NHS
North East and North Cumbria

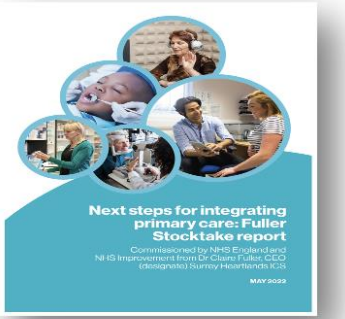
North East and North Cumbria ICB

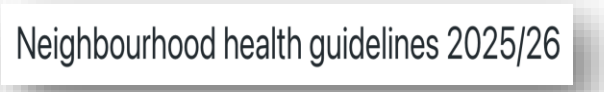
Integrated Neighbourhood Health

Policy into practice

- The government's health mission:
  - **from hospital to community**
  - **from treatment to prevention**
  - **from analogue to digital**

- 25-26 NHS planning guidance, Better Care Policy and the Neighbourhood Health guidelines highlight that the NHS 10-year plan will describe a 'shift' to Integrated Neighbourhood Health.





25-26 Core Publication Overview

NHS Operational Planning Guidance

4 key priorities:

- Reduce the time people wait for elective care
- Improve A&E waiting times and Ambulance response times
- Improve access to general practice and urgent dental care
- Improve patient flow through mental health crisis and acute pathways and Improve access to C&YP mental health

Alongside:

- Addressing inequalities and shift towards prevention
- Living within means, reducing waste and maximising productivity
- Making the shift from analogue to digital

Neighbourhood Health Guidelines

6 initial core components:

- Population Health Management
- Modern General Practice
- Standardise Community Health Services
- Neighbourhood MDTs
- Integrated Intermediate Care 'Home First' Approach
- Urgent Neighbourhood Services

With a specific focus for 25/26 on supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations

BCF Policy Framework

4 national conditions:

- Jointly agreed a plan (between ICB and Local Authority)
- Implementing the 2 BCF policy objectives*
- Complying with grant conditions and BCF funding conditions
- Complying with oversight and support processes

*** 2 Policy Objectives:**

- Reform to support the shift from sickness to prevention
- Reform to support people living independently and the shift from hospital to home

Community Health Services Guidance

Describes the core components of NHS ICB-funded community health services for C&YP and Adults across England, that should be considered in every neighbourhood including:

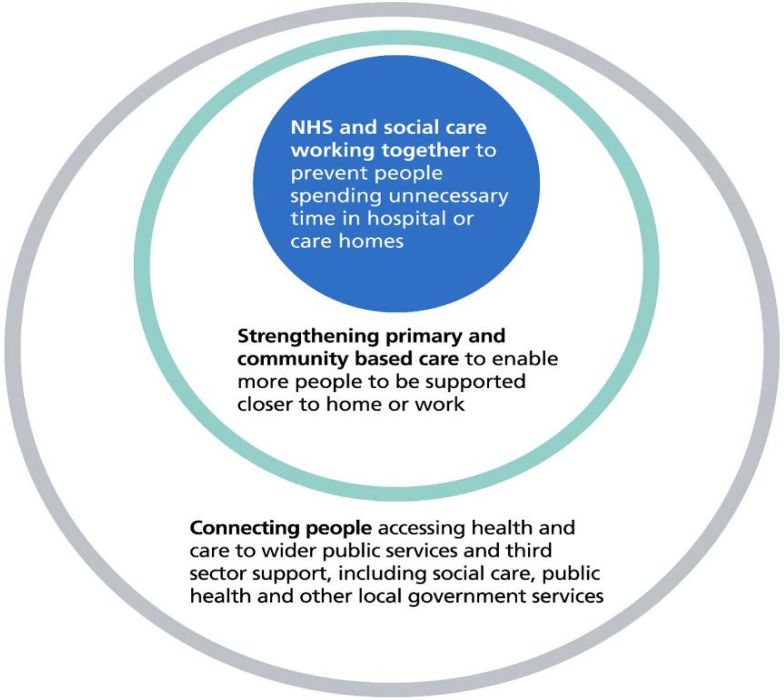
- 9 categories of Community Health Services for Adults
- 5 categories of Community Health Services for C&YP

With a view to codifying community health services as a mechanism to supporting demand and capacity assessment and planning with providers & ensure the best use of funding to meet local needs and priorities.

....With NHS 10 Year Plan due to be published in Spring 2025

Neighbourhood Health

- In 2025/26 NHS and social care work together to **prevent unnecessary time in hospitals or** care homes
- Next 5 years strengthen **out of hospital care** and connecting people to wider **public services** and **third-sector**
- **Warning** - overloading the concept of neighbourhood working so much that it becomes anything and everything (or nothing at all) – **agree what it means!**
(King's Fund, March 25)



INH 6 core components

Population health management

A person-level, longitudinal, linked dataset of all health and social care data, underpinned by appropriate data sharing and processing agreements, expanding to wider public services over time

A single system-wide PHM segmentation and risk stratification method, e.g. via Federated Data Platform

Modern general practice

ICBs should continue to support general practice with the delivery of the modern general practice model

This model should streamline care, improve access and continuity, and provision of more proactive care

Standardising community health services

Utilisation of the Standardising community health services publication to maximise use of funding for local needs and priorities, including commissioning of community health services

