Report of the Director Adults and Health & NHS Director of Place

Agenda Item
Meeting 26 September 2022

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

BETTER CARE FUND (BCF) 2022-23 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 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 local residents. ICB(s) and Local Authorities must enter into 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:

- A jointly agreed plan between local health and social care commissioners and signed of by the Health and Wellbeing Board.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution. (For 2022-23 this represents an increase of 5.66%)
- Investment in NHS commissioned out of hospital services
- Implementing the BCF policy objectives

2.3 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 broadly the same as in 2021-22. 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.

2.4 The BCF planning guidance for 2022-23 includes national performance metrics which are

- Avoidable admissions to hospital
- Admissions to residential and care homes
- Effectiveness of reablement
- Hospital discharges that are to the person's usual place of residence

2.5 The 2022-23 Better Care Fund Plan is included as appendix 1. It has been developed around the Health and Care Integration Plan 2021-24 and seeks to continue to deliver existing schemes.

2.6 The North Lincolnshire 2022-23 BCF plan is required to be submitted on 26 September 2022.

3. OPTIONS FOR CONSIDERATION

3.1 Option 1 – To formally agree and sign off the Better Care Fund Plan 2022-23

3.2 Option 2 – To not agree and sign off the Better Care Fund Plan 2022-23

4. ANALYSIS OF OPTIONS

4.1 Formally agreeing and signing off the Better Care Fund Plan 2022-23 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 2022-23 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 monies and the ICB 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 is 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 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 2022-23 Better Care Fund Plan.

Director of Adults & Health
and NHS Director of Place

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Date: 18 August 2022

Background Papers used in the preparation of this report:

Better Care Fund planning requirements 2022-23

North Lincolnshire Health and Care Integration Plan 2021-24 **-** https://www.northlincs.gov.uk/wp-content/uploads/2020/11/HC-Integration-Plan-2021-24.pdf

North Lincolnshire Council

North Lincolnshire Health and Care Partnership

North Lincolnshire Better Care Fund
2022-23 Narrative Plan

Introduction

North Lincolnshire Health and Wellbeing Board (HWBB) is a statutory committee of the council and the key partnership within North Lincolnshire committed to working together to improve the health and wellbeing of the local population and reduce health inequalities. The HWBB has a responsibility to promote and support partnership working and integration for health and wellbeing and overall responsibility for the North Lincolnshire Better Care Fund Plan. Bodies involved in preparing the plan are:

