NORTH LINCOLNSHIRE COUNCIL
HEALTH AND WELLBEING BOARD

2pm on Monday 19 June 2023

Conference Room f01e, Church Square House,
30-40 High Street, Scunthorpe

1. Welcome and Introductions

2. Substitutions

3. Declarations of Disclosable Pecuniary Interests and Personal or Personal and Prejudicial interests

4. To approve as a correct record the minutes of the meeting of the Health and Wellbeing Board held on 6 March 2023 (Pages 1 - 8)

5. Forward Plan and Actions from previous meetings

6. Questions from members of the public

PLEASE NOTE, ALL PAPERS WILL BE TAKEN 'AS READ' TO ENCOURAGE DISCUSSION

Integrated Working - Adults

7. Better Care Fund - End of Year Report 2022-23 - Joint report by the Director: Adults and Health, and the North Lincolnshire ICB Place Director. (Pages 9 - 12)

8. Better Care Fund (BCF) 2023-35 Plan Submission - Report by the ICB Place Director and the Director: Adults & Health (Pages 13 - 54)

9. Humber and North Yorkshire Integrated Care System Joint Forward Plan - Report by the North Lincolnshire NHS Place Director (Pages 55 - 130)

10. Approval Of Community First Strategy - Report by the North Lincolnshire NHS Place Director and the Director: Adults and Health (Pages 131 - 146)

11. Making it Real - Health and Social Care Integration Event Update - Report by the Director: Adults & Health and the North Lincolnshire NHS Place Director (Pages 147 - 150)

Integrated Working - Children.

12. Children's Commissioning Strategy - Integrated Working Update - Report by the Director: Children & Families (Pages 151 - 156)

13. Date and time of next meeting - 11 September 2023, 2pm

14. Any other items which the Chairman decides are urgent by reason of special circumstances which must be specified.

NORTH LINCOLNSHIRE COUNCIL

6 March 2023

- Present -

Cllr R Hannigan, J Allen, P Cowling, H Davis, H Dent, C Harrison, W Holmes, V Lawrence, A Matson, A Seale, P Thorpe, and D Ward

The Council met at Conference Room, Church Square House, 30-40 High Street, Scunthorpe.

502 **WELCOME AND INTRODUCTIONS**

Cllr Hannigan assumed the Chair, and welcomed everyone to the meeting, inviting them to introduce themselves.

503 **SUBSTITUTIONS**

Victoria Lawrence substituted for Karen Pavey

504 **DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS AND PERSONAL OR PERSONAL AND PREJUDICIAL INTERESTS**

There were no declarations of disclosable pecuniary interests and personal or personal and prejudicial interests.

505 **TO APPROVE AS A CORRECT RECORD THE MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 30 JANUARY 2023 AND TO AUTHORISE THE CHAIRMAN TO SIGN.**

Resolved - That the minutes of the meeting of the Health and Wellbeing Board, held on 30 January 2023, be approved as a correct record.

506 **FORWARD PLAN AND ACTIONS FROM PREVIOUS MEETINGS**

The Director: Governance and Communities confirmed that the Forward Plan was up to date, and that all forthcoming actions were timetabled. Board members were asked to feed through any additional business for inclusion on the Forward Plan.

507 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

There were no questions from members of the public.

508 **ADULT SOCIAL CARE DISCHARGE FUND 2023/24 - REPORT BY THE DIRECTOR: ADULTS AND HEALTH AND THE NHS PLACE DIRECTOR.**

The NHS Director of Place: North Lincolnshire and the Director: Adults and Health submitted a joint report requesting that the Health and Wellbeing Board formally agree and sign off the North Lincolnshire Adult Social Care Discharge Fund Plan 2023/24prior to formal submission to the National Better Care Team.

The Directors informed the Board that, in September 2022, the government announced its Plan for Patients. This plan committed £500 million for the remainder of 2022/23 with further funding in 2023/24 to support timely and safe discharge from hospital into the community by reducing the number of people delayed in hospital awaiting social care.

The focus for the additional funding was a 'home first' approach and discharge to assess (D2A). The addendum to the 2022 to 2023 Better Care Fund (BCF) policy framework and planning requirements set out further detail for how this fund would be distributed, as well as conditions governing its use. The aim of this funding was to prioritise those approaches that are most effective in freeing up the maximum number of hospital beds, and reducing the bed days lost within the funding available, to the most appropriate setting from hospital, including from mental health inpatient settings. Further details on the Discharge Fund were contained within the report.

The Chairman led a discussion of the Plan, highlighting that the details contained within the report were a reflection of a "moment in time", and that there was a wider discussion underway about what the local system should look like, and how to reach that point. It was highlighted that there was a need for funding issues to be resolved, and that there needed to be a shift from intensive support and treatment towards a preventative model.

Resolved – That that the Health and Wellbeing Board formally agree and sign off the Adult Social Care Discharge Fund Plan 2023/24 prior to formal submission to the National Better Care Team.

509 **NORTH LINCOLNSHIRE INTEGRATED CHILDREN'S TRUST AND CHILDREN'S COMMISSIONING STRATEGY 2022 REFRESH - REPORT BY THE DIRECTOR: CHILDREN AND FAMILIES.**

The Director: Children & Families submitted a report to update the Health and Wellbeing Board in relation to the Integrated Children's Trust and progress relating to the delivery of the Children's Commissioning Strategy 2022 Refresh.

The Director set out how the North Lincolnshire Health and Care Integration Plan set the strategic vision and principles for integrated working within North Lincolnshire.

Following the publication of the inaugural Children's Commissioning Strategy 2020/24 in September 2020, a 2022 refresh had been endorsed through appropriate partnership and democratic governance arrangements, including the Health and Wellbeing Board. The 2022 refresh aligned with the refreshed Place Partnership strategic intent and the new iteration of the Health and Care Integration Plan.

The 2022 refresh rearticulated the One Family Approach and the local ambition for children to be in their families, in their schools and in their communities; and it reset our integration priorities and commissioning intent across education, health and care for our children and families. The 2022 refresh also refines the 'shine a light' areas of focus, which were now focussed around:

- Emotional wellbeing and mental health
- Best start in life
- Adolescents and youth offer
- Outcomes for children and young people with vulnerabilities

The Board discussed the report, highlighting the need to reflect on differences between traditional health and social care provision, and local efforts to support families, often including a wider range of partners, providers and commissioners. It was agreed that this was also a discussion that should be had at the Integrated Care Board. The NHS Place Director confirmed that relevant discussions were underway at the Place Partnership to maintain a 'line of sight.'

Resolved – That the Health and Wellbeing Board note the update in relation to the Integrated Children's Trust and the Children's Commissioning Strategy Refresh 2022.

510 **STABLE HOMES, BUILT ON LOVE - IMPLEMENTATION AND CONSULTATION STRATEGY. REPORT BY THE DIRECTOR: CHILDREN AND FAMILIES.**

The Director: Children & Families submitted a report updating the Health and Wellbeing Board on the publication of the Stable Homes, Built on Love Implementation Strategy and Consultation; and to consider the implications and the local response.

The Director stated that the Stable Homes, Built on Love Implementation Strategy and Consultation was published on 13 February 2022 and was the Government's response and detailed plan to address the recommendations to reform Children's Social Care, as set out in the independent review of children's social care: Final report; Child Protection in England; and the Children's Social Care market study.

The Government's response was a once in a generation opportunity to reset

children's social care system to transform the lives of children and families. It set the tone and purpose of children's social care and was built around six key pillars, as follows:

1. Family Help provides the right support at the right time so that children can thrive with their families
2. A decisive multi agency child protection system
3. Unlocking the potential of family networks
4. Putting love, relationships and a stable home at the heart of being a child in care
5. A valued, supported and highly skilled social worker for every child who needs one
6. A system that continuously learns and improves, and makes better use of evidence and data

A summary of the key strands associated with each of the six key pillars was outlined in appendix 1 to the report.

The Director explained that Stable Homes, Built on Love identified 19 consultation questions and build in additional consultation(s) in relation to Children's Social Care National Framework and the Child and Family Social Worker Workforce. The deadline for all consultation responses was May 2023.

The Board discussed the report, querying funding issues and whether North Lincolnshire would be likely to be asked to participate as a pilot, given recent successes. It was confirmed that budgets were in place.

Resolved – (a) That the Health and Wellbeing Board note the publication of the Stable Homes, Built on Love Implementation Strategy and Consultation; support the ongoing local response to the consultations; and contribute to further discussion regarding local implications and implementation; and (b) that the Health and Wellbeing Board support North Lincolnshire acting as a national pilot area, if requested by government, in order to share local best practice with others.

511 **NEURODIVERSITY UPDATE ON PATHWAY - REPORT BY THE NHS PLACE DIRECTOR AND THE CHILDREN CARE GROUP DIRECTOR, RDASH**

The Chairman welcomed Helena Dent, Senior Commissioning Officer - North Lincolnshire Health and Care Partnership, Christina Harrison, Children Care Group Director – RDaSH, and Wendy Holmes, Head of Virtual School and Inclusion, to the meeting.

A report was submitted, which provided an update to the Health and Wellbeing Board on progress and developments relating to children's neurodiversity in North Lincolnshire. The paper explained current diagnostic demands and described the actions being taken to address this, whilst

highlighting how the increase in children being diagnosed as neurodiverse required a whole-system response, to ensure children and families needs are met.

Helena and Christina explained that neurodiversity was a priority issue for the Integrated Children's Trust and the Special Education Needs Disability (SEND) Standards Board due to the increased number of requests to assess North Lincolnshire children, over recent years. Children who were neurodiverse receive support from a wide range of education, social, health and voluntary services, to meet their identified needs.

The models for children under 5 years of age, and children and young people aged over 5, were described and discussed, along with details of waiting times, assessments, and support given whilst waiting.

The Board discussed the issues in some depth, asking questions about waiting times, increases in demands, transition from children's services to adult's support, work with schools and colleges and primary care, and potential solutions to minimise inequalities. It was confirmed that the model was based on ensuring that necessary support was in place, rather than receiving a formal diagnosis.

Resolved – That the Health and Wellbeing Board note and accept the report.

512 **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2022- THE DIVERSE COMMUNITIES OF GREATER LINCOLNSHIRE. REPORT BY THE DIRECTOR OF PUBLIC HEALTH**

The Director of Public Health presented a copy of their independent report on the state of people's health in Greater Lincolnshire, with a particular focus on the communities of North Lincolnshire.

It was explained that Directors of Public Health in England have a statutory duty to produce an independent annual report on the state of health of the people they serve. Local authorities have a statutory duty to publish the report and the report should be as accessible as possible to the wider public.

As part of an innovative public health pilot, the DPH report covers three local authority areas being: Lincolnshire County Council (LCC), North Lincolnshire Council (NLC) and North East Lincolnshire Council (NELC) – collectively referred to as Greater Lincolnshire. To reflect this inter-authority partnership, a single DPH report was written which encompassed the diverse communities of all three local authorities.

The Director stated their intention that the report would provide a strong evidence base for identifying opportunities for health and wellbeing improvement, providing a focus to engage agencies and communities about identifying collaborative solutions.

The Board welcomed the report and discussed opportunities to improve the

health and wellbeing of local people.

Resolved – (a) That the Health and Wellbeing Board welcome the report, and (b) that the Director note the feedback on its content.

513 **POPULATION HEALTH MANAGEMENT APPROACHES - REPORT BY THE DIRECTOR OF PUBLIC HEALTH**

The Director of Public Health submitted a short briefing report to provide insight into some of the core principles and objectives of population health management, as it features in the strategic integration intentions of the NHS and local partnerships. The report described the priorities for population health management development in North Lincolnshire and outlines progress to date.

The Director confirmed that developing approaches to population health management was a key responsibility of Integrated Care Systems (ICSs) and there was a great deal of work underway to define and operationalise it. There was therefore some leeway for the local ICS and its places to design and develop approaches which support local aspiration, within some clear parameters.

The Director stated that Population Health Management was an approach to using data insights to improve health and wellbeing now and in the future, and not a structure. It was highlighted that the local intention was to move to models of neighbourhood working for primary and community services. A step towards this would be the organising of communities into 'neighbourhoods', providing the defined populations required for this approach. The report contained further detail.

The Board discussed the report, highlighting the need to go beyond the partners represented at the meeting in order to implement the approach effectively.

Resolved – (a) That the Health and Wellbeing Board note the briefing and the initial steps being taken in local strategic frameworks and partnerships to create the ambition and conditions for Public Health Management to be successful in improving health in North Lincolnshire; (b) that the Board endorse the recommendation to develop PHM capability in North Lincolnshire using the approach described at Option Three in the report; and (c) that a further update be provided to the Board in autumn 2023.

514 **DATE AND TIME OF NEXT MEETING.**

The Director: Governance and Communities confirmed that the date and times of future Board meetings would be circulated in due course.

515 **ANY OTHER ITEMS WHICH THE CHAIRMAN DECIDES ARE URGENT BY REASON OF SPECIAL CIRCUMSTANCES WHICH MUST BE SPECIFIED.**

There was no urgent or additional business.

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Report of the Director Adults and Health & ICB Place Director

Agenda Item Meeting

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

BETTER CARE FUND (BCF) – END OF YEAR REPORT 2022-23

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1. To provide a summary of performance and progress against the Better Care Fund plan for 2022-23.

2. BACKGROUND INFORMATION

2.1 The Better Care Fund (BCF) is a national programme which covers both the NHS and Local Government and encourages integrated, joined up working between health and social care to improve the health and wellbeing of residents. ICB's and Local Authorities must enter a pooled budget arrangement and agree an integrated spending plan for the Better Care Fund.

2.2 Better Care Fund Plans must meet four national conditions, which are:

- Plans to be jointly agreed
- Enabling people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time
- Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

2.3 The North Lincolnshire Better Care Fund Plan 2022-23 was formally agreed by the Health and Wellbeing Board and submitted to the national BCF team in September 2022.

2.4 The BCF planning guidance for 2022-23 included national performance metrics devised to focus on the following improvement areas:

- Supporting people to stay in their own home during periods of acute ill health, avoiding admissions to hospital where possible
- Support people to return to their usual place of residence on discharge from hospital
- Reduce the numbers of people admitted to residential and nursing care homes
- Increase the effectiveness of reablement support to enable people to remain in their own homes for longer

2.5 Throughout 2022-23, North Lincolnshire has continued to meet the national conditions and all BCF schemes have been implemented. BCF funding has continued to have a positive impact on the integration of health and social care in North Lincolnshire and to support closer working across health, social care and the Voluntary and Community Sector. Partners have worked together in a joined-up way to improve the urgent community response and hospital discharge processes with a Home First ethos to support people to remain in their own homes for longer.

2.6 There have been a range of schemes aimed at reducing the number of avoidable admissions into hospital. However, we did not achieve our target in 22/23 and North Lincolnshire has continued to see an increase in non-elective hospital admissions with higher levels of acuity than expected. Our proactive frailty assessment service has been redesigned to target those people with highest frailty scores, aiming to proactively manage frailty at home and reduce the need for admission to hospital. Our virtual ward was mobilised in 2022 and has to date taken people as step-down from hospital. Plans for 23/24 include direct access to the virtual ward to support people to remain in their own home and prevent the need for a hospital admission where possible.

2.7 91% of people were discharged to their usual place of residence against a target of 92%. North Lincolnshire home care provider market has remained significantly challenged over the last year, despite recruitment and retention schemes. These schemes have supported an additional 475 hours per week for home care, however the demand significantly exceeds this. Current work focuses on use of alternative support for low-level non-statutory needs and transformation and recommissioning to further increase capacity across the home care sector to meet the demand.

2.8 The number of people entering long-term residential care has seen a significant increase this year with 273 people being admitted to residential care (706.8 per 100,000 population of over 65's against a target of 570 per 100,000 population). The capacity within the home care sector has impacted as above with several recruitment and retention initiatives continuing in the BCF Plan for 23/24 with further expansion of our Home First services also planned.

2.9 Improving reablement outcomes has continued to be a priority. There has been increasing volumes of people using our services with longer lengths of stay due to the complexity of people's needs. The target of 91.9% (proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services) was not met. The actual outturn for 2022-23 is 90.4% which while slightly below target is an improvement from 2021-21.

2.10 The BCF planning guidance for 2023-2025 has been published and the North Lincolnshire Health & Care system partners have jointly agreed a plan that focuses on improving discharge from hospital, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations, to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person.

3. OPTIONS FOR CONSIDERATION

3.1 To note the performance and progress of the North Lincolnshire Better Care Fund Plan 2022-23

4. ANALYSIS OF OPTIONS

4.1 Not applicable

5. FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)

5.1 The ICB met the requirements in relation to the minimum NHS minimum contribution.

5.2 The BCF fund includes the Disabled Facilities Grant (DFG), the iBCF monies and the CCG minimum allocation as follows:

DFG	£2,587,067
iBCF	£7,237,736
NHS minimum	£14,028,496
Total	£23,853,299

6. OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.)

6.1 There are no implications associated with this report, however the BCF 2022-23 plan was a key enabler for the delivery of the Health and Integration 2021-24 plan.

7. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

7.1 Not applicable.

8. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

8.1 Consultation on the development and delivery of the plan involved local NHS trusts, social care providers, voluntary and community sector partners.

8.2 There are no perceived conflicts of interest associated with this report.

9. RECOMMENDATIONS

9.1 It is requested that the Health and Wellbeing Board formally note the progress off the 2022-23 Better Care Fund Plan.

Director of Adults and Health &
ICB Place Director

Church Square House
SCUNTHORPE
North Lincolnshire
DN15 6NL
Author:
Date:

Background Papers used in the preparation of this report:

Report of the Director Adults & Health and ICB Director of Place | Agenda Item
Meeting

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

BETTER CARE FUND (BCF) 2023-25 PLAN SUBMISSION

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 To request that the Health and Wellbeing Board formally agree and sign off the North Lincolnshire Better Care Fund Plan 2023-25.

2. BACKGROUND INFORMATION

2.1 The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge from hospital, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations.

2.2 The vision for the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person.

2.3 ICB(s) and Local Authorities must enter into a pooled budget arrangement and agree an integrated spending plan for the Better Care Fund.

2.4 Better Care Fund Plans must meet four national conditions, which are:

- Plans to be jointly agreed
- Enabling people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time
- Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

2.5 The Better Care Fund must also include plans for how the Improved Better Care Fund (iBCF) grant will be utilised. The iBCF is paid directly to the council and the conditions remain the same as in 2022-23. These are:

- Meeting adult social care needs

- Reducing pressures on the NHS, including seasonal winter pressures
- Supporting more people to be discharged from hospital when they are ready
- Ensuring that the social care provider market is supported.

2.6 The Disabled Facilities Grant (DFG) is also pooled into the BCF to promote joined-up approaches to meeting people's needs to support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing.

2.7 The additional discharge funding is included within the plan for 23/25 and was approved separately by the HWBB in March 2023.

2.8 The BCF planning guidance for 2023-25 includes national performance metrics which are

- Avoidable admissions to hospital
- Emergency admissions to hospital following a fall
- People discharged from hospital to their usual place of residence
- People admitted to residential and nursing care homes
- Effectiveness of reablement

2.9 The 2023-25 Better Care Fund Plan is included as appendix 1. It has been developed around the Health and Care Plans to Integrate and seeks to continue to deliver existing schemes.

2.10 The North Lincolnshire 2023-25 BCF plan is required to be submitted on 28th June 2023.

3. OPTIONS FOR CONSIDERATION

3.1 Option 1 – To formally agree and sign off the Better Care Fund Plan 2023-25

3.2 Option 2 – To not agree to sign off the Better Care Fund Plan 2023-25

4. ANALYSIS OF OPTIONS

4.1 Formally agreeing and signing off the Better Care Fund Plan 2023-25 means that delivery of the plan can continue in line with national requirements.

4.2 Not agreeing and signing off the Better Care Fund Plan 2023-25 will affect both delivery and assurance of the plan and could result in funds be reclaimed.

5. FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)

5.1 The BCF fund includes the Disabled Facilities Grant (DFG), the iBCF, additional discharge monies and the ICB minimum allocation as follows:

DFG	£2,587,067
LA Discharge Fund	£1,014,719
ICB Discharge Fund	£1,051,000
iBCF	£7,237,736
NHS minimum	£14,822,509
Total	£26,713,031

6. OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.)

6.1 There are no implications associated with this report, however the BCF 2023-25 plan is a key enabler for the delivery of the Health and Care Plan to Integrate.

7. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

7.1 Not applicable at this stage. Integrated Impact Assessments are undertaken as appropriate in line with commissioning intentions.

8. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

8.1 Consultation on the development and delivery of the plan has involved local NHS trusts, social care providers, voluntary and community sector partners.

8.2 There are no perceived conflicts of interest associated with this report.

9. RECOMMENDATIONS

9.1 It is requested that the Health and Wellbeing Board formally agree and sign off the 2023-25 Better Care Fund Plan

DIRECTOR OFADULTS & HEALTH and ICB DIRECTOR OF PLACE

Church Square House
SCUNTHORPE
North Lincolnshire
Post Code
Author: Jane Ellerton Head of Integration of Services, Wendy Lawtey Assistant Director Integrated Care
Date: 9.6.23

Background Papers used in the preparation of this report Please see attached report

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North Lincolnshire BCF Narrative Plan 2023-25

Contents:

1. Introduction

This narrative plan supports the agreed spending plan and ambitions for BCF national metrics as set out in our supporting excel BCF planning template.

The approach described within this plan is based upon the principles and actions agreed within the North Lincolnshire Place Partnership Plan to Integrate 2023-26 which was approved by the North Lincolnshire Health and Wellbeing Board in January ‘23.

The 23/34 – 24/25 BCF plan has been formally approved by the North Lincolnshire Health and Wellbeing Board on 19th June ‘23.

Implementation of the plan is monitored via the Integrated Adult Partnership.

2. Partnerships & stakeholder engagement

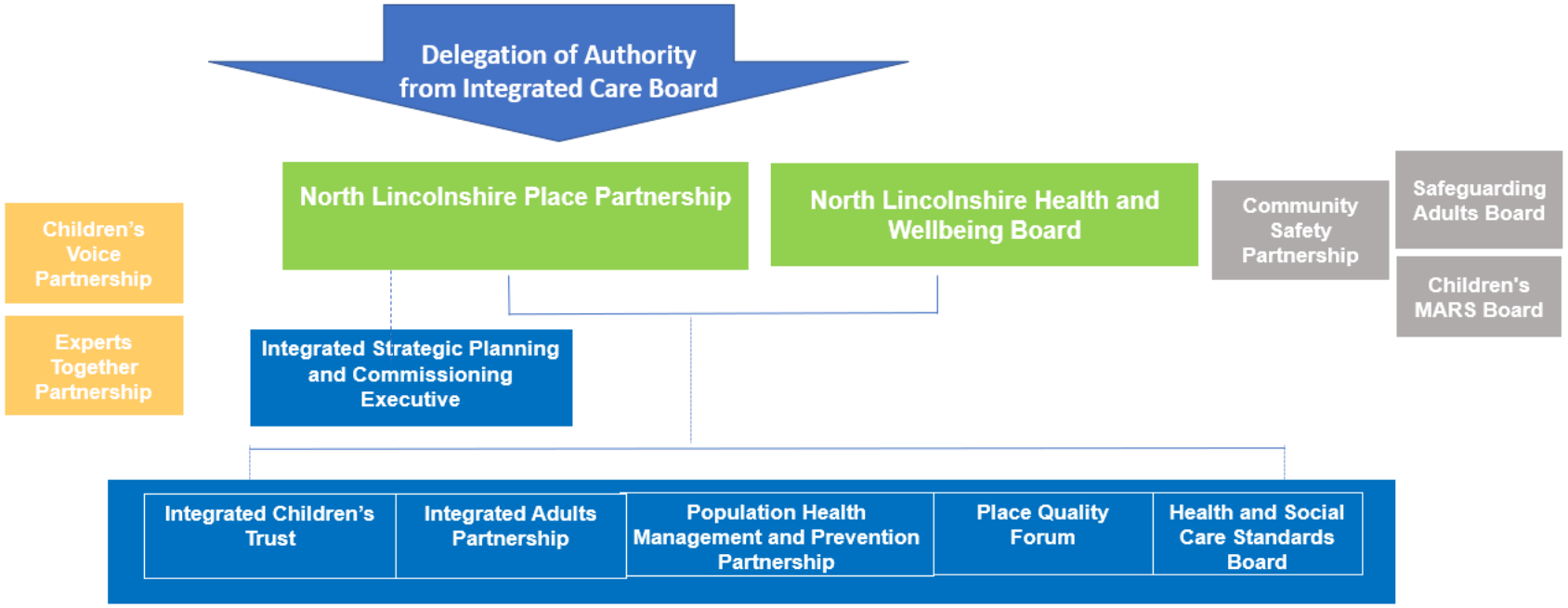
Partners and wider stakeholders involved in preparing the plan are:

- Northern Lincolnshire and Goole NHS Foundation Trust; Acute and Community services provider
- North Lincolnshire Council; Adult Social Care, Housing (including DFG), Communities
- Rotherham, Doncaster and South Humber NHS Foundation Trust; Mental Health Provider
- Lindsey Lodge Hospice and Healthcare
- North Lincolnshire Voluntary and Community Sector Alliance
- North Lincolnshire Health and Care Partnership, HNY ICB
- Clinical Leads Primary Care Networks
- Public engagement with Home Assistance Policy

3. Governance

The governance structure is well embedded within North Lincolnshire and is described below. This demonstrates how the Integrated Adults Partnership relates to the Health and Wellbeing Board and North Lincolnshire Place Partnership. The Integrated Adults Partnership has a responsibility for the oversight of the delivery of the Better Care Fund.

Integrated Care System/Place Governance Arrangements



4. Executive Summary

The North Lincolnshire Place Partnership was formed in January ‘22 with representation from local authority, Integrated Care Board and provider organisations including the voluntary sector.
The strategic intent for the Place partnership (slide 8) sets out our ambitions and priorities. Subsequent to this, we have developed a North Lincolnshire Community First Strategy which describes our plans for integration which sets out 3 key priorities;

1. Integrated Neighbourhood Teams
2. Integrated Urgent care
3. Integrated Strategic Commissioning and Safeguarding

There are a number of cross cutting enablers for success

- Single workforce strategy
- Digital enablement and innovation
- Collective use of resources
- Strong organisational change and transformational change management approaches

5. Key changes to previous plan

There are minor changes to our commissioned schemes from 2022-23, with Stroke and Dementia support moving to core funding and increased Home First capacity added. However, our integration plan provides the opportunity for these different elements to become integrated, providing coordinated person-centred care and support.

The BCF plan covers the following summarised schemes. The detail of these schemes are set out in the planning template;

- Home First capacity (community and residential)
- Frailty Assessment services; proactive and urgent response
- Community Urgent Response Team
- Hospital Social worker capacity
- Older peoples mental health ’
- Carer support service
- Community therapy and equipment services 7 day working
- Short-stay residential care/Reablement extra care flat
- Disabled Facilities Grants
- Social prescribing capacity builder

The iBCF will support the development of recovery and reablement support to younger adults with mental ill health and autism as well as supporting the wider care sector and Care Act duties.

6. North Lincolnshire Strategic Intent

Our Ambition

Our ambition is for North Lincolnshire to be the best place for all our residents to be safe, well, prosperous and connected; experiencing better health and wellbeing

People will;

- enjoy good health and wellbeing at any age and for their lifetime.
- live fulfilled lives in a secure place they can call home.
- have equality of opportunity to improve their health and play an active part in their community and enjoy purpose within their lives.

Our community first approach

Our transformation approach empowers and facilitates individuals of all ages including children and young people to participate in their own communities, putting people and communities at the heart of health and care. People will have personalised care, be enabled to self care and have control over their lives. People will get the best care closest to home. We will use our collective resources to improve outcomes for people and be informed by the voices of our diverse communities. We will use our Place assets and resources to strengthen prevention and community support, reducing the need for higher levels of care which is safe, effective and high quality in the right place at the right time. We will use the North Lincs £1 wisely and with integrity. We will ensure participation and prevention threads through all that we do. We will foster a culture of one team, enabling our workforce to achieve great outcomes for people and support the workforce to be well. We will ensure we have the most effective systems and enablers of change.

The ICS and Place Partnership will invest locally to deliver this strategic intent ensuring the community health and care system is the right size for the population, is organised to meet levels of need and inequalities; focuses on prevention at every level and opportunity; and is high quality. The Partnership will utilise digitally enabled care to support the individual and integration of the workforce. We will prioritise those most in need. We will enable partners to manage risk effectively, to work together to promote positive risk taking to improve the outcomes we aspire to.

Priorities for Collective Investment

- Mental health and wellbeing will thread through all that we do across all age
- Asset based community development will identify and work with the strengths of communities to level up North Lincolnshire
- Innovation will be supported including digital tools that enable individuals to maximise their health and wellbeing
- The health inequalities gap will reduce across our wards
- Access to health and care will take account of rural challenges
- Healthy life expectancy will improve for our population
- People with long term conditions such as lung and heart disease, will improve experience proportionately good health
- There will be a single workforce strategy covering; leadership and management, recruitment and retention, reward and recognition, career pathways, and talent development
- The integrated practise model will be person centred

7. National Condition One - Overall BCF Plan and approach to integration

Our approach to integration is set out within our Community First Strategy:

Integrated Neighbourhood Teams.

