North Lincolnshire
Health and Care Integration Plan 2021-2024
BCF Narrative Plan 2021-22

Approved by the North Lincolnshire Health and Wellbeing Board – June 2021

North Lincolnshire Council

NHS North Lincolnshire Clinical Commissioning Group

Introduction

This narrative plan supports the agreed spending plan and ambitions for the Better Care Fund 2021-22

The approach described within this plan is based upon the principles and actions agreed within the North Lincolnshire Health and Care Integration Plan 2021-24 which was approved by the North Lincolnshire Health and Wellbeing Board in June 2021 (pages 3 -16 of this plan).

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

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.

Who we are

safecare network

NHS North Lincolnshire Clinical Commissioning Group

NHS Rotherham Doncaster and South Humber NHS Foundation Trust

LINDSEY LODGE Hospice and Healthcare

4 PCNs East, South, North and West

North Lincolnshire Council www.northlincs.gov.uk

Voluntary Community & Social Enterprise Alliance North Lincolnshire

NHS Northern Lincolnshire and Goole NHS Foundation Trust

NHS East Midlands Ambulance Service NHS Trust

NHS Yorkshire Ambulance Service NHS Trust

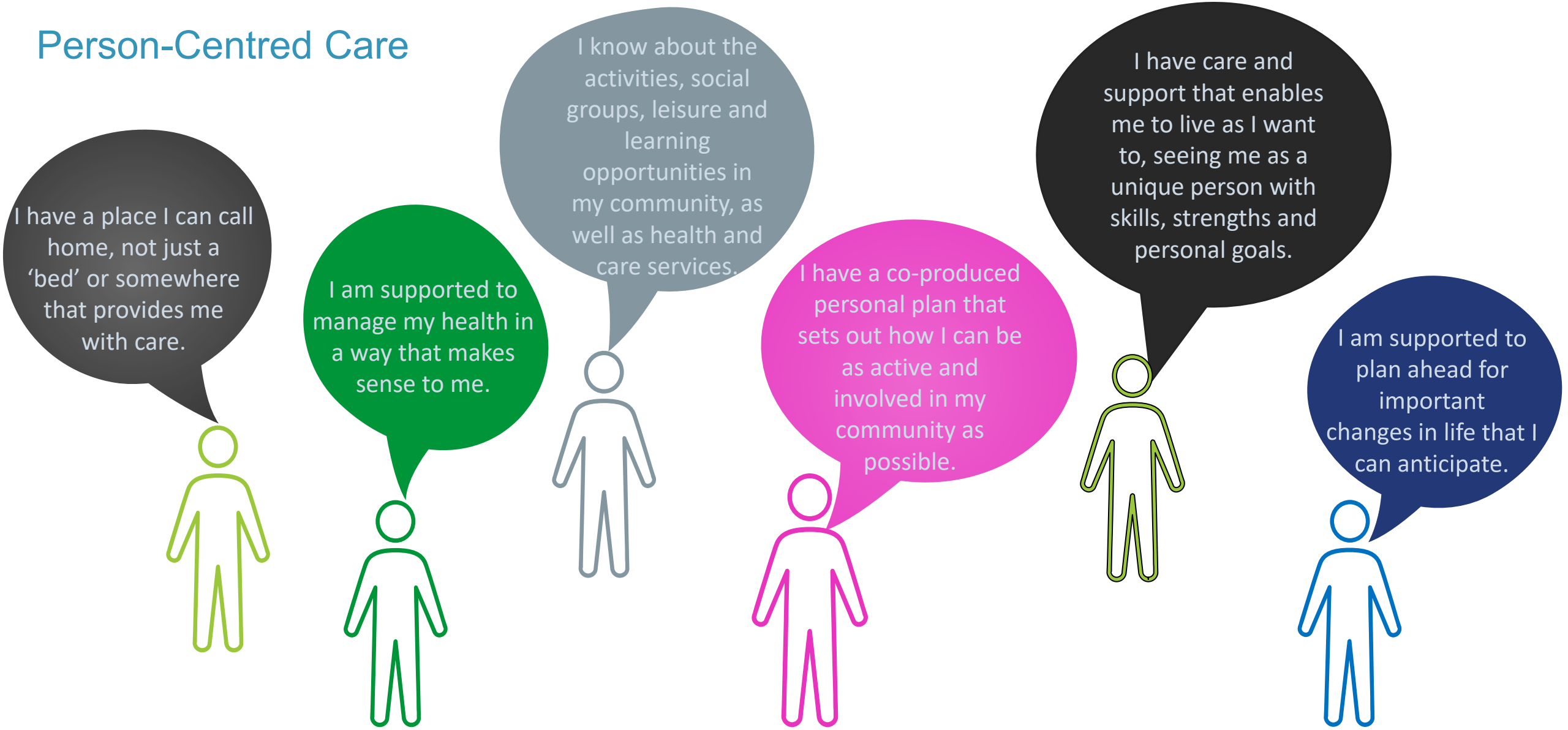
What we do well

- 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.

Our shared strategic principles

Enabling Self Help	***Care Closer to Home***
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.
Right Care Right Place	***Best Use of Resources***
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



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.

Supporting people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people

- 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.

- 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 handyperson service provides assistance to enable people to return home from hospital by providing minor adaptations, additionally the service also 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. We have streamlined our processes to speed up delivery of particular adaptations such as stairlifts.

- The Housing Advice and Support Service work with a range of people, across system partners, to provide advice and support to people who have multiple support needs around maintaining a roof over their head. 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.

