Humber and North Yorkshire
Health and Care Partnership

Joint Forward Plan

How we will deliver our strategy from 2023 - 2028

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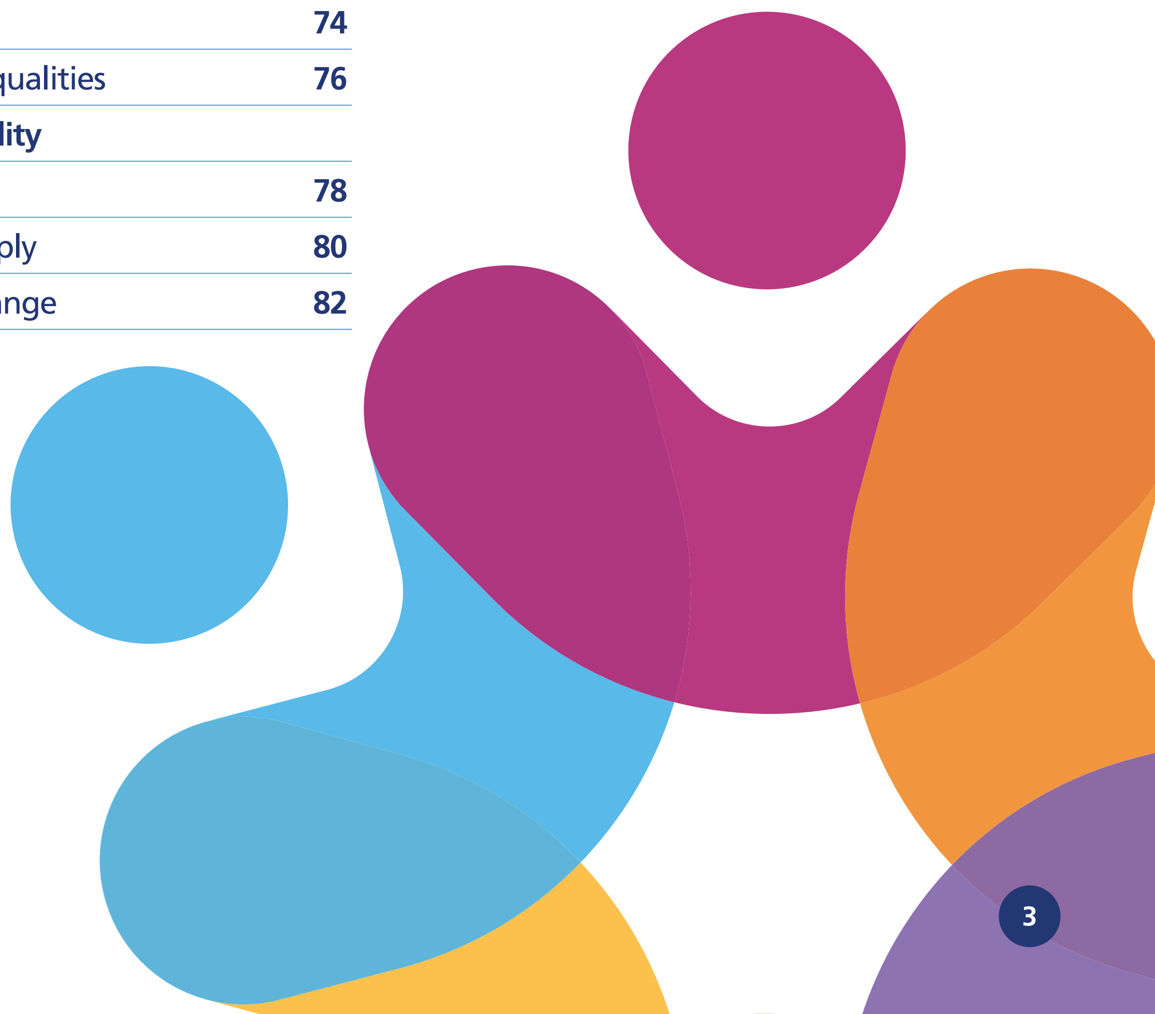


Introduction from the **ICB Chief Operating Officer and Deputy Chief Executive**

The Humber and North Yorkshire Integrated Care Board (ICB) is required to publish a Joint Forward Plan which sets out how the NHS will deliver the aims and ambitions set out in our wider system Integrated Care Strategy.

Joint Forward Plans must set out how ICBs intend to discharge their duty to have regard to the wider effect of decisions about the provision of health and care.

Our belief is that integrated care is about giving people the support they need, joined up across local councils, the NHS and other partners.

We have created the Joint Forward Plan from a 'bottom up' approach – seeking to bring together place and collaborative plans to describe how all parts of our ICB are working together with partners to deliver our ambitions through NHS commitments and to meet the needs of our local populations.

Our Joint forward plan brings into focus in one place:

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

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

We have set out the plan in two sections.

Section one will focus on integration, setting out how place and sector collaboratives will deliver the vision over the next five years and providing some tangible milestones for the next 12 months. This reflects the priorities and plans at place with health and wellbeing boards that deliver the ambition and vision of the strategy.

Section two describes how we will create the enabling conditions to achieve the vision by setting out an ICB wide overview of our structures and

ways of working to fulfil our partnership ambitions and meet legal requirements and sets out our key deliverables to achieve this in 2023/24.

The plan sets out our stall as to how the ICB will work to improve outcomes for our population, tackle health inequalities, improve productivity and make connections between health and wider issues. Including how the ICB will work with partners to address local social, environmental and economic conditions which impact on health and wellbeing.

The plan will be submitted to NHS England in June 2023 but our planning activities will continue beyond this. We will use the plan to track our progress and ensure continuous engagement through partners and with the public so that we build an ongoing five year programme to deliver our strategic aims.

This plan forms the basis of the ICB becoming a partner in the Humber and North Yorkshire System, providing transparency about how the ICB will empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending.

This will enable us to deliver on the promise of system working, as described in the Hewitt Review of Integrated Care Systems.

- Amanda Bloor

Hewitt Review of Integrated Care Systems

Use the camera on your smartphone to scan the QR code

www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems

Introducing **Humber and North Yorkshire ICB**

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

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

Our approach is based on the belief that we will be more successful in bringing about change if we work together.