We have committed to prioritise prevention and early help and to do this we will develop Integrated Neighbourhood Teams which will ensure a fully integrated response across health, social care, housing, employment and voluntary sectors. Integrated Neighbourhood Teams will be proactive in identifying people with, or at risk of developing, long term conditions and or disabilities, and for those who have existing conditions, will provide them and their carers with high-quality, person-centred care. This will include assessment of need, good care planning and coordination that enables self-care, better and faster access to local solutions and support reduction in the need for urgent care. This will support people to remain in their own homes, communities, families, schools and employment.

Urgent care

We understand that some people do get into crisis at times and what they need more than anything is a rapid response, but one that is aimed at **enabling** that person to remain in their current environment and retain their independence, choice and control over what happens, they are more likely to recover quickly and not 'decompensate' in hospitals or short-term care facilities. If a person has a need for urgent care, our workforce will work together so that the person gets the care they need through one single point of contact. Hospital and care home admissions will be minimised and if people are admitted to hospital or care homes, the time that people spend there will be minimised, with people returning to their homes supported with the right care. Our staff will work together enable people to live independently within families and communities.

8. National Condition One - Overall BCF Plan and approach to integration

Strategic Commissioning and Safeguarding.

We have agreed we will have a single Integrated Strategic Commissioning and Safeguarding approach that maximises Place resources to best effect to meet need and achieve the best quality of provision for residents and that focuses on those who are most vulnerable. We will make the best use of resources, doing it once doing it well in terms of strategic planning and managing the commissioned services transformation together as one team. We will work together to coproduce and commission appropriate arrangements for people with complex needs and to support the health and care sector to deliver their best in meeting those needs.

The schemes outlined within the BCF Plan will come together to ensure integrated commissioning, integrated neighbourhood teams and integrated urgent care.

Our Integrated Strategic commissioning plan 2020-24 is currently being refreshed with the following priorities:

- Reduction in out of area mental health and Learning disabilities placements
- Recommissioning of homecare provision
- Recommissioning of Carer Support services
- Recommissioning of Trauma services for Children and Young People

National Condition One - Overall BCF Plan and approach to integration

Strategic Commissioning and Safeguarding, continued

In addition, we have the following joint workstreams;

• Community Mental Health including housing and employment	• Mental Health Crisis
• Transforming Care Partnership for people with a learning disability	• Social Prescribing
• Integrated Children's Trust programme	• Community therapy
• Carer Strategy implementation	• Autism Strategy Implementation
• Dementia Strategy	• One Family approach
• Emotional Health and wellbeing – CYP	• SEND
• Early years	

Our governance arrangements set out in slide 5 show how our Integrated Strategic Planning and Commissioning Executive Group reports to the Health and Wellbeing Board and the Place Partnership. This senior Executive level group meets monthly to explore opportunities for integrated commissioning of services and to provide oversight of our jointly commissioned services.

9. National Condition Two - Enabling People to stay safe, well and independent at home for longer

North Lincolnshire Health and Care Partnership Community First Approach

North Lincolnshire Place Partners work collaboratively to utilise health and care data to develop detailed understanding of current and future needs at ward and PCN level. This approach is utilised in the JSNA which is a dynamic and flexible work programme to respond to local issues and changing needs.

Population health data is informing the development of integrated neighbourhood teams and proactive care in line with the Fuller Report published in May 2022.

Our range of Home First services, both residential rehab and home based reablement, provide the opportunity to maximise peoples independence, enabling people to remain in their own homes for longer. These services, alongside other BCF funded schemes such as therapy and community urgent response, will come together to provide the integrated urgent response to enable earlier discharge from hospital and avoid admission to hospital or residential care.

We have expanded our Home First capacity to reflect the increased demand for these services, and in the end to prevent delays to hospital discharge. We have used our acute hospital as the employer of additional capacity to address recruitment issues and are now working to integrate the teams to ensure best use of resources and equity of access. This approach also supports delivery of our virtual ward, for those who need support during their acute illness.

We have commissioned a Welcome Home service from the voluntary sector, however uptake of this has been lower than expected. We are therefore working closely with the service provider, and the hospital wards and discharge teams to increase awareness of the service, facilitate referrals to the service and reduce demand for Care at Home provision for short term support. Other schemes aimed at supporting people to stay well and independent for longer include: Intermediate care services, Frailty services (proactive and reactive), Community Response Team, community Locality teams, Older People's mental health service, Community therapy and equipment services, Aids and Adaptations and the Handyman services, support at home services, the Community Capacity Builder role linked to social prescribing, targeted assessments, social worker roles and assistive technology support.

The Disabled Facilities Grant (DFG) approach further integrates health and housing to develop person focused solutions to maximise and maintain independence. The Home Assistance Policy is currently being reviewed following a period of consultation and will provide a broader range of support, making use of the Regulatory Reform (Housing assistance) to use a portion of the DFG funding for discretionary services, for example hospital discharge assistance, rapid access to minor adaptations and handy person support to create micro environments. This policy will support people to remain in their own home for longer, with greater independence, reducing the need for long term residential care and reducing delayed hospital discharges.

10. National Condition Two – demand & capacity

Initial findings:
Urgent community care – demand is slightly lower than capacity, and this is demonstrated in performance metrics. There is a plan to increase capacity in Q3 to reflect the expected increase in demand from Q3 associated with the transformation via the Integrated Urgent care model

Referrals for Voluntary sector support via our Welcome Home service has been below plan, with significant underutilised capacity moving into 23/24, the focus is on ensuring the service is visible and responding to user feedback to increase utilisation.

Demand for short –term residential placements is high due to the limited capacity in Home care services, meaning people receive a higher level of care than needed. approximately 38% of those discharged on Pathway 2 could be managed on Pathway 1. In response to this, capacity in the Home First Team will be increased during Q2 and Q3 to meet the anticipated increase in demand (approx. +38%) for Reablement at Home services (P1) in 2023/24, which provides low-level intervention and support in the community.

North Lincolnshire Place has utilised the ASC discharge funding to place people in short stay care in order to maintain hospital flow. Whilst there has been investment in recruitment and retention initiatives through the ASC discharge fund, the impact of this has been limited- there has been increased recruitment, however some of this has been offset by leavers, with a net gain of 475 hrs/ week.

In taking forward the capacity and demand work, we will allocate dedicated resource to gain deeper understanding of the true service demand across all areas, including where demand to a service could be met by a universal service. This will support us remodel our capacity across services during 2023/24. Work has already commenced regarding matching capacity and demand at hospital discharge to reduce short term care home placements. The capacity and demand data will support our place based business case development for step down capacity.

11. National Condition Two - metrics

Our plans for integration support joint strategic commissioning arrangements, integrated neighbourhood teams and integrated urgent response. These plans will have a direct impact on the BCF metrics of unplanned admissions to hospital for chronic ambulatory conditions; emergency admissions following a fall; the number of people admitted to long term residential care and outcomes following rehabilitation and reablement.

Our target for reducing avoidable hospital admissions is based on local SUS data taking into account seasonality and impact of virtual ward & integrated urgent care. The plan takes into account the increase in admissions normally seen during Q4, which are most often respiratory related, and that the specific ACSC conditions does not include respiratory tract infection and pneumonia which are common conditions managed by our community urgent care services. We therefore expect the impact in terms of total admissions to be greater than that set out in the metric target.

The target for falls is based on local SUS data with ambition to get back to 2021-22 levels which is significantly less that our estimated year end position. During Q4, North Lincolnshire has rolled out the i-STUMBLE app and equipment to care homes and local Community nursing and therapy teams to support management of falls. 2023/24 will see a full year effect of this approach resulting is a reduction in ambulance calls and conveyance following falls.

National Condition Two - metrics cont'd

The target for discharge to usual residence is based on local SUS data with ambition to achieve annual aggregated position of 94.1% of people will be discharged to their usual place of residence in 2023/24. This target is set higher than the 22/23 target due to the increased capacity into the HomeFirst Service planned in 2023/24.

Homecare capacity remains an area of challenge, and whilst we have seen some increase in capacity over Q3/4 of 22/23 there is still a significant shortfall in capacity against demand of >150 clients per annum. Plans for 2023/24 include further development of the Care at Home market to increase capacity through recruitment and retention initiatives, single handed care and digital technology. In addition to this, local authority Home First capacity will be increased through role redesign and increased use of single-handed care. Both of these will support improvement in number of people discharged to usual place of residence.

The target for residential long-term admissions reflects our ambition to continue to receive care within the community and in their own homes. We are using the data from previous years admissions and knowledge of the wider social care picture to inform the setting of this target.

North Lincolnshire aims to make significant reductions in the number of people placed in residential care, we will continue to develop the BCF schemes that support delivery of this target including, pre-operative discharge planning to help people plan for their post operative care needs, rehabilitation and reablement in the community and in a short stay setting, MDT approach aligned to PCNs, front door and frailty pathways and support to providers to ensure sustainable home care services.

National Condition Two -metrics cont'd

The reablement target (number of people still at home 91 days) reflects the increased acuity and complexity of needs of people requiring rehabilitation and reablement. To support improvement in this metric we will undertake a system wide evaluation of the high demand from hospital discharges and the impact on effectiveness of reablement this may be having.

This year's BCF will support additional hours in the Community Home First service to enable more people to return straight home from hospital.

12. National Condition Three - Provide right care right place at the right time

Our residential short stay rehabilitation unit, Sir John Mason House, and our Community Home First model are key enablers for supporting people to live independently. This includes both discharge from hospital and step up from community to avoid hospital admissions.

Our integrated discharge hub teamwork in an integrated way to ensure as many people as possible receive the right care in the right place at the right time and, where they do receive a short-term placement, the team jointly manage the care of these people to discharge them home with the right support as soon as possible.

Capacity within home care provision has continued to be a challenge and we have utilised the Adult Social Care Discharge Grant to fund recruitment and retention initiatives to increase the workforce within the independent care sector.

This has seen some growth in home care capacity of 475hrs per week, however this is still lower than the level required to meet demand with approximately 1000 hrs additional capacity required. As a result, we know too many people are needing short stay residential placements. However, despite these challenges, North Lincolnshire performance on delayed discharges has improved, with a reduction from 653 delays during the period June- Oct 22 compared with 187 delays for the period Nov 22- Mar 23, despite an increase in overall hospital discharge numbers.

In addition, we have commenced a joint commissioning exercise in relation to care at home support that will be outcome focused and delivered at neighbourhood level. We are also investing in community capacity building to enable communities to connect and support residents without the need for statutory support.

13. National Condition Three - demand & capacity

Despite the capacity challenges within home care, the North Lincolnshire place partners have worked jointly to manage hospital flow and discharges to get the best outcomes for people within the resources available. Drawing on our strong working relationships, we have jointly developed plans to reduce the delays to hospital discharge. This has contributed to the NLAG % of patients discharged on the day from 35.8% in April 22 to 59.9% in April 23 and contributed to the NLAG wide NCTR position from 121 in April 22 to 61 in April 23 an improvement of 49.6%.

We aim to further build on this success by focusing on maximising the home care capacity through different ways of working, such as use of digital solutions, greater use of single-handed care and greater use of voluntary sector for low level support.

We will utilise the capacity and demand data to inform our transformation plans, exploring ways to maximise use of home based reablement to reduce demand for bedded intermediate care. However, should this still result in a shortfall, we will look at creative ways to commission this capacity whilst ensuring we achieve the right outcomes for people.

14. National Condition Three - metrics-discharge to normal place of residence

We know that some people discharged from hospital have received short stay residential placements due to capacity issues in our Home First Community service. This year BCF funding will be utilised to increase the capacity available, supporting more people to leave hospital and return to their own homes. These schemes will be continuation of schemes implemented using the 2022/23 discharge funding, in line with the grant requirements.

We will further develop recovery and reablement support for people leaving acute mental health hospitals and have established a Housing and Homeless Reduction Partnership. The partnership will focus on rehabilitative and recovery approaches which focus on the overall well-being of the person, including their physical and mental health and wellbeing, their level of social support (from a partner, family, or friends) and their level of community integration. We are currently piloting a discharge pathway to supported living and will evaluate this in Q1/2 to inform future planning.

Promoting recovery and rehabilitation includes enabling access to education, training, and employment alongside supporting people to find and participate in rewarding leisure and community activities. It is about enabling a person to build and live the life they choose, living in a place they call home, with friends and family that they care about and care about them, contributing socially and economically to their local community.

15. National condition Three – High Impact change mode

The North Lincolnshire Community First Strategy supports achieving the High Impact Change Model goals;

- Reducing Preventable Admissions to Hospital and Long-term Care
- Managing Transfers of Care

Reducing Preventable Admissions to Hospital and Long-term Care

Goal 1: **Prevent crisis**: Actions to prevent crises developing or advancing into preventable admissions

Goal 2: **Stop crisis becoming an admission**: Actions to divert or prevent an attendance at A&E becoming an admittance to hospital or long-term bed-based care.

Each of the five high impact changes are aligned as follows:

Integrated Neighbourhood Teams.

Change 1: Population Health Management approach to identify those most at risk

Change 2: Target and tailor interventions and support for those most at risk

Change 3: Practise effective multi-disciplinary working

Change 4: Educate and empower individuals to manage their health & wellbeing

Urgent care

Change 3: Practise effective multi-disciplinary working

Change 4: Educate and empower individuals to manage their health & wellbeing

Change 5: Provide a coordinated and rapid response to crises in the community

National condition Three – High Impact change model, continued

North Lincolnshire Health and Care Partnership

Community First Approach

Managing Transfers of Care

Early discharge planning; we are further integrating the range of services and functions to deliver an integrated urgent response to prevent avoidable admissions. The Northern Lincolnshire system Improvement Group continues to work to estimated discharge date and improved discharge planning and some improved is evident

Monitoring and responding to changes in demand and capacity; North /Lincolnshire forms a part of the Optica frontrunner. Joint commissioning of Homecare and care home provision. Market position statement supports providers with live, interactive data

Multi-disciplinary working; Integrated Discharge team well established, and will be further developed during 23/24 into the Integrated Urgent Response. This includes voluntary sector as a key component of this

Home First Discharge to assess; Integrated Discharge Team (IDT) work on principle of Discharge to Assess, however capacity within Home Care means that too many people are having short stay residential care. This will be managed during 23/24 through increased capacity within the Community Home First team

Flexible working patterns; The IDT and Unscheduled care teams work across 7 days

Trusted assessments; Integrated Teams work on Trusted Assessment basis to reduce duplication and increase response times

National condition Three – High Impact change model, continued

North Lincolnshire Health and Care Partnership
Community First Approach

Managing Transfers of Care

Engagement and Choice; the HNY ICB is developing a choice policy which will be adopted by each acute Trust within the ICB. In the interim, clinical leads have choice conversations where appropriate

Improve discharge to care homes; The system has recently undertaken an engagement exercise with all care homes to understand their issues and concerns and is responding to these. North Lincolnshire has supported Care Homes through the roll-out of the i-stumble app and equipment to support those in care homes who experience a fall, to ensure staff are trained and supported to lift residents where it is save to do so

Housing and related services; Using Homeless Prevention Grant to fund a Housing Advice Worker within the Integrated Discharge Team to support timely discharge, this is in addition to the established post within Mental Health. The DFG services such as handyperson and rapid support with adaptations & equipment support discharge planning and timely discharge.

See Appendices for further detail on current NL position.

16. National Condition Three - Care Act duties

BCF, iBCF and the ASC discharge grant will support Care Act duties in the following ways:

- Support to carers; assessments and direct payments to ensure carers can take short breaks and manage their health and wellbeing
- Assessment and review activities across all client groups, ensuring people have choice and control over their daily lives
- Supporting the independent care sector to provide quality support, recruit and retain staff
- Provide targeted support for people suffering stroke and affected by dementia
- Reablement support to frail, elderly and working age adults experiencing mental ill health

Compliance of Adult Social Care Outcome Framework (ASCOF) measures provides oversight of delivery of Care Act duties. National performance monitoring places North Lincolnshire within the top 5 of local authorities for the number of outcomes reported as within the top quartile nationally

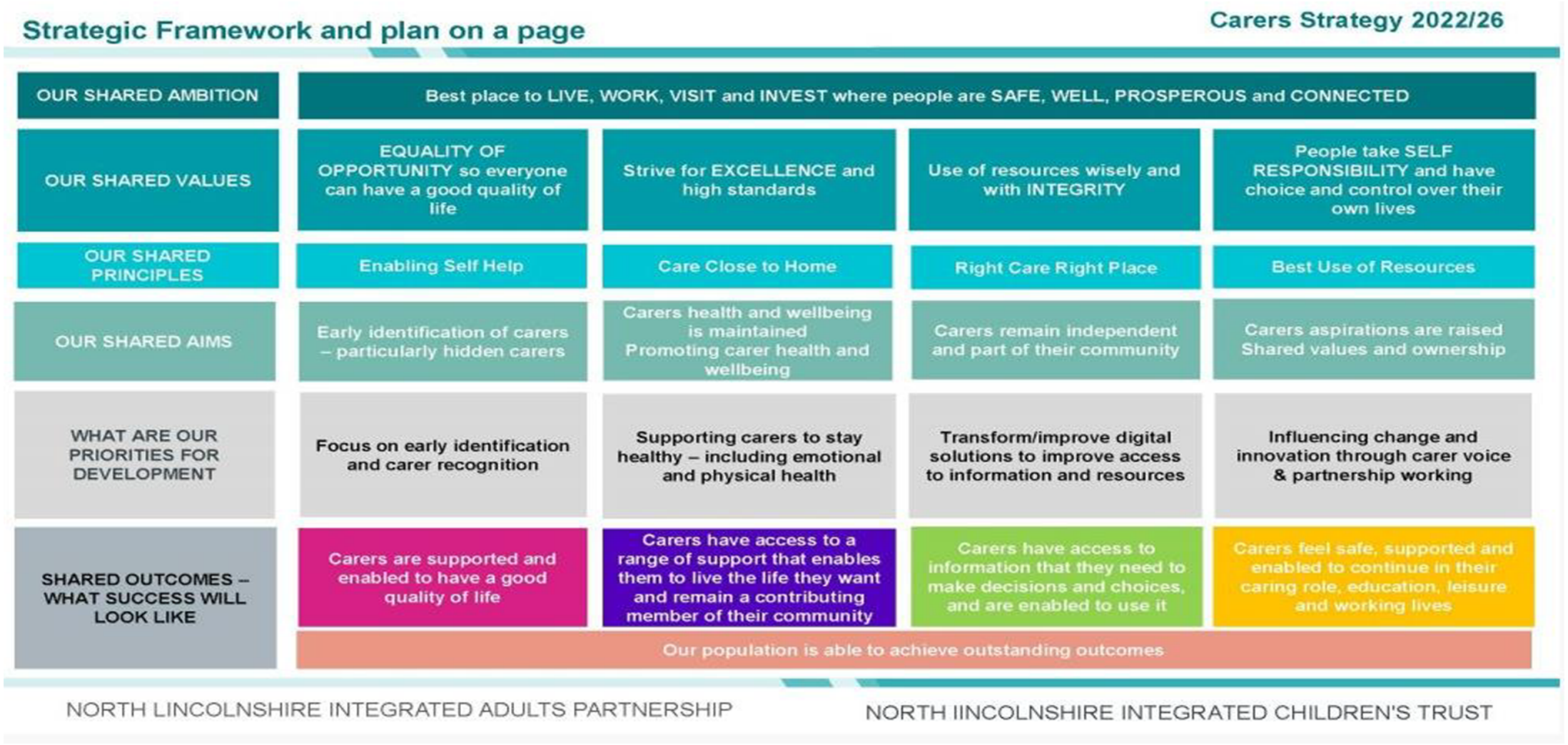
17. Supporting unpaid carers

The recommissioning of our Carer Support Services during 2023-2024 will engage with a range of carers and stakeholders and have a focus on the priorities identified through in the All-Age Carers Strategy 2022 –2026: identification of carers, supporting carers to stay healthy, improving access to information and resources, influencing change and innovation.

The Care Act 2014 recognises the equal importance of supporting carers and the people they care for and the targeted assessment and support function which sits in the council (the Family Carer Team), continues to work closely with health and other local partners to take a proactive approach into improving the experience, health, and wellbeing of carers, identifying opportunities for support for the carer including carers breaks.

The support function which sits within the council (Adults Support Team, supporting adults with complex needs) offers the opportunity for carers to receive some respite from their caring role whilst the person is supported in a safe and meaningful way.

Supporting unpaid carers, continued



18. Disabled Facilities Grant (DFG) and wider services

Our wider Housing Strategy includes priorities to improve health and wellbeing by ensuring safe and heathy homes and preventing crisis and enabling independence. Plans to deliver these priorities include review of existing supported housing for those with complex needs and development of a range of supported housing and 'move-on' accommodation. This will support those with a range of complex needs including mental health and learning disabilities, the homeless and our most frail population.

Our integrated commissioning plan includes the strategic approach to using housing support and DFG funding to support independence.

DFG funding is used holistically to support people to live independently in their own homes and includes the telecare service, minor adaptations through the handyperson service which support people being discharged from hospital, the community equipment store which provides equipment to help people to stay safe at home.

The Home Assistance Policy is currently being reviewed following a period of consultation across care and health partners including Integrated Strategic Planning and Commissioning Executive and will provide a broader range of support, making use of the Regulatory Reform (Housing assistance) to use a portion of the DFG funding for discretionary services, for example hospital discharge assistance, rapid access to minor adaptations and handy person support to create micro-environments. This will support people to remain in their own home for longer, with greater independence, reducing the need for long term residential care and reducing delayed hospital discharges.

We work at a system and place wide level to target people requiring urgent and complex special adaptations, reducing or delaying the number of people needing long term residential care through the adaptation of properties enabling people to continue to live at home. This brings together local authority, housing associations, social workers and therapists to create solutions for people to remain in their own homes.

Disabled Facilities Grant and wider services, continued

Our Home Assistance Policy aligns with the priorities of the BCF working in a flexible person-centred way to ensure we target our resources at those most vulnerable, to keep people safe and healthy at home and independent for as long as possible. Maximising the use of digital solutions/telecare to support people to maintain independence in their own home remains a priority. The ASC discharge fund has funded the procurement of a digital home care system, with 48 'robots' being set up, offering accessible, connected support to adults in their own homes.

During 2022-23 the policy was reviewed following consultation involving people with lived experience, local place partners and other key stakeholders. The revised policy incorporates feedback from the consultation and includes a revised range of schemes to help support people to remain independent, safe and healthy in their own homes. The policy is due to be approved in June 2023.

Disabled Facilities Grant and wider services, continued

We are currently undertaking a number of transformation improvement projects that are aimed at improving outcomes and activities that help people to remain independent and in their own homes. This includes:

- Safe and Sound (Home Security Measures) which aims to reduce the fear of crime and keep people safe in their own homes.
- Safe and Sound Sanctuary Scheme, making a property secure to support victims of domestic abuse by enhancing security measures.
- Crisis Repair Grant, enabling essential repairs that could be prejudicial to the health of vulnerable occupants.

Funding from DFG for these schemes is circa £500k

19. Disabled Facilities Grant and discretionary use

Our Independent Living Service provides free, impartial advice for people looking for assistance to stay living well at home for as long as possible. People receive advice, information and signposting, experience equipment, digital technologies and access a range of other services that promote independence and mobility at home and within the community.

The handyperson service provides assistance to enable people to return home from hospital by providing minor adaptations, additionally the service, in partnership with Occupational Therapy (OT) provides preventative adaptations that keep people safe in their own homes. This service has expanded, to providing a proactive assessment approach to identify hazards in the home and take appropriate remedial action in a timely manner.

20. Equality & Health Inequalities

The Joint Health and Wellbeing Strategy 2021-26 was approved by the Health and Wellbeing Board. In developing the strategy, learning from the Covid 19 pandemic was used to shape the direction of the strategy, recognizing the impact of health inequalities in outcomes experienced by our population, and how creating the right conditions can empower people to adopt positive health behaviours. The strategy also recognises the improvements achieved through the accelerated implementation of service and system change for the benefit of our population. It sets out six health and wellbeing themes to focus on over the next five years. These themes are:

- Keeping North Lincolnshire safe and well
- Babies and young people have the best start in life
- People enjoy healthy lives
- People experience equity of access to support their health and wellbeing
- Communities are enabled to be healthy and resilient
- To have the best systems and enablers to affect change

A Population Health Management and Prevention Partnership group has been established which reports to the Health and Wellbeing Board. This group will utilise Population Health Management principles and techniques to identify those populations most impacted by health inequalities and develop interventions to specifically address these inequalities.

Examples of workstreams which are focused on reducing health include:

- Reducing teenage pregnancy and improving resilience
- Supported self-management
- Housing and health
- Reducing number of pregnant women smoking at the time of delivery
- Improving outcomes for people affected by increased cost of living
- Support for large geographic community, identified as needing additional support to reduce health inequality gaps

Equality & Health Inequalities cont'd

Intelligence has identified specific populations within North Lincolnshire most impacted by the issues identified and plans are in development to target interventions. The workstreams on supported self-management and housing and health both support the BCF agenda, targeting interventions which will contribute to reducing hospital admission for those people who experience the greatest health inequalities. Our data shows that people experiencing the worst health outcomes are most likely to be resident in Lower Super Output Areas (LSOA) across North Lincolnshire.

The data is collectively helping to develop the appropriate and targeted interventions through our CORE20PLUS5 workstreams including targeted respiratory work to address those people at risk of admission, living in poor quality and cold homes. In addition, we have established a workstream which is looking at prevention and improvement of outcomes from those at risk of cardiovascular disease.

In identifying the pilot area for the Integrated Neighbourhood Teams, consideration was given to the areas with greatest health inequalities. Scunthorpe North is identified as the area with greatest health inequalities and has already commenced a pilot to tackle these. Particular health inequalities in Scunthorpe North include;

- Some of the most deprived areas within North Lincolnshire
- Higher proportion of low-income homes
- Highest proportion of private rental and houses of multiple occupancy
- Higher incidence of cold homes
- High proportion of ethnic diversity, particularly eastern European and Asian
- Life expectancy at birth within Scunthorpe North locality is significantly lower than North Lincolnshire as a whole. Around 3 years lower for males than the average for North Lincolnshire
- Higher levels of emergency admission for 18-64 yrs and over 65
- Higher mortality rate for preventable causes

Equality & Health Inequalities cont'd

Given the pilot already established in Scunthorpe North, Scunthorpe South, another area with significant inequalities was identified to pilot the integrated team approach. Learning from this will then be utilised in developing the roll-out across all five 'Neighbourhoods'.

Scunthorpe South experiences some similar health inequalities to Scunthorpe North in terms of;

- Adult life expectancy- slightly higher than Scunthorpe North but lower than other localities
- Second highest for hospital admissions for long term conditions
- Second highest for deaths under 75 yrs due to COPD
- Smoking in pregnancy rates are second worse in North Lincolnshire
- Under 5 yrs ED attendances is second worse (Scunthorpe North is worst)
- Highest level of free school meal eligibility
- Second highest proportion of under 5's living in the 30% most deprived (55.6% compared to lowest at 5.5%)

Current priorities in taking this work forward are agreeing the approach to identifying those with or at risk of developing long term conditions or disabilities and developing integrated, supporting care plans to maximise their health

Equality & Health Inequalities cont'd

A Population Health Management and Prevention Partnership group has been established which reports to the Health and Wellbeing Board. This group will utilise Population Health Management principles and techniques to identify those populations most impacted by health inequalities and develop interventions to specifically address these inequalities.

Examples of workstreams which are focused on reducing health include:

- Reducing teenage pregnancy and improving resilience
- Supported self-management
- Housing and health
- Reducing number of pregnant women smoking at the time of delivery
- Improving outcomes for people affected by increased cost of living
- Support for large geographic community, identified as needing additional support to reduce health inequality gaps

Equality & Health Inequalities cont'd

Intelligence has identified specific populations within North Lincolnshire most impacted by the issues identified and plans are in development to target interventions. The workstreams on supported self-management and housing and health both support the BCF agenda, targeting interventions which will contribute to reducing hospital admission for those people who experience the greatest health inequalities. Our data shows that people experiencing the worst health outcomes are most likely to be resident in Lower Super Output Areas (LSOA) across North Lincolnshire.

The data is collectively helping to develop the appropriate and targeted interventions through our CORE20PLUS5 workstreams including targeted respiratory work to address those people at risk of admission, living in poor quality and cold homes. In addition, we have established a workstream which is looking at prevention and improvement of outcomes from those at risk of cardiovascular disease.

In identifying the pilot area for the Integrated Neighbourhood Teams, consideration was given to the areas with greatest health inequalities. Scunthorpe North is identified as the area with greatest health inequalities and has already commenced a pilot to tackle these. Therefore Scunthorpe South, another area with significant inequalities was identified to pilot the integrated team approach. Learning from this will then be utilised in developing the roll-out across all five 'Neighbourhoods'.

Equality & Health Inequalities cont'd

North Lincolnshire Health and Care Partnership

Impact of BCF schemes on health inequalities

Many of the BCF schemes are designed to support a reduction in hospital admissions, improved hospital discharge, and increased access to rehabilitation and reablement.

We know that many of those people living with the greatest health inequalities have the greatest difficulty navigating health and care services, yet are often the most reliant on them. We know many of our BAME population are under-represented in some of our services such as Welcome Home, Carer Support and social prescribing. We are working with the providers of these services to understand how we can make these more accessible to these members of our community. This approach links with our plans for Integrated Neighbourhood teams, identifying those with the greatest need and supporting them to access community assets and to support self-management.