- We have recently opened the first extra care facility for people with dementia in North Lincolnshire and have used DFG funds to provide equipment and digital technology to enable independent living.

Our plans for improving recruitment and retention of staff in social care

A recruitment campaign has been launched called ‘Proud to Care’ which raises the profile of working in the care sector, encouraging more people to work in care and play a crucial part in supporting people to remain independent in their own homes. The Proud to Care Recruitment Hub continues to innovate through developing projects that will attract and enable people to join the social care workforce.

A strong offer in terms of adult social work development has been maintained and recruitment to social work apprentice placements has taken place along with the offer of work experience placements

Other solutions implemented include:

- Introduced various care worker discounts and perks
- Funded childcare for homecare workers until March 2022
- Provided funding for transport (scooter/moped scheme)
- DBS checks completed through LA to reduce time delays
- Funded skills for care membership for all regulated care providers
- Funded virtual induction training programme to support induction of new staff, re-induction for staff previously shielding, and potentially upskill staff within non-adult social care roles.
- Care Home Support Plan –tiered staffing support approach including mutual aid, and agreement in place to enable access to Acute provider bank staff
- Care Home Oversight Group – has provided support throughout the pandemic to the regulated care sector, more recently with regards to mandatory vaccinations
- Established a Welcome Home volunteer service, to reduce requirement for regulated care provision
- Use of non-framework providers in order to meet demand

Future solutions include the introduction of a single agency recruitment service along with a care academy.

Our plans for addressing equality and health inequalities

In September 2021, our Health and Wellbeing Board approved a new health and wellbeing strategy. The board also agreed a new strategic direction and principles that provide the basis for place planning and support the developing maturity of health and social integration.

The working aim for the development of the strategy is ***'By working together, to improve health and wellbeing and decrease disparities in health'.***

The health and wellbeing board have agreed six priorities for the new health and wellbeing strategy:

