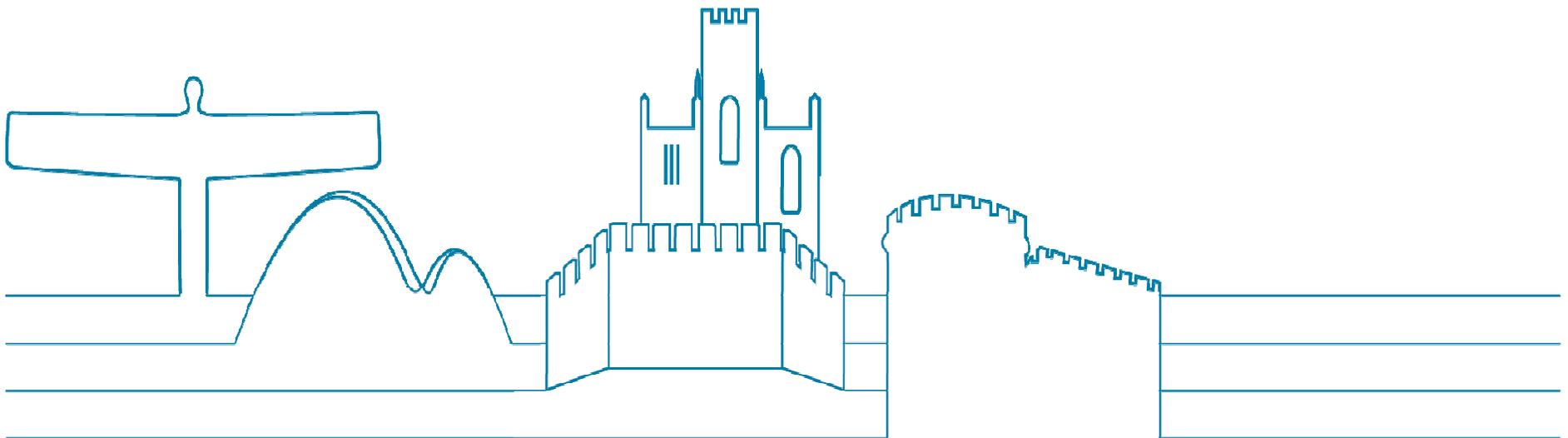




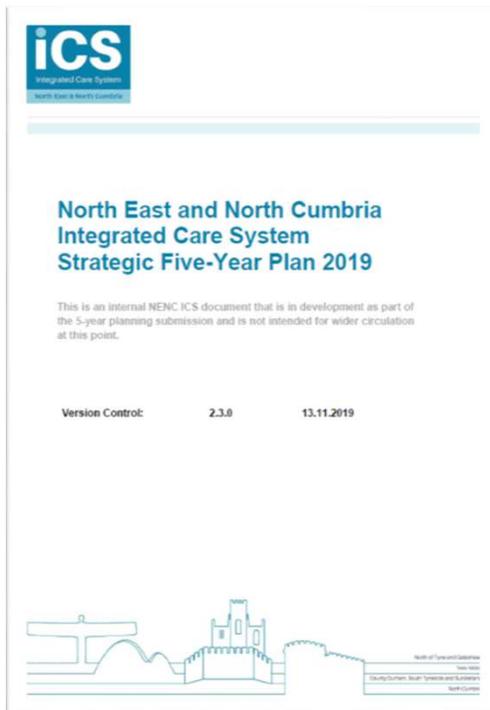
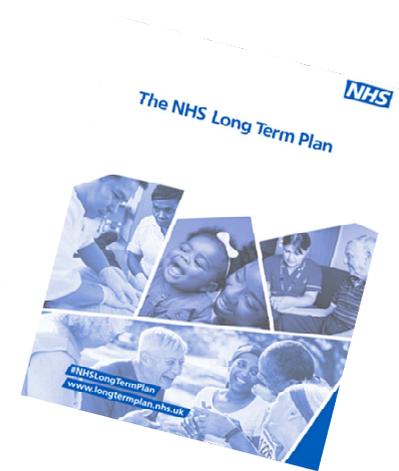
North East & North Cumbria Integrated Care System

JOINT OSC FOR THE NE & NORTH CUMBRIA ICS & NORTH &
CENTRAL ICPS
Mark Adams
North ICP Lead





In response to the Long Term Plan, Integrated Care Systems were asked to create their five-year strategic plans by November 2019 covering the period 2019/20 to 2023/24.



