The public health approach in the North East North Cumbria Integrated Care System

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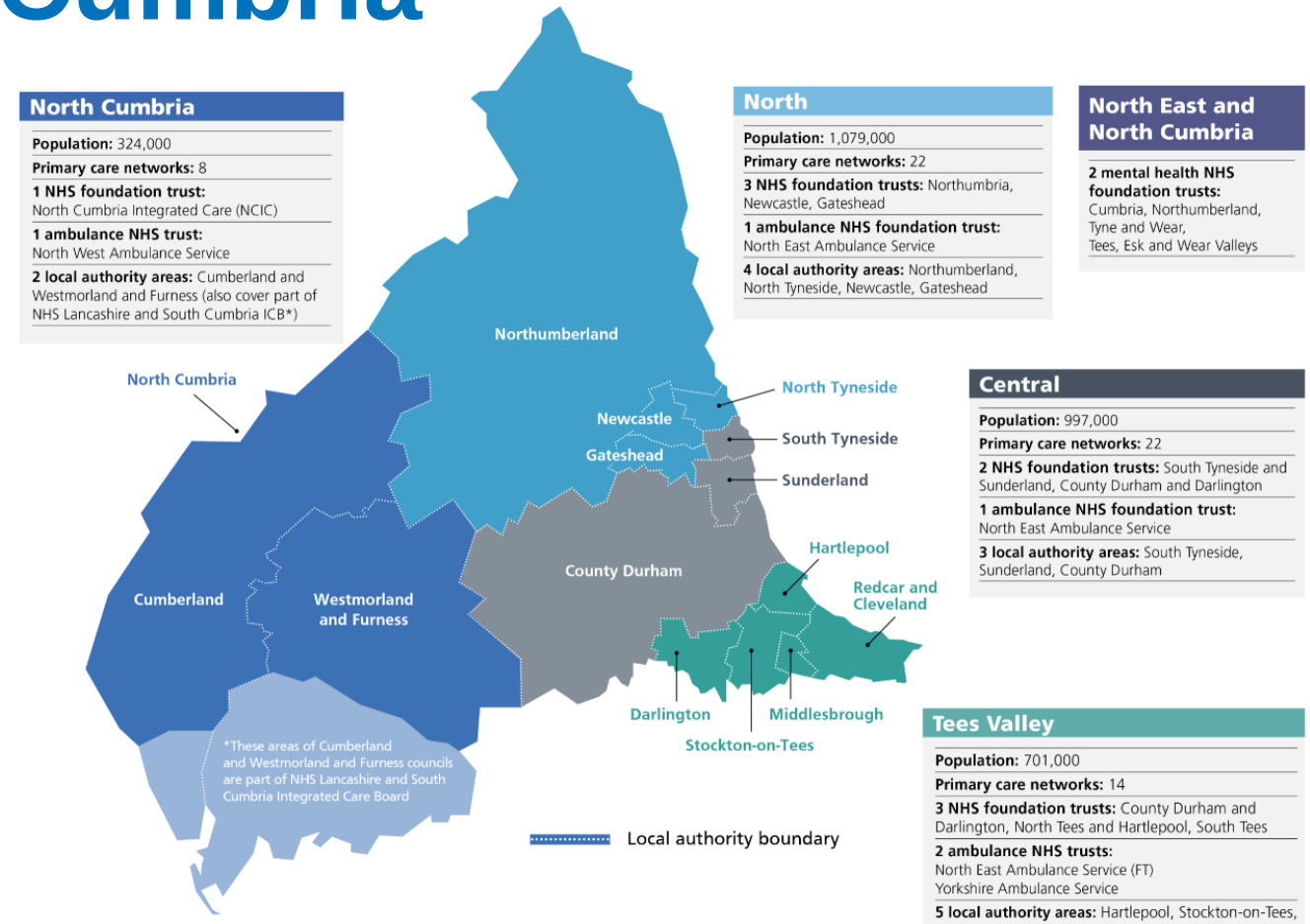
Our patch: the North East and North Cumbria