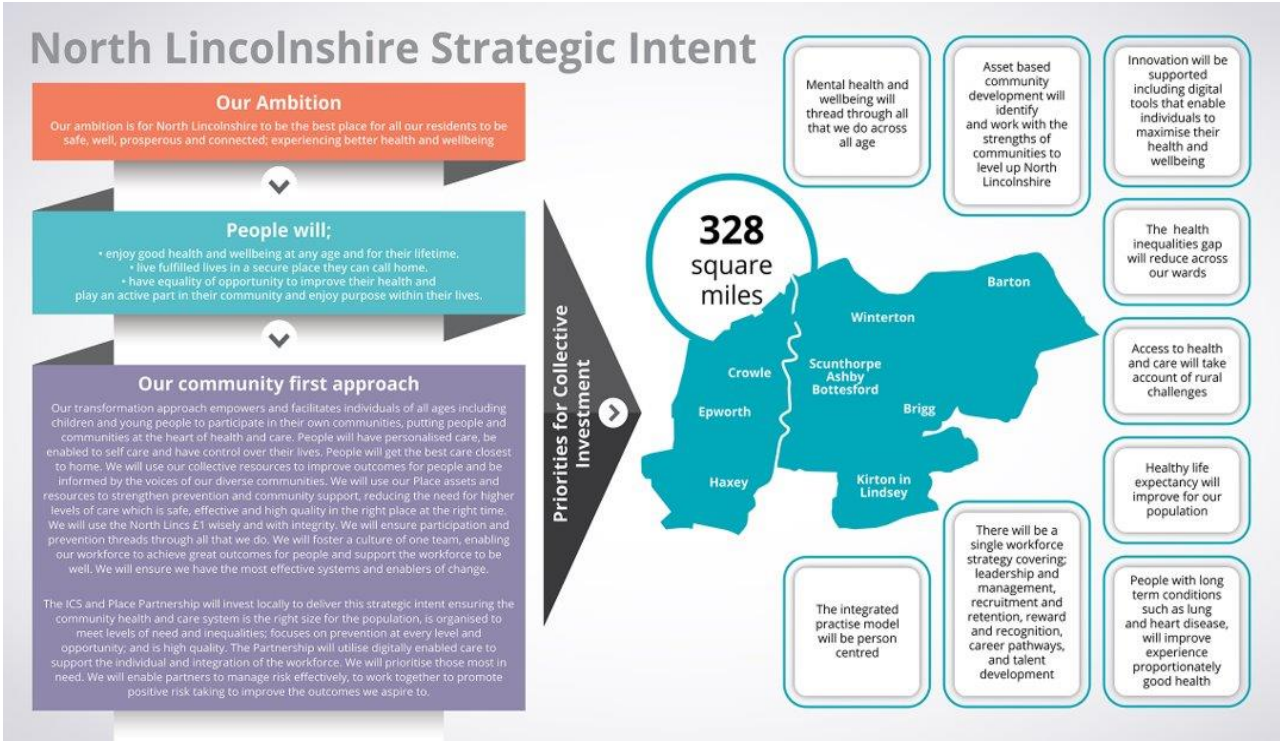
- Northern Lincolnshire and Goole NHS Foundation Trust; Acute and Community services provider
- North Lincolnshire Council; Adult Social Care, Housing (including DFG), Communities
- Rotherham, Doncaster and South Humber NHS Foundation Trust; Mental Health Provider
- Lindsey Lodge Hospice and Healthcare
- North Lincolnshire Voluntary and Community Sector Alliance
- North Lincolnshire Health and Care Partnership

North Lincolnshire Health and Wellbeing Board (HWBB) has a long-standing commitment to integrated working, which is reflected in the ambition set out in the North Lincolnshire Health and Care Integration plan 2021-24, approved by the HWBB. (Appendix 1). This is further reinforced in the draft North Lincolnshire Strategic Intent (Appendix 2) which has been developed to support the development of the Integrated Care Board Integrated Care Strategy.

The Health and Wellbeing Board provide the strategic leadership and resulting strategic plans and resource allocation. The Integrated Adults Partnership Commissioning Plan reinforces our joined-up approach, including our plan for reducing inequalities and sets our approach to implementing and delivering the commissioning intents that are described in the health and care integration plan.

Schemes specific to supporting people to stay at home include Frail & Elderly Assessment Service (FEAST), Community Response Team, DFGs, Home First Community, Specialist Assessment for Frail and Elderly. Inclusivity is at the core of our approach to integrated commissioning of our BCF schemes and more targeted approaches to reducing inequalities are evidenced in the dementia offer, stroke services, social prescribing, FEAST service, welcome home service and older people mental health schemes.

This BCF plan reflects the principles and actions set out in the Health and Care Integration Plan, and the relevant elements of the Integrated Adults Partnership workplan. In developing the plan, we have reflected on the recently developed Strategic Intent of the North Lincolnshire Place and the key priorities arising from that intent.



This has subsequently been consulted on with the broader membership of the Integrated Adults Partnership. The delivery of the Better Care Fund plan is monitored by the Integrated Adults Partnership (Appendix 3 IAP ToR):

Integrated Adults Partnership members 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

Executive summary - Priorities for 2022/23

The current health and care system within North Lincolnshire faces significant demand for hospital admission with higher acuity than in previous years. Whilst the Trust has continued to manage length of hospital stay, on discharge from the acute hospital more people have had ongoing care needs than previously. This increased demand for ongoing care support is set in a context of continued impact of the Coronavirus pandemic and the impact that has had on staff resource levels and infection related care home closures. As a result of this, there has been an increase in demand for rehabilitation and reablement, domiciliary care and short-term care home placements.