Connect mental and physical health services to ensure complete provision, and link with the VCFSE sector

Neighbourhood multidisciplinary teams (MDTs)

Multidisciplinary coordination of care for population cohorts with complex health and care or social needs who require support from multiple services and organisations

A core team assigned for complex case management, with links to an extended specialist team

A care coordinator assigned to every person or their carer in the cohort as a clear point of contact

Integrated intermediate care

Short-term rehab, reablement and recovery services delivered under a therapy-led approach

Home First approach to delivery of assessment and interventions, underpinned by step -up referrals and step- down planning directly between community and acute services

Urgent neighbourhood services

Standardise and scale services such as urgent community response and hospital at home, ensuring alignment with local demand, and with front-door acute services such as Urgent Treatment Centres

Involve senior clinical decision makers as part of a “call before convey” approach in ambulance services, and enable healthcare staff and care home workers to access clinical advice without needing to call 999

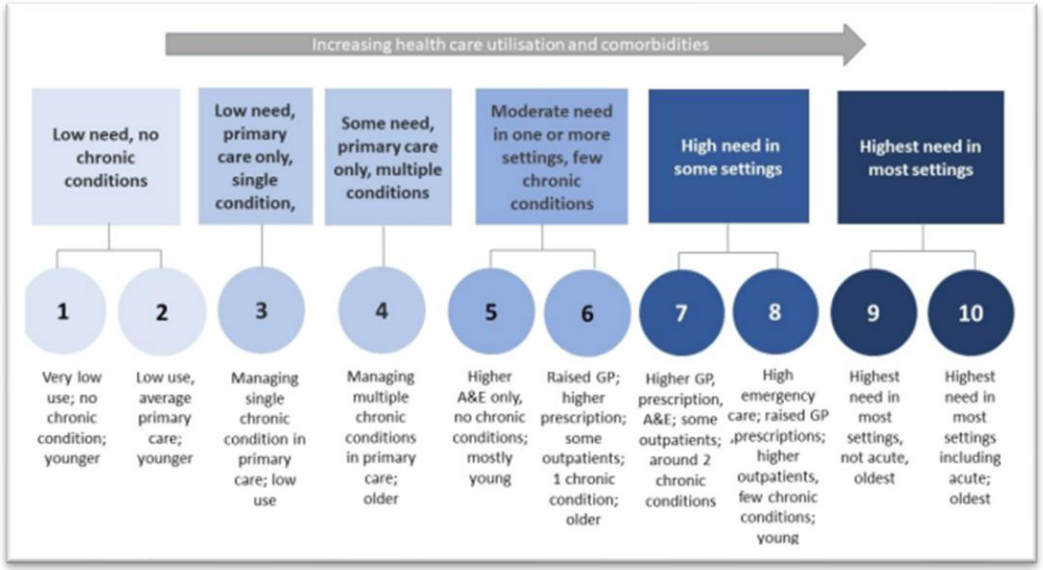
Population health intelligence

Focus on the greatest needs

Develop intelligence on the population – Population health information showing state of population health and identifying groups most at risk.

Focussing on high risk groups – People with complex health and care needs who require support from multiple organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs – NHS England.

Design and adapt – Using the outcomes of this to define the key issues and target required action based on the evidence. Mapping what services are available now.



'[One of the]essential steps for delivery of integrated care…requires an ***understanding of the population and their needs*** *using integrated data-sets'*

Lord Darzi – 2024 Independent investigation of the National Health Service in England

Population of focus

65+ people with complex needs (now and 2035)

- 656,000 residents (+167,000)
- 177,000 classified as frail (+46,000)

- X10 use of UEC services (housebound)
- 46,000 living with loneliness (+12,000)
- 39,000 confined to house (+9,000)

- 44% of all hospital attendances conveyed by ambulance are for 65+
- 37% of 111 calls are from most deprived areas (+11,000 calls)

- 36% of Category 1 and 3/4 999 calls are from most deprived areas
- 460 extra days in ambulance conveyances of Category 1 and 3/4 calls

- Pop health stats

- On average accounts for 23% all ED attendances
- > 1/3 of Type 1 A&E attendances from most deprived areas
- +18,000 attendances and +£4M in Type 1 A&E attendances

- On average account for 44% of all hospital admissions
- 31% of 0/1 LOS are from most deprived areas
- +8,155 patients per year (22 per day) and +£76M in Emergency Admission costs

Identifying our opportunity to do ‘better’

Proactive preventative and urgent responsive care

- PoP health stats

- 570,000 people in NENC eligible for proactive care:
  - Over 8,000 had five or more A&E attendances
  - 6,000 were admitted for an avoidable condition