Other BCF funded schemes are directly supporting those with the greatest health inequalities through DFG and Home Assistance, frailty services, therapy and community equipment, rehabilitation and reablement provision, increased hospital social worker capacity and Care at Home capacity

Appendices

- Community First strategy

Adobe Acrobat Document

- Integrated Commissioning Strategy

Adobe Acrobat Document

- Home Assistance Policy

Adobe Acrobat Document

- High Impact Change Model – Current NL position

Microsoft PowerPoint Presentat

Amendments following draft submission

Section:	Slide No:	Amendment:
-	2	Added contents page
Section 1	3	Confirmation of HWBB approval
Sections 6, 7 & 8	8 - 11	Added detail on approach to integration via the Community First approach
Section 8	10 -11	Integrated commissioning arrangements
Section 9	12	Amendment to the Home First and DFG section
Section 10	13	Further description added re increased capacity in HomeFirst Team to support increased demand for Pathway 1, including brief overview of impact of increased HomeFirst capacity on hospital discharge
Sections 13 & 14	18 & 19	Amendments to include impact of discharge funding schemes and compliance with grant requirements
Section 15	20-22	High Impact Change model amended
Sections 16 & 19	26-29	Expansion to DFG section
Section 20	30-35	Expansion on health inequalities
-	36	Appendices added
-	37	Summary of changes from draft

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Report of the North Lincolnshire NHS Place Director Agenda Item
Meeting 19th June 2023

NORTH LINCOLNSHIRE COUNCIL

North Lincolnshire Health and Wellbeing Board

REPORT TITLE

Humber and North Yorkshire Integrated Care System Joint Forward Plan

1. OBJECTIVE AND KEY POINTS IN THIS REPORT

The enclosed paper is a final draft of the Humber and North Yorkshire Integrated Care System (ICS) Joint Forward Plan (JFP), which will be submitted to the HNY Integrated Care Board (ICB) on the 14th of June.

Formal approval and sign off by the JFP by Health and Wellbeing Boards is not required, but there is an expectation that there has engagement at Place in the development of the Plan.

The Place team have been actively involved in development of the Plan in particular the North Lincolnshire element and local Partners have been involved in the development of the HNY Integrated Health and Care Strategy which sets the strategic direction for the HNY ICS. This has also considered the alignment to our direction of travel and vision for the North Lincolnshire Place as set out in the Strategic Intent and Community First Strategy.

RECOMMENDATIONS:
Members are asked to:

Note the enclosed JFP which will be submitted by the Humber and North Yorkshire ICB to NHS England following approval at the June ICB

2. BACKGROUND INFORMATION

2.1 The Health and Care Act 2022 sets the strategy and plan framework for integrated care systems and identifies the requirements for the development of the strategy and plans on different parts of the Integrated Care System. These ‘sibling documents’ create a single Integrated Care System Strategy and Plan Framework.

The three parts of the framework are the:

• **Integrated Health and Care Strategy** led by the Integrated Care Partnership focussed on the health, care and wellbeing needs of the local population and how we strategically intend to meet them in an integrated approach. This must have particular link and interdependencies with Health and Wellbeing Strategies. The North Lincolnshire Health and Wellbeing Board has previously considered the Humber and North Yorkshire Integrated Health and Care Strategy.
• **Joint Forward Plan** is how the ICB, and its Provider Partners will contribute to and deliver the strategy and other local priorities over a five-year period
• **Operational plan** which is a more detailed plan for 2 years and should reflect the NHS Long Term Plan requirements and multi-year planning guidance.

The enclosed paper is a final draft of the Joint Forward Plan which will be submitted to the Integrated Care Board on the 14th of June. Formal approval and sign off by the JFP by Health and Wellbeing Boards is not required, but there is an expectation that there has been engagement at Place in the development of the Plan. The Place team have been actively involved in development of the North Lincolnshire element of the Plan and local Partners have been involved in the development of the HNY Integrated Health and Care Strategy which sets the strategic direction. This has also considered the alignment to our direction of travel and vision for the Place as set out in the Strategic Intent and Community First Strategy.

3. OPTIONS FOR CONSIDERATION

3.1 Note the enclosed JFP which will be submitted by the Humber and North Yorkshire ICB to NHS England following approval at the June ICB

4. ANALYSIS OF OPTIONS

4.1 Not applicable

5. FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)

5.1 Not applicable

6. OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.)

6.1 Not Applicable

7. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

7.1 Not Applicable

8. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

8.1 Not Applicable

9. RECOMMENDATIONS

9.1 The Health and Wellbeing Board are asked to note the Humber and North Yorkshire Joint Forward Plan and the engagement which has been undertaken locally in the development of the Plan.

Alex Seale – North Lincolnshire NHS Place Director

Civic Centre/
Church Square House
SCUNTHORPE
North Lincolnshire

Author: Penny Gray, Director of Commissioning Strategy HNY ICB
Date: 19th June 2023

Background Papers used in the preparation of this report – HNY Joint Forward Plan

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Appendix A: What will success look like

How we will know we've succeeded

Start Well

We want every child to have the best start in life and enable everyone to be safe, grow and learn.

- It is easy for me to get the support I need for my child.
- I am safe. My family has what they need to look after me.
- I love school and I am ready to learn.
- I can tell a grown-up if I am feeling sad or worried.

Live Well

We want to ensure the next generation are healthier than the last and have the opportunity to thrive.

- There are exciting career opportunities for me.
- My mental health matters and I can get help when I'm struggling.
- I know what I can do to stay healthy.

Age Well

We want to ensure people live healthy and independent lives as long as possible by understanding what matters most to them.

- I find ways to stay active and keep healthy that work for me.
- I have meaningful employment, despite the barriers I face.
- I am on top of my condition and I know what to do if I need help.
- I get the care I need and don't get passed back and forth or get forgotten on a waiting list.

Die Well

We want to create an environment in which people can have positive conversations about death and dying.

- When things start to go wrong with my body, I have the care I need to keep living a good life.
- I only go to hospital if it's absolutely necessary.
- I can get advice and support for my health at home or nearby.
- I am as active as I can be. I enjoy having fun with my friends.
- I quit smoking and I feel great.
- I feel included – I have a place to belong.
- I feel able to talk about what kind of death I would like before I get sick.
- We are able to talk confidently with patients about their end of life wishes.
- Me and my family can choose how best to say goodbye.
- My wishes are known and respected.

Start Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
I am safe. My family has what they need to look after me.	Complete a serious violence needs assessment and develop a partnership response strategy Respond to the findings of the national audit of domestic abuse support in healthcare settings Map models of intervention for domestic abuse and adopt and spread best practice develop pathways for non-fatal strangulation, honour and faith-based abuse FGM and forced marriage Respond to children who are experiencing low levels of domestic abuse Ensure meaningful data collection to contribute to developing a better system understanding of domestic abuse Develop an ICB wide learning culture and ensure safeguarding training is of a high quality	
I know what I can do to stay healthy	Pilot health weight, diet and exercise support before LMNS roll out Develop our programme for early support and intervention	
	Build on Trauma Informed Care Programme to provide early intervention and prevention to support vulnerable children and young people	Improve access to mental health support for CYP in line with the national ambition
	Support perinatal mental health enabling improved access and increased offer of psychological interventions	improve access to perinatal mental health services
	Improve access to mental health support for children and young people	
My Mental health matters and I can get help when I'm struggling	Support perinatal mental health enabling improved access and increased offer of psychological interventions	
	Reduce reliance on inpatient care so that by March 2024 no more than 12-15 under 18s with a learning disability and/or autism per million are cared for in an inpatient setting	
	Ensure that 75% of people aged over 14 on a GP learning disability register receive an annual health check and action plan	
There are exciting career opportunities for me	Introduce health inequalities opportunities for health and care staff in HNY	

Start Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
		make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	2nd round of Ockenden peer review visits - evidence of safe, high quality care	
	CNST adherence including working to achieve Saving Babies Lives and support for gestational diabetes	make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Implementation of 3 year plan including new Pelvic Health services	
	Continue improvement against BAPM neonatal standards pre-term birth support	
	Continue research work with University of Hull research work into alcohol in pregnancy	
	Support LMNS equality and diversity programme to ensure equity	
	Continue to support recruitment and retention in trusts to maintain required staffing levels for maternity services	
	Develop strategy with HNY wider workforce supply planner	increase fill rates against funded establishment for neonatal mortality
	Implement maternity support worker scheme to ensure consistent competencies	
	Complete implementation of BadgerNet single maternity IT system	
	Ensure Yorkshire and Humber Care Record embedded for contextual launch	
	Review SI and quality performance for true data comparison and learning	
	Scope e-red book provision with partners	
It is easy for me to get the support I need for my child	Use a data driving approach to identify inequalities in access and experience for children and young people in mental health services	
	Trial the risk stratification tool for action for children and young people with asthma	
	Improve access to digital technology to manage diabetes	
	Roll out to all places the diabetes proverty proofing project	
	Benchmark services against core standards for children with epilepsy to identify priority areas for improvement	
	Deliver and evaluate our pilot programme with specialised nurse practitioners for children and young people with asthma	
	Embed a pathway between primary and secondary care to delivery national asthma standards	
	Increase access to dental services and improve orall health	
	Use data tracking and local feedback to identify areaqs of concern and risks for urgent and emergency care attendances	
	Develop a joint strategy including personalisation planning	
	Ensure Continuity of Carer teams are supported and developed in deprived areas	
	Continue provision of 'Ask a Midwife' service including birth plans, translation and interpretation support, surrogacy guidance	

Live Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
I am on top of my condition and I know what to do if I need help	Improve diagnostics for cancer - focussing on liver surveillance and cytosponge delivery	Meet the cancer faster diagnosis standard by March 2024
	Support awareness and diagnosis of cancer - targeting the 20% most deprived areas	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the early diagnosis ambition by 2028
	Deliver our programme of Living with and beyond cancer	
	Build on the early implementer site for Community Mental Health Transformation to continue to increase access to mental health support in the community	Increase the number of adults and older adults accessing IAPT treatment
	Build on the early implementer site for Community Mental Helath Transformation to continue to increase access to mental health support in the community	Achieve a 5% on year increase in the number of adults and older adults supported by community mental health services
	Develop a 3 year plan for inpatient services across Mental Health, Learning Disabilities and Autism	Work on eliminating inappropriate adult acute out of area placements
	Develop working arrangements with transforming care partnerships to deliver key priorities across learning disabilities and autism	Ensure 75% of people aged over 14 on GP learning disability registered receive an annual health check and health action plan by March 2024
	Develop a 3 year plan for inpatient services across Mental Health, Learning Disabilities and Autism	Reduce reliance on inpatient care, while improving the quality of inpatient care for adults with a learning disability and/or autistic
	For people in MH crisis expand the use of MH response vehicles following successful implementation on our patch via the Yorkshire Ambulance Service (YAS).	
	Ensure sustained improvement for the delivery of annual health checks for people with serious mental illness	
	Work with maternity programme to support perinatal mental health enabling improved access an increased offer of psychological interventions	
	Continue to invest in Health and Wellbeing programmes	
	Work with partner organisations to get closer to people suffering from health inequalities	
	Support more people and communities directly to increase digital access and support a digital strategy	
	Develop approach to addressing multi-morbidity starting with our cardiovascular disease detection and prevention plan	increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Develop strategies that focus on prevention for people with 1 long term health condition	
	Support investment at place including local authorities to target inequalities	
	Increase percentage of patients with hypertension treated to NICE guidance	
	Increase percentage of patients aged between 25 and 84 years old with a CVD risk score greater than 20% on lipid lowering therapies	
	Address health inequalities and make every contact count through our Winter Vaccination Board	
	Roll out the spring COVID booster campaign and plan for an anticipated COVID autumn booster campaign	

Live Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Planning, delivering and transforming services together with the planned care strategy	
	Work with clinical networks to share best practice and reduce unwarranted variation	
	The electronic patient record programme to support digital modernisation	
	Work together to ensure the clinical sustainability of fragile services	
	Implementation of prioritisation of people with learning disabilities on the waiting list	
	Improve treatment pathways including a stocktake of non-surgical oncology	Continue to reduce the number of patients waiting over 62 days
	Increase uptake and expansion of the Lung Health Checks programme	
	Support the 65 week delivery target through maximising capacity and utilising mutual aid	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Support waiting list reduction by reducing the number of follow ups without a procedure	Deliver the system specific activity target
	Optimise productivity through collectively utilising capacity	
	Plan, develop and implement the community diagnostic model with a target of 3% DNA for endoscopy and physiology	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 Ambition of 95%
	Agree utilisation improvement targets across modalities	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and a the diagnostic waiting time ambition
	Continue development of our neighbourhood teams	
	Utilise our Additional Roles Reimbursement Scheme to recruit an additional 217 individuals across Primary Care Networks	Continue to recruit ARRS roles by the end of March 2023
	Make it easier for people to contact a GP practice so that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently as assessed the same or next day according to clinical need	Make it easier for people to contact a GP practice
	Increase access to primary care by providing additional appointments and increasing the number of appointments available	Continue the trajectory to deliver 50m more appointments in general practice by March 2023
	Increase access to dental services with continued investment through procurements and flexible commissioning models	Recover dental activity improving units of dental activity towards pre-pandemic levels
	Continue to share best practice through a range of forums, showcase events, videos and case studies	
	Explore ways for the VCSE sector to engage in the design of services	
	Reduce unheralded walking patients to Emergency Departments	Improve A%E waiting times by March 2023
	Reduce the number of hospital conveyances, both to Emergency Departments and other hospital settings	Improve CAT 2 response times across 2023/24
	Support improved CAT 2 response times by reducing conveyances to hospital	Improve CAT 2 response times across 2023/24
	Improve ambulance handover times within emergency departments	Improve CAT 2 response times across 2023/24
	Reduce overcrowding in Emergency Departments	Improve A%E waiting times by March 2024

Live Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Support the reduction in >12 hour waits in emergency departments	Improve A%E waiting times by March 2024
	Undertake a full review of all urgent treatment centres	
	Improve type 3 performance reported and subsequent overall 4 hour standard	
	support reduction in emergency department crowding and time in department	Improve A%E waiting times by March 2024
	Ensure urgent treatment centres are compliant with national standards	
	Increase direct conveyance to urgent treatment centres supporting reduction in ambulance handover times and CAT 2 response	Improve CAT 2 response times across 2023/23
	Minimum opening hours of 12 hours a day 7 days a week to support same day emergency care	
	Align same day emergency care opening times to peak demand times	Improve A%E waiting times by March 2023
	Increase direct access to same day emergency care for 111, 999, crews on scenes and GPs without the need for ED assessment first	
	Implement referral based on exclusion criteria to maximise same day emergency care opportunities	
	Increase 0 day lengths of stay	Reduce adult general and acute bed occupancy
	Reduce emergency department crowding and wait times - improving 4-hour standard	Improve A%E waiting times by March 2023
	Co-ordinate an integrated high intensity user programme across the ICS	Improve A%E waiting times by March 2023
	Reduce the number of patients classed as high intensity users	Reduce adult general and acute bed occupancy
	Reduce re-attendance rates	Improve A%E waiting times by March 2023
	Increase the number of alternative care pathways available to patients which avoid emergency department and hospital	Reduce adult general and acute bed occupancy
	Develop the peri-operative business case	
	Submit business cases for the hub and spoke model for Community Diagnostic Centres	
	Implement the Scunthorpe Community Diagnostic hub	
	Undertake detailed modelling and engagement on our planned care 5 year strategy and approach	
	Consult on a set of proposals for the Humber Acute Services Review	
	Understand current services, effectiveness and risks for pharmacy, optometry and dental services	
	Align the Yorkshire and Humber screening and immunisation health inequalities action plan with ICB priorities	
	Work on identified clinical pathways to test out new ways of working for specialised services	

Live Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
I feel included - I have a place to belong	Improve data quality and reporting on health inequalities and develop a health inequalities plan across acute care	
	Continue to develop our Core20+5 ambassadors to promote health and wellbeing and reduce inequalities	
	Focus on digital inclusion, increasing the number of eligible population registering for the NHS App	
	Continue to embed a personalised care ethos	
	Connect with thriving communities through personalised care	
	Enrich personalised care approaches across health and care	
	Increase the numbers of organisations engaged, increasing levels of diversity	
	Track the reach of communications and public engagement	
	Support co-design within communities to ensure a diverse perspective on development and planning	
	Work through VCSE organisations to engage with people in coastal communities to understand their specific health and wellbeing needs	
	Increase utilisation of the VCSE sector to promote, engage and advocate for peoples' voice	
	Support greater understanding of communities across HNY and what matters to them	
	Embed Core20plus5 into integrated neighbourhood teams, starting in our coastal areas	Continue to address health inequalities and deliver on the Core20plus approach
	Address asylum seeker health needs	
	Scope out an inclusion health service that reaches all parts of the system	Continue to address health inequalities and deliver on the Core20plus approach
	Provide tools to improve population health and reduce variation through roll out of PHM support across primary care networks	Continue to address health inequalities and deliver on the Core20plus approach
	Integration Needs Assessment to make recommendations of where further integration should take place	
	Develop strategy to address health inequalities in coastal and port communities	Continue to address health inequalities and deliver on the Core20plus approach
I find ways to stay active and keep health that work for me	Utilise our Additional Roles Reimbursement Scheme to recruit an additional 217 individuals across Primary Care Networks	
	Develop a consistent approach to the management, recruitment and development of volunteers	
	Ensure that the wider determinants of ill health are considered in ICB planning	
	Influence and shape future investment in the VCSE sector to increase sustainability	

Live Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
I quit smoking and I feel great	implement a universal incentive scheme for tobacco control for smoking in pregnancy Invest in lung health checks Embed tobacco control in nursing and midwifery Launch media and communications campaign for tobacco control Prepare for the launch of the full model for tobacco control in 2024/25	
I have meaningful employment despite the barriers I face	Provider collaborative development programme for staff health and wellbeing, diversity and inclusion Offer every newly qualified GP and Practice Nurse access to our fellowship programme	

Age Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
I only go into hospital If its absolutely necessary	Reduce unnecessary admissions and conveyance to Emergency Departments through understanding alternative pathways that would support wider admission avoidance Improve data quality and implement faster data flows in community to support admission avoidance Complete waiting list audit to ensure we give visibility ot the total waiting list and support a reduction in the overall waiting list Provide system wide support to clinical networks to support a reduction in inequalities and improve health outcomes Utilise our Additional Roles Reimbursement Scheme to recruit an additional 217 individuals across Primary Care Networks Make it easier for people to contact a GP practice so that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently as assessed the same or next day according to clinical need Increase access to primary care by providing additional appointments and increasing the number of appointments available Continue development of our neighbourhood teams	Continue to recruit ARRS roles by the end of March 2023
	Increase the number of crisis first care contacts to reduce admissions to hospital	Consistently meet or exceed the 70% 2 hour urgent community response standard Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
I can get advice and support for my health at home or nearby	Increase the number of crisis first care contacts to reduce admissions to hospital Better understand the value of virtual wards to help inform their utilisation Complete system wide programme of support for a new model of intermediate care to support discharge and increase bed capacity through reducing 'no criteria to reside' Improve discharge pathways to reduce the number of bed days lost and improve patient flow Roll out OPTICA and virtual ward automation digital applications to support urgent and emergency care bed occupancy Utilise remote monitoring funding to purchase and deploy equipment in the pathways and places most challenged Focus on levelling up delivery against the dementia diagnosis targets across HNY so that resource is directed to places where the biggest improvements are needed	Recover the dementia diagnosis rate to 66.7%
I am as active as I can be	Continue to invest in Health and Wellbeing Programmes in Primary Care	

Die Well

Humber and North Yorkshire Health and Care Partnership

Strategic outcomes	JFP Outputs	Operational plan deliverables
My wishes are known and respected We are able to talk confidently with patients about their end of life wishes My wishes are known and respected	Increase the use of rehabilitation and reablement and support at home for palliative care Develop an ICS strategy for palliative and end of life care for children and young people Develop the ICB strategy and delivery plan, responding to the priorities identified in the stocktake	

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Humber and North Yorkshire
Health and Care Partnership

Joint Forward Plan

How we will deliver our strategy from 2023 - 2028

DRAFT: 5

Humber and North Yorkshire ICB Joint Forward Plan: Contents		
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INTRODUCTION

Introduction to the plan

The Integrated Care Board is required to publish a Joint Forward Plan which sets out how the NHS will deliver the aims and ambitions set out in our wider system Integrated Care Strategy. Joint Forward Plans must set out how ICBs intend to discharge their duty to have regard to the wider effect of decisions about the provision of health and care.

Our belief is that integrated care is about giving people the support they need, joined up across local councils, the NHS and other partners.
We have created the Joint Forward Plan from a 'bottom up' approach – seeking to bring together place and collaborative plans to describe how all parts of our ICB are working together with partners to deliver our ambitions through NHS commitments and to meet the needs of our local populations. Our Joint forward plan brings into focus in one place:

- What the NHS will deliver, fully aligned to wider system partnership ambitions
- How we are making an impact through place strategies, partnerships and plans, building on continuous engagement with our populations
- Ensuring that we are delivery focussed by including specific objectives for 2023/24

In bringing these existing plans and strategies into one place, the ICB can hold itself to account for our actions to support system and partners strategic aims and can ensure that we understand our progress and make adjustments to throughout the five years to ensure we deliver our shared vision.

We have set out the plan in two sections:

- Section one will focus on integration, setting out how place and sector collaboratives will deliver the vision over the next 5 years and providing some tangible milestones for the next 12 months. This reflects the priorities and plans at place with Health and Wellbeing boards that deliver the ambition and vision of the strategy.
- Section two describes how we will create the enabling conditions to achieve the vision by setting out an ICB wide overview of our structures and ways of working to fulfil our partnership ambitions and meet legal requirements and sets out our key deliverables to achieve this in 2023/24.

The plan sets out our stall as to how the ICB will work to improve outcomes for our population, tackle health inequalities, improve productivity and make connections between health and wider issues including how the ICB will work with partners to address local social, environmental and economic conditions which impact on health and wellbeing. The plan will be submitted to NHS England in June 2023 but our planning activities will continue beyond this. We will use the plan to track our progress and ensure continuous engagement through partners and with the public so that we build an ongoing five year programme to deliver our strategic aims.

This plan forms the basis of the ICB becoming a partner in the Humber and North Yorkshire system, providing transparency about how the ICB will empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending. This will enable us to deliver on the promise of system working, as described in the Hewitt Review of integrated care systems (The Hewitt Review: an independent review of integrated care systems (publishing.service.gov.uk)

Amanda Bloor
ICB Chief Operating Officer and Deputy Chief Executive

The NHS Humber and North Yorkshire Integrated Care Board (ICB) is a statutory NHS body with those functions and duties conferred to it as set out within the Health and Care Act 2022.

The ICB operates as a joint partnership with the Local Authorities, with wider system partners, adopting a collective and shared approach to decision-making and facilitating mutual accountability across the Integrated Care System (ICS).

Our approach is based on the belief that we will be more successful in bringing about change if we work together. The partnership has subscribed to a principle of subsidiarity, which means that most of our focus will be on continuing our work together to improve the health and wellbeing of the local population in each of our six 'places' .

Our purpose is to improve the lives of the people who live and work in Humber and North Yorkshire
We will do this by

- Improving outcomes
- Tackling inequalities
- Enhancing quality and productivity
- Supporting social and economic recovery

Humber and North Yorkshire Health and Care Partnership

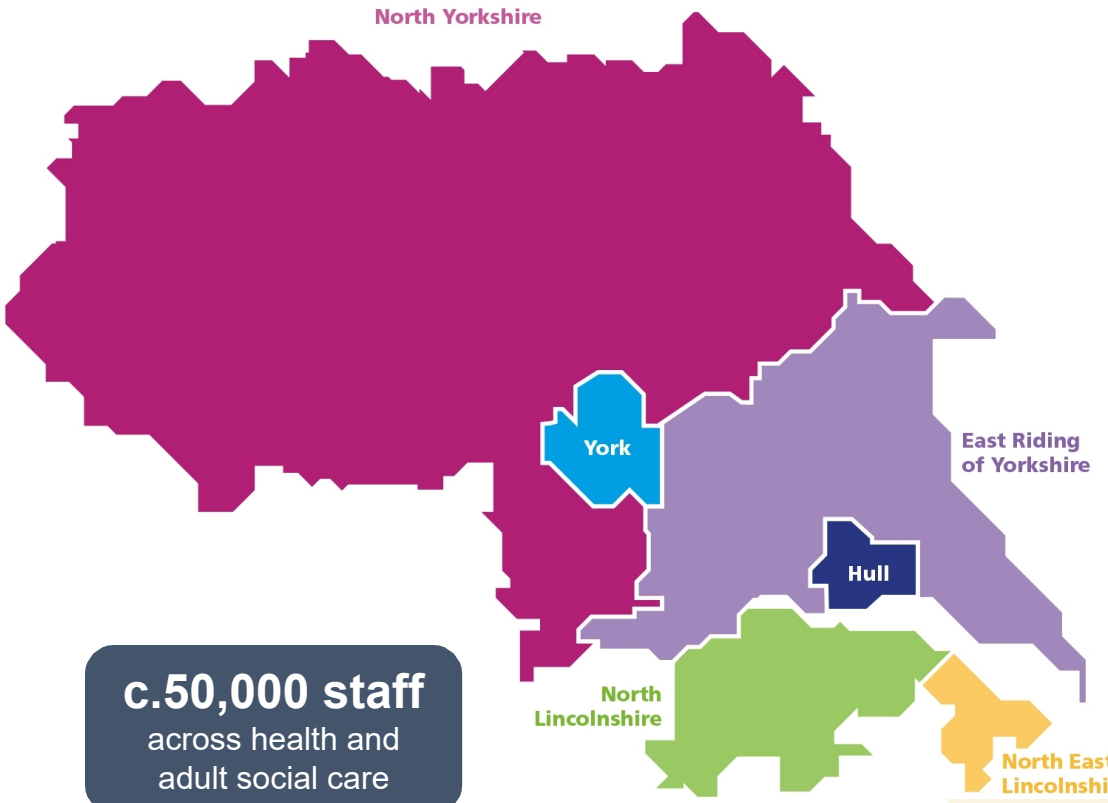
Our ways of working

- Establishing a collaborative culture based on trust
- Empowering place based and provider collaboratives
- Ensuring an honest public narrative
- Being transformative with a clear appetite for innovation
- Placing a greater emphasis on prevention and demand management
- Using shared data and intelligence to support decision making
- Influencing national and regional policy
- Learn by doing

Further information ICB-Constitution-and-Standing-Orders.pdf

Overview of our Partnership

We are second largest Integrated Care Board in England by land size with a population of 1.7million.



Humber and North Yorkshire Health and Care Partnership

1.7 million people

6 Local Authorities
(upper tier and unitary authorities)

550 care homes

180 home care companies

10 hospices

1000s of voluntary and community sector organisations

c.50,000 staff
across health and adult social care

Total budget of approx. £3.5bn

42 Primary Care Networks
(181 GP Practices)

4 acute hospital trusts
(operating across 9 sites)

3 mental health trusts

4 community / not for profit providers

2 ambulance trusts

Our **strategy** on a page

Our **ambition** is:

Humber and North Yorkshire Health and Care Partnership

for everyone in our population to live longer, healthier lives

by narrowing the gap in healthy life expectancy between the highest and lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035.

To reach that ambition our **vision** is to ensure that all our people:

Start Well — We want every child to have the best start in life and enable everyone to be safe, grow and learn.

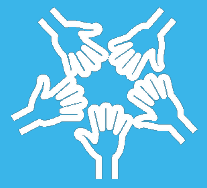
Live Well — We want to ensure the next generation are healthier than the last and have the opportunity to thrive.

Age Well — We want to ensure people live healthy and independent lives as long as possible by understanding what matters most to them.

Die Well — We want to create an environment in which people can have positive conversations about death and dying.

