

North East and North Cumbria Integrated Care System

1. Background and context

On the 19th of June 2019 the North East and North Cumbria was confirmed by NHS England as one of a small number of 'Integrated Care Systems' across the country. Securing this status is a real vote of confidence in the strength of how NHS organisations, and our partners, work together as system – but we know that there is much still to do to improve the health and wellbeing of the communities that we serve.

Our ICS is a collaboration of NHS commissioners and providers, and our partners, and not a new organisation with statutory powers. Subsidiarity remains our guiding principle, with the majority of our work focused in places and neighbourhood; but, alongside this, our ICS provides a mechanism to build consensus on those issues that need to be tackled at scale.

Whilst the quality of our health and care services is amongst the best in the country – with strong performance against key targets and progress tackling issues such as cancer death rates – we are not making fast enough improvements in improving the overall health of our population. *Healthy* life expectancy in the North East and North Cumbria remains amongst the poorest in England, with high unemployment and low levels of decent housing, and significant areas of deprivation. These contribute to some of the starkest health inequalities, early death rates and highest sickness levels in England, driving much of the pressure that health and social services struggle to manage, so we know things need to change.

Our ambition is to significantly improve health outcomes for people in the North East and North Cumbria (NENC) by working with, and through, communities, partner organisations and our staff. We are focused on creating a common purpose and joint ambition to drive improvements in health, wealth and wellbeing.

Working together across organisations in a coordinated and targeted way can have a major impact on health outcomes. This is demonstrated by the success we have had in reducing early deaths due to cardiovascular disease by 50% between 2001 and 2012. This was achieved through a systematic programme of health checks and stop-smoking initiatives, working with public health leads, GPs, pharmacists, hospitals and commissioners. The scale and ambition of this work is what our aspirant integrated care system wants to achieve across a number of our key priorities.

2. Our vision

By working with local communities and staff – and by ensuring system and clinical leaders spend time together to develop and agree joint plans – we are collectively developing priorities for an integrated care system that allows us to transform people's health and wellbeing and deal more effectively with the day to day challenges faced by services. Our vision is:

- To fundamentally shift health outcomes for the local people – working with our partners to challenge health inequalities and improve healthy life expectancy

- To continue to raise standards so services are high quality and delivered effectively. This includes making sure everyone has access to safe, quality care, at the right time and in the right place – whether in the community, hospital or another setting.
- To support staff in working across organisational boundaries and strengthen links between services based in different parts of the system, through more clinical networking and joint priorities.
- To value and develop our workforce – providing the opportunity to develop skills, knowledge and flexibility to work across multiple settings. We will focus on attracting people to our work in the organisations which make up our integrated care system and do more to retain our staff within the North East and North Cumbria.
- To make improved use of information and technology to personalise health and care services, reduce duplication of effort and speed up access to services, particularly for people who are at greatest risk of poor health outcomes.

3. The importance of working at ‘place’ with the added value of working ‘at scale’

Our integrated care system will build upon existing local place-based leadership and responsibilities of clinical commissioning groups, to plan and arrange services for local populations. This will involve 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.

While recognising that for most people their health and care needs are best met by integrated, place-based services, NHS organisations are committed to working together ‘at scale’, where appropriate to harness our collective resources and expertise to make faster progress on improving health outcomes.

For a small number of strategic issues working at scale makes sense and adds value. The geography of our ICS recognises the connections between communities and centres of population, how patients access services and move through existing systems, and established networks of health professionals who have a long history of collaboration and working together on shared issues.

This geography of our ICS is already reflected in the footprint of our Northern Clinical Senate and Northern Deanery, our Clinical Networks (including the Northern Cancer Alliance) and Joint CCG Committee, as well as our Urgent and Emergency Care Network, Academic Health Sciences Network and Local Professional Networks for Digital Care and Community Pharmacy services. We also plan and deliver prevention initiatives with our local authority partners on a NENC footprint, including our highly-regarded and effective tobacco and alcohol control programmes FRESH and Balance.

We see the advantage of working at this scale will allow us to:

- Collectively prioritise based on a shared understanding of need
- Target our investment on shared priorities
- Mobilise our collective resources – including our 170,000 strong health and care workforce
- Set stretching and consistent service standards – especially for vulnerable groups

- Manage pressures together as a system
- Share and spread best practice
- Make better use of technology and digital resources
- Develop shared functions and reduce duplication
- Acting with 'one voice' to represent the region, securing additional resources and influencing the direction of national health and care policy.

4. Working with our partners

Our local authority partners have told us consistently that working together with the NHS at place level through Health and Wellbeing Boards needs to be the fundamental building block of any integrated care system.

This will remain the scale at which we do the vast majority of our joint working with local authorities, especially the work we do together at neighbourhood level with integrated health and social care teams based on primary care networks, as well as the joint commissioning we do at local authority/CCG level - for example through the Better Care Fund and via joint Public Health initiatives.