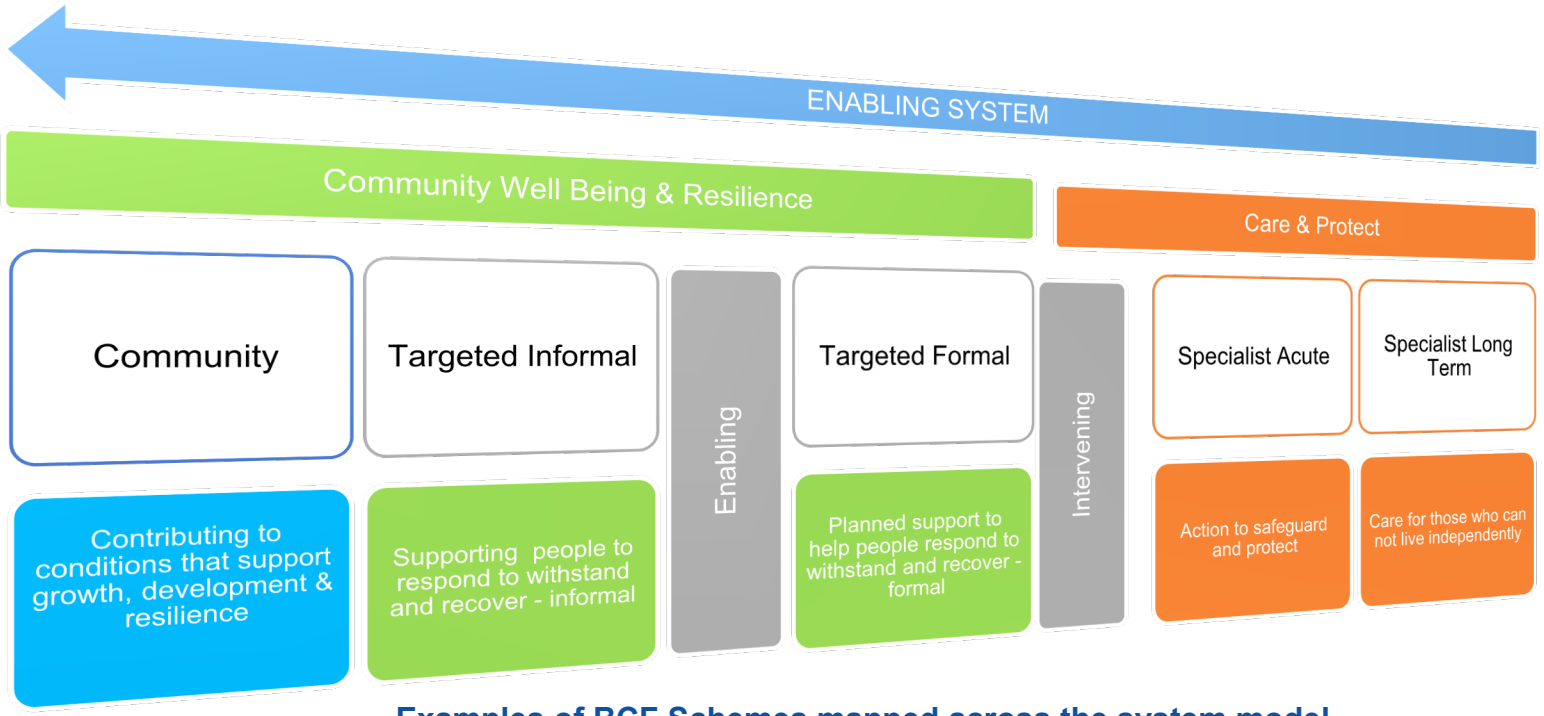
- Keep North Lincolnshire safe and well
- Babies, infants and young people to have the best start in life
- People live well to enjoy healthy lives
- People experience equity of access to support their health and wellbeing
- Communities are enabled to be healthy and resilient
- To have the best systems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

We have also agreed to incorporate the NHS nine commitments to urgent action in order tackle the impact of covid on health inequalities.

Our new 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.

Through the health and wellbeing board it has been agreed to establish a 'health management and prevention collaborative', which will use population health management techniques to identify amongst other things inequalities in service provision, access to services and prevention interventions.

There are no key changes to any of our schemes for 2021-22 since the previous BCF.



Examples of BCF Schemes mapped across the system model

- Community Hubs
- Independent Living Service
- Carers Support Service
- NHS Dementia Advisory Network
- Welcome Home VCS support for hospital discharges
- Home First Rehabilitation and Reablement
- FEAST
- Community Response Team (formerly RATL)
- Older people's mental health liaison
- Disabled Facilities Grants and wider housing services

Our system model describes our approach to supporting people at the lowest level of need, providing a range of early help and prevention services, reducing and delaying the need for specialist health and care services.