There has been a reduction in the number of permanent care home placements in 2022/23 compared to the previous year, however short-term placements (both health and social care funded) have increased. One of the key priorities for 22/23 is to ensure people are discharged on the most appropriate pathway to meet their needs, through right-sizing community-based provision to match demand.

Of those people discharged from hospital to rehabilitation and reablement services, there has been a small reduction in the percentage of those still at home 91 days after discharge. This is in part due to an increase in the number of those people receiving rehabilitation and reablement who subsequently died within the 91 days. This may be natural variation or a reflection of the higher acuity on discharge from hospital. There is a continuous process of data validation of this indicator to ensure data accuracy.

Where people are admitted to hospital, North Lincolnshire performs well in relation to length of stay compared to other places across the Humber and North Yorkshire ICB. The Trust is consistently in the top three out of 42 trusts in the Northern region for 7, 14 and 21+ length of stay, remaining under the target of 12% for 21+ LLOS. This is maintained through NLAG working closely with system partners to discharge patients on a D2A pathway. However, hospital flow remains a key priority for North Lincolnshire with specific focus on;

- avoiding admission through the use of alternative pathways
- ensure people are discharged on the most appropriate pathway,
- expansion of the workforce to support the most challenged discharge pathways,
- engagement with care homes to streamline processes and ensure high quality discharge

This BCF plan therefore has a high focus on avoiding hospital admission and supporting people home from hospital with an appropriate level of reablement to maximise their independence to live in their own home for as long as possible.

Strategic priorities outlined in our health and care integration plan 2021-24 are:

People

- Ensuring equity of access to all aspects of health and well-being using population health management techniques, and other intelligence for vulnerable groups to organise proactive support for them.
- Enabling people to live their best lives, ageing well, in their homes, in their communities; having choice and control over their lives, including the people who care for them.
- Enhancing the health and care of residents living in care settings.

System

- Support and develop Primary Care Networks (PCNs) to further align primary and community services.
- Simplify, modernise and further align health and care (reflecting system changes, including through technology and by joining up primary and secondary care where appropriate).
- Coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.
- Develop an integrated workforce strategy to enable new models of care to be delivered.

The priorities for collective investment detailed in our recently published strategic intent for North Lincolnshire are:

- 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 our wards
- Access to health and care will take account of rural challenges
- Health life expectancy will improve for our population
- People with long term conditions such as lung and heart disease, will improve experience proportionally 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 practise model will be person centred.

Key changes from the previous plan

In this submission North Lincolnshire aims to clarify the way BCF investment is utilised – this is because there has been significant change in the way local services are constructed and delivered which means that the descriptions used since the initial BCF plan no longer fully describe the service delivery models. These service changes have taken place over time as integrated models of care have become more established and embedded, and opportunity has been identified to redesign service models to reduce duplication and make best use of the North Lincolnshire financial resources. Services have adapted, and some services have amalgamated to form larger teams to ensure system resilience. However, the focus remains consistent- avoiding hospital admission, maximising independence through rehabilitation and reablement and building community capacity to support people to remain well.

In this plan and through other funding streams we have further maximised the Community First capacity to support and re-able people within their own homes. This reflects the recent increased utilisation of short-term residential placements due to the limited capacity in domiciliary care to meet needs. In order to ensure discharge flow from the hospital we have recently commissioned a specific care home to support discharges, however with limitations in domiciliary care capacity, the demand for short term placements has risen and additional spot purchase placements have been utilised. It is acknowledged that this results in people receiving a higher level of care than they need with implications in terms of impact on their independence and increased risk of needing long term care. Plans are in development to deliver the transformational and cultural change required to reduce reliance on bed-based care.

North Lincolnshire system partners have recently completed a system-wide baseline assessment against the 100-day challenge discharge indicators and are developing plans to address those indicators where potential for improvement has been identified. These indicators align with actions identified within the Hospital Discharge project which has been supported by NHS E/I.