Our local authority partners have also told us that there is scope for working together on a small number of strategic issues that transcend these boundaries. After a joint session with local authority social care, public health and housing colleagues in November 2018 we identified the following areas for further development and discussion.

- Population health and prevention
- Improving children's health and wellbeing
- Joint workforce development
- Digital care
- Commissioning services for vulnerable groups

On population health we are already working through our Prevention Board (co-chaired by system leaders from NHS and local authorities) to identify the strategic priorities we intend to invest in. This includes the £1million surplus from our commissioning support provider NECS which was allocated by the NECS Customer Board (made up of our 12 CCGs) to expanding alcohol and tobacco control initiatives and strengthening public health provision in our hospitals. NHS and local authority leads are also working together on innovative approaches to reduce smoking in pregnancy facilitated by the Yale University System Development programme.

ADASS and Public Health leads already participate in our strategic forums and are helping us to develop proposals on all of these issues for consideration by NHS and local authority decision-makers. We are also developing strategic partnership arrangements with HealthWatch and Voluntary Organisations Network North East (VONNE) to coordinate how we ensure a strong voice for service users and the voluntary sector in the development of our ICS.

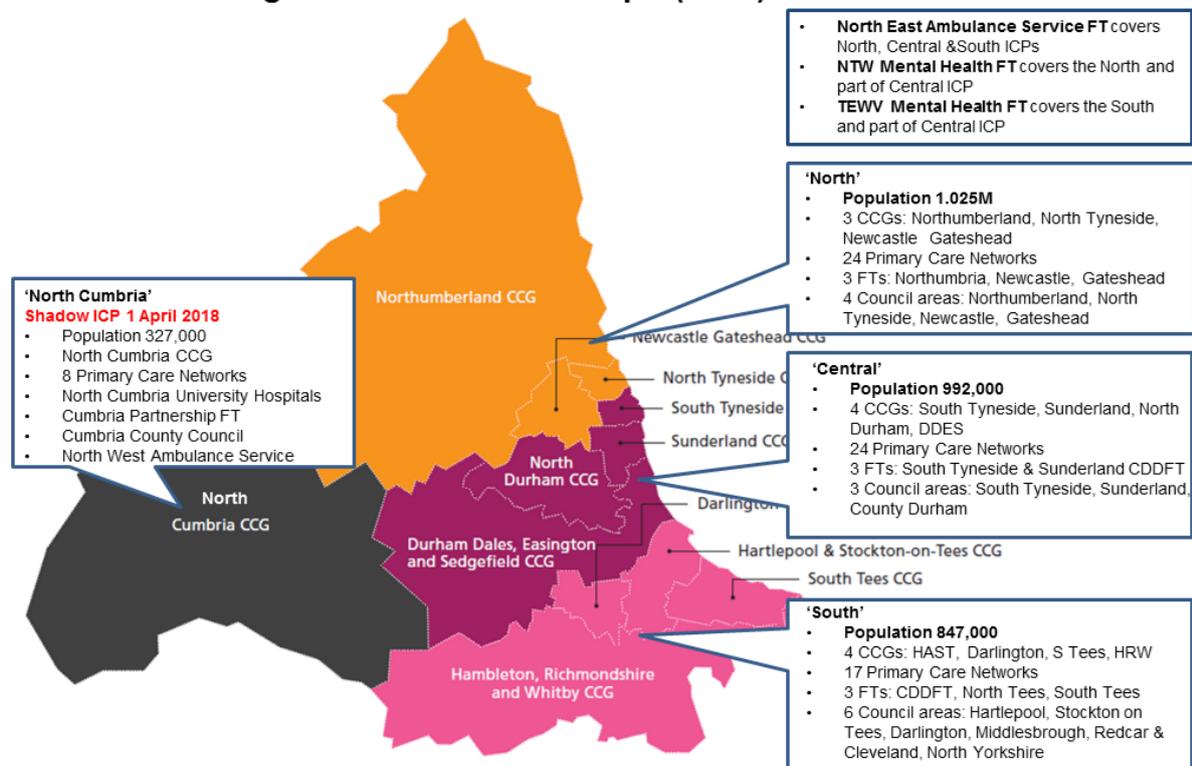
5. Our emerging operating model

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

As an ICS we are clear that subsidiarity is our guiding principle. It is in our 'places' where the majority of services will continue to be commissioned, planned and delivered, whilst those places can still work together with their neighbours at scale where this genuinely adds value. As one of the largest integrated care systems we recognise that our operating model is therefore different to other places, and that our constituent organisations work across three levels of scale:

Place – populations of circa 150,000 to 500,000 people will be the main focus for partnership working between the NHS and local authorities in our cities, boroughs and counties. In these areas, primary care networks (providing services to populations of circa 30,000-50,000 people) will support collaboration between GP practices, social care, other community based care providers and voluntary sector organisations and build upon work already underway.

