partnership

Actions	Responsibility	Short-term outcomes	Progress update
Develop and deliver a model for Family Hubs Consult and publish the Start for life offer. New NHS LTP Tobacco Dependency model will be implemented by quarter 4. Reducing Parental Conflict training is rolled out to frontline staff Implement the new breastfeeding strategy Review supply of healthy start vitamins especially for families eligible for the free scheme Effective implementation of Revised EYFS 2 Matters – promote the award for settings working with funded two-year-olds with more vulnerable children.	Best start in life (BSIL) steering group (multi-agency) Northumbria Healthcare NHS Foundation Trust Early Help (NTC) All partners (Breastfeeding Strategy Delivery Group) School Improvement Early Years (NTC) Early Help / Early Years (NTC)	Families have seamless access to information and support Reduction in smoking in pregnancy Increase uptake of healthy start vitamins especially for families eligible for the free scheme Practitioners' confidence and ability to provide support for parents in conflict will be improved Increase in breastfeeding in our more deprived communities. More children achieving a good level of development at the 2-2.5 year health and development review. More children achieving a good level of development at the end of reception	Former Children's Centres (Riverside, Shiremoor and Howdon) are operating as Family Hubs and the model is developing and expanding. Launched the Baby Breathe Pilot aimed at helping women who quit smoking during pregnancy to stay smoke-free. Parental conflict training has been successfully rolled out to 360 frontline practitioners. The new breastfeeding strategy was launched and actions including Best Start peer support groups were established with VODA. Access and uptake to vitamins and the healthy start scheme have improved following a local review. Families in financial hardship supported. The 2 Matters award has been widely promoted across eligible settings who support our most vulnerable children.

KPIs / outcomes
Across our most disadvantaged areas we will see: • Increase in the rates of breastfeeding • Reduction in smoking in pregnancy • More children achieving a good level of development at the 2-2.5 year health and development review. • Good level of development at age 5 with free school meal status (%)

Community Engagement and mobilising community assets
Consultation on the Start for Life offer and Family Hubs. VCSE will be a critical conduit for disseminating the start for life offer Delivery of the Breastfeeding Strategy includes peer support

Links to other priorities
Needs a dotted line to 'Ensuring a healthy standard of living for all' workstream. Addressing family poverty Healthy Standard of Living for All: parents/ carers are in secure employment or in training

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North Tyneside Council

Briefing note

APPENDIX 2

To: North Tyneside's Health and Wellbeing Board

Authors:

Rachel Nicholson, Senior Public Health Manager

Jo Connolly, Head of Service - 0-19 Children's Public Health Service

Kirsty McLanders, Public Health Manager

Lesley Davies, Senior Manager, Prevention Early Help

Date: October 2022

Title of Briefing: Delivering and developing a local Family Hub and Start for Life offer

Purpose of briefing: Summarise the national guidance on the objectives and delivery of Family Hubs

Ensure appropriate join-up with other relevant local activity including the emerging Community Hub model.

1. Background:

A Family Hub and Start for Life Programme Guide has been produced for the 75 local authorities receiving additional investment to transform their services into a family hub model. Funded authorities should open Hubs and offer family support from 2023 with recognition that they will not meet all the minimum expectations at this stage. All minimum expectations should be met by the end of the three-year programme – end of 2024/25.

Although North Tyneside has not received national Family Hub funding, the Authority did receive a share of 73K from the 'Building back better Recovery Fund' from the DFE. This was a joint bid with Stockton, based on our current Family Hub offer, and we were asked

to develop a self-assessment framework and Stockton developed a regional support group.

North Tyneside partners have already begun to map current provision and consider current gaps in our local Family Hub offer, in additional to some consultation with families. Therefore, the national guidance is timely and will be useful to benchmark our current approach against the national expectations.

The approach going forward will be to use the service expectations and model frameworks from the national guidance and assess locally how to improve outcomes most effectively for babies, children and families and reduce inequalities in outcomes, experiences, and access to services in North Tyneside.

2. Local Context

2.1. Strategic link – Equally Well

North Tyneside's Joint Health and Well Being Strategy 2021-2025, Equally Well: A healthier, fairer future for North Tyneside sets out our system wide local priorities for improving the health and wellbeing of our population and reflects the evidence in our local JSNA. Equally Well is available to view by clicking here

The Family Hub Model will support two key impact areas of Equally Well which the Children and Young Person's Partnership has responsibility for delivering:

1. Give every child the best start in life
2. Enable all children, young people, and adults to maximise their capabilities and have control over their lives

Equally Well has a focus on reducing health inequalities, therefore it is essential our approach to Family Hubs focuses on how to identify, reach and support our most vulnerable families and communities, including those who do not usually engage.

Currently North Tyneside's former Children's Centres (Riverside, Shiremoor and Howdon) are operating as Family Hubs with recognition that the future offer needs to be strengthened and widely publicised, in line with the national timetable as set out above.

Our model will also need to incorporate the possibility of a SEND Early Years Assessment Centre of Excellence at the Riverside Centre. The aim of the Assessment Centre is to ensure that children get assessments in an independent unit and those children who are able to can attend mainstream school, rather than special schools. The model is still being developed.

2.2. Community Hubs

North Tyneside Cabinet has a long-established commitment to implementing a Community Hub model as part of the Council's Customer Service Programme. The idea of a Community Hub is that it is a one stop shop for the community, offering not only advice and information, but services and activities that meet the need of residents.

The Covid-19 pandemic highlighted the changing way that residents use and access Council buildings and services which mean that teams must adapt to meet changing needs. In addition, the current Cost of Living crisis has uncovered further needs and opportunities that could be met through community hubs. An Officer Team is developing the Community Hub model and it is important that Family Hubs are referenced and a key component of this offer.

3. National Guidance: Family Hub objectives

Family hubs should offer non-stigmatising support to families from conception and two, and to those with children of all ages, which is 0-19 or up to 25 for those with special educational needs and disabilities (SEND), with a great Start for Life offer at their core.