North Lincolnshire is currently delivering a hospital discharge transformation project which aims to ensure people discharged from hospital are cared for in the right place, supporting them to regain independence to live in their own homes. A system wide improvement plan has been developed, which is monitored at the fortnightly Discharge Improvement Group, attended by all system partners. The plan has been developed using discharge guidance published in July 2022.

Key milestones within this plan are described below:

Key actions	Due date
Discharge planning to include EDD, reduced length of stay and discharge to the right setting	End Sept 22
Pro-active and timely discharge involving patient and carers to ensure patient is on most appropriate pathway	End Sept 22
Understanding capacity and demand for domiciliary care	End Oct 22

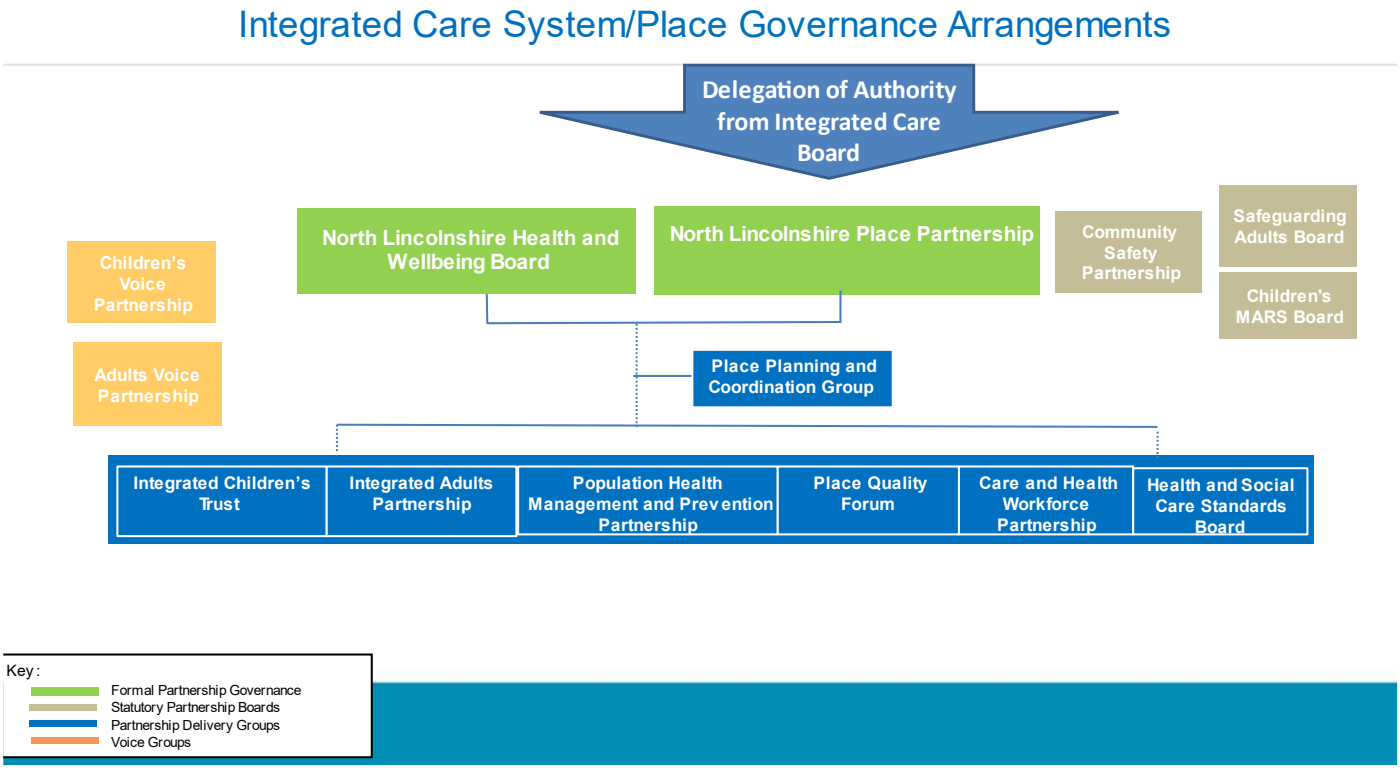
Ensuring consistent 7 day access to therapy/ increased therapy support to Home first	End Oct 22
Ensure data systems consistently report discharge by patient pathway, lost bed days and monitor discharge trends across the system	End Oct 22