One North East and North Cumbria ICS with four Integrated Care Partnerships (ICPs)

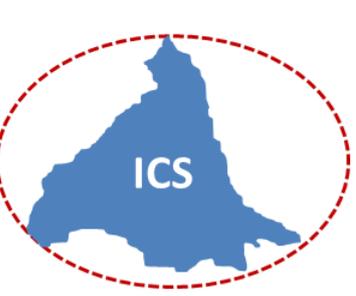


Integrated care partnerships (ICPs) – populations of around one million (with the exception of North Cumbria, which has unique geographical and demographic features). These are focused on collaboration and clinical networking between neighbouring NHS hospital trusts, to ensure safe and sustainable services. The geographies of our four integrated care partnerships are based on where people live, how patients use acute services and the location of hospital sites.

Through hospitals and clinical commissioning groups working more closely, ICPs will be able to plan and tailor care to the needs of the local population, while reducing some of the costs associated with planning and delivering services. Some ICPs are also exploring how to share and spread best practice in primary and community care from their constituent places. Our ICPs are also exploring with local and combined authorities how we can work together on local economic development and workplace health, and extending NHS employment opportunities to local people.

Integrated care system – a population of circa 3.1 million people, focussed on ‘at scale’ priorities that multiplies our collective impact.

Levels of working in our Integrated Care System:

<p>Places and neighbourhoods</p>		<p>Areas of focus</p> <ul style="list-style-type: none"> • Partnership working between NHS and local authorities via Health & Wellbeing Boards • Ensuring the quality, safety and accountability of local health services • Public and political engagement and consultation • Primary Care Network development • Health and Social Care Integration initiatives • Joint-working with the local voluntary sector
<p>Integrated Care Partnerships</p>		<ul style="list-style-type: none"> • Focus on acute services sustainability: clinical networking between neighbouring FTs and coordination of service development proposals • Working towards one streamlined commissioning hub per ICP for acute services, and a single, shared approach to financial planning and risk-sharing • Making best use of existing premises and facilities and jointly planning capital investments
<p>Integrated Care System</p>		<ul style="list-style-type: none"> • Strategic Commissioning (e.g. ambulance services) • Shared policy development • Overarching clinical strategy and clinical networks • Emerging ICS-level priorities: <ul style="list-style-type: none"> - Population Health & Prevention - Optimising Health Services - Workforce Transformation - Digital Care - Mental Health - Learning Disabilities

6. Joint priorities for an integrated care system

Our emerging joint priorities are focused on improving people’s health and wellbeing and ensuring safe and sustainability services, and have been informed by the views of senior doctors, nurses and other stakeholders. They are:

1. Improve **population health** through increasing public awareness and developing screening to better prevent, detect and manage the biggest causes of premature death: cancer, cardiovascular disease and respiratory disease.
2. Improving outcomes for people who experience periods of poor **mental health**, particularly those with severe and enduring mental illness, and doing more improve the emotional wellbeing and mental health of children and young people, and breaking down the barriers between physical and mental health services.
3. Transforming care for people with **learning disabilities** and improving the health and care services they receive so that more people can live in the community, with the right support, and close to home.

4. **Optimising the quality and sustainability** of health services, especially those identified as 'vulnerable' (for example due to workforce pressures), by delivering joint solutions devised by clinicians, to ensure all patients have fair access to safe and effective care.
5. By improving how we use **information technology** to meet the needs of care providers, patients and the public, helping people to make appointments, manage prescriptions and view health records online.
6. By building a motivated and flexible **workforce**, looking after their health and wellbeing and ensuring that they have the skills and support that they need, whilst developing how we recruit and retain staff in priority areas.

7. How will we make decisions together?

Engagement with patients and service users will remain at the heart of how we make decisions, at whatever level we work. For 'place-based' (CCG and local authority level) activity, we will continue to work through existing Health and Wellbeing Boards, which provide a crucial forum for local authorities, CCGs and wider partners to assess the needs of local populations and jointly commission services; as well as the governing bodies of CCGs and the boards of Foundation Trusts. The performance of local health services will continue to be examined by both local and regional Health Scrutiny Committees.

For issues that cut across wider boundaries, we are working to develop decision-making structures that are based on building consensus for working 'at scale'. Each ICS is required to establish a 'Partnership Assembly' that brings together NHS commissioners and providers with local authority and other partners. Our ambition is to establish such a body by early 2020, and we are currently in discussions with the leadership of local authorities across the North East and North Cumbria on how such a body is best constituted to maximize the impact we can make together on improving health and wellbeing outcomes for our population.