NHS
North East and
North Cumbria

Draft:

Joint Forward Plan 2023/24 – 2028/29

Version: 3 July 2023

**Better health
and wellbeing for all...**

Contents

Foreword – Samantha Allen

Following the publication of our Integrated Care Strategy, Better Health and Wellbeing for All, in December 2022, we have been working closely with our partner organisations to produce our Joint Forward Plan.

The Integrated Care Strategy, developed with the Integrated Care Partnership (ICP), requires a sustained collaboration across a broad range of partners and stakeholders, beyond the improvements to outcomes that health and care services can deliver in isolation.

Our draft Joint Forward Plan is complementary to this Strategy. It is a delivery plan for the parts of our strategy related particularly to NHS delivered or commissioned services, but within the broader partnership context.

Publication of this plan is a national requirement for all Integrated Care Boards (ICBs) and partner Foundation Trusts covering the period 2023/24 – 2028/29.

Our Joint Forward Plan provides a:

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

As part of our Joint Forward Plan, we have developed detailed action plans for:

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

In the same spirit as we have engaged with our system partners to create our integrated care strategy, we are seeking feedback and views on the Plan to deliver the ambitions agreed.

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

Samantha Allen

Chief Executive

North East and North Cumbria Integrated Care Board

1 Introduction to the Joint Forward Plan

What is the Joint Forward Plan?

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

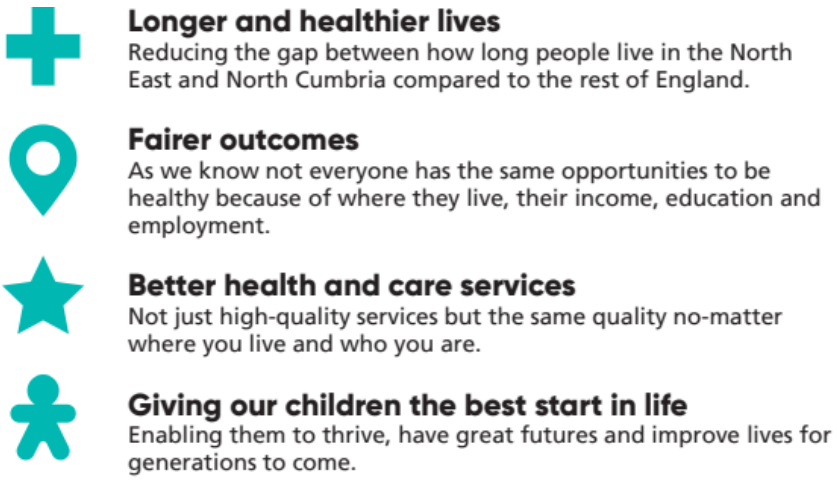
- Principle 1: Fully aligned with the wider systems ambitions
- Principle 2: Supporting subsidiarity, building on existing local strategies and plans and reflecting universal NHS commitments
- Principle 3: Delivery focussed, specific objectives, trajectories and milestones

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

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

Is this different to the Integrated Care Partnership (ICP) Strategy?

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



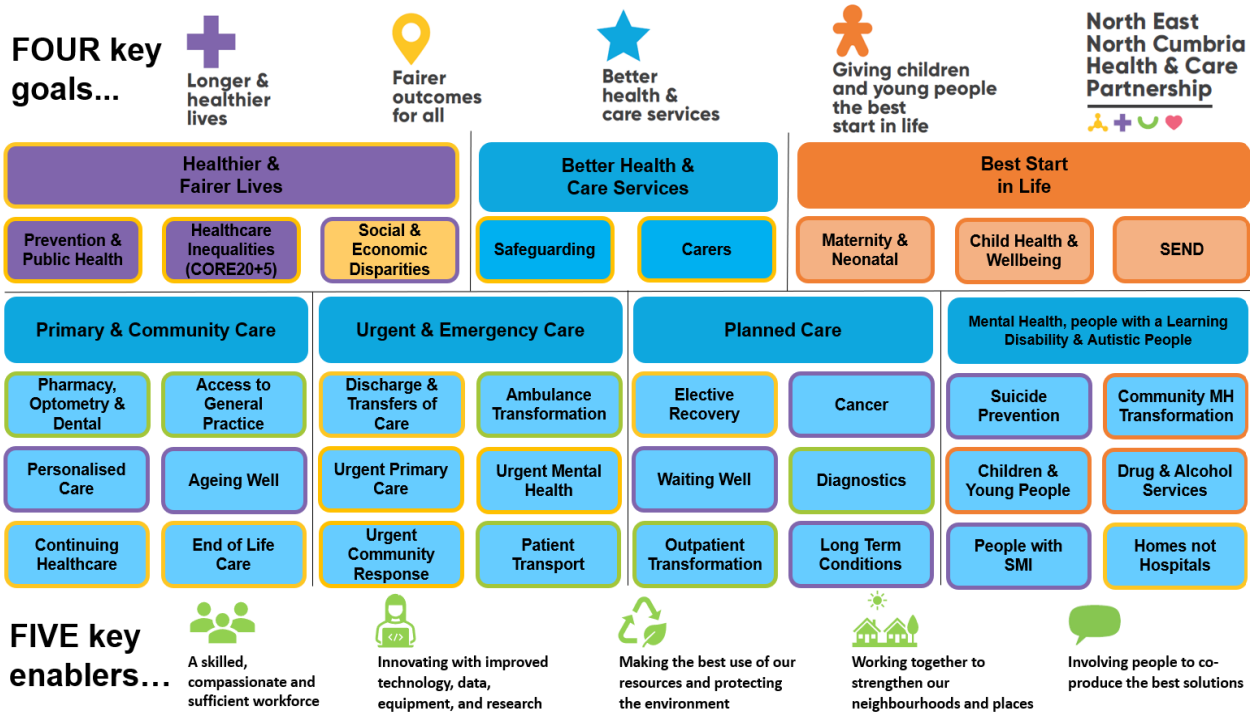
Our joint forward plan is complementary to the ICP Strategy. It is a delivery plan for the parts of our strategy related to NHS delivered or commissioned services, but in the broader partnership context.

What does the Joint Forward Plan cover?

Our Joint Forward Plan is aligned to ICP Strategy. It covers:

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

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



Are there any more detailed plans to support the Joint Forward plan?

As part of our Joint Forward Plan, we have developed action plans including:

- the integrated care strategy goals
- the integrated care strategy enablers
- each local authority Place or groups of Places
- key service areas, e.g., urgent and emergency care

The action plans are intended to address the immediate priorities and key deliverables, but also the longer-term transformation/development priorities. Our action plans include key deliverables – what we will deliver, and by when, and Measures of impact. Wherever possible the plans have been developed in

partnership, often through an existing integrated care system wide workstream or clinical network. Our action plans are informed by:

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

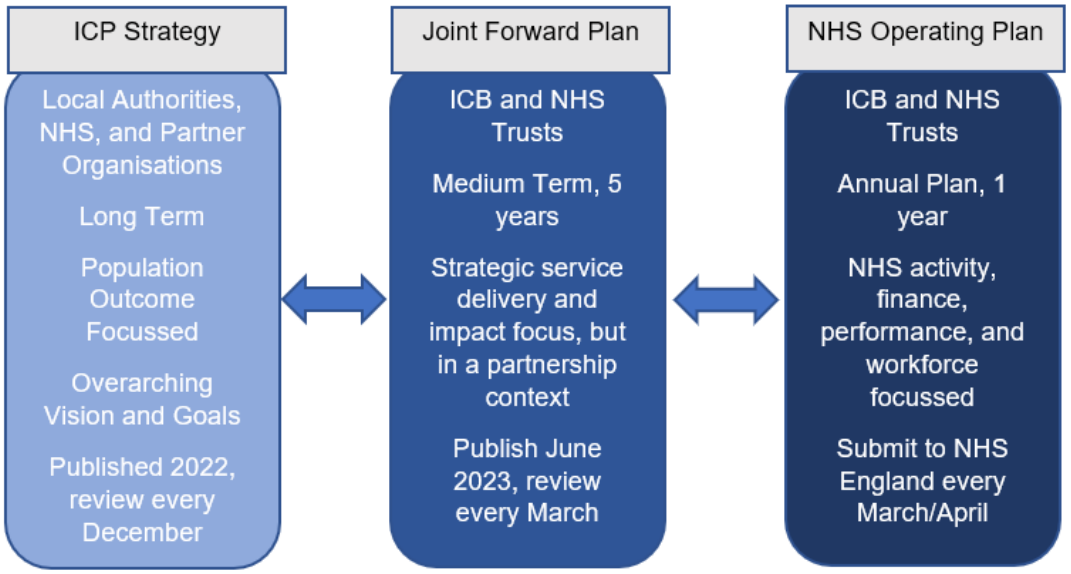
Will the Joint Forward Plan be Reviewed and Updated?