Family Hubs will:

- provide support to parents and carers so they can nurture their babies and children, improving health and education outcomes for all
- contribute to a reduction in inequalities in health and education outcomes for babies, children, and families across England by ensuring that support provided is communicated to all parents and carers, including those who are hardest to reach and/or most in need of it
- build the evidence base for what works when it comes to improving health and education outcomes for babies, children, and families in different delivery contexts

3.1 Family hub network

A family hub network is the totality of sites, partners, and physical, virtual, outreach services that are connected to the family hub. The family hub is the main site, however, some services may be based in other connected sites. Family hub buildings with co-located professionals and services are a feature of the family hub model, but

not where this compromises the offer to families in a location/area.

4. National Guidance: Family Hub Principles and Model Framework

The following principles are key to the family hub model:

- More accessible
- Better connected
- More relationship-centred

Family Hubs are a way of delivering the Supporting Families vison of an effective early help system.

Family Hubs should be designed and delivered according to the national Family Hub Model Framework. We have developed a **North Tyneside self-assessment spreadsheet** to benchmark our current approach which partners are currently using to assess our position against the national guidance.

Family Hubs should provide:

- Join-up of local partners involved in the early years and family support system – including local authorities, NHS, safeguarding, voluntary, community, faith and charity sector partners

- Strong local leadership and a commitment across partners to prioritise the early years, and support families with children of all ages.

- A skilled workforce working in integrated ways to provide families with universal and targeted support.

- Continuity of care between professionals and peer supporters, facilitated by the appropriate person for the family, to ensure families receive a seamless offer of support and do not have to repeat their story.

- Consultation with families, including young people, parents, and carers, to codesign and improve services.

- Ensure safeguarding underpins all aspects of Start for Life and family services delivered through family hubs, as set out in 'Working Together to Safeguard Children'.

- Provide high quality and evidence-based support.

In addition, the guidance advises:

Health and social care integration: joining up care for people, places and populations. Local areas should ensure that system-wide planning takes place so that all programmes and services in an Integrated Care System (ICS) area are working towards shared outcomes for families.

Building on other programmes and investments e.g. Early Help System transformation or with other funding sources, such as Reducing Parental Conflict support

5. National Guidance: Family Hub Service Expectations

Creating a consistent offer to families is a key objective of the Family Hub approach. Services should be available to families in the following three ways:

1. Face-to-face at a family hub

2. Through the family hub but received elsewhere in the network (for example, via outreach, at a youth centre, a clinical setting such as a maternity hub, a voluntary and community sector (VCS) organisation or a faith setting) virtually through the family hub, including static online information and/or

3. Interactive virtual service

National guidance sets out minimum service expectations and we have developed a further self-assessment around service expectations.

6. National Guidance: Local Needs Assessment

There is an expectation for a local population needs assessment to be carried out as local delivery models develop in the first year, or local areas should be able to demonstrate that such a process has recently been carried out.

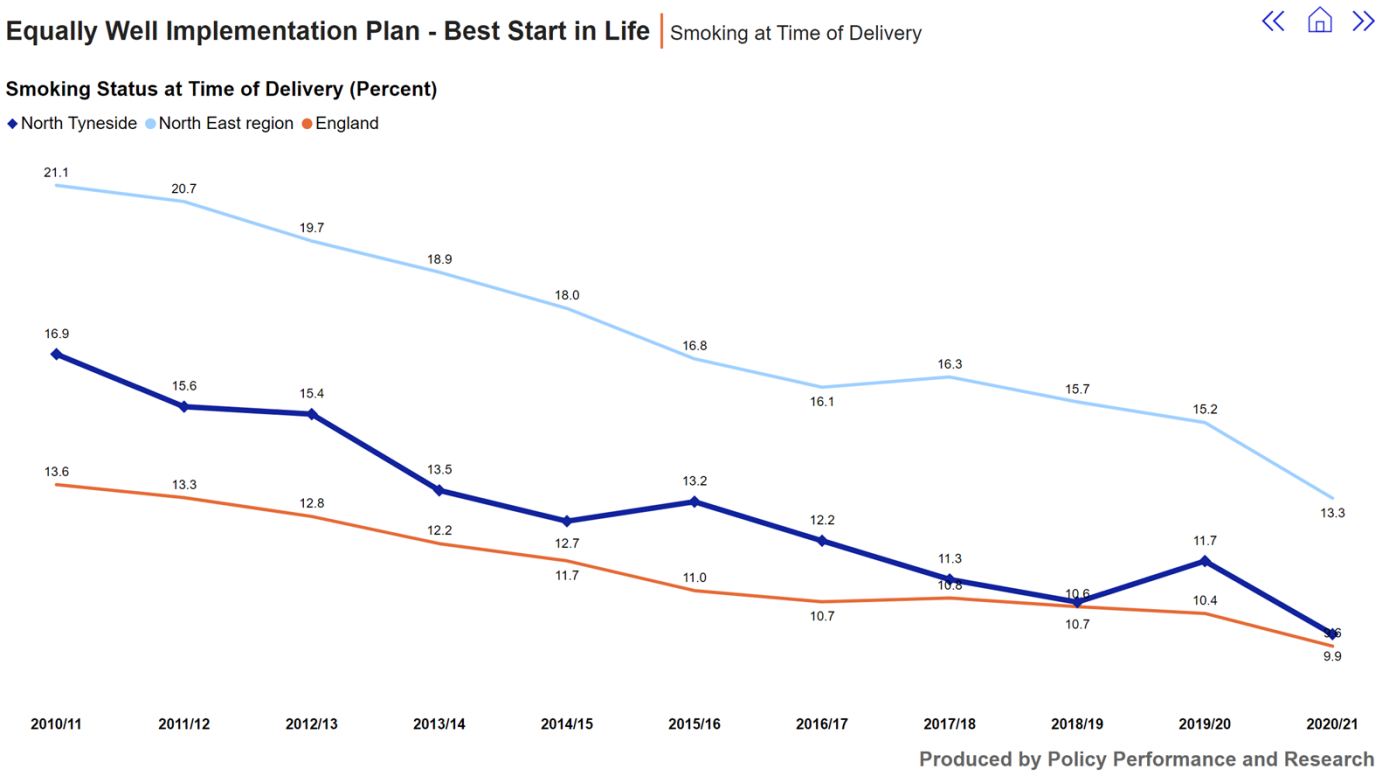
The local needs assessment should consider the wants and needs of different parents and carers (taking considerations such as age, deprivation status, ethnicity, substance misuse, domestic violence and other protected characteristics on board), and the barriers they may face to accessing services.