The partnership has subscribed to a principle of subsidiarity, which means that most of our focus will be on continuing our work together to improve the health and wellbeing of the local population in each of our six 'places'.

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

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

Our ways of working

- establishing a collaborative culture based on trust
- empowering place based and provider collaboratives
- ensuring an honest public narrative
- being transformative with a clear appetite for innovation
- placing a greater emphasis on prevention and demand management
- using shared data and intelligence to support decision making
- influencing national and regional policy
- learn by doing

Find out more in the ICB Constitution and Standing Orders

www.humberandnorthyorkshire.icb.nhs.uk/documents-and-publications

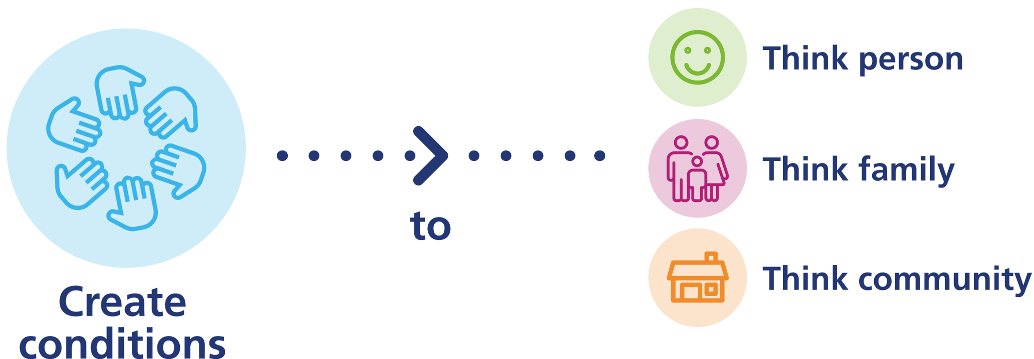
Our **strategy on a page**

Our ambition is:

for everyone in our population to live longer, healthier lives by narrowing the gap in healthy life expectancy between the highest and lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035.

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

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



Our partnership

We are the Humber and North Yorkshire Integrated Care Partnership part of one of 42 Integrated Care Systems (ICSs) established across England.

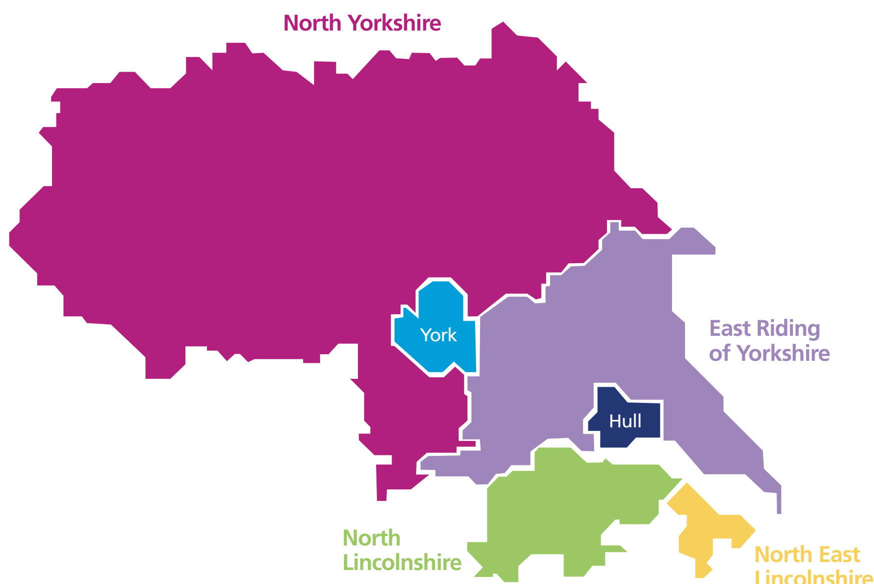
The Integrated Care Partnership (ICP) is a standalone statutory committee between Local Government and the NHS Integrated Care Board (ICB). We are responsible for developing the integrated health and care strategy to address the health, social care and public health needs of our population.

Our focus is on improving outcomes for our population, tackling health inequalities and making the connections between health and wider issues including socio-economic development, housing, employment and environment. We take a collective approach to decision-making and support mutual accountability across the Integrated Care System.

Total budget of approx. £3.5bn

1.7 million people

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



175 dental practices

325 community pharmacies

162 community optometry practices

43 Primary Care Networks (168 GP practices)

4 acute hospital trusts (operating across 9 sites)

2 ambulance trusts

4 mental health trusts

4 community / not-for-profit providers

6 Local Authorities (upper tier and unitary authorities)

550 care homes

180 home care companies

10 hospices

1000s of voluntary and community sector organisations

Delivering **our vision**

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

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

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

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

Our operating model

Our principles

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

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

For more information see the ICB Functions and Decisions Map

www.humberandnorthyorkshire.icb.nhs.uk/governance

safe and prudent

evolution, not revolution

partnership

local authority

delegation and subsidary, where appropriate

consistency, not conformity

shared vision, values and objectives

How we will **deliver our plan**

The aim of the Humber and North Yorkshire Operating Model is to emphasise the importance of place-based partnerships by ensuring that place and sector collaboratives are at the core of the delivery mechanism of the ICB, within an overall single operating model.

Place based leadership creates the right conditions for change, ensuring local system conversations can develop plans to address local priorities and health inequalities within the overall ICB strategy.

The role of place is to:

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

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

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

The sector collaboratives are responsible for:

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

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

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

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

- **agreeing local priorities with partners at each place, aligned to ICB priorities**
- **early engagement through place and sector collaboratives to respond to urgent care pressures and improve pathways for discharge through developing local plans for £18.1m adult and social care discharge funding**
- **developing integrated models of care with local authorities to reduce health inequalities**
- **working across place and sector collaboratives alongside local partners on the configuration of mental health services**

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

The vision for the hub has been inspired by the open, community led and de-stigmatising values of the Trieste Mental Health Model in Italy.