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

- Our implementation over the previous year and our maturing partnerships, integration and/or aligned programmes of work.
- Our learning, as we seek to be the 'best at getting better'.
- Changes in population needs, national policy, good practice, and legislation.
- The views of service users and communities, partners and partnerships including Health and Wellbeing Boards.

How do the different Plans fit together?

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



Our Healthcare Services

The NHS workforce across the North East and North Cumbria totals nearly 90, 000 full time equivalent. **Within the NHS our system includes:**

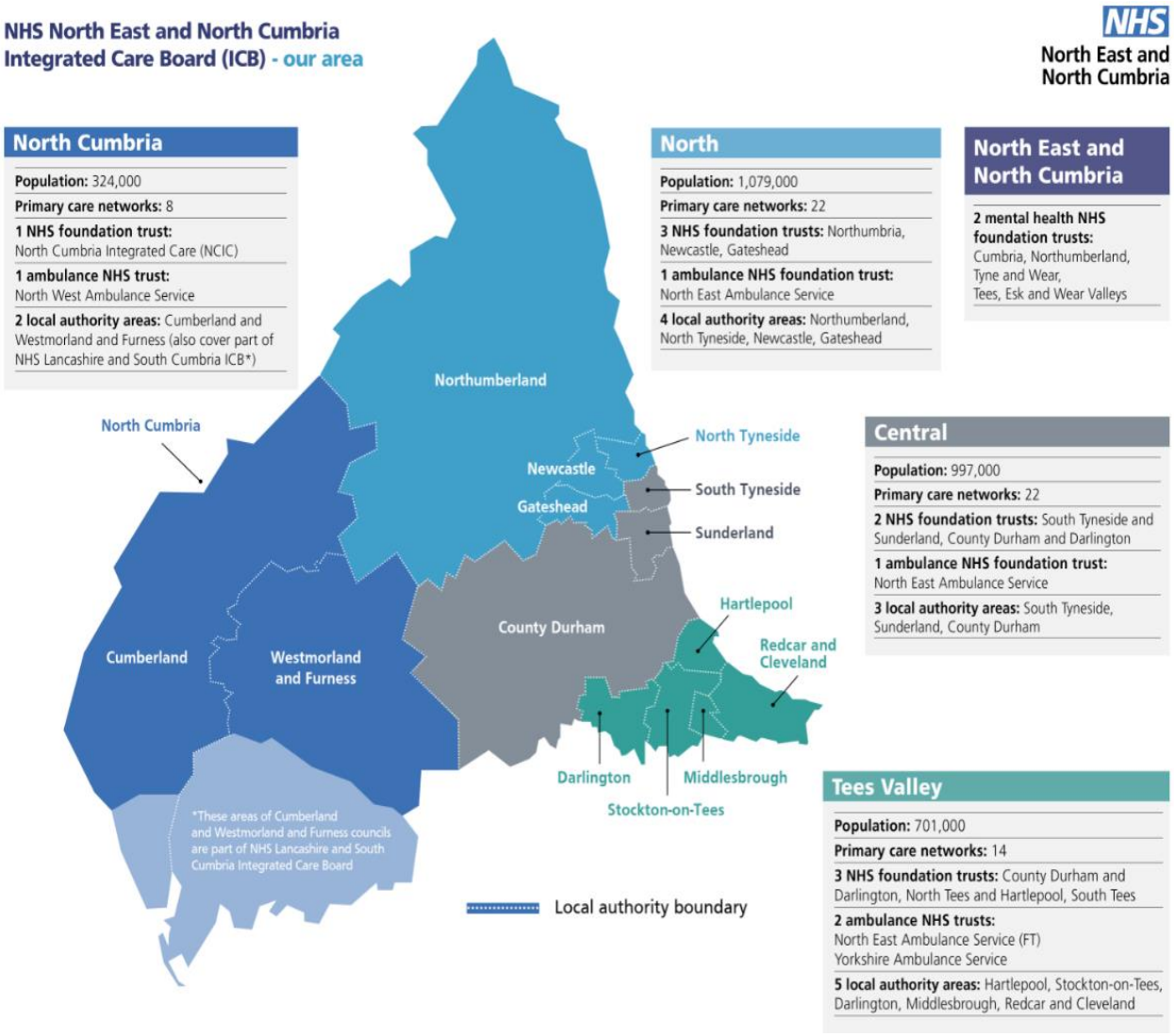
- General Practices, grouping together across 64 Primary Care Networks

- Community Pharmacies and Dental Practices
- Eight NHS Trusts predominantly (though not exclusively) delivering physical health community and hospital-based services
- Two mental health and learning disability NHS Trusts
- North East, and North West, Ambulance Services delivering NHS 111, non-emergency patient transport services and 999 paramedic emergency services
- NHS commissioned independent sector free at the point of delivery services.

Our Population

The North East and North Cumbria ICB includes a large and diverse geography, from cities and towns to rural and coastal communities:

- Our ICB covers the **largest resident population** of c3 million (2021 census)
- Our population is **older**, 21% are over 65 compared to 18.6% in England
- Our population experiences significant **socio-economic deprivation** - 1 in 3 people live in the most 20% deprived communities in England
- Our population experiences **health inequalities**. Life expectancy and healthy life expectancy at birth are significantly worse than the England average.



3 Longer, Healthier Lives and Fairer Outcomes

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3.1 Partnership Working

The Healthier Lives, Fairer Outcomes Programme is a system-wide approach to prevent ill health, reduce healthcare inequalities and support the NHS to play a greater role in addressing social and economic inequalities. The Healthier and Fairer Advisory Group is a sub-committee of the ICB Executive and provides oversight of three thematic workstreams, and three enabling workstreams, shown below:

Three **Workstreams**

- Prevention
- Healthcare Inequalities
- NHS Contribution to reducing Social and Economic inequalities

Three **Enabling** Workstreams

- Prevention
- Healthcare Inequalities
- NHS Contribution to reducing Social and Economic inequalities

All the Healthier and Fairer work programmes are delivered in partnership:

Healthier and Fairer partnership membership:

Each workstream is co-chaired by an ICB Medical Director and a Director of Public Health, with membership drawn from across the health and care system, including local government, Office for Health Inequalities and Disparities (OHID), VCSE, academia, Healthwatch, local government, ICB

3.2 Achieving the NHS prevention ambitions

We know that life expectancy and healthy life expectancy at birth in our region are lower than the rest of the country. Using these measures, the North east and North Cumbria has some of the worse health outcomes in England. There are also inequalities in life expectancy at birth between the most deprived 20% and least deprived areas within our region. In 2020/21, the difference in life expectancy was

approximately 8.1 years for women and 10.4 years for men. The difference is much larger than the comparable inequality gap for England. The NHS has a greater role in secondary prevention.

Objectives:

- Reduce harm from alcohol
- Increase the rate of 'Healthy weight'
- Reduce the smoking rate to 5% by 2030
- Improve the detection and management of the 3 high risk conditions for cardiovascular disease (Atrial Fibrillation, Hypertension, and Raised Cholesterol).
- To contribute to the development of a sustainable VCSE sector and strengthening of communities at place

3.3 Reducing Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups. The health of the population is influenced by multiple factors, often referred to as the wider determinants of health. Healthcare inequality refers to inequalities experienced by people and groups within the population regarding the access to, uptake and experience of, and outcomes associated with, the delivery of healthcare services.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The CORE20 are the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD), with one third of the NENC population falls within the 20% of the national population which is the most deprived.