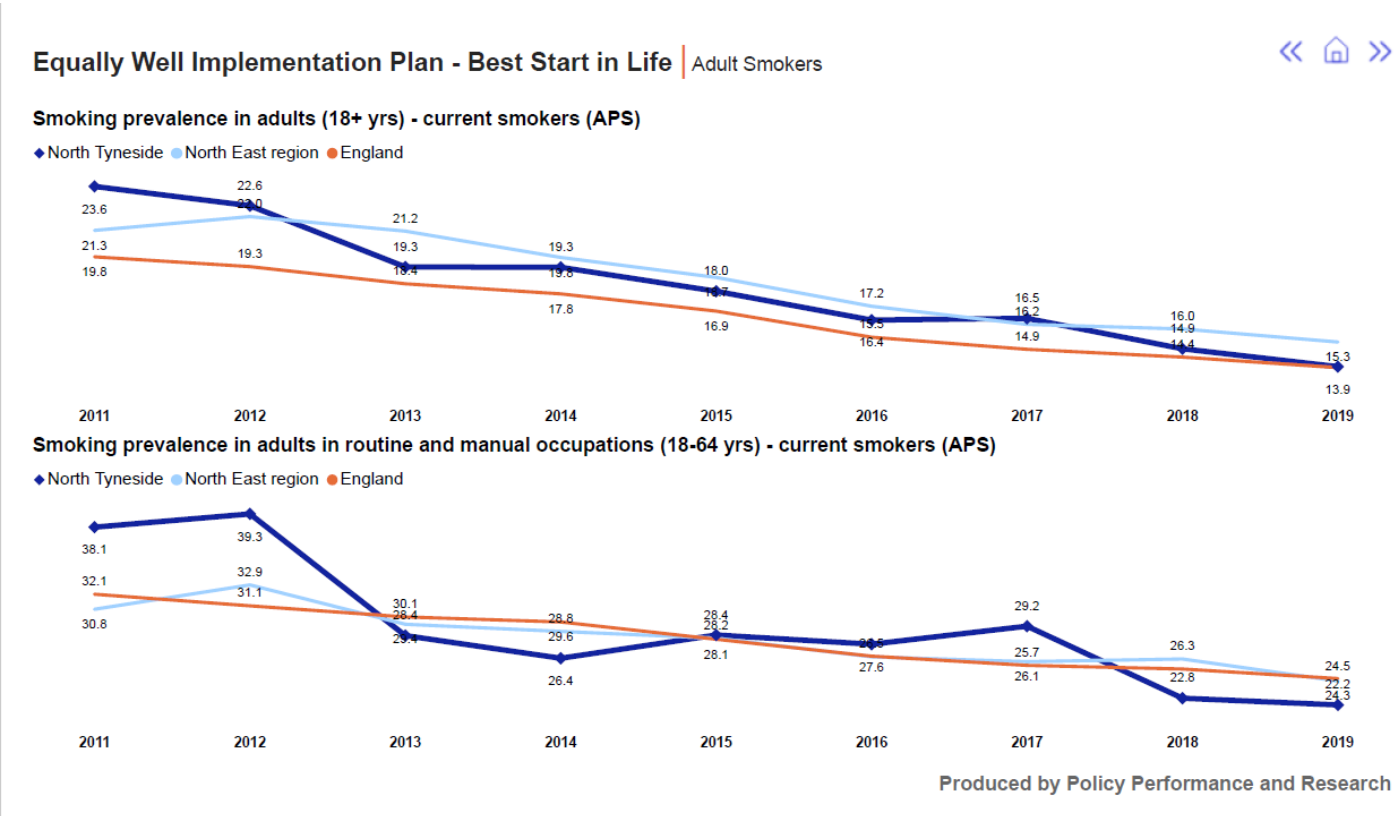
The scope of this needs assessment should reflect the scope of the family hubs programme: from conception through to age 19, or up to 25 for those with SEND; and the outcomes for babies, children, young people and families which family hubs are intended to achieve.

Currently data and intelligence on children, young people and families is held across different services and agencies. The Children and Young Person's partnership will need to ensure there is a comprehensive understanding of needs to inform the development of Family Hubs.