North Lincolnshire also has an active Care and Health Workforce Partnership which is taking forward actions to further develop community-based capacity, through a number of initiatives including:

- Development of a common language
- Common core knowledge and skills across the adult workforce
- Effective communication and engagement
- Information sharing
- Supporting development and transition
- Safeguarding and promoting welfare of the vulnerable adult
- Promoting wellbeing
- Making every contact count
- Multi-agency integrated working
- Risk management
- Assessment skills

Governance

Following the creation of the Integrated Care Board, the local governance systems are being revised to reflect the changes. The governance structure is described below. This demonstrates how the Integrated Adults Partnership and the Care and Health Workforce Partnerships relate to the Health and Wellbeing Board and North Lincolnshire Place Partnership. The Integrated Adults Partnership has a responsibility for oversight of the delivery of the Better Care Fund



Overall BCF plan and approach to integration

Priorities for integration are set out in the North Lincolnshire Health and Care Integration Plan 2019-2024, which aims to maximise the benefits to the population through integrated commissioning. Further to this, the Place Partnership has developed its Strategic Intent and is reviewing the current programmes to ensure alignment to the Strategic Intent. Oversight of the work programme is via the Place Executive as set out in the governance chart above.

Our approach to joint/collaborative strategic commissioning is set out in our IAP Strategic commissioning plan 2020-24. This plan demonstrates the person-centred approach to care including a number of 'I' statements which describe the outcomes we aim to deliver. Our approach to integration has enabled us to increase capacity to drive forward our approach to integration, which can be evidenced through the development of a number of integrated posts, including a place based executive discharge lead.

There are no significant changes to any of our commissioned schemes for 2022-23. The BCF plan covers the following summarised schemes. The detail of these schemes is 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 people's mental health liaison
- 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

Implementing the BCF Policy Objectives (national condition four)

Our overarching approach to meeting the national condition four objectives is routed the work of our Integrated Adults Partnership. This has two focused strands, one being living well and the other being ageing well. The aims of the IAP is to deliver the health and care integration plan in line with the shared strategic principles of enabling self-help, care closer to home, right care, right place and best use of resources.

Schemes that directly contribute to the delivery of the policy objectives include:

- Targeted support for younger adults
- Alternative solutions to live well at home
- Residential care placement sufficiency review
- Development and implementation of the Carers Strategy
- Intermediate tier sufficiency, system flow and pathways
- Integrated model for social prescribing

<u>Enable people to stay well, safe and independent at home for longer</u>

Collaboratively, we commission a number of services that support this objective, for example, carers support, home equipment services and therapy. These are personalised and adopt an asset-based approach. In terms of service delivery health and care teams are co-located where possible and operate as multidisciplinary teams to reduce duplication and maximise positive outcomes.

Personalised budgets are actively encouraged and facilitated to ensure people benefit from personalised and creative solutions, designed by them, to meet their needs. The Disabled Facilities Grant (DFG) approach further integrates health and housing to develop person focused solutions to maximise and maintain independence.

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.

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. All schemes are monitored and adapted as necessary in response to anticipated needs.

<u>Provide the right care in the right place at the right time</u>

Collaboratively, we commission a number of services that support this objective, for example, home first hospital discharge social workers contributing to multi agency discharge planning, community home first capacity to provide rehabilitation and reablement in a person's own home and home care packages.

Throughout the period of the covid pandemic it is recognised that some people discharged from hospital have received short stay residential placement due to capacity issues in domiciliary care. Our integrated discharge hub team, work 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.

Personalised budgets are actively encouraged and facilitated in order to ensure people benefit from personalised and creative solutions to meet their needs. The DFG approach further integrates health and housing to develop person focused solutions to maximise and maintain independence.

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.