Adults Objectives:

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

Children and Young People Objectives:

- Reduce the over reliance on reliver medications and decrease the number of asthma attacks.
- Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase the proportion of those with Type 2 diabetes receiving recommended NICE care processes.
- Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
- Reduce the number of tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under
- Improve access rates to mental health services, for certain ethnic groups, age, gender, and deprivation.
- Embed smoking cessation in all appropriate delivery plans.

3.4 NHS contribution to reducing social & economic inequalities - Social and economic conditions are influenced by policy choices beyond the NHS's control. The ICB is committed to working collaboratively alongside partners to make change.

Objectives:

- Health literacy approach improving the way we communicate.
- Poverty proofing health settings to removes barriers to improving healthcare access, experience, and outcomes.
- Maximising digital solutions, while guarding against digital exclusion.
- Anchor institutions network to maximise their impact.

3.5 Embed Population Health Management - Our Population Health Management approach is a key *enabler*. Our approach is data driven to help plan and deliver care that maximise health outcomes and reduces health inequalities.

Note: This priority is closely aligned the **Digital** enabler in section 6.

Objectives:

- Create a full longitudinal dataset (primary, secondary, mental health, social care, community data, blue light services)
- Multi partner intelligence function and population health analytics
- Support culture change, behaviour and develop skills across the system to embed population health into mainstream decision making.

3.6 Pregnancy and postnatal healthcare.

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

Objectives:

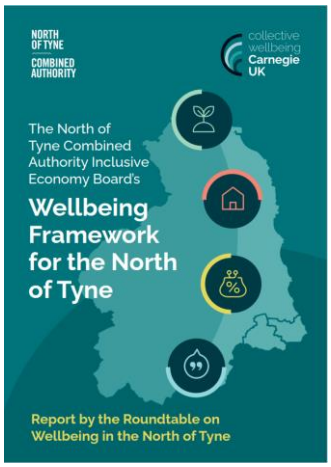
- Focusing on the Core20+ maternity framework, work with pregnant women to improve access and care for them and their support systems in the 20% most deprived deciles, with Black, Asian or Minority Ethnicities and/or with complex social factors.
- Anticipatory care for groups at highest risk of health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

3.7 Housing

We are working with partners to develop a plan, linked to the Healthier and Fairer programme, to effect positive change in relation to housing and its impact on health and wellbeing. An inaugural Housing, Health and Care Conference was held in May 2023. Based on feedback, the proposed that the key areas of work for this plan are:

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

3.8 Work and Health



The Department for Health and Social Care and Department for Work and Pensions Joint Work and Health Unit invited the North of Tyne Combined and Local Authorities to explore the development of a work and health strategy with the ICB. This focussed on tackling the health barriers people face in accessing and sustaining good work.

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

External mapping support from IPPR North identified:

- the opportunity of devolution to develop a shared programme to address inequalities in health and wellbeing outcomes
- Focusing on what works to inform the investment principles
- Co-designing a formal work and health system, connecting frontline services in our places
- Creating more 'good work' in the local public and private sector, including through anchor institutions to widen employment pathways
- Promote the principles of good work through initiatives such as the Better Health at Work Scheme and North of Tyne Combined Authority's Good Work Pledge
- Explore Community Wealth Building approaches to develop local supply chains, improve employment conditions, and increase the socially productive use of wealth and assets

3.9 **Carers and Volunteers –** Family and informal carers, including young carers, often experience significant challenges in accessing the right support for the person they care for and for themselves, and often experience a significant impact on their own health and wellbeing. We need to place carers at the centre of our work, including to improve their own health outcomes. Developing programmes for volunteers is a huge opportunity, building on the high levels of civic engagement across the North east and North Cumbria.

Objectives:

- Embed support for carers in all of our work programmes, improve access for support for carers, and consider the impact on carers in all of our assessments of service changes.
- Ensure the voice of carers is included in all of our engagement programmes.
- Maximise the opportunities to support volunteers and strengthen formal programmes for people who generously give their time and skills to support our services in voluntary roles.

4 Best Start in Life

4.1 Maternity and Neonatal

Partnership Working

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

Listening to women and families with compassion which promotes safer care - Listening, understanding, and acting improves maternity outcomes and experiences

Objectives

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

Supporting our workforce to develop their skills and capacity - good models of care can only be delivered by skilled teams with sufficient capacity.

Objectives

- Grow our workforce: sufficient staffing levels across the whole team supported undergraduate training and establishment.
- Value and retain our workforce and Invest in skills

Developing and sustaining a culture of safety to benefit everyone - a safety culture improves the experience of care for women and babies and supports staff.

Objectives

- Develop a positive safety culture: leaders understand 'how it feels to work here' and everyone takes responsibility for safer care.
- A compassionate approach to learning from safety incidents.
- Support and oversight: services receive support before serious problems arise, in line with the Perinatal Quality Surveillance Model.

Meeting standards that underpin our ambition - this plan does not introduce new standards but ensures that these enablers are consistently in place to support care.

Objectives

- Standards to ensure best practice: implementation of best practice such as Saving Babies Lives, and rationalisation of standards.
- Data to inform learning: improve the timeliness and accuracy of data and implement the Kirkup report to "read the signals."
- Make better use of digital technology: the implementation of electronic patient records supports flows of information and women to have digital access to their care records.

4.2 Children and Young People

Note: Children and Young People are included in all the service, enabler, and place plans in the later sections of this Plan.

Partnership Working

Our Child Health and Wellbeing Network provides a valued role in bringing together partners across the system to have a clear focus on children and young people's health and wellbeing. The wide reach of this work connects into other areas of governance both at place and in other regional work – for example in the Mental Health ICB workstream, and Local Authority LAC or First 1001 Days. Involvement of children, young people, and families, needs to take place in earnest, including media that is engaging to and initiatives addressing areas of importance to young people.

Mental Health and Wellbeing in Children and Young People and Mothers in the Perinatal and Maternal Health Phases - Mental Health was the highest priority following feedback, highlighted by professionals and the children and young people. **Note:** This section is aligned to the objective in **section 5**.

Objectives:

- Improve access to mental health support in line with the national ambition accessing NHS funded services.
- Reduce reliance on inpatient care, while improving the quality of inpatient care for those who need it.
- Skill children, young people, and the workforce to support mental health and resilience.

Long Term Conditions in Children and Young People - Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever-increasing demand for healthcare services.

Objectives:

- NHS England's Children and Young People's Transformation Programme relevant to long term conditions including Epilepsy, Diabetes, Asthma, Clinics for Excessive Weight, and Transitions.
- Integration Centre to drive innovations into our most disadvantaged communities including areas relevant to long term conditions.
- Deliver Core20PLUS5 work focused into these areas enhanced by the NENC local application of the framework.

Complex and vulnerable and special educational needs, health inequalities and the impact of Covid – The impact of Covid on our children and young people is well documented. Core20PLUS5 is a national approach to reduce health inequalities. Specific consideration should be taken for the inclusion of young carers, inclusion health groups and other socially excluded groups.

Objectives:

- Equitable recovery of elective waiting for children and young people
- Deliver the children and young people's Core20PLUS5 framework
- Meet the regulatory framework and good practice for SEND.

Best Start in Life, Pre-school Needs, and Perinatal - Best Start in Life Vision for 1001 Critical Days.

Objectives:

- Connect especially with place and local authority partners.
- Initiatives that skill children, young people, and the workforce to support best start in life, preschool needs, and perinatal mental health.

