North Lincolnshire Health and Care Partnership

1st Community First Approach

North Lincolnshire BCF Narrative Plan 2023-25

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North Lincolnshire Health and Care Partnership

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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

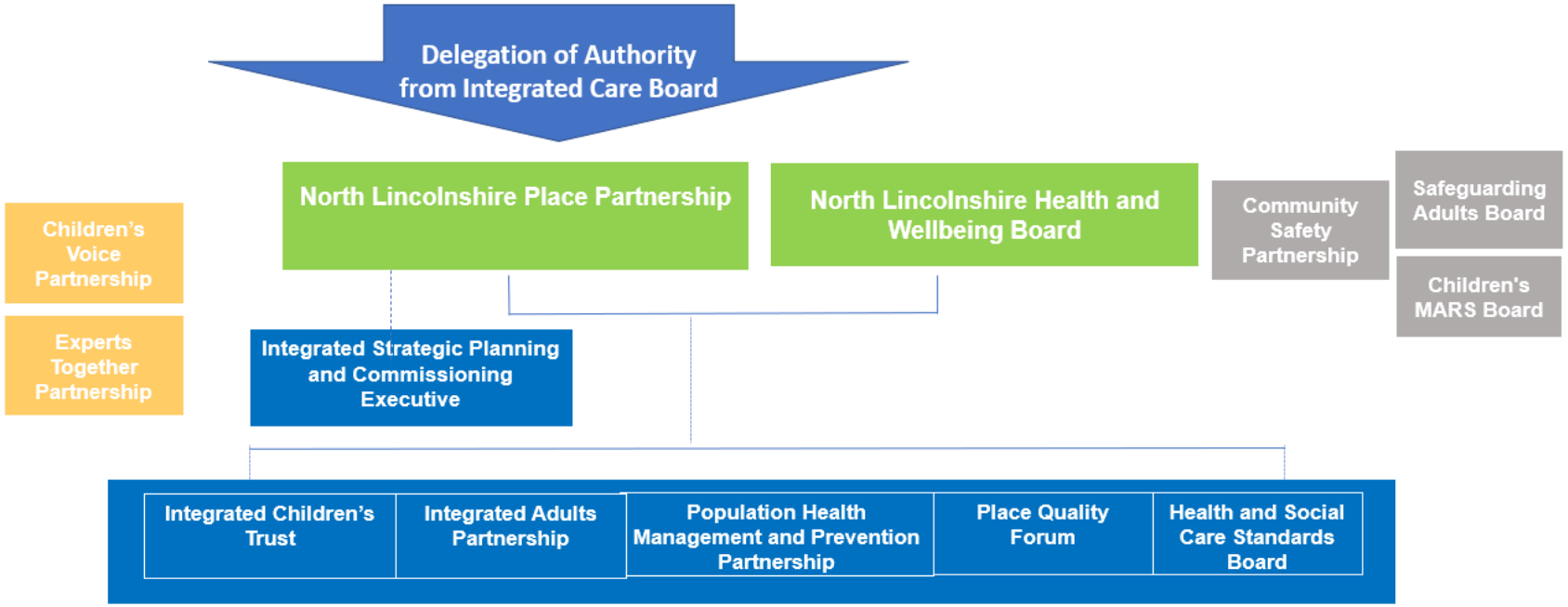
Partners and wider stakeholders involved in preparing the plan are:

- 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



Key:
- Formal Partnership Governance
- Statutory Partnership Boards
- Partnership Delivery Groups
- Voice Groups

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.

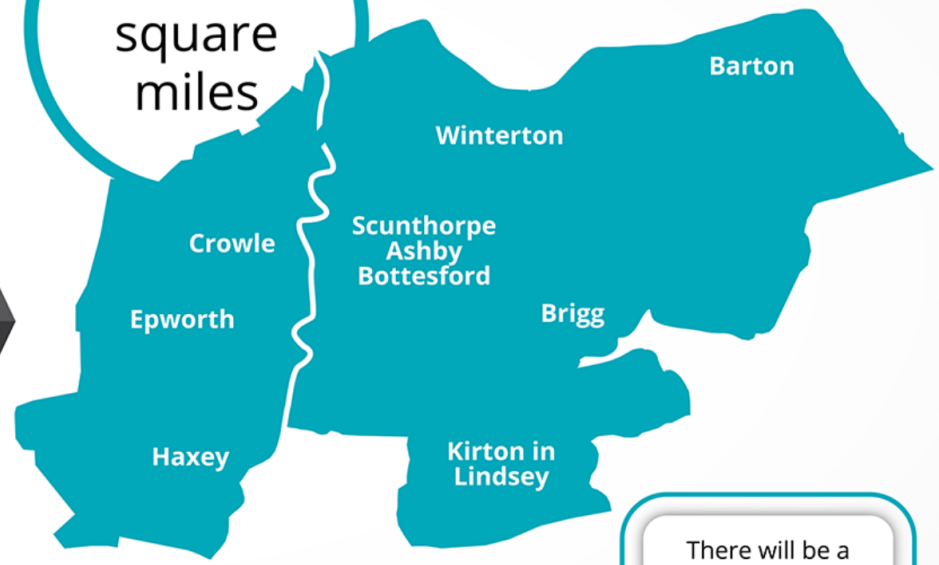
Our community first approach

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

328 square miles



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.