North Cumbria

Population: 324,000
Primary care networks: 8
1 NHS foundation trust: North Cumbria Integrated Care (NCIC)
1 ambulance NHS trust: North West Ambulance Service
2 local authority areas: Cumberland and Westmorland and Furness (also cover part of NHS Lancashire and South Cumbria ICB*)

North

Population: 1,079,000
Primary care networks: 22
3 NHS foundation trusts: Northumbria, Newcastle, Gateshead
1 ambulance NHS foundation trust: North East Ambulance Service
4 local authority areas: Northumberland, North Tyneside, Newcastle, Gateshead

North East and North Cumbria

2 mental health NHS foundation trusts: Cumbria, Northumberland, Tyne and Wear, Tees, Esk and Wear Valleys

Central

Population: 997,000
Primary care networks: 22
2 NHS foundation trusts: South Tyneside and Sunderland, County Durham and Darlington
1 ambulance NHS foundation trust: North East Ambulance Service
3 local authority areas: South Tyneside, Sunderland, County Durham

Tees Valley

Population: 701,000
Primary care networks: 14
3 NHS foundation trusts: County Durham and Darlington, North Tees and Hartlepool, South Tees
2 ambulance NHS trusts: North East Ambulance Service (FT) Yorkshire Ambulance Service
5 local authority areas: Hartlepool, Stockton-on-Tees, Darlington, Middlesbrough, Redcar and Cleveland

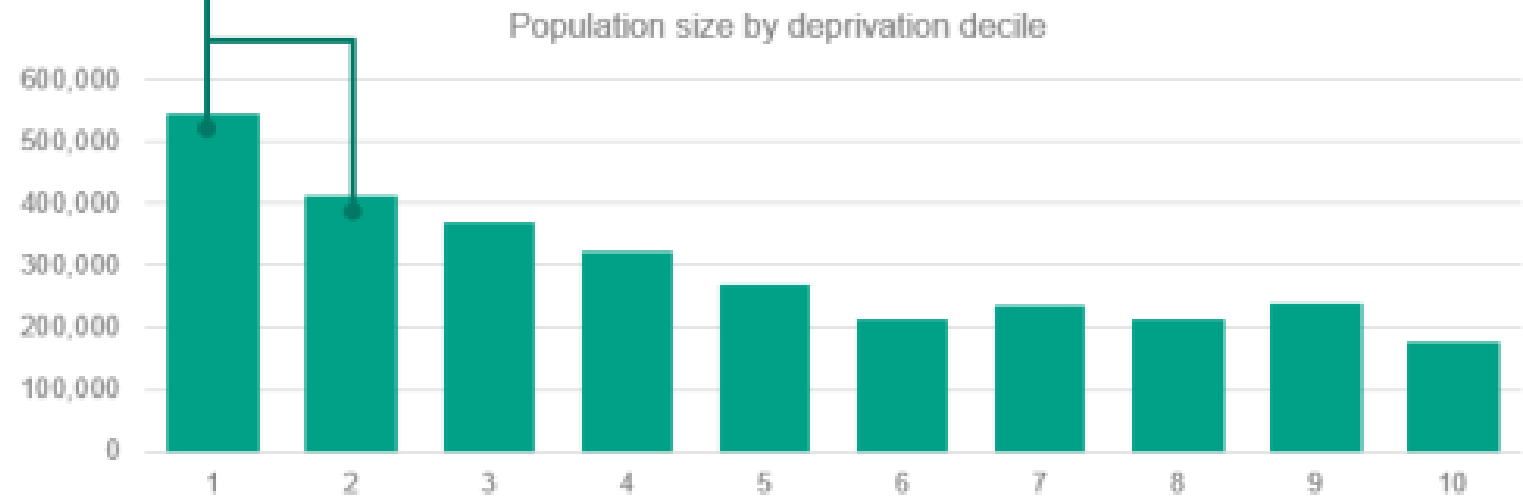
We have a strong and proud history of **working together**.

The quality of our **health and care services** is rated amongst the best in the NHS.