5 Improving Health and Care Services

5.1 Overview

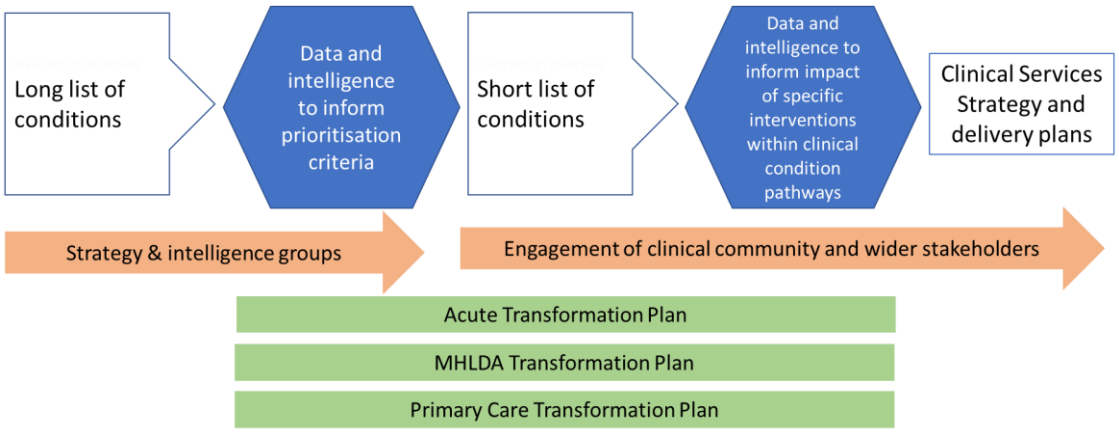
Health and care services in the North East and North Cumbria have a strong foundation to build on. Our integrated care strategy included the key goal to ensure that our providers in our Integrated Care System are rated as 'good' or 'outstanding' by the Care Quality Commission (CQC). To support our work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

Strategic Principles

- Shift towards self-management and care closer to or in the home
- Better care co-ordination and personalisation
- Step change in prevention and early intervention
- Evidence base interventions; reduction in unwarranted variation
- Improved sustainability of secondary and tertiary care; hub and spoke models, using technology and pathways to keep care as local as possible but not at expense of best possible outcome
- More holistic care towards end of life
- More timely access
- Fairer outcomes contribution reducing health care inequalities
- Improving the local integration of services with partners

The framework above will also support the development of our **Clinical Services Plan** led by the **Provider Collaborative** ICB Executive Medical Director with extensive clinical stakeholder involvement. This work is at an early stage.

Data, intelligence, and insight from system clinical engagement will be used to determine some initial, condition specific priorities for the clinical strategy. The approach is underpinned by population health data, to identify interventions that have the greatest impact on healthy life expectancy and reducing health inequalities.



The ICB will work in partnership with provider collaboratives and clinical networks to ensure sustainable services, maximising opportunities to develop our our highly skilled and committed workforce. The clinical services strategy will support our clinical community in understanding the impact they can have on ensuring the best start in life, healthier lives, fairer outcomes, and ultimately improving health and care services for the people of the North East and North Cumbria.

5.2 Provider Collaboratives

North East and North Cumbria
Primary Care Collaborative

We are working with partners to develop a Primary Care Collaborative covering General Practice, Pharmacy, Optometry and Dentistry. The proposed functions are:

- relationships across all four primary care contractor groups.
- representative voice into the Integrated Care System.
- co-design the Primary Care Strategy as an equal partner.
- collaborate across the North East and North Cumbria where beneficial.
- work with and influence other provider and clinical networks.
- Fuller Stocktake delivery and the transformation and stability of primary care.

Mental Health, Learning Disability and Autism Provider Collaborative

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

- Children and Young People Mental Health inpatient services

- Adult Low and Medium Secure Services
- Adult Eating Disorder Services.

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

North East and North Cumbria Provider Collaborative

The Collaborative was formed in 2021 to create a vehicle for foundation trusts to collaborate to achieve better outcomes than each provider could deliver on their own. Th Collaborative contributes to the delivery of the NENC Integrated Care Strategy, in particular its long-term goal of 'Better Health and Care Services' by:

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

The Collaborative is a key point of collective leadership and has potential to develop further as an important part of our governance structures.

NENC Provider Collaborative Members:

- Northumbria Healthcare NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust

- South Tyneside and Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

- North Cumbria Integrated Care NHS Foundation Trust

- North East Ambulance Service NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust

5.3 Ageing Well Service Plan

Partnership Working:

The Ageing Well programme operates at a system-level but driven by place-based partnerships. Our approach is to foster real change, supporting delivery through relationships, collaboration and sharing of best practice.

Urgent Community Response - Providing urgent care to people in their own homes within two-hours if their health suddenly deteriorates.

Objectives:

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

Proactive Care (Formally known as Anticipatory Care) – proactive, personalised care and support for people living with frailty and/or multiple long-term conditions.

Objective: Improve support for Integrated Neighbourhood Teams (INTs) to implement the national Proactive Care model.

Enhanced Health in Care Homes (EHiCH) - Enabling proactive care and support to residents and their families.

Objectives:

- Support Integrated Neighbourhood Teams on the EHiCH model.
- Reduce variation in EHiCH outcomes across the ICB.

Community Health Services Digital - Driving forward digital transformation with community health services to improve patient care.

Objectives

- Improve the use and quality of data within the Community Service Data Set (CSDS)
- Increase the number of community providers utilising the Great North Care Record (GNCR) / Shared Care Record
- Increase learning and sharing of digitally enabled community care and support across the ICB

Supporting the workforce - the Enhanced Care for Older People (EnCOP) workforce competency framework

Objective: Increase the uptake and utilisation of EnCoP as a workforce development programme across the ICB.

5.4 Autism & Neurodevelopmental Service Plan

Note: This section is interdependent with the **Learning Disability** section 5.6.

Partnership Working: ICB and partners are developing a broad and inclusive Mental Health, Learning Disability and Autism Collaborative. Inclusive groups will be codesigned and form part of the overall governance structure for the learning disability and autism programme. There will be a separate group focused on autism.

Improved autism and neurodevelopmental pathways - Commissioners, providers, and delivery partners across all pathways will listen and learn from people who have a lived experience and their families and supporters.

Objectives

- Improve our early help and support offer so that people do not have a diagnosis to receive help and support.
- Work with partners and lived experience experts to design a new 'needs led' pathway to help support children, young people, adults, parents, and carers where a person has a need associated with autism or a neurodevelopmental difference
- Improve the diagnostic element of the service to ensure people do not have to undergo unnecessary assessments over a long period of time
- Improve our post diagnostic support offer

Improving outcomes for autistic people and people with neurodiversity - by addressing stigma, enhancing access to support, improving education and employment opportunities, fostering acceptance, and providing appropriate healthcare, we can work towards a more equitable future.

Objectives

- Tackling health and care inequalities for autistic people
- Right support in the community and supporting people in inpatient care

5.5 Cancer Service Plan

Partnership Working

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

Early Diagnosis - Increase cancers diagnosed at an early stage.

Objectives:

- Improve timely presentation and access to Primary Care, specifically target 20% most deprived and other communities of health inequality.
- Continue to support both national and local innovation programmes.
- Targeted Lung Health Checks (TLHC rolled out across the region.
- Delivery of expansion plans for TLHCs in 2023 – 2027.
- Ensure uptake of lung health checks is above 50%
- Continue to support the clinical trial of NHS Galleri technology (specifically targeting most deprived 20%)
- Support early diagnosis, non specific symptoms pathways, and the extension of the NHS bowel screening programme to 54-year-olds.

Faster Diagnosis Standard and Operational Performance - Faster Diagnosis standard and reducing the number of the longest waiting patients on pathways.

Objectives:

- Statutory cancer waiting time standards, improving year on year.
- Maintain priority pathway changes for lower GI, skin (tele-dermatology) and prostate cancer.
- Place based primary care cancer leads to promote and improve the pathways locally for people presenting with non-specific symptoms.
- Combined pathway for upper and lower Gastro-intestinal cancers.
- Robotic data processes to improve data quality and reporting.
- Rollout of the Digital patient tracking list dashboard.
- Capacity and demand in patient pathways against waiting times.

Treatment variation and Personalised Care - Improving the quality and uptake of personalised care, identify gaps in access and address health inequalities.

Objectives:

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

Improving Experience of Care - capacity within the workforce and involving patients in developing services is key to a good experience of care.