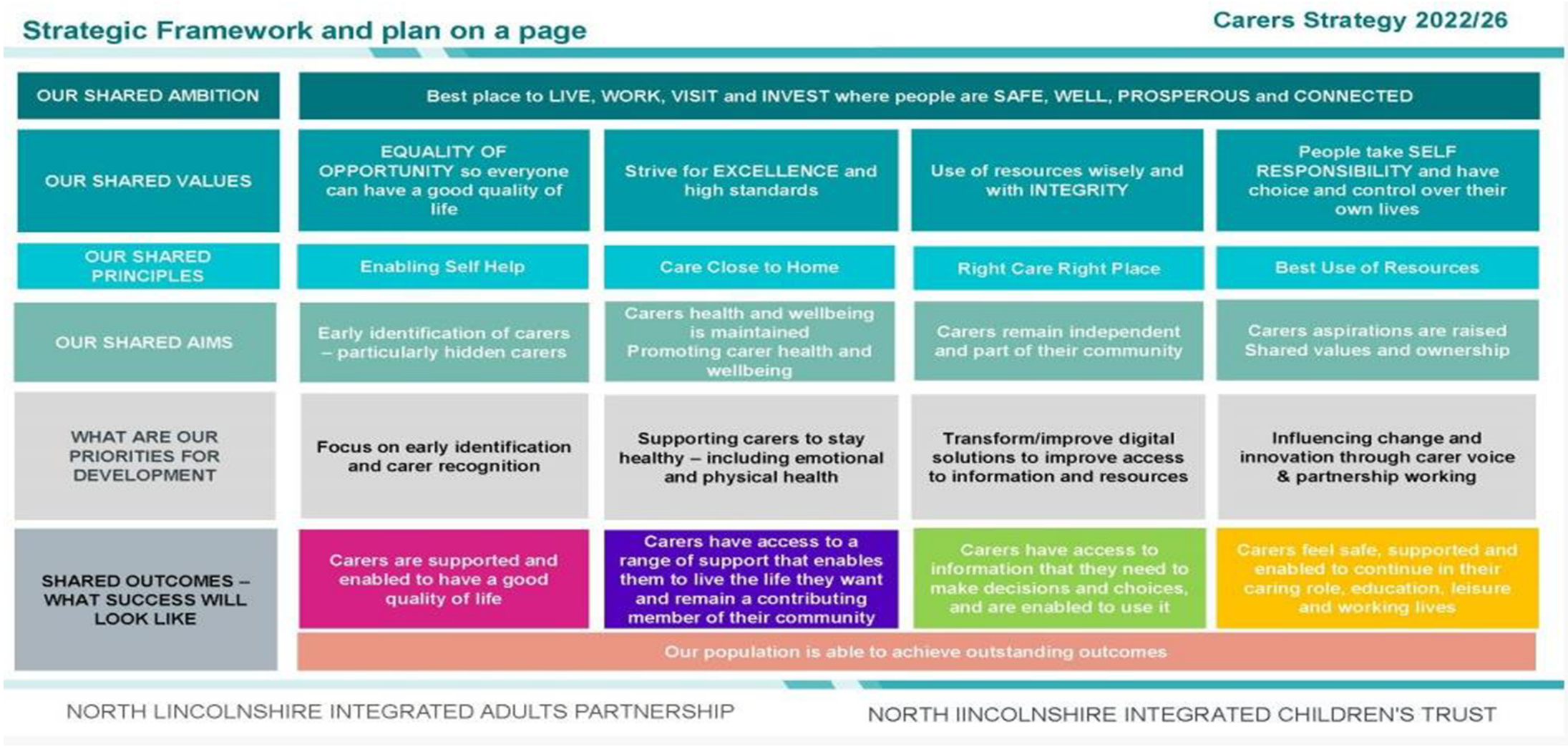
The Care Act 2014 recognises the equal importance of supporting carers and the people they care for and the targeted assessment and support function which sits in the council (the Family Carer Team), continues to work closely with health and other local partners to take a proactive approach into improving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

North Lincolnshire Health and Care Partnership

1st Community First Approach

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
werPoint Presentat

Amendments following draft submission

North Lincolnshire Health and Care Partnership

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