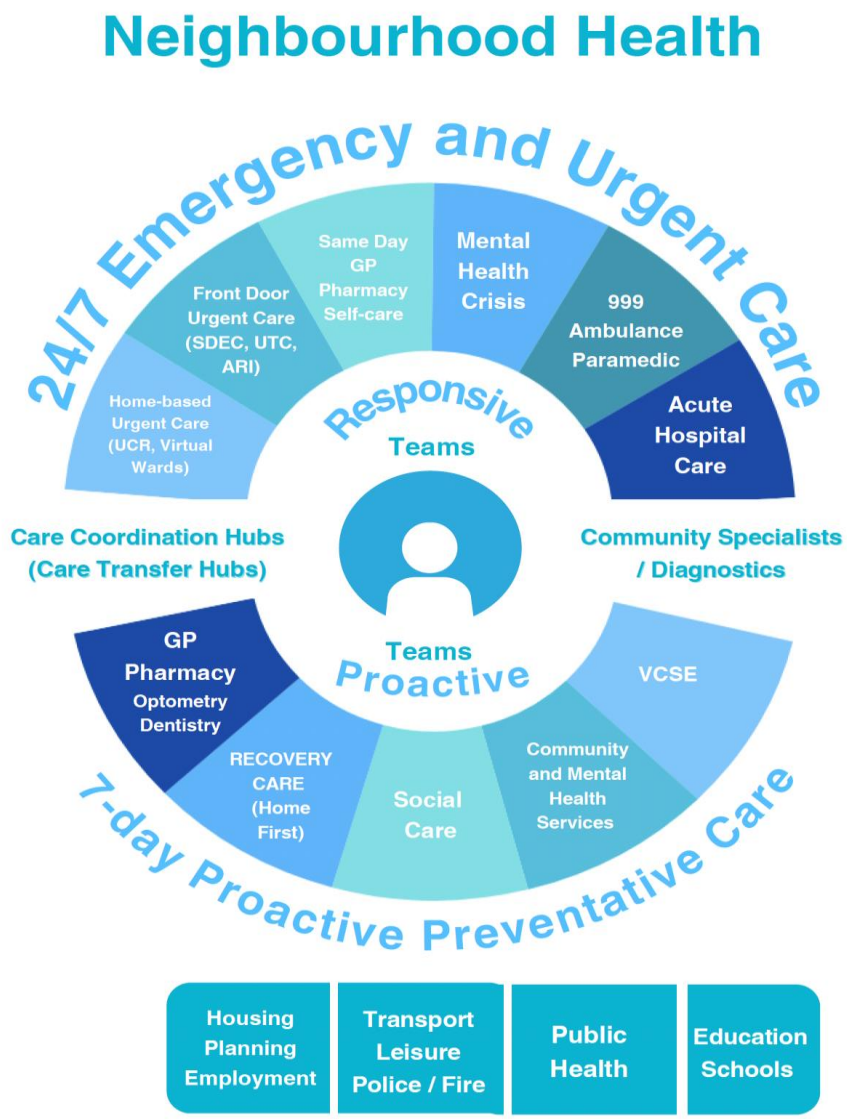
- 26.9% of ambulance Cat 3/4 calls result in conveyance to hospital

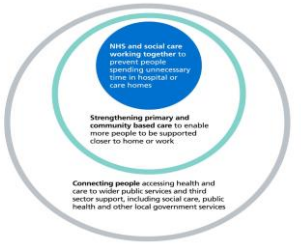
- 29.5% of all A&E attendances were recorded as having ‘non-urgent’ illnesses
- 51% of UTC attendances were recorded as having ‘non-urgent’ illnesses

- Of all admissions, 10.2% were avoidable with an average length of stay of 5 days, which equates to 191,230 bed days
- Nearly 36,000 emergency spells for people with palliative care needs per year
- 531 people were in a hospital beds with NCTR week ending 5/1/25

Policy to framework

- Urgent neighbourhood services
- Integrated intermediate care
- Neighbourhood multidisciplinary teams
- Standardising community health services
- Modern general practice
- Population health management



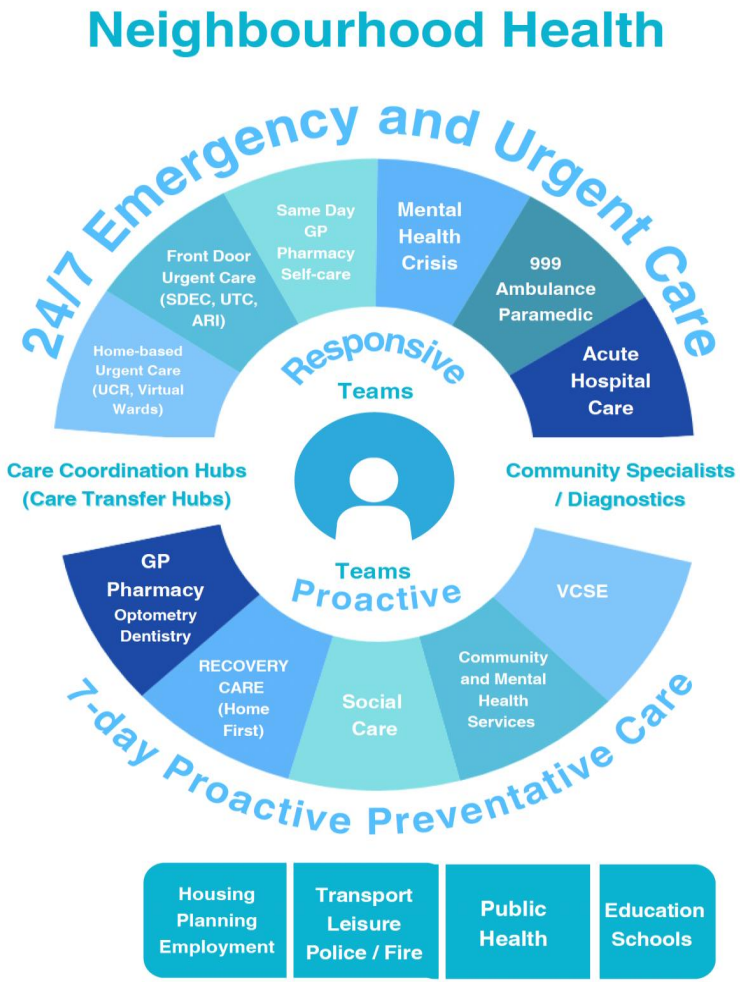


Treatment to prevention | Hospital to community | Analogue to digital

Integrated access via care coordination – step up and step down from crisis to recovery and prevention