North Lincolnshire has undertaken a self-assessment against the high impact change model for managing transfers of care and developed action plans in order to improve performance and implement high impact changes. This work is taken forward through the system discharge workstream, which, through partnership working aims to improve the discharge planning process. Current workstreams include;

- Early discharge planning to ensure consistent use of estimated discharge date
- Integrated Discharge Team approach to discharge planning to improve co-ordination , joint/trusted assessment and effective discharge
- Home first/ discharge to assess, to maximise the community capacity to discharge people to their own home where appropriate and to reduce delayed discharges
- Enhancing health in care homes with a focus on exploring the best delivery models to achieve the best outcomes through the Enhanced Health in Care Homes enhanced service to reduce unnecessary hospital admissions

More recently North Lincolnshire has completed a self-assessment against the 100-day challenge acute hospital discharge requirements and is implementing plans in response**.** Our identified top priorities in this workstream are;

1. Identify patients needing complex discharge support early
2. Set expected date of discharge (EDD), and discharge within 48 hours of admission
3. Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges

A number of our established BCF funded schemes support delivery of our HICM and 100 day challenge priorities set out above, including Home First schemes (community, residential and hospital), hospital social worker team, increasing Community support, Intermediate care including the rehabilitation flat and Lindsey Lodge hospice beds for the most complex discharges.

Supporting unpaid carers.

Carer support services are jointly commissioned in North Lincolnshire with the service funded via the BCF. This provides dedicated carer support service focusing on prevention and early intervention to better identify and support carers in North Lincolnshire.

The service supports carers to avoid crisis through delivering befriending, counselling, training, activities, peer support and key worker support. Where carers have longer term needs; usually requiring regular replacement care, the Family Carer Team will work with the carer, the person they are caring for and social work leads to assess their needs and access a Direct Payment. Direct payment funding will be sought to enable carers to have a break if they are at crisis or to enable them to continue to fulfil their caring role.

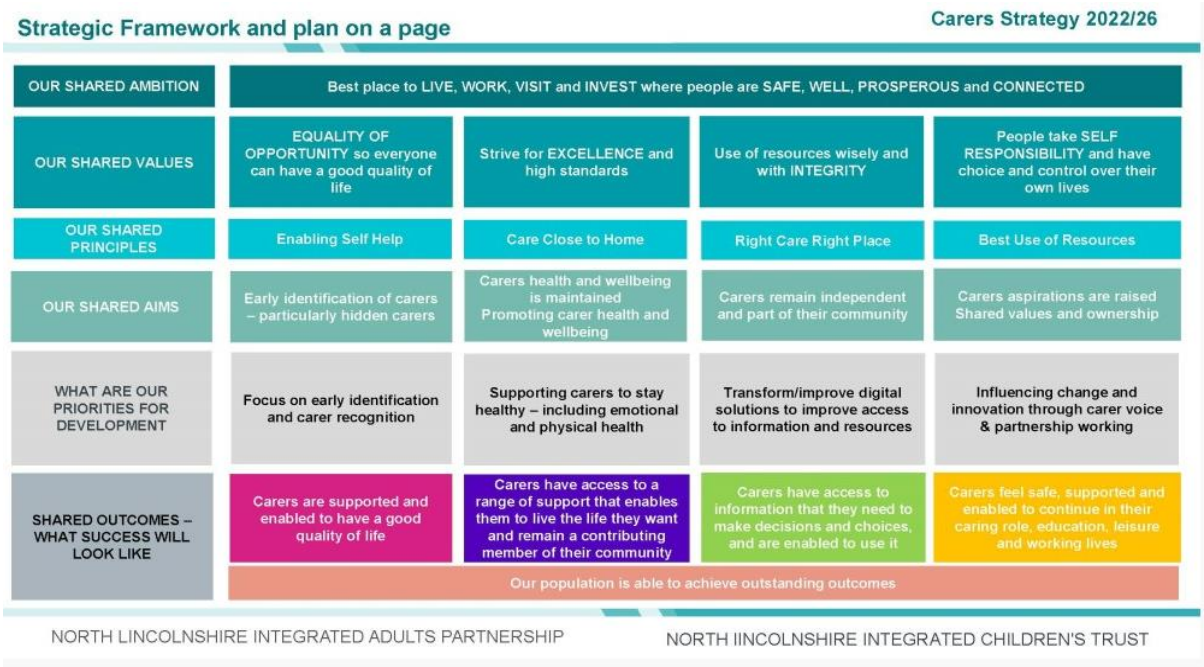
Feedback on this support highlights that 87% of those who access the Family Carer Team are satisfied with their support.

