



Leadership Board (Extraordinary Meeting)

Tuesday 11th October, 2016 at 2.00 pm

Meeting to be held in a Committee Room, Civic Centre, Gateshead Council, Regent Street, Gateshead, NE8 1HH

www.northeastca.gov.uk

SUPPLEMENTAL AGENDA

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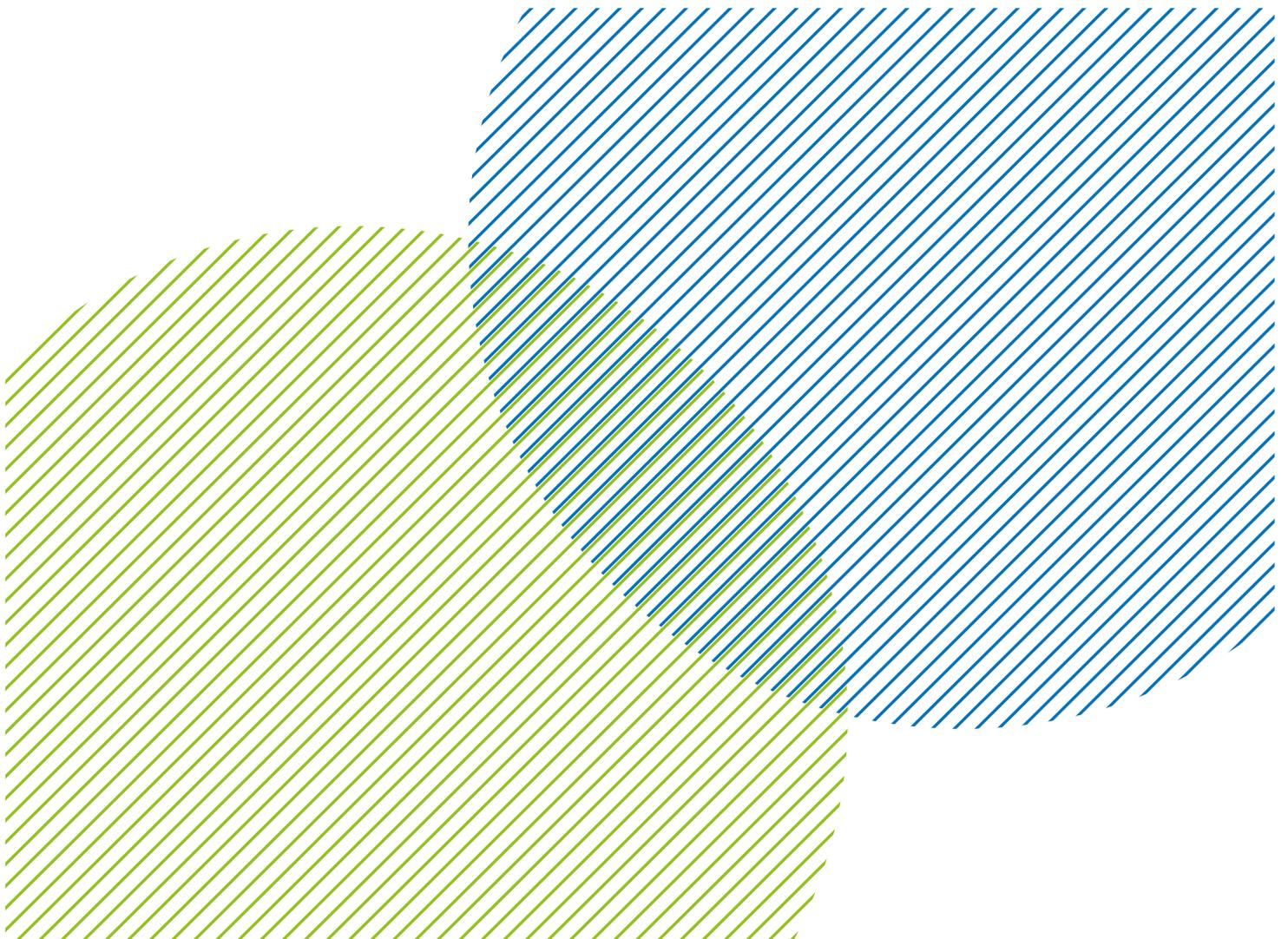
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To All Members

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Health and Wealth - Closing the Gap in the North East

Executive Summary of the Report
of the North East Commission
for Health and Social Care Integration



Foreword by Duncan Selbie, Chief Executive of Public Health England and Chair of the Commission

I am delighted to have been given the opportunity to chair the North East Commission for Health and Social Care Integration. The North East is a region of vital strategic importance, with a proud history, strong identity and deep sense of community. In taking on this role I was particularly struck by the way in which civic and business leaders had developed an economic vision for their region that was both outward facing and had human capital development, and therefore people, at its heart.

The starting point for the Commission was that we were concerned with health outcomes much more than with organisational structures. So this is a report about improving health and wellbeing, not about NHS and local authority services. We hear a lot about budget deficits in health and social care, but the deficit we have focussed on is healthy life expectancy.

The title of the report has been carefully chosen. Health and wealth are two sides of the same coin – closing the health and wealth gap in the North East, compared to the UK as a whole, was the Commission's number one priority. Poor health and shorter life expectancy are both consequences and causes of the fact that average Gross Value Added (GVA) per capita in the region is only three quarters of the national average. The Prime Minister has said that inequality in healthy life expectancy is unacceptable and that she wants social and economic reform that will establish an 'economy that works for everyone'. Our report sets out how the North East can lead the way on this.

The North East has strong acute health services and increases in life expectancy along with reductions in smoking have been greater than elsewhere in the UK. But there is no hiding from the fact that health outcomes are poor and that health inequalities within the region are far too great. Closing the healthy life expectancy gap with the rest of the UK over the next decade would add 400,000 additional years of active, healthy life for the people of the region.

That's why our first recommendation is that the entire system needs to shift its priority towards prevention. We see this through two lenses: risk assessment and life cycle. By far the greatest risk is smoking, which is why we support intensifying the focus on programmes to reduce smoking. But the other key focus for prevention should be improving outcomes across the life cycle from school readiness, through good and fulfilling employment to healthy and independent old age.

We propose that North East civic and health leaders should set a target for radically increasing preventive spending across the health and public service system. To kick start this, we have proposed the establishment of a prevention investment fund, that will bring together contributions from all partners that stand to gain from the expected savings, including central government.

What gets done is what gets measured, so this commitment to prevention needs to be backed by accurate and transparent data on spending across the system. To help with this the Chartered Institute of Public Finance and Accountancy (CIPFA) was commissioned by North East leaders in health and social care to undertake the first public sector balance sheet review for any English region. Local partners now have a methodology for identifying spend and they can use this to review the extent to which the ambition to increase preventive expenditure is being met.

Nowhere is the link between health and wealth more important than in relation to work. Good work is both the best route out of poverty and the surest basis for good health. That's why we make a series of recommendations in the report that improve support for keeping people in work, and put in-work progression at the heart of the North East Strategic Economic Plan. These include: training and support for primary care staff to get people back to work quickly; addressing mental health across the system; and encouraging employers to improve workplace wellbeing.

This report is a call to action. The Commission urges leaders in local government, the NHS, the business community and voluntary sector to work together with local people to achieve better health and wellbeing outcomes. This needs to be delivered by every part of the system. Whilst the specific devolution deal under consideration by the North East Combined Authority (NECA) has not been taken forward, all involved have reiterated their commitment to the principle of devolution. Devolution, population based health improvement, and the drive to improve life chances across the North East, are long term imperatives. The Commission report sets out a clear agenda for closing the health and wealth gap. I hope that local and national leaders will study it carefully and then work together to enact its recommendations.

A report like this is the product of thousands of hours of consideration of evidence, policy development, commission debate and sheer hard work. My fellow commission members have generously donated their time and wisdom. Hundreds of people volunteered to come to evidence sessions across the North East to give us their views. Rosemary Granger did a fabulous job as programme director, supported by a great team, with Helen Dickinson valiantly holding the pen on the final report. To all those people, a profound thank you from me. Together, we have produced a report which we hope will make a real difference to the health and wealth of the North East.

The full report is available on www.northeastca.gov.uk

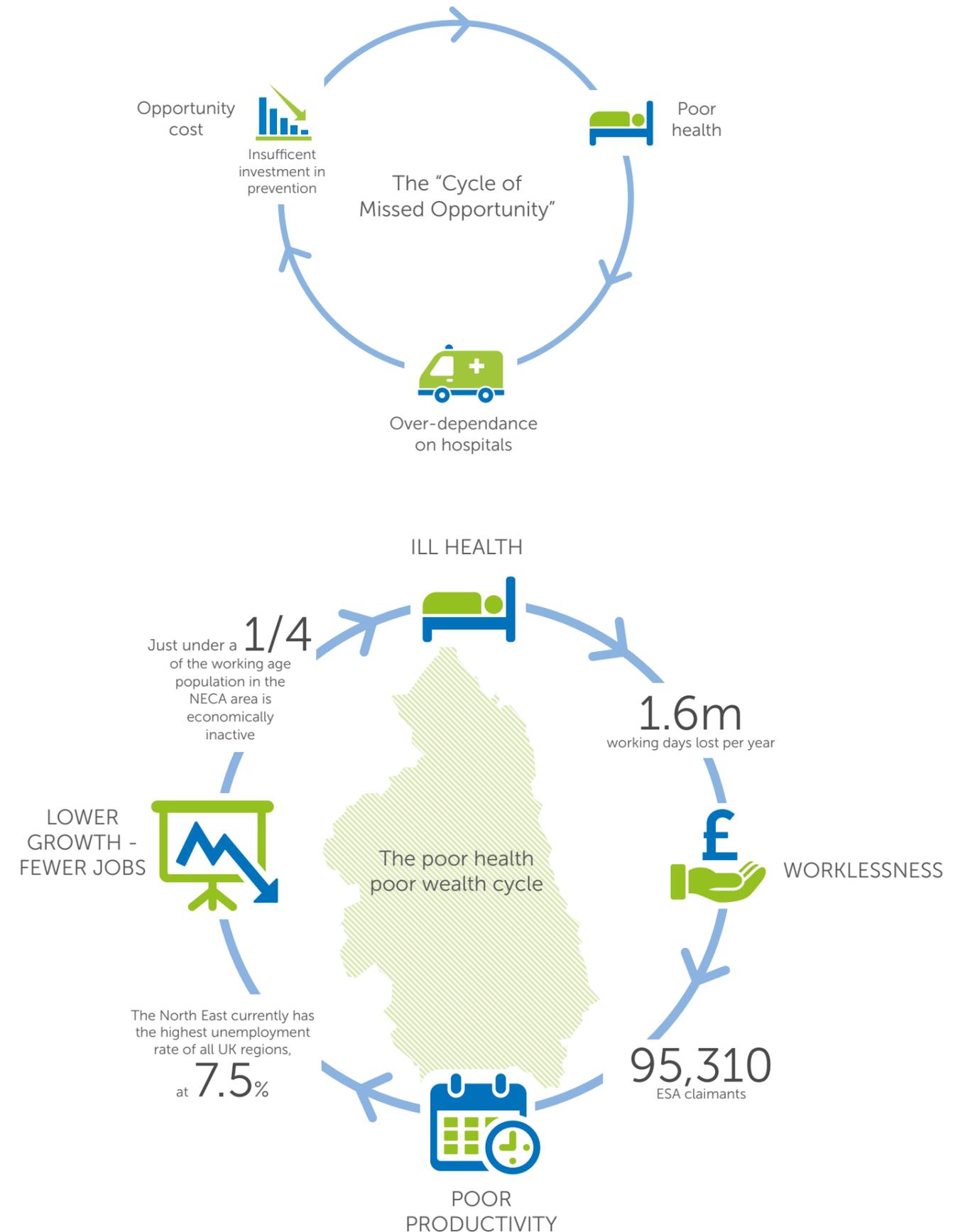


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Commission Chair and Chief Executive of Public Health England

Executive summary

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The North East Commission for Health and Social Care Integration was established to cut through this vicious circle. The Commission was set up by NECA, local NHS organisations and Public Health England as part of the North East devolution deal, with all organisations recognising the value of an independent group of national experts able to take a fresh look at the issues and the scope to address these through joint working. This report of the Commission sets out a vision for transforming the health and wellbeing of North East residents and in so doing helping to improve the performance of its economy and the prosperity of its people. It is a call to action for leaders across the health and care system in the NECA area. While NECA is no longer planning to take forward a mayoral devolution model at the current time, the report remains as relevant as ever and its recommendations can be implemented through existing structures in parallel with further discussions on devolution.



The NECA area spends £5.2bn on health and care each year. Of this over 60% is spent on tackling the consequences of ill health through hospital and specialist care, over 20 times the 3% devoted to public health. Spend is organised around institutions, not individuals' needs. Hospitals are over-used, with high levels of unplanned and emergency admissions. This reliance on hospital care is neither necessary nor affordable: it reflects an over-focus on treating disease at the expense of preventing it arising in the first place. There is a clear need for a substantial shift in financial and workforce resources to prevention, with people helped to manage long-term conditions better and stay well at home for longer.

Recommendation 1: NECA partners should set themselves an ambition to radically increase preventive spending across the health and care system and wider determinants of health and wellbeing.



Freeing up the resources needed to radically increase preventive spending will be challenging but is absolutely vital for the step change in population health to occur. Shifting funding and the workforce away from a focus on treating people in hospital to helping them stay well in the community will require a radical change to configuration and capacity of hospital services. The Sustainability and Transformation Plan (STP)¹ process offers an opportunity to achieve this change. Through the STPs, partners across NECA are redesigning a model of care not suited to addressing underlying health needs. A changed acute care landscape - alongside improvements in primary care, prevention, moving care closer to home and sustaining a robust social care sector - will be a key element of a more integrated, efficient, prevention-focussed health and care system that will improve health and wellbeing outcomes.

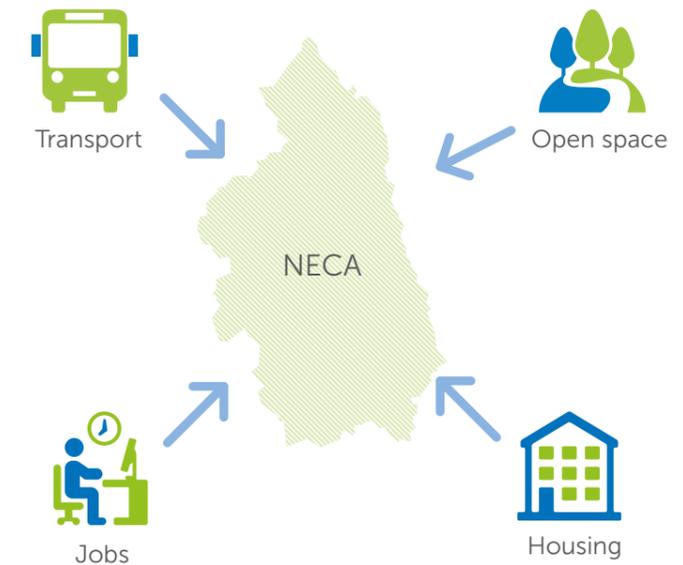
However, the STP process alone will not be sufficient to deliver the change recommended in this report. The Commission's vision of a system focussed on wellbeing will require increased preventive investment across the life course and in areas beyond the health and care system, such as housing quality and early years support. Addressing these wider determinants of health will require public, private and voluntary partners across the NECA area to unite around a shared vision of a society which supports people to make the right choices for their health and wellbeing. Promoting wellbeing must be integral to all public

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policy decisions, for example considering the health and wellbeing impacts of planning, transport or skills policies. This leads to the Commission's second recommendation.

Recommendation 2: Public sector partners across the NECA area should integrate preventive action and action to tackle inequalities in all decisions.

NECA partners must integrate prevention and wellbeing in all activity.



At present preventive spending is spread across health, care and wider public services, with little visibility or transparency in the amount or distribution of overall preventive spend. The region should work with the Chartered Institute of Public Finance and Accountancy (CIPFA) to establish a baseline of current preventive spend and methodology to track increase in spending over time, as well as acting as a pilot area to trial work being carried out by Public Health England and CIPFA to develop tools to assess the effectiveness of public health investment.

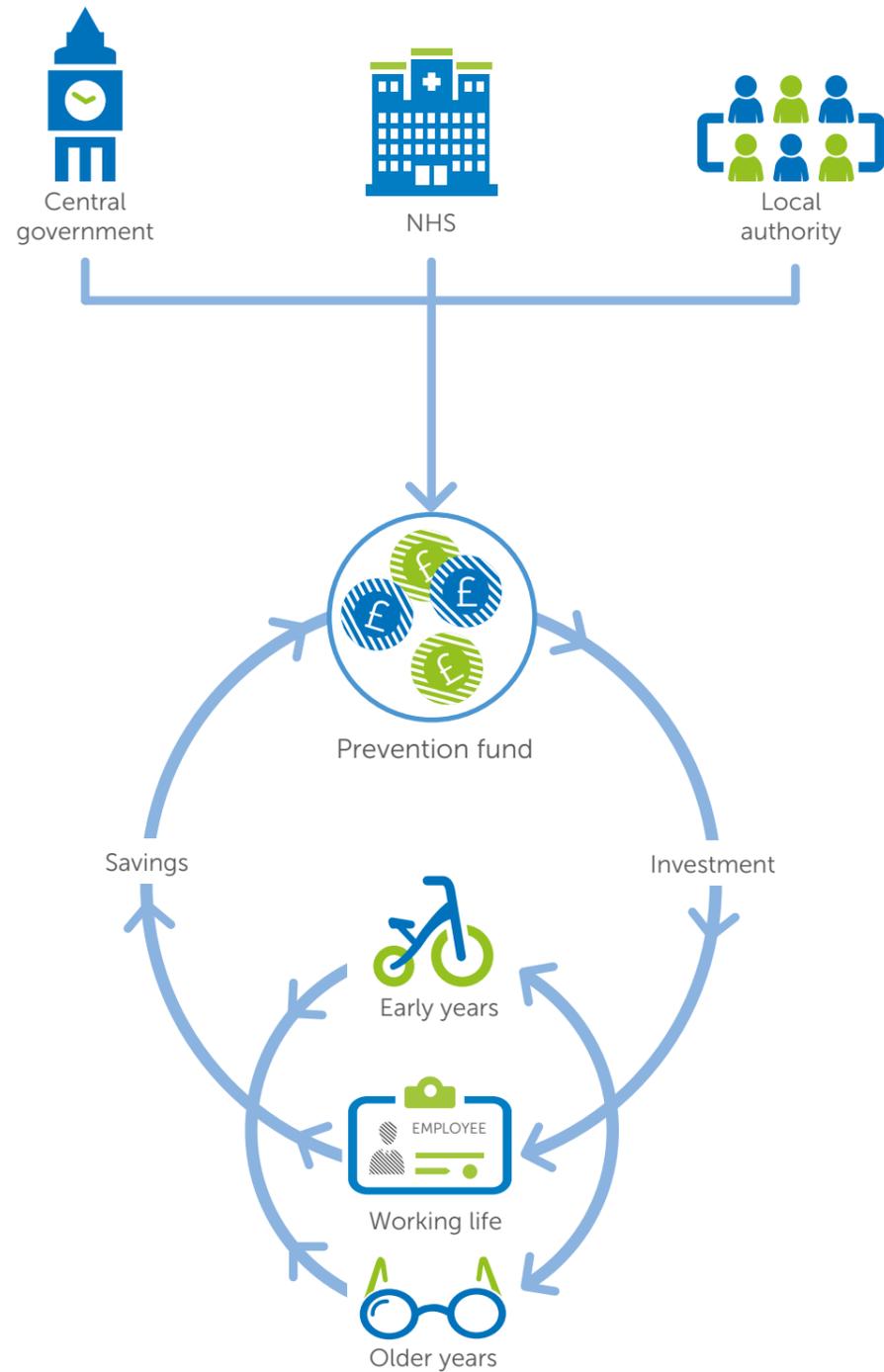
To ensure preventive spend is not diverted to other areas, allocated funds should be ring-fenced to a dedicated preventive investment fund. Partners can be confident that this represents value for money. The National Institute for Health and Care Excellence has concluded that "Most activities aimed at improving the public's health are extremely good value for money – and generally offer more health benefits than the alternatives tested, even though some of the benefits may not be realised in the short term."² The fund should be managed on a cross-system basis, investing in interventions likely to have the greatest impact across the health and care system irrespective of the original source of the funding.