Objectives:

- Community engagement structure to enable Coproduction throughout
- Use insight and feedback to coproduced (with people with relevant lived experience and staff) quality improvement action plans.
- Enable skill mix and maximise the productivity of the current workforce
- Ensure supply, recruitment and retention and upskilling of the Cancer Clinical Nurse Specialist workforce.
- Work with national and regional teams to address the need to expand the cancer workforce, particularly in non-surgical oncology.

5.6 Elective Care & Diagnostics Service Plan

Partnership Working:

The Strategic Elective Care Board (SECB) has senior representation from the Provider Collaborative, Primary and Secondary Care, the ICB, NHSE, the Northern Cancer Alliance and the Diagnostic Programme Board. The SECB feeds into the Provider Leadership Board which is made up of Chief Executives of all 11 FTs in the system including Mental Health and Ambulance providers. Chief Operating Officers from the 8 acute Trusts also meet regularly with specific focus on Elective Recovery.

Elimination of long waits and reduction in the overall size of the waiting list - Achieve national ambitions and constitutional.

Objectives

- To eliminate long waits for elective care, achieving the national objectives for 23/24 and future years
- Eliminate waits of over 65 weeks by March 2024 except when patients choose to wait longer and complex spinal surgery (with reduced waits)
- Deliver the system specific value weighted activity target as agreed through the operational planning process
- Choice at point of referral and at subsequent points in the pathway
- To support Trusts with the greatest challenges
- Digital solutions that support patient choice and elective recovery.

Clinical Transformation and reduced unwarranted variation - Excellence in Basics programme to optimise capacity with potential for centres of excellence.

Objectives:

- To achieve national targets for productivity and efficiency
- Deliver Right Procedure, Right Place
- Reduction in outpatient follow-up in line with the national ambition

Specialty Based Development Work - Specialty-based approach to improvement harnessing shared learning through the establishment of Clinical Alliances.

Objectives

- Implement the high volume, low complexity best practice pathways
- To have choice for patients where appropriate
- To have the right clinical workforce

Diagnostic programme - Reduce variation and therefore increasing equity of access to services in all geographical locations. Focusing on areas of greatest need using a wide range of metrics including health inequalities.

Objectives:

- Increase capacity to meet demand, delivering activity to meet elective and cancer backlogs as well as the diagnostic waiting time ambition.
- Diagnostic workforce supply, retention, skill mix and ways of working.
- Network maturity in Imaging, Pathology and Endoscopy.
- Digital diagnostic roadmap, developing interoperability.

5.7 Learning Disabilities Service Plan

Partnership Working

We are developing a broad and inclusive Mental Health, Learning Disability and Autism Collaborative. We will improve quality by giving people, their families and supporters a strong voice in through co-production. We will keep people at the centre of their own care and treatment. **Note**: This section is interdependent with the Autistic People section 5.3.

Reduce reliance on inpatient care - reducing reliance on inpatient care and developing the housing care and support (based on each person's needs and preferences) to enable people to live healthy and positive lives in the community.

Objectives:

- Increase community-based support options.
- Dynamic Support Registers at Place and community model investment.
- Appropriate Hospital length of stay reflecting the treatment needed.
- Discharge planning begins on admission using tools such as the 12 Point Discharge Plan.
- Reduce the number of patients in long term segregation and seclusion through application of the Independent C(E)TR process.

Improving the quality of care and support - Ensure people receive high-quality care and support that respects their rights, promotes their well-being, and enables them to lead fulfilling lives as valued members of society.

Objectives:

- Host commissioner oversight visits to all specialist inpatient services.
- Ensure the quality of advocacy is improved.
- Ensure lessons from the Whorlton Hall Safeguarding Adults Review.

Improving health outcomes - Making reasonable adjustments standard across services, carrying out more annual health checks and vaccinations, and adopting the learning from Learning Disabilities Mortality Reviews (LeDeR.

Objectives:

- Use learning from LeDeR to prevent avoidable deaths and ill health.
- Influenza and Covid -19 vaccinations to prevent serious illness.
- Ensure cancer pathways are reasonably adjusted.
- Ensure treatment for long term conditions is reasonably adjusted.

5.8 Mental Health Plan

Partnership Working:

Mental Health, Learning Disabilities and Autism Sub-Committee - The sub-committee provides leadership for the delivery and commissioning of NHS mental health and learning disability services across the life course, including Children, Young People, Adults and Older adults. It is a decision-making body with executive representation and delegated authority from the ICB.

North and South Partnerships - Our Partnership Boards are responsible for providing leadership across their allocated geographies of NENC ICB, which are co-terminus with CNTW and TEWV.

Place based Partnerships - Our place-based partnerships form a link between places and whole system.

Community Transformation and Improving Access to Services - integrated primary and community care for adults and older adults with severe mental illnesses (SMI) and more common mental health problems, such as anxiety and depression.

Objectives:

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

Preventing Suicide- increasing knowledge and skills to include prevention and work with partners including local authority public health teams.

Objective

- Halve the difference in the suicide rate between our ICP and England in 2019/2021 (three year rolling average) by 2029/31.
- Improve access to services for people who express suicidal ideation.
- Develop and deliver public information campaigns to raise awareness of ways to support people experiencing mental health difficulties.
- Use data to inform targeted interventions to prevent suicide clusters.

Transformed Neurodevelopmental Pathways - Children, young people and Adults wait too long to be assessed in neurodevelopmental diagnostic pathways, delays to assessment can delay the implementation of Education, Health, and Care Plans.

Objectives

- Improve our early help and support offer so that people do not have to be diagnosed with a neurodevelopmental disorder to receive help.
- Work together to design a new 'needs led' pathway to help support children, young people, adults, parents, and carers where a person has a need associated with a neurodevelopmental difference.
- Improve the diagnostic element so people do not have unnecessary assessments over an elongated period to receive a diagnosis.
- Improve our post diagnostic support offer.

Children and Young Peoples' Mental Health- access closer to home, reduce unnecessary delays, and specialist mental health care based young people's needs.

Objectives

- Coverage of mental health support teams for schools as national funding / workforce development allows.
- Work in partnership to deliver new models of care.
- Commission early-intervention "getting help" services particularly those with reach into underserved communities.
- Seamless working between primary care, paediatric inpatient units, and mental health providers to improve the eating disorder pathways.
- Crisis/intensive home treatment teams to minimise inpatient admissions, but where necessary, beds as near to home as possible.
- Increase access to perinatal services and move towards offering 2-year support across as investment and workforce challenges allow.

Developing safe, therapeutic, rights-based approach to in-patient care - co-produce the model for trauma and autism informed therapeutic inpatient care.

Objectives

- A culture within inpatient care that is safe, personalised and enables patients and staff to flourish.
- Oversight and support structure that identifies issues early. Challenged services will have timely, effective, and coordinated recovery support.
- Line of sight into the mental health inpatient pathways with the same parity as physical health.
- Eliminate out of area admissions in mental health pathways.

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

Partnership Working:

Palliative and End of Life Care is part of clinical subject areas and workstreams such as Primary Care and Urgent and Emergency Care. The PEoLC Network reports to the National PEoLC Team via the North East and Yorkshire PEoLC Strategic Clinical Network (SCN) and sits within the Northern Cancer Alliance. Further work is required to ensure that this is the best governance framework for this NENC Network.

Improving access - remove the barriers preventing access to PEoLC services.

Objectives:

- Increase the number of patients captured on primary care PEoLC registers including children and young people
- 24/7 generalist PEoLC services provided across all places
- 24/7 remote access to specialist palliative care (SPC) advice for staff and carers across all places
- 7-day face to face SPC services provided across all places including the use of Virtual Wards or other models for PEoLC

Improving Quality – using data to address variation in PEoLC service provision.

Objectives

- Improve the quality of services for locally identified priority groups
- A confident workforce across statutory and VCSE sectors with the support and capability to deliver high quality PEoLC.
- Personalised and community focused approaches to improve the PEoLC experience for patients and carers (including Social Prescribing).
- High quality PEoLC for all, irrespective of age, condition, or diagnosis.

