Humber Health and Care System

Operational Plan 2020-21

(**DRAFT**)

About the Humber

Our Ambition

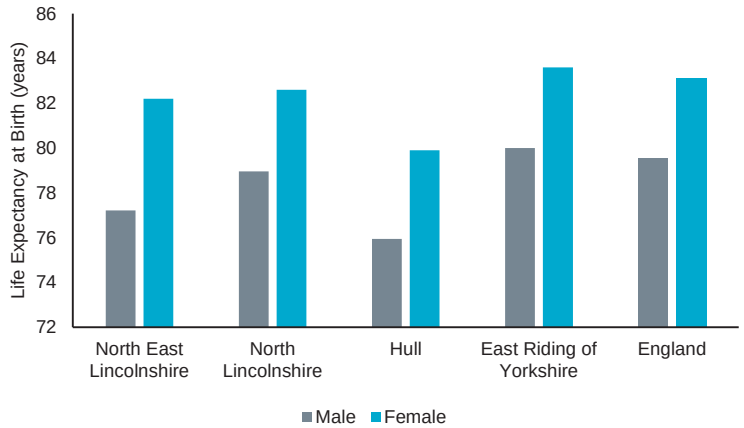
To deliver a recovery plan which supports health and wellbeing across our population, with a focus on addressing health inequalities which have been exacerbated as a result of the C-19 outbreak and response.

To achieve this, our existing ambitions to support people to stay physically and mentally well and manage their conditions in community settings must accelerate, prioritising those who are most at risk, clinically and socially.

Humber Facts

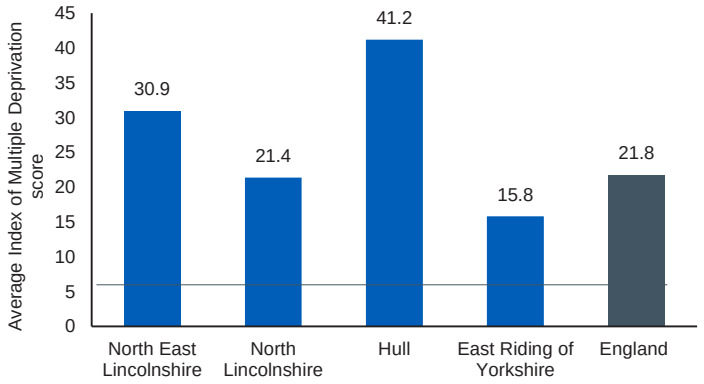
- 21 different organisations and 17 Primary Care Networks (PCN's
- 919,600 projected population 2026
- The population is ageing with the number of people aged 65+ growing considerably faster than younger age groups
- North East Lincolnshire and Hull are within the top 20 most deprived areas in England. Averages mask significant areas of socio-economic deprivation in North Lincolnshire and the East Riding

Age - The average age in the Humber is 42



Source: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017

Deprivation



Source: Department of Communities and Local Government (DCLG)

Our Priorities

Our Issues

- Providing ongoing care and treatment of COVID-19 cases, including post-COVID care and maintaining availability of surge capacity
- Operating within reduced capacity across health and social care due to the impact of infection minimisation and other policy responses
- Managing the consequences of the system response to COVID-19, including:
    - deferred and delayed care
    - impact on system performance (list size and waiting times
    - missed prevention opportunities
    - healthcare-avoiding patient response