Integrated delivery – person centred, proactive/ preventative MDTs and urgent responsive services

NENC ICB INH 25-26 Strategic Focus



- Focus on **older people with complex needs** (frailty)

- Focus on **LDT planning** for:
  - Integrated, coordinated planning and commissioning to enact the 'shift'
  - Integrated access via care coordination – step up and step down, intermediate care
  - Integrated delivery – person centred, proactive/ preventative MDT approach

- Focus on an **ICS level framework:**
  - Year 25/26 plans building up to the 10 year ambition, based on the 6 core components of Integrated Neighbourhood Health articulated at place.

Policy to people

An older person with complex needs

A person becomes unwell at home with a water infection, confusion and a temperature. Their family check their **NHS appt** and ring the **CCH** which accesses the person's records

CCH send an **Urgent Responsive Care** team in 2hrs, offering **point of care blood** tests and a bladder scan. The person wishes to stay at home

The **Acute Frailty Service** initiates IV therapies, delivered by the **community pharmacy**, an urgent care package for overnight and provides **monitoring technology**

Over 7 days, the person improve, mental health liaise offer support for delirium and a **digital holistic needs assessment** is started.

After 7 days, the **neighbourhood proactive care team** completes the assessment, and a digital care plan is shared to all services and the CCH

The person's house is equipped for independence and offered **home-based reablement.** The **community mental health team** diagnose dementia and the **MDT** rationalised medications

A person is given an urgent **community scan for worsening blood test** and speciality **advice and guidance** recommends a catheter initiated by the continence team.

Age UK, part of the MDT offers drop-in support and activities for mobility and memory. The person's **care coordinator** starts **advance care planning**

After 12months of wellbeing and support, the person dies peacefully at home based on his wishes and his family are offered **bereavement support**.

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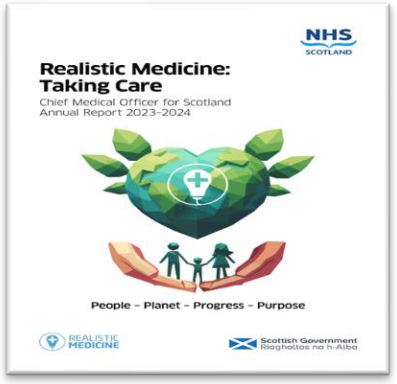
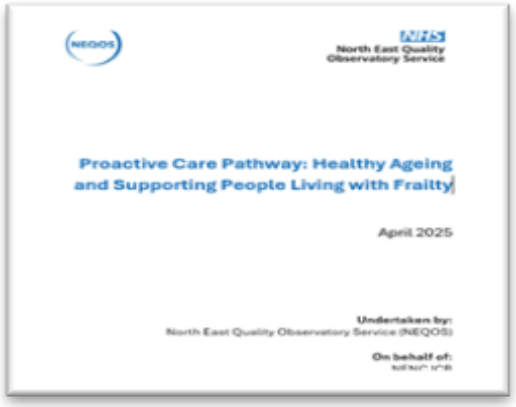
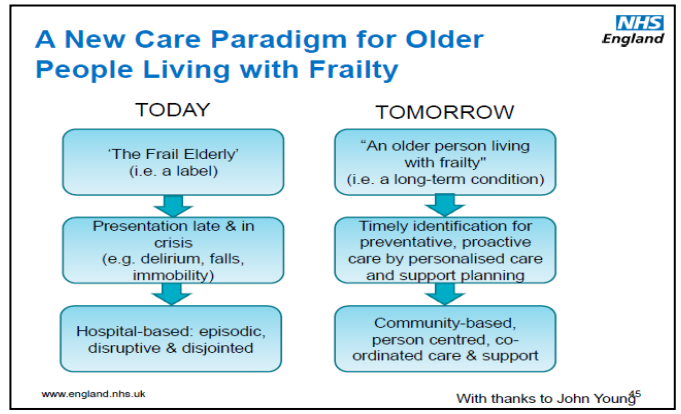
Policy to practice