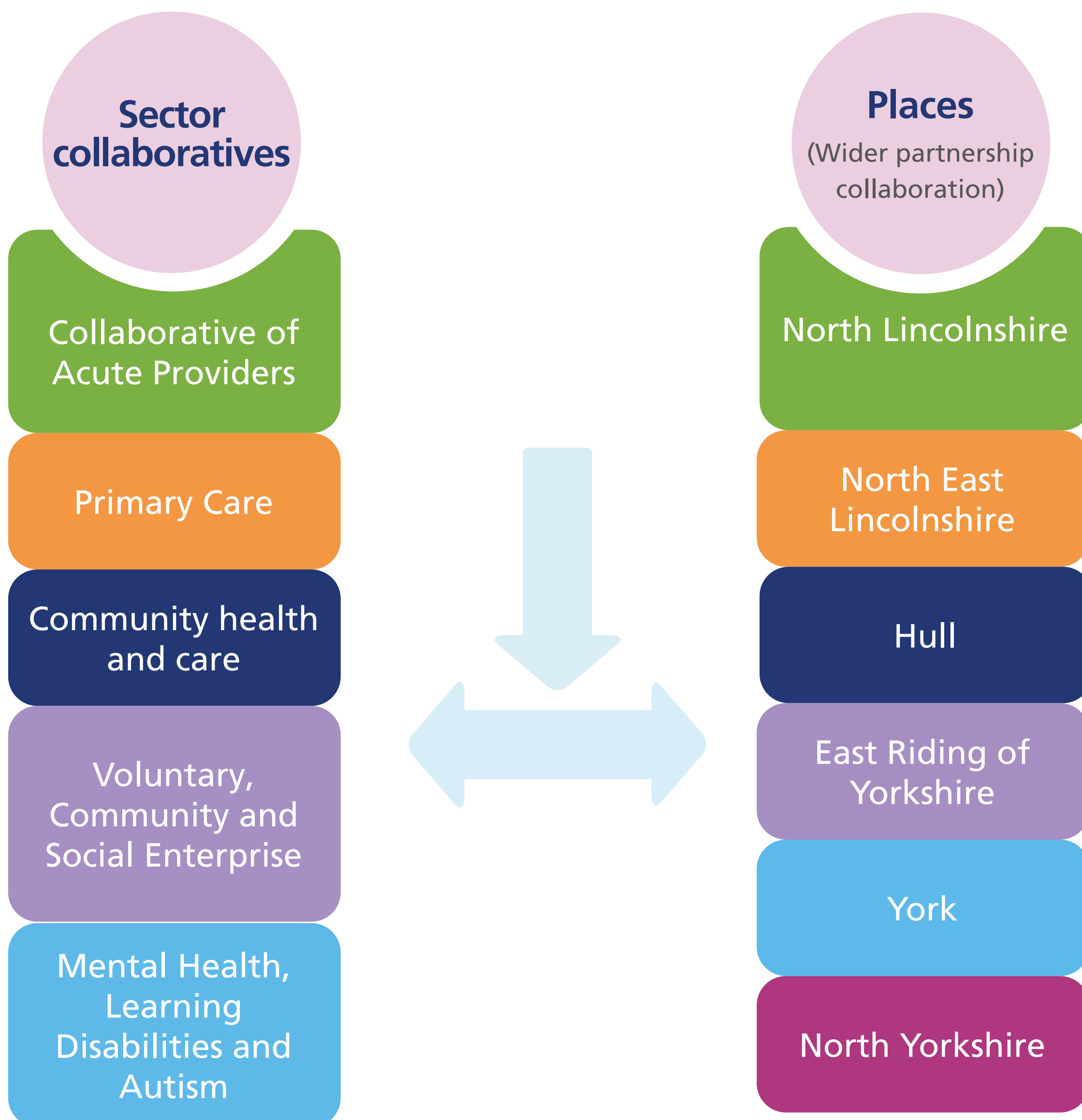
Compassionate care, strengths based and trauma informed approaches, reflection and relational activism all underpin the approach at the hub.

Our operating model

ICB single approach to planning and system accountability:

- alignment of vision and ambition to create capacity and capability for transformational change
- generating efficiencies through 'doing things once'
- assurance of system wide accountability and reporting

Delivering to local priorities and populations through:



Our operating model: **developments in 2023/24**

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

Allocation of delegated resources to deliver the plan in each place and setting principles for how they should be allocated across services and providers.

Arrange for the provision of health services in line with allocated resources, including putting in place contracts to secure delivery of its plan and supporting providers to lead major service transformation programmes to achieve agreed outcomes.

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

Throughout 2022/23, places have been engaged in discussions about local autonomy and delegation of local decision making. Three development sessions were held during 2022.

These sessions were facilitated by Capsticks with the six local authority Chief Executives, the ICB Chief Operating officer, Executive Director of Finance, Executive Director Corporate Affairs and Place Directors to review national guidance, options for delivery and local priorities. The following arrangements have been agreed for 2023/24.

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

North East Lincolnshire has a proud and lengthy history of working in an integrated way in respect of health and care for the last fifteen years as the Clinical Commissioning Group (CCG) was delegated by the local authority to commission adult social care. Over the years, through a section 75 agreement intensive collaboration has resulted in joined up services, posts and governance processes.

Our core model of care will be the Accountable Teams Model, embodying teams working together to meet the health and care needs of people, their carers and families. Rolling this model out erases the 'lines in the system' created by organisational needs and boundaries, and will be founded upon:

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

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

Place priorities: health and wellbeing North Yorkshire

Our ambition

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

- **think 'people':** In North Yorkshire, we will work with our communities who experience the poorest health outcomes to make sure that they can access and benefit from the services and opportunities they need
- **think 'place':** In North Yorkshire, where you live should help you stay well and happy. We want to make sure that where you live does not unfairly reduce the quality of your health or length of your life
- **think 'population health and prevention':** In North Yorkshire, we will improve the health of all our residents by prioritising interventions that will make the most difference and that make sense to do at scale.