To deliver the ambition and vision, our **intentions** are to:

Create conditions



focus on creating the conditions to enable and empower our people, communities and organisations to achieve change

to

Think person — enabling our people to live healthy, independent and safe lives as long as possible by understanding what matters to them

Think family — supporting families to enable everyone to be safe, grow and learn and ensure every child has the best start in life

Think community — an all-inclusive community approach to ensure the next generation are healthier than the last and have the opportunity to thrive

SECTION 1: DELIVERING OUR VISION

1.1 What this section covers

Humber and North Yorkshire Health and Care Partnership

This section sets out how Humber and North Yorkshire ICB will work in partnership with local health and care organisations collaboratively in the interests of our population to improve health and wellbeing.
It sets out:

- How we have developed our operating model to embed our duty of integrated working, throughout our organisation to improve quality and reduce inequalities
- Outline how we will deliver improvements to realise our strategic vision and ambition, focussing on what changes will be made in 2023/24
- Outline how we will deliver our population health and prevention ambitions
- Set out key system developments in commissioning that will take place in 2023/24
- How we will address the particular needs of vulnerable groups as set out in guidance

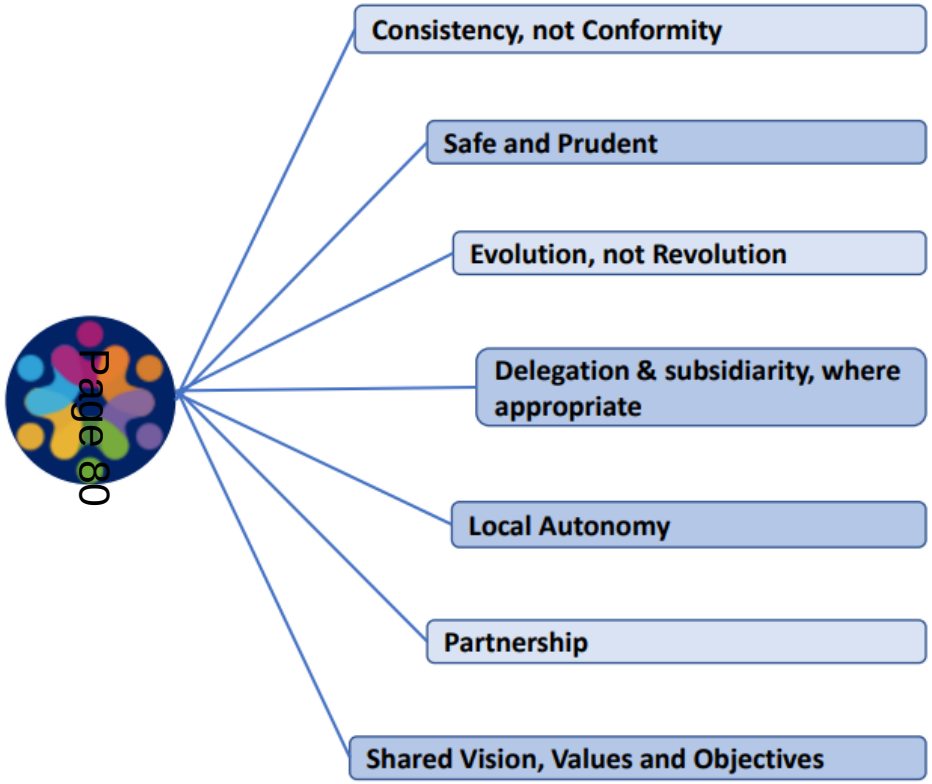
Embedded in our ICB operating model is delivery at place. A key element of our delivery is through the Joint Local Health and Wellbeing (JLHW)Strategies developed at place with Local Authority partners. The plan includes a summary of each JLHW, setting out how each of our places will work and support delivery of these local plans, within our overarching ICB plan.

This plan aims to summarise rather than duplicate the detailed work through our places and collaboratives. It 'sets out the stall' of the ICB and its contribution to as a partner to improving the health and wellbeing of our populations, encouraging transparency to enable local autonomy for delivery.

1.2 Our operating model

Humber and North Yorkshire Health and Care Partnership

Our principles



The ICS is now in its first substantial year of existence after the ICB was legally established in July 2022. As a system we want to assess our progress to date and consider how to maintain and develop our effectiveness in 2023/24. In 2023/24 we will build on these principles to:

- Build on the current work in place to tackle inequalities
- Accelerate our ability to deliver transformation by bringing data together
- Ensure a coherent approach to quality improvement linked to performance management with clear expectations of roles and responsibilities, a culture of self reporting of problems and peer review through place and collaboratives
- Balance 'designing tomorrow, delivering today' - equally keeping our focus on prevention, demand management and transformation – and being conscious and deliberate in our programmes
- Widen our impact through improving population health
- Support and invest in our clinical and professional leadership and organisational culture
- Make sure we have a comprehensive commitment to engagement with all our partners

For more information see the ICB Functions and Decision Map PowerPoint Presentation (icb.nhs.uk)

1.2 How we will deliver our plan

Humber and North Yorkshire Health and Care Partnership

The aim of the Humber and North Yorkshire Operating Model is to emphasise the importance of place-based partnerships by ensuring that place and sector collaboratives was at the core of the delivery mechanism of the ICB, within an overall single operating model. Place based leadership creates the right conditions for change, ensuring local system conversations can develop plans to address local priorities and health inequalities within the overall ICB strategy.

The role of place is to

- develop and deliver integration and service transformation in line with the ICS strategy and place priorities as set out in the Joint Local Health and Wellbeing Strategies
- lead and assure mutual responsibility and accountability at place for deliverables set out in the NHS plan
- deliver place efficiency plans on behalf of the ICS system

This is led by facilitating and negotiating close partnership working with local providers, local authorities, voluntary and community sector partners and populations to agree priorities within the Integrated Health and Care Strategy and the Joint Local Health and Wellbeing Strategies.

Sector collaboratives bring the provider delivery partners together to transform services at scale, doing things once to share learning and reduce variation, working closely with place partners. The sector collaboratives are responsible for:

- Delivery on key operational targets as set out in the NHS Long Term Plan and Operating Planning Guidance
- Act between provider members, place, and other delivery partners to deliver transformation at scale, as part of the ICB strategy

This matrix and collaborative approach between place and sector-based collaboratives is underpinned by the ICB, which sets the strategy, supports system wide planning and is accountable for financial and operational performance.

The purpose of our model is to support the principles of subsidiarity and delegation, ensuring that we adopt the principles of local decision making and autonomy to meet population needs while creating a whole system approach to maximise efficiencies by 'doing things once' where appropriate.

Examples

In 2022/23 there have been good examples of where the model of place led system and collaborative working has created the right strategic environment for delivery and service transformation:

- Agreeing local priorities with partners at each place, aligned to ICB priorities
- Early engagement through place and sector collaboratives to respond to urgent care pressures and improve pathways for discharge through developing local plans for £18.1m Adult and Social Care Discharge Funding.
- Developing integrated models of care with Local Authorities to reduce health inequalities
- Working across place and sector collaboratives alongside local partners on the configuration of Mental Health services

Case Study: Strengthening York's integrated community offer:

The **York Community Mental Health Hub** is a supportive environment where people can access support from the hub team – which includes a hub manager, mental health clinician, peer supporters, carer support, social worker, recovery worker and social prescriber - when they need it and have their needs met in a timely way.

The vision for the hub has been inspired by the open, community led and de-stigmatising values of the Trieste mental health model in Italy.

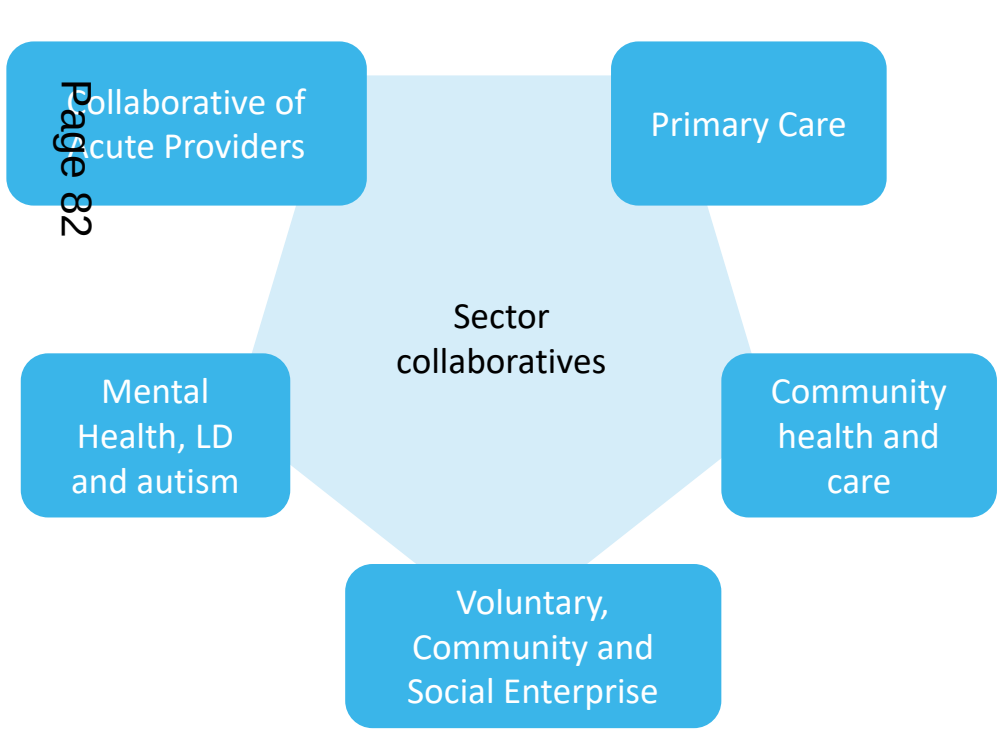
Compassionate care, strengths based and trauma informed approaches, reflection and relational activism all underpin the approach at the hub.

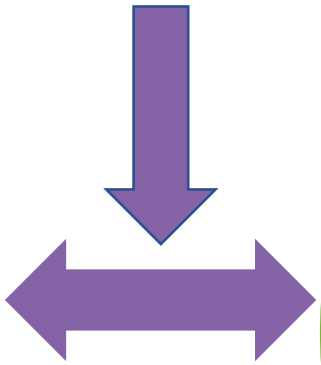
Our operating model

ICB single approach to planning and system accountability:

- Alignment of vision and ambition to create capacity and capability for transformational change
- Generating efficiencies through 'doing things once'
- Assurance of system wide accountability and reporting

Delivering to local priorities and populations through:





1.2 Our operating model: developments in 2023/24

Humber and North Yorkshire Health and Care Partnership

The ICB Scheme of Reservation and Delegation delegates to place directors:

- Allocation of delegated resources to deliver the plan in each place and setting principles for how they should be allocated across services and providers
- Arrange for the provision of health services in line with allocated resources, including putting in place contracts to secure delivery of its plan and supporting providers to lead major service transformation programmes to achieve agreed outcomes.

This means that place-based leadership teams have the autonomy and flexibility to look at allocations holistically, and work with partners to agree how spending can support local priorities to address health inequalities within the overall ICB strategic approach and governance. Governance - Humber and North Yorkshire Integrated Care Board (ICB)

Throughout 2022/23, places have been engaged in discussions about local autonomy and delegation of local decision making. Three development sessions were held during 2022. These sessions were facilitated by Capsticks with the 6 local authority Chief Executives, the ICB Chief Operating officer, Executive Director of Finance, Executive Director Corporate Affairs and Place Directors to review national guidance, options for delivery and local priorities. The following arrangements have been agreed for 2023/24

Place	Intentions for 2023/24
North Lincolnshire	Delegation to continue through place director, discharged through local place committee.
North East Lincolnshire	Establish a Joint Committee.
Hull	Delegation to continue through place director, discharged through a local place committee.
East Riding of Yorkshire	Delegation to continue through place director, discharged through a local place committee
City of York	Delegation to continue through place director, discharged through a local place committee.
North Yorkshire	Delegation to continue through place director, discharged through a local place committee.

Case study

North East Lincolnshire has a proud and lengthy history of working in an integrated way in respect of Health and Care for the last fifteen years as the CCG was delegated by the local authority to commission adult social care. Over the years, through a section 75 agreement intensive collaboration has resulted in joined up services, posts and governance processes. Our core model of care will be the Accountable Teams model, embodying teams working together to meet the health and care needs of people, their carers and families. Rolling this model out erases the 'lines in the system' created by organisational needs and boundaries, and will be founded upon:

- One referral to the right person at the right time
- "Accountable Care Teams' – avoiding often complicated and time-consuming transfers between services, professionals and organisations
- Shared data; digitally enabled; capable and empowered staff; and tailored care
- Delivering home first and virtual wards

We have already successfully delivered the Connected Health model in Cardiology, breaking down barriers between primary and secondary care to eliminate waiting lists for this specialty – we will roll this out for other pathways of care and other specialties.

Place priorities: Health and wellbeing North Yorkshire

Humber and North Yorkshire Health and Care Partnership

Our ambition

For all residents of North Yorkshire to have a fair chance of living a fulfilling life, free from preventable ill health, 'adding years to life and life to years'

Think 'People': In North Yorkshire, we will work with our communities who experience the poorest health outcomes to make sure that they can access and benefit from the services and opportunities they need

Think 'Place': In North Yorkshire, where you live should help you stay well and happy. We want to make sure that where you live does not unfairly reduce the quality of your health or length of your life.

Think 'Population Health and Prevention': In North Yorkshire, we will improve the health of all our residents by prioritising interventions that will make the most difference and that make sense to do at scale.

Where we are now:

- People already affected by health inequalities before the pandemic have been disproportionately affected by COVID-19, leading to even greater inequality
- Over three 5ths of adults are overweight or obese – similar to the national average
- Healthy life expectancy (number of years lived without serious illness) for women is below the England average, and over the past 9 years, has not increased.
- 25% of our population is estimated to have a life long illness
- Our population is ageing – 1 and 4 people in North Yorkshire is over 65
- People who live in the wards with the highest life expectancy live 12.6 years (women) and 15.4 years (men) longer than those in the wards with the lowest life expectancy.

Our priorities

What we will deliver in 2023/24

A comprehensive and integrated health and social care model

- Enable the four Local Care Partnerships to lead the design of the local integrated model
- In partnership with York, redesign and deliver a new single fully integrated 24/7 urgent care specification
- Develop and deliver a business case for a new integrated model for intermediate care
- Support discharge and flow through intermediate care with new hub and system monitoring arrangements
- Develop population health management and prevention through a PCN programme and cardiovascular dashboard
- Deliver crisis response and virtual ward beds in line with 23/24 trajectories
- Establish North Yorkshire VSCE assembly by Community First Yorkshire

A high quality care sector, with sufficient capacity to meet demand

- Develop innovative models for domiciliary care, including care built on community strengths.
- To further support provider sustainability the Council will review the timescale for moving residential placements to actual cost of care
- Work with care providers to implement the national charging reforms for adult social care and the NHS discharge pathway.
- Develop robust SOPs to maximise utilisation and flow within independent sector
- Prepare proposals for transforming local authority in house domiciliary care provision.

A strong workforce

- Develop more balanced/varied roles with appropriate rewards.
- Develop innovative approaches to recruitment and innovative workforce models.
- Identify opportunities for cross sector working and roles.
- Support international recruitment across sectors.
- 12 oral health practitioners due to complete apprenticeship in August 2023 with opportunities to undertake roles in Yorkshire and Humber area
- Appoint Legacy Registered Manager Mentor to be appointed to provide support for Registered Managers across the North Yorkshire and York areas.

Prevention and public health: adding life to years and years to life

- Refresh the Health and Wellbeing Strategy
- Expand PHM review cycles across PCNs
- Appoint a joint post between NY Place and NYC to lead on Health Inequalities and Population Health.
- E-Cigarettes to be used as a harm reduction tool as part of the Living well Smokefree Service
- Implement Drug Treatment Plan for 23/24
- Support people to maintain good mental health with timely access to effective primary, secondary and specialist services when needed.
- Support people to be physically active across all ages and stages of the life course.
- Influence through the strength of the partnership the wider determinants of health with a focus on coastal communities.
- Promote and invest in stronger communities and strategic commissioning of the VCSE.
- Engage people in a dialogue about self-care, early help, loneliness and using digital tools.

1.3 Place priorities: Health and Wellbeing - York

Humber and North Yorkshire Health and Care Partnership

Our vision	**Over the next decade, York will become healthier, and that health will be fairer**	York Place will support delivery of the six Big Ambitions of our Health and Wellbeing Strategy 2022-2032 • Become a health generating city • Prevent now to avoid later harm • Start good health and wellbeing young		• Make good health more equal across the city • Work to make York a mentally healthy city • Build a collaborative health and care system		
Where we are now?	York has an aging and growing population, with increases in hospital care, social care and GP usage	York's red flags are alcohol consumption, multiple complex needs, drug related deaths and student health	1 in 9 people in York have more than one long term condition, and there is an elective backlog across primary and secondary care.	Under 18 admissions for Mental Health need with a high prevalence of common Mental Health illness, high suicide and high self harm rates	1 in 10 people smoke, 2 in 3 adults are overweight or obese and 1 in 7 live with depression	York has a widening inequalities gap in healthy life expectancy, heath of those living with a learning disability and school readiness
Our priorities	**Strengthen York's integrated community offer**	**Implement an integrated Urgent and Emergency Care offer**	**Further develop primary and secondary shared care models**	**Develop a partnership based, inclusive model for children, young people and families**	**Embed an integrated prevention and early intervention model**	**Drive social and economic development**
What will this mean for citizens?	Greater access to personalised support and integrated care outside of hospital, to helps people live well and independently at home for longer.	A safe, reliable, and resilient service where duplication is reduced, providing remote visits on a 24/7 basis to provide a better experience for patients.	Shared care models between patients, specialist GPs and other specialists to deliver a personalised, seamless and holistic care experience.	Working together for children, young people, and families to raise a healthy generation of children. where work is done in partnership to raise a healthy generation who grow into healthy and independent adults.	A shift to prevention and early intervention, enabling people to live healthier, longer lives, and reducing the gap in health inequalities between the most and least deprived communities in York.	Working at the heart of communities to use and grow the assets we have, maximising our collective capability, working in partnership taking a cradle to career approach.
What we will deliver in 2023/24?	Develop an Integrated community frailty Single Point of Access hub including mapping, outcomes and delivery model.	Work in partnership with North Yorkshire on the redesign of urgent care, developing a single fully integrated 24/7 specification.	Re-establish a clinically-led Primary/Secondary Care Interface Group to explore opportunities for shared care pathway development	Across health, social care and education we will identify the barriers to overcome through working together, we will have taken the first step, and we will have a plan for action.	Acceleration of a prevention programme for long-term conditions to support delivery of the prevention actions in the York HWB Strategy 2022-2032 Action Plan.	Fulfil our role to as an ICS to support the three city strategies, and as an anchor institution for development, housing, workforce, and supporting vulnerable groups.

Delivering at place: Health and Wellbeing Hull

Our ambition and priorities

Integration

- Embed a Population health approach to understanding our population across primary care, working with partners in the system i.e. LA, VCSE, citizens advice, which will focus on the Core20+5 all ages.
- Integrated pathways will be prioritised to improve benefits from services and efficient use of resources to support the improvement of patient experience
- Implement Integrated Neighbourhood teams at Hull place

Primary care Priorities

- Workforce
- Improve Primary care access
- Population Health & inequalities – Core 20+5 – all ages

Inequalities

- Supporting self care to help people live longer in good health in the community, reducing the mortality gap in Hull.
- Improve access to health services, integrated provision in health and social care.

Where we are now:

BEHAVIOURAL	PHYSIOLOGICAL	BEHAVIOURAL	BEHAVIOURAL	RISK	RISK	RISK
17% of current smokers in the population – though the prevalence has generally been decreasing the rates vary widely	For **males**, around 42% of the life expectancy gap between the most and least deprived wards within Hull is made up of circulatory disease and cancer	71% of adults are classified as overweight or obese 28% of children in reception are overweight or obese	55% Adults Physically Active	71% of people are in employment	47% GCSE attainment 8 score	33% of children are in relative low income families

Our Priorities

Integrated neighbourhood teams	Improve services for patients	Population Health	Inequalities

What we will deliver in 2023/24

Integrated neighbourhood teams		Improve services for patients		Population Health	Inequalities
Roll out our project to support people in receipt of home care across the city to deliver integrated neighbourhood teams	Work with community, mental health and voluntary sector organisations to deliver the care at home project	Work with our priority areas across local trusts and community providers to improve access at the time of need focusing in on elective care and cancer Continue our joint improvement plans for SEND	Deliver our system anticipatory care and urgent emergency care programmes to reduce admissions to hospital and improve integrated discharge processes	Ensure Hull Primary Care Networks embed a population health management approach to identify patients that may need a clinical review to support health prevention. Work across public health and with our local authority to employ a trauma informed approach to developing models for inclusion health	Focus our approach to reduce variation, with focus on core 20+5, using data analysis and clinical peer review to improve care locally. Tobacco control workplace & deprived community targeted outreach Provide primary Care in Children's Centres

5 publication

1.3 Place priorities: Health and Wellbeing - North East Lincolnshire

Humber and North Yorkshire Health and Care Partnership

Our ambition

Our local community, health and care system is currently building on a lengthy, proud and powerful history of collaborative and integrated working ensuring our community, health and care organisations work hand in glove and this has benefitted local people for many years. Our Health and Care partnership enables partners to work together where a multi-agency approach is required to tackle and deliver local priorities whilst still undertaking their own functions and service delivery.
Our local community, health and care system is becoming more holistic – bringing together and delivering mental, physical and social care together for both children and adults. As a place we will continue to work in an integrated way to deliver better outcomes for our population, linking in on a system and collaborative level, where working together in this way supports better outcomes for our population. We will work together to reduce unfair and avoidable differences in health across the population, with a focus on reducing inequalities, and ensure that our residents are at the heart of all we do. We will come together across population groups in Accountable Care Teams using a population health approach to do this.

Where we are now:

- NEL has a 156,940-resident population of mostly coastal and urban communities. NEL has variation in inequalities and deprivation: 37.7% of population live in 20% most deprived areas.
- In the 2021 census 43.1% of the population reported very good health compared to 48.5% nationally. 35% reported good health compared to 33.7% nationally
- NEL is in the highest 10% nationally for fuel poverty at 21%. Across the area it ranges from 7.6% in the least deprived up to 26% in the most deprived areas.
- NEL has the highest premature birth rate in England and 1 in 4 children live in poverty.

Our Outcomes

- Improve health outcomes and access to healthcare and reduce health inequalities
- Improve outcomes for children, young people and families
- Improve mental health outcomes
- Strengthen our local health and care workforce
- Reduce the number of people in hospital

Our Key Impact Areas

- Primary & Community Care
- Children, Young People & Families
- Mental Health
- Workforce
- Frailty

What we will deliver in 2023/24

- Implement Integrated Neighbourhood Teams
- Expand Connected Health Model

- Produce CYPF Strategy and implement
- Deliver Best Start for Life Programme
- Improve outcomes for Children Looked After

- Co-produce a Mental Health Strategy and implement
- CYP MH Transformation (Eating Disorder, Neurodiversity, Children Looked After)

- Develop HCP People Plan
- Continue International recruitment programme
- Expand Grow Our Own programme
- Develop Joint and flexible posts

- Establish End of Life Accountable Care Team, develop the clinical model and workforce.
- Continue Accelerated Home First programme
- Reduce avoidable admissions

1.3 Place priorities: Health and Wellbeing - North Lincolnshire

Humber and North Yorkshire Health and Care Partnership

Our ambition

North Lincolnshire will be the best place for all of our residents to be safe, well, prosperous and connected; experiencing better health and wellbeing, delivered through our Community First approach. People will;

- Enjoy good health and wellbeing at any age and for their lifetime
- Live fulfilled lives in a secure place they can call home

Have equality of opportunity to improve their health, play an active part in their community and enjoy purpose in their lives

Adult smoking rates continue to fall and were less than the England average in both 2020and 2021. We will study this reduction and ensure that the pattern continues

Where we are now:

4.2% adults have coronary heart disease compared to England average of 3%	Recorded prevalence of depression is 14.3% compared with England average of 12.3%	The Local population of over 65s is expected to grow by a further 30% by 2042	Adult smoking rates have dropped from 17.8% in 2019 to 12.3% in 2021	72% or the population were overweight or obsess in 2019/20 up from 67% in 2015/16	16.9%women smoking at the time of giving birth compared to England average of 9.1%

Our Priorities

Mental health and wellbeing with thread through all that we do, across all ages	Innovation will be supported including digital tools that enable individuals to maximise health and wellbeing	Asset based community development will identify and work with the strengths of our communities to level up North Lincolnshire	The health inequalities gap will reduce across our wards	Healthy life expectancy will improve	Access to health and care takes account of rural challenges	The integrated practise model will be person centred	People with long term conditions will experience proportionately good health	There will be a single workforce strategy covering leadership and management, recruitment and retention, reward and recognition, career pathways and talent development

What we will deliver in 2023/24

- Ensure our plans reflect the voice of our communities by working with our Experts Together partnership and Children's Voice partnership
- Embed a Population Health Management approach in all service developments to tackle health inequalities and improve outcomes for those most disadvantaged
- Develop our workforce to support delivery of improved outcomes through integration
- Develop and implement the Scunthorpe South Integrated Neighbourhood team, focusing on our most vulnerable, high risk populations, and share best practice with other Neighbourhoods
- Delivery of an integrated urgent care model, including an integrated health and care Single Point of Access and utilising our Home First model, supporting people in the community, or where hospital admission is required, supporting them home and maximising recovery
- Develop our local provider market to support best value provision of in area care for our population with particular focus on CHC and mental health/learning disability
- Deliver a Community Diagnostic Hub to stream planned diagnostics to a community facility to enable delivery of diagnostic targets
- Embed our local frailty model to reduce hospital admissions through proactive care and community delivered care, maximising independence
- Deliver a plan for improved Primary Care access including plans for better management of capacity, estate and digital
- Deliver the Connected Health Network approach to outpatient transformation to reduce hospital outpatient referrals and follow ups
- Development of sustainable neurodiversity pathway for Children and Young People including pre and post diagnosis support
- Identify prevention opportunities to support demand management , including delivery of cardio-vascular disease prevention programme
- *Develop and implement our clinical delivery model for Palliative and End of Life care, with a focus on early identification and utilisation of Electronic Palliative Care Co-ordination system and ReSPECT in line with the Northern Lincolnshire Palliative End of Life Care strategy*

1.3 Place priorities: Health and Wellbeing - East Riding

Humber and North Yorkshire Health and Care Partnership

Our ambition

An East Riding where all residents are supported to enjoy their maximum potential for health, wellbeing and participation throughout their lives:

- Children and Young People enjoy good health and wellbeing
- Working age adults reduce their risk of ill health
- Residents achieve healthy, independent ageing
- Health inequalities are reduced

Where we are now:

People in East Riding are dying years earlier than they should	We don't have the things we need like warm homes and healthy food – we are worrying about making ends meet	This can result in increased stress, high blood pressure and a weaker immune system	This doesn't impact on people equally

Our priorities

Taking a population health approach	Joining up assets in the community	Avoiding dependency and reducing escalation	Accessing health and care services in a timely manner	Raising aspirations

Our population health approach has resulted in a proposed set of multi-year programmes that are based around improving the health of the population, reducing inequalities and ensuring access to high quality services

Rural and coastal communities	Bridlington place based programme	Adult emotional health and wellbeing	Children and young people	Workforce challenges	Communications, engagement and insight development	Rehabilitation and intermediate care	Integrated neighbourhood teams	Inclusion groups

What we will deliver in 2023/24

In 23/24 we will:

- Establish 3 test and learn sites for integrated neighbourhood teams in Driffield, Goole and Holderness
- Understand more about how to reduce inequalities in health outcomes for people living in our rural and coastal communities through a rapid health and social care needs assessment and working with partners to uncover current challenges and priorities to develop and deliver a partnership action plan
- Develop our programme for Bridlington place focussing on key areas including education, health and care, transport, employment and housing and agree our immediate priorities
- Develop and implement a graduated response to children and young people's emotional health and wellbeing needs. Incorporating a response to Core20plus5
- Align our ERY workforce plans to population health needs and develop work experience placements across health and care for GCSE and A level students
- Understand capacity and demand across rehabilitation and intermediate care and explore commercial options to bring different services together under the banner of maximising independence to confirm the ambition for all pathway 1 discharges to be with 'intermediate care'.

Community Health and Care Sector Collaborative (CHCC)

Strategic Ambition: To deliver person centred care closer to home wherever possible, through a shared sense of ambition thus creating a common narrative in relation to the expectations of "integration." That treats all with the same equity and values the contribution others can bring to collective working we aspire to, in a partnership and in integrated way to deliver a true Primary Health Care Approach and improves population health care outcomes and addresses inequalities.

The CHCC brings together system leaders across the ICS together to facilitate and promote collaboration through giving visibility to *inequalities* and *variation* in order that we can address this via adopting a system approach to the redesign of specific pathways of care to support care closer to home.

The core purpose of the Collaborative is to support large scale system transformational at pace with a specific focus on:

- Alternative community pathways that avoid admission to hospital via the development of self referral pathways and alternative pathways in the community.
- Support the wider elective recovery agenda by having a clear focus on discharge transformation that demonstrates consistent reduction in those patients that no longer need to be in hospital (improving discharge, reducing 'no criteria to reside' and length of stay).
- Embed digital innovation to support admission avoidance and improve discharge by adopting a system wide approach to digital transformation (Optica, wider remote monitoring and virtual ward expansion).
- Increase system wide visibility to the community resources that we have and how we are using them and how we reconfigure these resources to deliver our system efficiency ambitions.
- Support the statutory ICB responsibility to deliver All Age Palliative End of Life care aligned to the National Ambitions Framework and service specification through co production with people with lived experience
- Support wider system learning and education – do things once and do it well to improve the quality of care and services that we provide

Priorities	What we will deliver in 2023/24
Embed alternative community pathways to avoid admissions to hospital	Increase the number of crisis first care contacts to reduce admissions to hospital
	Better understand the value of virtual wards to help inform utilisation
	Complete system wide programme of support for a new model of intermediate care to support discharge and increase bed capacity through reducing 'no criteria to reside'
	Reduce unnecessary admissions and conveyance to Emergency Departments through understanding alternative pathways that would support wider admission avoidance
Improve patient flow with a focus on discharge to support wider elective recovery	Improve discharge pathways to reduce the number of bed days lost and improve patient flow
	Increase the use of rehabilitation and reablement and support at home for palliative care
Embed digital innovations to support admission avoidance, improve discharge and support digital pathways of care	Roll-out OPTICA and Virtual Ward automation digital applications to support Urgent and Emergency Care bed occupancy
	Utilise Remote Monitoring funding to purchase and deploy equipment in the pathways and places most challenged.
	Improve data quality and implement faster data flows in community to support admission avoidance
Increase system wide understanding of wider community resources	Complete system stock take of palliative and end of life care to inform ICB statutory responsibility to delivery against national strategy
	Complete waiting list audit to ensure we give visibility to total waiting list to support a reduction in the overall waiting list
	Provide system wide support to clinical networks (Diabetes, stroke & respiratory to ensure we support a reduction in inequalities and improve health outcomes

1.4 Community Health and Care collaborative: Palliative and End of Life Care

Humber and North Yorkshire Health and Care Partnership

Strategic ambition:
Our strategic ambition is to ensure we have a clear strategy across Humber and North Yorkshire where by we are clear as to the equitable access to services irrespective of age or geography , we address unwarranted variation and promote equity of access to Palliative and End of Life Services. We create an environment where people can have positive conversations about death and dying, ensuring we understand their end of life wishes, and people can make choices which are known, respected and can be delivered.