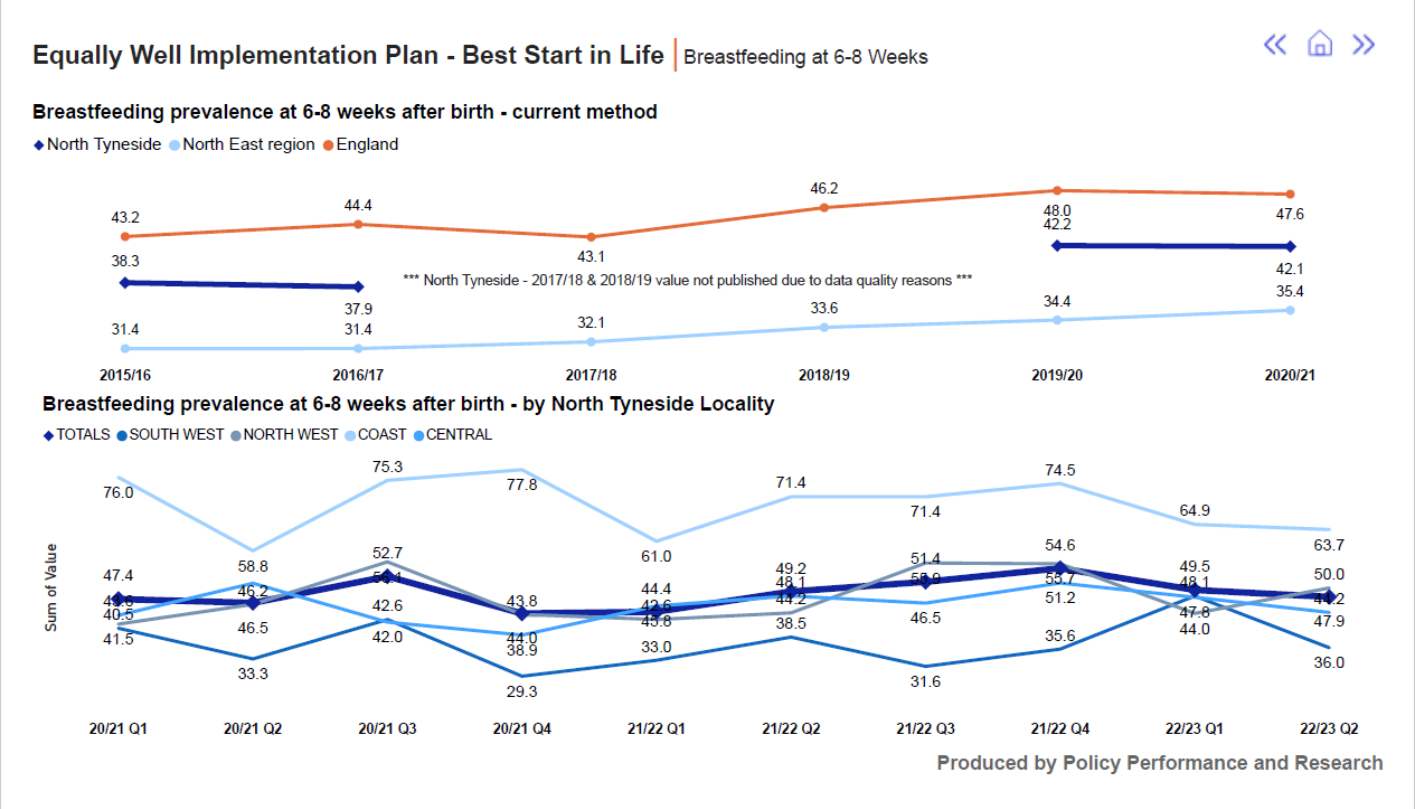
APPENDIX 3 – Performance indicators: Best Start in Life