Savings from the fund will accrue to a range of partners including commissioners and providers of health and care services and substantial savings to central government can be expected through lower welfare payments and higher growth as more people remain well enough to work.

Recommendation 3: Increased preventive spend should be assigned to a dedicated preventive investment fund managed on a cross-system basis and bringing together contributions from all partners who stand to benefit from the expected savings, including central government.

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Prevention fund will help people help themselves to stay well

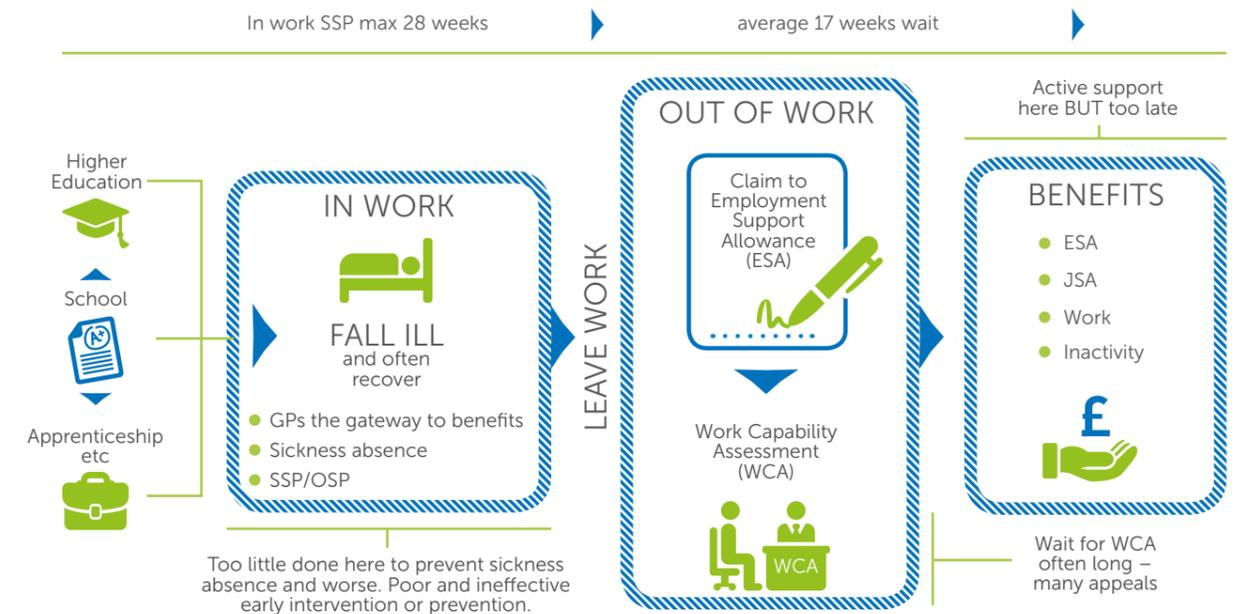


It will be for NECA partners to identify and determine the exact allocation of increased preventive resources to meet the needs of the region. However, the particular challenges faced by the NECA area suggest that increased resource could be divided between early years support, wider determinants of health, sustaining social care while improving integration with health services and lifestyle-based secondary prevention. Smoking prevention should be a key priority. The Fresh North East programme commissioned by all the NECA local authorities has already contributed to the fastest decline in smoking in any region in England over the past decade but smoking continues to be the primary cause of preventable illness and premature death.

A radical increase in preventive investment should have a significant impact on narrowing the health gap between the NECA area and the country as a whole and mitigating the increase in demands on health and care services in the medium to long-run. However, without good jobs and meaningful activity such as volunteering, preventive spend will not be enough to overcome the NECA area's wellbeing challenges. Meaningful work or other activity is one of the most important determinants of health but the North East currently has the highest unemployment rate of all UK regions. This acts as a significant barrier to economic growth through wasted labour force capacity. It is also a significant public health issue, due to the negative health impacts of unemployment. The Commission believes greater action to help people stay in work and return to work after sickness is essential. This work should complement NECA's existing work on Employment, Skills and Inclusion, with its focus on supporting those hardest to help and furthest from the labour market.

Recommendation 4: NECA partners should develop a programme of primary care training to support primary care staff in helping people access the best support to enable them to get back to work as quickly as possible.

Too few drivers in the journey keeping people in work.



● SSP - Statutory Sick Pay ● OSP - Occupational Sick Pay ● JSA - Job Seekers Allowance

Mental health is a particularly significant barrier to work in the NECA area, with over half of those claiming Employment and Support Allowance doing so due to a mental health condition.

Recommendation 5: The Commission recommends addressing mental health at three levels:

- i. improve the leadership and skills of managers at all levels within NHS and local authority organisations to create a supportive environment that enables employees to be proactive in protecting their own wellbeing;
- ii. commissioners of IAPT services should work with their service providers to ensure employment support is included as part of the Improving Access to Psychological Therapies (IAPT) offer on a sustainable basis, to support those individuals who require this service to avoid sickness absence or to return to work as quickly as possible;
- iii. NHS commissioners and providers should work with the NECA Employment, Skills and Inclusion workstreams to develop an integrated employment and health service.

Alongside the health and care system, employers have a key role to play in maintaining and improving the health and wellbeing of their workforce and supporting those with health conditions to remain in the workforce.

Recommendation 6: The Better Health at Work Award (BHAWA) scheme should be the preferred approach for employers to adopt to improve workplace wellbeing. NECA partners should set a target for the proportion of the workforce working for employers involved in the award scheme, and monitor progress towards this target.

Increasing employment and ensuring employment opportunities are high quality and offer the opportunity to progress is vital to health and wellbeing. NECA's Strategic Economic Plan sets a high level objective of achieving more and better jobs for the region.

Recommendation 7: The refreshed Strategic Economic Plan and NECA's employment and skills programme should continue to address the importance of in-work progression and job quality.

Achieving the Commission's vision of a radical shift in funding to prevention will require strong and visionary leadership from across the health and care system and the courage to make difficult decisions in order to protect the prize of long-term health improvement that this funding will enable. Ensuring prevention investment is focussed in areas where it will have greatest impact will require leaders to take on shared responsibility for outcomes, putting aside organisational boundaries and interests to lead a cultural change to the health and care system.

Recommendation 8: Leaders within organisations will need to look beyond the interests of their own organisations to drive improvement in wellbeing outcomes across NECA, leading a cultural change to a health and care system in which each health and care £ is used most effectively to support wellbeing, independent of the source of the funding.

Partners across NECA have already demonstrated the benefits of such a collaborative approach through the highly successful Fresh North East smoking cessation programme, which has contributed to the fastest decline in smoking of any region in England over the past decade. The region's ambitious and challenging target of reducing smoking prevalence to 5% by 2025 provides a further opportunity to bring partners together for a system-wide approach to meeting a shared goal.

Recommendation 9: Governance should be established at NECA level to drive forward implementation of these recommendations, bringing together local authorities, Clinical Commissioning Groups (CCGs), NHS Foundation Trusts (FTs) and the voluntary sector to progress the health and wellbeing agenda through shared accountability and a focus on implementation and delivery.

It is essential that this new system integrates with the current STP governance arrangements. The arrangements should enable agreement and oversight of a core set of North East outcomes, including the target proposed above for preventive spend, and oversight and allocation of the preventive investment fund. They should not require a 'one size fits all' approach across the NECA area; on some issues a NECA-wide approach will be most effective, while on others it will be appropriate for local health and care partners to have the flexibility to determine how best to meet the agreed outcomes.

As well as funding, the region's assets will also need to be aligned with this new approach. There must be a commitment to develop a shared approach to use of the region's key assets, including the workforce, the estate and information assets; and community and voluntary sector assets.

To enable the transition to a more integrated system in which resource is focussed where it can have greatest impact, the Commission has one final recommendation.

Recommendation 10: The NECA area should align financial payment systems and incentives with the overall objectives of the health and care system to improve health and wellbeing and reduce health inequalities.

The action called for needs to be delivered by every part of the system. This report sets out a clear agenda for shifting the priority from response to prevention across the health and social care system and wider determinants of health. It calls for a much greater focus on supporting people with health conditions to secure and remain in employment, contributing to their own and the region's prosperity and hence to the wellbeing of future generations. And it challenges leaders to be bold, working in new ways to break down organisational barriers and work for the wellbeing of the people of the NECA area. As such, a commitment needs to be given by all parts of the system to design the mechanisms that will deliver the new model and improvements in outcomes rather than being constrained by the levers and processes that are currently in place.

The prize is great: closing the gap in healthy life expectancy with the nation as a whole over the next decade would lead to 400,000 additional years of active healthy life for the people of the NECA area. The Commission hopes that local and national leaders will study this report carefully and work together to enact its recommendations.

Health and Social Care Integration Commission members



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Commission Chair and Chief
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Dr Amit Bhargava

Chief Clinical Officer for NHS Crawley
Clinical Commissioning Group and Executive
Board member of NHS Alliance



Professor Dame Carol Black

Expert advisor on health and work to
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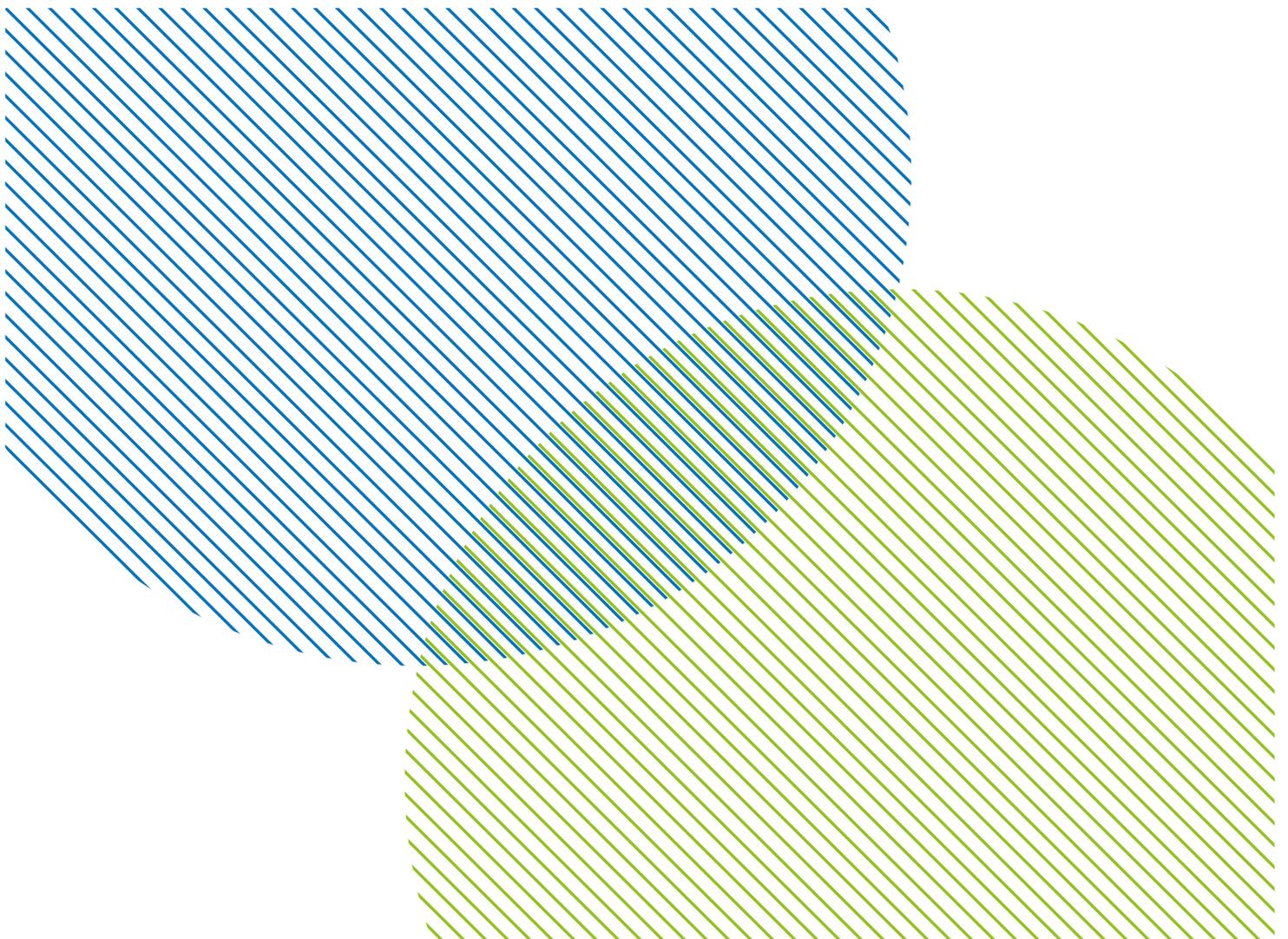
This report can be made available in
alternative formats and languages on request.

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for Health and Social Care Integration



Foreword by Duncan Selbie, Chief Executive of Public Health England and Chair of the Commission

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The starting point for the Commission was that we were concerned with health outcomes much more than with organisational structures. So this is a report about improving health and wellbeing, not about NHS and local authority services. We hear a lot about budget deficits in health and social care, but the deficit we have focussed on is healthy life expectancy.

The title of the report has been carefully chosen. Health and wealth are two sides of the same coin – closing the health and wealth gap in the North East, compared to the UK as a whole, was the Commission's number one priority. Poor health and shorter life expectancy are both consequences and causes of the fact that average Gross Value Added (GVA) per capita in the region is only three quarters of the national average. The Prime Minister has said that inequality in healthy life expectancy is unacceptable and that she wants social and economic reform that will establish an 'economy that works for everyone'. Our report sets out how the North East can lead the way on this.

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That's why our first recommendation is that the entire system needs to shift its priority towards prevention. We see this through two lenses: risk assessment and life cycle. By far the greatest risk is smoking, which is why we support intensifying the focus on programmes to reduce smoking. But the other key focus for prevention should be improving outcomes across the life cycle from school readiness, through good and fulfilling employment to healthy and independent old age.

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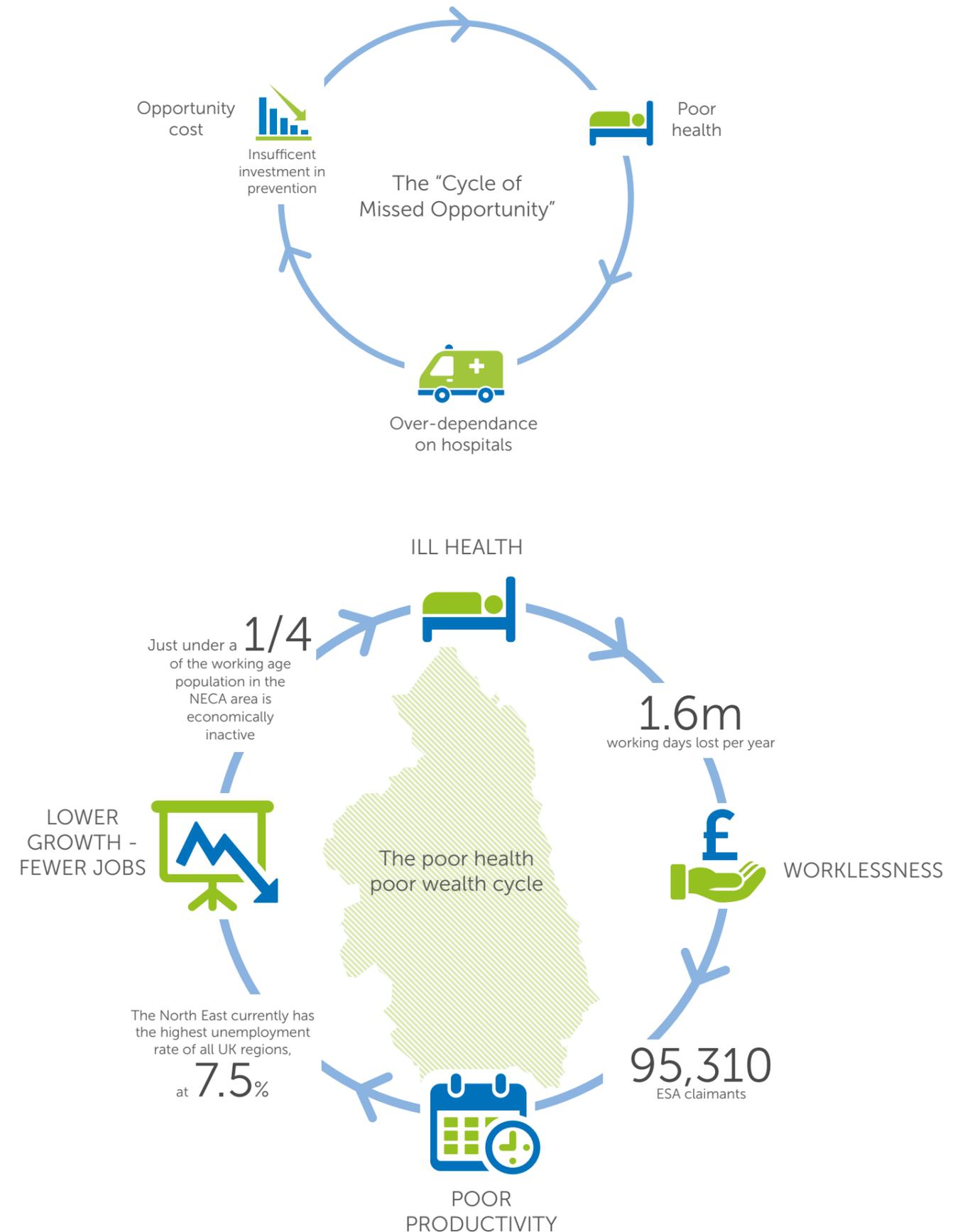
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Executive summary