The palliative and end of live care programme aims to:
Work to ensure that there is secure and equitable provision of care, for all ages, across Humber and North Yorkshire to deliver specialist palliative care services and access to information
Ensure access to general medical and nursing services out of hours and rapid response to maintain continuity of care and thereby supporting patient's preferences and choice.
Complete an equalities and health inequalities impact assessment and action plan focussed on palliative and end of life care

The ICB has completed a stock take and has identified 7 priorities to take forward into ICB strategy and delivery plans:

- System-wide variation
- Need for standardisation
- Ensure Children and Young People's Palliative and End of Life Care needs are integrated within the strategy
- Ensure we discharge our statutory duties and satisfy the CQC single assessment inspection framework due to be launched in late 2023
- Develop our strategic ambition
- Revise our governance structure to demonstrate how we are discharging our responsibilities
- Complete an ICB Workforce assessment to identify and address any potential gaps and variation

What we will deliver in 2023/24

Take forward the priorities identified in the stocktake against the national ambitions framework in order to understand the gaps against the six ambitions:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

Use the outputs from the Ambitions stocktake to inform:

- ICB All Age Palliative End of Life Strategy
- Work with our 6 places on core delivery plans
- Align our system governance to give oversight and assurance as to the progress we are making

1.4 Voluntary, Community and Social Enterprise (VCSE) collaborative

Humber and North Yorkshire Health and Care Partnership

Strategic ambition:
The collaborative will work strategically with VCSE organisations to enable them to support the ICS strategy by helping people to stay active and keep healthy, to feel included and to feel on top of their condition and know what to do if they need help.

The VCSE Sector is a huge asset, covering nearly 15,000 organisations across HNY and over 23,000 full time equivalent employees. The sector overall is estimated to be worth £4.2bn combined social and economic value. These organisations support and work with individuals and communities largely around supporting health and wellbeing.

The VCSE sector collaborative provides a strategic group that engages and facilitates the engagement of the ICS with the VCSE sector.

The VCSE sector collaborative has 6 representatives linking into each ICB place. They are tasked with understanding their place and VCSE sector within it.

Each place representative holds a VCSE place based assembly which is a collective of VCSE organisations and provide a mechanisms to speak to the sector as one voice per place. They are designed as a two way mechanism – ensuring that the VCSE, place and system are connected.

The sector collaborative also supports co-ordination of health messages and captures work, impacts and thoughts of the VCSE sector to influence planning decisions.

As a collaborative our ambition is to:

- Promote greater understanding of the VCSE sector – knowing itself better and ensuring that the ICS is better able to work with us effectively
- Ensure that the VCSE sector are a strategic and equal partner, involved in planning and design as well as delivery
- Advocate for increased investment and long term contracts to deliver on health agendas and support sustainability within the sector
- Support greater links to key communities, giving people and communities a voice to work with based on their needs and wants
- Work with key partners to improve outcomes and address health inequalities through delivery by shaping service design and representing peoples voice
- Support and contribute to the delivery of operational priorities within the NHS E Long Term Plan and other operational and ICB priorities

Priorities	What we will deliver in 2023/24
Support the approach to engagement and involvement across the ICB	Increase numbers of organisation engaged, increasing levels of diversity. Track the reach of communications and public engagement Through the collaborative, support co-design within communities to ensure a diverse perspective on development and planning
Reduce inequalities	Work with partner organisations to get closer to people suffering from health inequalities Work through VCSE organisations to support more people and communities directly, to increase digital access to healthcare and support the development and delivery of a digital strategy Work through VCSE organisations to engage with people in coastal areas to understand their specific health and wellbeing needs
Increase the voice of patients and the public	Increase utilisation of the VCSE sector to promote, engage and advocate for people's voice Explore ways for the VCSE sector to engage in the design of services, supporting collaborative working driven by the patient voice Support greater understanding of communities across HNY and what matters to them
Support wider system development	Influence and shape future investment in the VCSE sector to increase sustainability Ensure that the wider determinants of health and wellbeing are considered in ICB planning and delivery Develop a consistent approach to the management, recruitment and development of volunteers

1.4 Primary Care Collaborative

Humber and North Yorkshire Health and Care Partnership

Strategic aim:
We will ensure people can Live Well and Age Well by making sure that people get the care that they need and don't get passed back and forth and that people only need to go into hospital when absolutely necessary. People will feel on top of their condition and know what to do if they need help.
Our investment in primary care workforce will support meaningful employment.
We will invest in health and wellbeing programmes and so that people can stay active and keep healthy.

Primary Care Access Recovery Plan
The demands on general practice have never been greater, with record numbers of appointments being delivered. Supported by investment, we will focus on delivering the plan that responds to patient feedback and sets out measures that will make a difference now to staff and patients, focusing efforts on taking pressure off teams, and supporting general practice to manage the 8am rush, and restore patient satisfaction with improved experience of access. Working across our 6 Places we will support practices and primary care networks to deliver on the requirements of the 2023/24 GP contract.
We will continue to work with our Community Pharmacy colleagues to expand their vital role by consulting on a Pharmacy First service. We will embed the oral contraception and blood pressure services along side the Pharmacy First service.

What we will deliver in 2023/24

Increase access to services

- We will focus on Digital Inclusion in collaboration with the Voluntary sector and promote the benefits of the NHS App increasing further from 51% of the eligible population registering for the App
- Make it easier for people to contact a GP practice so that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently as assessed the same or next day according to clinical need
- We will increase access to primary care by providing additional appointments and increasing the number of appointments available
- We will continue to increase access to Dental Services with continued investment through procurements and flexible commissioning models

Develop our workforce

- We will continue to share best practice across our ICB through a range of forums, showcase events, videos and case studies

We will invest in our workforce:-

- In 23/24 we will offer every newly qualified GP and Practice Nurse access to our Fellowship Programme
- We will fully utilise our Additional Roles Reimbursement Scheme (ARRS) budget recruiting an additional 217 individuals across our Primary Care Networks (PCNs)

Promote health and wellbeing and reduce health inequalities

- We will continue to develop our Core 20Plus 5 programme with our **Core20PLUS Ambassadors**
- We will continue to develop our neighbourhood teams
- We will continue to invest in Health and Wellbeing programmes

1.4 Mental Health, Learning Disability and Autism collaborative

Humber and North Yorkshire Health and Care Partnership

Strategic aim:
We will ensure that people can get the help they need when they are struggling, know what to do if they need help and can get the care they need when they need it.
We will support people to Age Well and can get advice and support for their health at home or nearby through diagnostic pathways for dementia

The HNY Mental Health, Learning Disabilities and Autism collaborative is comprised of health and care partners, including (VCSE and third sector) responsible for the commissioning and delivery of MH and LDA services across our ICB footprint. The collaborative has been in existence for 5 years, initially as a partnership aiming to improves services and then developing into more formal arrangements with a nominated lead provider (Humber Teaching NHS Foundation Trust). We have worked closely with local places and providers throughout the existence of the collaborative and have developed strong working relationships that promote transparency despite the challenging wider financial and service delivery environment.

The collaborative works with partners to collectively:

- Lead on system wide transformation programmes
- Improve quality and safety
- Monitor performance
- Enhance partnership working including establishing robust links with colleagues across the local authority, Voluntary, Community and Social Enterprise Sector, Primary and Secondary Care.
- Share best practice
- Deliver value for money by achieving economies of scale
- Jointly bid for ICB level funding to enhance the delivery of ICB objectives

Through 2023/24 will build on our existing track record to expand the level and visibility of co-production and engagement across all elements of our programme and work with system partners to join up engagement processes that may currently be happening in other parts of the system.

Priorities	What we will deliver in 2023/24 TBC
Community Mental Health Transformation	Develop a 3-year plan for our inpatient services across Mental Health, Learning Disabilities and Autism. This will focus on quality, we will also review the resource available to the system and configure services to deliver the best possible outcomes for patients.
	Develop working arrangements with our transforming care partnerships to deliver key priorities across learning disabilities and autism such as, roll out of the Oliver McGowan training, the national inpatient review and delivery of annual LD health checks.
	In 2022/23 we made significant progress in delivering annual health checks for people with serious mental illness (SMI), we will bolster this in 2023/24 and ensure the improvement is sustained for the coming years.
	Building on the success of the early implementer site for Community Mental Health Transformation across Hull and the East Riding of Yorkshire, we will continue to increase access to mental health support in the community including early intervention in psychosis (EIP) and individual placement support (IPS – employment support).
Children and Young People's Mental Health	We will build on the work being done by our Trauma Informed Care Programme to provide early intervention and prevention support to vulnerable children and young people, with a particular focus on those at risk of entering the youth justice system.
Urgent and Emergency Care Mental Health	For people in MH crisis, we will expand the use of MH response vehicles following successful implementation on our patch via the Yorkshire Ambulance Service (YAS).
Perinatal mental health	Working with the maternity programme, support perinatal mental health enabling improved access and increased offer of psychological interventions
Dementia care	We will focus on levelling up delivery against the dementia diagnosis targets across the HNY ICB patch, so that resource is directed to places where the biggest improvements are needed.

1.4 Collaboration of Acute Providers (CAP)

Humber and North Yorkshire Collaboration of Acute Providers

Strategic aim:
we will ensure people to get the care they need, when they need it, and not get passed back and forth or forgotten about

The Collaborative is focussed on 'at-scale' programmes covering more than one acute trust. The trusts that make up the collaborative are:

- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

The main purpose of the Collaborative is to use our collective expertise and resources to ensure that our people have timely access to the same standard of acute care and are supported to achieve their best health.

Our Vision and aims are to

Ensure quality and safety: to collectively deliver the highest quality hospital services across our four Trusts, focussed on the patient and reducing unwarranted variation, so all patients across Humber and North Yorkshire can access the same high quality levels of care, wherever they live.

Transformation and Innovation: To transform services to ensure the safest, most effective and most efficient care within the resources available

Collaboration and Partnership: to be excellent partners in our health and care systems and to work together where collaboration will bring benefit to patients, staff or the best use of resources.

Social Responsibility: To play our full part in reducing Health Inequalities within Humber and North Yorkshire and to optimise our impact as Anchor Institutions

Priorities		What we will deliver in 2023/24
Improving outcomes for patients through our Clinical Programmes	Cancer Alliance	Support awareness and diagnosis – targeting the 20% most deprived areas Improve treatment pathways – including stocktake of non-surgical oncology Improve diagnostics for cancer focussing on liver surveillance and cytosponge delivery Increase uptake and expansion of the Lung Health Checks programme Deliver our Living with and Beyond cancer programme
	Elective care	Support 65 week delivery target through maximising capacity and utilising mutual aid Support waiting list reduction by reducing the number of follow ups without a procedure Optimise productivity through collectively utilising capacity
	Diagnostics	Plan, develop and implement the community diagnostic model with a target of 3% DNA for endoscopy and physiology Agree utilisation improvement targets across modalities
Addressing health inequalities		Improve data quality and reporting on health inequalities to support the development of a health inequalities plan across acute care Implement of prioritisation of people with learning disabilities on the waiting list
Digital to enable transformation		Electronic patient record programme to support digital modernisation Develop the peri-operative business case
Provider collaborative development programme		Recruitment and retention, leadership and capacity, physical and mental wellbeing, learning and continuous improvement, staff experience, quality , diversity and inclusion
Clinical service configuration and sustainability		Planning delivering and transforming services together the planned care strategy Work with clinical networks to share best practice and reduce unwarranted variation Work together to ensure clinical sustainability of fragile services

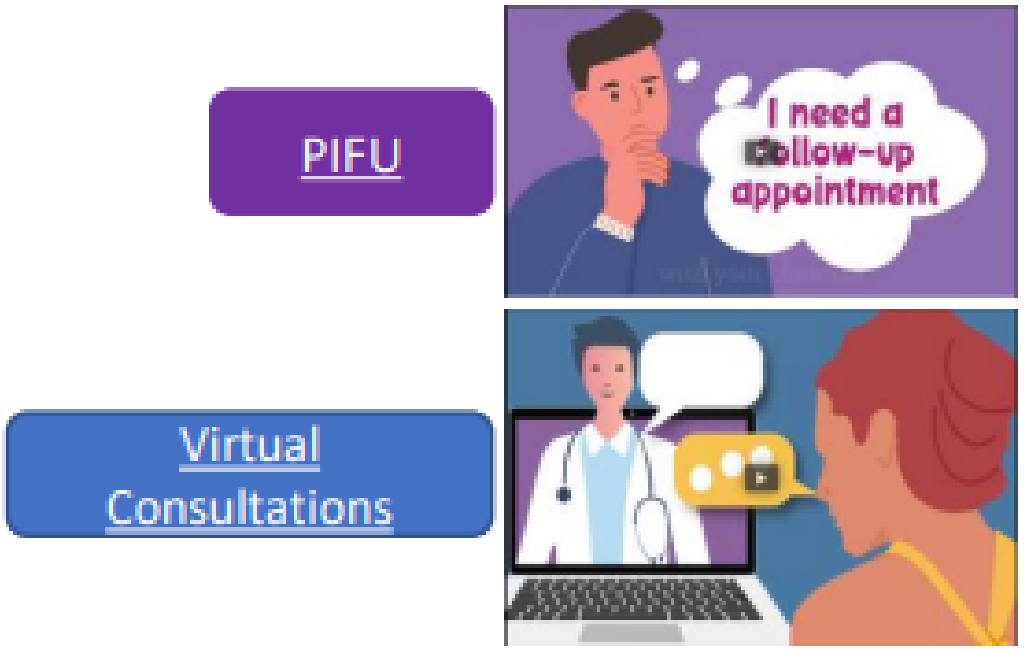
1.4 Outpatients transformation and personalised care

Humber and North Yorkshire Collaboration of Acute Providers

Case study:
Patient initiated follow ups and virtual consultations are a key focus for the delivery of outpatient appointments in alternative ways, We have recognised that a personalised care approach and shared decision making is a key enablers for wide spread adoption. However we realised that there was a lack of clear patient focussed information that we could utilise, so we set about devising our own.

The HNY personalised care group discussed options and felt that short animations would be the way forward. These could be used to support and empower patients and clinicians by explaining what these alternative ways of receiving their care are. They could be reflected on provider websites and other social media platforms as well as potentially used in a clinic setting.
We commissioned help to create two patient animations. Storyboards were drawn up and once finalised the animations were created.
Animations went live at the end of July 2022 and are available on You Tube Humber & North Yorkshire Health & Care Partnership – YouTube

We have received a lot of national an regional interest and received many compliments. The group will continue to widen adoption of the videos and continue to engage with patients.



1.4 Urgent & Emergency Care (UEC) ICS-wide Programme

Humber and North Yorkshire Collaboration of Acute Providers

Strategic aim:
To provide patients with **safe, effective and easily accessible UEC services**, with **limited variation** and as standardised as possible, whilst recognising the needs of our diverse population

Each Place within HNY have developed their own UEC Improvement plans based on local pressures, the national recovery plan and recognised good practice Identifying areas of commonality, and opportunities to deliver at scale, the UEC Programme has selected 3 key priorities from these plans to deliver across the System, providing support and best practice to delivery. These 3 priorities have the scope to have the biggest impact on UEC quality and performance, improving patient outcomes and experience of care

NHS 111

We know we have many entry points to the unplanned care system which can lead to confusion. Often the public access the service that they are familiar with which may not be the service that could be most appropriately meets their needs. NHS 111 can be / should be instrumental in sign pointing / helping the public navigate the right service to minimise any delay. We will ensure there is continuous improvement to the Director of Services and ensure NHS 111 has the right access points to ensure patients receive the right care in the right setting.

We will work with Yorkshire Ambulance Service, the regional provider of NHS 111 to maximise integration with urgent care services and directing patients to the right service or care advice across Humber and North Yorkshire

Priorities		What we will deliver in 2023/24
Improve and simplify access to the right Urgent and Emergency Care service for patients	Single Point of Access	Reduce unheralded walk-in patients to Emergency Departments Reduce the number of ambulance conveyances, both to Emergency Departments and other hospital settings Increase the number of alternative care pathways available to patients which avoid Emergency Department and hospital
	Front Door Streaming	Support improved CAT 2 response times by reducing conveyances to hospital Improve ambulance handover times within Emergency Departments Reduce overcrowding in Emergency Departments Support the reduction in >12 hour waits in department
	Alternative Care Pathways	
Urgent Treatment Centres	Co-located UTCs	Undertake a full review of all Urgent Treatment Centres across HNY – collocated and standalone Improve type 3 performance reporting and subsequent overall 4-hour standard Support reduction in Emergency Department crowding and time in department
	National Standards	Ensure Urgent Treatment Centres compliant with National Standards, improving patient awareness, and understanding of the Urgent Treatment Centre offer, along with consistent access to care Increase direct conveyance to Urgent Treatment Centres, supporting reduction in ambulance handover times and CAT2 response
Same Day Emergency Care	Opening Hours	Ensure minimum opening hours of 12 hours a day, 7 days a week Align same day emergency care opening times to Emergency Department peak demand times
	Direct Access	Increase direct access to same day emergency care for 111, 999, crews on scenes and GPs, without the need for Emergency Department assessment first Implement referral based on exclusion criteria to maximise same day emergency care opportunities
	Surgical & paediatrics	Increase 0 day Lengths of Stay Reduce Emergency Department crowding and wait times – improving 4-hour standard
High Intensity Users		Coordinate an integrated high intensity user programme across the ICS Reduce number of patients classed as high intensity users Reduce reattendance rates

1.5 Population Health, Prevention and Health Inequalities

Humber and North Yorkshire Health and Care Partnership

Strategic Aim:
We will help people to Start Well, Live Well and Age Well by ensuring that people feel included and know what to do if they need help. We will deliver this through 6 workstreams

Core20PLUS5 Adults	Core20PLUS5 Children	Prevention and risk factors	Public Health Functions	Population Health Intelligence	ICP building blocks
Coordinate and oversee delivery of the System's approach to Core20Plus5	Link with system partners to reduce healthcare inequalities for children and young people	Oversee the ICB delivery of long term plan priorities of Alcohol Tobacco Obesity	Oversee the winter vaccination programme and support the transition of public health commissioning	Oversee the implementation of Population Health Management (PHM) tools	Support the ICP to carry out its function to improve population health and reduce inequalities

2022/23 has been a moment for the Committee to identify its shared priorities, establish ways of working that create connections across the system, and begin delivering ambitious programmes that maximise the opportunities of our Integrated Care System. Going forward into 2023/24, the Committee plans to accelerate these programmes.

What we will deliver in 2023/24

Embed Core20PLUS5 into the work of integrated neighbourhood teams, starting in our coastal areas Develop our approach to addressing multi-morbidity starting with our cardiovascular disease prevention and detection plan Continue of our approach to address asylum seeker health needs Scope out an inclusion health service that reaches all parts of the system	Trial the risk stratification tool to identify areas of action for children and young people with asthma Use a data driven approach to identify inequalities in access and experience of children and young people in mental health services	Develop HNY Centre of excellence in Tobacco Control In 2023/24 we will: Invest in lung health checks Embed tobacco control in nursing and midwifery Support investment at place including local authorities to target inequalities Develop strategies that focus on prevention for people with 1 long term condition from developing other conditions Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%.	Build on the success of our Joint Winter Vaccination Board to address health inequalities and make every contact count Roll out the spring COVID booster campaign and plan for an anticipated COVID autumn booster campaign	Provide the tools at local level to improve population health and reduce variation through continuing our 2 year programme to roll out PHM support across primary care networks and place leaders Stand up a robust measurement and evaluation framework with a focus on Core20PLUS5	Establish an Integration Needs Assessment Steering Group to make recommendations on where further integration should take place Develop a strategy to address health disparities in coastal and port communities where we have some of our most significant health inequalities Introduce health inequalities fellowship opportunities for health and care staff in HNY

5 publication

Population Health and Prevention: Tobacco control

Humber and North Yorkshire ICB recognises tobacco use as the single largest preventable cause of ill health, responsible for half of the difference in life expectancy between the least and most deprived. Our efforts to tackle this burden of ill health are twofold.

Firstly, through our successful Treating Tobacco Dependency Programme we are embedding smoking cessation into maternity, acute and mental health pathways in the region, as well as into Lung Health checks. So far, from September 2022 – May 2023 1126 patients have received an intervention, and of the 549 outcomes that are due, 245 (45%) have been quits. In 2023/24 we will continue to support Trusts with the rollout of the NHS long term plan and embed tobacco dependency treatment into Lung Health Checks in North Lincolnshire and North East Lincolnshire.

Secondly, financial resource has been secured for the establishment of a comprehensive tobacco control programme – the Centre for Excellence in Tobacco Control. The programme will deliver:

Co-ordination across the ICB	System investment	Place –based investment
• Well-funded regional communications and mass media campaigns • Illicit tobacco leadership • A strong HNY voice to lobby and advocate on behalf of effective national policy • Policy expertise/data intelligence e.g. vaping • Research and evaluation • Long-term leadership and quality improvement for NHS tobacco dependency treatment services	• Lung health checks • Sector-specific support e.g. primary care and community pharmacy • Systematic approach to work within social care and housing services • Embedding tobacco control in nursing, midwifery and undergraduate/postgraduate medical information	• Supporting local stop smoking services to provide NICE-standard services including e-cigarettes • Investment in financial incentives for pregnant smokers • Funded very brief advice (VBA) resources and training capacity • Funding for Local Authorities to target inequalities

The tobacco control leadership will be through experienced specialised programme lead and team, supporting tobacco alliances and leadership quality improvement of NHS stop smoking services, leading communications across HNY. The communications vision is to ensure strong coherent messages that prompts more quit attempts and connects smokers with effective support and/or quit aids.

What we will deliver in 2023/24

Continue roll out of embedded smoking cessation in Lung Health Checks and launch the programme in North Lincolnshire and North East Lincolnshire	Launch our media and communications campaign	Expand the current programme core team so that we can launch the full model for the start of 2024/25

Population Health and Prevention: Case studies

Cardiovascular disease (CVD) disproportionately impacts on our most deprived populations and is a driver of inequalities in mortality at ICB level. Opportunities to influence CVD risk range across the life-course, from pre-conception and antenatal factors through to end-of-life considerations. In Humber and North Yorkshire we will optimise the whole system working through the ICB in our approach to cardio-vascular prevention and detection

Preconception and antenatal approaches will require working across the Partnership and into the Local Maternity and Neonatal Service, and the Maternal Medicine Network to tackle intrauterine risk factors like maternal smoking.

There will also be partnership working with Local Authority teams in relation to childhood, adolescent, and adult risk factors like physical inactivity, unhealthy weight, and opportunities to better identify CVD risk using NHS Health Checks.

NHS providers across Secondary, and the breadth of Primary Care will continue to accelerate the identification and optimal management of significant, cross-cutting risk factors like high blood pressure and high lipids, in addition to identifying individuals who may have undiagnosed Familial Hypercholesterolaemia and treat them to effectively negate the increased risk of developing CVD that their genetics adds.

Primary, Secondary, and Community Care will also work together to ensure appropriate and equitable access to cardiac and stroke rehabilitation and ultimately person-centred advanced care planning.

All of this is being developed and delivered at Places and neighbourhoods, looking through an inequalities lens using the core20plus approach, utilising a population health management approach and underlying principles.

1.5 Personalised care

Humber and North Yorkshire Health and Care Partnership

The comprehensive model of personalised care helps to establish a whole-population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes

In Humber and North Yorkshire we have established our system approach to personalised care. Personalised Care is much more than patient experience, it is an holistic approach that is integral to our approach to population health and reducing health inequalities as it starts from a position of talking to the individual and finding out what matters to them, their immediate family circumstances and the support they get or could receive from their wider community – enabling us to Think Person, Think Family, Think Community.

We aim to embed and enable the principles of personalised care across our programmes. For example, the Population Health and Prevention programme have endorsed a principle of Personalised Care in the commissioning of Inclusion Health Services

Case Study

Creation of Rural East Riding and North Yorkshire community based 'micro support' businesses/social enterprises which will deliver local personalised care including: Home Care and Day Services, increasing access to appropriate, responsive and quality personal support, developing local business opportunities and reducing staff travel time and related carbon emissions

Partners

- Working in partnership With Carers Pus Yorkshire in North Yorkshire and Yorkshire in Business in East Riding who are hosting the Co-ordinator roles in each area

Current Project Status

- Marketing Material in place including logo, Facebook page and website under construction
- Introduction pack developed including Quality Standard, basic policies and procedures and guidelines

North Yorkshire Area (co-ordinator appointed January 2023)

- Regular steering group meetings (7 members) overseeing progress
- Monthly meeting for new and existing Micro Providers (12) in Hunmanby and Filey

East Riding Area (co-ordinator appointed May 2023)

- Establishing local contacts, existing businesses and drop in places
- 6 expressed interest in becoming Micro Providers
- Contacting potential steering group members

What we will deliver in 2023/24

Embedding a Personalised Care Ethos

- Training & Development

Connecting with Thriving Communities

- Community Based Micro Support
- Digital Health Hubs
- Social Prescribing & Supported Self Management
- Early Intervention at the Ironstone Community Hub
- Children & Young People Social Prescribing - SEND & PHBs / Care Leavers / York Extension
- Community Support Organisation (CSO) Capacity to support Frail individuals
- Proactive Social Prescribing in York
- Brain Health Café in York
- Scarborough Children and Young People's Social Prescribing – Social, Emotional and Mental Health (SEMH)

Enriching Personalised Care approaches across health and care

- Maternity
- Local Maternity and Neonatal Systems (LMNS) Gestational Diabetes Pilot
- Hospital Discharge (Palliative & End of Life Personalised Care & Support Planning)
- Waiting Well - HUTH – Social Prescribing / Obesity
- Palliative Care – Care Planning
- VCS – PHB Knowledge and Understanding
- Personalised Joint Care and Support Planning Toolset for Learning Disability - integrating health and care

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1.6 Addressing the particular needs of children and young people

Humber and North Yorkshire Health and Care Partnership

Strategic Aim: The vison for all our Children & Young People's is to start well, enabling them to live and age well and if their life is shortened, to end their life well.

The children & young people's alliance meets every 2 months and membership comprises of multiple stakeholders across the ICS. The alliance oversees the delivery of the service innovation and improvement described in the Long term plan and the Children and Young People national transformation programme with a specific focus on integration and long- term conditions such as asthma, diabetes and epilepsy. Population health data and analysis combines feedback with each of our 6 places across our footprint to inform the strategies required. This includes addressing health inequalities and inequalities, an example of which is the diabetes poverty proofing projects underway in two of the most deprived areas in HNY, the learning from which will be utilised system wide.

Our child voice strategy – the ICB side children and young peoples engagement and co-production strategy will support work to develop and deliver a consistent and effective voice and influence for children and young people across the ICB and ensure those involved are representative of our diverse communities. This will be in place by autumn of 2023

CYP Core20Plus5

HNY is in the process of including an Lower Super Output Area approach into the Indices of Multiple Deprivation data to ensure pockets of deprivation in more affluent Local Authorities s are also included in projects. We will also look at wider data associated with risk linked to the Public Health Fingertips data, as well as other sources e.g., Joint Strategic Needs Assessments.

Plus: Vulnerable CYP are being identified as part of all workstreams, with particular focus on those with increased risk including those with protected characteristics. These include ethnic minority communities, inclusion health groups, people with a learning disability and autistic people, coastal communities with pockets of deprivation hidden amongst relative affluence and protected characteristic groups. Specific consideration should be given to the inclusion of young carers, looked after children/care leavers, those in contact with the justice system and LGBT people. Learning disability and Autism, SEND and children with complex needs and/or disabilities and impact on 'was not brought' rates.

Priorities	What we will deliver in 2023/24
Diabetes	Improve access to digital technology to manage diabetes
	Roll out to all places the diabetes poverty proofing project
Epilepsy	Benchmark services against core standards for children with epilepsy to identify priority areas for improvement
Asthma	Deliver and evaluate our pilot programme with specialised nurse practitioners for children and young people with asthma
	Embed a pathway between primary and secondary care to deliver national asthma standards
Other priorities	Increase access to dental services and improve oral health
	Develop an ICS strategy for palliative and end of life care
	Develop our programme for early support and intervention
	Use data tracking and local feedback to identify areas of concern and risks for urgent and emergency care attendances
	Develop a joint strategy including personalisation planning
Mental health, learning disability and/or autism – delivered with the sector collaborative	Improve access to mental health support for children and young people
	Support perinatal mental health enabling improved access and increased offer of psychological interventions
	Reduce reliance on inpatient care so that by March 2024 no more than 12 – 15 under 18s with a learning disability and/or autism per million are cared for in an inpatient setting
	With the Mental Health, Learning Disability and Autism collaborative ensure that 75% of people aged over 14 on GP learning disability registers receive an annual health check and action plan

1.6 Addressing particular needs in perinatal and neonatal care

Humber and North Yorkshire Health and Care Partnership

The strategic aim is to ensure that it is easy for parents to get the care and support they need for their children and has the care and support they need.

