
North Lincolnshire Health and Care Integration Plan 2021-2024

North Lincolnshire Partners



4 PCNs East, South,
North and West



Introduction

This is an update of the five year plan first published in 2019 and is set in the context of the Health and Wellbeing boards responsibilities to promote integration. The plan shows how we intend to focus on transforming the lives of people of North Lincolnshire, through developing a sustainable, enabling integrated Health and Social Care system that empowers our local population, unlocks and builds community capacity.

This plan sets out:

- our place
- our people
- our shared ambition for people and the workforce
- who we are and what we do together
- what we do well
- our shared strategic principles
- what people have told us
- our main achievements since the original 2019 plan
- our strategic priorities.

Partners have committed to improving outcomes for the population and place of North Lincolnshire: safe, well, prosperous and connected are the outcomes that we are working together to improve. A detailed action plan sits beneath the plan to monitor and review our progress and achievements.

Our place is

- ✓ A fantastic place – an area of expansive countryside, contrasting landscapes, scenic beauty, vibrant market towns and home to world class steel processing and manufacturing.
- ✓ A place to live. It's home to 172,000 people, where average wages for those in full time work are higher than the regional average and with lower house prices.
- ✓ A place to grow up. Where 9 out of 10 children and young people attend a good or outstanding early years setting, school or college and go on to achieve better outcomes than the England averages.
- ✓ A place to grow older. Where life expectancy is at its highest level, continuing to improve each year and where quality of care provision is high. All homecare providers are rated as good and most care homes rated as good or better.
- ✓ A place for outdoor living. With over 600 miles of footpaths, cycle ways and water ways as well as 17 nature reserves and quality parks and green spaces (four with Green Flags Award). There are a range of sports and leisure facilities and cultural arts venues that promote our local history and heritage.
- ✓ A place for businesses to grow. With access to the UK's major centres, Europe and beyond through road, rail, air and sea, there is lots of potential to invest and diversify.



Our People

In 2019 21.4% of our population are aged 65+ compared with 18.4% for England.

In the 2011 census of North Lincolnshire, there were approximately 70,680 households. Over a quarter (27.5%) of those were one person households.

By 2039 our North Lincolnshire population is predicted to increase by 4.2%.

There has been an estimated growth of 23.5% in the number of people aged over 85.

An ageing population may influence housing needs, requiring more accessible housing options.

The 2011 census showed 1 in 9 people are caring for someone else (19,000 people).

In 2011 5.8% of people reported their health as poor / very poor, and 19.3% reported a long term illness or disability.

Our ambition

Partners have signed up to a shared ambition for North Lincolnshire to be the **Best place to live, work, visit and invest** and for all our residents to be **safe, well, prosperous and connected**.



Health and Care Integration Plan

We have also signed up to focus on transforming the lives of people of North Lincolnshire through developing a **Sustainable – Enabling** Integrated Care System across all life stages and levels of need, that **empowers** our local population and **unlocks** and builds community capacity.

The persons' voice is at the heart of all we do.

Work in partnership for the good of our population.

Safeguarding partnerships.

Quality community and education provision.

High performing Council services.

North Lincolnshire CCG rated good NHS Oversight Framework rating.

Agreed focus on early help.

Focus on Place to support thriving communities.

Healthy work place scheme for local business.

Know our populations.

What we do well

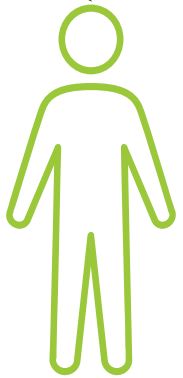


Our shared strategic principles

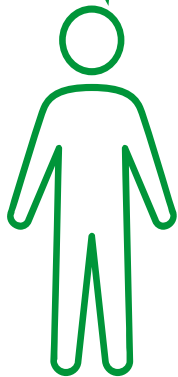
<i>Enabling Self Help</i>	<i>Care Closer to Home</i>
Helping people in ways that reduces or delays their need for care and support encourages self responsibility and is empowering for individuals and their families.	People expect services to work together to enable them to have their needs met within their locality when ever possible. Adults achieve better outcomes when they remain in familiar settings.
<i>Right Care Right Place</i>	<i>Best Use of Resources</i>
When people require health and care, getting the person to the most appropriate setting to meet their needs enables better outcomes, specifically where the care needed is specialist. It also means the care delivered has to be right and for the right length of time.	Continually looking to find the most cost effective way of meeting peoples needs in hospital and in the community, using our organisational assets makes sure people are in the centre and involving local people in the future design of local services is more sustainable; as is a workforce who attends to their own health and is aware of the empowering nature of self help is a must.