An older person with complex needs





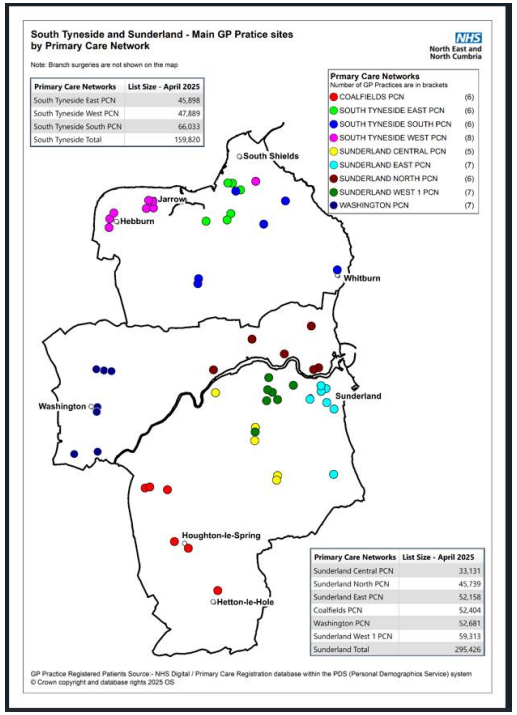


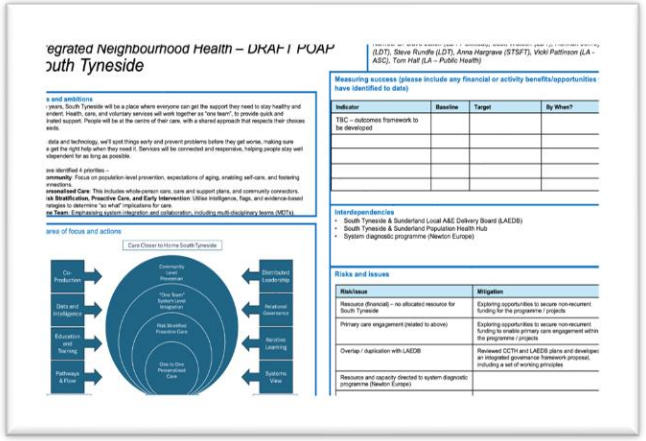
Local plans are in place:

- Urgent Responsive Care
- Proactive Frailty Care

Policy to service planning

An older person with complex needs e.g. *South Tyneside and Sunderland*



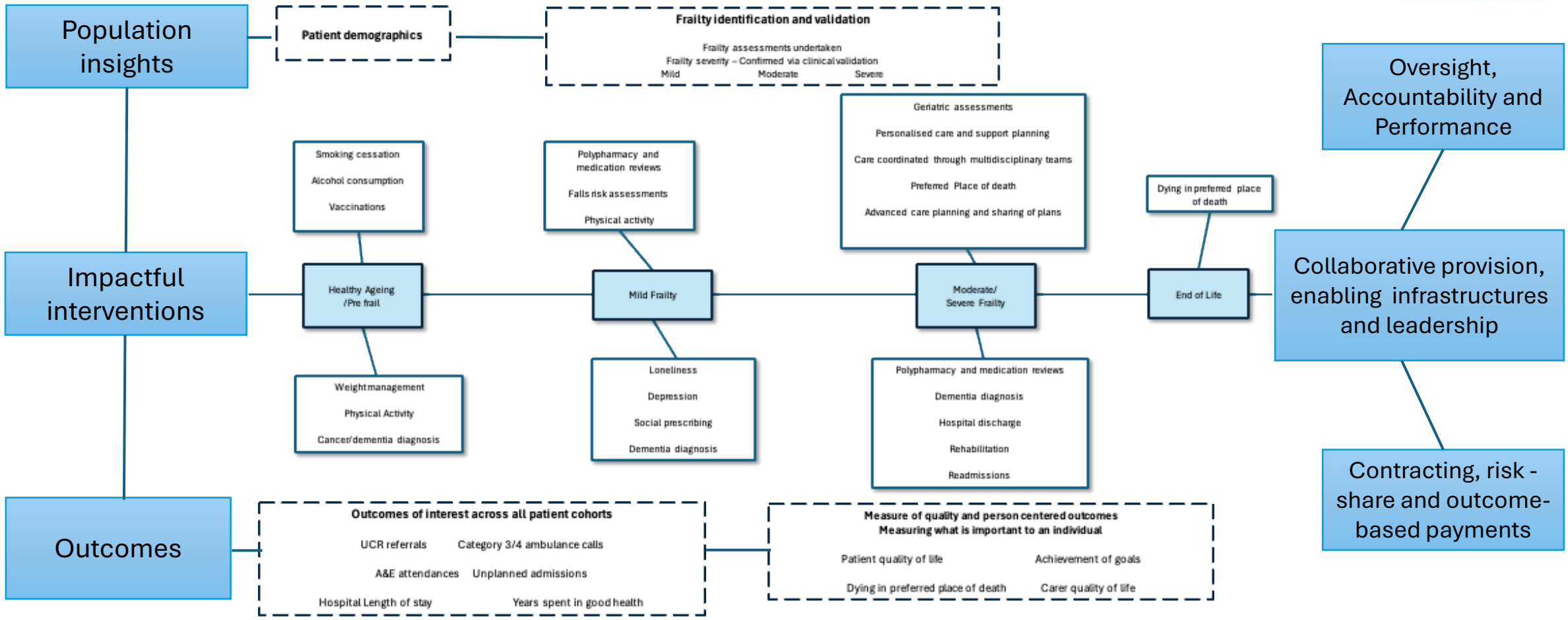


Local INH blueprint themes

- System approach, frailty focus
- Metrics relating to reduction in unplanned admissions, workforce numbers, investment in VCSE, LAWP metrics.
- Local governance support structures
- Improving MDT care co-ordination for frailty
- Development of proactive, personalised care approaches
- Identified risks – workforce capacity, engagement, system pressures impacting on ability to drive change, culture and attitude.