The Local Maternity and Neonatal System (LMNS), co-produced with service users is: '***for maternity and neonatal services in Humber and North Yorkshire to be kind as well as safe for all, by supporting and enabling our teams to consistently provide personalised, supportive and informed care, with empathy, understanding and compassion'.***

The LMNS works across maternity and neonatal providers to support the various workstreams going on at place and combine those required regionally and nationally to reduce duplication and improve consistency. From the 3-year plan:

- Listening to women and families with compassion which promotes safer care
- Supporting our workforce to develop their skills and capacity to provide high-quality care
- Developing and sustaining a culture of safety to benefit everyone
- Meeting and improving standards and structures that underpin our national ambition

Locally we also prioritise prevention and population health; reducing inequalities across our communities and ensuring underrepresented groups have a voice.

Core20Plus5 Adult
Inclusive of Maternity Continuity of Carer; evidence based to describe better outcomes particularly in perinatal mental health and safe birthing.
Currently targets are paused nationally; we have teams in North East Lincolnshire and plans to reinstate teams in other areas. Focus on equity of provision means teams planned for more deprived areas and in groups such as younger parents, LGBTQ+ families, those with disability etc.
MVP: the Maternity Voices Partnership local groups are looking to expand in 23/24 to reflect their increased workload; more capacity and resources are required across HNY and particularly in areas of pressure including some parts of our cities and coastal communities. We will also be reviewing the scope of these groups around covering Neonatal family engagement and ensuring accessibility to best care.

Priorities	What we will deliver in 2023/24
Safety & Quality	2nd round of Ockenden/East Kent Peer Review visits; evidence safe, high quality care
	Support for CNST adherence, including working alongside providers to achieve Saving Babies Lives v3 – new update includes support for gestational diabetes
	Implementation of 3 year plan priorities including new Pelvic Health Services
	Continue improvement against BAPM7 neonatal standards/pre-term birth support
Choice & Personalisation	Ensure Continuity of Carer teams are supported and developed in deprived areas
	Continue provision of 'Ask A Midwife' service, LMNS birth plans and supplementary sheets, unit videos, translation & interpretation support, surrogacy guidance etc.
	Support LMNS Equity & Equality and Cultural Diversity lead work to ensure equity
Enablers (Prevention & Workforce)	Continue research work with University of Hull into alcohol support in pregnancy
	Work with the Tobacco Control team to implement a universal incentive scheme
	Commence the pilot of heathy weight, diet and exercise support before LMNS rollout
	Continue to support recruitment and retention leads in Trusts, maintain links with HEI training, progress international recruitment to maintain required staffing levels
	Develop strategy with the HNY Midwifery Workforce Supply Planner and HEE
	Implement the Maternity Support Worker scheme to ensure consistent competencies
	Support perinatal and maternal mental health schemes enabling improved access
Digital	Complete implementation of BadgerNet single Maternity IT System across HNY
	Ensure Yorkshire & Humber Care Record embedded for contextual launch
	Review SI/Quality/Performance reporting for true data comparison and learning
	Scope E-Red Book provision with partners

1.6 Addressing the needs of victims of abuse

Humber and North Yorkshire Health and Care Partnership

The ICB will undertake duties in relation to serious violence as a specified authority and work with other specified authorities to prevent and reduce serious violence including sexual violence and domestic abuse

- Completion of a serious violence needs assessment.
- Developing a partnership response strategy setting out how serious violence will be addressed.
- Producing a local delivery plan to tackle serious violence with a focus on high impact actions.
- Coordinating a project to develop a comprehensive baseline assessment of current data sharing between authorities and identify how improvements in access to data would support reduction in serious violence.
- Development of a mutually agreed definition of serious violence.
- Delivery of trauma informed training to key members of the workforce.

We will work with statutory safeguarding partners to:

- Respond to the findings of the national Audit of Domestic Abuse Support in Healthcare Settings
- Map models of intervention for domestic abuse across the ICB to adopt and spread best practice.
- Strengthen existing ICB wide governance and strategic processes in relation to domestic abuse.
- Working with statutory safeguarding partners at Place further develop pathways for non-fatal strangulation, honour and faith-based abuse, FGM and forced marriage.
- Respond to children as victims of domestic abuse through early intervention programmes of work with families who are experiencing low levels of domestic abuse to prevent escalation such a PITSTOP.
- Ensure meaningful data collection from within the NHS contributes to developing a better system wide understanding of domestic abuse.

The ICB will support our staff to discharge their duty to safeguard children and vulnerable adults by:

- Developing an ICB wide learning culture through which recommendations from national and local statutory reviews including Domestic Homicide Reviews are utilised to improve practice.
- Ensuring safeguarding training is of a high quality, and enables staff to recognise and respond to signs of abuse, including domestic abuse and sexual violence, in a timely fashion.
- Supporting staff who are victims of domestic abuse, and ensure managers and HR teams are equipped with the skills and knowledge to offer the right support when staff disclose abuse.

5 publication

We will publish our Serious Violence Strategy for each local government area by 31 January 2024

Case Study

In North East Lincolnshire we have maintained an active partnership with the Local Authority and a range of other stakeholders in respect of domestic abuse and sexual violence for the last decade and have contributed to the cost of services addressing the needs of victims and perpetrators over the years.

We have made a recurrent financial contribution to local services for the last three financial years and this will continue. We co-produced the North East Lincolnshire Domestic Abuse Strategy with the Local Authority and all local stakeholders during 2020. The strategy considers female genital mutilation, so called honour based violence and forced marriage. We are currently working with the Local Authority to design and implement a commissioning process for local services mandated under the Domestic Abuse Act 2021 which will focus on:

- Refuge accommodation
- Safe dispersed Accommodation
- Community Outreach support
- Sanctuary Scheme
- MARAC Co-ordination
- Specialist support for children and young people affected by domestic abuse

New commissioned services will be operational in August 2023 and will deliver a range of outcomes associated with the Domestic Abuse Act. These outcomes focus on the recovery journey for victims/survivors and optimising their resilience and ability to live independently free from violence and abuse. The overall long term outcome we intend to achieve with this work is the reduction in prevalence of domestic abuse and the reduction of children in care as a result of domestic abuse and sexual violence.

The LMNS has worked with providers across HNY to implement the ICON strategy ‘Babies cry, you can cope’ to reduce the incidence of abusive head trauma. Midwives, Neonatal Nurses, Health Visitors and other partners redirect families to supportive information about when baby crying peaks, what the differences are if babies are born early and how to manage the feelings this brings to parents when they are already stressed and sleep deprived. Specific care is taken for dads and partners who are often excluded from processes during labour, birth and beyond and hence miss out on key support.

1.7 System developments: Deliver today to transform tomorrow

Humber and North Yorkshire Health and Care Partnership

Listening to patients' experiences of their care – and to the views of the NHS staff who provide it – plays a crucial part in delivering services that are safe, effective and continuously improving.
Insight does not come from a single source: from a single survey, patient story, focus group or public meeting. It's about using a combination of sources to understand a number of different issues and then to ask: "How do we use what we've found out – positive and negative – to improve the quality of every patient's experience?"
Insight can tell us things that other performance data cannot, particularly about how people feel about hugely important issues such as dignity, compassion and respect.

In 2023/24 we will undertake a programme of patient and staff insights gathering activities to inform a long term transformative approach to how people think about their health and access to health services. We will focus on three priority areas of our strategy:

- Making sure that people know what to do to stay healthy
- That people get the care that they need and don't get passed back and forth or get forgotten
- That people only go into hospital – as an outpatient or inpatient – when it is absolutely necessary

This will inform our longer term approach by understanding our populations, experiences, outcomes and needs. This means that we will be able to embed radical change, to better manage rising demand for elective care and improve patients experience and access to care when they need it.

1.7 System developments: developing our operating model

Humber and North Yorkshire Health and Care Partnership

System wide priorities – doing things once

Integration

Work across the ICB system and at place to develop and deliver an integrated model of care to ensure that:

- People know what to do to stay healthy
- People get the care they need and don't get passed back and forth or get forgotten
- People only go into hospital when it is necessary and only for as long as medically needed
- Delivery plans for each place should support the work of the sector collaboratives to reduce follow ups, improve patient flow and address discharge challenges focusing on no criteria to reside/lengths of stay

Quality Efficiency and Productivity Programme

HNY Quality Efficiency and Productivity Programme has identified 5 priority areas to be delivered across the system via the Place and Collaborative teams; these are:

1. Reducing unwarranted variation
2. Follow Up reduction (including Patient Initiated FU)
3. Prescribing
4. No Criteria to reside (reducing average length of stay universally)
5. Continuing Health Care and Section 117

The programme will realise the scope, scale of system opportunity, impact on quality, efficiency and productivity by:

Aligning costs to strategy: Differentiate the strategically-critical 'good costs' i.e. waiting list reduction / targeted health inequalities funds from the non-essential 'bad costs' i.e. pay growth/contracting costs/locum costs

Harnessing the value of the ICS operating model: do once where makes sense (not just replicating the commissioner provider split at 6 places)/act as a system facilitator/deliver service transformation through a) place (with LA's Primary Care & Social Care & Community) b) sector collaboratives

Aiming high: use technology, innovation and new ways of working to radically reduce and streamline the cost base/increase capacity i.e. Out-patient follow up/addressing clinical variation/one workforce

Setting direction and showing leadership: Deliver cost reduction as part of a strategic, business transformation programme = HNY Quality Efficiency Productivity Programme

Creating a culture of continuous improvement for our staff: '100 ways ' – no stone unturned, improving efficiency and reducing costs, encourage calculated risk, no blame culture

System developments: acute and planned care

Humber Acute Services Review

The Humber Acute Services programme is about finding the best way to organise our hospital services so we can deliver better care in the future. This can address the challenges we face of:

- Shortages and skills gaps in our workforce
- Services not meeting clinical and waiting time standards
- Buildings, equipment and digital infrastructure not being up to scratch

In 2022 we involved clinical teams, patients and the public the design and evaluate different solutions.

In 2023/24 we will develop a set of proposals to consult with the public on. We expect that this will include more than one option. The decision on which model of care to implement will only be taken after consultation for implementation from 2024 – 2030

For more information visit our website – www.humberandnorthyorkshire.org.uk/humberacutereview/

Planned Care 5 year strategy approach

Through the Collaborative of Acute Providers (CAP) partners will develop a planned care strategy during 2023/24. The strategy will aim to:

- Improve access and patient health outcomes
- Refocus planned care services with a focus on productive, efficient models
- Build an ICS model that is able to meet the demand of the population
- Address health inequalities and reduce variation
- Improve system resilience
- Improve system working
- Build on digitally enabled care solutions
- Based on place wherever possible
- Ensure compliance with national policy and guidance

Our future models will consider how to maximise existing dedicated elective facilities and develop high volume, low complexity (day case) hubs and specialist inpatient elective hub(s). This will help us to deliver what patients and the public have told us is most important to them – being seen and treated as quickly as possible.

In 2023/24 we will undertake detailed modelling and engagement to build the case for change

We expect the programme will be over five years starting in 2023/24

Community Diagnostic Centres

The National Policy for Community Diagnostic Centres will enable investment to increase diagnostic capacity and reduce elective – especially cancer – waiting list times, reduce health inequalities and deliver a better more personalised experience for patients. This will be delivered through a 'hub and spoke' model.
In Humber and North Yorkshire demand is expected to increase significantly over the next 10 years and so we need to develop our diagnostic service at scale and over an extended period and we will need to maximise the use of national funding.

In 2023/24 we will:

- Submit business cases for our hub and spoke model for the ICB and
- Implement the Scunthorpe Community Diagnostic Hub, approved by NHS E in March 2023 to be operational on 1st April 2024

1.7 System developments: Pharmacy, Optometry and Dental services

Humber and North Yorkshire Health and Care Partnership

In April 2023 commissioning of Pharmacy, Optometry and Dental services were delegated from NHS England to ICBs. Delegation provides an opportunity to support increased autonomy at a local system level, backed up by appropriate regional and national support, which can improve access to services and improve health outcomes.

Dental health inequalities

In Humber and North Yorkshire there are approximately 170 General Dental Service providers for our population.

Oral health inequalities exist:

- Those in the most deprived areas experience poorer oral health across all age groups
- In vulnerable children known to the social care system, individuals with severe physical and/or learning disabilities, those with poor mental health, older adults, homeless, asylum seekers, refugees and migrants

Data and evidence surrounding oral health inequalities is variable and complex, but we know that they also exist:

- In relation to oral cancer as well as in vulnerable groups with long-standing medical conditions, substance misuse, prisoners/prison leavers and Gypsy, Roma and Traveller communities

What we will deliver in 2023/24
Understanding current services, effectiveness and risks
Improving access
Prevention with a focus on 2-11 year olds, residents of care homes and inclusion health services
Using data and clinical input to prioritise actions
Focus on workforce - both recruitment and retention
We will continue to work with our Community Pharmacy and Optometrists to maximise the skills and capacity to support our patients in accessing care close to home

1.7 System developments: Public Health commissioning– screening and immunisation

Humber and North Yorkshire Health and Care Partnership

Commissioning will be central to the NHS meeting the challenges it faces today and in the future, and in ensuring that the NHS delivers the triple aim of improved population health, quality of care and cost-control. In order to deliver the triple aim, commissioning will need to continue to develop as it has since its inception.
There will be a need for commissioners to work more closely together, aligning their objectives with providers and taking a more strategic, place-based approach to commissioning. Integrated Care Systems will all play key roles working with NHS England commissioners to secure the benefit of working together across a system to deliver for patients. Specifically, improving quality of care, reducing inequalities across communities and delivering best value.

For NHS public health functions (Screening (cancer and non-cancer), Immunisations including COVID-19 and flu, and Child Health Information Systems) commissioning responsibility will remain with NHS England. We still have detailed work to do due to the complexity of the services commissioned by NHS E for screening and immunisation pathways. Over the course of 2023/24 national and regional NHS England teams will support progress towards joint working.
In 2023/24 in Humber and North Yorkshire NHS England regional commissioners and the ICB will work together to

What we will deliver in 2023/24

- Align the Yorkshire and Humber screening and immunisation health inequalities action plan with ICB priorities
- Respond to anticipated national strategies for screening and immunisation for the ICB
- Work in partnership to deliver the programme for bowel cancer screening

1.7 System developments: specialised commissioning

Humber and North Yorkshire Health and Care Partnership

In Yorkshire and Humber we have a long history of working collaboratively with NHS E commissioners to improve clinical pathways.

In 2022 NHS England set out its ambition of giving responsibility for managing local population health needs, tackling inequalities and addressing fragmented pathways of care through enabling delegation to ICBs of specialised commissioning. The aim is that by giving ICBs responsibility for a broader range of functions, we will be able to design services and pathways of care that better meet local priorities. We will have greater flexibility to integrate services across care pathways, ensuring continuity for patients and improved health outcomes for the population.

In April 2023 A Joint Committee was formed between the three Yorkshire and Humber ICBs and NHS England. The role of the committee is to oversee the delegation of the approximately 60 specialised services to ICBs from NHS England by April 2024.

What we will deliver in 2023/24

In preparation for the full delegation of services the NHS E and Yorkshire and Humber ICBs will jointly work to identify priority clinical pathways to test out new ways of working in partnership across the system so that we can secure the benefit of working together for patients. The aim is to improve the quality of care, reduce inequalities across communities and deliver best value.

Healthy childhood	Cardiovascular	Cardiovascular	Cancer	Other
Neonatal Care – To work with the Yorkshire and Humber Neonatal Operational Delivery Network and Local Maternity and Neonatal Networks (LMNS) to deliver the 5-year plans for the implementation of the national Neonatal Critical Care Review to reduce neonatal mortality.	**Mechanical Thrombectomy for Stroke -** To improve access to Mechanical Thrombectomy across the region by optimising the use of current in-hours services.	**Renal Dialysis -** Working through the Yorkshire and Humber Renal Network actively reduce the need for renal dialysis by actively focussing on interventional and alternative treatments.	**Radiotherapy and Chemotherapy -** To work with providers of Paediatric Radiotherapy, Chemotherapy, Oncology Services, and Cancer Alliances to develop new and sustainable service models	**Adult Critical Care-** Develop an Adult Critical Care Transfer Service that will support best use of critical care capacity across the Yorkshire and the Humber.

Measurable Outcomes:

- Number of patients accessing thrombectomy service
- Stillbirth and neonatal mortality rate
- Cancer 5 year survival rates
- Reduced rate of growth in new referrals to renal dialysis units

Mitigating climate change

Acting on the climate crisis is a clear, yet still neglected, priority for public health. There is now a large body of work making a clear link between climate change and health. The impacts of climate change on health can be direct—relating primarily to changes in the frequency of extreme weather (such as heatwaves, drought, fires, floods, or storms)—and indirect, through changes on ecosystems (for example, water-borne diseases, and air pollution) and through effects mediated by human systems (such as occupational impacts, undernutrition, mental health, but also migration and conflict).

In 2023/24 we will work across our system partners to embed our sustainability impact assessment across new policy areas and developments

1.7 System developments: Integrated system social care strategic leadership forum

Humber and North Yorkshire Health and Care Partnership

The strategic forum has been established to provide a platform where leaders across health and social care and the wider Integrated Care System can come together to focus on common priorities, sharing insight and intelligence and collectively identify opportunities for improvement and wider system collaboration.
The particular focus is to strengthen the opportunity for senior ICB leaders and Directors of Adult Social Care to come together to discuss system wider issues and challenges with a view to supporting a collaborative approach and collective solutions. The aim is to supplement and strengthen both discussions and actions across the wider ICS geographical footprint.
In 2023/24 the forum will develop an agreed action plan aligned to Health and Care Integration.

The focus will be on the following core areas:

Sufficiency and sustainability of prevention strategies

- Wider focus on prevention and waiting well via a whole system approach
- Winter capacity issues - short term fixes not sustainable and opportunities missed
- Short term/non recurrent funding versus long term funding needed for the sector
- Equitable distribution of funds/grants
- Understand and agree how mutual assurance frameworks need to align

Workforce

- Retaining the social care work force - cost of living crisis
- Profile of the sector - changing the narrative
- Parity for the social care work force
- Link with wider workforce development and new roles e.g. AHP/ARSS - others

Sustainability of the care sector and engagement

- Fair Cost of Care uplifts
- Care fee uplifts
- Significant inflationary pressures on the sector- energy and fuel
- Care provider failure and withdrawals from the market increasing

SECTION 2: CREATING THE CONDITIONS FOR DELIVERY

2.1 What this section covers

Humber and North Yorkshire Health and Care Partnership

Our ICS strategy sets out how we will create the conditions to enable and empower our people, communities and organisations to achieve change.

This section of the Joint Forward Plan sets out how the ICB will create these conditions in how we work within our organisation and with our partners to embed this way of working in everything we do, and to meet our statutory requirements and obligations.

In this section we will set out:

- How we will work to improve the quality of services provided
- How we will make plans to improve the efficiency and sustainability of use of resources
- How we will create an enabling structure to provide transparency and to meet our statutory obligations
- How the ICB will support wider social and economic development as a system partner

2.2 Nursing and Quality – delivering our duty to improve quality

The ICB Quality Committee is established in line with national guidance including key senior leadership members across the system. The Quality Committee is an executive committee of the ICB board. Each place have established quality place groups and operate in accordance with the ICB Quality Assurance Framework. In 2023/24 we will

- continue to implement our system approach to quality management in accordance with National Quality Board Guidance including managing performance as set out in the guidance.

Quality Risk Response and Escalation in ICSs; Guidance on System Quality Groups

- Establish the ICB virtual safeguarding hub, to co-ordinate functions to support delivery, provide mutual aid and deliver programmes of work at scale to articulate best clinical practice in safeguarding.

Our ambitions include

- delivering safe, personal, kind, professional and high-quality maternity care. improving the lives of **children**, young people and adults with **learning disabilities** and or autism who display behaviours that challenge.
- supporting people to live well by greater working together across health and care to address determinants of health and ill health
- ensuring people age well by improving NHS care in Care Homes focussing on infection control, hydration, tissue viability and medication management
- ensuring people end their lives well by ensuring a consistent and comprehensive implementation of the national framework for Ambitions for Palliative and End of Live Care.

Case study

The hydration project in care home settings aims to improve the hydration of residents to reduce instances of UTI's and dehydration. Achievement of the objective will see a reduction in the number of residents with a UTI requiring antibiotics. This is a collaborative project across the ICS. Through improving recognition and response to hydration needs of residents in care homes, we aim to:

Reduce avoidable harm caused through poor hydration.

Enhance clinical outcomes

Improve experience for residents in care homes.

Improve staff experience/ safety culture.

Improve antimicrobial stewardship.

Priorities for 2023/24

Creating constant quality and improvement opportunities – championing a culture of curiosity, ensuring quality is everyone's responsibility and striving to be better
Continue to develop and embed the strategic quality governance arrangements for example Place Quality Group and the Quality Committee (Board Assurance Framework)

Embed the operational quality systems
To include the range of statutory and regulatory responsibilities

Safeguarding
Provide assurance of system arrangements

Further develop the safety insight involvement and improvement
In particular the patient safety incident response framework and learning from the patient safety events (LPSE)

Service user experience
To develop a focus on service user experience, including better use of insight and feedback

Trust
Building trust across the system to support mutual accountability and mutual responsibility

2.2 Quality: reducing inequalities

Humber and North Yorkshire Health and Care Partnership

The Population Health and Prevention Executive Committee oversees the ICB's ambition to improve outcomes in population health and healthcare. It is a partnership between the six local authorities, the ICB, and providers. The plans reflect with those partners and, in instances with those who have lived experience of needs the Committee is planning to address. The Committee's membership reflects the operating model of the ICB. Its executive lead is Amanda Bloor (Deputy Chief Executive and Chief Operating Officer of the ICB) and it is co-chaired by Louise Wallace (Director of Public Health for North Yorkshire) and Julia Weldon (Director of Public Health for Hull City). The committee will support the ICP to carry out its function to improve population health and reduce inequalities in healthy life expectancy. It will do this by:

- Providing population health and prevention leadership and oversight to support the vision of helping the population to "start well, live well, age well and end life well."
- Influencing decision making, at scale, and supporting place-based delivery to improve population health, tackle health inequalities and prevention.
- Ensuring the approach to population health management is front and centre of the work of the HNY Health and Care Partnership and is embedded within programmes and workstreams.
- Ensuring the effective delivery of key programmes to reduce and address health inequalities across the system.

2022/23 has been a moment for the Committee to identify its shared priorities, establish ways of working that create connections across the system, and begin delivering ambitious programmes that maximise the opportunities of our Integrated Care System. We have seen Places, Providers and Collaboratives enhance their individual and collective responsibilities towards health inequalities via resources, governance and actions. Going forward into 2023/24, the Committee plans to accelerate these programmes and seek further alignment to the newly developed Integrated Care Strategy.

Priorities for 2023/24

Inclusion health:
Fully scope out inclusion health service that reaches all parts of the system

Education and training:
Introduce health inequalities opportunities to health and care staff and co-ordinate public health training opportunities in the ICB for Junior Doctors and Registrars so that we can upskill the next generation of the health and care workforce with expertise to deliver integrated care that maximises healthy life's

Measurement:
Stand up a robust measurement and evaluation framework against the committee's programmes, with a focus on Core20PLUS5

Major conditions:
Develop strategies that focus on preventing people with one long term condition from develop their 2nd, 3rd and 4th condition.

Finance.
Establish an expert finance sub-group that will make recommendations to the ICB on the allocation of resources that address population health, prevention and health inequalities

Health Inequalities Funding DESCRIBE PROCESS FOR 23/24

Using the NHS England ICB Place Based Allocation Tool, each of the six individual places were grouped at GP practice level to determine their Relative Need Indexes and associated population sizes. This was done at GP level because some of the Places are not coterminous with their Local Authorities. Combining these to ICB level gave a relative percentage of the ICB's Weighted Health Inequalities Population attributable to each Place which was then used as the basis for the allocation.

HNY have developed a number of schemes in 22/23 in collaboration with Local Authority partners which are approved and via the Committee and have a quantifiable allocation and measurable impact:

- Expanded Tobacco Control and Dependency Treatment Programme
- Perinatal Weight Management project trial
- Programme management support to coordinate the CVD prevention pathway
- Addressing Premature Births through a Maternal Wellbeing Programme
- Care and support for victims/survivors of Domestic Abuse
- Inclusion Health - Weight Management
- GP Drop-in Service in Rainbow Children's Centre
- Family & School Links project: support with anxiety related school absence
- GP outreach Urgent Care/Dental Care Service for Sex workers
- Cultural Community café and recreation facilities for asylum seekers – adults and children

2.3 Efficiency and sustainability: financial duties

Humber and North Yorkshire Health and Care Partnership

The system faces a significant underlying financial pressure as we move into 2023/24 and beyond.

Humber and North Yorkshire ICB has a brought forward cumulative deficit of £96m and under the current guidelines subject to delivering financial balance in 2022/23 and 2023/24 this deficit will be written off.

The financial regime that has been in place during the COVID pandemic has increased the cost base of the organisations within the Humber and North Yorkshire area.

Whilst there is a clear ambition and move towards establishing system financial control there remain organisation statutory financial duties that do not always enable a "system first" approach.

Provision continues to be significantly fragmented which can make delivering efficient and effective end to end pathways challenging.

Fair, equitable and realistic financial targets should be established.

The architecture that has been created through the Health and Social Care Act 2022 is described as permissive and therefore there is an opportunity to design the rules to fit the requirements of Humber and North Yorkshire for 2023/24 and beyond.

- Enable the ICS including its constituent organisations to deliver operational and strategic goals
- Enable the system to deliver on the triple aim of Improving population health, Improving the quality of services and Improving value for the system
- Ensures that each organisation is not financially disadvantaged at the expense of another (Equity)
- Delivers financial balance at organisation and system level
- Incorporates learning from last years process
- Aim to live within our means - recognise the constraints in which we operate and don't have unrealistic expectations
- We have collective ownership of the challenge and will work collaboratively to problem solve
- Seek to align plans with agreed assumptions as early as possible including revenue, capital activity and workforce
- Keep it simple as much as possible – avoid protracted bidding processes – be pragmatic
- Open book and transparent
- Open to constructive challenge
- Seek optimum solution for the ICS – recognising this may create issues at an organisation/place level – but have confidence this will be recognised as part of the planning process
- Seek to agree a Financial Risk Management strategy as early as possible
- Develop and adopt a sustainability impact assessment for any new investments or financial decisions
- We will develop efficiency and productivity plans at organisation, place and system
- Be prepared to test the efficacy and efficiency of existing investments and make disinvestment recommendations.

Our approach to financial planning

Short term

Quantify our gaps quickly
Explore rapidly in year opportunities
Keep it simple and realistic
Establish our process with place and collaboratives as our prime planning route
Fully exploit the digital agenda
Ensure system rigour
Develop a system lens to demand management

Beyond 1 year

Describe our three year position and stick to it
Identify our key areas of fragility
Align national and local planning parametres
Keep a strategic focus on capital planning

2.3 Efficiency and sustainability: financial duties

Humber and North Yorkshire Health and Care Partnership

Priorities	What we will deliver in 2023/24
Embed the ICB approach to driving value and eradicating waste	Align costs to strategy: Differentiate the strategically-critical 'good costs' i.e. waiting list reduction / targeted health inequalities funds from the non-essential 'bad costs' i.e. pay growth/contracting costs/locum costs Harness the value of the ICS operating model: do once where makes sense (not just replicating the commissioner provider split at 6 places)/act as a system facilitator/deliver service transformation through a) place (with LA's Primary Care & Social Care & Community) b) sector collaboratives Aim high: use technology, innovation and new ways of working to radically reduce and streamline the cost base/increase capacity i.e. Out-patient follow up/addressing clinical variation/one workforce and continued investment in renewable energy Set direction and show leadership: Deliver cost reduction as part of a strategic, business transformation programme = HNY Quality Efficiency Productivity Programme Create a culture of continuous improvement for our staff: '100 ways ' – no stone unturned, improving efficiency and reducing costs, encourage calculated risk, no blame culture
Develop our systematic approach to planning, ensuring system accountability and transparency	Establish system wide ICB planning meetings to hold ourselves to account and embed our core principles to planning and accountability.
Publish our Joint Capital Resource plan	In line with NHS E guidance we will develop and publish a narrative explanation on the full 12 months period from April 2022 to March 2023 making sure that we embed our principles of: • decisions taken closer to the communities they affect are likely to lead to better outcomes. • collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and • collaboration between providers (ambulance, hospital, and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

2.3 Efficiency and sustainability: Procurement and supply

Humber and North Yorkshire Health and Care Partnership

The ICB will generate system efficiencies through 'doing things once' to maximise efficiency and ensuring aggregation of spend, demonstrating best value.

Three acute trusts within the ICB have appointed a single Director of Procurement who has presented a business case for a centralised procurement function delivering services on behalf of all three trusts (note: Harrogate are aligned to West Yorkshire ICB for procurement) This business case was approved by all three Trust Board's in February 2023.

The business case included a single governance structure and standard set of SFI's relating to procurement and contracting which was accepted by each Board. The proposed governance structure aligns to the Public Contract Regulations 2015 as well as other horizontal policy requirements such as Greener NHS sustainable procurement programme and tackling modern slavery within government supply chains. As part of the business case specific resource within Procurement has been approved for governance & assurance and sustainability & social value.

A key facet of the business case is to move beyond cost-down and to incentivise procurement to deliver value across the organisation. A new savings policy has been developed which encourages procurement to think beyond, and count the benefit of, wider value to the system such as how procurement decisions can reduce a patients length of stay, improve theatre efficiency or reduce cost within the community.