Improving Sustainability - patients of all-ages will be able to access a range of PEoLC services, which are equitable and meet diverse needs.

Objectives

- All-age PEoLC services that are sustainably commissioned.
- PEoLC services for children and young people including in transition.
- Increase the use of Virtual Wards for this population
- Ensure commissioning and clinical leadership at place for PEoLC.

5.10 Personalised Care Plan

Partnership Working:

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

Embed personalised care approaches across all workstreams – Harness the universal approach to personalised care throughout all workstreams.

Objectives:

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

Support PCNs to recruit Additional Roles Reimbursement Scheme (ARRS) - social prescribing link workers, care co-ordinators and health and wellbeing coaches are key to the NHS Long Term Plan commitments on personalised care.

Objectives

- Ensure all PCNs have social prescribing link workers.
- Expansion of ARRS roles, for example in perinatal mental health and for autistic people.

Maternity - ensure all women have personalised and safe care through a personalised care plan and are supported to make informed choices.

Objectives

- Support LMNS colleagues in embedding Personalised Care, in line with the Three-Year Delivery Plan for Maternity and Neonatal Services.

5.11 Pharmacy and Medicine

Partnership Working

Medicines are the most common and most evidence-based intervention in healthcare. Managing the use medicines well is a statutory responsibility of the ICB

and contributes to the goals within its Integrated Care Strategy. The ICB spends £560 million on prescribing in primary care each year, nearly 10% of the ICB budget.

Decreasing Antibiotic Prescribing Report implementation - The reduction and appropriate use of Antimicrobial Resistance (AMR).

Objectives

- Delivery of bespoke practice level AMR reports to every practice in the ICB every 2-months for three years
- Practice engagement with the reports to affect behavioural change.
- A reduction in antibiotic prescribing and variation across the region

Increasing capacity for Point of Care (POC) Testing - to support antimicrobial stewardship in primary care

Objectives

- Resources for POC testing capacity and support to effectively utilise POC testing in primary care.
- Support stakeholders to undertake POC testing within the pathways
- Evaluate impact of the pathways

Point of care testing service in community pharmacies.

Objectives:

- Increase use of community pharmacies to manage common infections, supported by pathways, point of care testing and supply of medicines.

Proactive medicines optimisation system across all GP practices

Objectives:

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

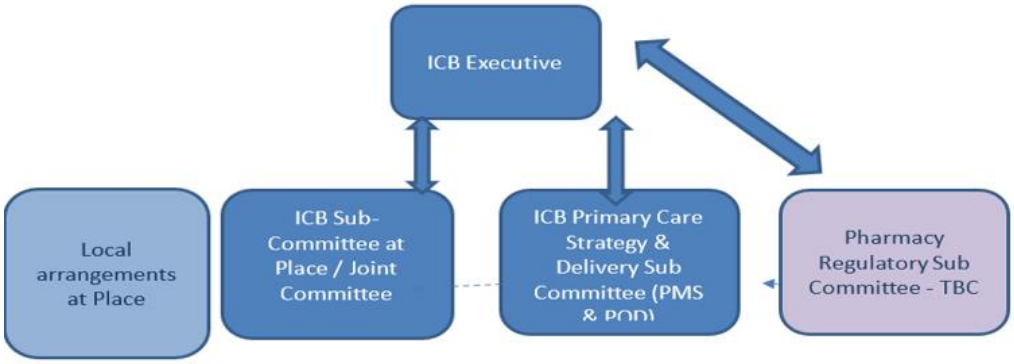
Deliver the national programme to **reduce over medication of people with a learning disability (STOMP/STAMP)**

Objectives:

- Recruit Consultant Pharmacist in employed to deliver change ICB wide.
- Reduction in inappropriate prescribing across the ICB.
- Education and support to address over and inappropriate prescribing for children and young people with a learning disability.
- Comprehensive ICB plans to address STOMP/STAMP.

5.12 Primary Care

Partnership Working - the chart below summarises the governance arrangements supporting Primary Care, which continue to be under review.



Access - Eliminate the challenge to access appointments.

Objectives:

- Ensure equitable and good access to general practice services to meet future demand.

Integrated Neighbourhood Teams - The Fuller Stocktake vision for integrating primary care, bringing together teams to improve care for whole populations.

Objectives:

- Establish integrated neighbourhood teams to cover the full population.
- Neighbourhood services that address inequalities and support Core20PLUS5 populations.
- Integrated neighbourhood teams with active all community partners.
- The collaborative provision of services leading to improved patient journeys, joined up systems, and patient centred personalised care

Stability & Resilience - Improve the delivery of general practice services and understand how to deal with the growing patient demand and complexity.

Objectives:

- A stable and resilient General Practice
- Provider change with minimum negative impact for patients
- Primary care voice is represented at place and system level
- Establish a NENC ICB wide Primary Care Provider Collaborative

Workforce / Estates / Digital - There is a need to upgrade Practice telephony to support patient communication with Practices.

Objectives:

- Sufficient and diverse workforce that provide high quality services
- A fit for purpose estate that meets the needs of practice and PCNs
- IT solutions that support the transformation including telephony systems

Pharmacy / Optometry / Dentistry – From April 2023, the ICB became responsible for the pharmacy, optometry and dental services enabling partnership working.

Objectives:

- Ensure pharmacy, optometry, and dental responsibility transfer well.
- Support pharmacy, optometry, and dentistry transformation
- Provision of high quality, accessible services to all, improving access.

5.13 Safeguarding and Cared for Children (including Care Leavers)

Partnership Working:

Each priority will be led by a senior NHS safeguarding lead (denoted as workstreams), will be reviewed with oversight from the Integrated Care System Health Safeguarding Executive, and updated in line with national guidance.

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

Objectives:

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

Transitional Safeguarding - Investing in support to address harm and its impacts at this life stage can help reduce the need for more costly intervention later in life.

Objectives

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

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

Objective

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

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

Objectives:

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

5.14 Specialised Commissioning Plan

Partnership Working: Specialised Commissioning

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

Ensure the ICB is ready for the delegation of specialised commissioning from April 2024 - delegation of specialised commissioning is anticipated from April 2024.

Objectives:

- Model for how specialised commissioning will operate from April 2024.
- Conduct due diligence on services due to transfer to the ICB.

Transform non-surgical oncology service delivery - Treatments and pathways across radiotherapy, genomics and chemotherapy continue to advance.

Objectives:

- Provide long term sustainability of the service (workforce and capacity)
- Reduce clinical risk and variation.
- Contracting and finance model to facilitate a new commissioning model.
- Improve digital connectivity across provider systems.

Transform Gynaecology Oncology service provision

Objectives:

- Clinical model making to reduce variation and fragmentation.
- Improve coordination and management of patients across the system
- Provide long term sustainability of the service (workforce and capacity.
- Commissioning model with contracting and finance agreements in place.

Transform Neuro-rehabilitation services - The pathway spans NHS England and ICB commissioned services providing an opportunity for joint-working.

Objectives:

- Improve patient flow in and out of in-patient provision.
- Ensure appropriate and timely referrals into in-patient provision.
- Ensure appropriate pathways and care closest to home where possible.
- Improve data reporting and review in line with targets.

5.15 Urgent & Emergency Care Service Plan

Partnership Working:

System leadership is provided through the Urgent and Emergency Care (UEC) Network Board. Its membership includes Trust Chief Executives who chair the five Local Accident and Emergency Delivery Boards (LADBs).

Increasing urgent and emergency care capacity - Reduce bed occupancy rates, increase the number of staffed hospital beds, and increase ambulance capacity.

Objectives:

- Reducing adult general and acute bed occupancy to below 92%.
- Increasing ambulance capacity through single points of access for paramedics for specific services; increasing clinical assessment in ambulance control centres and mental health expertise
- Eliminate ambulance handovers over 59 minutes
- Improved ambulance response times for Category 2 incidents

Improving Discharge - Once people no longer need hospital care, being at home or in a community setting is the best place for them to continue recovery.