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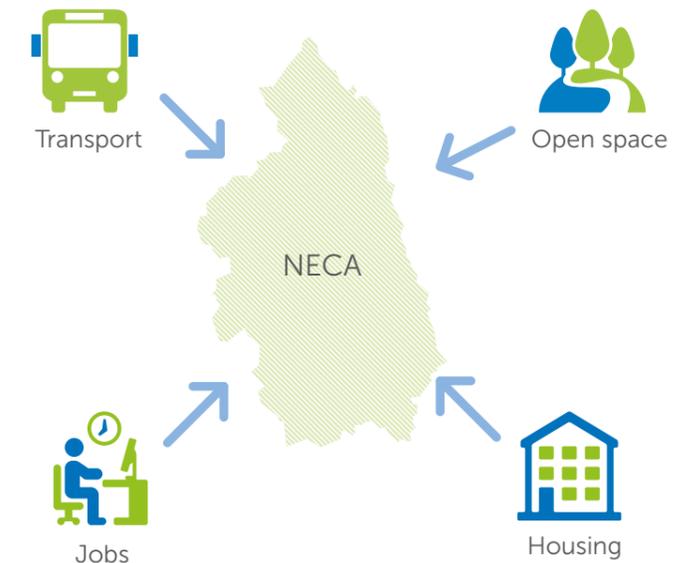
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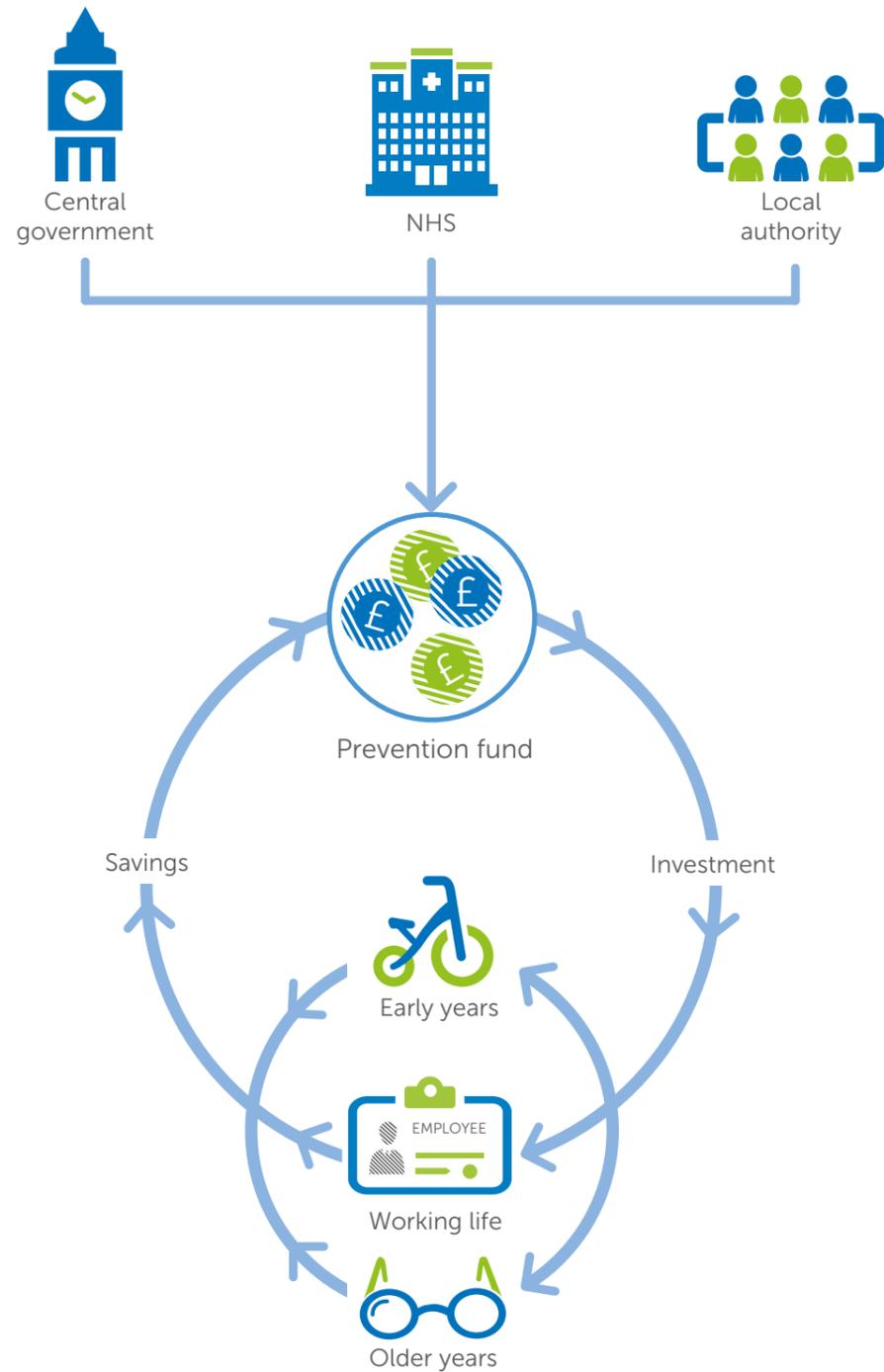
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Prevention fund will help people help themselves to stay well

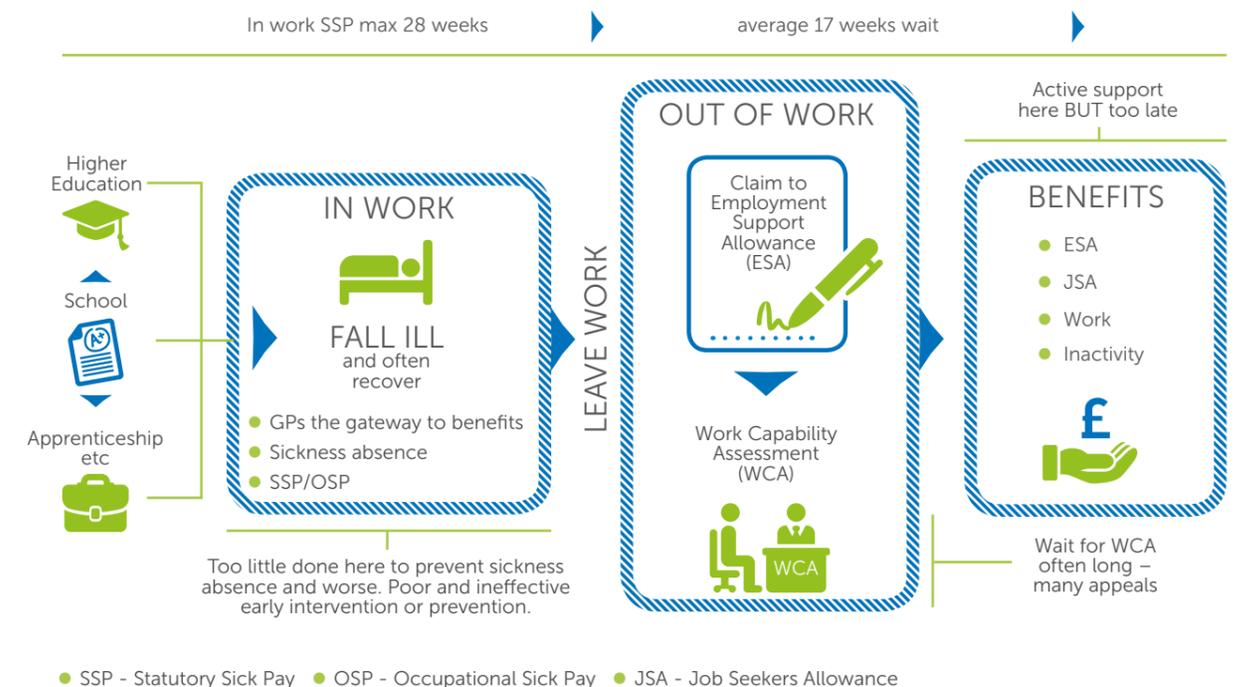


It will be for NECA partners to identify and determine the exact allocation of increased preventive resources to meet the needs of the region. However, the particular challenges faced by the NECA area suggest that increased resource could be divided between early years support, wider determinants of health, sustaining social care while improving integration with health services and lifestyle-based secondary prevention. Smoking prevention should be a key priority. The Fresh North East programme commissioned by all the NECA local authorities has already contributed to the fastest decline in smoking in any region in England over the past decade but smoking continues to be the primary cause of preventable illness and premature death.

A radical increase in preventive investment should have a significant impact on narrowing the health gap between the NECA area and the country as a whole and mitigating the increase in demands on health and care services in the medium to long-run. However, without good jobs and meaningful activity such as volunteering, preventive spend will not be enough to overcome the NECA area's wellbeing challenges. Meaningful work or other activity is one of the most important determinants of health but the North East currently has the highest unemployment rate of all UK regions. This acts as a significant barrier to economic growth through wasted labour force capacity. It is also a significant public health issue, due to the negative health impacts of unemployment. The Commission believes greater action to help people stay in work and return to work after sickness is essential. This work should complement NECA's existing work on Employment, Skills and Inclusion, with its focus on supporting those hardest to help and furthest from the labour market.

Recommendation 4: NECA partners should develop a programme of primary care training to support primary care staff in helping people access the best support to enable them to get back to work as quickly as possible.

Too few drivers in the journey keeping people in work.



Mental health is a particularly significant barrier to work in the NECA area, with over half of those claiming Employment and Support Allowance doing so due to a mental health condition.

Recommendation 5: The Commission recommends addressing mental health at three levels:

- i. improve the leadership and skills of managers at all levels within NHS and local authority organisations to create a supportive environment that enables employees to be proactive in protecting their own wellbeing;
- ii. commissioners of IAPT services should work with their service providers to ensure employment support is included as part of the Improving Access to Psychological Therapies (IAPT) offer on a sustainable basis, to support those individuals who require this service to avoid sickness absence or to return to work as quickly as possible;
- iii. NHS commissioners and providers should work with the NECA Employment, Skills and Inclusion workstreams to develop an integrated employment and health service.

Alongside the health and care system, employers have a key role to play in maintaining and improving the health and wellbeing of their workforce and supporting those with health conditions to remain in the workforce.

Recommendation 6: The Better Health at Work Award (BHAWA) scheme should be the preferred approach for employers to adopt to improve workplace wellbeing. NECA partners should set a target for the proportion of the workforce working for employers involved in the award scheme, and monitor progress towards this target.

Increasing employment and ensuring employment opportunities are high quality and offer the opportunity to progress is vital to health and wellbeing. NECA's Strategic Economic Plan sets a high level objective of achieving more and better jobs for the region.

Recommendation 7: The refreshed Strategic Economic Plan and NECA's employment and skills programme should continue to address the importance of in-work progression and job quality.

Achieving the Commission's vision of a radical shift in funding to prevention will require strong and visionary leadership from across the health and care system and the courage to make difficult decisions in order to protect the prize of long-term health improvement that this funding will enable. Ensuring prevention investment is focussed in areas where it will have greatest impact will require leaders to take on shared responsibility for outcomes, putting aside organisational boundaries and interests to lead a cultural change to the health and care system.

Recommendation 8: Leaders within organisations will need to look beyond the interests of their own organisations to drive improvement in wellbeing outcomes across NECA, leading a cultural change to a health and care system in which each health and care £ is used most effectively to support wellbeing, independent of the source of the funding.

Partners across NECA have already demonstrated the benefits of such a collaborative approach through the highly successful Fresh North East smoking cessation programme, which has contributed to the fastest decline in smoking of any region in England over the past decade. The region's ambitious and challenging target of reducing smoking prevalence to 5% by 2025 provides a further opportunity to bring partners together for a system-wide approach to meeting a shared goal.

Recommendation 9: Governance should be established at NECA level to drive forward implementation of these recommendations, bringing together local authorities, Clinical Commissioning Groups (CCGs), NHS Foundation Trusts (FTs) and the voluntary sector to progress the health and wellbeing agenda through shared accountability and a focus on implementation and delivery.

It is essential that this new system integrates with the current STP governance arrangements. The arrangements should enable agreement and oversight of a core set of North East outcomes, including the target proposed above for preventive spend, and oversight and allocation of the preventive investment fund. They should not require a 'one size fits all' approach across the NECA area; on some issues a NECA-wide approach will be most effective, while on others it will be appropriate for local health and care partners to have the flexibility to determine how best to meet the agreed outcomes.

As well as funding, the region's assets will also need to be aligned with this new approach. There must be a commitment to develop a shared approach to use of the region's key assets, including the workforce, the estate and information assets; and community and voluntary sector assets.

To enable the transition to a more integrated system in which resource is focussed where it can have greatest impact, the Commission has one final recommendation.

Recommendation 10: The NECA area should align financial payment systems and incentives with the overall objectives of the health and care system to improve health and wellbeing and reduce health inequalities.

The action called for needs to be delivered by every part of the system. This report sets out a clear agenda for shifting the priority from response to prevention across the health and social care system and wider determinants of health. It calls for a much greater focus on supporting people with health conditions to secure and remain in employment, contributing to their own and the region's prosperity and hence to the wellbeing of future generations. And it challenges leaders to be bold, working in new ways to break down organisational barriers and work for the wellbeing of the people of the NECA area. As such, a commitment needs to be given by all parts of the system to design the mechanisms that will deliver the new model and improvements in outcomes rather than being constrained by the levers and processes that are currently in place.

The prize is great: closing the gap in healthy life expectancy with the nation as a whole over the next decade would lead to 400,000 additional years of active healthy life for the people of the NECA area. The Commission hopes that local and national leaders will study this report carefully and work together to enact its recommendations.

Why a Commission for health and social care integration?

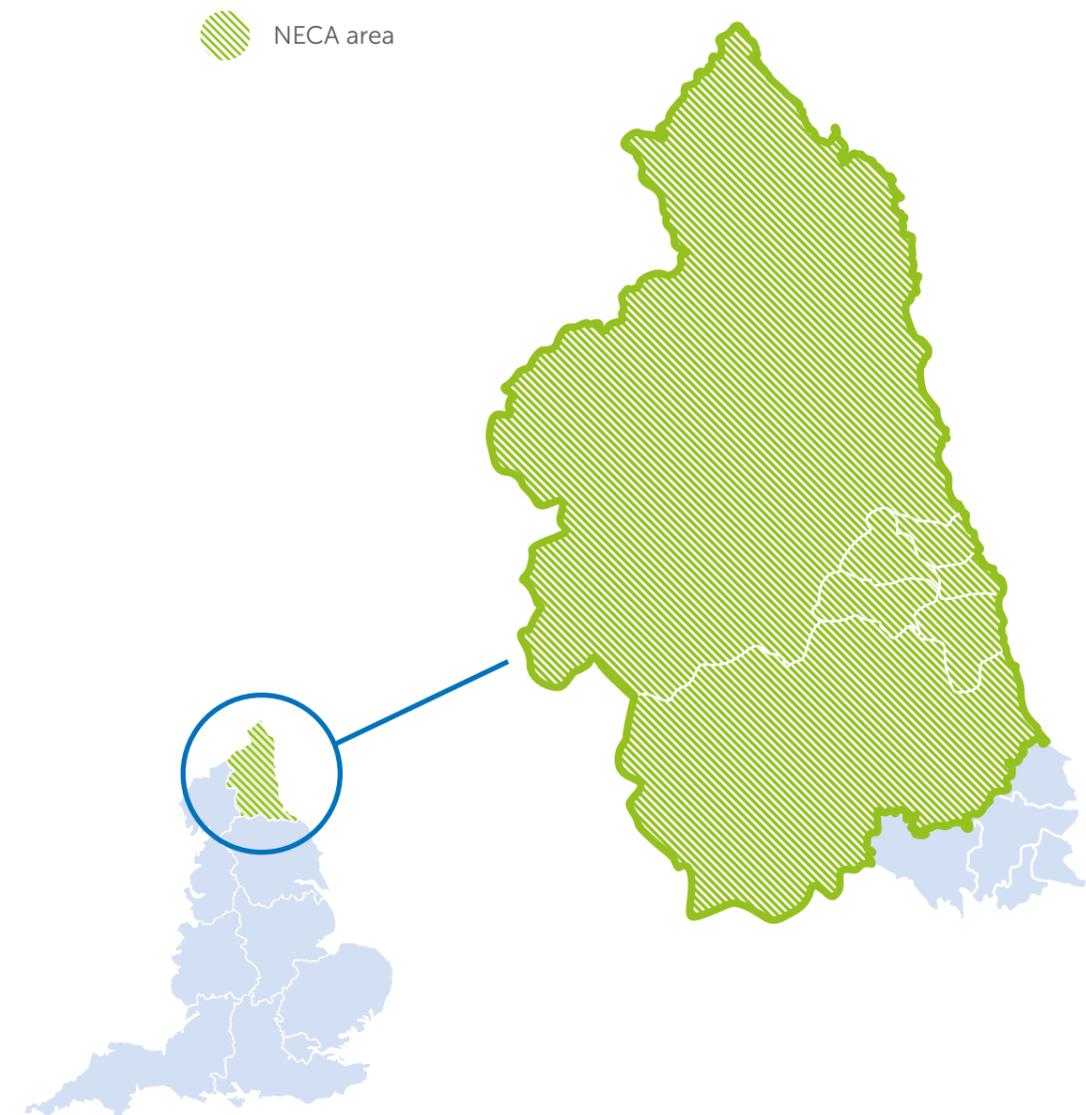
The North East has strong health and care services and life expectancy is increasing faster than other parts of the country. But too many residents still suffer from poor health and wellbeing, with many unable to work and trapped in a cycle of poverty and poor health whilst at the same time health and care services are beginning to feel the pressures of a relentless increase in demand at a time of national financial constraint. Recognising this challenge NECA, the region's NHS organisations and Public Health England have joined together to establish this Commission in order to improve wellbeing across the NECA area. This chapter describes the area's health and care geography, the role of the Commission and how the Commission has gone about its work.

1.1 Health and care services in the NECA area

Health and care services in the NECA area serve a varied geographical area

The North East Combined Authority area brings together the seven local authorities of Northumberland, Tyne and Wear and County Durham, representing around two million people spread over one of the largest combined authorities in the country by geographical area. The NECA region includes urban centre and inner city areas, suburbs and commuter villages, and significant rural areas in the north and west comprising market towns, villages and some of the most sparsely populated areas of England.

The seven constituent local authorities of Durham County Council, Gateshead Council, Newcastle City Council, Northumberland County Council, North Tyneside Council, South Tyneside Council and Sunderland City Council are each responsible for providing public health, child protection and adult social care services in their areas, in addition to their wider responsibilities for growth, transport, environmental services, parks and creating a sense of place.



In relation to the NHS, the NECA area covers seven Clinical Commissioning Groups (CCGs) and nine NHS Foundation Trusts (FTs): six acute trusts, two mental health trusts and one ambulance service. Some of these FTs also serve geographical areas that fall outside the NECA area, and several provide specialised services for populations beyond the NECA boundary, particularly to residents of Cumbria. People living in County Durham access acute hospital services both within the NECA area to the north and in Teesside to the south. To take account of these patient flows the three FTs which cross combined authority boundaries (i.e. County Durham and Darlington NHS FT, Tees, Esk and Wear Valleys NHS FT and North East Ambulance Service NHS FT) are involved in discussions on health service provision in both the NECA area and Teesside.

1.2 Why a Commission for Health and Social Care Integration

Addressing the health and social care needs of the NECA area forms a key plank of local leaders' vision for the future of the region.

The NECA Strategic Economic Plan sets out the region's ambition for a thriving economy which builds on the region's sectoral strengths, excellent universities, loyal workforce and international outlook to provide more and better jobs for the people of the region. NECA's leaders have been clear that achieving this goal requires greater control over political and economic decision making to be focussed in the region. Local politicians and institutions with a thorough understanding of the NECA area are better able to take a place-based view, bringing together a range of policy levers to respond to the specific challenges and opportunities for the region.

Ensuring the people of the NECA area have access to world class health and social care provision and access to the best evidence based support and interventions for health improvement is key to the region's human capital agenda. In October 2015, as part of a proposed devolution deal agreed between NECA and central government, NECA and the NHS agreed jointly to establish the North East Commission for Health and Social Care Integration, to establish the scope and basis for integration, deeper collaboration and devolution across the combined authority's area to improve outcomes and reduce health inequalities. This document is the Commission's report to NHS and local authority partners and gives its views on how partners can work together to improve health and wellbeing across the region. Its remit is set out in a framing document available on the NECA website.³ The section of the framing document setting out the focus of inquiry for the Commission is included at Annex A.

Although NECA leaders decided in September 2016 not to take forward the devolution deal at that time, all involved have reiterated their commitment to the principle of devolution. The work of this Commission remains hugely relevant and its recommendations can be taken forward through existing structures independent of decisions on the pace of devolution for the region.

1.3 The Commission's approach

The Commission members have carried out their work in consultation with a wide range of NECA area stakeholders, and taking account of the NHS STP process⁴.