Where we are now

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

Our priorities

- A comprehensive and integrated health and social care model
- A high quality care sector, with sufficient capacity to meet demand
- A strong workforce
- Prevention and public health: adding life to years and years to life

What we will deliver in 2023/24

We will:

- enable the four Local Care Partnerships to lead the design of the local integrated model
- in partnership with York, redesign and deliver a new single fully integrated 24/7 urgent care specification
- develop and deliver a business case for a new integrated model for intermediate care
- support discharge and flow through intermediate care with new hub and system monitoring arrangements
- develop population health management and prevention through a Primary Care Network (PCN) programme and cardiovascular dashboard
- deliver crisis response and virtual ward beds in line with 23/24 trajectories
- establish North Yorkshire VCSE assembly by Community First Yorkshire
- develop innovative models for domiciliary care, including care built on community strengths
- to further support provider sustainability, the Council will review the timescale for moving residential placements to actual cost of care
- work with care providers to implement the national charging reforms for adult social care and the NHS discharge pathway
- develop robust Standard Operating Procedures (SOPs) to maximise utilisation and flow within independent sector
- prepare proposals for transforming local authority in house domiciliary care provision
- develop more balanced/varied roles with appropriate rewards
- develop innovative approaches to recruitment and innovative workforce models
- identify opportunities for cross sector working and roles
- support international recruitment across sectors
- 12 oral health practitioners due to complete apprenticeship in August 2023 with opportunities to undertake roles in Yorkshire and Humber area
- legacy registered manager mentor to be appointed to provide support for registered managers across the North Yorkshire and York areas
- refresh the Health and Wellbeing Strategy
- expand population health management (PHM) review cycles across PCNs
- appoint a joint post between North Yorkshire Place and North Yorkshire Council to lead on health inequalities and population health
- e-cigarettes to be used as a harm reduction tool as part of the Living Well Smokefree Service
- implement Drug Treatment Plan for 23/24
- support people to maintain good mental health with timely access to effective primary, secondary and specialist services when needed
- support people to be physically active across all ages and stages of the life course
- influence through the strength of the partnership the wider determinants of health with a focus on coastal communities
- promote and invest in stronger communities and strategic commissioning of the Voluntary, Community and Social Enterprise Sector
- engage people in a dialogue about self-care, early help, loneliness and using digital tools

Place priorities: health and wellbeing York

Our vision

Over the next decade, York will become healthier, and that health will be fairer.

York Place will support delivery of the six big ambitions of our Health and Wellbeing Strategy 2022-2032:

- become a health generating city
- prevent now to avoid later harm
- start good health and wellbeing young
- make good health more equal across the city
- work to make York a mentally healthy city
- build a collaborative health and care system

Where we are now

- York has an ageing and growing population, with increases in hospital care, social care and GP usage
- York's red flags are alcohol consumption, multiple complex needs, drug related deaths and student health
- one in nine people in York have more than one long-term condition, and there is an elective backlog across primary and secondary care.
- Under 18 admissions for mental health need with a high prevalence of common mental health illness, high suicide and high self harm rates
- one in ten people smoke, two in three adults are overweight or obese and one in seven live with depression
- York has a widening inequalities gap in healthy life expectancy, heath of those living with a learning disability and school readiness

What we will deliver in 2023/24

- develop an Integrated Community Frailty Single Point of Access Hub including mapping, outcomes and delivery model
- work in partnership with North Yorkshire on the redesign of urgent care, developing a single fully integrated 24/7 specification
- re-establish a clinically-led Primary/Secondary Care Interface Group to explore opportunities for shared care pathway development
- across health, social care and education we will identify the barriers to overcome through working together, we will have taken the first step, and we will have a plan for action
- acceleration of a prevention programme for long-term conditions to support delivery of the prevention actions in the York Health and Wellbeing Strategy 2022-2032 Action Plan.
- fulfil our role as an ICS to support the three city strategies, and as an anchor institution for development, housing, workforce, and supporting vulnerable groups.

Our priorities

- Strengthen York's integrated community offer
- Implement an integrated urgent and emergency care offer
- Further develop primary and secondary shared care models
- Develop a partnership based, inclusive model for children, young people and families
- Embed an Integrated Prevention and Early Intervention Model
- Drive social and economic development

What will this mean for citizens?

Strengthen York's integrated community offer

Greater access to personalised support and integrated care outside of hospital, to help people live well and independently at home for longer.

Implement an integrated urgent and emergency care offer

A safe, reliable, and resilient service where duplication is reduced, providing remote visits on a 24/7 basis to provide a better experience for patients.

Further develop primary and secondary shared care models

Shared care models between patients, specialist GPs and other specialists to deliver a personalised, seamless and holistic care experience.

Develop a partnership based, inclusive model for children, young people and families

Work in partnership for children, young people, and families to raise a healthy generation who grow into healthy and independent adults.

Embed an Integrated Prevention and Early Intervention Model

A shift to prevention and early intervention, enabling people to live healthier, longer lives, and reducing the gap in health inequalities between the most and least deprived communities in York.

Drive social and economic development

Working at the heart of communities to use and grow the assets we have, maximising our collective capability, working in partnership taking a cradle to career approach.

Place priorities: health and wellbeing Hull

Our ambition

Integration

- embed a population health approach to understanding our population across primary care, working with partners in the system i.e. local authority, VCSE sector, citizens advice, which will focus on the Core20PLUS5, all ages
- integrated pathways will be prioritised to improve benefits from services and efficient use of resources to support the improvement of patient experience
- implement Integrated Neighbourhood Teams

Primary care Priorities

- workforce
- improve primary care access
- population health & inequalities – Core20PLUS5, all ages

Inequalities

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

Where we are now

- 17% of population currently smokes – though the prevalence has generally been decreasing the rates vary widely
- for males, around 42% of the life expectancy gap between the most and least deprived wards within Hull is made up of circulatory disease and cancer
- 71% of adults are classified as overweight or obese. 28% of children in reception are overweight or obese
- 55% of adults are physically active
- 71% of people are in employment
- 47% GCSE attainment 8 score
- 33% of children are in relative low income families

Our priorities

Integrated Neighbourhood Teams

Improve services for patients

Population health

Inequalities

What we will deliver in 2023/24

- roll out our project to support people in receipt of home care across the city to deliver Integrated Neighbourhood Teams
- work with community, mental health and voluntary sector organisations to deliver the Care at Home Project
- work with our priority areas across local trusts and community providers to improve access at the time of need focusing in on elective care and cancer
- continue our joint improvement plans for special educational needs and disabilities (SEND)
- deliver our system Anticipatory Care and Urgent Emergency Care Programmes to reduce admissions to hospital and improve integrated discharge processes
- ensure Hull Primary Care Networks embed a population health management approach to identify patients that may need a clinical review to support health prevention
- work across public health and with our local authority to employ a trauma informed approach to developing models for inclusion health
- focus our approach to reduce variation, with focus on Core20PLUS5, using data analysis and clinical peer review to improve care locally
- tobacco control workplace & deprived community targeted outreach
- provide primary care in children's centres

Place priorities: health and wellbeing

North East Lincolnshire

Our ambition

Our local community, health and care system is currently building on a lengthy, proud and powerful history of collaborative and integrated working ensuring our community, health and care organisations work hand in glove and this has benefitted local people for many years.