Following collaboration at place, across the ICP and ICS, the NCNE ICS plan was submitted, the plan recognises that Place is paramount.



ICS Strategic 5 year plan

Building further on work from the last 2 years the plan outlines how we will;

- Bring together local organisations in a pragmatic and practical way
- Ensure patients get more options, better support, and properly joined-up care at the right time and place
- Relieve pressure on A&Es through more effective population health management and service coordination
- Strengthen our contribution to prevention and tackling health inequalities to help people stay healthy and moderate demand on the NHS
- Develop a new 'system architecture' that delivers strategic action on workforce transformation, digitally-enabled care, and the collaborative approaches to innovation and efficiency that will restore our whole ICS to financial balance



One integrated care system, supporting our ‘places’ and integrated care partnerships.

Places and neighbourhoods



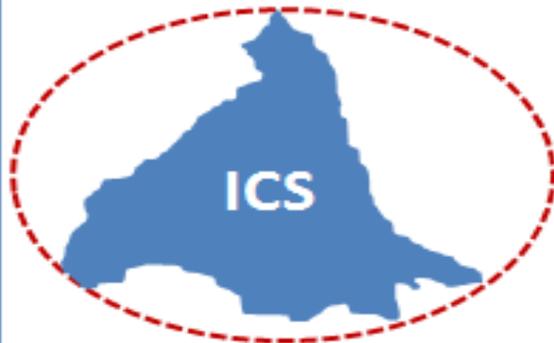
- Partnership working between NHS and local authorities via **Health & Wellbeing Boards**
- Ensuring the quality, safety and accountability of local health services
- Primary Care Network development
- Health and Social Care Integration initiatives
- Joint-working with the local voluntary sector (eg social prescribing)
- Embedding population health management
- Public and political engagement and consultation

Integrated Care Partnerships



- Focus on acute services sustainability: clinical networking between neighbouring FTs and coordination of service development proposals
- One streamlined commissioning hub per ICP
- Working towards a single, shared approach to finances, and risk-sharing.
- Joint capital planning and sharing premises
- Identify and share best practice, reducing unwarranted variation in care and outcomes