The five Commission members bring a range of expertise and perspective from across the health and care system. The Commission is chaired by Duncan Selbie, chief executive of Public Health England, working with Dr Amit Bhargava, chief clinical officer for the NHS Crawley CCG and executive board member of NHS Alliance; Professor Dame Carol Black, expert advisor on health and work to Department of Health and Public Health England and principal, Newnham College, Cambridge; Rob Whiteman, chief executive of the CIPFA; and Tom Wright, chief executive of Age UK and chair of the Richmond Group of leading health charities.

The five independent Commission members are joined by four ex-officio members to facilitate connections with NECA area and national partners. These are Steven Mason, chief executive of Northumberland County Council and NECA lead on the Commission⁵; Nicola Bailey, chief operating officer for NHS North Durham CCG and NHS Durham Dales, Easington and Sedgefield CCG and CCG lead for the Commission; Tim Rideout, Director of Commissioning Operations – Cumbria and the North East – NHS England and Director of Improvement and Delivery – Cumbria and the North East – NHS Improvement; and William Vineall, director of acute quality and care policy at the Department of Health.

In developing this report the Commission has worked closely with local health and care stakeholders, seeking views from across the region through a call for evidence and holding listening events in each of the seven local authority areas to gather views, in addition to an event organised for the voluntary, community and social enterprise sector (VCSE). What we learned from these conversations, and common themes that emerged from this work which have influenced our conclusions, are set out in Annex B.

This input included contributions about the importance of a more joined up and integrated approach to addressing the health and wellbeing inequalities experienced by the NECA population; views about the barriers to achieving this and suggestions about how this could be tackled.

There were strong messages about the need for approaches that value the skills, talents, capacity, knowledge, connections, potential or 'assets' in communities and seek to increase people's control over their own health. This contrasts with the traditional approach of public bodies in focussing on the needs and problems within communities, such as deprivation or health-damaging behaviours.

Colleagues emphasised the importance of economic growth and employment as essential in improving the health and wellbeing of local people and the need for employers to develop initiatives to help employees stay healthy.

There were also valuable contributions that highlighted how the statutory sector could work differently to enable the potential of the VCSE to be fully realised and how the VCSE sector could adapt and change to ensure they are in the best possible position to engage as full partners in this challenging agenda.

These events and the evidence gathered were invaluable to the Commission's work, and it would like to thank all the local organisations and partners who took the time to participate or give their views.

⁴ STPs are part of the NHS planning requirements designed to support delivery of the NHS Five year forward view by 2020/21

⁵ This role was filled by Jane Robinson, Chief Executive of Gateshead Council, until she moved on to a new role in late July 2016.

³ <http://www.northeastca.gov.uk/devolution/commission-health-and-social-care-integration-north-east>

The Commission has also worked collaboratively with local health and care organisations, testing emerging thinking with a steering group of representatives of NECA and NHS partners. The Commission has also taken a close interest in development of STPs for the region. These plans set out how local partners will work together to deliver the NHS Five Year Forward View vision of a more efficient and sustainable health and care system, built around the needs of local populations⁶. The Commission work and STP process share a common focus on prevention and developing services around the individual. However, the two remain distinct: the Commission has a wider remit to consider drivers of health and wellbeing beyond the health and care sector, while the STPs address specific local service decisions which are not within the remit of the Commission.

Commission members identified three core themes that would provide a framework for their work, to enable them to respond to the challenge they were set:

- A shift to prevention
- Health, wellbeing and productivity
- System leadership and governance

These core themes guided the evidence gathering process and act as a framework for this document and the Commission's recommendations. In each of these areas the Commission has been focussed on wellbeing in its widest sense, including both mental and physical health but also social wellbeing and overall happiness.

In developing its recommendations the Commission has been aware that they may require action at different levels and geographies, in order to strike the right balance between responding to the needs of individual communities and securing efficiencies through working at larger scale and avoiding duplication of effort. Some of the recommendations will require action by individual local authorities or CCGs; some at local health economy level where it makes sense for two or three local authorities and CCGs to work together; and some at NECA level or beyond where this provides greatest opportunity to improve outcomes.



⁶ Further background on the STP process is available at <https://www.england.nhs.uk/ourwork/futurehns/deliver-forward-view/stp/>

The case for change

2.1 A vision for a new health and care system

A more integrated, efficient, prevention-focussed health and care system will improve health and wellbeing outcomes, contribute to regional growth and ensure financial stability for the long-term.

Life expectancy in the NECA area is increasing faster than anywhere else in the country, driven particularly by falls in smoking rates.

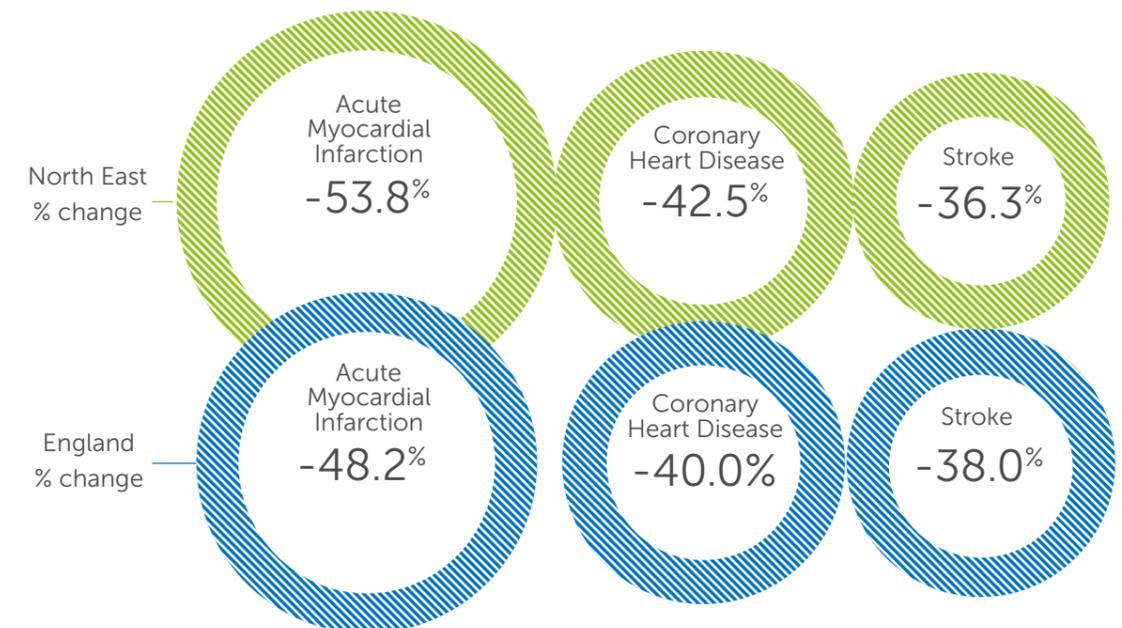


Change in adult smoking rates 2005-2015 North East



Change in adult smoking rates 2005-2015 England

Mortality rates from smoking related diseases (2005-2014)

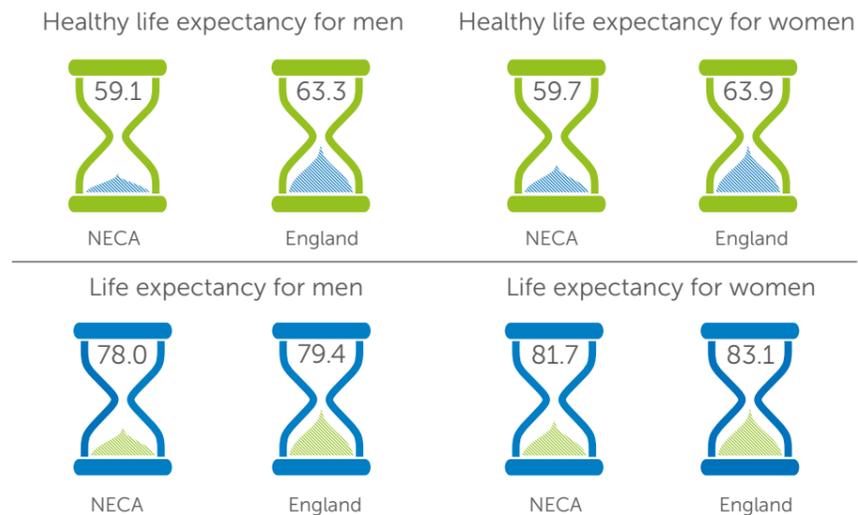


The region in many areas has strong health and care services including some of the best organisations in the country. However, increasing demand and ongoing financial constraints, coupled with shortages in some key workforce groups, means that maintaining this level of performance becomes increasingly difficult. Moreover, the health and wellbeing gap with the rest of the UK remains too high. The region continues to face health and wellbeing challenges in cancer, chronic obstructive pulmonary disease (COPD), diabetes, mental health problems and rising levels of excess weight – all of which lead to increased pressure on services. Integration and increased joint working across the NECA area offer the opportunity to accelerate the pace of improvement and deliver a step change in health outcomes for the people of the region.

The imperative to retain highest quality services through any transition, the different accountability structures in health and social care, and the varied geography and health economies across the NECA area will make change challenging. But the poor current health outcomes and scale of the financial gap demonstrate that inaction is not an option. System transformation is essential to tackle the entrenched health inequalities within the NECA area and between this area and the rest of the country, to ensure a financially sustainable health and care system which can continue to provide strong services to the people of the NECA area for the long term, and to equip the people to be able to play an active role in society and the economy. As an illustration of the scale of change possible, if the NECA area reached national average healthy life expectancy in a decade's time this would amount to 400,000 additional years of active, healthy life for the people of the region.

2.2 Health and wellbeing services and outcomes in the NECA area

The NECA area has strong health and care services; but levels of health and wellbeing do not reflect this.



The NECA area benefits from a strong health and care system to support the health and wellbeing of the population. However, services are under pressure due to increasing demands of an ageing population, workforce shortages, costs associated with technical advances and financial constraints.

The region has good coverage of high quality primary care services, with fewer patients per GP, higher patient satisfaction and higher practice outcomes standards than the country as a whole.⁷ This strong position could be at risk as a cohort of older, more experienced GPs leave the workforce at retirement.

In addition to workforce challenges, demands of the disease burden in an ageing population are likely to increase pressure on primary care services.

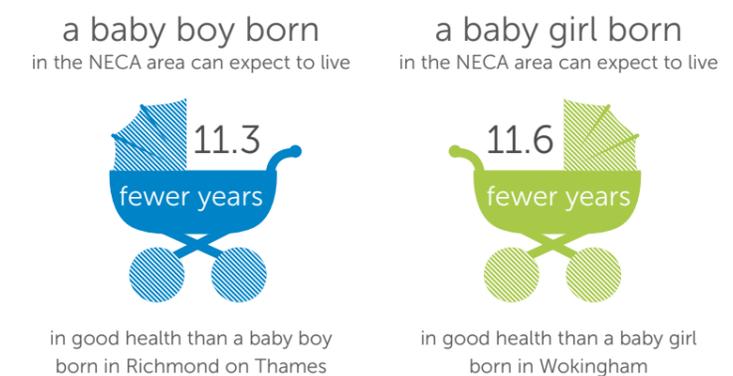
Five of NECA's seven CCGs are rated 'good' or 'outstanding' by NHS England. Across the region performance in adult social care against the National Adult Social Care Outcomes Framework (ASCOf)⁸ measures is strong when compared nationally (drawn from ADASS north east benchmarking work), with all local authorities working in partnership with a strong voluntary and community sector.

The NECA area is served by an strong hospital network including three FTs rated 'outstanding' by the Care Quality Commission. Practitioners across the region have access to new ideas and research through the strong public and private sector Research & Development and innovation capability in universities and the region's pharmaceuticals and biotech sector. Strong partnerships between research and healthcare delivery have led to the region being recognised internationally as a leading academic and innovation centre for bioscience research and trials, including in ageing and genomics.

Beyond the health and care sector itself, the region's community and cultural assets also contribute to wellbeing. Commission members were struck by the strong sense of community identity and pride of place which emerged from all their listening events across the region. In addition, the region is rich in green space in and on the edges of the major conurbations, together with an outstanding rural landscape and coastline, providing opportunities to get active. A robust public transport network in the core urban areas and strong commitment to sustainable travel options provide opportunities to integrate walking and cycling into everyday life.

However, despite these strong regional health and wellbeing assets, the region's health and wellbeing outcomes remain challenging. Life expectancy and healthy life expectancy for women and men are lower than the national average. People in the NECA area are less happy, more anxious, heavier and less active than the population of the country as a whole. While significant in-roads have been made to cardiovascular disease mortality and reduction in smoking prevalence and teenage conceptions, there is still a long way to go.

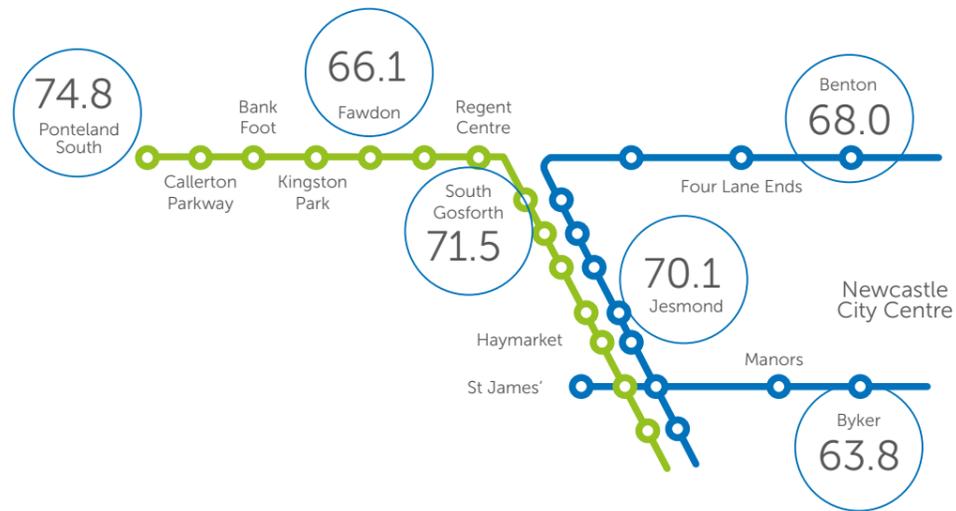
Some of these poor outcomes relate to behavioural factors. Smoking levels, alcohol and drug use and poor diet are more prevalent in the region than nationally. Children deserve to have the best start in life but the high levels of smoking during pregnancy and low levels of breastfeeding are not enabling this to happen. All this means that a baby born in the NECA area can expect to live more than a decade fewer years in good health than one born in Richmond on Thames or Wokingham.



⁷ Data Sources: https://data.gov.uk/dataset/general_and_personal_medical_services_england; Description of General Practice Outcome Standards: General Practice Outcome Standards: Introduction (August 2014), www.primarycare.nhs.uk; CCG report (July 2016 publication) aggregated data collected from Jul-Sept 2015 and Jan-Mar 2016, <https://gp-patient.co.uk/surveys-and-reports>

⁸ <https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-ascof-2015-to-2016>

Some poor outcomes relate to economic inclusion in a region where Gross Value Added (GVA) per head, at £18,111, is around three quarters of the national average. The NECA area currently has the highest unemployment rate of all UK regions at 7.5% against a UK figure of 4.9%⁹, and almost 60% of those claiming out of work benefits are long-term claimants of over 2 years. Differences in economic circumstances lead to significant health inequalities within the NECA area. The adaptation of part of the Tyne and Wear Metro map below illustrates how healthy life expectancy for adults aged 55 varies in communities within a relatively small geographical area.



Healthy life expectancy along the Newcastle Metro for adults aged 55

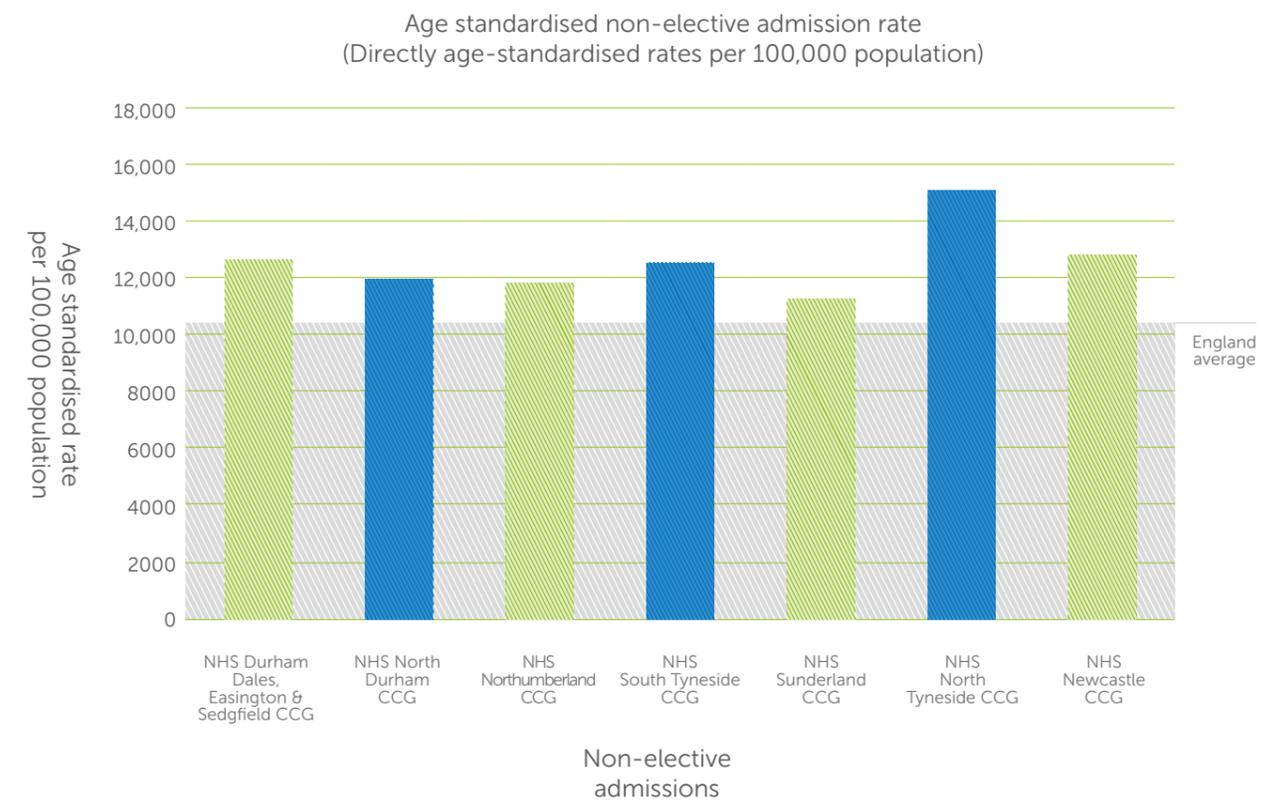
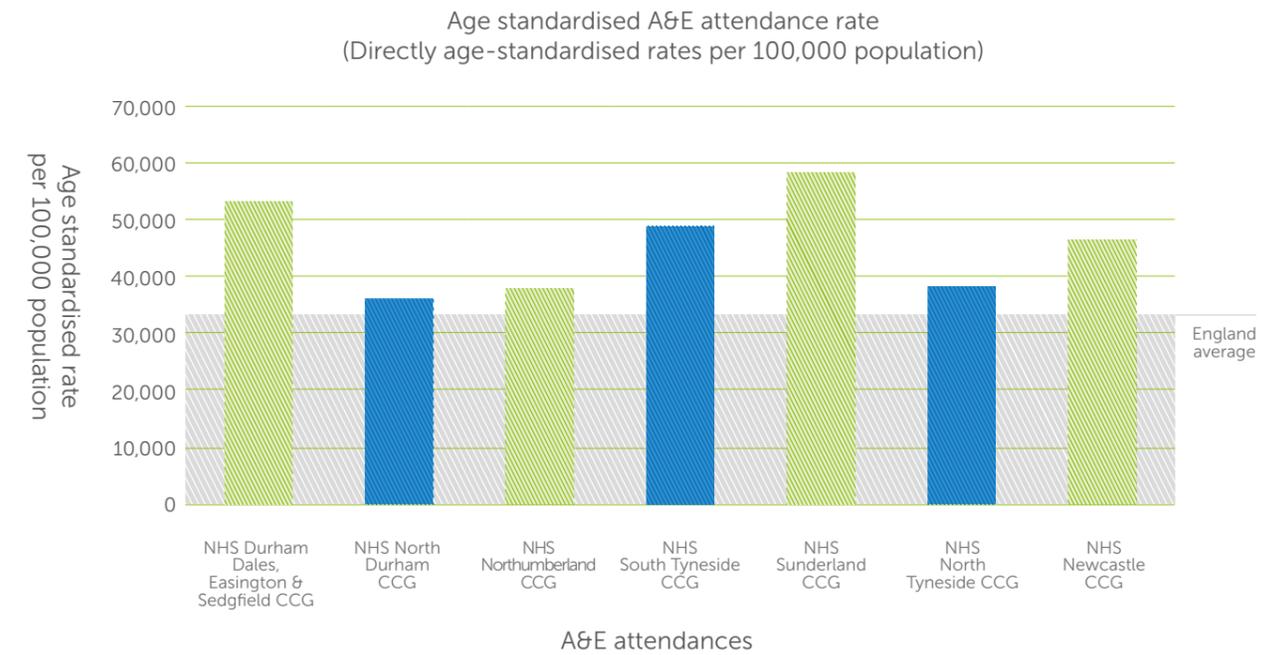
Source: Newcastle University Institute for Ageing, Healthy Life Simulation Final Report

The region's social and economic context impacts on its young people; levels of child poverty are high and while school readiness and employment and training rates for young people are improving, outcomes for young people remain below those in other parts of the country. In addition, emotional resilience and wellbeing including a sense of happiness and social connectedness are critical to wellbeing across the whole life course, yet may be harder to achieve when individuals and communities are under pressure.