Policy to Strategic Commissioning

Frailty: Whole pathway of care

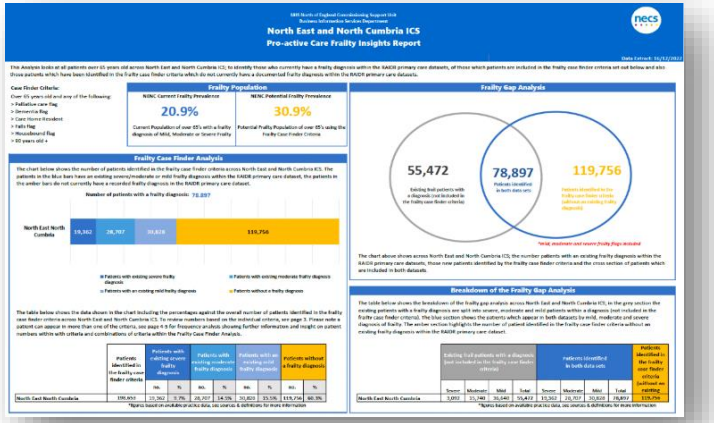


Strategic Planning

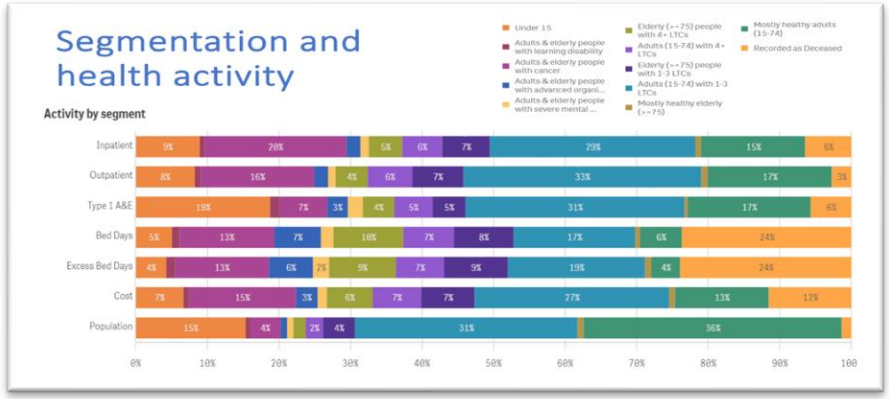
Insights and intelligence

- Proactive Care Dashboard in Primary Care suite on RAIDR – lens of frailty, health inequalities and secondary care activity.

- Frailty intelligence reports to help places better improve the identification and diagnosis for frailty – segmentation / risk stratification