Despite this, our **health outcomes** are amongst the worst in the country.
Our ambition is to change this by working together as an **Integrated Care System.**

North East
North Cumbria
Health & Care
Partnership

32% of the NENC population are estimated to live in the two most deprived neighbourhoods[1]



Source: ONS mid 2020 population estimates and index of multiple deprivation

Public Health Specialists across NENC ICS by organisation

Public Health Consultants in Foundation Trusts

- Tees, Esk & Wear Valley Mental Health Trust
- Cumbria, Northumberland, Tyne and Wear Mental Health Trust
- Durham & Darlington NHS Foundation Trust
- North Tees & Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- Gateshead health NHS Foundation Trust
- Newcastle Hospitals NHS Foundation Trust
- South Tyneside & Sunderland NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- North Cumbria Integrated Care NHS Foundation Trust

Local Authority (DsPH and PH teams)

- Durham County Council
- Darlington Borough Council
- Hartlepool Borough Council
- Stockton-on-Tees Borough Council
- Middlesbrough Borough Council
- Redcar & Cleveland Borough Council
- Gateshead Borough Council
- Newcastle City Council
- South Tyneside Borough Council
- Sunderland City Council
- Northumberland County Council
- North Tyneside Borough Council
- Cumberland Council
- Westmorland & Furness Council

PH Specialists within other Regional Bodies

- ADPH Network
- Newcastle University/ ARC (NE&C)
- UKHSA
- NHSE NE&Y
- OHID NE/analyst
- NECS/0.4wte Director of PHM in ICB

NENC ICB

Working better together as a public health family

The Kings Fund

Facilitated support from the Kings Fund to:

- share how we are all currently working with the ICS
- hear from experience elsewhere
- agree principles for working better together as a public health family

Additionally, the Kings Fund interviewed ICB Executives to understand what they wanted from public health to inform our approach:

- acknowledged we are starting from a good foundation of collaboration
- help to identify priorities and those opportunities where we could scale work
- wanted expertise from the public health family, not replace or compete with it
- wanted the common purpose ‘us’ rather than ‘them and us’- advocate together for our population

Principles for the NENC public health family (agreed Oct 2022)

WHAT DO I NEED TO DO DIFFERENTLY AS A LEADER?	• Create space and time • Share and learn • Engage and contribute • Collaborate and advocate
WHAT DO OUR ORGANISATIONS NEED TO DO DIFFERENTLY?	• Contribute to a whole system approach • Recognise our organisations are part of the ICS
WHAT DOES THE PUBLIC HEALTH FAMILY NEED TO DO COLLECTIVELY?	• Develop, adopt and deploy • Invest in ourselves as a family and in others • Provide a clear position for, and with, the ICS • Contribute to the ICS
WHAT DO WE NEED OUR ICS TO DO, OR DO COLLECTIVELY/ DIFFERENTLY?	• Focus on what it can do best • Take ‘subsidiarity of place’ seriously • Support and seek public health expertise as appropriate, timely and proportionate

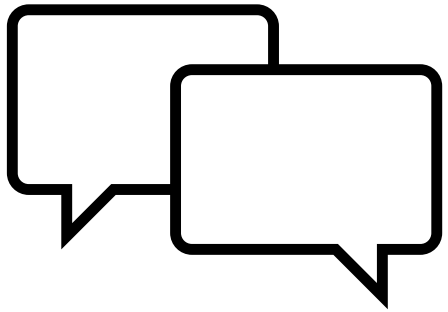
Principles for the NENC public health family (Oct 22)

WHAT DOES THE PUBLIC HEALTH FAMILY NEED TO DO COLLECTIVELY?