Indicator 1: Smoking status at time of delivery

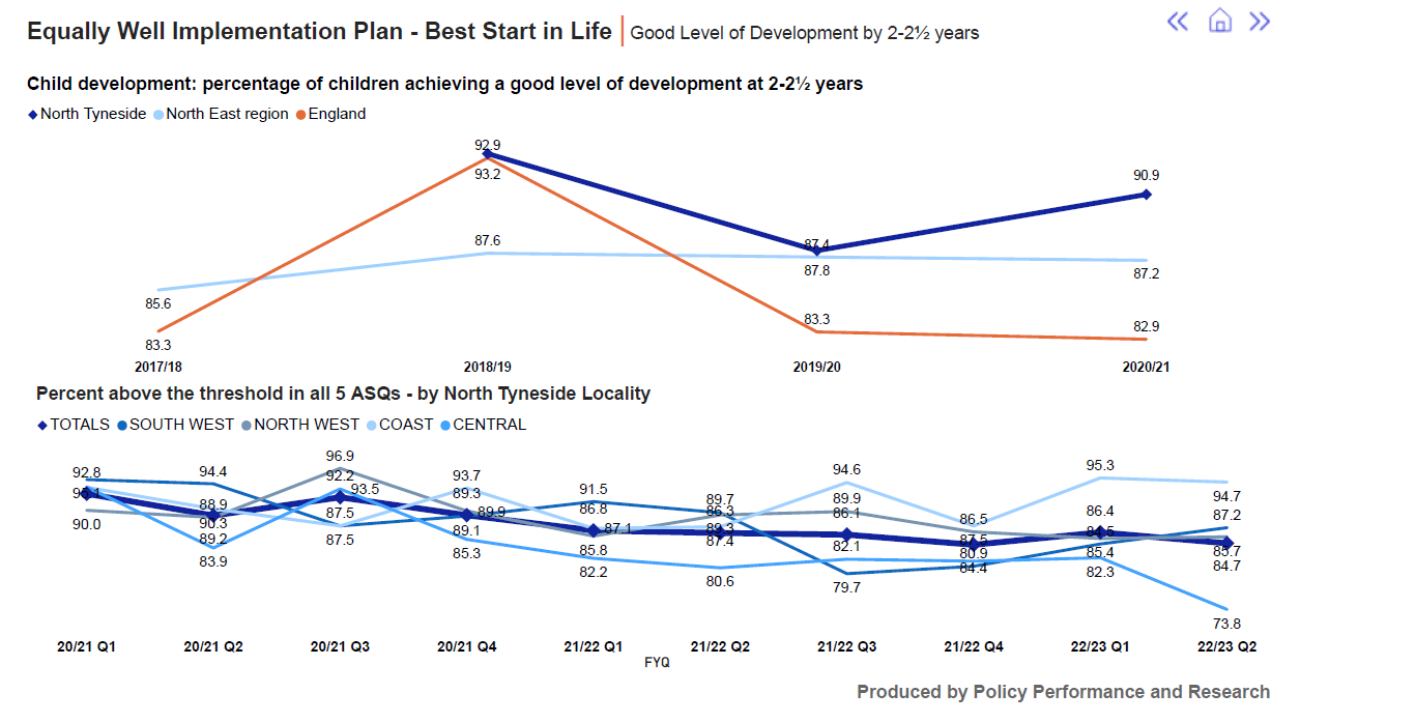




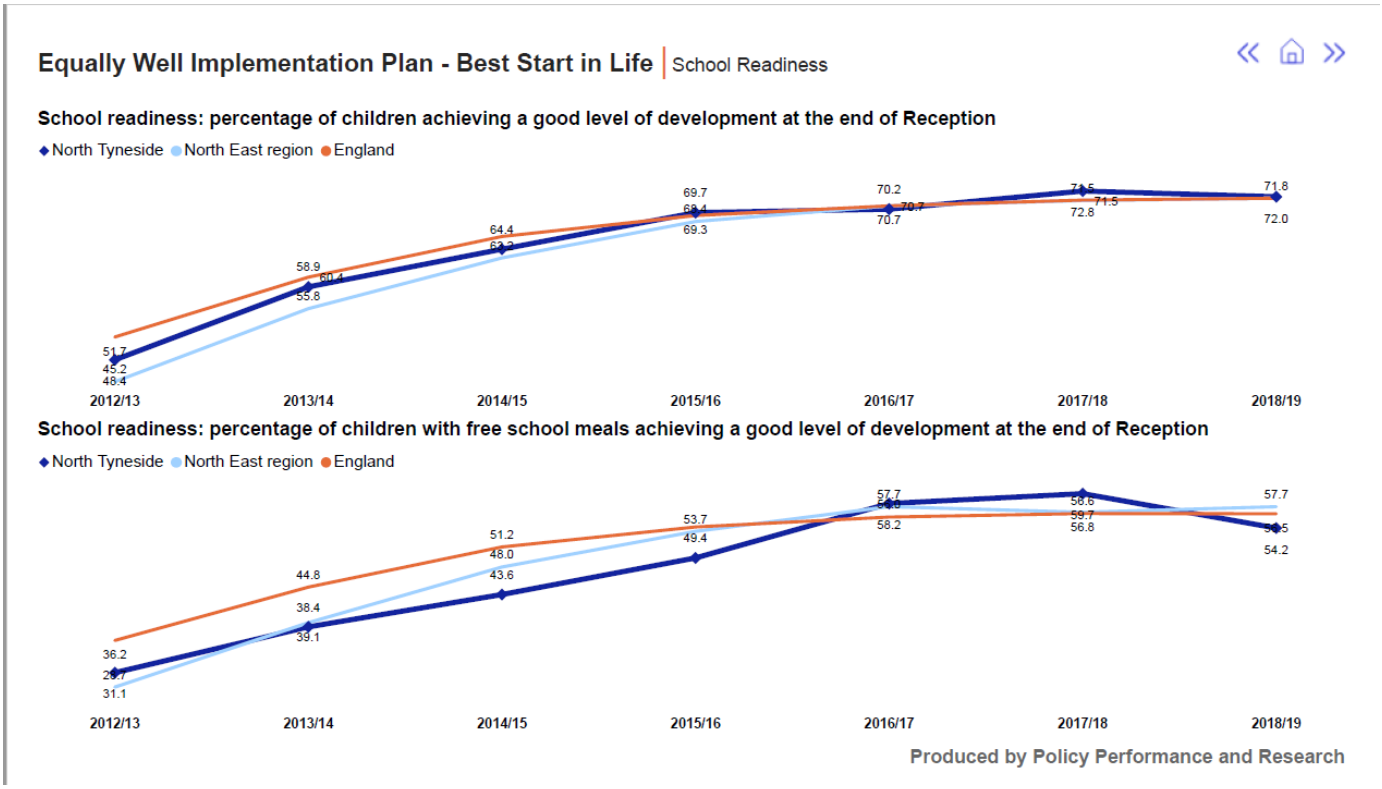
Indicator 2: Breastfeeding prevalence at 6-8 weeks after birth



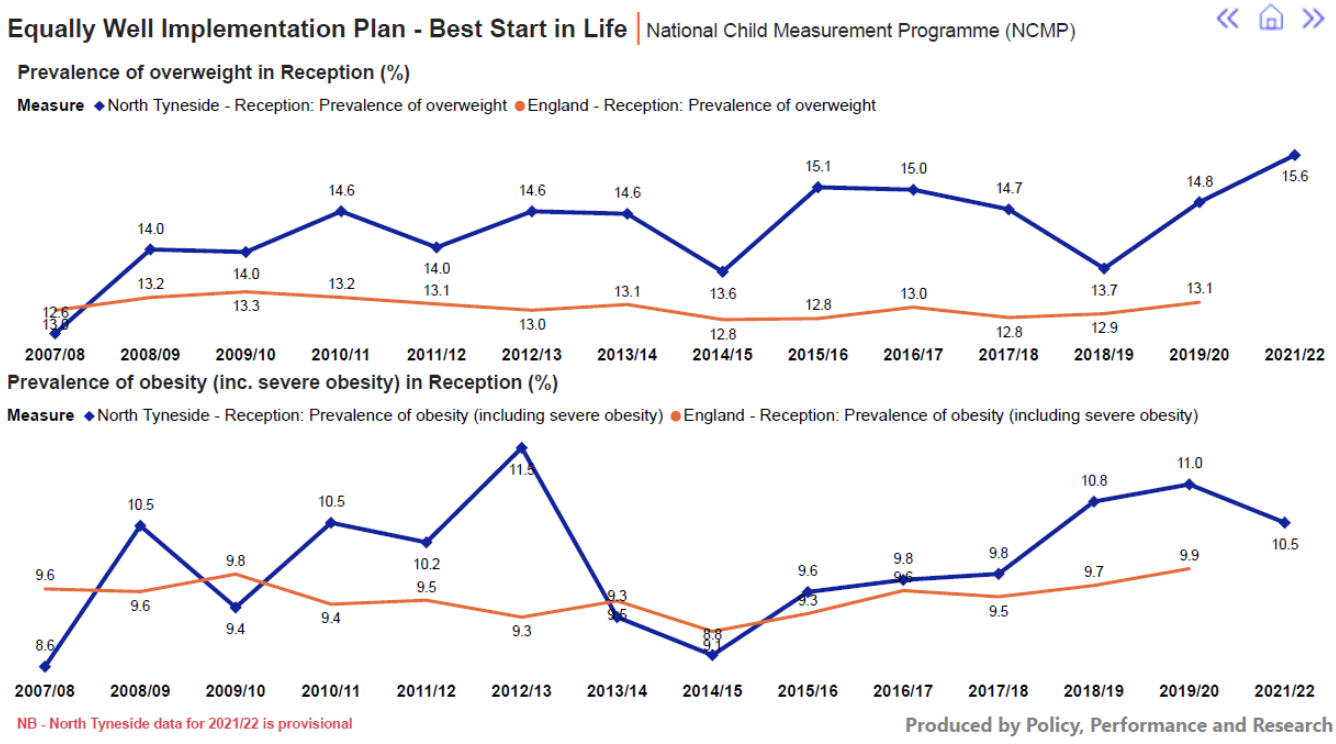
Indicator 3: Good level of development at 2-2 ½ years of age