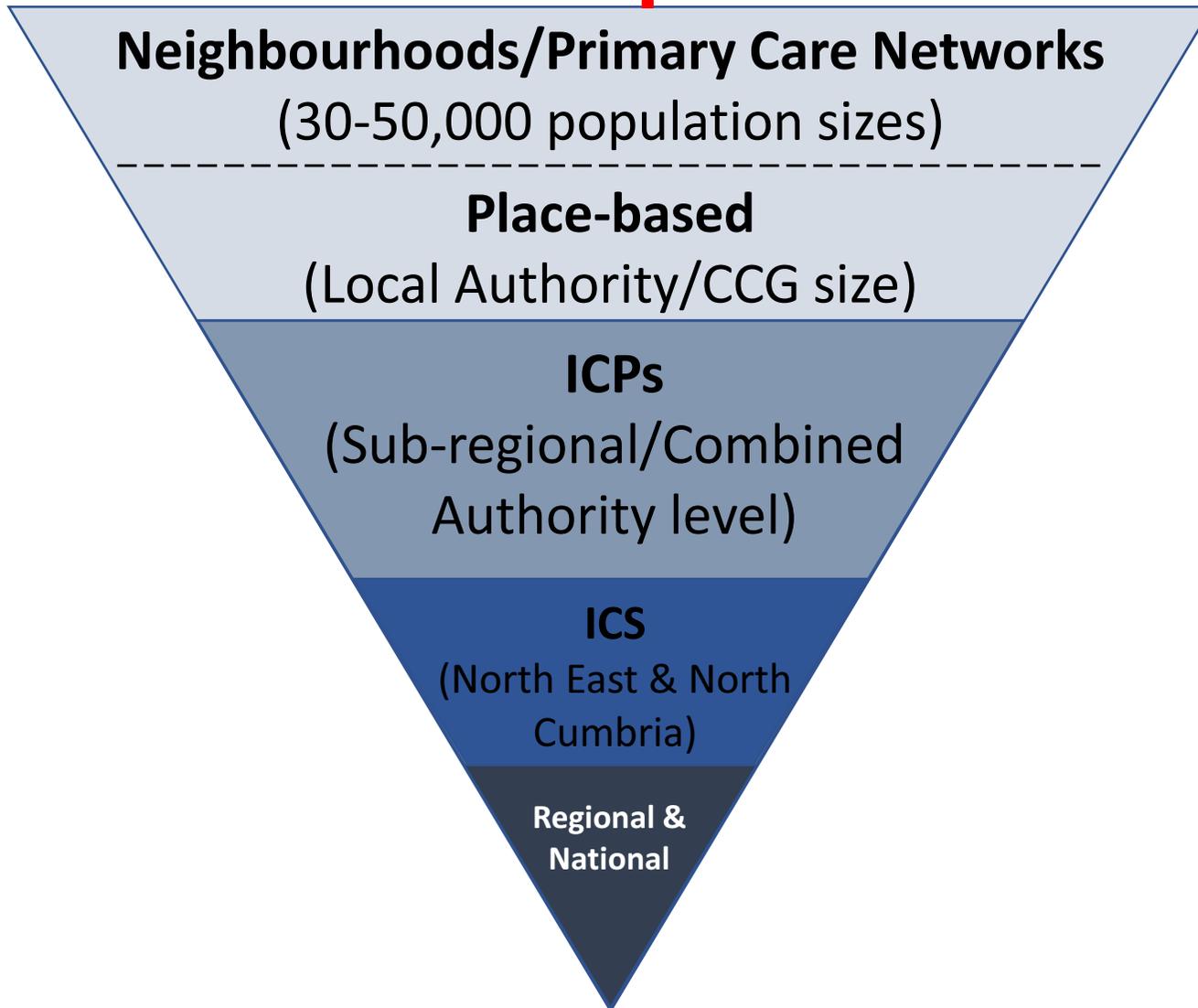
Integrated Care System



- Strategic Commissioning (e.g. ambulance)
- Overarching clinical strategy and clinical networks
- Shared policy development
- Emerging ICS-level priorities:
 - Population Health & Prevention
 - Optimising Health Services
 - Workforce Transformation
 - Digital Care
 - Mental Health
 - Learning Disabilities



People





North of Tyne and Gateshead Integrated Care Partnership (ICP) key messages

- Collective strength and commitment to deliver much more for the people that we serve, under the broad headers of health, wealth and wellbeing.
- Most important level of working ‘place’ based
- 2 strategic principles that guide our approach to the ICP
 - i) the relationship between Local Authority defined Places, the ICP and the ICS, based on principles of subsidiarity.
 - ii) recognition that the ICP is a collaboration of equal partners, i.e. the NHS and Local Authorities, building up from strong partnership arrangements in each of the four Local Authority areas.



Health, Wealth and Wellbeing

- Improving health, wealth and wellbeing are key areas of focus across all organisations within the ICP.
- Tackling inequalities and unwarranted variation are common themes building up from local Health and Wellbeing / Wellbeing for Life Strategies.
- 3 ICP priority areas:
 1. Climate Change and Sustainability
 2. Workforce, Employment & Skills
 3. Prevention

Collectively our health and social care system is one of the largest employers in the area, and we have an opportunity to consider what we can do to influence and support a wider agenda over and above our current joint work in respect of social care and health issues



Local integration at place

- The need to bring care closer to home is greater than it has ever been
- Patients want care to be tailored to their needs, involved in decisions about their care to enable them to live life to the full, and as independently as possible; they want and expect to be cared for at home or as locally as possible.