⁹ Office for National Statistics, Regional Labour Market Statistics in the UK: August 2016 - <http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/regionallabourmarket/august2016>

These deep-rooted, underlying health and societal issues lead to higher use of higher intervention services. There is over-reliance and over-utilisation of hospital based services with significant numbers of preventable and unplanned admissions. The charts below show how A&E attendance and unplanned admissions to hospital are both higher in each of NECA's CCGs than in England as a whole.



Source: Hospital episode statistics 2014/15

Frail elderly people with multiple conditions account for 70% of occupied bed days, yet a significant proportion of patients would not need to be in hospital if other care services were available.

At any one time, 25-35% of beds are occupied by people who could be treated somewhere else. Permanent admissions to residential care are higher than in other regions. More children are looked after than in other parts of the country. In each case the quality of service and outcomes achieved are good. However, the overuse of these intensive services implies that people could be being helped earlier and closer to their homes and communities, before their situation reaches a crisis point. And these services are expensive, putting financial strain on the system and limiting the ability to maximise opportunities to invest in early intervention and the prevention of ill health. In short, the system is over-focussed on the treatment of ill health and its consequences, at the expense of preventing it. As an illustration of the scale of change possible, if the NECA area reached national average healthy life expectancy in a decade's time this would amount to 400,000 additional years of active, healthy life for the people of the region.¹⁰

2.3 Financial snapshot – resources available

The NECA area has significant financial resources to devote to health and wellbeing; but rising demand and constrained budgets are putting increasing stress on the system.

To support the Commission's work, the Commission asked the CIPFA to produce a 'balance sheet' for the NECA area health and care system. The balance sheet consolidates assets, liabilities, income and expenditure for the entire system to give a clear snapshot of the financial position of the region.

This work found that public spending on health and care across the NECA area amounted to around £5.2bn in financial year 14/15. Of this, just under 20% is devoted to primary care, 16% to adult social care, over 60% to hospital-based and specialist services and only 3% to public health.

It is clear that spend on managing the costs of ill health completely dwarfs spend on keeping people well. This risks becoming self-perpetuating, as low spend on preventive activity increases pressures and the need to spend on hospital care.

Over the next five years resources are expected to become increasingly constrained through a combination of rising demand - people are living longer, but with increasingly complex health and care needs - and increasing cost pressures, for example, due to introduction of the National Living Wage. Social care budgets are under particularly intense pressure, raising serious risks for the health system. Social care plays a critical preventive function within the wider health and social care system, maintaining people's ability to live independently and ensuring that deterioration in people's health is picked up early.

Partners across the NECA area health and care system have worked together through the STP process to identify the impact of rising demand on the system. They have concluded that a 'business as usual' path of continuing to respond to rising demand would lead to a significant gap between cost of providing services and the resources available by 2020.

The gap as a proportion of current resource is largest in social care due to the combined impact of falling real terms budgets, an ageing population and introduction of the National Living Wage. Service reductions needed to bridge this gap are likely to increase pressure on primary, community and acute health services and hence increase the gap in those areas still further. It is clear that without change the system is financially unsustainable.

However, annual spending forms only one part of the overall picture of the financial health of the NECA area health and care system. Health and care partners also own £2.2bn in assets in the form of buildings, IT systems and reserves. These assets also need to be used as effectively as possible to improve the wellbeing of local people. The One Public Estate programme¹¹ offers opportunities to look at how some of these assets could be shared more and used more effectively.

Where does the NECA health and care £ go



¹⁰ Public Health England calculations

¹¹ The One Public Estate programme, led by the Local Government Association and Cabinet Office, enables local councils and other public sector organisations to share buildings and services, reduce running costs and release land to boost development.

2.4 Making best use of resources

At national level the Marmot Review *Fair Society, Healthy Lives*¹², the Wanless Review *Securing Good Care for Older People*¹³ and the NHS Five Year Forward View have all emphasised the potential for more integrated and prevention focussed services both to improve outcomes and enable significant efficiencies. Organisations and practitioners across the region are already responding to this challenge with new approaches and innovations. The Commission's role is to bring together local and national best practice to trace a path for this transformation in the NECA area.

Some may say that the continued existence of this cycle of missed opportunity more than a decade after it was first talked about is a failure of the approaches adopted to tackle it in recent years. In fact in many instances the reverse is true. Leaders within social care, the NHS and public health have not stood passively by. The NECA area can point to numerous examples where innovation in service has closed the gaps in health outcomes, health inequalities and quality of care to the national standard more quickly than many other parts of the country.

By acknowledging the areas where the NECA area must do more, by building on the approaches that have proved they make a difference and could go further still with additional investment and then focussing on the initiatives necessary to release and protect this investment, these gaps can be closed further still.



¹² Fair Society, Healthy Lives: The Marmot Review, February 2010. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

¹³ Securing Good Care for Older People, Derek Wanless 2006. <http://www.kingsfund.org.uk/projects/wanless-social-care-review>

Chapter 3

A shift to prevention: helping people live well for longer

Previous chapters have set out the impact of over-investing in treatment of ill health at the expense of keeping people well, together with the strong view from partners across the region that early intervention and prevention are key to improving health outcomes. The NHS Five Year Forward View stresses the importance of prevention as an essential element for viability of future services, while the Marmot Review identified it as key to reducing health inequalities.¹⁴ This chapter sets out the Commission's views on how the NECA area can break through the cycle of missed opportunity to achieve a step change in prevention.

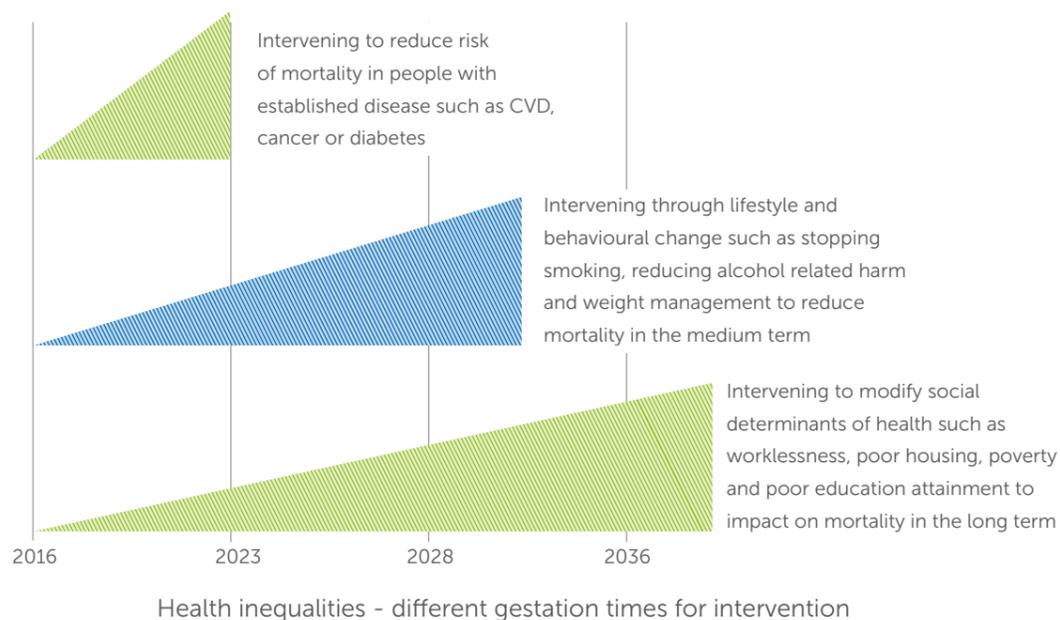
3.1 What does the Commission mean by prevention?

As a region with higher use of hospitals and other acute services than much of the country, a shift to early intervention to prevent the need to access secondary services has clear potential to improve individuals' wellbeing. In essence, prevention means helping people to stay well for longer. Prevention activity can be focussed on achieving change over timescales varying from a few days to whole lifetimes and can take a number of forms.

- Primary prevention i.e. preventing health problems developing in the first place. Key to wellbeing is ensuring that all feel they have a place and role in the community, summed up in the phrase 'a home, a friend and a job'. This means that much primary prevention depends not on health specific interventions but on wider economic and social policy. Policies on transport, planning and the environment also play a key role given their potential to encourage or discourage active lifestyles. Early years approaches are critical, given that evidence shows the social gradient in health is already evident in indicators such as school readiness, childhood obesity and children's dental health. In practice there are very few areas of public policy which cannot contribute to primary prevention – although the health impacts of policy are not integrated in decision-making in all these areas.
- Secondary prevention i.e. action to ameliorate and curtail ill health in its earlier stages so as to avoid greater subsequent problems and need. This will not only provide benefits but also release resources in the short to medium term. There are many conditions for which effective, low cost, community-based interventions can substitute for higher cost health and care approaches (e.g. falls, cardiovascular disease (CVD) rehabilitation, depression, chronic obstructive pulmonary disease).
- Tertiary prevention – reducing the impact of disease on people's health and wellbeing.

¹⁴ Fair Society, Healthy Lives: The Marmot Review, February 2010. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

Intervention in each of these areas will yield improvements in wellbeing outcomes over different timescales. While secondary and tertiary prevention measures can yield savings in the need for acute care within months or years, enabling financial savings to be reinvested in greater prevention, some actions on the wider policy determinants of wellbeing will yield results over decades. This is illustrated in the chart below.



3.2 Achieving a step change in priority of prevention activity

Overcoming the entrenched health inequalities in the NECA area will require a strong, collective focus on key issues with greatest impact on health and wellbeing outcomes, such as:

- early resilience – providing a best start in life for all children;
- greater control for individuals over their life and circumstances;
- fair employment and good work for all;
- health at work and play, action to address social isolation and loneliness, and concerted action to achieve an age-friendly environment for all ages;
- strengthening the role and impact of ill health prevention, including through low-cost, community based approaches (secondary prevention).

The previous chapter set out the vicious circle of over-spending on treating ill health while under-spending on actions to prevent ill health. There is widespread recognition across the NECA area of the need to shift investment from acute care to prevention and care close to the home. To overcome this, **NECA partners should set themselves an ambition to radically increase preventive spending across the health and care system and wider determinants of health and wellbeing (recommendation 1)**. Partners can be confident that this represents value for money. The National Institute for Health and Care Excellence has concluded that *“Most activities aimed at improving the public’s health are extremely good value for money – and generally offer more health benefits than the alternatives tested, even though some of the benefits may not be realised in the short term.”*¹⁵ Such activities include stop smoking services, healthy eating initiatives, physical activity programmes, alcohol interventions, mental health at work and safe sex initiatives.

¹⁵ National Institute for Health and Care Excellence, Local Government briefing LGB10, September 2013 www.nice.org.uk/guidance/lgb10

Measuring the current extent of preventive spend is challenging, with no consistent methodology developed at national level. At present preventive spending is spread across local authorities, Public Health England, the NHS, third sector activity and other public funding relating to the wider determinants of wellbeing. **The Commission recommends that the region should act as a national exemplar in transparency and effectiveness of preventive spend by becoming the first in the country to measure, monitor and report on spend year on year.** The region should work with CIPFA to establish a baseline of current preventive spend and methodology to track increase in spending over time. To demonstrate effectiveness of this spend, NECA should also act as a pilot area to trial work being carried out by Public Health England and CIPFA to develop tools to assess public health investment. This work aims to ensure that public money is spent more effectively by enabling the whole system case for public health investment to be presented in an objective manner, to inform investment decisions.

The Commission believes it should be up to NECA partners to work together with CIPFA to agree a target increase in preventive spend against which progress can be monitored, measured and reported. However, based on the Marmot report¹⁶ conclusions, we would expect an appropriate increase to be around £160m a year by 2020/21. Such an increase will both improve outcomes and wellbeing for current and future generations of residents, and would be expected to also improve financial sustainability by reducing pressure on expensive acute services.

Health and care partners have many levers to address health and wellbeing over and above directing the use of their own resources. Many of the drivers of health and wellbeing depend on economic, environmental and social policy rather than health and care interventions. **The Commission therefore recommends that public sector partners across the NECA area should integrate preventive action and action to tackle inequalities in all decisions (recommendation 2)**. This will ensure that health and wellbeing impacts are fully factored into decisions on policies over which NECA partners have a degree of control i.e. public transport, leisure facilities, housing, planning and skills. Partners will need to consider how they can demonstrate that this recommendation is being met, for example through an audit trail in decision documents.

3.3 Making it happen

Increasing the resource invested in prevention will yield improved outcomes and lower use of expensive acute services over time; from months and years in the case of secondary prevention interventions to decades and lifetimes in the case of action on the wider determinants of health. The timing disconnect between making a preventive investment and benefiting from the resulting financial savings has been a key barrier to realising a shift to prevention in the past, due to the need for ‘double running’ of preventive and acute services in the period before the investment impacts.

The STP process offers an opportunity to overcome this barrier. Through the STPs, partners across NECA are redesigning a model of care not suited to addressing underlying health needs. A changed acute care landscape will free up resources to improve prevention, community-based care and social care, as well as encourage individuals to take greater responsibility for their own health and wellbeing.

¹⁶ The estimate of £160m is based on Marmot’s recommendation that prevention spend be doubled from 4 to 8% of total NHS spend, and estimating what that would imply for the NECA area.

Savings from the change will accrue to a range of partners – in addition to providers of health and care services, the Commission would expect substantial savings to central government through lower welfare payments as more people remain well enough to work. **The Commission recommends that increased preventive spend should be assigned to a dedicated preventive investment fund managed on a cross-system basis and bringing together contributions from all partners who stand to benefit from the expected savings, including central government.**

Freeing up resources from current budgets is unlikely to be possible without reconfiguration of acute services to improve efficiency, alongside transformation of primary and community health and social care. Achieving these changes will be hard; it will be vital to remain focussed on the end goal of releasing resources to enable them to be used where they will have greater impact on the region's wellbeing.

Over time the Commission would expect this increased investment in prevention to become self-sustaining. Secondary prevention interventions can yield improved outcomes in a few years or even months, releasing resources which can be reinvested in the fund to further the virtuous circle of preventive investment and improved wellbeing.

3.4 How could increased preventive resources be used?

It will be for NECA partners to determine the exact allocation of increased preventive resources to meet the needs of the region. However, the particular challenges faced by the NECA area suggest that increased resource could be divided between early years support, wider determinants of health, lifestyle-based secondary prevention and sustaining social care while improving integration with health services. Social care is in a precarious state across the region because of the cumulative impact of austerity and has a critical preventive function within the wider health and social care system, maintaining people's ability to live independently and ensuring that deterioration in people's health is picked up early.

In each of these four areas there are examples of good practice in parts of the NECA area which could be scaled up to bring benefits consistently across the area.

Early years

A range of early years packages could be funded through new preventive investment. These would be geared to fit with local circumstances across NECA and would be determined by community priorities and needs, and up-to-date evidence of effectiveness. The approaches could, for example, include:

- **Baby Clear** is the first region-wide approach in England to the challenging issue of smoking in pregnancy. Implementation began in 2012/13 and since this point, maternal smoking rates have fallen by 4% (from 20.7% to 16.7%) compared to a 2.6% decline nationally; referrals of pregnant women to the Stop Smoking Service more than doubled and the odds of quitting during pregnancy nearly doubled. Birthweight was 6.5% higher for babies born to women who quit during pregnancy compared to those who continued smoking.

- **Basic Incredible Years** – an evidenced based parenting programme which includes home learning support between weekly sessions.
- **Expanded Speech and Language Therapy offer** – providing intensive support and intervention for children aged 10 months to 2 years whilst using science based models, working with the wider workforce and parents to increase knowledge and skills in relation to speech and language development.

There are also three key areas where greater collaboration in children's social care will reap significant benefits for children and families across the NECA area and for the efficiency of the services provided. The combined authority provides a solid platform to help broker arrangements between authorities, sharing learning to drive up improvement in all areas. The three areas are:

- **People and leadership:** bringing the best people into the profession and developing leaders equipped to nurture practice excellence. For example, this could involve combining commissioning and purchasing power to incentivise providers to innovate or developing a single employing body.
- **Practice and systems:** creating the right environment for excellent practice and innovation to flourish. For example, a regional approach to adoption, standardisation of processes across areas, intelligence and information sharing.
- **Governance and accountability:** using data to show us strengths and weaknesses in the system, and developing innovative new organisational models. For example, developing a combined authority approach to a Looked After Children strategy with a particular focus on children on the edge of care, placement sufficiency and care leavers; or a combined authority approach to corporate parenting.

Wider determinants of health

The Marmot Review proffered a range of recommendations with impact across the life course. These included the following areas of activity which could be implemented across NECA:

- **Improving active travel** – increasingly recognised as an essential component of a health improvement strategy, active travel allows the embedding of healthier behaviours into activities of daily living to a degree that obviates the need for active choice and personal scheduling.
- **Improving access and quality of green and open spaces** - following the lead of New York in its 'PlanYC' ("ensure that all New Yorkers live within a 10 minute walk of a park").
- **Improve the food environment** – there is potential to tackle obesity at local level through a strategic approach to issues such as planning and licensing of fast food outlets, incentives for healthy eating, school and hospital meal provision, holiday hunger and foodbanks.
- **Reducing fuel poverty** – Initiatives to reduce fuel poverty (through e.g. 'boilers on prescription') are widely thought to be both effective and potentially cost effective means of improving wellbeing and health.
- **Improving community capital and reduce social isolation** – this should be implicit throughout NECA's wellbeing work.

- **Increase access to life-long learning, including work based learning and apprenticeships** – the NECA area embraces four universities and a great variety of colleges, schools and training support. Life-long learning is a powerful tool in improving wellbeing and health, and there is a case for seeing this as a contributor to health and wellbeing, as well as increasing social contact and engagement.
- **Increasing availability of high quality affordable housing for all ages** – many local authorities are exploring approaches to improve housing conditions in the private rented sector, including voluntary accreditation and compulsory schemes through the use of selective licensing. In the future much of the increased demand for housing will come from older people. How this demand is met and the ability of the planning system to respond to this change will affect both older people's ability to live well independently and the opportunities available across the housing market generally. Attractive housing options for older people need to be available across all sectors of the market, which are close to public transport and community services, can accommodate age-related disabilities, and are in older person friendly neighbourhoods.