A three-year Procurement Strategy has been developed and approved by the Trust Board's which seeks to:

- Support the aims and vision of the ICS and collaborative members;
- Create a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Support supplier rationalisation and cost savings;
- Ensure standardised robust product selection and range management practices are in place;
- Ensure that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensure innovative and robust Supplier Relationship Management (SRM);
- Develop P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enable effective partnering with senior stakeholders, internal customers and suppliers;
- Ensure all staff are given the opportunity to develop their potential.

Aims and objectives of the procurement transformation programme

- Embed robust procurement and contracting governance and decision making in accordance with the ICB's governance framework through supporting individuals and teams across the ICB to understand processes and know how to access support from the Procurement and Contracting team.
- Transform how the Procurement and Contracting team operates to improve efficiency and reduce duplication while maintaining strategic support for Places.
- Establish a roadmap for the rationalisation of ICB contracts to improve consistency and maximise the efficiency of contract management.
- Deliver an effective procurement plan for the ICB which balances procurement regulations, legislation and assessed risks.
- Develop an ICB Contract Management Framework of standardised approach and procedures.
- Complete the implementation of the single ICB e-Contract Register.

Priorities	What we will deliver in 2023/24
Standardise procurement data and systems	Develop a single contract database which ensures all contracts are visible in one place and informs the collaborative annual work plan
	Implement a single procurement catalogue to standardise pricing and maximise volume across the trusts
	Implement a single procure-to-pay system which will provide greater visibility of what is being procured, from whom and for how much. This will help identify opportunities for product standardisation balancing financial benefit, patient safety and supply chain resilience
	Ensure a single inventory management system linked to Scan-for-Safety allowing the collaborative to track products across the trusts and better manage stockholding

2.3 Efficiency and sustainability: duty as to climate change

Humber and North Yorkshire Health and Care Partnership

The Health and Care Act 2022, the legislation that bought about Integrated Care Boards (ICB) also enshrined in law a commitment by the NHS in England to consider climate change in all decisions. At Humber and North Yorkshire ICB, we not only recognise our legislative commitments to climate change but aspire to move faster and further becoming recognised as national leaders in responding to the climate emergency through increased mitigation, investment and at the same time ensuring a just and inclusive transition – ensuring on one is left behind.

Our HNY response to the challenges of climate change will be set out in the ICS Green Plan and overseen at the highest level of organisation with an ICB board level Senior Responsible Officer (SRO) for Sustainability. Providing system leadership, working with partners across our communities our work on sustainability will mirror the commitments of the wider Yorkshire and Humber Climate Change Commission in the effective delivery of

1. Net Zero – reducing greenhouse gas emissions
2. Climate Resilience (Adaptation) – resilient healthcare in the face of a changing climate
3. Nature & Biodiversity – supporting ecosystem recovery
4. Just and Inclusive Transition – transitioning to a net-zero carbon economy in a way that is fair and equitable for all

HNY will establish dedicated functions and identify required resources commensurate with the scale of the challenge of discharging our duty to climate change in line with local priorities and arrangements.

The ambitions articulated in the ICS Green Plan, a system-wide delivery plan to cut emissions, adapt to a changing climate, increase biodiversity and ensure a just transition.

A three-year strategy based on the aspirations set out in "Delivering a Net Zero National Health Service" this sees our response to climate change woven into all aspect of our ICS ways of working. In 2023/24 we will continue focus on Green Plans to reduce environmental impact focussing on our priority areas

Priorities	Our deliverables
Data and performance	• Establish metrics linked to the Greener NHS Dashboard to monitor key performance of the ICS commitments to climate change • Develop a carbon footprint dashboard to establish the carbon account of the ICB
Digital enablers	Digital initiatives can play a key role in supporting a net-zero economy by increasing efficiency, reducing waste, and optimising energy usage including: • Digital supply chain management - procurement of low energy equipment • Research and implementation of "power down" software • Energy-efficient data centres
Estates	There are a number of estate initiatives that will be built into our estates strategy for primary, secondary, tertiary and community care to support the transition to net-zero including: • Costed plans to decarbonise the estate • Increase building energy efficiency • On-site generation of renewable energy and heat • Optimising building usage
Travel and transport	• Collaboration with partners to support modal shift initiatives to public transport and active travel alternatives for staff and patients including walking and cycling • Support the transition to electric vehicles including through staff benefit schemes • Transition of owned and leased fleet to Ultra Low and Zero Emission Vehicles
Procurement and supply	From April 2023 all contracts above £5m per annum the NHS will require supplies to publish a Carbon Reduction Plan. From April 2024 the NHS will extend this requirement to cover all procurement, More information can be found at the Net Zero Supplier Roadmap https://www.england.nhs.uk/greenernhs/get-involved/suppliers/)
Medicines	• Decommission desflurane completely given the availability of clinically safe, more environmentally friendly, and cost-effective alternatives • Reduce carbon footprint of inhaler prescribing • Reduce emissions from nitrous oxide and mixed nitrous oxide products in manifold cylinders

2.4 Creating an enabling infrastructure: promoting involvement

Humber and North Yorkshire Health and Care Partnership

By giving everyone an equal voice, listening to people who use services and empowering them to be part of the design and decision making about services we become aware of ideas and aspects of service that may not have been considered, enabling us to make positive change. Although we have a legal duty to involve people, we believe local people know their communities best, building relationships and trust by making sure everyone has a voice and that decision making is underpinned by robust evidence, we can make sure that services meet the needs of the local community. Creating opportunities for patients and the public to be involved and contribute, by sharing power and co-producing services and solutions The Integrated Care Board has a legal duty to involve patients and the public in decision making and service development. There are clear standards for public engagement to shape decisions, monitor quality and to set priorities.

These come from a number of sources, including:

- Legislation
- The NHS Constitution
- Existing National Guidance
- Integrated Care System (ICS) Guidance

Our co-produced vision for engagement, aligns with the principles described in 'Building strong integrated care systems everywhere', and describes what engagement and involvement is and how we will achieve it

Building on the best practice already in place across our six places we will

Visit our engagement portal - https://humbernorthyorkshire.engage-360.co.uk/

Let's get better.

HNY Health and Care Partnership recognise that there is a part for us all to play in looking after our health and the health of those around us. Here you can find all the information you need to help live a more healthy and active life whilst learning about the health services in your area.

On the first of April 2023 a new website was launched by the NHS in Humber and North Yorkshire to help people start well, live well and age well. Let's Get Better brings together lots of health and wellbeing information to support people throughout their lives and helps people choose well and get the care they need when they're unwell.

The Let's Get Talking blog celebrates the people, places and potential that our area has to offer. The programme will be supported by social and digital media, print and online partnerships and health advice videos.

Further development is planned including enhancing local content and increasing information on commissioned services, voluntary and community sector and community support in each area, plus specific LGBTQIA+ health information and advice and enhanced accessibility

Visit www.letsgetbetter.co.uk for more information.

Patient Engagement Portals

An NHS Patient Engagement Portal is a digital platform that allows patients to access their healthcare information, communicate with healthcare providers and manage their health in a more convenient and efficient manner.
For patients this will mean a more consistent experience that improves access, visibility and control for patients on elective care pathways.
It will enable a single point of entry digital 'front door' to NHS services through the NHS App.

In 2023/24 the ICB has been successful in securing funding which will extend the coverage and expand the functionality and impact of Patient Portals

Involvement – case studies

Humber and North Yorkshire Health and Care Partnership

The Mental Health Learning Disability and autism sector collaborative
We have a strong track record of engaging with the public in development of the collaborative's priority programmes and we have some excellent examples of where this has been done effectively.

As part of our children and young people's mental health programme we have held extensive engagement with children and young people, particularly in relation to the delivery the trauma informed care programme.

- We have a dedicated co-production and engagement lead, who has ensured that we are working collaboratively with the children and young people we are supporting to recognise their needs and thoughts on what will work best to support them. Service developments and strategic plans alike will be **demonstrably** co-produced
- Collaborative led engagement processes that will ,by default, be arranged and delivered across health and care boundaries (Local authority, primary care, VCSE etc)
- People with lived experience will be represented across our collaborative programme, it's key priority workstreams and programme governance.

- In North East Lincolnshire we are committed to a high level of co-production and engagement when designing and delivering patient involvement and patient choice
- Our award-winning engagement team works closely with commissioning leads in all areas of work to ensure that patient views are gathered (including from those groups which are hard to reach), considered and fed into the process of service development
- We have developed the North East Lincs Commitment (our local engagement strategy, named Talking, Listening and Working Together which has been endorsed and agreed by the Local Authority, the North East Lincolnshire Health and Care Partnership and the local voluntary and community sector. This commitment articulates how we will all work together to the benefit of local residents
- We maintain an involvement database(Accord) of several thousand local residents who have expressed interest in being part of consultation on local health services
- Our approach to engagement and involvement was consistently rated Green star as part of the CCG Assurance Framework
- All of the actions taken in relation to engagement serve to enable us to meet our legal requirements
- We will apply this same approach to engagement on local plans

The Local Maternity and Neonatal System works very closely with Maternity Voices Partnerships (MVPs) based in each place and with a coordinating lead to link into regional and national initiatives. The MVPs host regular meetings, engage through social media, oversee production of guidance and processes, and support the oversight and assurance processes of the LMNS within their local hospitals to ensure families needs are met. They also have a cultural diversity lead across HNY who supports linkages into different community, faith, racial, LGBTQ+ and other minority groups to ensure they are effectively represented in these discussions.

2.5 Creating and enabling infrastructure: appropriate advice

Humber and North Yorkshire Health and Care Partnership

Clinical and Care Professionals are the cornerstone of the ICB - a key enabler in delivering the ambitions of the Joint Forward Plan. The ICB has a model of Clinical Place Directors, who have a dual role to provide leadership within their respective places and operate strategically across the ICB. Each Clinical Place Director collaborates with a virtual team of clinical and care professionals within their respective places. They provide expert clinical advice and facilitate the culture change needed to deliver fully integrated care, across programmes, places, networks and collaboratives
Alongside this, leading Clinical and Care Professionals from across ICB geographies coalesce on a weekly basis to learn, share and develop clinically led solutions to the various systemic issues facing the ICB.

A core purpose and ambition of the directorate is to drive and facilitate culture change through clinical and professional leadership, at all layers of our complex system. We will do this through

Clinical effectiveness
Developing improved clinical pathways and policies to reduce unwarranted variation, improve quality and reduce inequalities

Digital
Developing the digital strategy and vision to address digital exclusion, develop shared records and support business intelligence

Research and Innovation
Growing our knowledge and capacity to scale up innovation

Medicines optimisation
Ensuring the most effective, appropriate, safe and sustainable use of medicines

Our priorities

Take forward and agree a way forward for a digital solution to better pathway standardisation to reduce unwarranted variation and support system transformation for patients

Develop clinical leadership to champion and embed clinical transformation within place, collaboratives, and system partners

Develop a structure for clinical networks operating in the ICB which will provide visibility of work and enable the ICB to drive effectiveness and efficiency through agreed network work programmes

Embed streamlined clinical decision making processes for the harmonisation of existing and introduction of new clinical policies

2.4 Creating an enabling infrastructure: Innovation, Research and Improvement

Humber and North Yorkshire Health and Care Partnership

Vision
Support and grow an exemplar system that enables and facilitates research, innovation and improvement to realise the HNY ICP ambition for everyone in our population to liver longer healthier lives.

Mission
Innovation, research and improvement are critical elements of a thriving health and care system. IRIS will be the front door into, and out of, the HNY system for innovation, research and improvement. The virtual hub will connect partners across our system to maximise our assets and resources.

What will IRIS do to realises its mission and vision?

Single front door
- For industry, life sciences sector, arms length bodies, academia.
- Facilitate rapid adoption, spread, scaling up of innovation and best practise.

Virtual hub for stakeholders
- Harness existing networks, activity, and resources to create a joined-up system that encourages, promotes and enables research, innovation and improvement.
- Matching making function to facilitate new collaborations.

Demand signalling
- Communicating ICS priorities and 'grand challenges' to researchers and innovators.

Culture Change
- Education, training and upskilling the workforce to provide colleagues with the knowledge and tools that they need to embed research, innovation, and improvement.
- Promoting research in primary, secondary and social care.

A data driven and evidence based system will enable:

- Cultural change and staff empowerment – those who do the work know the solutions
- Better outcomes for people
- Standardisation of systems and processes
- Recruitment and retention of talent
- Better use of resources

Case Study
The Mental Health, LD and Autism sector collaborative are a national vanguard programme in Community Mental health and children and young people, which has included much innovation and new models of working. We will build on this and share knowledge and emerging best practice across the system and region. Have services in place around community mental health and children and young people's mental health (in particular) that are built on innovative models of care and pathway design arising from the national vanguard sites.

Case Study
The Local Maternity and Neonatal System are working in conjunction with Oxford Brookes University on a study to determine the impact of water births on the experience and outcomes of women and birthing people. This will support the evidence base and describe the benefits of other schemes such as the birth pool hire scheme piloted.

2.4 Creating an enabling infrastructure: Innovation, Research and Improvement

Humber and North Yorkshire Health and Care Partnership

What will success look like?

1. Grow local healthcare innovation knowledge and capacity
2. Support local healthcare innovator and economic development
3. Fixing our local healthcare 'grand challenges'
4. Scaling up any local fixes beyond HNY ICS
5. Be an exemplar health and social care system for research, innovation and improvement

In 2023/24 we will:

1. Launch a support a programme of organisation development linked to our priorities:

- Host a launch event and support ongoing engagement and relationship building
- Identify two ICP 'grand challenges' for IRIS to drive activity toward
- Create the ICP strategy for research, innovation and improvement
- Perform a comprehensive stocktake of what resources exists in the system and develop a plan for how best to deploy them
- Create new partnerships with education and industry particularly around big data and data analytics

2. Create the right decision making structures to support innovation, research and improvement

- Identify and agree the governance for IRIS
- Primary care research and development function sits within IRIS
- Identify a Senior Responsible Owner within the ICB to champion and lead the programme
- Build capacity within the team

3. Adopt NHS Impact to create the culture and conditions for continuous improvement across the ICS.

- Engage with NHE on the adoption of NHS Impact
- Learn lessons internally and from other peer ICBs
- Engage with global leading vendors to identify opportunities for clinical and operational improvement and sustainable change

2.4 Creating an enabling infrastructure: our digital strategy

Humber and North Yorkshire Health and Care Partnership

Our digital vision is 'to deliver digital and information services and solutions that enable citizens to Start well, Live well, Age well and End their lives well.'

Humber and North Yorkshire Health and Care Partnership will embed digital transformation as an integral part of our clinical, business and population health strategies.

We will:

- Use digital to improve the way services are designed, delivered and managed in an integrated way, with a clear focus on the individual and their experience, and where health and care professionals can make the best decisions because they have the information they need at the point of car when they need it
- Optimise the value of data to create intelligence to be used routinely to improve patient safety, delivery better health outcomes and tackle inequalities
- Nurture a thriving digital health and care ecosystem, supporting research and innovation, developing skills and capabilities and recognised internally as an exemplar of innovation and digitisation

Strategic Priorities

- Well led
- Smart foundations
- Support people
- Improve care
- Empower citizens
- Healthy populations
- Safe practice

Case Study:
The Humber and North Yorkshire Digital Inclusion Steering Group continues to ensure that services across the health and care system are designed to be as inclusive as possible. For example, East Riding of Yorkshire Council are working with the LGA to create a Digital Inclusion Tool to support service users to find the right digital support to suit their needs. The project started in January 2023 and will run until December 2023. The Holderness ward within East Riding will be used as a test area for the project. East Riding of Yorkshire Council Services, GP practices and Community Groups will test and evaluate it before wider rollout. The Digital Inclusion Steering Group continues to grow and support the ICB to expand and support stakeholders in knowledge sharing and networking in 2023/24

Our deliverables and priorities in 2023/24

Well led	Develop of a unified approach to digital based on a distributed leadership model with the intention that a refreshed system wide approach
Smart foundations	Continue to deploy the Yorkshire and Humber Care Record across all areas of Health and Social care Collaborate to rationalise and develop our Electronic Patient Record systems, delivering the required elements of the programme
Empower Citizens	Continue to implement the actions set out in the Digital Inclusion Strategy and Plan
Healthy populations	Develop and implement a self-sustaining, system-wide, multi-disciplinary data and analytical collaborative model – that produces high-quality, locally-relevant intelligence to enable leaders at all levels to make decisions informed by evidence.

2.4 Creating an enabling infrastructure: Our People Strategy

Humber and North Yorkshire Health and Care Partnership

Our People Strategy and approach will enable long term system development via **a long-term architecture for the people challenge.** It will set out the ICB approach to promoting education and training and to supporting our workforce. Growing our workforce will also provide a key building block to supporting wider social and economic development

- Distributed leadership – sharing control, responsibility and risk
- Developing leaders as individuals and as a community
- Recognising and developing the key role of the convenor as a catalyst

Through ensuring system leadership development we will build connections between workforce redesign and service change aspirations in sector collaboratives and at place. This will drive purpose and create and shared understanding to support collaborative delivery of change projects, selected tactically for impact, timeliness, momentum and shared interest. We will build connections between workforce.

We will build strong foundations through our 'strategy house'. This sets out how our leadership community is organising its collaborative thinking and planning around People and Workforce. to make Humber and North Yorkshire a better place to live and work through

The building blocks of our strategy house:

Be the best place to work	Grow and train our workforce
Embrace new ways of working	Demonstrate system leadership
Building strong foundations	

Case study

The Humber and North Yorkshire Mental Health Resilience Hub has supported many health and care staff (including emergency services) throughout and beyond the covid pandemic. This vital work has undoubtedly contributed to the wellbeing of staff and by extension the wider population (families and patients). We would like to see the continuation of initiatives like the resilience hub, where the impact extends beyond the individual being supported.

What we will deliver in 2023/24

TBC - May 2023 RACHAEL BAILLIE SMITH

2.4 Creating an enabling infrastructure: Supporting Wider Social and Economic Development

Humber and North Yorkshire Health and Care Partnership

We share the responsibility for improving health with our people who live and work in Humber and North Yorkshire. As organisations we have extensive assets at our disposal and using our collective power and influence we can use these to put in place **building blocks for health** (see diagram below). These building blocks are the underlying circumstances that affect the health, lives and life chances of our people. Improving these underlying circumstances has a direct impact on the people's health and provide opportunities for our populations to thrive.

Utilising our partnerships and our history of working with our communities, we will look to optimise the arrangements to impact positively on our communities and support through our actions addressing the gaps in the building blocks of health, to deliver the aims and aspirations for better health and improved lives for our people and communities.

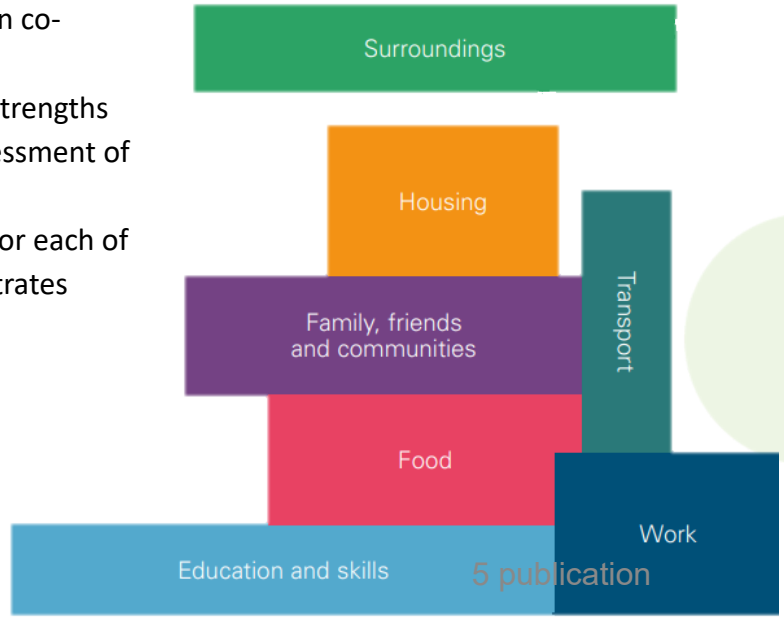
As the organisations that are one of, if not the biggest employers, in each of our six Places, we are committed to **positively contributing** to making a difference for local people by:

- Seeking to enable local economic growth by buying local and supporting the creation of a strong infrastructure that attracts and builds businesses in our area
- Creating greater access to work by growing the workforce of the future and providing opportunities for people to develop their skills and giving our people a purpose
- Reducing our environmental impact and making our contribution to the Net Zero Climate targets.

What we will deliver in 2023/24

- Establish a health and care anchor network that can co-ordinate and motivate the strategic approach
- Understand the health and care system collective strengths and areas for collaboration through a baseline assessment of anchor activity
- Develop shared ambition, and co-ordinated plans for each of the anchor pillars with measurement that demonstrates health and care organisations social value

Courtesy of the Health Foundation



5 publication

Case study

In North East Lincolnshire we recognise the important part we have to play in supporting wider social and economic development in the Borough and we are utilising our partnerships and long history of integrated working to optimise the arrangements to impact positively on our communities.

One of our key priorities is workforce development and this is being facilitated through the North East Lincolnshire Health and Care Partnership and involves partners from across Health and Care.

Its broad aim is to ensure a thriving workforce in Health and Care locally. It has a focus on development of local talent through engagement with further and higher education institutions and bringing together the potential health and care employers with local curricula in order to help shape the workforce for the future. In addition to this the Workforce group will:

- Develop a joint approach to international recruitment focused on nursing and medical staff - specific focus on supporting refugees in 2022/23 to gain meaningful employment in health and care
- Join up activity across partner organisations in initiatives with schools to support increased capacity and impact
- Develop joint or flexible posts and posts which offer a career development pathway between partners and across health and social care.

We are conscious that our ability to influence the local community extends beyond workforce and we are actively undertaking a review of estates and facilities alongside partners to ensure we are optimising our physical estate and promoting environmental sustainability within this.

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Report of the Director of Adults and Health (NLC)
and NHS Place Director (HCP)

Agenda Item
Meeting 19 June 2023

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

APPROVAL OF COMMUNITY FIRST STRATEGY

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 The North Lincolnshire Health and Wellbeing Board and the Place Partnership has a focus on transforming the lives of people in North Lincolnshire through an integrated health and social care system.

1.2 A key strand of this transformation is our Community First Approach. A final draft Community First Strategy has been developed and now requires approval by the Health and Wellbeing Board.

2. BACKGROUND INFORMATION

2.1 The Community First Approach will enable people and ensure that they get the right care, in the right place at the right time. Based on prevention and enabling self-help, people will be able to act to keep themselves well.

2.2 The Community First Approach will make it easy for communities to help people in ways that reduces their need for more health or social care and support, through offering services that meet need, enabling communities and building the right capacity within communities. People and their families will be empowered to support themselves and self-responsibility for wellbeing will be encouraged.

2.3 When people have a need for more health and social care support, people will get the best care, closest to home. This care will be

personalised and will be provided in a way that ensures people have control over their lives.

2.4 Everyone involved in community wellbeing, health and social care will work together and seamlessly to ensure people's needs are met. People who are most in need will be prioritised.

2.5 A Community First Strategy (see appendix A) has been developed which sets the direction and overall plan of action to achieve the Community First Approach.

3. OPTIONS FOR CONSIDERATION

3.1 Option 1 – Approve the Community First Strategy.

Option 2 – Do not approve the Community First Strategy.

4. ANALYSIS OF OPTIONS

4.1 Approving the Community First Strategy will ensure that the health and social care system in North Lincolnshire has clear direction and a plan to achieve the Community First Approach. The Community First Strategy is a fundamental component in achieving health and social care integration in North Lincolnshire. Approving the Community First Strategy will ensure the person and family are at the heart of everything we do. It will place Community at the very heart of our wellbeing.

4.2 People will be enabled to keep well, with prevention prioritised together with early help. Integrated Neighbourhood Teams will ensure a fully integrated response across health, social care, housing, employment and voluntary sectors.

4.3 People will have urgent needs met quickly by establishing our unplanned care response into a fully Integrated Urgent Care system wide approach. We understand that some people do get into crisis at times and what they need more than anything is a rapid response, but one that is aimed at enabling that person to remain in their current environment and retain their independence, choice and control over what happens, will mean that they are more likely to recover quickly and not 'decondition' in hospitals or care facilities.

4.4 People will be safe and have good quality provision enable through a single Integrated Strategic Commissioning and Safeguarding approach that maximises Place resources to best effect to meet need and achieve the best quality of provision for residents, focused on those who are most vulnerable. We will make the best use of resources, doing it once doing it well in terms of strategic planning and managing the commissioned

services transformation together as one team. We will work together to coproduce and commission appropriate arrangements for people with complex needs and to support the health and care sector to deliver their best in meeting those needs.

4.5 Improvements will be realised across the following nine areas of collective focus for our system:

- Mental Health and wellbeing will thread through all that we do across all ages
- Asset based community development will identify and work with the strengths of communities to level up North Lincolnshire
- Innovation will be supported including digital tools that enable individuals to maximise their health and wellbeing
- The health inequalities gap will reduce across all of our wards
- Healthy life expectancy will improve for our population
- Access to health and care will take account of rural challenges
- People with long term conditions such and lung and heart disease will experience proportionately better health
- There will be a single workforce strategy covering leadership and management, recruitment and retention, reward and recognition, career pathways and talent development
- The integrated practice model will be person centred

4.6 The Community First Strategy will ensure that our care and support is designed to meet people's need at the lowest level, with those most in need being prioritised. A single Neighbourhood based Planning Tool based on our population management approach will be used by all the organisations to understand need and inform proactive approaches to designing and delivering support that will improve people's health and wellbeing.

4.7 In addition to a single Planning Tool, there are five other tools, or enablers, that will be used. These are set out below.

- A Single Workforce Strategy will enable everyone working within health and social care to share the same collaborative ambition, Strategic Intent and Community First Approach.
- Digital Enablement and Innovation will help people to get digitally enabled care where this is the right thing for them, facilitate greater integration and co-production across all organisations involved in health and social care and support the design of preventative, personalised care for those that need it.
- Collective Use of Resources will ensure that the money, people, assets, expertise, experience and leadership that North Lincolnshire has are put to the best, most effective and efficient use.
- Strong Organisational Change and Transformational Change Management Approaches will make sure that the difference is achieved

and continually delivers even better health and wellbeing outcomes for everyone in North Lincolnshire.
- Sustainability will be at the heart of all that we do.

4.8 Not approving the Community First Strategy will result in the health and social care system not having a clear direction or plan of action to achieve the benefits set out above.

5. FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)

5.1 These are set out in paragraph 4.7 above.

6. OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.)

6.1 The Community First Strategy places sustainability at the heart of all that we do. It will ensure that we take responsibility and enable positive action on the environment. We will make sure our Community First Transformation is safe for the environment, self-sustaining and provides opportunities for everyone by connecting people with nature so they benefit from improved health and well-being.

6.2 The Community First Strategy replaces the North Lincolnshire Health and Care Integration Plan 2021-2024. The Community First Strategy sets the direction and is the overall plan of action to integrate health and social care in North Lincolnshire, through the Community First Approach.

7. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

7.1 No adverse impacts have been identified.

8. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

8.1 There has been extensive engagement with stakeholders across the Place Partnership. There is significant positive support for the direction and plan set out in the Community First Strategy.

9. RECOMMENDATIONS

9.1 That the Community First Strategy (see appendix A) be approved by the Health and Wellbeing Board.

DIRECTOR OF ADULTS AND HEALTH (NLC) AND NHS PLACE DIRECTOR (HCP)

Church Square House
SCUNTHORPE

North Lincolnshire
DN15 6NL
Author: Nolan Bennett
Date: 7th June 2023

Background Papers used in the preparation of this report – none

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Appendix A – Community First Strategy (Final Version For Approval)

[See accompanying paper]

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Community First Strategy
North Lincolnshire Place Plan for Health and Care Integration

June 2023

Version For Approval 0.8

Our shared ambition

Our ambition is for North Lincolnshire to be the best place for all our residents to be safe, well, prosperous and connected; experiencing better health and wellbeing.

This means that people will:

- Enjoy good health and wellbeing at any age and for their lifetime
- Live fulfilled lives in a secure place they can call home
- Have equality of opportunity to improve their health, play an active part in their community and enjoy purpose within their lives

Our Approach - Community First

Our transformation approach empowers and facilitates individuals of all ages including children and young people to participate in their own communities, putting people and communities at the heart of health and care. People will have personalised care, be enabled to self-care and have control over their lives. People will get the best care closest to home. We will use our collective resources to improve outcomes for people and be informed by the voices of our diverse communities. We will use our Place assets and resources to strengthen prevention and community support, reducing the need for higher levels of care which is safe, effective and high quality in the right place at the right time. We will use the North Lincolnshire pound wisely and with integrity. We will ensure participation and prevention threads through all that we do. We will foster a culture of one team, enabling our workforce to achieve great outcomes for people and support the workforce to be well. We will ensure we have the most effective systems and enablers of change.

The ICS and Place Partnership will invest locally to deliver this strategic intent ensuring the community health and care system is the right size for the population, is organised to meet levels of need and inequalities; focuses on prevention at every level and opportunity; and is high quality. The Partnership will utilise digitally enabled care to support the individual and integration of the workforce. We will prioritise those most in need. We will enable partners to manage risk effectively, to work together to promote positive risk taking to improve the outcomes we aspire to.

What Difference Will Community First Make?