Our Response

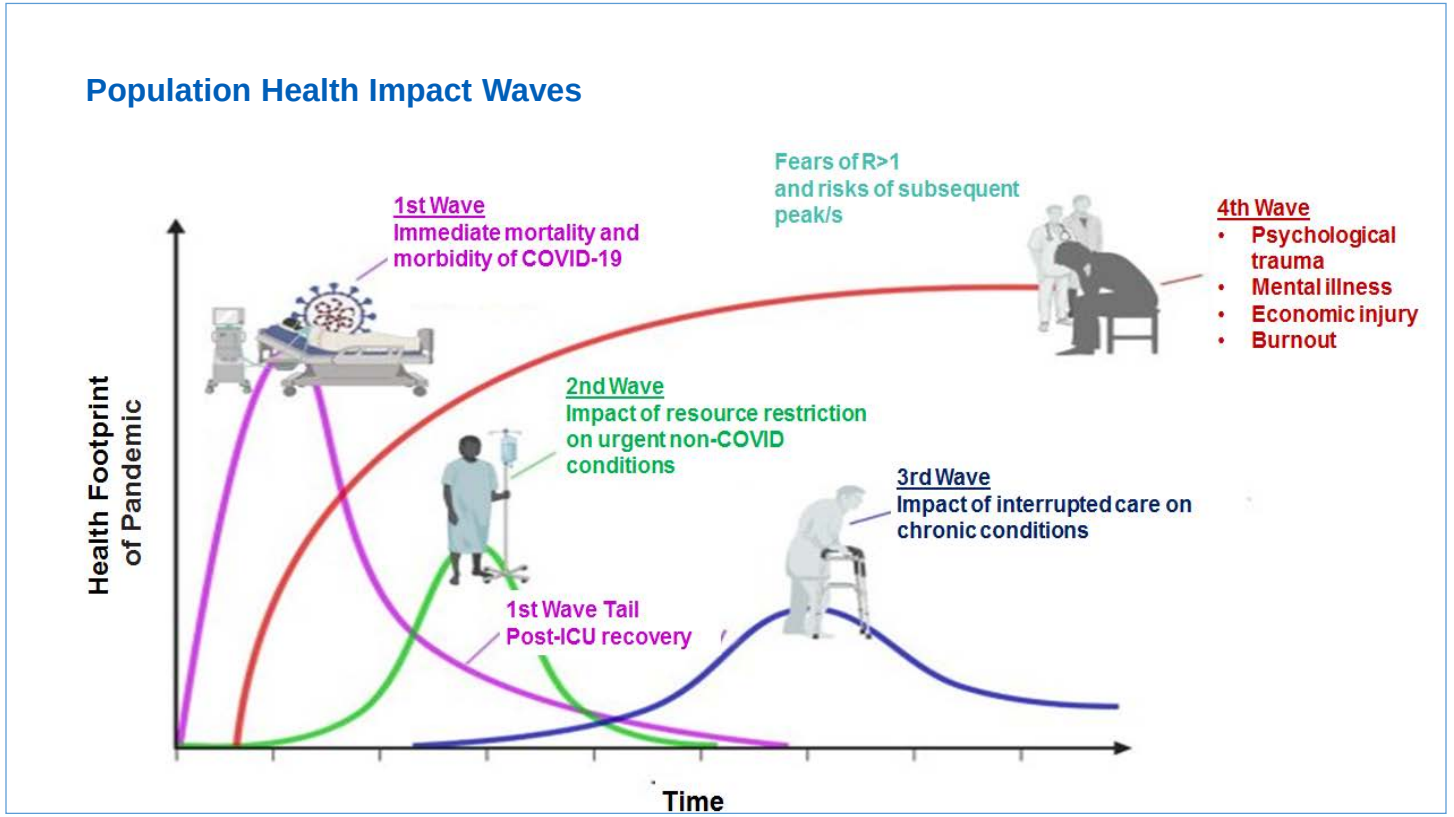
- Identify and support the most vulnerable, including work to address health inequalities
- Identify people who are at risk of becoming mentally and physically unwell and providing integrated care and support within communities to avoid hospital admissions
- Develop primary, community and mental health capacity, services and workforce to safely manage higher volumes and higher risk patients
- Maximise the use of available acute capacity, prioritising patients at the highest risk
- Capitalise on innovations introduced during the immediate COVID response

Assessing the Impact on our Population

Our plan uses a Population Health Management (PHM) approach based on Impact Waves to identify groups within our population who will be the most vulnerable during the COVID recovery period.