Our Health and Care Partnership enables partners to work together where a multi-agency approach is required to tackle and deliver local priorities whilst still undertaking their own functions and service delivery.

Our local community, health and care system is becoming more holistic – bringing together and delivering mental, physical and social care together for both children and adults.

As a place we will continue to work in an integrated way to deliver better outcomes for our population, linking in on a system and collaborative level, where working together in this way supports better outcomes for our population.

We will work together to reduce unfair and avoidable differences in health across the population, with a focus on reducing inequalities, and ensure that our residents are at the heart of all we do. We will come together across population groups in Accountable Care Teams using a population health approach to do this.

Where we are now

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

Our outcomes

Our key impact areas

What we will deliver in 2023/24

We will:

- implement Integrated Neighbourhood Teams
- expand Connected Health Model
- produce and implement Children, Young People and Family Strategy
- deliver Best Start for Life Programme
- improve outcomes for looked after children
- co-produce and implement a Mental Health Strategy
- Children and Young People's Mental Health Transformation (eating disorders, neurodiversity, looked after children)
- develop Health and Care Partnership People Plan
- continue International Recruitment Programme
- expand Grow Our Own Programme
- develop joint and flexible posts
- establish End of Life Accountable Care Team, develop the clinical model and workforce
- continue Accelerated Home First Programme
- reduce avoidable admissions

Place priorities: health and wellbeing

North Lincolnshire

Our ambition

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

- enjoy good health and wellbeing at any age and for their lifetime
- live fulfilled lives in a secure place they can call home
- have equality of opportunity to improve their health, play an active part in their community and enjoy purpose in their lives
- adult smoking rates continue to fall and were less than the England average in both 2020and 2021. We will study this reduction and ensure that the pattern continues

Where we are now

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

Our priorities

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

What we will deliver in 2023/24

We will:

- ensure our plans reflect the voice of our communities by working with our Experts Together Partnership and Children's Voice Partnership
- embed a population health management approach in all service developments to tackle health inequalities and improve outcomes for those most disadvantaged
- develop our workforce to support delivery of improved outcomes through integration
- develop and implement the Scunthorpe South Integrated Neighbourhood Team, focusing on our most vulnerable, high risk populations, and share best practice with other neighbourhoods
- delivery of an Integrated Urgent Care Model, including an integrated health and care single point of access and utilising our Home First Model, supporting people in the community, or where hospital admission is required, supporting them at home and maximising recovery
- develop our local provider market to support best value provision of in area care for our population with particular focus on continuing health care and mental health and learning disability
- deliver a Community Diagnostic Hub to stream planned diagnostics to a community facility to enable delivery of diagnostic targets
- embed our Local Frailty Model to reduce hospital admissions through proactive care and community delivered care, maximising independence
- deliver a plan for improved primary care access including plans for better management of capacity, estate and digital
- deliver the Connected Health Network Approach to outpatient transformation to reduce hospital outpatient referrals and follow ups
- development of sustainable neurodiversity pathway for children and young people including pre and post diagnosis support
- identify prevention opportunities to support demand management, including delivery of cardio-vascular disease prevention programme
- develop and implement our clinical delivery model for palliative and end of life care, with a focus on early identification and utilisation of Electronic Palliative Care Co-ordination System and ReSPECT in line with the Northern Lincolnshire Palliative End of Life Care Strategy

Place priorities: health and wellbeing East Riding of Yorkshire

Our ambition

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

- children and young people enjoy good health and wellbeing
- working age adults reduce their risk of ill health
- residents achieve healthy, independent ageing
- health inequalities are reduced

Where we are now

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

Our priorities

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

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

- rural and coastal communities
- Bridlington place based programme
- adult emotional health and wellbeing
- children and young people
- workforce challenges
- communications, engagement and insight development
- rehabilitation and intermediate care
- Integrated Neighbourhood Teams
- inclusion groups

What we will deliver in 2023/24

We will:

- establish three test and learn sites for Integrated Neighbourhood Teams in Driffield, Goole and Holderness
- understand more about how to reduce inequalities in health outcomes for people living in our rural and coastal communities through a rapid health and social care needs assessment and working with partners to uncover current challenges and priorities to develop and deliver a partnership action plan
- develop our programme for Bridlington place focusing on key areas including education, health and care, transport, employment and housing and agree our immediate priorities
- develop and implement a graduated response to children and young people's emotional health and wellbeing needs. Incorporating a response to Core20PLUS5
- align our East Riding of Yorkshire workforce plans to population health needs and develop work experience placements across health and care for GCSE and A-level students
- understand capacity and demand across rehabilitation and intermediate care and explore commercial options to bring different services together under the banner of maximising independence to confirm the ambition for all pathway 1 discharges to be with 'intermediate care'.

Community Health and Care Collaborative (CHCC)

Strategic ambition

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

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

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

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

Our priorities

Embed alternative community pathways to avoid admissions to hospital	Improve patient flow with a focus on discharge to support wider elective recovery	Embed digital innovations to support admission avoidance, improve discharge and support digital pathways of care	Increase system-wide understanding of wider community resources

What we will deliver in 2023/24

We will:

- increase the number of crisis first care contacts to reduce admissions to hospital
- better understand the value of virtual wards to help inform utilisation
- complete system-wide programme of support for a new model of intermediate care to support discharge and increase bed capacity through reducing 'no criteria to reside'
- reduce unnecessary admissions and conveyance to Emergency Departments through understanding alternative pathways that would support wider admission avoidance
- improve discharge pathways to reduce the number of bed days lost and improve patient flow
- increase the use of rehabilitation and reablement and support at home for palliative care
- roll-out OPTICA and virtual ward automation digital applications to support urgent and emergency care bed occupancy
- utilise remote monitoring funding to purchase and deploy equipment in the pathways and places most challenged
- improve data quality and implement faster data flows in community to support admission avoidance
- complete system stock take of palliative and end of life care to inform ICB statutory responsibility to delivery against national strategy
- complete waiting list audit to ensure we give visibility to total waiting list to support a reduction in the overall waiting list
- provide system wide support to clinical networks (diabetes, stroke & respiratory) to ensure we support a reduction in inequalities and improve health outcomes