Place-Based approaches to integrating services are being developed, our aim is to increase the scale and integration of out of hospital services, based around communities and improve population health outcomes through:

- Northumberland System Transformation Board.
- North Tyneside Future Care Programme.
- Newcastle Joint Executive Group and Joint Delivery Group.
- Gateshead Health & Care System.



Durham, South Tyneside and Sunderland Integrated Care Partnership (ICP) key messages

We will

- **work collaboratively** and, where appropriate, **combine resources** and **maximise economies of scale**.
- develop a **culture that promotes alliance working** between organisations and our citizens across the ICP.
- continue to **engage with patients and service users and the public at place** and **ICP level** to help us **develop and realise our ambitions for the system**, while contributing to and collaborating with the wider ICS, including strategic enablers such as finance, workforce, digital and estates.

Our ambition is to transform health and care outcomes building on the primacy of place-based working across health and social care, underpinned by a long history of partnership working.



Health, Wealth and Wellbeing

We are **committed to working ‘at scale’ on strategic issues**, where it makes sense and adds value, **shifting our focus from a system that treats ill health to one that keeps people well for longer.**

Excellent work continues to be carried out at ‘place’, led and supported by the Health and Wellbeing Boards, **delivered collaboratively by health, local authorities and voluntary and community partners** and supported by the Better Care Fund.

This positively impacts people’s lives and improves their **health, wellbeing and wealth, eg**

- **Partnership approach in County Durham** to addressing issues relating to health and housing.
- In **South Tyneside** the local plan includes **work on strategic housing developments and system wide recruitment** development under the **‘Love South Tyneside’ banner.**
- Focussing on the key elements of the **Healthy City Plan** as part of the overall Sunderland City Plan **including smoking, alcohol and a good early start in life.**



Local integration at place

Whilst not diminishing what can be achieved by **working together ‘at scale’**, the health and care needs of the majority of people are best met **by integrated, place-based services**.

We are building on a **long history of effective partnership** working to deliver **quality, person centred, joined up care** that meets the needs of the local population and **improves health and wellbeing**.

We intend to achieve greater integration by:

- **Joining up** the planning and delivery of health and care services through **integrated strategic and operational commissioning**
- **Developing senior joint roles at place level** with each of the **three councils** to create a partnership culture, create and sustain system wide improvement, **strengthen integration across the ICP footprint**.
- Using **formalised collaboration agreements**, e.g. All Together Better and South Tyneside Alliance.



Tees Valley Integrated Care Partnership (ICP) key messages

Working across **Hartlepool, Stockton, Darlington, South Tees, Hambleton, Richmondshire and Whitby** our ICP has been set up to **focus on “place”** and ensure the **sustainability of services for the local population** that meets **quality and clinical standards** as well as workforce challenges, core performance and financial standards.

We have a **clear ambition across our ICP** to improve **health and wellbeing**, support **delivery of the best possible outcomes** and to ensure our system is sustainable. We will do this through **building on the strong foundations** we have developed in terms of our collaborative approach to **place-based working across** health and social care.

Transformation across our ICP footprint will deliver a **positive shift towards improving “population health”**; – moving from **fragmentation to integration** in care delivery, but also **tackling the significant wider determinants of the health and wellbeing** for our population.



Health wealth and wellbeing

A **population health management approach** will be used to tailor how we will **deliver, improve and commission** responsive and tailored local health and care services from a **Primary Care Network level and at scale**.

An ICP wide **joint programme of work**, with Local Authority Public Health Teams has been identified to address some of the **underlying causes of ill health**, aimed at the following key areas;

- Reducing; tobacco dependency, excess weight, and the impact of alcohol
- Air quality.
- Screening and immunisation.
- Making every contact count.
- Antimicrobial resistance
- Health inequalities.



Local integration at place

- Our ICP will **build upon existing local place-based leadership**
- **This will involve all 18 of our local primary care networks** (GPs and other health and care professionals) and NHS foundation trusts, **working with local authority and voluntary sector partners**, in improving health and wellbeing through extending the reach and effectiveness of our services.
- Our **place-based approaches vary from place to place across the ICP** based on the needs of the local population, the configurations of services that have historically been available and the relationships in place between the various health and care organisations
- The **integration of primary care, social care and hospital care** will be vital to the delivery of **effective and high-quality services**.