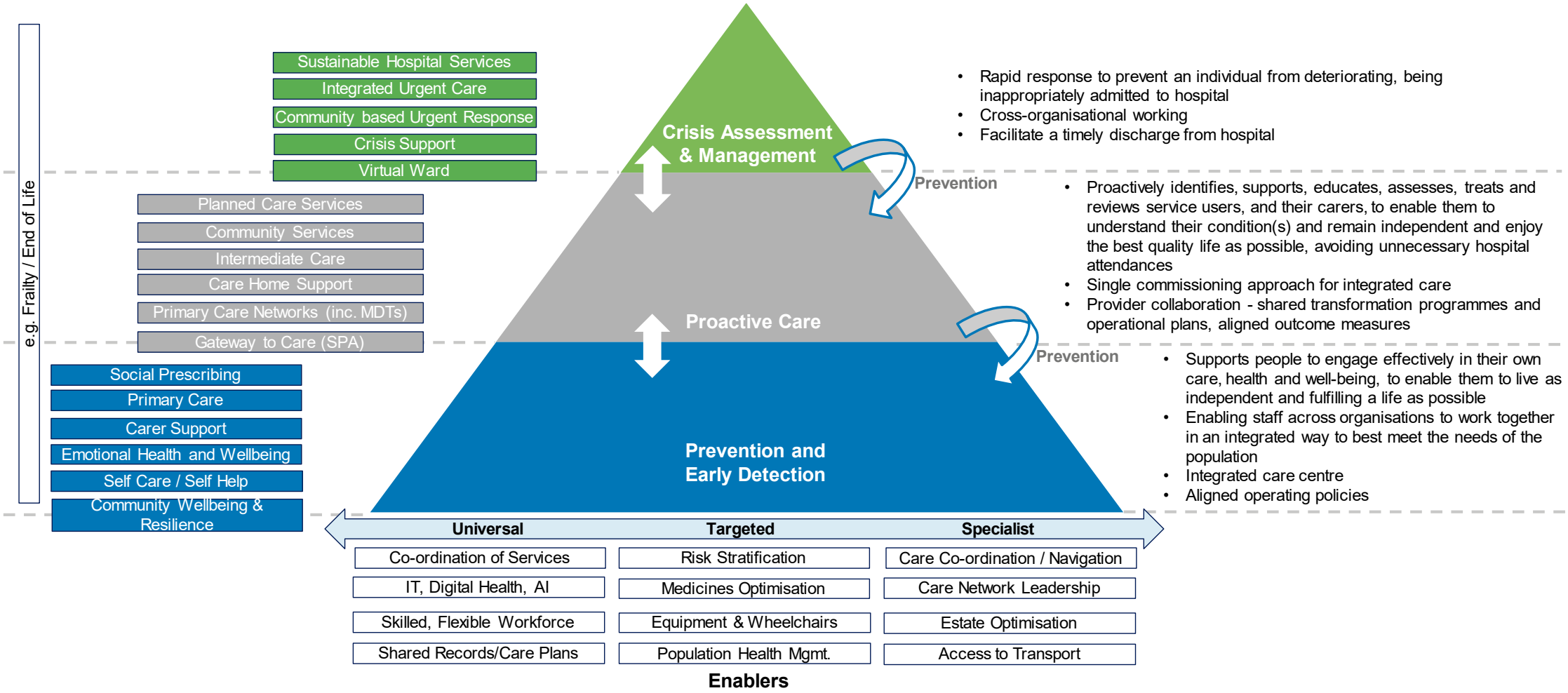
Examples of this in practice include the establishment of our community hubs, enhanced use of digital technologies to identify and support needs early.

Where appropriate targeted support such as pre-operative discharge planning to enable people to return to independence is provided. Further targeted support including rehabilitation and reablement through the Home First offer is also provided where needed.