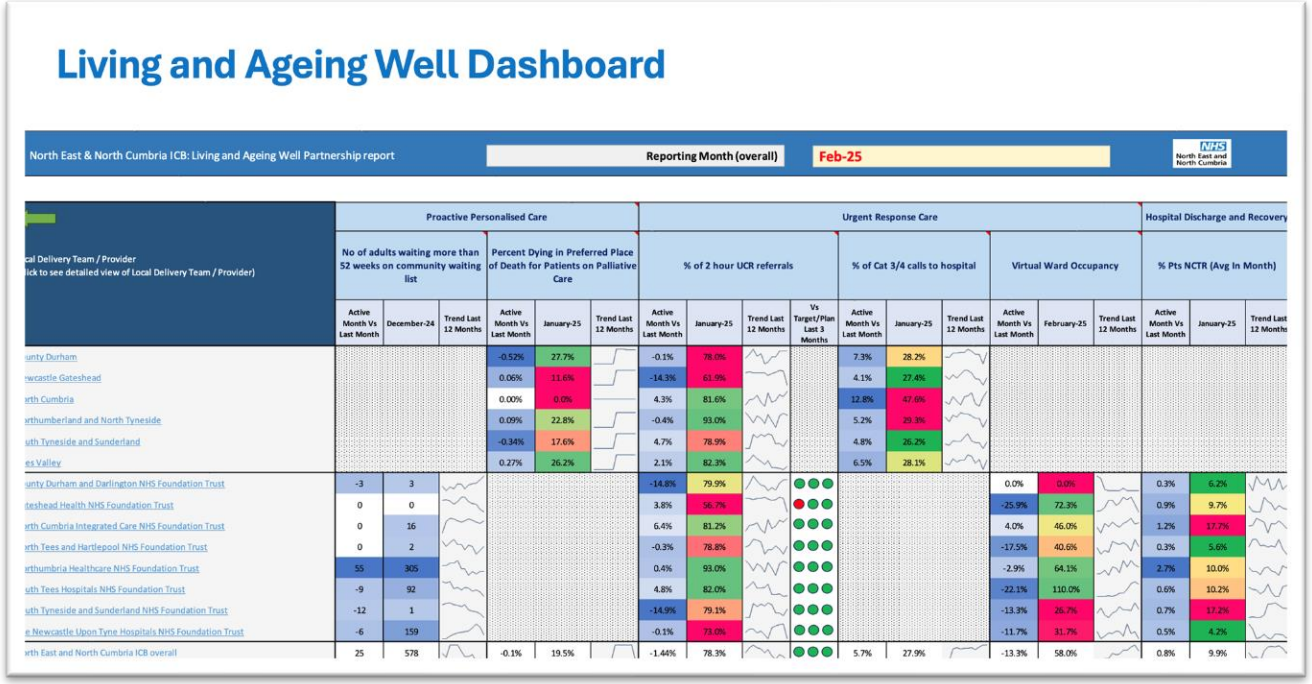


- NENC is incubator site for national PHM tool development



Strategic monitoring and evaluation

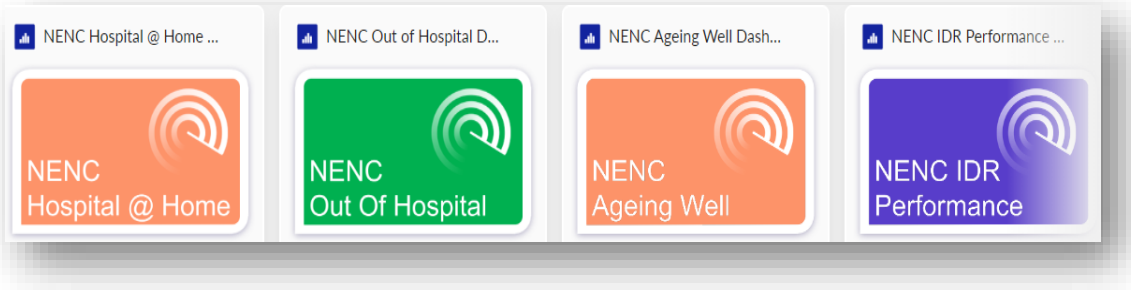
Measurement and outcomes

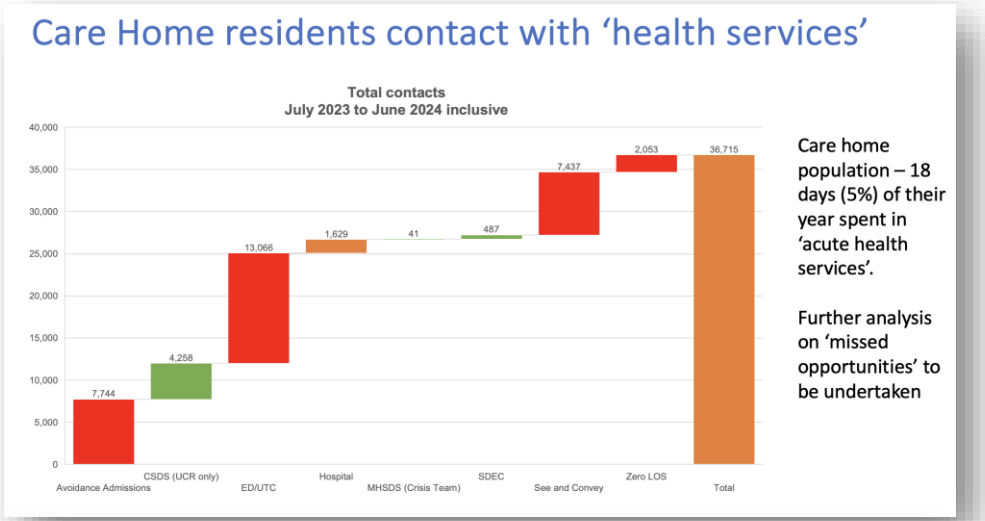


Living and Ageing Well Dashboard

North East & North Cumbria ICB: Living and Ageing Well Partnership report — Reporting Month (overall): Feb-25 — NHS North East and North Cumbria

Local Delivery Team / Provider (click to see detailed view of Local Delivery Team / Provider)	Proactive Personalised Care						Urgent Response Care										Hospital Discharge and Recovery		
	No of adults waiting more than 52 weeks on community waiting list			Percent Dying in Preferred Place of Death for Patients on Palliative Care			% of 2 hour UCR referrals				% of Cat 3/4 calls to hospital			Virtual Ward Occupancy			% Pts NCTR (Avg In Month)		
	Active Month Vs Last Month	December-24	Trend Last 12 Months	Active Month Vs Last Month	January-25	Trend Last 12 Months	Active Month Vs Last Month	January-25	Trend Last 12 Months	Vs Target/Plan Last 3 Months	Active Month Vs Last Month	January-25	Trend Last 12 Months	Active Month Vs Last Month	February-25	Trend Last 12 Months	Active Month Vs Last Month	January-25	Trend Last 12 Months
unty Durham				-0.52%	27.7%		-0.1%	78.0%			7.3%	28.2%							
wcastle Gateshead				0.06%	11.6%		-14.3%	61.9%			4.1%	27.4%							
rth Cumbria				0.00%	0.0%		4.3%	81.6%			12.8%	47.6%							
rthumberland and North Tyneside				0.09%	22.8%		-0.4%	93.0%			5.2%	29.3%							
uth Tyneside and Sunderland				-0.34%	17.6%		4.7%	78.9%			4.8%	26.2%							
es Valley				0.27%	26.2%		2.1%	82.3%			6.5%	28.1%							
unty Durham and Darlington NHS Foundation Trust	-3	3					-14.8%	79.9%						0.0%	0.0%		0.3%	6.2%	
teshead Health NHS Foundation Trust	0	0					3.8%	56.7%						-25.9%	72.3%		0.9%	9.7%	
rth Cumbria Integrated Care NHS Foundation Trust	0	16					6.4%	81.2%						4.0%	46.0%		1.2%	17.7%	
rth Tees and Hartlepool NHS Foundation Trust	0	2					-0.3%	78.8%						-17.5%	40.6%		0.3%	5.6%	
rthumbria Healthcare NHS Foundation Trust	55	305					0.4%	93.0%						-2.9%	64.1%		2.7%	10.0%	
uth Tees Hospitals NHS Foundation Trust	-9	92					4.8%	82.0%						-22.1%	110.0%		0.6%	10.2%	
uth Tyneside and Sunderland NHS Foundation Trust	-12	1					-14.9%	79.1%						-13.3%	26.7%		0.7%	17.2%	
e Newcastle Upon Tyne Hospitals NHS Foundation Trust	-6	159					-0.1%	73.0%						-11.7%	31.7%		0.5%	4.2%	
rth East and North Cumbria ICB overall	25	578		-0.1%	19.5%		-1.44%	78.3%			5.7%	27.9%		-13.3%	58.0%		0.8%	9.9%	