North Cumbria Integrated Care Partnership (ICP) key messages

Our **health and care providers and commissioners** are working in partnership with the **County Council, the Third Sector and our community** to develop an **integrated care partnership**.

North Cumbria ICP Strategic Aims:

1. Improve the health and care outcomes of our local communities and support people of all ages to be in control of their own health.
2. Build health and care services around our local communities.
3. Provide safe and sustainable high-quality services across our sparsely populated area.

North Cumbria ICP Strategic Enablers:

- A. Be a great place to work and develop.
- B. Integrate how health and care organisations work together.
- C. Live within our means and use our resources wisely.
- D. Deliver digitally enabled care.



Health, wealth and wellbeing

Climate Change & Sustainability

- Climate Change is now recognised as the biggest public health threat this century, we recognise that climate change has significant implications for our current and future health and wellbeing.

Workforce, Employment and Skills

- We have difficulty in attracting people to work here and pursue their careers in the region, and we have an aging workforce, of which 3.15% could retire now and a further 15.73% within the next five years. Our People Plan identifies objectives to ensure that we have the optimum number of the workforce, with the best mix of skills, to support our communities in 2025

Prevention

- We are building a population health system that focuses on prevention, supporting patients to make the right choices about their health and reducing variation in outcomes that exist across our communities.



Local integration at place

Eight Integrated Care Communities of Health and social care professionals, GPs, voluntary sector and community are working together as one team to support the health and wellbeing of local people.

Their focus is to help people manage long term health conditions, improve access to information about healthier lifestyles and provide more care out of hospital

The specific changes outlined below will support local integration:

- include mental health, muscular treatment service and children's services.
- develop pathways of care for patients that join together primary, community & secondary care, improve quality and experience.
- involve communities in shaping future services, linked to developing thriving communities.
- utilise technology to monitor people's health at home and develop interventions and target disease areas across communities.
- increase in use of the Third Sector and social prescribing.
- Primary Care Networks (PCNs) delivering significant changes to how care is provided in communities.



Aims and ambitions of the six priority workstreams

Programme	Ambitions
Population health and preventions	<ul style="list-style-type: none"> • By 2023/24 - All people admitted to hospital that smoke will be offered NHS-funded tobacco treatment services leading to a reduction in adult smoking prevalence to 5% or below by 2025 • By 2028 - At least 90% of the NHS fleet will use low-emissions engines and primary heating from coal and oil fuel in NHS sites will be fully phased out • By 2029 - Halved the gap in average healthy life expectancy for both men and women between the NECN ICS and the England average and raised the average healthy life expectancy for men and women to a floor target of 60.0 years
Mental Health	<ul style="list-style-type: none"> • By 2020 - We will have multi agency mental health priority area working groups in place to take forward system led objectives (aligned to the ICS structures and emerging primary care networks) to improve the mental health and wellbeing of our communities • By 2021 - As an integrated system we will demonstrate measurable progress in relation to achieving the NHS LTP ambitions and, through qualitative feedback, monitor the impact of service change on patient experience and work force provision • By 2028 - We will have needs led services in place to address the population health needs and wellbeing of our communities. This will be achieved through joint commissioning arrangements and a flexible, skilled work force



Aims and ambitions of the six priority workstreams

<p>Learning Disabilities and Autism</p>	<ul style="list-style-type: none"> • By 2020 there will be reduction in reliance on inpatient care for people with a learning disability, autism or both to 37 inpatients per million adult population, with a further reduction to 30 inpatients per million adult population by 2023/24 • By 2023/24 no more than 12 to 15 children or young people with a learning disability, autism or both per million, will be cared for in an inpatient facility • By 2023/24 - 75% of people on the learning disability register will have had an annual health check • By 2023/24 - Seven day, intensive, crisis and community services will be available for all children and adults with learning disability Autism or both • By 2023/24 - Health checks will be in place for children in residential schools • By 2023/24 – There will be a "digital flag" in patient records that will signify to staff that someone has a learning disability or autism • By 2023/24 - Children with a learning disability, autism or both with the most complex needs will each have a designated keyworker to ensure that they are being best supported • By 2023/24 - All care commissioned by the NHS will need to meet the Learning Disability Improvement Standard, with a particular focus upon seclusion, long-term segregation, and restraint • By 2023/24 – There will be a reduction in Out of area / 52 week residential placements • By 2023/24 at least half of supported internship opportunities, targeted at people with a learning disability, autism or both, will be converted to paid employment over the first five years of the Long Term Plan
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Aims and ambitions of the six priority workstreams