Coordinated preventive support for people with complex and long-term needs

While there is much that can be done to prevent, reduce or delay the onset of disabling long-term health conditions, supporting people who have these conditions to remain independent and to reduce their need for hospital care and other crisis services will continue to be a central challenge for the health and social care system. Indeed, the number of people with long-term conditions is likely to continue to increase, as a consequence of the very success of better health services and improved public health in prolonging life, including the lives of people with conditions which would once have resulted in early death. The NHS Five Year Forward View estimates that health services for people with long term conditions now account for 70% of NHS resources, and this group also accounts for almost all adult social care services and a significant and growing element of children's social care.

While this is not a new issue, it remains a central challenge for the NHS which it has not yet fully adjusted to. One crucial element of an effective response is the identification of the population most at risk. NECA partners should



build on existing initiatives across the NECA area for the identification of NHS patients at highest risk, using both improved IT systems and existing professional knowledge. Financial mechanisms need to be reviewed to ensure that they are not obstructing an effective focus on this group of people, for instance through Year Of Care funding¹⁷ or through broader changes such as the proposed Accountable Care Organisation in Northumberland.

The organisational separation between health and social care services has also become an increasing problem. There are many effective integrated arrangements already in place between health and social care organisations in the NECA area, but to achieve the objectives of this report and of the STP planning process, it will be essential for NECA partners to continue to learn from each other about what works best. There are opportunities at NECA level to shape professional training programmes and organisational cultures so as to promote an understanding that all those working with a person with long-term needs are involved in a single joint enterprise, which needs to be coordinated and centred on the person.

Among the forms of integration which are likely to be most effective are:

- Arrangements in which a single lead professional has an oversight of all health and social care support provided to an individual, both in the community and if possible in hospital, and is in a position to be able to ensure that the person's overall experience is of a coherent system which responds effectively to their most important needs and which focuses on maintaining their independence and their control over their own lives.
- Joint mechanisms across health and social care for giving people control over personal budgets/personal health budgets for their care and support.
- Shared system-wide approaches to working with carers as partners, to ensure that the people who are often best placed to identify opportunities to make care more effective are not sidelined by professionals when decisions are made.
- Recognition across the system that treatment and the meeting of physical needs is only part of what is needed to keep people healthy, and that good mental health, social connectedness, dignity and a sense of purpose are often at least as important in maintaining people's resilience.
- Integrated approaches to rehabilitation and reablement, maximising people's ability to recover from health crises or injuries, and ensuring that hospitals and other institutional settings are used only when they are clearly the best option.
- Working arrangements which ensure that both front-line staff and managers at all levels in different services that support the same group of people are in frequent formal and informal contact - for instance through joint appointments, co-location or frequent joint meetings.

As well as improving the coordination of health and social care for individuals, it is crucial to ensure that the services which people depend on have sufficient and sustainable capacity. One step towards this should be an integrated approach between health and social care commissioners to the management of the market which now provides most long-term care services, whether they are funded as social care, as continuing healthcare, or as jointly-funded aftercare for people who have been detained in hospital for mental health treatment.

¹⁷ Year of Care is an approach that aims to introduce and embed personalised care planning in routine care for people with long term conditions and to introduce a funding model to support it.

Other secondary prevention initiatives

As well as improving coordination of support for people with complex and long-term needs, NECA partners could establish a menu of secondary preventive, exercise and lifestyle based options, geared to the needs and preferences of individuals, for specific common conditions. These would delay or substitute for clinical interventions. Conditions amenable to these delivery pathways would include:

1. Diabetes prevention
2. Secondary prevention of coronary heart disease
3. Musculoskeletal (specific diagnoses and sub-pathways e.g. meniscal tear)
4. Depression
5. Hypertension
6. Heart failure
7. Stroke rehabilitation
8. Peripheral vascular disease
9. Family-based support for obesity / excess weight

Entry to the pathways would be either by clinical referral or, within clearly agreed criteria, as a consequence of diagnosis within an NHS Health Check. The area would lend itself well to a results driven approach in order to incentivise providers to maximise the degree of intervention and hence the impact on demand for acute services.

Risk stratification and prioritising high complexity, high cost and low volume patients

A key element of secondary prevention is risk stratification to enable the health and care system to prioritise high complexity, high cost patients. Such an approach can improve quality of life and health and wellbeing outcomes for this cohort of patients, as well as contributing to more effective use of resources. The Commission is aware of the progress made by the North of England Commissioning Support Unit to develop RAIDR, a healthcare intelligence tool, developed with GPs to provide a single portal to help improve quality, safety and efficiency. This includes risk stratification tools. However, in common with many other similar approaches elsewhere, further work is needed to broaden the scope of such tools to take account of wider factors that affect the needs of these patients and then to further develop multi-disciplinary team working to coordinate care for this population.

In a recent lecture at the Institute of Global Health Innovation Dr David Blumenthal, president of the Commonwealth Fund, described the range of factors influencing the health status of these patients including that they are more likely to be older, to have multiple chronic conditions, to experience functional disability and behavioural health problems, to have socio-economic problems and to be near the end of life. This highlights the need to ensure that there is a focus on the non-clinical aspects of care as much as the clinical and the need for effective integrated care.¹⁸

Smoking, tobacco control, brief interventions and Making Every Contact Count

The NECA area has made remarkable progress in smoking reduction over recent years through the Fresh: Smoke Free programme for the North East, which is recognised nationally and internationally for its work in this field. There is evidence at population level, that the impact of campaigns is dose-related –

that is, the more you spend the bigger the impact. Further investment would therefore ensure the region could sustain the downward pressure on smoking achieved in recent years. The Commission strongly supports the commitment made by all Health and Wellbeing Boards within the NECA area to reduce smoking prevalence to 5% by 2025.

Despite the success of Fresh, there remains much to be done to address the levels of smoking and tobacco-related ill health in the NECA area. Not least, the continued heavy burden of chronic obstructive pulmonary disease continues to impose an appalling burden of illness, death and heavy service dependency. It is essential that this is tackled, alongside the problems of cardiovascular disease and cancer that dominate discussion of tobacco's problems. Addressing smoking should be fundamental to all clinical practice. This is demonstrated by the success of decisions by both Northumberland Tyne and Wear NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust to go fully smoke free, as part of their wider health improvement strategy to address physical health needs for those with mental ill health. Targeting pregnant smokers through the programme locally called Baby Clear is particularly important.

Similarly, clinical encounters offer fertile opportunities for brief interventions on alcohol and obesity. Healthcare professionals need appropriate support and training to understand that low cost interventions on their part in these circumstances, despite the many failures they will experience, are among the most effective and cost-effective actions they can take to improve the health of their patients.

The Commission proposes that action to support Making Every Contact Count (MECC) should be actively funded through increased preventive spend alongside funding by Health Education England, providing training, continuing professional development and practical action to ensure that preventive actions are taken by health professionals at all available opportunities, and that these are adequately coordinated with community-based services provided by local authorities.

In addition, partners could consider how the proposed Local Workforce Action Board¹⁹ can develop the skills of the wider health and care workforce to consistently and systematically connect people to local 'assets' – those non-medical services, facilities, networks and activities that do so much to reduce health inequalities and enhance individual and community resilience – and mainstream the principles of shared decision-making and self care to empower people to better manage their own health.



¹⁹ Health Education England local branches are to be replaced by Local Workforce Action Boards

¹⁸ <https://www.periscope.tv/w/1OwGWqkVjynxQ>

Health, wellbeing and productivity

4.1 Health and work in the NECA area

Meaningful work or other activity is one of the most important determinants of health. Equally, a healthy workforce is essential to productivity and hence to growing the regional economy and attracting more and better jobs which are central to the region's economic strategy.

One of the most significant impediments to economic growth in the NECA area is the high level of economic inactivity. Just under a quarter of the working age population in the NECA area is economically inactive, 2.8 percentage points higher than in England as a whole. The North East currently has the highest unemployment rate of all UK regions, at 7.5% against a UK figure of 4.9%.²⁰ 149,140 residents claim out of work benefits, amounting to 12% of the working age population, against 9% for Great Britain. 89,010 of these are long term claimants of over two years. Almost two-thirds are ESA claimants and have a health condition that either prevents them from working or limits the type of work they can do.²¹ This acts as a significant barrier to economic growth through wasted labour force capacity. It is also a significant public health issue, due to the negative health impacts of unemployment.

The table below shows the age profile and distribution of unemployment in the NECA area for the year April 2015 to March 2016, with the statistics for Great Britain included for comparison.

Unemployment rate by age cohort	% of working age population					
	16-64	16-19	20-24	25-34	35-49	50-64
County Durham	6.9	11.0	15.2	9.4	4.9	3.6
Gateshead	6.3	20.8	12.7	5.5	4.9	3.2
Newcastle upon Tyne	8.9	12.2	17.3	8.2	7.1	5.4
North Tyneside	6.2	23.9	8.4	6.1	3.1	5.9
Northumberland	6.3	14.8	21.9	5.9	5.0	2.6
South Tyneside	9.1	20.0	21.8	9.3	4.1	7.4
Sunderland	8.8	44.5	11.6	12.2	4.2	5.0
NECA	7.4	19.9	15.8	8.2	4.9	4.3
Great Britain	5.3	21.6	10.7	4.8	3.4	3.4

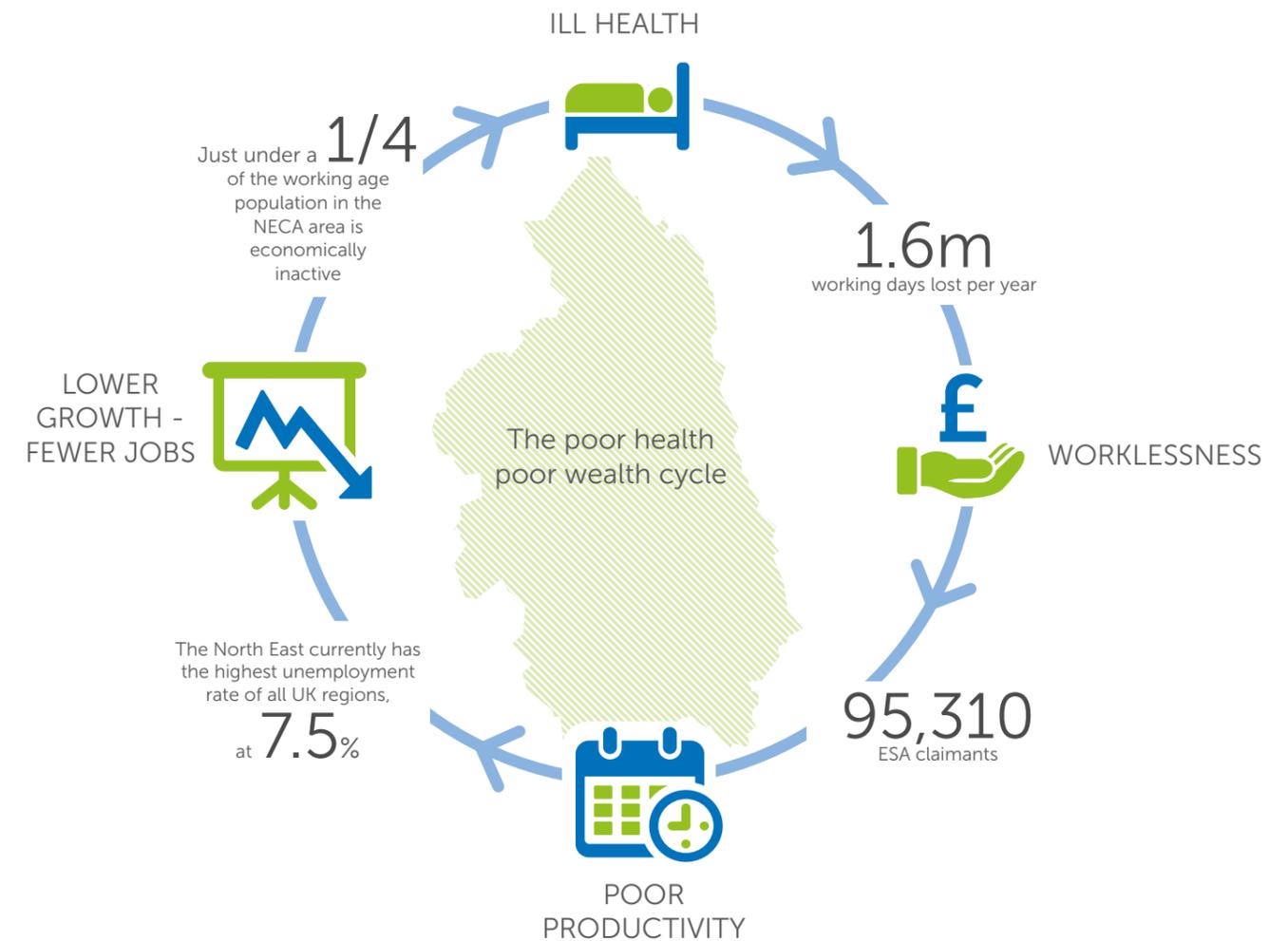
This burden of ill health weighs on productivity and constrains the ability of the economy to grow. In 2011/12 6,000 people suffered from work-related illness in the NECA area – nearly 1% of the workforce – and 1.6 million working days were lost due to workplace injury and ill health.²²

²⁰ Office for National Statistics, Regional Labour Market Statistics in the UK: August 2016 <http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/regionalabourmarket/august2016>

²¹ ONS quarterly labour market data February 2016

²² Better Health At Work Award

The Marmot Review stated that patterns of employment both reflect and reinforce the social gradient in health and that there are serious inequalities of access to labour market opportunities. Rates of unemployment are highest among those with no or few qualifications and skills, people with disabilities and mental ill health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people. When in work, these same groups are more likely to be in low paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Many are trapped in a cycle of low paid, poor quality work and unemployment.



Making it easier for people who experience ill health to stay in work and helping people to return to work as soon as possible is an essential element of this theme of the Commission's work. Creating good and safe work within an environment that promotes the health and wellbeing of employees is key. This includes ending in-work poverty.

These challenges have already been recognised by NECA. Employment, Skills and Inclusion have been a core priority for NECA since its establishment, with the aim of:

- increasing the economic participation rate in the NECA area, assisting people to take up education, training and employment opportunities to increase life chances and economic wellbeing;
- providing support to those most distant from the labour market, where necessary assisting people to overcome disadvantage and poverty;
- tailoring support to meet the specific needs and circumstances of individuals through targeted intensive support and mentoring.

The NECA aim is to create an integrated employment and skills system tailored to specific local needs to raise labour market participation and skills, increase productivity, improve the life chances of young people, help people into work and meet the skills shortages experienced by employers. More specifically, NECA ambitions are to a) target specialised support for residents who are out of work, hard-to-help and long-term unemployed and b) facilitate integration of employment and specialist health services.

NECA research indicates that unemployed people with health conditions and those aged 50+ face a wider set of barriers to work than jobseekers as a whole. Mainstream labour market interventions delivered by Jobcentre Plus and contracted programmes, such as Work Programme, have performed most poorly in job outcomes for participants who claim ESA and have health conditions. Programmes tend to be poorly joined up, focussing on job-search and moving people off benefits quickly without fully addressing the health condition and associated issues that are acting as the barrier to work. This strongly indicates the need for more specialist support to treat health conditions as part of a well integrated employment and health service.

In addressing economic inactivity due to health issues, there is a spectrum of need from intervening early in sickness absence to prevent people from moving into longer term sickness absence to supporting those most distant from the labour market due to entrenched and complex issues which hinder their ability to enter or return to work. In keeping with the Commission's focus on prevention, the recommendations in the remainder of this chapter are aimed at changing outcomes for those currently in the workforce, including those who may have been absent from work due to ill health for six months before they enter the benefits system.

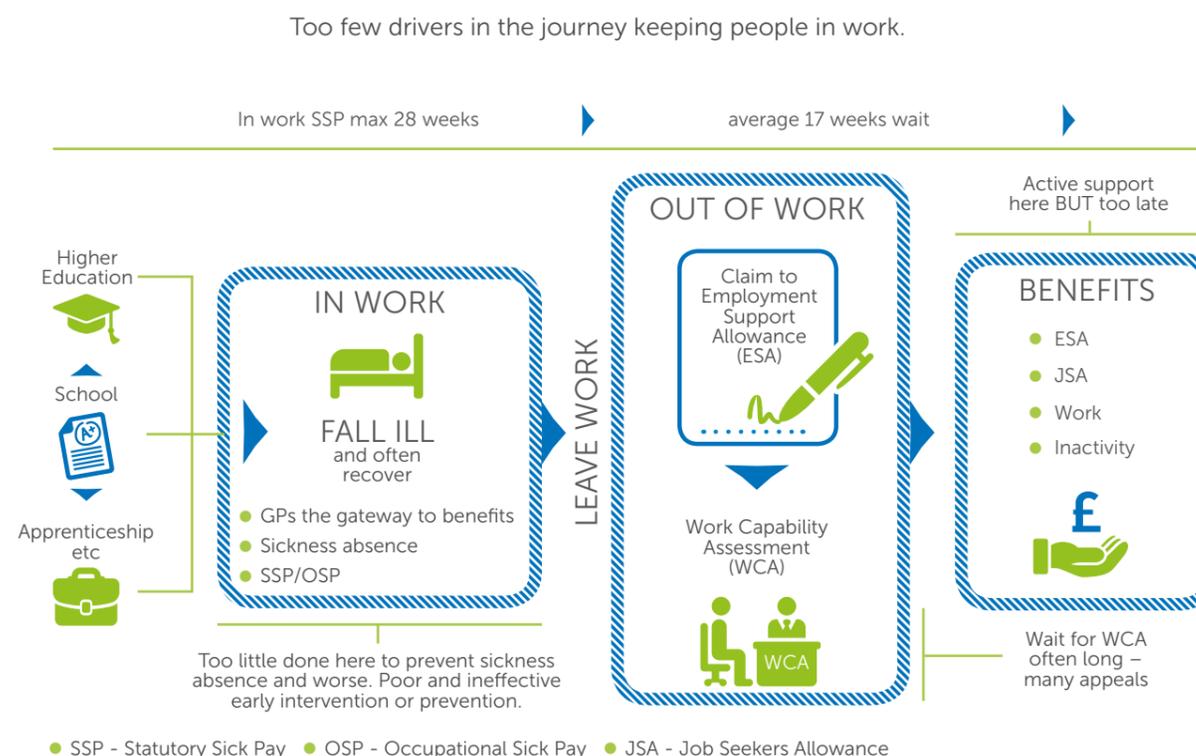
4.2 Benefits of action

Ensuring more individuals are able to work or engage in meaningful voluntary activity benefits both them as an individual, employers and the economy and society as a whole. Good work is known to be a factor in maintaining health and wellbeing. A healthy workforce is beneficial to employers too. By creating a positive, safe and healthy environment for employees, companies can increase morale, improve employees' work-life balance and, in turn, positively impact the business. Healthy workers are more motivated to stay in work, recover from sickness quicker and are at less risk of long-term illness. Organisations stand to make substantial cost savings by promoting health in the workplace and reducing sickness absence.

A healthy workforce can improve productivity and contribute to attracting new investment and jobs. And for society as a whole, maintaining people in work keeps the number dependent on support from others as low as possible.

4.3 Early intervention in sickness absence

Currently in the journey from work and wellbeing towards benefits there are too few drivers to keep people in work and ensure that as few people as possible enter the benefits system. Evidence suggests that just 13% of employers offer access to occupational health services and nearly two-thirds of employers took no measures in the last 12 months to help keep employees with health problems in work or facilitate their return to work. The chart below illustrates this challenge.