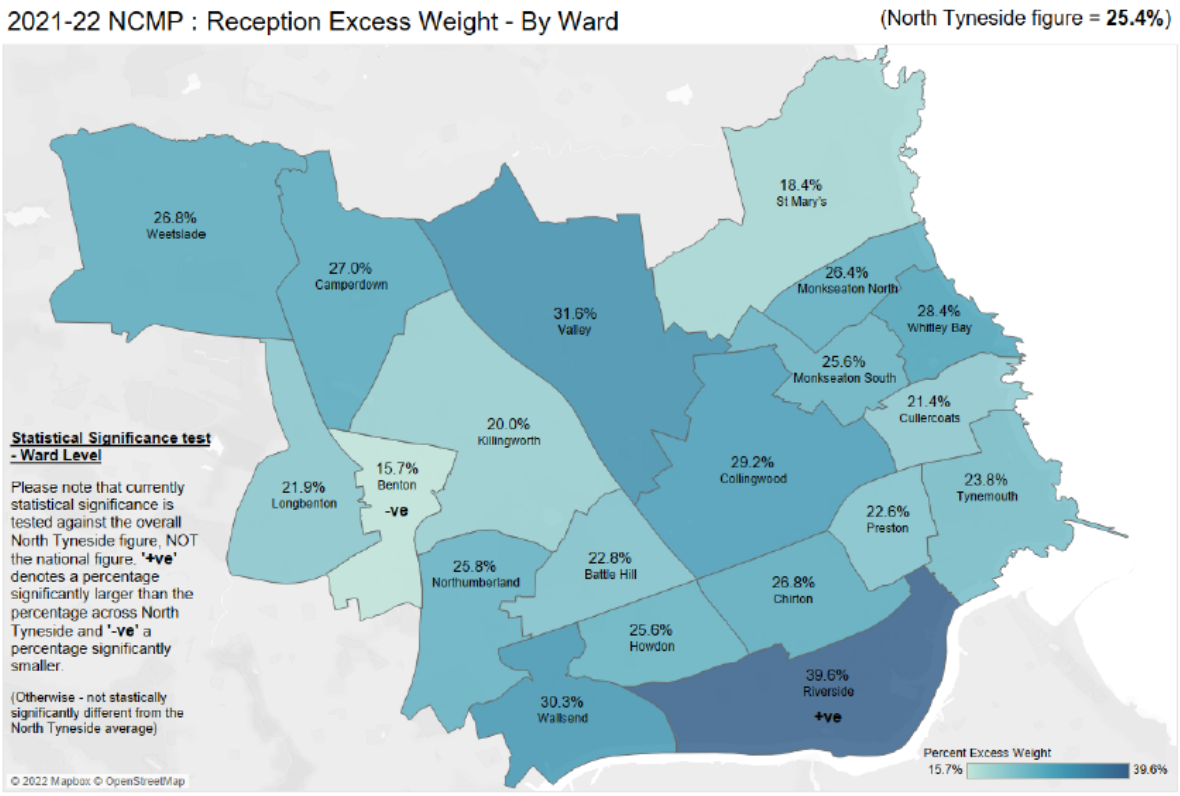
Indicator 4: School Readiness: achieving a good level of development at the end of Reception



Indicator 5: National Child Measurement Programme – end of Reception



Map by Ward showing excess weight by ward



Produced by Policy, Performance & Research

North Tyneside Health & Wellbeing Board Report

Date: 10 November 2022

Title: Update on the Healthy Standard of Living for All Implementation Plan

Report from : Assistant Chief Executive, North Tyneside Council

Report Author: Vicki Nixon, Senior Manager Participation, Advocacy & Engagement (Tel: 0191 643 8215)

Relevant Partnership Poverty Intervention Partnership Board

1. Equally Well: Ensure and Healthy Standard of Living for All Progress Update:

This item relates to Ensuring a Healthy Standard of Living for All theme of the Joint Health and Wellbeing Strategy, "Equally Well: A healthier, fairer future for North Tyneside 2021-2025".

As outlined in Equally Well this means that we want a fair economy that works for and includes everyone where the benefits of the economy are spread, so that all communities in North Tyneside flourish and grow equally.

2. Recommendation(s):

The Board is recommended to note the progress in delivering the Ensure a Healthy Standard of Living for All theme by the Poverty Intervention Partnership Board

3. Progress update

The Poverty Intervention Partnership Board is responsible for the leadership and governance of this theme. The progress against actions in the implementation to achieve Ensure a Healthy Standard of Living for All.

Highlights of achievement include:

The Poverty Intervention Partnership Board met and agreed Terms of Reference and membership. A Poverty Intervention Network has been introduced to support a wider discussion with organisations across North Tyneside.

The HAF program was successfully delivered over Easter and Summer school holiday periods with targets set by DfE exceeded.

- A Food North Tyneside event was delivered which brought together all organisations working across the food landscape in North Tyneside. The focus of the event was addressing food insecurity, food waste and access to nutritious food. It is intended that the event will be the first stages in the development of a food strategy for North Tyneside. The next step will be to facilitate a workshop alongside Food Britain at the State of the Area Conference.