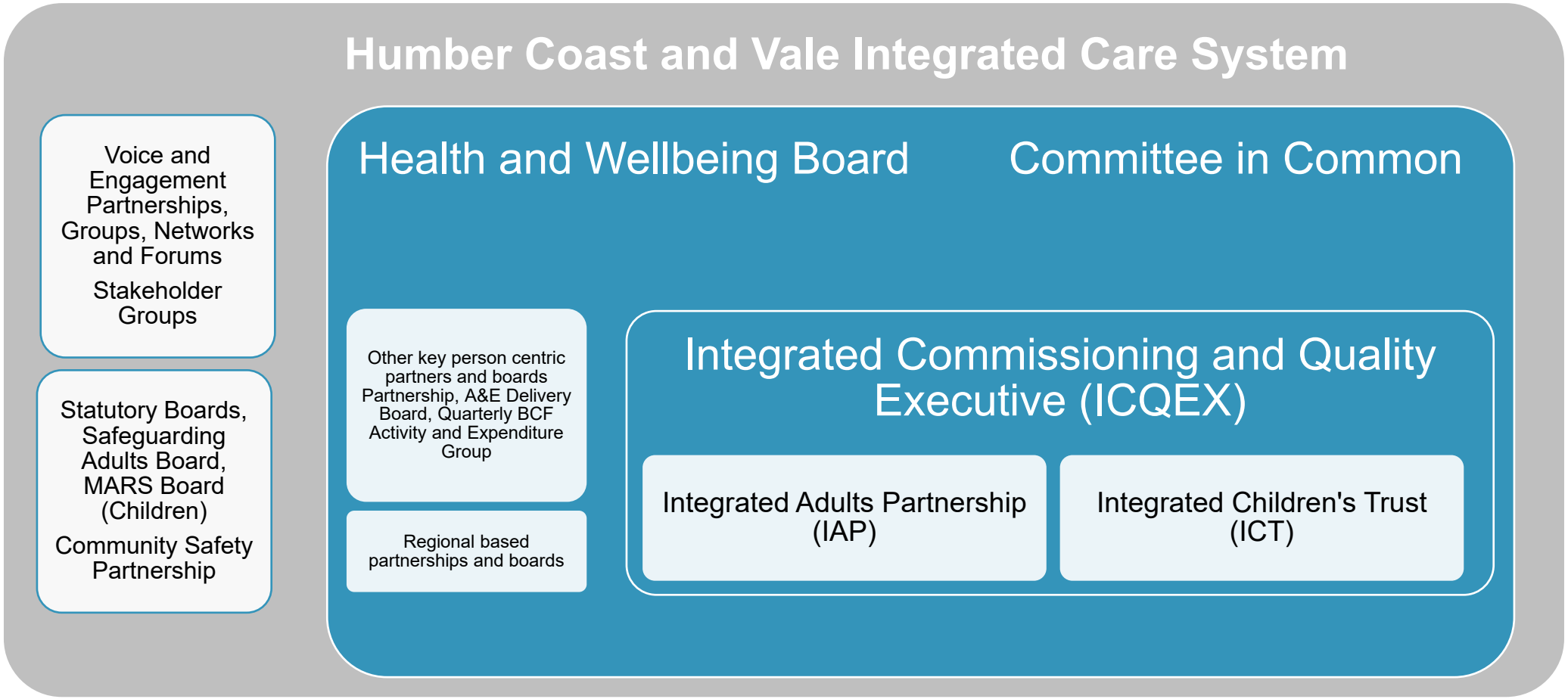
Where there are higher levels of need at a specialist or acute long-term level our one system approach delivers a flexible person-centred approach to health and care provision, ensuring independence is maximised.

The COVID-19 pandemic has provided opportunities to enhance the pace of integration building stronger relationships and greater understanding of the benefits of working collaborating at a strategic and operational level across the system to improve outcomes for people.

The Community Health Model below describes how a person will be managed in the community through pro-active integrated care and support pathways with a focus on prevention, early detection and self management. Working closely with partners across the local health and care system to provide a universal, targeted and specialist offer. Through this approach people are enabled to lead a more independent life in their own home and community for longer. This model is delivered as a collaborative response with all system partners as detailed in the health and care integration plan (p.8, IAP ToR (3) and the HWBB ToR (1).



Governance is provided through robust performance and governance frameworks. Through monitoring, oversight, challenge and resolution, led through established partnership arrangements, we are in the best position to respond proactively and ensure our commissioned services are the best they can be.



KLOE reference guide:

KLOE	Page reference	Supporting evidence / documents (Documents referred to below are embedded on page 21)
Stakeholder engagement	• Page 8 of this plan identifies the partners who have collaborated to develop and deliver our Health and Care Integration Plan 2021-24 and BCF schemes • The Integrated Adults Partnership (IAP) includes wider place partners who work strategically and operationally.	• Health and Wellbeing Board (HWB) Terms of Reference outlines the partners who are involved in developing and delivering our health and care integration agenda (1) • Integrated Commissioning Quality Executive (ICQEX) Terms of Reference demonstrate the joint working between the council and the CCG on health and care integration (2) • Integrated Adult Partnership (IAP) Terms of Reference further evidence our engagement and involvement arrangements (3) • This comprehensive structure of engagement has provided a more robust framework for the development and delivery of our integration and BCF plans and has included a broad range of local partners, VCS reps, housing and DFG leads..
Priorities	• Page 14 of the health and care integration plan sets out shared strategic priorities for 2021-24	• There have been no key changes since the previous BCF. Our intentions are to improve outcomes for the people supported across the North Lincolnshire system. • The IAP Strategic Commissioning Plan 2020-24 (pages 16-17) evidence our shared commissioning intents/priorities, including the specific priorities and progress for 2021-22. (4)
Governance	• Page 17 of this plan illustrates the governance arrangements for our Health and Care Integration Plan and delivery of the BCF schemes	• Health and Wellbeing Board (HWB) Terms of Reference further evidence our governance arrangements (1) • Integrated Commissioning Quality Executive (ICQEX) Terms of Reference further evidence our governance arrangements (2) • Integrated Adults Partnership (IAP) Terms of Reference further evidence our governance arrangements (3)
Overall approach to integration	• Pages 3 – 16 of this plan is our approved and published Health and Care Integration Plan setting out our approach to integration since the last BCF plan was agreed. • Pages 11-13 of this plan is our Integrated Health and Care Plan demonstrating our person-centred approach to care in supporting people to remain independent at home.	• Our IAP Strategic Commissioning Plan 2020-24 evidences our approach to commissioning integrated services.(4) • The IAP Strategic Commissioning Plan 2020-24 (pages 11-12) evidences the commissioning intentions to developing alternative solutions to living well at home. (4) • Health & Care Integration Action Plans (5a, 5b) • We have also increased capacity to drive forward our approach to integration through the development of a number of integrated posts, including a place-based discharge lead.
Supporting discharge	• Page 10 of this plan are our shared strategic principles sets out our commitment to improving outcomes for people being discharged hospital.	• The Home First BCF funded scheme supports safe, timely and effective discharge • The IAP Strategic Commissioning Plan 2020-24 (page 10, 12, 16) discusses the commissioning priorities and intentions for supporting hospital discharges (4) • An Integrated Discharge and rapid response team has been established to support people leaving hospital. In addition, a welcome home service with the voluntary sector is in place to reduce the risk of readmission by providing wrap around care to support the person during the post discharge period with social care needs. • The Hospital to Home presentation evidences the activity supporting the discharge to assess model and increase collaboration across the system to support discharges (7) • Designated step down/step up placements are also in place. The step-up placements are used for those people for whom hospital admission can be avoided by provision of residential care within reach of community health services. Step down placements facilitate timely discharge, avoiding delayed discharge associated with ongoing care needs and provides an element of reablement.
Disabled Facilities Grant and wider services	• Page 18 of this plan illustrates our approach to bringing together health, care and housing services to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people	• The IAP Strategic Commissioning Plan 2020-24 (pages 11-12) discusses our commissioning intentions to continue to develop alternative housing provision to support independence (4) • Our home assistance policy aligns with the priorities of the BCF for using the monies flexibly to target resources to the most vulnerable • DFG funds were used to provide equipment in Myos House Extra Care Facility (first NL Extra Care facility for people with dementia)
Equality and health inequalities	• Page 19 of this plan describes our plans for addressing equality and health inequalities including changes from the previous BCF plan and how the inequalities are being addressed.	• The IAP Strategic Commissioning Plan 2020-24 pages 4 and 6 describes our shared values and evidences the focus on equality through our outcomes (4) • Health and Wellbeing Strategy, including progress update for refresh of strategy agreed by Health and Wellbeing Board in Sept 2021 (6, 6a, 6b)

Supporting documents

1  1	Health and Wellbeing Board Terms of Reference
2  2	Integrated Commissioning Quality Executive Terms of Ref
3  3	Integrated Adults Partnership Terms of Reference
4  4	Integrated Adults Partnership Strategic Commissioning Plan
5  5a  5b	Health and Care Integration Plan & Delivery Plan
6  6  6a  6b	Health and Wellbeing Strategy Update Report – Sept 2021
7  7	Hospital to Home presentation
8  8	Home Assistance Policy