Source: Professor Dame Carol Black

In order to intervene earlier in sickness absence, to reduce the length of sickness absence and to support people to return to work rather than moving towards benefits and economic inactivity, **the Commission recommends that NECA partners develop a programme of training to support primary care professionals in helping people access the best support to enable them to get back to work as quickly as possible (recommendation 4)**. This would be tailored to both staff in training and their trainers, and continuing professional development of those in current practice. The programme would include the use of the Fit for Work service and the use of informative fit notes that aid employers and employees. Examples of such programmes supported by the Royal College of General Practitioners already exist, developed with Cardiff University and Department for Work and Pensions. In addition a shared decision-making tool has been developed and is currently being piloted. The tool aims to improve conversations between health professionals (i.e. it can be used in a range of clinical settings, not just primary care) and patients as they discuss work and health to enable the clinicians and the patient together to decide on the best course of action.

4.4 Mental health

While unemployment and the benefit claimant count is gradually decreasing, there remain a large number of ESA and Job Seeker's Allowance (JSA) claimants with health conditions, a significant proportion are mental health related. Of the 95,310 NECA residents out of work and claiming ESA almost half have a mental or behavioural disorder and 1 in 7 suffer from a musculoskeletal disease.²³

Employment Support Allowance claimants (Feb 2016)

Area	Mental ill health	Diseases of the musculoskeletal system	Other	TOTAL
North East	46,120	13,670	35,520	95,310
County Durham	12,610	4,130	10,070	26,810
Gateshead	4,900	1,360	3,780	10,040
Newcastle upon Tyne	7,440	1,860	4,950	14,250
North Tyneside	4,050	1,250	3,370	8,670
Northumberland	5,490	1,640	4,560	11,690
South Tyneside	4,020	1,160	2,960	8,140
Sunderland	7,620	2,270	5,830	15,720

ONS Quarterly data - February 2016

Given the prominence of mental ill health as one of the leading reasons for sickness absence and the high proportion of ESA claimants with mental ill health, addressing the issue is critical. **The Commission recommends addressing mental health at three levels (recommendation 5):**

- i) **Improve the leadership and skills of managers at all levels within local authority and NHS organisations** to develop awareness of managers in relation to mental health and to create a supportive environment, and to develop policies and a workplace culture that enables employees to be proactive in protecting their own wellbeing and therefore tackle issues of stress, anxiety and depression as early as possible. National Institute for Health and Care Excellence instead of guidance on 'Workplace health: management practices' sets out how this can be achieved.²⁴
- ii) **Commissioners of Improving Access to Psychological Therapies (IAPT) services should work with their service providers to ensure employment support is included as part of the IAPT offer on a sustainable basis. This needs to be developed as part of a consistent approach across the area.** This would support those individuals who require this service to avoid sickness absence or to return to work as quickly as possible. It will also be important to ensure that IAPT services have the capacity required to keep waiting times for treatment as short as possible to ensure a timely response to those at risk of sickness absence.

²³ ONS Quarterly data - February 2016

²⁴ <https://www.nice.org.uk/guidance/ng13>

- iii) **NHS commissioners and providers should work with the NECA Employment, Skills and Inclusion workstream to develop an integrated employment and health service.** Such an integrated approach, delivered by employment specialists and health professionals tailored to the needs of individuals, would support job retention and progression in-work through condition management and skills development. Individual Placement and Support (IPS) should be considered as part of this service offer to address employment issues for those with more complex mental health problems. IPS is one of the most robust interventions available for people with severe mental health problems who wish to gain and sustain employment.²⁵

4.5 The role of employers

Employers have a key role to play in maintaining and improving the mental and physical health and wellbeing of their workforce, and supporting those with health conditions to remain in the workforce. As discussed earlier in this chapter, promoting a healthy workplace has considerable benefits for employers and can lead to decreased absenteeism, increased productivity and improved performance as well as enhancing an organisation's reputation and standing with staff, stakeholders and the wider community.

Many public, private and voluntary sector organisations in the NECA area already make significant efforts to address the health of their workforce. However, there is a need to expand this effort to as many organisations as possible if there is to be an impact on the 1.6 million working days lost due to workplace injury and ill health in 2011/12 in the NECA area.

The Better Health at Work Award (BHAWA) was established to raise awareness of health and wellbeing issues in the workplace in order to combat poor health in the NECA area. It is based on a partnership including the wider North East region's twelve local authorities, the NHS and the Northern Trades Union Congress, with support and endorsement from Public Health England. BHAWA takes an evidence based approach in which individuals benefit from increased access to health information and interventions while employers benefit from improved morale, dramatically lower levels of absenteeism and increased productivity. An evaluation of the scheme carried out in 2012 by Public Health North East, Durham University and Brightpurpose summarised as follows: 'The evaluation demonstrates that the BHAWA is highly regarded by employers and workplace health teams. Employers value benefits for their staff and organisations while workplace health teams are passionate about the BHAWA and dedicated to support employers in creating healthier workplaces.'

The Commission recommends that the BHAWA scheme should be the preferred approach for employers to adopt to improve workplace wellbeing, and that NECA partners set a target for the proportion of the workforce working for employers involved in the scheme, and monitor progress towards this target (recommendation 6). As part of this, consideration should be given to sustaining and expanding the BHAWA scheme in order to achieve this target, including ensuring the scheme is accessible and relevant to NECA's high population of small and medium enterprises.

²⁵ Centre for Mental Health: review of the effectiveness of individual placement and support in the UK www.centreformentalhealth.org.uk/ips-evidence

4.6 Good work for all

The Strategic Economic Plan for the NECA area stresses the need not only for more jobs but also for better jobs. The Commission strongly endorses this approach. Job quality is essential to workforce health and hence to productivity and economic growth. Professor Sir Michael Marmot's research and the Work Foundation have identified key features of good work, including stable and safe work, fair employment, flexible arrangements, promoting health and wellbeing, providing opportunities for promotion and growth, participation in decision making. Good jobs can include physically and psychologically demanding roles, which do not need to have a heavy toll on the health of the workforce if the features of good work are present.

In contrast, poor quality jobs can have a significant and detrimental impact on health. Evidence suggests that those in the poorest quality jobs involving a combination of psychosocial adversities (high demands, low control, poor security) have similar or higher risk of psychological distress than those unemployed,²⁶ and that health benefits of becoming employed depend on the quality of job obtained.²⁷ Survey evidence indicates that work-related stress is most prevalent among those earning under £19,000, and is higher in the public sector than the private sector.²⁸

Given the clear importance of job quality for wellbeing, **the Commission recommends that the refreshed Strategic Economic Plan and NECA's Employment, Skills and Inclusion programme continue to address the importance of in-work progression and job quality (recommendation 7),** including consideration of the characteristics of good work as listed above.

The recommendations of this chapter have focussed on those in the workforce at present, including those who may have been absent from work due to ill health for up to six months before they enter the benefits system. The recommendations complement NECA's work on Employment, Skills and Inclusion, where much of the effort is focused on those most distant from the labour market. As NECA partners take forward these recommendations it will be important to align with the NECA's Employment, Skills and Inclusion work to develop a comprehensive approach to address economic inactivity.



²⁶ Broom et al 2006 – Broom D, D'Souza R, Strazdins L et al. (2006) The lesser evil: bad jobs or unemployment? A survey of mid-aged Australians. *Social Science and Medicine* 63: 575–86

²⁷ Butterfield et al 2011 – The psychosocial quality of work determines whether employment has benefits for mental health: results from a longitudinal national household panel survey oem.bmj.com

²⁸ Britain's Healthiest Workplace Survey 2016

System leadership

5.1 Shared responsibility for wellbeing across NECA

Achieving the Commission's vision of a radical shift in funding to prevention will require strong and visionary leadership from across the health and care system. Ensuring prevention investment is focussed in areas where it will have greatest impact will require leaders to take on shared responsibility for outcomes, putting aside organisational boundaries and interests to lead a cultural change to the health and care system. The source of prevention funding should not matter; instead leaders should focus on how each pound of prevention spend can best improve outcomes, with financial benefits of improving health recycled into further prevention.

Leaders within organisations will need to look beyond the interests of their own organisations to drive improvement in wellbeing outcomes across NECA, leading a cultural change to a health and care system in which each health and care £ is used most effectively to support wellbeing, independent of the source of the funding (recommendation 8).

Key characteristics of the new culture should include:

- i. in making resource allocation decisions, NECA partners adopt a whole system approach of spending each health and care £ to achieve the greatest social and economic return, independent of the source of funding;
- ii. leaders champion NECA's health and social care approach with the public and wider stakeholders such as local employers;
- iii. health and wellbeing outcomes are embedded in all decision making i.e. 'health proofing' everything that is done;
- iv. the importance of service reconfiguration in securing a sustainable system that can shift resources to prevention is recognised;
- v. the increasing role of local authorities and the business sector in relation to the wider determinants of health is recognised;
- vi. there is commitment to develop a shared approach to use of the region's key assets – the workforce, the estate, and information assets;
- vii. health and wellbeing is a core priority for top management of all organisations and the strategic importance and benefits of a healthy workplace is valued;
- viii. in recognition of the critical contribution of the VCSE to this agenda, adjustments are made to enable the sector to participate as equal partners and valued mainstream providers.

There are already many examples of successful joint working across health and care across the region, in particular in the five Vanguard projects piloting new models of joined up care.²⁹ These include Northumberland's development of an Accountable Care Organisation to ensure a seamless patient experience across health and care boundaries; All Together Better Sunderland working to improve links between its hospitals and community services to enable better coordinated,

²⁹ NHS Vanguard programme: <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/>

individually tailored care in the home; and the Gateshead Care Home Project to provide improved health support for care home residents.

The success of smoking cessation work in the North East demonstrates what can be achieved through this 'whole system' approach. Smoking is the primary cause of preventable illness and premature death and is the single biggest cause of inequality in death rates between rich and poor in the UK. Around 15 people in the North East die each day from smoking, and smoking is estimated to cost society approximately £775m each year in the North East. For these reasons the North East has been at the forefront of tackling smoking levels via the Fresh North East programme commissioned by all NECA local authorities. Across the region Fresh has contributed to smoking declining by more than a third from 2005 to 2015, the biggest decline of any region in England and smoking-related mortality declining faster than the national average. In addition, the BabyClear programme to reduce smoking rates in pregnancy has seen maternal smoking rates fall by 4% since implementation compared to 2.6% nationally. A final example is the support provided to Northumberland Tyne and Wear NHS FT and Tees, Esk and Wear Valleys NHS FT in the introduction of a smoke free policy which was achieved during 2016. If this work was replicated across the whole of the NHS, social care, community and voluntary sector organisations there would be a measurable change in smoking reduction.

Embedding this type of whole system working to implement the recommendations in this report will require a new, system-wide approach to governance. **The Commission recommends that an overarching governance system be established at NECA level to drive forward implementation of these recommendations, bringing together local authorities, CCGs, NHS FTs and the voluntary sector to progress the health and wellbeing agenda through shared accountability and a focus on implementation and delivery (recommendation 9).** It is essential that these governance arrangements integrate with those developed for the STPs. New arrangements should enable partners to agree and oversee delivery of a core set of NECA area outcomes, including the targets proposed above for preventive spend and employer engagement in workforce health.

For some outcomes a NECA-wide approach will be most effective. Local authorities and CCGs would retain their existing statutory responsibilities, but should commit to working within a shared strategic framework. On other issues it will be appropriate for local health and care partners to have the flexibility to determine how best to meet the agreed outcomes, with accountability to system partners for delivery.

New governance arrangements should also enable oversight and allocation of the preventive funding identified to support double running and pump priming new or additional service provision, including ensuring that this was safeguarded for genuine prevention activity. Over time these arrangements could evolve to provide system leadership across the entirety of the health and care system.

5.2 Making it work

New governance arrangements alone will not deliver the integrated, outcome-focussed system the region needs.

Alongside governance arrangements to incentivise a system-based approach, **the NECA area should also align financial payment systems and incentives with the overall objectives of the health and care system to improve health and wellbeing (recommendation 10).** A programme of work should be established, under the leadership of the CCGs and linked to ongoing national initiatives in this area, to design a tariff system that will:

- i. create alignment to agreed objectives to improve health and wellbeing;
- ii. ensure clear links between investment and outcomes;
- iii. ensure financial stability for the whole system;
- iv. incorporate an agreed approach to risk management and risk sharing;
- v. be part of a whole system approach, building on the STPs, to reduce unnecessary activity and deliver more care closer to home;
- vi. avoid a return to old style block contracts which stifle innovation.

The work would focus on local payment systems and would not impact on national level commissioning of specialised services.

Taken together, the Commission's recommendations on increasing preventive spend, ensuring a system approach and aligning payment incentives should ensure every NECA health and social care £ is spent as effectively as possible to improve the health and wellbeing of the people of the NECA area.



Conclusion and recommendations

The NECA area has strong health and care services but life expectancy and key health and wellbeing indicators remain stubbornly low. Overuse of acute services leads to resources over-focussed on managing ill health at the expense of tackling its underlying causes, including addressing wider determinants of health. To address these issues **NECA partners should set themselves an ambition to radically increase preventive spending across the health and care system and wider determinants of health and wellbeing (recommendation 1)**. At present preventive spending is spread across health, care and wider public services, with little visibility or transparency in the amount or distribution of overall preventive spend. The region should act as a national exemplar in transparency and effectiveness of preventive spend by becoming the first in the country to measure, monitor and report on spend year on year. The region should work with CIPFA to establish a baseline of current preventive spend and methodology to track increase in spending over time. To demonstrate effectiveness of this spend, NECA should also act as a pilot area to trial the Public Health England and CIPFA prudential code for preventive investment.

Deprivation and life style factors are key contributors to the wellbeing gap in the NECA area. Addressing these requires action beyond the health and care sector. **The Commission therefore recommends that public sector partners across the NECA area should integrate preventive action and action to tackle inequalities in all decisions (recommendation 2)**. This will ensure that health and wellbeing impacts are fully factored in to decisions on economic, social and environmental policies over which NECA partners have a degree of control.

Achieving the increased level of preventive investment recommended by this report will require additional front-loaded resource, enabling double running of services as preventive services develop and realise savings over time. **As set out in chapter 3, increased preventive spend should be assigned to a dedicated preventive investment fund managed on a cross-system basis and bringing together contributions from all partners who stand to benefit from the expected savings, including central government (recommendation 3)**. Over time this preventive investment fund should become self-sustaining as preventive activity reduces pressure on services, releasing savings which can be recycled to further preventive investment. Chapter 3 contains a range of proposals on how such increased spend could be used to good effect.

A radical increase in preventive investment should have a significant impact on narrowing the health gap between the NECA area and the country as a whole. However, without good jobs and meaningful activity, preventive spend will not be enough to overcome the NECA area's wellbeing challenges. The North East currently has the highest unemployment rate of all UK regions, at 7.5% against a UK figure of 4.9%.³⁰ This acts as a significant barrier to economic growth through wasted labour force capacity. It is also a significant public health issue, due to the negative health impacts of unemployment. The Commission believes greater action to help people stay in work and return to work after sickness is essential to tackling the NECA area's economic and wellbeing challenges.

³⁰ Office for National Statistics, Regional Labour Market Statistics in the UK: August 2016 - <http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/regionallabourmarket/august2016>

In order to intervene earlier in sickness absence to reduce the length of sickness absence and support people to return to work rather than moving towards benefits and economic inactivity, **the Commission recommends NECA partners develop a programme of primary care training to support primary care in helping people access the best support to enable them to get back to work as quickly as possible (recommendation 4)**. Given the prominence of mental ill health as one of the reasons for sickness absence, the Commission also **recommends addressing mental health at three levels (recommendation 5)**:

- i. **improve the leadership and skills of managers at all levels within local authorities and NHS organisations** to create a supportive environment that enables employees to be proactive in protecting their own wellbeing;
- ii. **commissioners of IAPT services should work with their service providers to ensure employment support is included as part of the IAPT offer on a sustainable basis** to support those individuals who require this service to avoid sickness absence or to return to work as quickly as possible;
- iii. **NHS commissioners and providers should work with the NECA Employment, Skills and Inclusion workstreams to develop an integrated employment and health service.**

Employers have a key role to play in maintaining and improving the mental and physical health and wellbeing of their workforce and supporting those with health conditions to remain in the workforce. **The Commission recommends that the BHAWA scheme should be the preferred approach for employers to adopt to improve workplace wellbeing, and that NECA partners set a target for the proportion of the workforce working for employers involved in the award scheme, and monitor progress towards this target (recommendation 6)**. As part of this, consideration should be given to sustaining and expanding the BHAWA scheme that would be necessary to achieve such a target.

Increasing employment and ensuring employment opportunities are high quality and offer the opportunity to progress is vital to health and wellbeing. NECA's Strategic Economic Plan sets a high level objective of achieving more and better jobs for the region. **The Commission recommends that the refreshed Strategic Economic Plan and NECA's employment and skills programme continue to address the importance of in-work progression and job quality (recommendation 7)**.

Achieving the Commission's vision of a radical shift in funding to prevention will require strong and visionary leadership from across the health and care system. Ensuring prevention investment is focussed in areas where it will have greatest impact will require leaders to take on shared responsibility for outcomes, putting aside organisational boundaries and interests to lead a cultural change to the care and health system. **Leaders within organisations will need to look beyond the interests of their own organisations to drive improvement in wellbeing outcomes across NECA, leading a cultural change to a health and care system in which each health and care £ is used most effectively to support wellbeing, independent of the source of the funding (recommendation 8)**.

Leaders will need to agree and oversee delivery of a core set of North East outcomes, including the targets proposed above for preventive spend and employer engagement in workforce health. A mechanism will be needed to provide oversight and allocation of the preventive investment fund. The Commission therefore recommends that **a governance system should be established at NECA level to drive forward implementation of these recommendations, bringing together local authorities, CCGs, NHS FTs and the voluntary sector to progress the health and wellbeing agenda through shared accountability and a focus on implementation and delivery (recommendation 9)**. It is essential that this integrates with STP governance structures.

The new approach will need to recognise the different geographical scales appropriate for different types of activity or integration: on some issues the new governance system could directly oversee pan-NECA delivery; on others action at local level may be more appropriate and the new governance system could hold different areas within the region to account for meeting agreed outcomes, while leaving local care and health partners with full flexibility on how these outcomes are met.

To support this transition, **the NECA area should align financial payment systems and incentives with the overall objectives of the health and care system to improve health and wellbeing (recommendation 10)**. A programme of work should be established, under the leadership of the CCGs, to design a tariff system that will;

- i. create alignment to agreed objectives to improve health and wellbeing;
- ii. ensure clear links between investment and outcomes;
- iii. ensure financial stability for the whole system;
- iv. incorporate an agreed approach to risk management and risk sharing;
- v. be part of a whole system approach, building on the STPs, to reduce unnecessary activity and deliver more care closer to home;
- vi. avoid a return to old style block contracts which stifle innovation.

The work would focus on local payment systems and would not impact on national level commissioning of specialised services.

The action called for needs to be delivered by every part of the system. Taken together the recommendations above on increasing preventive spend, ensuring people get the support they need to enable them to stay well and in work and creating a system-wide approach should ensure that every NECA health and social care £ is spent as effectively as possible to improve the health, wealth and wellbeing of the people of the NECA area. The prize is great: closing the gap in healthy life expectancy with the nation as a whole over the next decade would lead to 400,000 additional years of active, healthy life for the people of the NECA area. The Commission hopes that local and national leaders will study this report carefully and work together to enact its recommendations.