- We are actively involved in supporting the North of Tyne Poverty Truth Commission. Poverty Truth Commissions, seek to discover the answer to the question, 'what if people who struggled against poverty were involved in making decisions about tackling poverty?' The commissioners for each Commission comprise two groups of people. Around half of the commissioners are people with a lived experience of the struggle against poverty. The other half are leaders within the city or region. Collectively they work to understand the nature of poverty, what are some of the underlying issues that create poverty and explore creative ways of addressing them.

- Poverty proofing the school day continues with 27 schools now underway. The aim of the project is to make sure costs associated with school do not make things worse for families already struggling to keep their head above water, and that children should not miss out on school activities and experiences because of money. Children can routinely face unintentional stigma and discrimination because of poverty and this project aims to address this.

- From 1st November we have 'warm welcome' hubs across the borough, which sees our Customer First Centres and libraries, as well as community and voluntary sector organisations, extending their support to residents by offering a comfortable space to relax. For those who wish to get involved, additional free activities and hot drinks are also offered. This is not means-tested and is available for all residents.

- The rising cost of living, through increasing energy, food, and fuel costs, is affecting many of us. The council is committed to supporting our residents, especially those most impacted, and our businesses. A new section has been created on the website where you will find the support available from the Council, advice, and signposting to other relevant organisations. This includes help for families and individuals, whether you're working or not. The rising cost of living, and the support to help to deal with it, is changing quickly. We will regularly review and update these pages to reflect this and to make sure help is always available to those who need it. The support is categorised into support for families, older people, all residents, including low-income households and businesses.

- Support for residents by delivering projects with essentials such as food, energy and clothing has been delivered using the Household Support Fund. Plans have been developed to use the HSF to support the priorities identified in the borough. These include:

    1. The commitment to fund Free School Meal families with vouchers for £15.00 per week of each school holiday, including the Easter break so a total of 6 weeks as Easter starts on 31.03.23
    2. An amount for welfare provision to operate an application-based offer based on estimated demand

3. Some targeted support for those on Council Tax Support that have fallen through the net of the other government pay-outs for example Rising Cost of Living Payments or Disability Cost of Living Payments. So, these are the people just on carers allowance, in receipt of contribution-based benefits or on very low wages or other low incomes.
4. Funding to CAB and the food bank.
5. The commitment to support warm school clothing for part of the £45.00 cost per child. And a small amount for non-Free School Meal families.
6. Funding for exceptional housing costs

Within these projects we have given special consideration to carers which has been raised as a specific group of residents who may be struggling financially at the current time

- Families with children who are living in poverty often struggle to be able to afford the regular costs for school uniform, shoes, or winter costs and this can contribute significantly to the key impacts of poverty. This can be a particular issue where schools require their own branded items of clothing to be worn as part of their uniform policy. We have worked with 16 schools in North Tyneside to develop their own preloved uniform scheme, addressing both the cost of buying school clothing as well as the environmental impact of buying new clothing. Part of this includes developing their uniform policy.

4. Performance indicators

The Poverty Intervention Partnership Board is currently working on a set of KPI's to ensure that work is monitored so that all communities in North Tyneside flourish and grow equally.

The Holiday Activity and Food program is delivered in North Tyneside targeting children from low-income families to access nutritious food and enriching activities during school holiday periods (Easter, Summer, and Christmas). During the Easter holidays, 1309 children attended the HAF program, and 2241 children attended the summer HAF program. These attendances exceeded targets set with the Department of Education, 82.2 % of children accessed HAF were FSM eligible and 16.6% of children attending were identified as SEND which is higher than the national average.

5. Community engagement

As Equally Well explains attempts to tackle inequalities must be done in collaboration with those affected, Healthwatch carried out a consultation on the Equally Well implementation plan. Using those findings, we are shaping the work of the Poverty Invention Partnership Board ensuring that we are addressing residents' priorities in creating a healthy standard of living for all.

The creation of the Poverty Intervention Partnership Network means that we can continue conversations with those organisations supporting residents.

The State of the Area Conference 2022 will be delivering workshops on the cost-of-living crisis and how we support our residents. The findings from this event will further shape the work of the Poverty Intervention Partnership Board.

6 Appendices:

None

7 Contact officers:

Jaqueline Laughton, Assistant Chief Executive and Monitoring Officer
Vicki Nixon, Senior Manager Participation, Advocacy & Engagement
Kerry Nesbitt, Social Inclusion Manager

8 Background information:

COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

9 Finance and other resources

The Healthy Standard of Living for all themes will be supported by delivery of projects funded through the Household Support Fund and the Poverty Intervention Fund.

10 Legal

The Board has a duty under Section 195 of the Health & Social Care Act 2012 to encourage partners to work closely together and in an integrated manner for the purpose of advancing the health and wellbeing of the people in the area.

11 Human rights

There are no human rights implications directly arising from this report.

12 Equalities and diversity

There are no equality and diversity implications arising directly from this report.

An EIA is being undertaken by the Poverty Intervention Partnership Board to ensure that all work delivered through this partnership advances equality of opportunity between people who have a protected characteristic and those who don't

13 Risk management

Any risks identified can be managed following the Council and partners' existing risk processes.

14 Crime and disorder

There are no crime and disorder implications directly arising from this report.

North Tyneside
Health & Wellbeing Board Report
Date: 10 November 2022

Title: Review of Membership of the Board

Report from : Law & Governance, North Tyneside Council

Report Author: Michael Robson, Democratic Services Officer (Tel: 0191 643 5359)

1. Purpose:

This report invites the Board to review its membership to ensure that the range of organisations represented at meetings are appropriate in terms of delivering the ambitions set out in the Joint Local Health & Wellbeing Strategy.

2. Recommendation(s):

The Board is recommended to:

a) appoint the following additional persons as members of the Board:
   i. the Council's Assistant Chief Executive,
   ii. the Council's Director of Regeneration and Economic Development,
   iii. the Council's Director of Housing and Property Services,
   iv. the Council's Assistant Director of Education, Employment and Skills,
   v. a representative from the Poverty Intervention Partnership Board; and
   vi. a representative from the North Tyneside Business Forum; and

b) remove the appointment of a representative from the North Tyneside Safeguarding Adults Board from membership of the Board.