Person-Centred Care

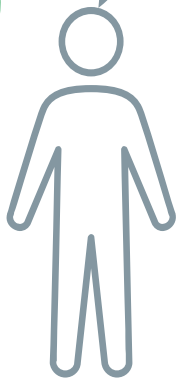
I have a place I can call home, not just a 'bed' or somewhere that provides me with care.



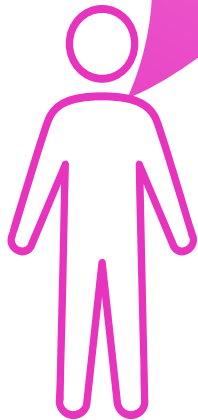
I am supported to manage my health in a way that makes sense to me.



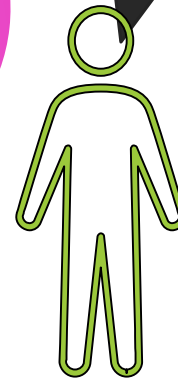
I know about the activities, social groups, leisure and learning opportunities in my community, as well as health and care services.



I have a co-produced personal plan that sets out how I can be as active and involved in my community as possible.



I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals.



I am supported to plan ahead for important changes in life that I can anticipate.



Our main achievements 2019-21 include

- A 'community first' approach was applied, putting the person at the heart of everything we do. In addition to providing information, advice, and guidance; connecting more vulnerable residents and families to direct support from within their community (Appendix A & B).
- A new 'Welcome Home' service to support people leaving hospital has been developed with the voluntary sector to ensure people returning have everything they need at home.
- A single point of access for community health and social care has been created and provides the public and professionals a single contact point for advice and support.
- A GP role has been established to support an urgent response to people in crisis in their own homes, alongside community health and social care resulting in a reduction in avoidable hospital admissions and A&E attendances.
- The Urgent Treatment Centre providing urgent care without the need to attend A&E, was implemented and is provided at Scunthorpe General Hospital.
- A joint approach to supporting frail and elderly residents has been developed which will enable a pro-active approach to supporting people living with long term health and support needs.
- Focused reviews on the hospital discharge process, highlighted what needs to be different moving forward to enable people to leave hospital at the right time and support them to remain in their own homes.
- The Primary Care Networks (GP arrangements Appendix C) covering North Lincolnshire are now well established and have been pivotal in delivering the vaccination programme.
- The vaccination program for COVID-19 has had a high uptake locally with all groups offered the vaccine within timescales.

Our main achievements 2019-21 continued

- The mental health community model has been developed, providing support to people with mental ill health, closer to home.
- A draft strategy has been developed for palliative end of life care and is currently out for consultation across North Lincolnshire.
- Infection prevention control training has been provided to all front-line care home and homecare staff, keeping people safe and well and reducing the spread of infection.
- Partners have adapted to new ways of working using technology, and people in receipt of care and support have embraced this change.
- Workforce plans changed to support our response during the COVID-19 pandemic. People were deployed differently to take on new roles and transferred to contribute to our emergency response within acute, community and social care settings.
- A&E departments altered across the region to help respond to Covid-19 and winter pressures.
- Humber, Coast and Vale staff resilience hub was launched to support health, care and emergency service workers who may be struggling from the impact of Covid-19.
- Tablet devices were provided to ensure that care home residents could remain connected to GPs from the outset of the Covid-19 pandemic.
- Electronic Palliative Care Co-ordination Systems (EPaCCS) and ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) were implemented.
- A standard competency framework for end of life care skills across partners was implemented, and working together to develop standard training for agreed priority areas. Three initial priorities are being developed: clinical practice/direct patient care; communications skills and symptom management including last days of life.