'Right Place - UEC mismatch'

Measurement and outcomes

An older person with complex needs

Health Inequalities

Proactive Preventative Care

- Frailty assessment / diagnosis
- Vaccination uptake
- Falls, SMR, depression, dementia
- Social Prescribing
- MH access
- Personalisation – choice / SDM / continuity
- PCSP + Advanced Care Planning

Urgent Responsive Care

- % reside criteria + DRD
- PH budgets
- UCR /VW referrals
- Ambulance C3/C5 + 999 falls
- A&E attendances > 65year
- SDEC frailty – SAMIT 75
- Admissions ACSCs / Falls /End of Life

FRAILTY OUTCOMES

- Lives spent in ill-health
- Frailty prevalence
- Days in dwelling of choice
- Social Isolation
- Care Home placement
- Reablement at 91 days / outcomes
- Place of death
- Quality of life / experience – staff / person
- Winter fuel payments

Real-time meaningful measurement

‘What Matters’ outcomes

Strategic procurement of services

Designing services, shaping supply, capacity and demand

- **Designing service**
  - Supporting organisational delivery across best practice and sharing (working groups)

- **Capacity and demand**
  - Formal planning, trajectories
  - Informal 1:1 with providers, understanding true demand and workforce capacity

- **Contractual and funding levers**
  - Use of incentives and outcomes-based payments
  - Align contract specifications to develop ‘whole pathways’. For example, contract shifts

Public Health / LA	VCFSE	General Practice Primary care	Acute and Community	Ambulance	Social Care
Communication on staying connected, active and healthy	Screening for loneliness and bereavement	Proactive Care Screening for frailty, CGA (falls, medicine) and MDT	Acute Care Service (align frailty SDEC, VW, UCR and WITH OOH GP)	CAS (align ambulance CAS ‘offer’ WITH local SPOAs)	D2A / Intermediate Care (align WITH care homes, domiciliary and community-therapy / nursing)
Advocacy and financial support	Social connectivity WITH SPLW in primary care	Urgent Care Service GP /Pharmacy WITH UCR/SDEC/UTCs /ARI			

Enabling Neighbourhood Health

ICB actions for 25/26

- 3 key reflections from partners – NH isn't new, risk are clear, frailty insight and performance is helping us move from ambition to action
- Agree strategic principles, outcomes and ambitions across priority populations
- Explore further strategic enabling functions – insights, measurement, learning and sharing, funding, ICS-partner engagement and planning
- Re-fine role of place-based committees – local design, oversight, commissioning, engagement with HWB and public
- Over the coming months, the Living and Ageing Well Partnership via Local Delivery Teams will continue to support service development:
    - Finalise place-based blueprints for Neighbourhood Health
    - ICB events in May to support proactive care for frailty/ Urgent Responsive Care Model .
    - Use our data insights to drive improvement across all localities.

Core Components	25/26 priorities (examples)
Population Health Management	• PCN DES CAIP requirements to identify cohort of patients for risk stratification 25/26 (frailty) - provide data to practices and PCNs (via proactive frailty RAIDR tool) and support national incubator PHM tool development
Modern General Practice	• Workforce - Increased care navigation through training and development • Estates - Increasing clinical space to deliver appointments / MDT working (f2f and virtual) • Primary Care Digital First - maximizing use of tools • Pharmacy First - expanding uptake of the offer for 7 common conditions
Standardising Community Health Services	• Develop understanding of financial, capacity & demand and gap analysis baseline for community service universal offer across system aligned to local commissioned service review
Neighbourhood MDTs	• Deliver system wide event to share best practice, identify opportunities, role in providing home based preventative model of care and consider development of commissioning framework
Integrated Intermediate Care 'Home First'	• Develop plans (output to be determined) inline with ICC (aligning of Care Transfer Hubs with SPOAs) and national BCF and IMC policy
Urgent Neighbourhood Services	• ARI /Virtual Ward / UCR and Acute Frailty SDEC – develop specification for approval • Care Coordination– 'urgent care' assets aligned to capacity & demand modelling (planning assumptions) with SPOAs and bespoke work on care home population

INH - board development discussion (themes)

- **Overall approach**
  - ‘Form’ versus ‘Function’ perspective?
- **Prioritisation**
  - Older people with complex needs versus other population cohorts?
- **Oversight and development**
  - LAWP *plus* cross-sector development group?
- **Develop a INH commissioning framework e.g.** *frailty exemplar*
  - If so, how to make this happen?