The targeted assessment and support function which sits in the council (the Family Carer Team) works closely with health and other local partners through a delivery partnership to take a proactive approach into improving the experience, health, and wellbeing of carers. This includes the delivery of key projects, including Primary and Secondary Carer Resource Pack and market shaping activities which will be delivered in collaboration with the carers support service and Family Carer Team as well as key health partners.

The current carer support service contract is due to end during 2022/23 and we are working with service users, the public and stakeholders to understand how the current provision meets needs. This will inform the future specification for the service. The current service has adapted significantly during the covid period to maintain support, and the engagement work will help establish how the support needs to be designed in the future and ensure all carers can and know how to access support if they want or need it.

We have recently developed and launched our carers strategy 2022-6. This sets out how we will identify and support carers to help them stay well and healthy in their role, provide them with the resources they need to keep connected and to give them a voice in services that are developed and need developing.

The Care Act 2014 recognises the equal importance of supporting carers and the people they care for. There are over 19,000 carers in North Lincolnshire and the diagram below illustrates our strategic framework and plan on a page for supporting carers of all ages.



Disabled Facilities Grant (DFG) and wider services

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

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.

The Housing Advice and Support Service work across system partners to provide advice and support to people who have multiple support needs and supports them to remain in their own homes and enable independent living. Examples of alternative housing options including the Poplar Tree Avenue supported living accommodation for young people with disabilities enabling them to live independently. The development of a flagship extra care housing scheme (Myos House) for people with early onset dementia provides alternate accommodation choices for people who live with dementia and their partners. Environmental Health also play a part and can, when needed, step in and ensure work is carried out to address health and safety hazards in the home, where they particularly impact on older people or work in partnership with social care around mental health and hoarding needs.

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 to stay safe at home. Any capital underspends at the end of one financial year (e.g. resulting from COVID related blockages in the system) are re-phased to finance additional expenditure in the following financial year to meet the demand for grants to be utilised in the delivery of the home assistance programme in future years.

Our home assistance policy provides a strategic holistic framework to keep people safe and well and to live independently in their own homes for as long possible. A priority for 2022-23 onwards is to maximise the use of digital solutions/telecare to support people to maintain independence in their own home. 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. We are looking to expand this service to provide a proactive assessment approach to identify hazards in the home and take appropriate remedial action in a timely manner.

We work at a system and place wide level to target the disabled facilities grant towards 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. We have streamlined our processes to speed up delivery of particular adaptations such as stairlifts.

We have established a Health and Housing workstream as part of the Population Health Management and Prevention Partnership arrangements to identify those priority areas where collaborative working and integrated approaches can support people to remain well and independent in their own homes for longer.

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:

- reviewing our approach to Disabled Facilities Grants and Home Assistance Policy
- Strategic review of housing needs and the development of a new housing strategy and supporting governance arrangements
- Review of the Home Choice Lincs housing allocations arrangements with a focus on ensuring the needs of vulnerable people are improved

Equality and health inequalities

In November 2021 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 recognizes 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

Our refreshed health and wellbeing strategy is based on evidence set out in our Joint Strategic Needs Assessment which is currently being refreshed. We have recently updated our ward profiles that provide valuable intelligence and insight on health inequalities across North Lincolnshire, and these have also helped shape the new health and wellbeing strategy. Insight gained from the Covid 19 pandemic has highlighted local health inequalities, particularly in relation to those living in our most deprived areas and our BAME community, many of whom also live in the most deprived areas.