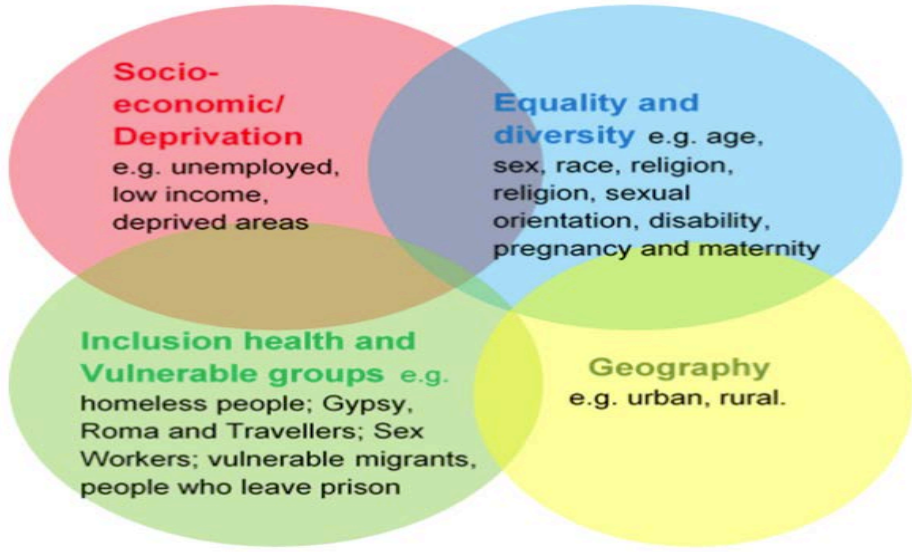
Initial findings indicate the direct and indirect impacts of COVID disproportionately affect already disadvantaged communities:

- Excess COVID infection and mortality among BAME groups and people living in disadvantaged areas.
- Reduced access to healthcare is likely to affect disadvantaged communities more acutely
- Economic threat, mental health worries due to lockdown and educational disadvantage all threaten the poorest and most marginalised communities the most.
- Children and young people will be one of the groups most affected.



Humber Equality Impact Assessment

Approach



Royal College of Physicians model

Initial Findings

- Significant BAME impact – higher mortality + highlighting & exacerbating pre-COVID inequalities
- Hearing access can be affected by mask wearing
- Impact of lockdown measures on disabled people
- Access to accessible info for people with learning disabilities, national reports and assurance needed on people not accessing services
- End of life impact - faith groups
- Toll on mental health + reduced access to services
- Pregnancy and maternity – loss of shared milestones during pregnancy
- Gender inequality:
  - Significantly higher mortality for males
  - Impact on women includes stress of taking greater household and caring responsibilities
  - Financial inequalities heightened
  - Gender based violence increased

Key Groups

- Low income families / food poverty
- SEND and at-risk children
- Victims of Domestic Abuse
- C-19 Shielded Groups
- BAME communities and workforce
- People and carers over 70's
- People with existing mental health problems
- People experiencing mental health and psychological issues
- Marginalised Groups – refugees, migrants
- People with addictions
- People with LD and Autism

Phase 3 Plan and gap analysis

What are the big themes?

- How we plan for a potential 2nd wave of Covid 19
- How we plan for the winter in conjunction with a potential 2nd wave of Covid 19
- How we mange the above two issues and mitigate the reduction in access to non covid patients as experienced in the Phases 1 and 2 of the emergency response
- How do we address the backlogs of patients across the system who have not received the care they would have received in normal circumstances
- How do we address the health and well being of the public, patients and staff
- How do we address the inequalities in the system that may have been exacerbated in this situation
- How do we capture and enhance the good work undertaken across all sectors, embracing the news ways of working and cooperation to ensure we do not lose the benefits we have all experienced
- How do we embrace the flexibility of the workforce and organisations that we have experienced
- How do we maintain the benefits from technology whilst ensuring the inequalities from digitally disadvantaged are addressed

Supporting our Population

Supporting the whole population to stay well is crucial to addressing the long term health and wellbeing impact of the COVID outbreak and response as well as for managing demand for health and care services. It will also be crucial to design services to address the needs of vulnerable groups, within the community and close to where they live whenever possible

Helping our Population to Stay Well

- Maintaining uptake of vaccinations and immunisations, including flu.
- Restarting cancer screening and encouraging uptake:
- Campaigns promoting appropriate access routes for health services, e.g. Talk before you Walk models
- Engage with local communities to understand how public attitudes and behaviours have changed in relation to accessing healthcare
- Recognising and promoting the role of the voluntary sector in supporting our population to stay well