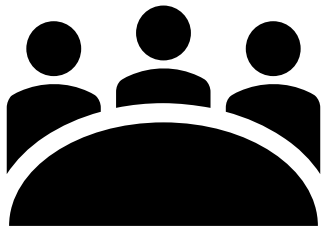
- **Develop, adopt and deploy** - A shared public health family narrative, Agreement on roles, responsibilities, lines of communication
- **Invest in ourselves as a family and in others** - Come together to share info/intelligence to operate more effectively, cross workforce not just specialist PH, help new leaders to develop
- **Provide a clear position for, and with, the ICS -** where the PH family Lead, Collaborate & Advocate, focus on population health gain, clarity on where specialist PH input is required
- **Contribute to the ICS** - set out the PH offer to the ICS

WHAT DO WE NEED OUR ICS TO DO, OR DO COLLECTIVELY/ DIFFERENTLY?

- **Focus on what it can do best -** systematically and at-scale on healthcare inequalities, strong partner on wider determinants (anchor role)
- **Take 'subsidiarity of place' seriously –** see place as the building block with ICS action as required, work in partnership with other tiers (e.g. Combined Authorities)
- **Support and seek public health expertise as appropriate, timely and proportionate -** right people/right time/right issues; ensure PH advice given is at the right level, contribute to PH infrastructure



Putting this into action



Communicating / working more effectively to support the ICS

- ✓ Coordinating bi-monthly meetings for the public health leads linking with the ICS
- ✓ Identified a small resource for coordination of the comms across the PH family for ICS engagement
- ✓ Expanded the ADPH NE with Cumbria Councils
- ✓ Re-established the Healthcare Public Health network

Partnership working

- ✓ DPH representation on ICB Board and where capacity allows the Executive
- ✓ Updated the PH leads list and describe what undertaking this lead role means
- ✓ Describe the ‘PH offer’ to ICS at region and place building on the previous core offer to CCGs
- ✓ Map the interface between ADPH Networks and other ICS workstreams
- ✓ Develop a shared understanding of key terms e.g., health inequalities, healthcare inequalities, prevention and population health
- ✓ Ensure input to the ICP Strategy and provide guidance through the new Healthier and Fairer Group
- ✓ Meet with the ICB Exec twice a year to review our approach

Specialist Public Health in the ICS

Aims

- Retain the benefits of public health skills and expertise to the strategic planning and commissioning of NHS services
- Focus on reducing inequalities and demand on the NHS; Core20PLUS5 (Adults and Children & Young People)
- Reflect the emerging architecture of the ICS, at NENC level, Area ICP, local place and by organisation.
- Utilise the expertise of specialist public health in all organisations

Specialist Public Health Leadership at each tier

Place	• Local Authority Public Health (DsPH statutory functions) linking to Health & Wellbeing Boards • PH Consultants in NHS Trusts
Area ICP	• Local Authority Public Health led collaborative arrangement
ICP/ICB	Combination of the following as appropriate: • Nominated DsPH (or their representatives) on behalf of ADsPH • Population Health Management from NECS • Consultants in PH from NHS Trusts • Input to NENC ICS from: OHID, UKHSA, NHSEI • Input to NENC ICS from: ARC, Fuse (as required)

Specialist Public Health Functions

"Healthcare public health (HCPH) is concerned with maximising the population benefits of healthcare and reducing health inequalities while meeting the needs of individuals and groups, by prioritising available resources, by preventing diseases and by improving health related outcomes through design, access, utilisation and evaluation of effective and efficient health and social care interventions, settings and pathways of care." FPH 2017

Strategic planning and collaboration

- **assessing needs using data and intelligence e.g. Picture of Health NEY**
- **population segmentation and insight**
- **reviewing service provision against evidence-based interventions e.g. via clinical networks**
- **priority setting and value-maximisation methods**
- **creating connections and relationships to improve integration, efficiency and outcomes**

Advice on commissioning

- **service review methodology and critical appraisal of evidence e.g. IFRs**
- **designing shape and structure of supply to be proactive and fair**
- **provide advice on how services should meet the needs of priority population groups**

Monitoring and evaluation

- **supporting co-production with the public**
- **supporting learning and reflection processes with staff and populations**
- **demonstrating impact**
- **supporting collaboration with academic partners and research institutions**