Objectives:

- Joint discharge processes building on Home First, Discharge to assess and Transfer of Care Hubs.
- Digital solutions to ensure accuracy and access to data including 'live' discharge dashboards.
- Implement a stronger approach to 'own' medically optimised lists
- Scaling Up Intermediate Care
- Scaling Up Social Care Services, learning from Winter 2022/23
- Review of neuro rehabilitation

Expanding care outside hospital - Care closer to, or at, home to avoid the deconditioning and prolonged recovery that can accompany a hospital stay.

Objectives:

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

Making It Easier to Access the Right Care - Ensure that the urgent and emergency care system is responsive to the needs of patients.

Objectives:

- Further expansion of 111 online and clinical assessment models.
- Increase direct booking into primary care.
- Improve access for people needing mental health support including 24/7 urgent mental health helplines accessible via the 111.
- Alternative offers to 999 and A&E for urgent care.
- Implement 24/7 co-located urgent treatment centres (UTC) in emergency departments maximising the "see and treat" approach.
- Expand Same day Emergency Care services (SDEC) to at least 12 hours a day, 7 days a week
- Greater integration with GP out of hours services and greater clinical support for community-based teams.

6 Our Enablers

6.1 Skilled, Sufficient and Empowered Workforce

Note: This section will be reviewed when the National People Plan is published.

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

Workforce supply across the system, including a key focus on retention - Covid recovery depends on a healthy, supported and engaged workforce.

Objectives

- Ensure safe staffing levels across all our services and sectors.
- Widen participation to allow people to join the NHS and Social Care.
- Work effectively with Higher Educational Institutions.
- Campaign highlighting opportunities of working in health and social care.

Workforce health and wellbeing across the system - There is wide variation in staff experience in our system, with examples of good practice to build on.

Objectives:

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

System Leadership and Talent - integration is dependent on how we work and learn together. Good leadership is at the centre of our model for ensuring that we work beyond organisational and professional boundaries.

Objectives

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

Equality, Diversity, and Inclusion (EDI) - a long-term plan to become the most equitable and inclusive place to work in the health and social care sector.

Objectives:

- Improved EDI capability and knowledge.
- Legal compliance and exceeding expectations.
- Listen to people to build psychological safety, improve their lived experience, to create the best workplace environment.

Retention - Support offers so we are an employer of choice. Listening to our people we will review human resources pathways and induction, so staff have the best start.

Objectives

- Valuing our workforce, enabling them to make their best contribution.
- Career structures across and between health and social care, removing barriers preventing people to entering the workforce.

New Ways of Working - adapt to technological advances and role development.

Objective:

Review role functions to allow for different workforce models, and as technology progresses, including incorporating artificial intelligence.

The development of the learning and improvement community - Our aim is to be **'the best at getting better',** embedding learning and improvement at every layer.

Objectives

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

6.2 Working Together at Place and in Neighbourhoods

Partnership Working at Place

We will further strengthen our partnerships with governance and decision arrangements. The context for place-based partnerships includes:

- The preservation of well-established place-based working arrangements involving partners from health, local authorities and the voluntary, community and social enterprise (VCSE) sectors.
- Place-based partnerships are not statutory bodies. The 2022 Health and Care Act did not create a legal requirement for Place-Based Partnerships. It does allow for ICBs to delegate some functions and budgets to local committees as part of place-based partnerships.

Place-based partnerships focus on joining up and co-ordinating services, addressing the social and economic factors that influence health and wellbeing, and supporting the quality and sustainability of local services. Priorities vary depending on the vision and goals agreed locally through Health and Wellbeing Boards. Place-based arrangements will fulfil three interdependent functions:

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

Strengthening our Partnerships - Timeline

From April 2023:

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

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

6.3 Involving People to Co-produce the Best Solutions

Partnership Working

Triangulation of intelligence and stakeholder feedback is a key enabler to delivering our commitments. This is coupled with proactive engagement to gain the very best

understanding of service users, partners, and stakeholders. We cultivate partnership working across our Integrated Care Partnership and support our VCSE sector to flourish and build relationships at system and place.

Raise the profile of involvement across the ICB and ICP

Objectives

- Bring together involvement, building on existing assets and strengths.
- Forward plan for involvement and evaluating impact linking with community networks and research organisations.
- Priorities identified with our communities and partners.
- Develop a formal subcommittee of the Quality and Safety Committee.

Develop ways to **listen**, with mechanisms to collect **lived experience.**

Objectives:

- Establish a Citizens Panel to support engagement
- Involvement toolkit to support engagement across the ICB
- Demonstrate impact of the lived experience stories

Deliver a programme of **communications** to establish strong relationships with **internal and external stakeholders**.

Objectives

- Campaign programmes on access, prevention, and population health.
- Identity for the Partnership, ICB and 'Better health and wellbeing for all'.

Model for **communications delivery** for the organisation and system

Objectives

- Delivery unit with networks and communications system leadership
- Creative hub to deliver digital communications and campaigns
- Interactive web and digital presence for the Partnership and ICB

Effective **partnership** development.

Objectives

- Support the Strategic ICP, Area ICPs and system leadership groups.
- Networks with local authority professional forums
- Engagement mechanisms with the independent care provider sector.
- Support for health initiatives with the Combined and Local Authorities.

Deliver effective **stakeholder management**.

Objectives

- Stakeholder feedback processes including complaints and compliments, triangulating and analysing trends.
- Work with Scrutiny Committees and Health and Wellbeing Boards.
- Support the VCSE sector, ensuring their voice is heard.

6.4 Best use of Resources and Protecting the Environment

Financial Plan

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

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

The national funding formula considers the North East and North Cumbria to be over-funded, so funding growth will be lower than other areas. Convergence also reduces growth funding on a glide path to a level of funding that is reduced post-covid. Our priority now is to develop a sustainable medium and long-term financial recovery plan over the next three to five years.

Financial Sustainability - Living Within our Means

Objectives

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

Financial Fairness - Investing in Health Equity

Objectives

- Allocating resources within the ICB to address inequalities
- Allocating resources within places to address inequalities
- Exceeding national aim to spend 1% of the ICB budget on prevention
- Directing discretionary resources where they can have biggest impact

Priority 3 - Allocative Efficiency - Allocating resources effectively

Objectives

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

Priority 4 - Maximising Value with Partners

Objectives

- Aligned investments with social care at place, and to improve the sustainability of the care sector.
- Work with public health teams to ensure best value from the "1%" spend on prevention and targeted in the places to have the most impact.
- Work with the 3rd sector to develop framework arrangements to deliver best value from the sector in a financially sustainable way.

Estates Service Plan

Partnership Working: Local Place based Strategic Estate Groups (SEGs) support the delivery of the ICB Estates Strategy. These groups include representation from: place based ICB teams, local Authorities, acute and mental health trusts, community services as well as wider estates partners NHS Property Services and Community Health Partnerships. All PCNs across the ICB supported the development of place-based estate plans.

Work with the **Provider Collaborative to prioritise and optimise our investment in estates** across health care services **is under development.**

Appropriate and integrated workplace - staff working in a more agile way.

Objectives:

- A range of workspaces with a high-quality and inclusive environment
- Create financial savings that can be recycled back into other services.

Reduction in the void budget – Review vacant estate to ensure efficiencies can be delivered (where appropriate) and space can be used to support frontline care. Our objective is to reduce cost of void estate by 1% per annum

6.5 Innovating with Improved Technology, Equipment and Estates

Research and Innovation

Partnership Working: In November 2022, the ICB organised a regional Research & Innovation Partnerships Forum. The forum brought together leadership from all six universities in the region, the foundation trusts, research active primary care providers, local authorities, voluntary sector organisations, regionally based National Institute for Health and Care Research (NIHR) bodies and those involved in regional economic development initiatives and set the framework for our priorities.

Increase **inward investment** in research funding and innovation

Objectives

- Regional, national, and international recognition of our research and innovation assets
- Support the development of new collaborations
- Increase overall research funding and innovation investment

Make research evidence **more accessible to decision makers** and increase research and innovation **directly relevant to the needs of the system**.