Community Health and Care Collaborative:

Palliative and End of Life Care

Strategic ambition

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

The Palliative and End of Live Care Programme aims to:

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

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

- system-wide variation
- need for standardisation
- ensure children and young people's palliative and end of life care needs are integrated within the strategy
- ensure we discharge our statutory duties and satisfy the CQC single assessment inspection framework due to be launched in late 2023
- develop our strategic ambition
- revise our governance structure to demonstrate how we are discharging our responsibilities
- complete an ICB workforce assessment to identify and address any potential gaps and variation

What we will deliver in 2023/24

We will:

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

- each person is seen as an individual
- each person gets fair access to care
- maximising comfort and wellbeing
- care is co-ordinated
- all staff are prepared to care
- each community is prepared to help

Use the outputs from the Ambitions stocktake to inform:

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

Voluntary, Community and Social Enterprise (VCSE) Collaborative

Strategic ambition

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

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

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

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

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

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

As a collaborative our ambition is to:

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

Our priorities

Support the approach to engagement and involvement across the ICB	Reduce inequalities	Increase the voice of patients and the public	Support wider system development

What we will deliver in 2023/24

We will:

- increase numbers of organisation engaged, increasing levels of diversity
- track the reach of communications and public engagement
- through the collaborative, support co-design within communities to ensure a diverse perspective on development and planning
- work with partner organisations to get closer to people suffering from health inequalities
- work through VCSE organisations to support more people and communities directly, to increase digital access to healthcare and support the development and delivery of a digital strategy
- work through VCSE organisations to engage with people in coastal areas to understand their specific health and wellbeing needs
- increase utilisation of the VCSE sector to promote, engage and advocate for people's voice
- explore ways for the VCSE sector to engage in the design of services, supporting collaborative working driven by the patient voice
- support greater understanding of communities across HNY and what matters to them
- influence and shape future investment in the VCSE sector to increase sustainability
- ensure that the wider determinants of health and wellbeing are considered in ICB planning and delivery
- develop a consistent approach to the management, recruitment and development of volunteers

Primary Care Collaborative

Strategic ambition

We will ensure people can live well and age well by making sure that people get the care that they need and don't get passed back and forth and that people only need to go into hospital when absolutely necessary.

People will feel on top of their condition and know what to do if they need help. Our investment in primary care workforce will support meaningful employment. We will invest in health and wellbeing programmes and so that people can stay active and keep healthy.

What we will deliver in 2023/24

We will:

Increase access to services

- we will focus on digital inclusion in collaboration with the voluntary sector and promote the benefits of the NHS app increasing further from 51% of the eligible population registering for the app
- make it easier for people to contact a GP practice so that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- we will increase access to primary care by providing additional appointments and increasing the number of appointments available
- we will continue to increase access to dental services with continued investment through procurements and flexible commissioning models

Develop our workforce

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

We will invest in our workforce:

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

Promote health and wellbeing and reduce health inequalities

- we will continue to develop our Core20PLUS5 Programme with our Core20PLUS Ambassadors
- we will continue to develop our Neighbourhood Teams
- we will continue to invest in health and wellbeing programmes

Primary Care Access Recovery Plan

The demands on general practice have never been greater, with record numbers of appointments being delivered.

Supported by investment, we will focus on delivering the plan that responds to patient feedback and sets out measures that will make a difference now to staff and patients, focusing efforts on taking pressure off teams, and supporting general practice to manage the 8am rush, and restore patient satisfaction with improved experience of access.

Working across our six places we will support practices and primary care networks to deliver on the requirements of the 2023/24 GP contract.

We will continue to work with our community pharmacy colleagues to expand their vital role by consulting on a Pharmacy First Service. We will embed the oral contraception and blood pressure services along side the Pharmacy First Service.

Mental Health, Learning Disability and Autism Collaborative

Strategic ambition

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

The Humber and North Yorkshire Mental Health, Learning Disabilities and Autism Collaborative is comprised of health and care partners, including (VCSE and third sector) responsible for the commissioning and delivery of mental health, learning disability and autism services across our ICB footprint.

The Collaborative has been in existence for five years, initially as a partnership aiming to improve services and then developing into more formal arrangements with a nominated lead provider (Humber Teaching NHS Foundation Trust).

We have worked closely with local places and providers throughout the existence of the collaborative and have developed strong working relationships that promote transparency despite the challenging wider financial and service delivery environment.

The Collaborative works with partners to collectively:

- lead on system-wide transformation programmes
- improve quality and safety
- monitor performance
- enhance partnership working including establishing robust links with colleagues across the local authority, VCSE sector, primary and secondary care.
- share best practice
- deliver value for money by achieving economies of scale
- jointly bid for ICB level funding to enhance the delivery of ICB objectives

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

Our priorities

Community mental health transformation | Children and young people's mental health | Urgent and emergency care mental health | Perinatal mental health | Dementia care

What we will deliver in 2023/24

We will:

- develop a three-year plan for our inpatient services across mental health, learning disabilities and autism. This will focus on quality, we will also review the resource available to the system and configure services to deliver the best possible outcomes for patients
- develop working arrangements with our transforming care partnerships to deliver key priorities across learning disabilities and autism such as, roll out of the Oliver McGowan training, the national inpatient review and delivery of learning disability annual health checks
- in 2022/23 we made significant progress in delivering annual health checks for people with serious mental illness (SMI), we will bolster this in 2023/24 and ensure the improvement is sustained for the coming years
- building on the success of the early implementer site for community mental health transformation across Hull and the East Riding of Yorkshire, we will continue to increase access to mental health support in the community including early intervention in psychosis (EIP) and individual placement support (IPS – employment support)
- we will build on the work being done by our Trauma Informed Care Programme to provide early intervention and prevention support to vulnerable children and young people, with a particular focus on those at risk of entering the Youth Justice System
- for people in mental health crisis, we will expand the use of mental health response vehicles following successful implementation on our patch via the Yorkshire Ambulance Service (YAS)
- working with the Maternity Programme, support perinatal mental health enabling improved access and increased offer of psychological interventions
- we will focus on levelling up delivery against the dementia diagnosis targets across the Humber and North Yorms ICB patch, so that resource is directed to places where the biggest improvements are needed

Collaboration of Acute Providers (CAP)

Strategic ambition

We will ensure people to get the care they need, when they need it, and not get passed back and forth or forgotten about.