Role of named specialist Public Health leads in ICS

The public health lead(s) will either be a Director of Public Health, Deputy Director, Consultant or Specialist working in either Local Authorities, OHID, NHS Foundation Trusts, NECS or the UKHSA

The nominated lead(s):

- will provide specialist public advice on data, evidence, intelligence and evaluation to support the ICS ambition of addressing healthcare inequalities and driving action on prevention (primary, secondary and tertiary) in order to improve population health
- are there on behalf of the specialist public health community as topic/theme leads rather than on behalf of their individual organisation
- will provide updates back to colleagues through the bi-monthly public health community ICS leads meeting or if required will act as a connector to other public health colleagues either in organisations or through other networks e.g. ADPH topic/life course networks, Healthcare Public Health Network.
- will identify opportunities where work is already underway at place in order to avoid duplication. Equally, public health leads will identify opportunities where work can be delivered at scale or priorities can be agreed across the larger footprint and delivered regionally or at place.
- will try to articulate where public health will lead, collaborate or advocate

Committee

NENC ICB Exec Committee

DPH representative: Tom Hall

Advisory group

ICS Healthier & Fairer Advisory Group

Co-Chair: Amanda Healy (DPH), NECS/ICB: Edward Kunonga, OHID: Claire Sullivan

Business Support Group
Amanda Healy, Edward Kunonga, Claire Sullivan

Workstream

Prevention workstream

Co-Chair: Alice Wiseman, OHID: Claire Mathews, FT: Esther Mireku

HealthCare Inequalities workstream

Co-Chair: Gerry Taylor, NECS/ICB: Edward Kunonga, OHID: Sarah Sowden, Becky James

NHS support to broader social economic disparities

Co-Chair: Mark Adams, NECS/ICB: Edward Kunonga, OHID: Becky James

Workstream Projects

Alcohol	Tobacco dependency	Healthier weight & treating obesity	CVD network / hyper-tension	PH Prevention in Maternity	C20 + 5 CYP	C20 + 5	Deep End	Inclusion Health/ Multiple and Complex Needs	Waiting Well	Anchor network	Poverty Proofing (clinical pathways)	Digital Inclusion	Health Literacy
Alice Wiseman	Amanda Healy	Craig Blundred	Wendy Burke	Wendy Burke	Wendy Burke	Edward Kunonga	Alice Wiseman	Tanja Braun	Esther Mireku	Mark Adams	Mark Adams	Mark Adams	Mark Adams
Tanja Braun	Alice Wiseman	Leslie Jones	Claire Mathews	David Gardiner	David Gardiner		Andy Graham	Michelle Mancini	Edward Kunonga	Ryan Swiers	Catherine Parker	Ryan Swiers	Ryan Swiers
Ryan Swiers	Balsam Ahmed	Claire Mathews					Sarah Sowden	Becky James		Becky James	Becky James	Becky James	Becky James
Claire Sullivan	Leslie Jones												
Michelle Mancini	David Gardiner												

Enabling workstreams

Population Health Management: coding – Chair: Edward Kunonga, Tom Hall, Ryan Swiers, Balsam Ahmed, Esther Mireku, Mia Moilanen

CABA: Healthier Communities & Community Connectors Network – Becky James

Workforce Development: Health Inequalities Academy – Gill O'Neill, Jill Harland, Claire Sullivan, Becky James

Other ICS networks with named specialist Public Health Support

Other ICS Networks	DPH/LA Consultants	PH FT Consultants/NECS	OHID	UKHSA
ICS Mental Health	Wendy Burke	Edward Kunonga, Catherine Parker	Glyn Smith	
Child Health and Wellbeing Network	Wendy Burke, Lorraine Hughes		David Gardiner	
Emergency Preparedness, Resilience, and Response (EPRR) – Local Health Resilience Partnership	Amanda Healy, Sarah Bowman-Abouna			Emmanuel Okpo
NENC Flu and COVID-19 Vaccination Board	Colin Cox			
Public Health Oversight Group	Gerry Taylor			
NENC SVOC Lead Directors Meeting	Colin Cox			