We recognise that as local leaders we have the opportunity at Place to consider and design our own plan for integration that we can own, design and deliver for the people of North Lincolnshire. Our Community First Strategy is depicted in outcomes as follows:

The **Person and Family** are at the heart of everything we do. Across North Lincolnshire all organisations involved in health and social care will work together to enable people to live independently within families, schools and communities. This is important because it helps people to enjoy a better sense of wellbeing and keeps them close to the people that matter.

Community is at the very heart of our wellbeing, we will make sure people get the information, advice, guidance and help to keep themselves well and we will support carers to enjoy good health and wellbeing whilst continuing to care for their loved ones. We will make sure they get this from, and within, their communities. We will use what we know about the needs of people and the communities they live in to shape and target the way in which this help is designed and delivered.

People are enabled to keep well. We have committed to prioritise prevention and early help and to do this we will develop **Integrated Neighbourhood Teams** which will ensure a fully integrated response across health, social care, housing, employment and voluntary sectors. Integrated Neighbourhood Teams will be proactive in identifying people with, or at risk of developing, long term conditions and or disabilities, and for those who have existing conditions, will provide them and their carers with high-quality, person-centred care. This will include assessment of need, good care planning and coordination that enables self-care, better and faster access to local solutions and support reduction in the need for urgent care. This will support people to remain in their own homes, communities, families, schools and employment.

Many people will have social, psychological, economic and environmental factors that cause additional complexities to their needs and therefore this will be underpinned by a population health management approach to target our interventions most effectively, including a holistic assessment based on a sociomedical care model.

People will have urgent needs met quickly by establishing our unplanned care response into a fully **Integrated Urgent Care** system wide approach. We understand that some people do get into crisis at times and what they need more than anything is a rapid response, but one that is aimed at enabling that person to remain in their current environment and retain their independence, choice

and control over what happens will mean that they are more likely to recover quickly and not 'decondition' in hospitals or care facilities.

If a person has a need for urgent care, our workforce will work together so that the person gets the care they need through one single point of contact. The care they get will feel seamless to them, and wherever possible the person will get the care within their community. Hospital and care home admissions will be minimised and if people are admitted to hospital or care homes, the time that people spend there will be minimised, with people returning to their homes supported with the right care. Our staff will work together enable people to live independently within families and communities.

People will be safe and have good quality provision. We have agreed we will have a single **Integrated Strategic Commissioning and Safeguarding** approach that maximises Place resources to best effect to meet need and achieve the best quality of provision for residents and that focuses on those who are most vulnerable. We will make the best use of resources, doing it once doing it well in terms of strategic planning and managing the commissioned services transformation together as one team. We will work together to coproduce and commission appropriate arrangements for people with complex needs and to support the health and care sector to deliver their best in meeting those needs.

Focusing on these outcomes for our plans for integration as described above will enable us to deliver improvements in nine areas of collective focus for our system:

North Lincolnshire Health and Care Partnership

- Mental Health and wellbeing will thread through all that we do across all ages
- Asset based community development will identify and work with the strengths of communities to level up North Lincolnshire
- Innovation will be supported including digital tools that enable individuals to maximise their health and wellbeing

- The health inequalities gap will reduce across all of our wards
- Healthy life expectancy will improve for our population
- Access to health and care will take account of rural challenges
- People with long term conditions such and lung and heart disease will experience proportionately better health
- There will be a single workforce strategy covering leadership and management, recruitment and retention, reward and recognition, career pathways and talent development
- The integrated practice model will be person centred

Experts Together - What Success Will Sound Like

Our Experts Together Partnership, acting as the voice of local users of services, will ensure that we measure and deliver the outcomes in our plans.

We will seek everyone's views, using a coproduced tool. When everyone who needs health and social care support feels and says what is set out below, then we will know we have made the difference.

I have agreed care and support.
Everyone works well together and with me.

I have care and support that
lets me live how I want to live.

I have care and support that see's me as a unique person
with my own skills, strengths, and goals.

I can get information and advice about
my health and support.

I can get information on how to
keep myself fit and healthy.

I can get information on how to
look after my overall wellbeing.

I am supported to plan ahead for
important changes in my life that I expect to happen.

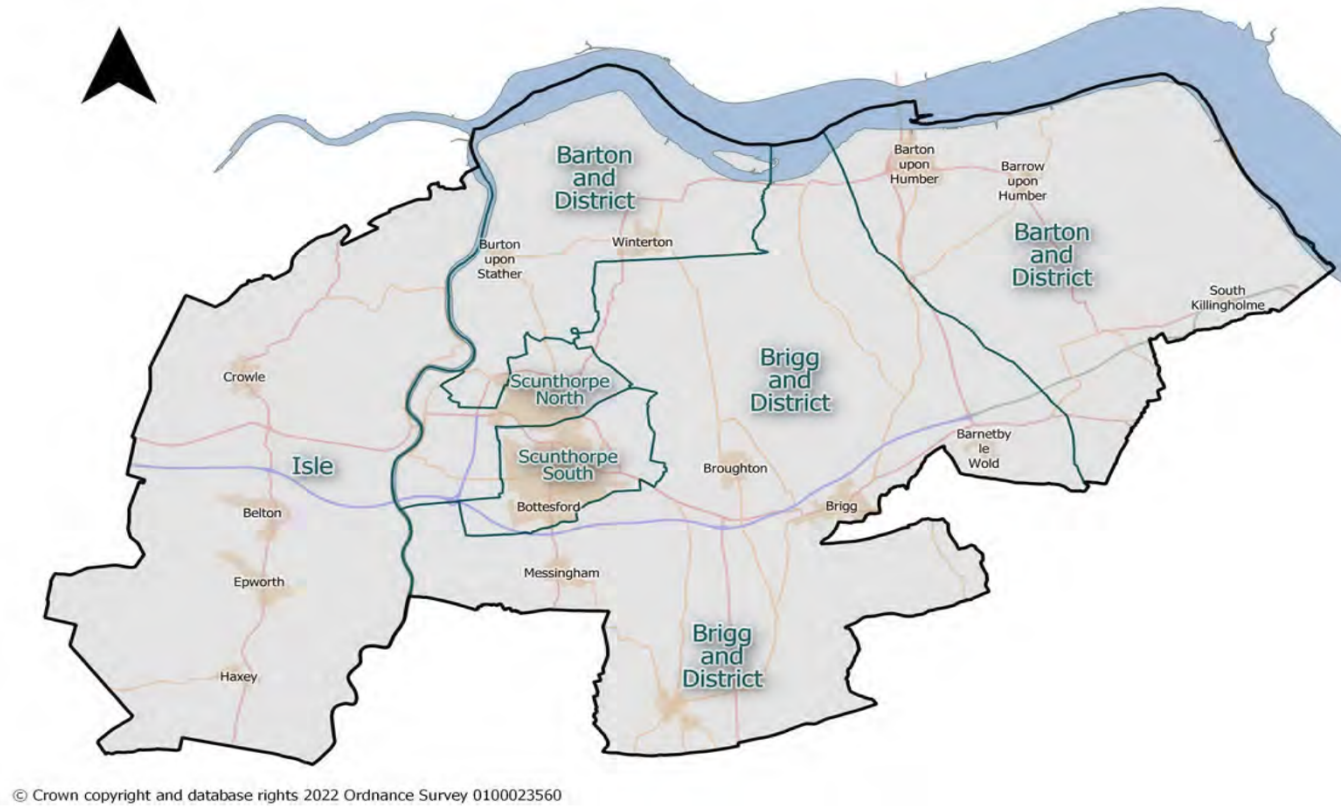
When I change services, there is a plan
for what happens next and who does what.

I feel safe.

I am supported to understand
any risks and keep myself safe.

The Tools That We Will Use To Enable Us

Our plans to develop **Integrated Neighbourhood Teams**, **Integrated Urgent Care** and **Integrated Strategic Commissioning & Safeguarding** will be designed to meet people's need at the lowest level, with those most in need being prioritised. A single Neighbourhood based Planning Tool based on our population management approach will be used by all the organisations to understand need and inform proactive approaches to designing and delivering support that will improve people's health and wellbeing. This means that care and support can be better tailored to meet people's need, health and care services will be more joined-up and better use of public resources will be achieved. This Planning Tool will enable the needs of people in North Lincolnshire to be understood as a single area (172,000 people), Neighbourhood (around 40,000 people) or LSOA (around 1,750 people). And importantly it will enable us to place every individual person at the centre of the tailored, personalised care that they need. The five Neighbourhoods the Planning Tool is based on is shown below.



Locality	Population
Barton and District	34,498
Brigg and District	30,952
Isle comprising	23,298
Scunthorpe North	28,106

Scunthorpe South	55,894
North Lincolnshire	172,748

In addition to a single Planning Tool, there are five other tools, or enablers, that will be used. These are set out below.

A **Single Workforce Strategy** will enable everyone working within health and social care to share the same collaborative ambition, Strategic Intent and Community First Approach.

Strategic workforce planning will train and develop the workforce, enhance a mobile and transferable workforce, offer clear professional development opportunities and progression pathways. This will support recruitment and retention.

Shared systems and processes will be developed which will underpin a common language and a common identity. This will also help create joint accountability and drive integration. We will use data, insight and digital innovation to enable and support the workforce to be and do the best that we all can.

Inclusive and compassionate leadership will embed mutual respect, enhancing equality, diversity and inclusion within the workforce. Workforce wellbeing and engagement will foster a culture of one team and a team of teams, where everyone in the workforce feels:

- Safe to be themselves
- Well, resilient and highly motivated
- Valued and engaged, and
- Connected and high performing.

Digital Enablement and Innovation will help people to get digitally enabled care where this is the right thing for them, facilitate greater integration and co-production across all organisations involved in health and social care and support the design of preventative, personlised care for those that need it.

Collective Use of Resources will ensure that the money, people, assets, expertise, experience and leadership that North Lincolnshire has are put to the best, most effective and efficient use. We have agreed a single Place based approach with all partners to capital planning and estates utilisation that will enable the best use of our facilities and resources.

Strong Organisational Change and Transformational Change Management Approaches will make sure that the difference is achieved and continually delivers even better health and wellbeing outcomes for everyone in North Lincolnshire. Understanding each other's team structures and ways of working and establishing shared values, behaviors, understanding, vision and agreements all contribute to this, with clear and joint accountability by all partners.

Sustainability will be at the heart of all that we do. We will take responsibility and enable positive action on the environment. We will make sure our Community First Transformation is safe for the environment, self-sustaining and provides opportunities for everyone by connecting people with nature so they benefit from improved health and well-being.

In Summary… Community First - Making It Real

Community First will enable people and ensure that they get the right care, in the right place at the right time. Based on prevention and enabling self-help, people will be able to act to keep themselves well. We will make it easy for communities to help people in ways that reduces their need for more health or social care and support, through offering services that meet need, enabling communities and building the right capacity within communities. People and their families will be empowered to support themselves and self-responsibility for wellbeing will be encouraged.

When people have a need for more health and social care support, people will get the best care, closest to home. This care will be personalised and will be provided in a way that ensures people have control over their lives.

Everyone involved in community wellbeing, health and social care will work together and seamlessly to ensure people's needs are met. People who are most in need will be prioritised.

Community First will make a difference to everyone who needs support, in the same way that Adam's story makes a difference for him and his family.

Adam's Story: How our Approach to Integration Can Make a Difference

- Adam is a 37 year old with Autism and learning disabilities who has asthma, for which he has had repeated attendance at A&E.
- He previously lived with parents, now he is in his own supported living flat.
- In the last 6 months he had started to have increasing episodes of aggression and caused substantial damage to his property and which is leaving him very distressed.
- His care provider felt that they could no longer safely meet his needs and gave notice on his care package. This was therefore offered to other local providers, none of whom felt confident to meet his needs. Given there were no local options, an out of area placement was sought. This resulted in him being moved to a residential placement in Leeds due to the need to find a placement within the week.
- He is moved within 1 week of the agreement of the plan.
- This has impacted family visits and Adam is distressed. Family are concerned about his recovery, health and wellbeing.
- There are routine case management visits to review his care, but Adam won't engage. No formal or CQC concerns, but the staff don't seem to have a good relationship with Adam and incidents and restraints have increased. This is causing further distress to Adam.
- He has attended ED several times due to poorly controlled asthma and self injury.
- Adam has a Care and Treatment Review review planned for the next month.

North Lincolnshire Health and Care Partnership

Adam's Story: People are Enabled to be Keep Well

- Adam has been identified as having enhanced needs by the Integrated Neighbourhood team
- He has appropriate support to manage his asthma. He is gaining confidence and has an easy read care plan to help him
- The Team have undertaken a holistic needs assessment with him and taken a personalised approach to meeting his needs

- The Team also use social prescribing to ensure Adam is able to participate in community activities and volunteering opportunities. They work with the provider who feel that additional activities would help Adam feel his days have purpose and identify a range of offers for Adam in his local community. Adam's support team accompany him to his choice of activities, spread throughout the week. Adam starts to look forward to these sessions and is volunteering at the local charity shop with a view to seeking employment. The team note he is much improved, he has more confidence in managing his asthma, and he says he feels happier because he can get out and do activities.

Adam's Story: People have their Urgent Needs Met Quickly

- Adam's Integrated Neighbourhood Team work closely together to ensure Adam understands his asthma and how to take his inhalers. But this doesn't mean Adam never gets ill. Last week he got extremely breathless. He finds this frightening and worried that he needed to go to hospital - Adam has always been frightened of hospitals. However his support workers know how to help him.
- His support worker rang the local Single Point of Access, where they spoke to a clinician who gave immediate advice.
- It was agreed that Adam needed to be seen in the Urgent Care Service for a full assessment and treatment – it was agreed the support worker could take him there to reduce Adam's anxiety about hospitals.
- On arrival, Adam is taken to the Urgent care Service in Emergency Department and assessed. He needed investigations, however it was agreed that he should be managed on Same Day Emergency Care (SDEC) with the plan to get him home the same day.
- On SDEC, he is treated quickly and starts to show signs of improvement.
- Discharge planning start immediately to reduce the time Adam needs to spend in hospital. His support worker stays with him and this helps his anxiety.
- The Hospital discharge team have access to all the information they need to ensure he can be discharged with all his support needs in place. The community team schedule a visit to Adam at home the following day
- He is discharged from SDEC the same day.

Adam's Story : People Have Safe and Good Quality Provision

- Recently, Adam's needs have become more complex.
- Due to the strong provider engagement in North Lincolnshire, there is ongoing partnership and collaboration between the provider and other agencies across North Lincolnshire to ensure staff have the skills and competencies to manage Adam's increasing needs.
- Staff in his supported living accommodation have been trained to recognise early any deterioration and contact the North Lincolnshire Complex care team to discuss how to best support him.

- The Team advise and put in place some additional Positive Behavioural Support (PBS) to help manage Adam's increasing agitation. The staff at his supported living accommodation also increase their input to help Adam with his emotional regulation. They have a shared risk plan and access to support from the MDT 24/7 to support Adam remain at home.
- Adam responds well and although occasionally aggressive, he is not violent and is managing his behaviour. There is greater understanding around Adam's communication and the environment is adjusted to be conducive to meeting his needs. This includes adjustments and use of technology to support his sensory needs. He is now safely supported at home.

North Lincolnshire Health and Care Partnership

Next Steps

Once this overarching Strategy is approved for publication by the Health and Well being Board there will be detailed plans that identify how we will deliver our aspirations, coproduced by partners and with identified leadership arrangements for delivery of our plans across our Place partners, these action plans will be regularly reviewed and discussed at the various governance groups with quarterly summary reports being formally presented to the Health and Well-being board as it progresses.

Report of the Director of Adults and Health (NLC)
and NHS Place Director (HCP)

Agenda Item
Meeting 19 June 2023

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

'MAKING IT REAL' HEALTH AND SOCIAL CARE INTEGRATION EVENT - UPDATE

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 On 22nd May 2023 the Place Partnership hosted the 'Making It Real' Health and Social Care Integration event.

1.2 Over 160 leaders from across health and social care took part, finding the event both useful and informative. Feedback from the event assures us that participants now have an excellent understanding of North Lincolnshire's Community First Approach to health and social care integration.

1.3 Further actions are being planned and implemented. These will build on the success of this event and the momentum it has created.

2. BACKGROUND INFORMATION

2.1 Under the oversight of the Health and Wellbeing Board and the Place Partnership, the Community First Approach has been developed. Community First will achieve health and social care integration in North Lincolnshire. It will enable people and ensure that they get the right care, in the right place at the right time. Based on prevention and enabling self-help, people will be able to act to keep themselves well. The person and family will be at the heart of everything the health and social care system does.

2.2 The Community First Approach is transformational. And whilst national drivers such as the Health and Social Care Act 2022 and the Fuller Report are highlighting the importance of, and need for, health and social care integration, it is the action we take locally that will make this integration a reality.

2.3 Part of the action we have already taken within North Lincolnshire includes the 'Making It Real' Health and Social Care Integration event. The event was hosted by the Place Partnership and took place on 22nd May 2023 at The Baths Hall in Scunthorpe.

2.4 Over 160 leaders from across health and social care attended this event, which has been identified as the most important event about health and social care in North Lincolnshire in 2023. At the event, leaders found out about the Integrated Care Systems plans, and plans within North Lincolnshire, to work in an integrated, person-centred way, meaning that people will experience better health and wellbeing outcomes.

2.5 Leaders also heard from North Lincolnshire's 'Experts Together'. The voices of people who need support from the health and social care system really helped everyone attending the event to understand what Person-Centred means.

2.6 Senior leaders representing each Place Partner helped everyone understand why health and social care integration is important to them, through an engaging round table discussion. This demonstrated how integration will deliver improvement across the system in a way that clearly showed the whole really is more than the sum of the parts.

2.7 And leaders found out more about how integration will ensure people in North Lincolnshire will be enabled to keep well, with prevention prioritised together with early help, with a focus on:

- **Integrated Neighbourhood Teams** ensuring a fully integrated response across health, social care, housing, employment and voluntary sectors.
- People having urgent needs met quickly by establishing our unplanned care response into a fully **Integrated Urgent Care** system wide approach.
- People being safe and having good quality provision enabled through a single **Integrated Strategic Commissioning and Safeguarding** approach that maximises Place resources to best effect to meet need and achieves the best quality of provision for residents, focused on those who are most vulnerable.

The 160+ leaders also shared their experiences and began to shape how the health and care system will work better together.

2.8 The event also provided a really valuable opportunity for people to network with colleagues from across the health and social care system.

2.9 Feedback from the event confirms it's success. Post-event evaluation highlights that over 84% people found the event useful and informative with over 70% now better understanding North Lincolnshire's Strategic Intent, including the Community First Approach. And over 84% of people now better understand what Person-Centred means.

2.10 Following the event, work has commenced on feeding the thoughts and ideas of the leaders who attended into the delivery plans for achieving integration across the areas of Integrated Neighbourhood Teams, Integrated Urgent Care and Integrated Strategic Commissioning and Safeguarding. Post-event evaluation has been progressed, as highlighted in paragraph 2.9. Plans are in place for our ambition, vision and Community First Strategy to be shared with all stakeholders, including significantly the public, via a web presence and this will be a foundation to further communication, engagement and culture change activity. An area of professional practice will be created using the NHS Futures platform. And future events targeted at achieving further integration and enabling professional networking will be hosted. These will benefit our local plans for health and social care integration and the Integrated Care System more widely.

3. OPTIONS FOR CONSIDERATION

3.1 There are no options as this report is for information only.

4. ANALYSIS OF OPTIONS

4.1 There are no options as this report is for information only.

5. FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)

5.1 There are no resource implications as this report is for information only.

6. OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.)

6.1 There are no other implications as this report is for information only.

7. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

7.1 N/A.

8. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

8.1 Post-event evaluation will be a key part of evidencing outcomes of consultation as the Community First Approach is further developed and implemented.

9. **RECOMMENDATIONS**

9.1 That the update contained throughout this report and further actions noted in paragraph 2.10 be noted and endorsed.

DIRECTOR OF ADULTS AND HEALTH (NLC) AND NHS PLACE DIRECTOR (HCP)

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Author: Nolan Bennett
Date: 8th June 2023

Background Papers used in the preparation of this report – none

Report of the
Director of Children and Families

Agenda Item No:

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

CHILDREN'S COMMISSIONING STRATEGY: INTEGRATED WORKING UPDATE

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 The purpose of this report is to update the Health and Wellbeing Board of progress relating to the delivery of the Children's Commissioning Strategy Refresh, specifically our focus on developing our integrated children and families offer and the impact on children, young people and families

2. BACKGROUND INFORMATION

2.1 Through our One Family Approach, we work together with schools as the primary partner, wider partners and the community to build on and further strengthen our integrated offer for all children and young people so they thrive in their families, achieve in their schools and flourish in their communities.

2.2 The North Lincolnshire Health and Care Integration Plan sets the strategic vision and principles for integrated working within North Lincolnshire. Led through the Integrated Children's Trust, and through the Children's Commissioning Strategy Refresh 2022, we continue to work towards our ambition for children and young people leading to positive outcomes.

2.3 Set in the context of our One Family Approach, the Children's Commissioning Strategy Refresh resets our integration priorities and commissioning intent across education, health and care for our children and families. This aligns with the refreshed Place Partnership strategic intent and the new iteration of the Health and Care Integration Plan.

2.4 There continues to be an amplified focus on developing our integrated offer for children and families to meet need at the earliest point, enabling sustainable change within families. Through the Integrated Children's Trust, we have also identified four 'shine a light' areas of focus, to drive forward partnership action and system change to contribute to improving outcomes for our children and young people, as follows:

- Emotional wellbeing and mental health
- Best start in life
- Adolescents and youth offer
- Outcomes for children and young people with vulnerabilities

3 OPTIONS FOR CONSIDERATION

3.1 Through our partnership and governance arrangements, and our ongoing commitment to listening, learning, reviewing and adapting, we continue to deliver against the Children's Commissioning Strategy Refresh. We understand the impact of partnership action and how this is contributing to outcomes for our children and young people.

3.2 The Health and Wellbeing Board is asked to note the key headlines relating to progress in delivering the Children's Commissioning Strategy Refresh, as follows:

Partnership working activity and developments (relating to integration priorities and shine a light areas of focus)

Led by systems leaders and managers, there has continued to be strong partnership working across the children and families workforce, from a whole family perspective, which has enabled a range of activity and developments, including but not exhaustive:

- Leaders and managers across the children and families workforce attended and contributed to the North Lincolnshire Health and Care Integration event in May 2023 at which there was an ongoing focus on children and families within the context of the wider health and care integration agenda, and an aligned direction of travel in relation to our neighbourhood approach

- There is an ongoing focus and continued oversight on CAMHS wrap around support and the neurodiversity pathway, which demonstrates that:

    - the percentage of young people seen via the CAMHS Getting Help Pathway within 10 weeks compliance is consistently 100% against the 95% target
    - CAMHS triage all referrals for complexity and risk within 24 hours of referral
    - in Q3 and Q4 2022/23, there has been a reduction in referral rates and waiting lists for neurodiversity services

- An initial mapping exercise has been undertaken to understand the scope of the integrated children and families offer and the associated resources / assets. There has continued to be meaningful conversations to scope and develop the arrangements, which has led to the establishment of an Integrated Children and Families Offer Strategic Steering Group. At the inaugural meeting, at which there will be representation from agencies and organisation to reflect 'whole family' working, there will be creative discussions around how the integrated offer can be further developed, along with proposals to roll out in specific areas. It is anticipated that this will then be presented at the July Integrated Children's Trust for endorsement and implementation. This direction of travel will be based on core principles, as follows:

    - Neighbourhood-based integrated approaches
    - Enabling resilience and flourishing communities
    - Focused on outcomes and impact
    - Keeping people safe and well
    - Fewest best interventions providing the right help at the right time
    - Partnerships with neighbourhoods, communities and resources
    - Asset based community development and insight into the community
    - Flexibility and innovation
    - Equality of access and opportunity, integrated resources targeted to the most vulnerable
    - Family-led through co-production
    - A needs-led and insight informed offer
    - Enables resilience through connections and relationships

- The current Youth Offer has been shared across the partnership and there is clarity as to how the offer is advertised across websites, social media platforms, via local communities. Work has also progressed to further develop the Integrated Youth Offer and development plan, which has been shaped and influenced by young people's views and experiences, and through co-production, this will enable the offer to meet the needs of young people and have a positive impact. The integrated Youth Offer, which is due to be presented at the July Integrated Children's Trust for endorsement, demonstrates that local providers have the capacity and skills to deliver effective services to young people; evidence of aspirational programmes; and ongoing support to grow the role of voluntary community and faith organisations

- There has been an agreement in principle for the development of a Corporate Grandparent Offer, which will strengthen the offer of help and support available to care leavers who are also parents, and their children. Work is underway across the partnership to develop the offer for consideration via upcoming Corporate Parenting governance arrangements, with the intention that it be launched via Corporate Parenting Week 2023. This will also further enhance the All Age Care Leavers offer which was previously agreed across the partnership and is now in place and being utilised by our Care Leavers. As a result, this is having a positive impact on the continuation of relationships and the offer of support as and when needed

- Work has progressed to develop the Complex Campus and Trent View Post 16 Special School, both of which are on target to open in Autumn 2023. These capital projects will contribute to the enhanced offer and equity of access in relation to children and young people with complex needs and disabilities in relation to their health, care and educational outcomes

- Preparations are underway for an Education and Aspirations for All Age Vulnerable Children and Young People event to consider our current offer to support children and young people's education, learning and aspirations across the spectrum of need; and to identify opportunities for further development, innovation and integrated working and to rearticulate our future offer

Creating the conditions

There continues to be a focus on developing our enablers i.e. in relation to our workforce and stakeholder voice and engagement, in order to create the conditions across the partnership to develop and embed our integrated children and families offer, for example:

- We have utilised the Children's Challenge across the established governance arrangements as a means of challenging and supporting agencies and organisations to take partnership action. Examples of the Children's Challenge in Action include a focus on emotional wellbeing, education and aspirations and safe spaces. As a result:

    - system leaders have engaged in creative conversations with children in care to further develop relationships and reinforce their corporate parenting roles

    - there is an ongoing commitment to ensuring dedicated capacity to support children in care and care leavers regarding their education, training and employment
    - there is greater clarity and awareness of the offer from With Me In Mind (Mental Health Support Teams in schools)
    - there is co-productive work underway to raise awareness of safe spaces, to develop branding, and to clarify anticipated behaviours and responses from across the workforce

- Across the partnership, we remain committed to seeking the views of our children and young people through the 'Children and Young People's Lives Surveys. The Secondary Lives survey was rolled out in the 2022/23 academic year and has now closed. The emerging themes and key headlines are due to be reported into the relevant partnership and governance arrangements in the next period, which will help to shape and influence partnership action, including in relation to the development of the integrated children and families offer

- There is an ongoing focus on trauma informed training and development across the children and families workforce, including bespoke training across leaders and managers in the Health community and Local Authority. Further work is proposed to develop the One Family Approach practice model to amplify the focus on trauma information practice and formulation

- Parent/carer panel(s) are becoming established as a mechanism for enabling co-production in relation to the Best Start for Family Hubs, as part of the integrated children and families offer. Family Voice representatives have worked closely with leaders and managers to ensure that partnership action takes account of the views and experiences of children and families and they have led on raising awareness of the work of the panels across the Children and Young People's Partnership. Examples of positive feedback include:

    - the venues are a safe space and comfort zone for families
    - staff have helped new and anxious parents
    - staff have gone above and beyond to support families (whole family approach)
    - gives children a good start in life
    - empowers parents and instils confidence
    - offer stress free time for parents to spend time with their children
    - friendships are formed so parents have someone they can talk to
    - one big family ethos
    - support for different language and cultures

Performance and populations

Overall, there has been a positive impact on managing risk, demand and populations which is aligned with our core values and statutory responsibilities, for example:

- Front door activity is stable, there has been a reduction in the number of referrals, and all assessments are completed within 45 days
- The numbers of children in care remains low and is consistently below comparators

- Overall, care leavers aged 17, 18 and 19 to 21 are in suitable accommodation, which is above comparators
- The percentage of care leavers in education, training or employment aged 17, 18 and 19 to 21 has continued to improve and is above comparators
- The number of all children, including those receiving SEN support, at Early Years Foundation Stage, who have achieved a good level of development has increased
- The overall absence rate and persistent absence rate in special schools has improved (with North Lincolnshire being the highest ranked Local Authority) and there are consistently no exclusions in special schools
- Exclusions for children receiving SEN support remains low (and has further improved)
- The overall absence rate for children in care remains low
- The number of first time entrants to the criminal justice system continues to reduce in the context of an increase in the proportion of prevention, diversion and out of court programmes
- No children have been sentenced to custody for over three years

4. **ANALYSIS OF OPTIONS**

4.1 Via the Integrated Children's Trust, there is a continued and amplified focus on developing the integrated children and families offer through the implementation of the Children's Commissioning Strategy Refresh, and to delivering against the identified shine a light areas of focus, to improve outcomes for our children and families.

5. **FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)**

5.1 There are no specific resource implications associated with this report.

6. OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.)

6.1 There are no other relevant implications associated with this report.

7. **OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)**

7.1 Not applicable.

8. **OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED**

8.1 Not applicable.

9. **RECOMMENDATIONS**

9.1 That the Health and Wellbeing Board notes the update in relation to the delivery of the Children's Commissioning Strategy Refresh, specifically our focus on developing our integrated children and families offer and the impact on children and families.

DIRECTOR OF CHILDREN AND FAMILIES

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Date: June 2023

Background Papers: None