Objectives:

- Optimise research resources across the system
- Develop an inclusive research culture reflective of the needs of the full diversity of the North East & North Cumbria population
- Improve mechanisms for research dissemination and support

Stimulate a **culture of innovation** across the system and sectors

Objectives

- Enhance support for both early-stage innovation and for the adoption of evidence backed solutions
- Encourage collaborative innovation and knowledge sharing
- Concentrate efforts on key ICB priorities and system wide unmet needs
- Showcase and promote promising innovation

Digital Enabler Plan

Partnership Working - our governance for the Digital Care Programme include our Digital Planning Council, supported by the Digital Strategy and Innovation Group and the Digital Delivery Group. The partnership structures are supported by the ICB Digital Directorate and are connected to each of our workstreams as an enabling function.

Digital First Primary Care: Make sure the right digital tools are available to support Practices and PCNs to adapt to demand and capacity challenges.

Objectives

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

Supporting System Recovery: Through the expansion and adoption of digital, data and technology solutions and services, information sharing and interoperability.

Objectives

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

Digitising Social Care (adult care homes and domiciliary care) – support the expanded use of digital social care records within adult social care.

Objectives

- Digital social care records in care homes and domiciliary care.
- Network of digital social care champions to build on and promote success amongst the harder to reach care providers.
- Identify resources for future care technology.
- Communication plan, to promote the opportunities and achievements.

Frontline Digitisation - Aim to ensure every trust has an electronic patient record system in place meeting key capabilities by March 2026.

Objectives

- To level up digital maturity of Electronic Patient Records (EPRs) across the ICS in secondary care provider organisations.
- Achieve the Minimum Viable Product (MVP) functionality for every EPR, as outlined by NHS England, across all Trusts.

Data Driven Decision Capabilities - To have the very best Business Intelligence (BI) service in the NHS, exploiting the digital and data assets available.

Objectives

- Intelligence functionality and population health management analytics.
- Longitudinal dataset (primary, secondary, mental health, social care, community data, blue light services)
- Increase access to reports & insight using self-service technologies
- Predictive analytics to move from a model of Hindsight (past) and Insight (present) reporting to Foresight (future)

Digital Inclusion - Aim to address and respond to mitigating against digital inequalities, for the residents with fair access for all.

Objectives

- Understand the scale of the problems and contributing factors.
- Develop and agree NENC ICS digital inclusion and strategy.
- Enhance access to services through digital tools, options, and resources.

7 Place

Introduction

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

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

Place and North East and North Cumbria wide Plans

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

Focus of Place Plans

Place plans cover immediate priorities for 2023/24, and longer-term transformation and development plans until 2028/29. Place plans respond to local context and the needs of the area's population. The Plans also all cover consistent themes from the ICP strategy that are best delivered through working at Place. These areas of focus are summarised below, noting that the way they are delivered will appropriately vary between and across Places.

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

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

Examples:

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

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

Examples:

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

Improving Health and Care Services – All Place Plans support the delivery of the North East and North Cumbria wide service Plans; areas of focus include:

Integrated Neighbourhood Teams, Primary Care and Community Services

Examples

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

Urgent and Emergency Care

Examples

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

Mental Health, Learning Disability and Autistic People

Examples

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

Enabling Plans – All Place Plans address each of the enabling Plans in section 6. Working together to strengthen our neighbourhoods and places is a particular focus.

Examples

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

8 Delivering the Joint Forward Plan

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

Timetable and Engagement

NHE England requires ICBs, and their partner NHS trusts to publish their first Joint Forward Plan (JFP) by 30 June 2023 and share the plans with their Integrated Care Partnership (ICP) and Health and Well-being Boards. In March 2023, the ICB set out its approach to use the Joint Forward Plan as its delivery plan for the Integrated Care Strategy, and to work with its existing strategic programme and place-based teams and leads for the key enabling strategies to develop the plan content.

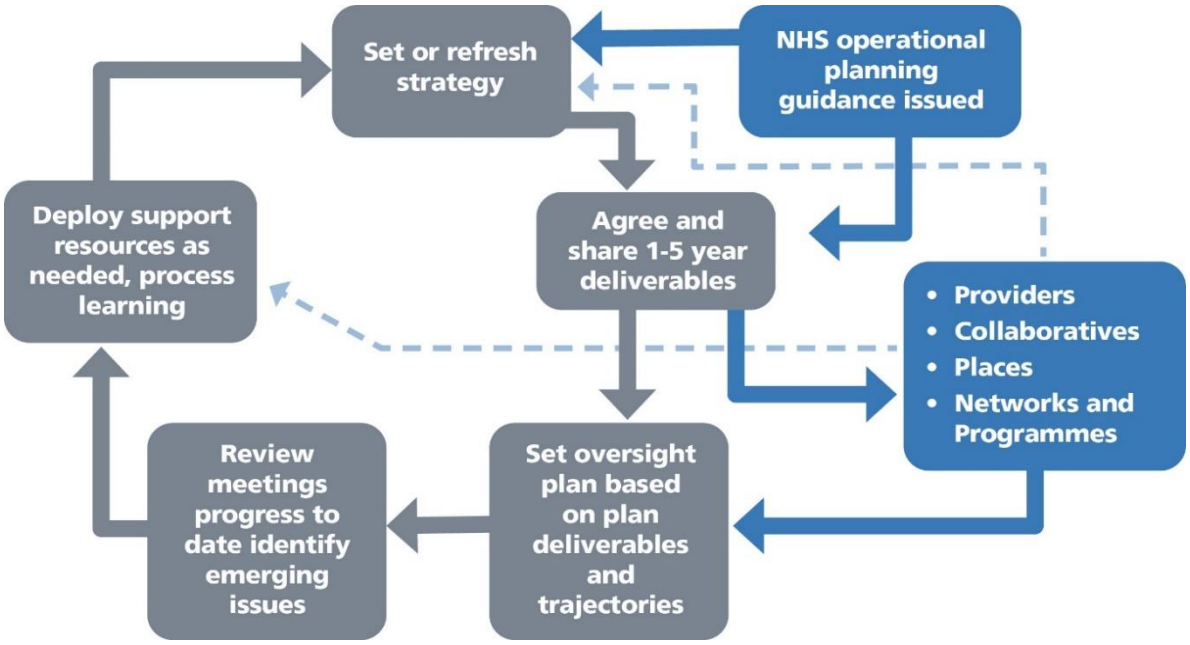
Collectively the ICP ensured a broad engagement approach to the development of the ICP Strategy 'Better Health and Wellbeing for all'. This included publishing an early draft to support stakeholder feedback. To maintain the commitment to stakeholder engagement, during July – August, stakeholders will be encouraged to provide feedback on the JFP and the associated action plans. This will specifically include the Integrated Care Partnership, NHS Trusts, Health Watch and Health and Wellbeing Boards. Endorsement of the Plan will be requested from those stakeholders as appropriate.

A revised version of the Joint Forward plan will be published in September 2023 Subsequently, ICBs and their partner NHS Trusts will be required to publish an annual update of the Joint Forward Plan, beginning in March 2024.

Deployment

Working with our partners, the ICB has developed a robust framework to deliver the Integrated Care Strategy set by the Integrated Care Partnership and this Joint

Forward Plan. The ICB Oversight Framework articulates the ICB Cycle of Business, as set out in the figure below:



Programme support

Each discrete plan that makes up the Joint Forward Plan will have a:

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

Governance

In line with the national guidance the approach to the final approval of the Joint Forward Plan will be agreed by the ICB and partner NHS Trusts. The ICB will then receive regular reports on the progress in completing the actions identified within the plans. This will take the form of a 'strategy deployment milestone tracker' which will come to the Board twice each year. The Executive Committee has delegated responsibility for the delivery of plans and will ensure that it has a formal reporting line from all the groups with responsibility of a section of the Joint Forward Plan.

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

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

Using data and insight

The ICB is working with partners to ensure we maximise our capability to use data to drive our decision making and plans in line with the furtherance of our integrated care strategy. During 2023/24 we will reform our business intelligence and population health management capacity and capability to:

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

Refining the ICB's operating model

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

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