Annex A

Extract from the Commission Framing document agreed in February 2016, setting out the focus of inquiry for the Commission³¹

Establishing the Commission for Health and Social Care Integration

The focus of Inquiry for the Commission

A number of common themes have emerged from the November workshop and other fora where HSC devolution and the role of the Commission have been discussed. These themes are drawn together in this paper to form the key themes and ways of working required to move the HSC devolution agenda forward and to provide direction for the Commission. It is clear that the Commission cannot address all of the potential areas and developments that further integration and devolution could bring but it can serve as a catalyst for increasing the pace and scale of change in HSC integration by recommending the first steps in what will inevitably be an evolutionary process.

The themes for the Commission to pursue and report on are:

- How to ensure, in a context of shifting overall resources, sufficient investment in prevention in order to improve health outcomes and reduce health inequalities between the NECA population and England and also within the NECA population and, aligned to this, how to support the shift from reliance on hospital-based care to self care, independence and care closer to home?
- What would a human capital development focus for health and social care look like and what are the people strengths that we can build on? How can the public sector support economic regeneration and vice versa. For example, how can health and social care services support NECA's priority to address barriers to employment; how can human capital development help to address gaps in the health and social care workforce and how can public sector investment contribute to improving the health and wellbeing of local people?
- To explore the benefits of devolution over and above the existing flexibilities we already have for integrated working, focussing on delivering a clear and comprehensive set of benefits.
- Aligned to the point above, consideration of what financial arrangements would have to underpin the shift to prevention and more community based care and greater integration of health and social care commissioning and provision. How could this be supported by the NHS sustainability and transformation fund and what metrics should be used to measure progress, especially against the early intervention priority.

³¹ full version of the framing document can be found at www.northeastca.gov.uk

- What would the deal look like between local leaders, national government, regulators and the local autonomous institutions to deliver this change, including how local leaders of health and social care could jointly support major service reconfigurations to establish safe, sustainable services and potential changes to commissioning arrangements across a wider population footprint
- To describe the system leadership challenge presented by the scale of transformation required and how this could be addressed.

There are two cross cutting areas that need to be considered in conjunction with the themes above:

- To address the challenges that differing geographies between combined authorities and health networks may present, including consideration of patient flows into and out of the NECA area and how neighbouring combined authority areas could benefit from devolution to the NECA area.
- To identify explicit connections and interdependencies with the other devolution themes, particularly human capital development.

The following operating principles will apply to the Commission's work:

- it will be positioned as a joint endeavour between NECA and the NHS from the outset
- its modus operandi will be shared with all key stakeholders to ensure it has the trust and confidence of all stakeholders
- clear reporting and accountability arrangements will be established for the work and outputs of the Commission
- the membership of the Commission should reflect the task that it has been asked to carry out
- where possible each Commissioner will lead a stream of work linked to the core themes of inquiry
- the Commission should be given the support and resources it needs in order to carry out its task. This is not only in terms of involving the right people but also access to sufficient capacity in areas such as analytics and economics, to enable it review the evidence base and give credibility to the economic case for change
- the Commission should enable stakeholders to be effectively involved with the other seven devolution work streams and equally, help those work streams assist the integration of health and social care

Stakeholder views

This Annex describes the key messages that the Commission heard through the engagement that they carried out. It highlights common themes that emerged as well as some specific responses which provide a flavour of the debate. These examples are just a small sample of the rich tapestry of views, suggestions and evidence received.

B.1 Our approach

Critical to the success of the Commission and the work to implement its recommendations, is the ongoing engagement with, and support from, all the key partners. The Commission has taken an open approach to engagement, involving partners and the public from across the region. It sought input in three ways: listening events; a call for evidence, and a specific event with voluntary sector organisations.

In each case questions were focussed on the core themes at the centre of the work of the Commission:

- Supporting people to stay well and independent (a shift to prevention)
- Focussing more on health, work and wellbeing (health, wellbeing and productivity)
- Exploring opportunities to improve health and wellbeing through devolution (system leadership and governance).

Listening Events

Throughout April and May, seven listening events were held, one in each local authority area. Each event was chaired by one of the Commission members and enabled them to hear from a cross section of stakeholders about their interests in the work of the commission.

Over 300 participants attended these events with a wide and diverse range of attendees including statutory bodies (local authorities, NHS, Tyne and Wear Fire Service, Northumbria Police), regional partners (including Public Health England, social care providers) and the voluntary sector (including a range of carers' associations and voluntary sector provider organisations). The events were attended by a number of councillors, including some chairs and members of Health and Wellbeing Boards.

Call for Evidence

In April, the Commission invited people and organisations from across the NECA area to submit written evidence to inform their work, based on the themes set out above. The Commission received 161 documents from 89 diverse organisations and individuals. A full list of organisations which responded can be found at Annex C. Some of the submissions had been written specifically for the Commission, others were reports, presentations or articles that were thought to be of use.

Voluntary Sector event

This event was held when the Commission was in a position to present some of the emerging themes from the feedback we had received from the listening events and call for evidence and led us to pose the following questions:

- How does the system need to change to enable the voluntary sector to play its part?
- How is the sector going to change to deliver the NECA/ NHS ambitions for a shift in focus to improving health and wellbeing?

Approximately 75 people attended from across the NECA area, representing a wide range of organisations.

B.2 Common messages and themes

Supporting people to stay well and independent

“we should have one system.....one budget.....with a focus on collaboration and system integration”

Views from the event in Gateshead

The NHS Five Year Forward View, published in October 2014, gave a clear message on prevention: ‘If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.’³⁰

This message was supported by numerous organisations who submitted evidence and there was a strongly held view that the focus of the Commission’s recommendations should be on investing in prevention. Many respondents pointed to significant evidence to support the case for more prevention and stressed the need to provide more targeted services, which are funded, commissioned and delivered in partnership with statutory and voluntary sector organisations.

Respondents also highlighted the potential of community-centred approaches to improve health and well-being. These approaches value the skills, talents, capacity, skills, knowledge, connection, potential or ‘assets’ in communities and seek to increase people’s control over their own health. This contrasts with the traditional approach of public bodies in focussing on the needs and problems within communities, such as deprivation or health-damaging behaviours. Commission members heard about a strong ambition to achieve a better balance between traditional service delivery and community approaches by helping to build more cohesive resilient communities.

Other issues raised included:

- the financial arrangements that would need to underpin the shift to prevention and more community based care;
- developing commissioning frameworks which incentivised the whole system to ‘do the right thing’ and the need for transformation funding to enable partners to deliver change;
- the challenges of measuring outcomes and benefits of increased prevention investment, and developing a regional model of how to evaluate “return on investment”;

³⁰ Five Year Forward View, NHS October 2014, see <https://www.england.nhs.uk/ourwork/futurenhs/>

- a plea to build public health and prevention agendas into mainstream commissioning and provision;
- a place-based focus which would build on the assets already in communities;
- the links between social isolation and poor physical and mental health;
- the success of local initiatives like Fresh and Balance tobacco and alcohol control programmes, Ways to Wellness in Newcastle and others;
- housing quality was identified as a critical element in improving health and wellbeing.

Focusing more on health, work and wellbeing

“We need to encourage employers to see the value in investing in health and wellbeing initiatives to support their workforce”

Views from the event held in South Tyneside

Two key areas were highlighted:

- the importance of economic growth and employment as essential in improving the health and wellbeing of local people;
- the need for employers to develop initiatives to help employees stay healthy.

Public Health England submitted a report which acknowledges strong correlation between improving health of the local population and economic prosperity.

The view from many of the submissions was that as system leaders, health and care organisations have a responsibility to ensure their staff take ownership for their health as well as encouraging staff to promote healthy living and healthy lifestyles among the patients and clients they see.

Other issues raised included:

- the need for employers to support carers;
- the positive health impact of volunteering;
- supporting employers to have ‘healthy workplaces’;
- the need to focus on mental health as well as physical health at work and the support some employers will need to promote the mental health of their workforce, and to support individual workers who are experiencing poor mental health.

Exploring opportunities to improve health and wellbeing through devolution – including system leadership/governance

“There must be a strong and collective voice across NECA and the NHS – to encourage the pooling of funding and responsibilities”

Attendee at Sunderland event

One of the strong themes that emerged from the evidence was the need for a NECA-wide approach to change. There was a general view that the current system feels fragmented, and the Commission was encouraged to be bold, to think big and to be aspirational in identifying their recommendations. Many respondents argued that stronger strategic leadership across local authorities and

healthcare would be beneficial to residents within the NECA area. Other issues raised included:

- The opportunity to develop clear links between health and care objectives and policy decisions on the wider determinants of wellbeing, for example the use of health impact assessments, in order to embed health and wellbeing into every major policy decision. Participants also mentioned the need to pursue devolved powers to enhance social housing.
- The importance of the health and care partners across the NECA area showing leadership so that system-wide savings from a shift to prevention are not recycled into temporary additional funding that delays necessary changes to ways of working and locations of services that are not financially or clinically sustainable in the long term.
- The need to use devolution as an opportunity to redress the shortfalls in funding in the NECA area and to secure additional resource to tackle the prevention agenda head on.
- Resources to support public health initiatives should be protected, with health and wellbeing being seen as everyone's business.

Role of the Voluntary Sector

An event took place on 30 June to encourage the voluntary, community and social enterprise sectors to have a say on the shape of future health and wellbeing services and support across the area and how the sector can be an equal partner. The event highlighted the strength of the voluntary sector in the NECA area and explored how their contribution could be maximised.

The overwhelming message was in relation to the 'offer' from the sector. Participants were keen to highlight the value brought by community organisations which are often closer to communities than statutory partners, and are therefore able to influence and support behaviour change more effectively. Smaller organisations can also work more quickly and can be more responsive than the statutory sector and are a valuable source of local intelligence.

Other issues highlighted were:

- the current barriers for voluntary and community sector organisations i.e. procurement and commissioning processes used to award contracts could be much more accessible to the small organisations in the sector which have limited administration and procurement expertise;
- involving local organisations in the specification of new services and needs assessments;
- the acute financial pressures on the sector and the loss of many organisations and projects;
- the need to acknowledge the true costs of providing services (including accommodation and infrastructure costs).

Those reading the Commission's report will identify where common themes and issues from the engagement described here have contributed to the work of the Commission. However, it has proved difficult to do justice within the confines of the report to the range and complexity of the contributions received from so many individuals and organisations. The Commission will therefore produce a separate engagement report which will be available after it's report has been published.

Annex C

Organisations which responded to the call for evidence

Accenture	Mental Health and Wellbeing Group	Northumberland Wildlife Trust
Age UK	Newcastle City Council and Partners - Newcastle System Integration Taskforce	Public Health England
Age UK Newcastle	Newcastle Council for Voluntary Service	Royal National Institute of Blind People (RNIB)
Age UK South Tyneside	Newcastle Gateshead Clinical Commissioning Group	Shelter
Alzheimer's Society	Newcastle Director of Public Health	Sight Service
Association of North East Councils	Newcastle Society for Blind People	Slow Shopping
Beamish - The Living Museum of the North	Newcastle upon Tyne Hospitals NHS Foundation Trust	South Tyneside Council - Integrated Care & Commissioning
Business Durham	NHS North Tyneside	South Tyneside NHS Foundation Trust
Carers Trust	North East Ambulance Service NHS Foundation Trust	Sunderland City Council, Health and Wellbeing Board
Changing Lives	North East Autism Society	Sunderland Clinical Commissioning Group
County Durham and Darlington NHS Foundation Trust	North East Directors of Public Health	Sunderland Out of Hospital Vanguard
Cumbria and North East Local Eye Health Network	North East Local Enterprise Partnership (NELEP)	Tees Esk and Wear Valleys NHS Foundation Trust
Durham and Darlington Local Pharmaceutical Committee	North East Local Nature Partnership	The Academic Health Science Network for the North East and North Cumbria
Durham Alliance for Community Care	North East Trading Standards	The Open University in the North
Durham County Council	North of England Commissioning Support Unit	The Richmond Group of Charities
Durham Dales Health Federation	North of Tyne Local Pharmaceutical Committee	Thirteen
Durham University, Public Health Geography	North Tyneside Clinical Commissioning Group	TUC Better Health at Work
Durham University, Centre for Public Policy and Health	North Tyneside Council Public Health	Voices from the Frontline & Homeless Link
Escape	North Tyneside Winter Support Network	VONNE
Foyer Federation Change Your Mind about Young People (CYMaYP)	Northern England Clinical Networks	Ways to Wellness
Fresh and Balance	Northumberland Community Voluntary Action (CVA)	Wellbeing for Life
Gateshead Council	Northumberland County Council	Women's Commissioning Support Unit (NE)
Gateshead NHS Foundation Trust & Gateshead Care Partnership	Northumberland Vanguard	
Greater Manchester Public Health Network		Individual Contributions
Healthwatch Gateshead		Guy Pilkington
Healthwatch Middlesbrough		Iain Kitt
Helen McCardle Care		John King
Helping Hand North East		Julia Bates
International Community Organisations of Sunderland		Paul Goldsmith
London School of Economics (LSE)		Sheila Beniams

This report can be made available in alternative formats and languages on request.

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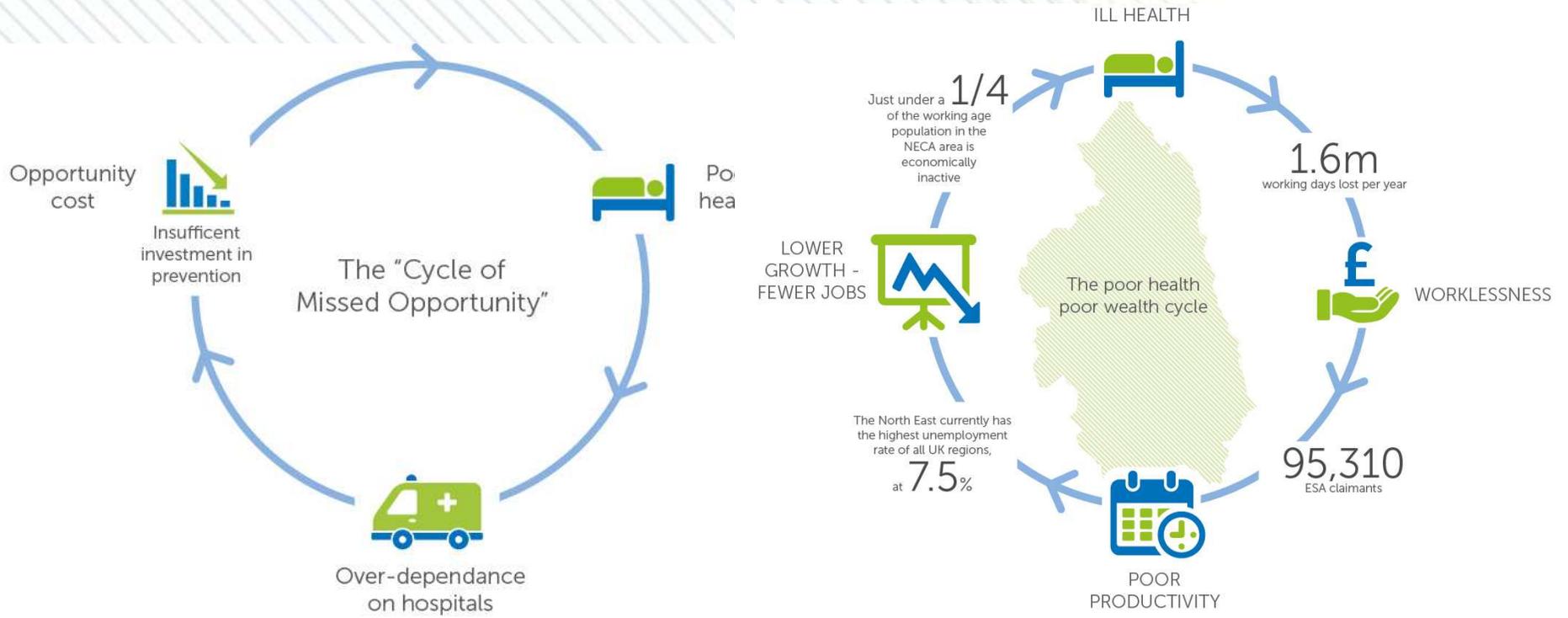
**‘Health and Wealth – Closing the
Gap in the North East’**
Report of the North East Commission for
Health and Social Care Integration

Duncan Selbie
Chair of the Commission
Chief Executive Public Health England

Joint NECA/NHS Commission for Health and Social Care Integration

- Commission was established as part of the proposed devolution deal agreed between NECA and central government in September 2015.
- In February 2016 the Commission met for the first time and included four members who are national experts in their own fields in health and social care. The Commission met on a further three occasions up to September 2016, as well as carrying out work on behalf of the Commission between meetings
- The Commission has worked closely with local stakeholders, seeking views from across the region through:
 - A call for evidence
 - Holding listening events in each of the seven local authority areas
 - Specific event for the voluntary, community and social enterprise sector
 - A steering group including colleagues from health, social care and public health

The barriers to closing the gap



‘Health and wealth: closing the gap in the North East’

The report:

- Recognises the strength of health and care assets in the North East and points out that the North East is making faster progress in increasing life expectancy than any other region of the UK, although a significant health and wellbeing gap remains.
- Outlines a vision for transforming the health and wellbeing of people living across the North East and, in doing so, closing the gap with the rest of the UK and helping to improve the economy and the prosperity of individuals.
- Identifies 10 far reaching recommendations which include calls for a radical increase in preventive spending and for greater action to help people with health conditions to secure and remain in work.
- Challenges leaders of health and care organisations to be bold and work in new ways to break down organisational barriers to ensure the wellbeing of the people living across the NECA area.

Recommendations: A shift to prevention

Recommendation 1: NECA partners should set themselves an ambition to radically increase preventive spending across the health and care systems and wider determinants of health and wellbeing.

Recommendation 2: Public sector partners across the NECA area should integrate preventive action and action to tackle inequalities in all decisions.

Recommendation 3: Increased preventive spend should be assigned to a dedicated investment fund managed on a cross-system basis and bringing together contributions from all partners who stand to benefit from the expected savings, including central government.

Recommendations: Health and Work

Recommendation 4: NECA partners should develop a programme of primary care training to support primary care staff in helping people access the best support to enable them to get back to work as quickly as possible.

Recommendation 5: The Commission recommends addressing mental health at three levels:

- Enhancing leadership skills to create a supportive environment
- Including employment support in Improving Access to Psychological Therapies (IAPT) services
- Developing an integrated employment and health service

Recommendation 6: NECA partners should set a target for the proportion of the workforce working for employers involved in the Better Health At Work Award scheme and the scheme should be the preferred approach for employers to adopt to improve workplace wellbeing

Recommendation 7: The refreshed Strategic Economic Plan and NECA's employment and skills programme should continue to address the importance of in-work progression and job quality.

Recommendations: System Leadership

Recommendation 8: Leaders within organisations will need to look beyond the interests of their own organisations to drive improvement in wellbeing objectives across the NECA area, leading a cultural change to a health and care system in which each health and care £ is used most effectively to support health and wellbeing, independent of the source of funding.

Recommendation 9: Governance system should be established at NECA level to drive forward implementation of these recommendations, bringing together local authorities, Clinical Commissioning Groups, NHS Foundation Trusts and the voluntary sector to progress the health and wellbeing agenda through shared accountability and a focus on implementation and delivery.

Recommendation 10: The NECA area should align financial payment systems and incentives with the overall objectives of the health and care system to improve health and wellbeing and reduce health inequalities.

And finally.....

- The action called for needs to be delivered by every part of the system.
- Taken together the recommendations on
 - increasing preventive spend
 - ensuring people get the support they need to enable them to stay well and in work
 - creating a system-wide approach

should ensure that every NECA health and social care £ is spent as effectively as possible to improve the health, wealth and wellbeing of the people of the NECA area.

- **The prize is great: closing the gap in healthy life expectancy with the nation as a whole over the next decade would lead to 400,000 additional years of active, healthy life for the people of the NECA area.**

Questions

Duncan Selbie, Chief Executive Public Health England

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