Our Strategic Priorities



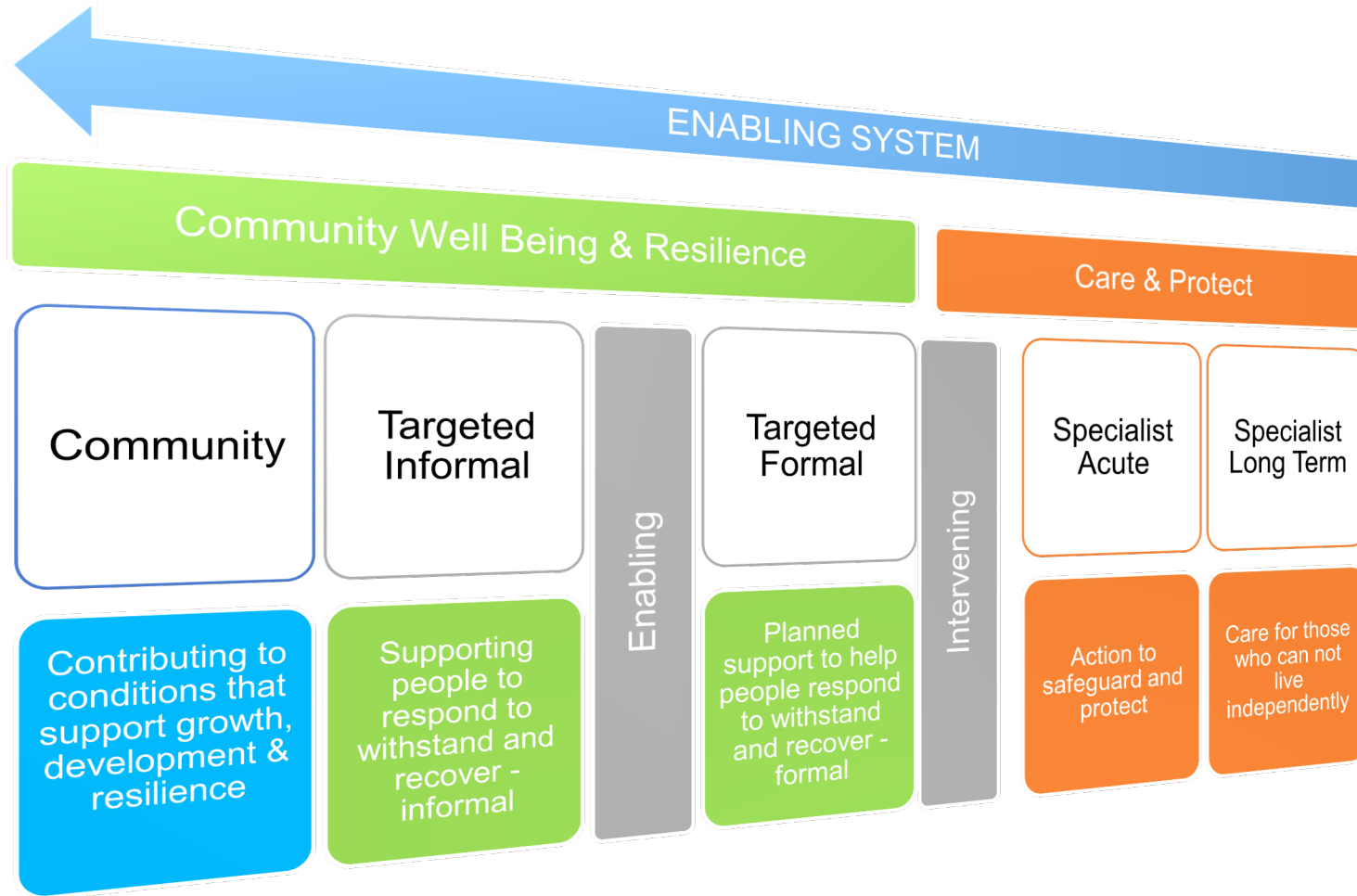
People

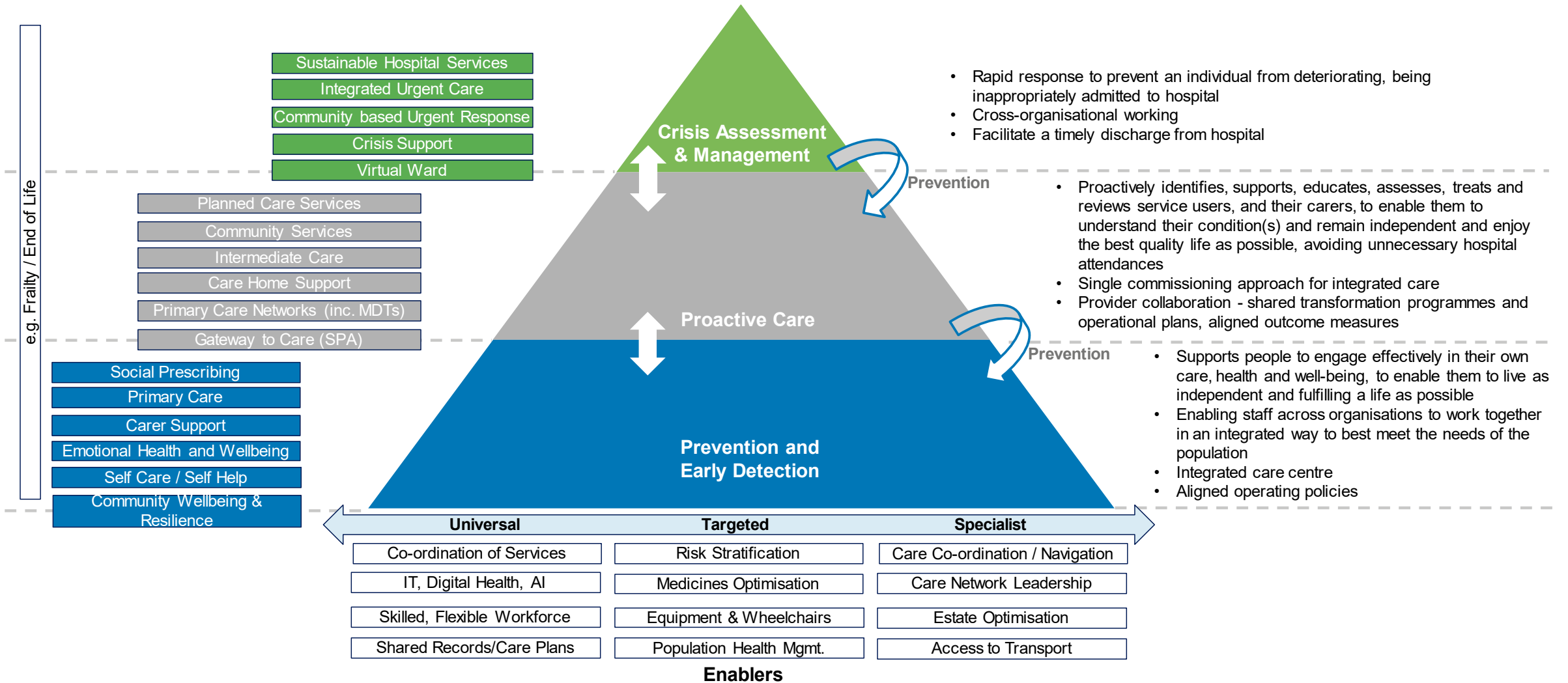
- Ensuring equity of access to all aspects of health and well-being using population health management techniques, and other intelligence for vulnerable groups to organise proactive support for them.
- Enabling people to live their best lives, ageing well, in their homes, in their communities; having 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.







East PCN – population 31,639 (Apr 2021)

- The Killingholme Surgery
- Riverside Surgery (Brigg)
- Barnetby Medical Centre
- West Town Surgery (Barton on Humber)
- The Medical Centre (Barnetby)
- Trent View Medical Practice

North PCN – population 33,329 (Apr 2021)

- Central Surgery (Barton on Humber)
- Winterton Medical Practice
- Bridge Street Surgery (Brigg)

South PCN – population 73,063 (Apr 2021)

- Cambridge Avenue Medical Centre
- Ancora Medical Practice
- Ashby Turn Primary Care Centre
- Kirton Lindsey and Scotter Surgery
- West Common Lane Teaching Practice
- Cedar Medical Practice

West PCN – population 44,511 (Apr 2021)

- South Axholme Practice
- Church Lane Medical Centre
- The Oswald Road Medical Centre
- The Birches Medical Practice
- Market Hill