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

Intelligence has identified specific populations within North Lincolnshire most impacted by these issues 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. However, more recently we are anticipating that the increase in cost of living is likely to impact in 'new' geographic areas not typically associated with deprivation and work is being undertaken to understand the impact and consider mitigation.

The data are 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.

As part of the PHM approach all PCNs have been provided with comprehensive data packs which identify key data and intelligence around:

- Demographics
- Maternity
- Serious Mental Illness
- COPD
- Hypertension
- Other determinants of health
- Healthy Well

The data packs can be used to identify a population within the PCN experiencing inequality in health provision and/or outcomes and develop a plan to tackle the unmet needs of that population. The data shows that CVD is a significant cause of mortality and an a workstream is set up to put in place interventions to for those most at risk of CVD.

The recommissioning of our Carer Support Services during 2022/23 and 23/24 will engage with a range of carers and stakeholders and using equality and diversity data, we will target those communities who are under-represented in current services in order to understand any barriers to accessing carer support. These barriers will then be addressed in the new commission. Data shows that young carers, male carers and those from a BAME background are under-represented in the Carer Support Service.

Several other BCF funded schemes target those with the greatest health inequalities, including non-elective admissions, FEAST, specialist assessment of the frail and elderly and the Urgent Community Response team. In particular are those people experiencing cardiac and respiratory disease which is most prominent in our areas of highest deprivation.

There are no key changes to any of our schemes for 2022-23 since the previous BCF submission.

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.

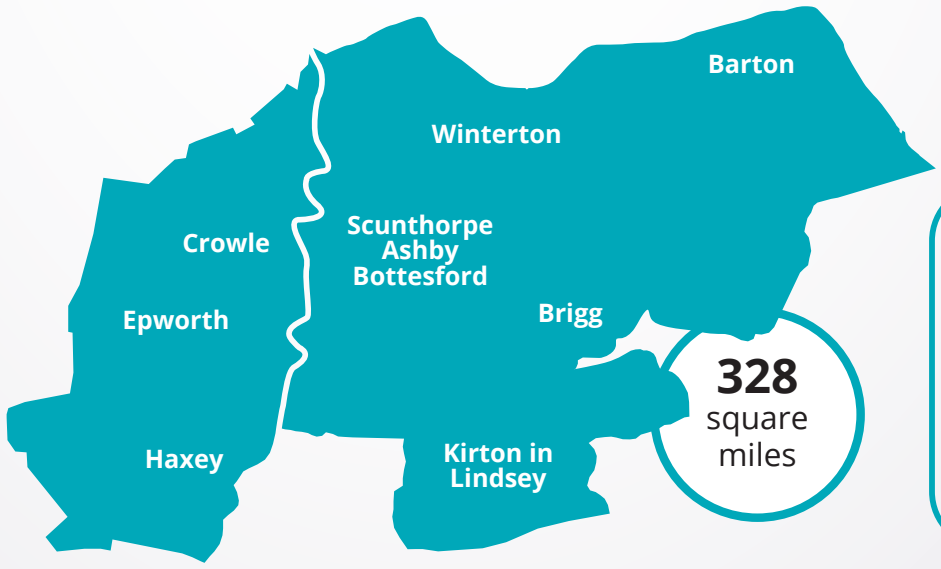
The ICS and Place Partnership will invest locally to deliver this strategic intent ensuring the community health and care system is the right size for the population, is organised to meet levels of need and inequalities; focuses on prevention at every level and opportunity; and is high quality. The Partnership 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

The integrated practise model will be person centred

Mental health and wellbeing will thread through all that we do across all age

There will be a single workforce strategy covering; leadership and management, recruitment and retention, reward and recognition, career pathways, and talent development



Asset based community development will identify and work with the strengths of communities to level up North Lincolnshire

People with long term conditions such as lung and heart disease, will improve experience proportionately good health

Healthy life expectancy will improve for our population

Access to health and care will take account of rural challenges

The health inequalities gap will reduce across our wards

Innovation will be supported including digital tools that enable individuals to maximise their health and wellbeing