Addressing Health Inequalities

- Accelerating existing programmes to address longer term, pre-covid health inequalities e.g. prevalence and impact of CVD, early diagnosis of cancer
- Working with Places to accelerate existing work to address the wider determinants of health

Supporting Vulnerable Groups

- Volunteer hub and community/voluntary sector support for vulnerable people, including shielding groups
- Access to social prescribing for marginalised, vulnerable and isolated groups
- Health checks for people with learning disability and severe mental illness
- Access to carers support teams for frail and complex patients and their carers.
- Address backlogs and manage expected surge in services for vulnerable children and young people, including SEND
- Support digital inclusion and maintain non-digital access routes to avoid excluding vulnerable groups
- Work with Active Humber to support people who are disproportionately affected by the pandemic to access sport and physical activity
- Work with the Voluntary and Community Sector, individuals and their families to develop community resilience
- Work with local authority and VCSE to offer support to households in food poverty

Planning Requirement: Phase 3

NHSE/I Phase 3 Planning Requirement
A -Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter
B- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.
C- Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention

Plan Overview

Sector	Focus Areas
Primary Care	• **Support to care homes.** • **Cancer screening & immunisation. Learning disability and mental health physical health checks** • **Embedding total triage model and online service offers**
Community Care	• **Integrated frailty model** of targeted, proactive, interventions to include prevention, proactive support and crisis management • Support to care homes • Rapid access for community and primary care to **specialist support and advice from Respiratory Physicians** Sustaining the COVID-19 **Hospital Discharge Service** Requirements
Learning Disability and Autism	• Maintain **digital offer / re-introduction of face to face appointments** • Complete recruitment and establishment of **Forensic Outreach Liaison Service** • Reinstate / Introduce **preventative activities** • **Safeguarding and CETR**
Mental Health	• Manage the **IAPT Surge** • Maintain the **Crisis Response** • Manage the **Psychological Impact of C19 on the population** • Support to **Children and Young People** • Continued delivery of the **Mental Health Long Term Plan**
Acute Sector	• **Clinical triage** of referrals and deployment of advice and guidance, streaming straight to test etc • Embedding **remote consultation** by both telephone and video • **Clinical validation** of patients awaiting follow up and moving patients to patient-initiated follow-up pathways • **Radiology review of diagnostic requests**; redirection to lower invasive tests where appropriate • Clinical prioritisation processes that **target resource at highest priority cases** • Use of **independent sector capacity** • **Urgent and emergency care** NHS 111 First, Talk Before You Walk, Winter Assurance

Local Place Priorities

Sector	Deliverables	Outcomes
Primary Care	1. Primary Care Networks Additional Roles 2. PCN Organisational Development to take on wider roles and functions	Increased primary care capacity Patients seen by the most appropriate person Increased patient and staff satisfaction PCN organisational structures in place Development of local clinical leaders Robust governance arrangements in place PCNs make best use of resources
Community Care	1. Ironstone Centre Utilisation	• Improved utilisation of clinical space to meet Place needs
Learning Disability and Autism	1. Adult Neurodiversity pathways 2. Implementation of action plan from Humber Peer review	• Timely access to services • People supported in a way that best meets their needs and supports independence
Mental Health	1. Increasing dementia diagnosis rate	• Increase in number of people with dementia who have a diagnosis • Integrated pathway for diagnosis and post diagnostic support
Urgent and Emergency Care	1. NL Urgent care review	• Pathways structured to best meet patient clinical needs • Improved patient experience through reduced waits and patient being seen by most appropriate person
Acute Sector	1. Community Multi Disciplinary Team (MDT) model 2. Clinical Pathway Redesign: Cardiology (links to Community MDT model) 3. Clinical Pathway Redesign: Gastroenterology 4. Clinical Pathway Redesign; Respiratory (links to Community MDT model)	• Better integration of care for patients • Shared responsibility of care between patient, specialist and GP • Streamlined pathways of care • Increased access to community based care, whilst retaining specialist input for those patients requiring it