The collaborative is focussed on 'at-scale' programmes covering more than one acute trust.

The trusts that make up the collaborative are:

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

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

Our vision and aims

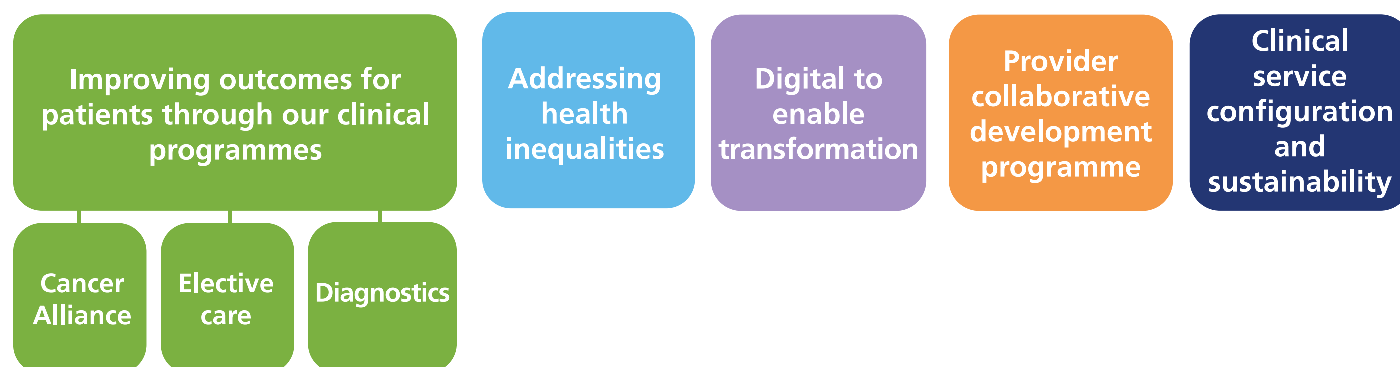
Ensure quality and safety: to collectively deliver the highest quality hospital services across our four trusts, focused on the patient and reducing unwarranted variation, so all patients across Humber and North Yorkshire can access the same high quality levels of care, wherever they live.

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

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

Social responsibility: to play our full part in reducing health inequalities within Humber and North Yorkshire and to optimise our impact as anchor institutions.

Our priorities



What we will deliver in 2023/24

We will:

- support awareness and diagnosis – targeting the 20% most deprived areas
- improve treatment pathways – including stocktake of non-surgical oncology
- improve diagnostics for cancer focusing on liver surveillance and cytosponge delivery
- increase uptake and expansion of the Lung Health Check Programme
- deliver our Living with and Beyond Cancer Programme
- support 65 week delivery target through maximising capacity and utilising mutual aid
- support waiting list reduction by reducing the number of follow ups without a procedure
- optimise productivity through collectively utilising capacity
- plan, develop and implement the community diagnostic model with a target of 3% DNA for endoscopy and physiology
- agree utilisation improvement targets across modalities
- improve data quality and reporting on health inequalities to support the development of a health inequalities plan across acute care
- implement prioritisation of people with learning disabilities on the waiting list
- Electronic Patient Record Programme to support digital modernisation
- develop the peri-operative business case
- recruitment and retention, leadership and capacity, physical and mental wellbeing, learning and continuous improvement, staff experience, quality, diversity and inclusion
- planning, delivering and transforming services together under the Planned Care Strategy
- work with clinical networks to share best practice and reduce unwarranted variation
- work together to ensure clinical sustainability of fragile services

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

The Humber and North Yorkshire Personalised Care Group discussed options and felt that short animations would be the way forward. These could be used to support and empower patients and clinicians by explaining what these alternative ways of receiving their care are.

They could be reflected on provider websites and other social media platforms as well as potentially used in a clinic setting.

We commissioned help to create two patient animations. Storyboards were drawn up and once finalised the animations were created.

Animations went live at the end of July 2022 and are available on Humber & North Yorkshire Health & Care Partnership YouTube.

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

Urgent & Emergency Care (UEC) ICS-wide Programme

Strategic ambition

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

Each Place within HNY has developed their own UEC Improvement Plans based on local pressures, the national recovery plan and recognised good practice.

Identifying areas of commonality, and opportunities to deliver at scale, the UEC Programme has selected three key priorities from these plans to deliver across the system, providing support and best practice to delivery.

These three priorities have the scope to have the biggest impact on UEC quality and performance, improving patient outcomes and experience of care.

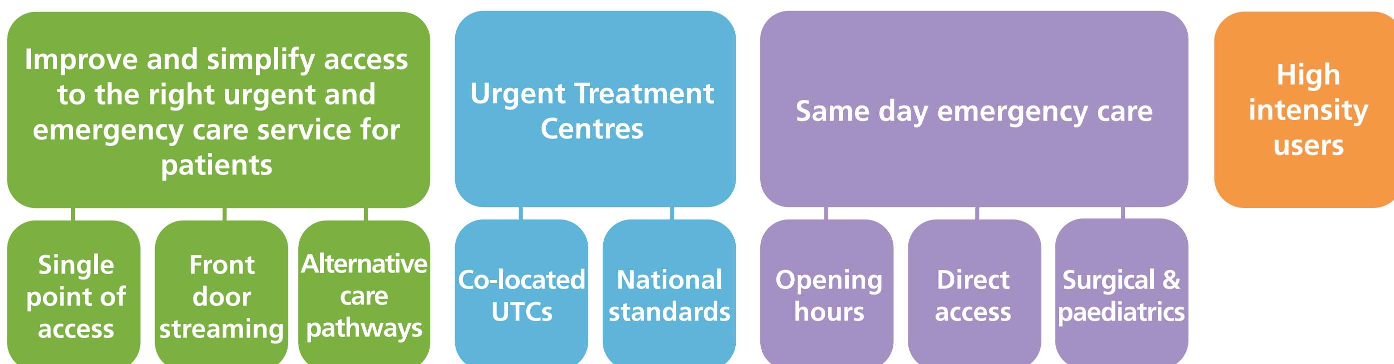
NHS 111

We know we have many entry points to the Unplanned Care System which can lead to confusion. Often the public access the service that they are familiar with which may not be the service that could be most appropriately meets their needs. NHS 111 should be instrumental in signposting and helping the public navigate the right service to minimise any delay.