3. Policy Framework

This item relates to the operation of the Board and so there are no direct links with delivery of the Joint Health and Wellbeing Strategy 2022-25.

4. Information:

4.1 In accordance with the Health and Social Care Act 2012 the membership of the Health and Wellbeing Board must comprise of:-

a) the Elected Mayor and/or at least one councillor as nominated by the Elected Mayor;
b) the Director of Adult Social Services;
c) the Director of Children's Services;
d) the Director of Public Health;
e) a representative of the North East and North Cumbria Integrated Care Board;
f) a representative of Healthwatch North Tyneside;

g) for the purpose of participating in the preparation of the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy, a representative of NHS England; and
h) such additional persons as the Board or the Council think appropriate.

4.2 Since its establishment the Board, using the power to appoint additional persons, has agreed to appoint representatives from the following organisations:-

a) an additional representative from the North East and North Cumbria Integrated Care Board;
b) an additional representative from the Healthwatch North Tyneside
c) Northumbria Healthcare NHS Foundation Trust
d) Newcastle upon Tyne Hospitals NHS Foundation Trust
e) Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
f) The four Primary Care Networks in North Tyneside
g) Community and Voluntary Sector Chief Officer Group
h) Age UK North Tyneside
i) YMCA North Tyneside
j) North Tyneside Safeguarding Adults Board
k) North of Tyne Pharmaceutical Committee
l) TyneHealth
m) North East Ambulance Service
n) Tyne & Wear Fire and Rescue Service
o) Northumbria Police

4.3 At its previous meeting the Board agreed that the Chair, Deputy Chair and other leading members of the Board review its membership to ensure that the range of organisations represented at meetings are appropriate in terms of delivering the ambitions set out in the Joint Local Health & Wellbeing Strategy (JLHWS) and any recommendations for changes to the membership be presented to the Board for consideration at a future meeting.

4.4 The Chair and Deputy Chair have reviewed the membership with the Director of Public Health, the Director of Healthwatch and the ICBs Director of Place. They acknowledged that there needed to be broader representation on the Board to reflect the ambitions contained in the Strategy relating to the wider determinants such as education, employment and housing.

4.5 Following this review it is suggested that the following additional persons be appointed to the Board:

a) The Council's Assistant Chief Executive, currently Jackie Laughton, in recognition of the key role this post holder has in preparing and delivering the JLHWS and its implementation plan;
b) The Council's Director of Regeneration and Economic Development, currently John Sparkes, as many of the outcomes related to reducing health inequalities will be delivered indirectly by plans such as North Tyneside's Inclusive Economy Strategy and its Employment and Skills Strategy;
c) The Council's Director of Housing and Property Services, currently Peter Mennell, in recognition that housing is one of the key wider determinants of an individuals' health;
d) The Council's Assistant Director of Education, Employment and Skills, currently Lisa Cook, as the JLHWS recognises that educational attainment is a key determinant of health particularly in the early years and it seeks to make North Tyneside an even greater place for children and young people to thrive, where all can access a high-class education with a culture of inclusion and achievement;

e) a representative from the Poverty Intervention Partnership Board to reflect the importance of tackling poverty as the greatest preventable threat to health and being fundamental to addressing health inequalities; and

f) a representative from the North Tyneside Business Forum. The Forum is a supportive network helping to support local business and providing a link to a wider network of business groups and associations. The Forum could assist the Board in delivering the ambitions contained in the JLHWS by for example identifying barriers to growth, encouraging local businesses to take social responsibility for our people, our place and our economy and to promote good health within the workplace.

4.6 For some time the North Tyneside Safeguarding Adults Board has not been represented on the Board. Since this appointment there have been significant changes in the multi-agency safeguarding arrangements for adults and for children and young people. In view of these factors it is suggested that this position be removed from the membership.

4.7 If these proposed changes are agreed they will increase the number of members on the Board from 29 to 34 members.

5. Decision options:

The Board may decide to either:-

a) approve the recommendations set out in Section 2 of the report; or

b) consider and agree alternative changes to the membership of the Board.

6. Reasons for recommended option:

The Board is recommended to agree option a) to secure appropriate representation on the Board to deliver the ambitions set out in the Joint Local Health & Wellbeing Strategy

7. Appendices:

None.

8. Contact officers:

Michael Robson, Clerk to the Board, Law & Governance. Tel 643 5359

9. Background information:

The following background papers/information have been used in the compilation of this report and are available at the office of the author:

(1) Health and Social Care Act 2012

(2) The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

(3) Report to the Board June 2013 and associated minute.

(4) Equally Well: A healthier, fairer future for North Tyneside. North Tyneside's Joint Local Health & Wellbeing Strategy 2021-25

COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

9 Finance and other resources

The costs associated with the operation of the Board will be contained within existing budgets.

10 Legal

Section 194 of the Health and Social Care Act 2012 states that a local authority must appoint specified persons to a Health and Wellbeing Board and that the Board may appoint such other persons as it thinks is appropriate.

11 Consultation/community engagement

Consultation has been undertaken with the Director of Public Health, the North East and North Cumbria ICB and the Chair of the Board, Councillor Karen Clark.

12 Human rights

There are no Human Rights implications arising from this report.

13 Equalities and diversity

There are no equalities implications arising from this report.

14 Risk management

A risk assessment has not been undertaken in connection to this matter.

15 Crime and disorder

There are no crime and disorder implications directly arising from this report.

16 Environment and sustainability

There are no environment and sustainability issues arising from this report.

SIGN OFF

Chair/Deputy Chair of the Board	X
Interim Director of Children's Services	X
Interim Director of Adult Services	X
Director of Healthwatch North Tyneside	X
Director of Public Health	X
ICB Director of Place	X
Assistant Chief Executive	X