Programme Leadership

North East North Cumbria Health & Care Partnership

Workstreams:

Are led by quadrumvirate, ensuring a system-based approach:

- Clinical lead
- Association of Directors of Public Health lead
- Strategic Manager
- Office of health Improvement and Disparities lead

Identify where to:

- Lead
- Collaborate
- Advocate

Examples of Success

What we have achieved as a system

Investment

Secured £13.6m ICB Health Inequalities allocation every year for 5 years

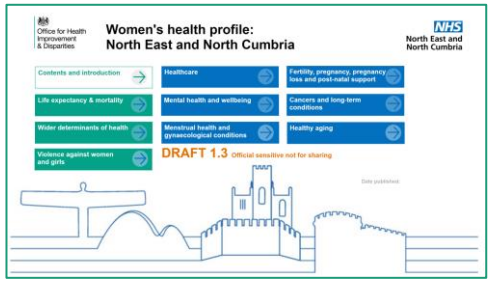
Match funded the LAs to fund Fresh the regional tobacco control office	Ensured every Acute Trust had an Alcohol Care Team and expanded weight management services	Scaled health literacy and poverty proofing programmes into NHS settings across the ICS	Contributed £9m over 3 years to support better access to general healthcare for people with multiple and complex needs	Invested in our Deep End Network	Worked with our VCSE to build on the community champions and community connector programme	Worked with the NENC ARC to embed research and evaluation into the programme

Tools and Products

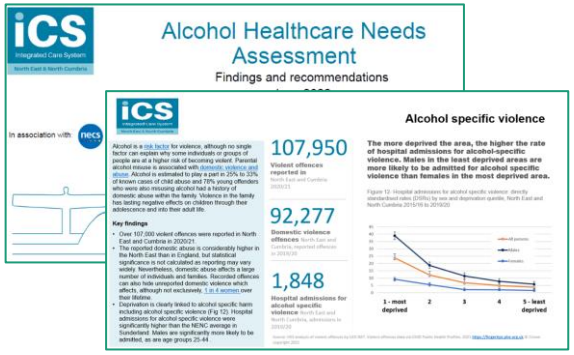
Supporting system learning:

- Healthcare Inequalities Toolkit
- Champions learning set
- Vaccine inequalities workspace

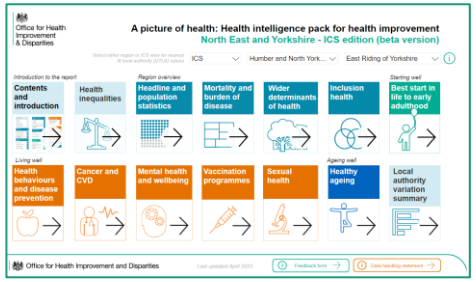
Bespoke data tools and resources (LKIS):