Workforce	<ul style="list-style-type: none"> • Make the North East and North Cumbria to be the best place to work, with a focus on adaptability, wellbeing and population health • Recruiting, developing, appreciating and retaining the best people • Continue to be recognised locally, regionally and nationally as a leading respected region with regards to workforce practice and solutions • Becoming a great place to work • Getting, Workforce, Supply and Education Right • Supporting and valuing leadership at all levels
Digital Care	<ul style="list-style-type: none"> • By 2020 - The first NHS Trust(s), Mental Health Trust, Primary Care settings and Local Authority will be connected to, and sharing information via the Great North Care Record Health Information Exchange • By 2021 – Video/online consultations will be available in primary care • In 2020/21 – We will enable the personalisation of care with 100% of the population having the ability to access their care plan and communications from their care professionals via the NHS App • By 2023/24 - 100% of women will have the ability to access their online maternity record • From 2020 – under the Optimising Health Services work stream, we will improve a range of diagnostic services through the implementation of collaborative digital services



Aims and ambitions of the six priority workstreams

Optimising Health Services	<ul style="list-style-type: none"> • By 2020 - We will have comprehensive ICS Clinical engagement and influence addressing the priority areas of the Long-Term Plans • By 2021 - We will have started delivering across the ICS on key LTP metrics such as rapid community responses, increased detection of Familial Hypercholesterolemia and earlier cancer diagnosis rates • By 2028 - Our current clinical vulnerabilities across the ICS will have been addressed and sustained through place based, ICP and ICS level working
Cancer	<ul style="list-style-type: none"> • By 2020 - TBC% of patients will receive a diagnosis of cancer within 28 days • By 2021 - We will agree differential time to treatment pathways for each tumour site • By 2028 - Over 3,500 people will survive cancer for at least five years each year
Urgent and Emergency Care	<ul style="list-style-type: none"> • By 2020 - All hospitals with a major Emergency Department will: <ul style="list-style-type: none"> provide SDEC services at least 12 hours a day, 7 days p/w provide an acute frailty service for at least 70 hours per week record 100% of patient activity in ED, UTCs and SDEC via ECDS Implement the Clinical Standards Review Further reduce DToC, in partnership with LAs • By 2021 - CAS will typically act as the single point of access for patients, carers and health professionals for IUC and discharge from hospital care



Ways of working to reduce Health Inequalities

- As an ICS we have a collective strength and commitment to deliver much more for the people that we serve.
- The most important level of working for us all is **'place' based work** for the people who live within the boundaries of each of the local authorities.
- **Partnership working at a place level** is key to the achievement of our ambition.
- Using **evidence-based tools and techniques** will support us to change our system approaches to deliver better health and wellbeing outcomes.
- This is illustrated in the interventions for health inequalities triangle which illustrates the contribution that **different parts of the whole system need** to make to systematically reduce harm from tobacco and hence health inequalities.

Civic-level Interventions

- Ambition 5% prevalence by 2025 for all Health and Wellbeing boards and the ICS
- 6% smoking at time of delivery
- ICS Global Health Leadership Initiative

Health and wellbeing and Integrated Care systems

- Focus groups with local women
- Feedback on pathway
- Tobacco control

- Specialist stop smoking services
- Refreshed group
- Changing language
- Pathways and practice
- Embedding guidance and Standards
- Local Maternity system prevention co-ordinator

Community-centred Interventions

Service-based Interventions



Next steps

Communications and Engagement colleagues will work with the ICS core team to develop the shorter, public facing version of the strategic plan early 2020 for sharing with regional partners