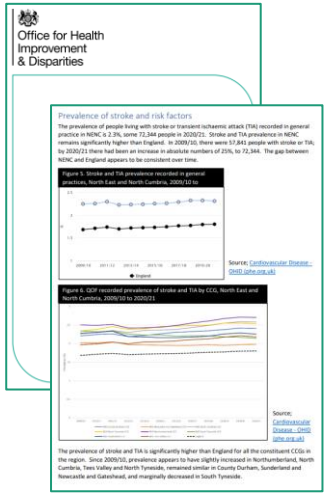
Women's Health Report



Alcohol Healthcare Needs Assessment



A Picture of Health



Stroke Health Inequalities

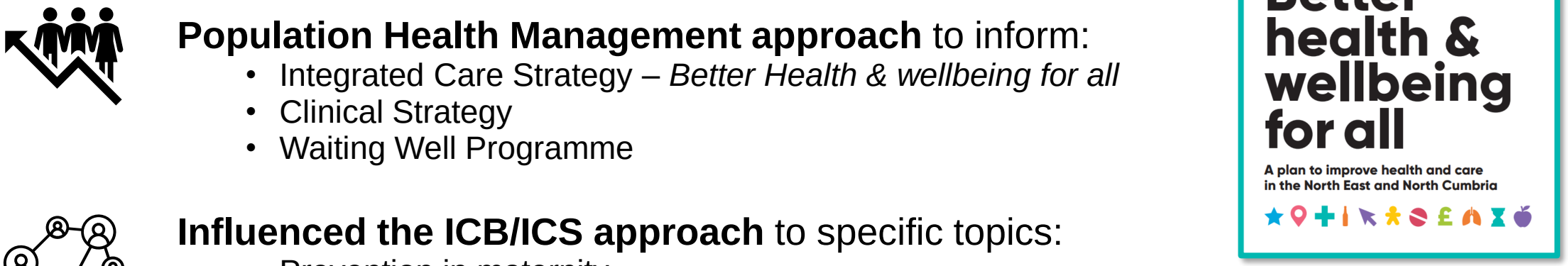
In development:

- Development of Health Equity Learning Academy to upskill the NENC workforce

Ways of Working

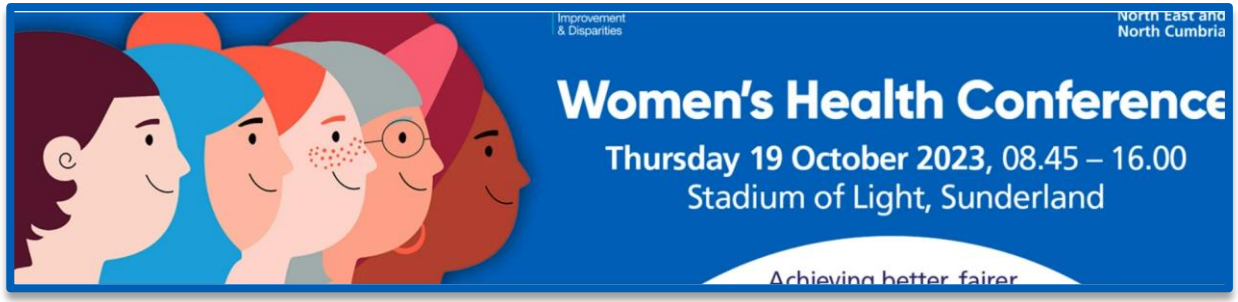
Population Health Management approach to inform:

- Integrated Care Strategy – *Better Health & wellbeing for all*
- Clinical Strategy
- Waiting Well Programme



Influenced the ICB/ICS approach to specific topics:

- Prevention in maternity
- Suicide prevention
- Vaping Position Statement



Increasing Capacity / capability

- Analyst Training
- PH Intelligence apprenticeships

Joint System Events/Training

- Children's Mental Health Summit
- Smokefree Future Conference
- Health Inequalities webinar series for ICBs (NE&Y)
- Women's Health Conference
- Vaccine Inequalities Summit

Reflections from DsPH and ICB Executives

working together across the ICS with a public health focus has helped us to better understand healthcare inequalities and the part that we can all play in reducing these inequalities in the North East

True collaboration is built on a foundation of relationships of trust and transparency. Building PH into the ICS as an equal partner has been instrumental in enhancing the relationships. Prevention is firmly embedded in the ICS strategy and understood to be key to improving population level health outcomes whilst also ensuring the longer-term sustainability of the NHS. Collective action on our three biggest causes of preventable mortality and morbidity, alcohol, tobacco and unhealthy food has resulted in implementation of evidence led but innovative solutions with tangible outcomes.

Across the NENC we have managed to set the tone for a mutually beneficial relationship between the ICB and PH at all levels; from grass-roots working through to strategic decision-making. Our challenge is to keep checking ourselves against the original ambitions and strategic intent to improve health and wellbeing and reduce inequalities, while weathering the storms of system financial challenge, operational pressures and organisational change.

The integration and way of working together is a real strength in our ICS

The public health approach of working with the ICB rather than having parallel structures has meant a high level of input from many, with some key successes. This has become a two way process rather than an offer. We now need to maintain the focus on health inequalities through a time of change.