We will ensure there is continuous improvement to the Directory of Services and ensure NHS 111 has the right access points to ensure patients receive the right care in the right setting.

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

Our priorities



What we will deliver in 2023/24

We will:

- reduce unheralded walk-in patients to Emergency Departments
- reduce the number of ambulance conveyances, both to Emergency Departments and other hospital settings
- increase the number of alternative care pathways available to patients which avoid Emergency Department and hospital
- support improved CAT 2 response times by reducing conveyances to hospital
- improve ambulance handover times within Emergency Departments
- reduce overcrowding in Emergency Departments
- support the reduction in >12 hour waits in department
- undertake a full review of all Urgent Treatment Centres across HNY – co-located and standalone
- improve type three performance reporting and subsequent overall four hour standard
- support reduction in Emergency Department crowding and time in department
- ensure Urgent Treatment Centres are compliant with national standards, improving patient awareness, and understanding of the Urgent Treatment Centre offer, along with consistent access to care
- increase direct conveyance to Urgent Treatment Centres, supporting reduction in ambulance handover times and CAT2 response
- ensure minimum opening hours of 12 hours a day, seven days a week
- align same day emergency care opening times to Emergency Department peak demand times
- increase direct access to same day emergency care for 111, 999, crews on scenes and GPs, without the need for Emergency Department assessment first
- implement referral based on exclusion criteria to maximise same day emergency care opportunities
- increase 0 day lengths of stay
- reduce Emergency Department crowding and wait times – improving 4-hour standard
- co-ordinate an Integrated High Intensity User Programme across the ICS
- reduce number of patients classed as high intensity users
- reduce reattendance rates

Population health prevention and health inequalities

Strategic ambition

We will help people to start well, live well and age well by ensuring that people feel included and know what to do if they need help. We will deliver this through six workstreams.

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

Our priorities

Core20PLUS5 adults

- co-ordinate and oversee delivery of the system's approach to Core20PLUS5

Core20PLUS5 children

- link with system partners to reduce healthcare inequalities for children and young people

Prevention and risk factors

- oversee the ICB delivery of long term plan priorities of:
  - alcohol
  - tobacco
  - obestiy

Public health functions

- oversee the winter vaccination programme and support the transition of public health commissioning

Population health intelligence

- oversee the implementation of Population Health Management (PHM) tools

ICP building blocks

- support the ICP to carry out its function to improve population health and reduce inequalities

What we will deliver in 2023/24

We will:

- embed Core20PLUS5 into the work of Integrated Neighbourhood Teams, starting in our coastal areas
- develop our approach to addressing multi-morbidity starting with our cardiovascular disease prevention and detection plan
- continue our approach to address asylum seeker health needs
- scope out an inclusion health service that reaches all parts of the system
- trial the risk stratification tool to identify areas of action for children and young people with asthma
- use a data driven approach to identify inequalities in access and experience of children and young people in mental health services
- build on the success of our Joint Winter Vaccination Board to address health inequalities and make every contact count
- roll out the spring COVID booster campaign and plan for an anticipated COVID autumn booster campaign
- provide the tools at local level to improve population health and reduce variation through continuing our two year programme to roll out PHM support across primary care networks and place leaders
- stand up a robust measurement and evaluation framework with a focus on Core20PLUS5
- establish an Integration Needs Assessment Steering Group to make recommendations on where further integration should take place
- develop a strategy to address health disparities in coastal and port communities where we have some of our most significant health inequalities
- Introduce health inequalities fellowship opportunities for health and care staff in HNY

Develop HNY Centre of Excellence in Tobacco Control In 2023/24 we will:

- invest in lung health checks
- embed tobacco control in nursing and midwifery
- support investment at place including local authorities to target inequalities
- develop strategies that focus on prevention for people with one long term condition from developing other conditions
- increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%

Population health and prevention: **tobacco control**

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

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

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

Co-ordination across the ICB

- well-funded regional communications and mass media campaigns
- illicit tobacco leadership
- a strong HNY voice to lobby and advocate on behalf of effective national policy
- policy expertise/data intelligence e.g. vaping
- research and evaluation
- long-term leadership and quality improvement for NHS tobacco dependency treatment services

System investment

- lung health checks
- sector-specific support e.g. primary care and community pharmacy
- systematic approach to work within social care and housing services
- embedding tobacco control in nursing, midwifery and undergraduate/ postgraduate medical information

Place-based investment

- supporting local stop smoking services to provide NICE-standard services including e-cigarettes
- investment in financial incentives for pregnant smokers
- funded very brief advice (VBA) resources and training capacity
- funding for local authorities to target inequalities

The tobacco control leadership will be through experienced specialised programme lead and team, supporting tobacco alliances and leadership quality improvement of NHS stop smoking services, leading communications across Humber and North Yorkshire.

The communications vision is to ensure strong coherent messages that prompts more quit attempts and connects smokers with effective support and/or quit aids.

What we will deliver in 2023/24

We will:

- continue roll out of embedded smoking cessation in lung health checks and launch the programme in North Lincolnshire and North East Lincolnshire
- launch our media and communications campaign
- expand the current programme core team so that we can launch the full model for the start of 2024/25

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

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

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

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

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

All of this is being developed and delivered at places and neighbourhoods, looking through an inequalities lens using the Core20PLUS5 approach, utilising a population health management approach and underlying principles.

Personalised Care

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

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

We aim to embed and enable the principles of personalised care across our programmes. For example, the Population Health and Prevention Programme has endorsed a principle of personalised care in the commissioning of inclusion health services.

Case Study

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

Partners

- working in partnership with Carers Plus Yorkshire in North Yorkshire and Yorkshire in Business in East Riding who are hosting the co-ordinator roles in each area

Current project status

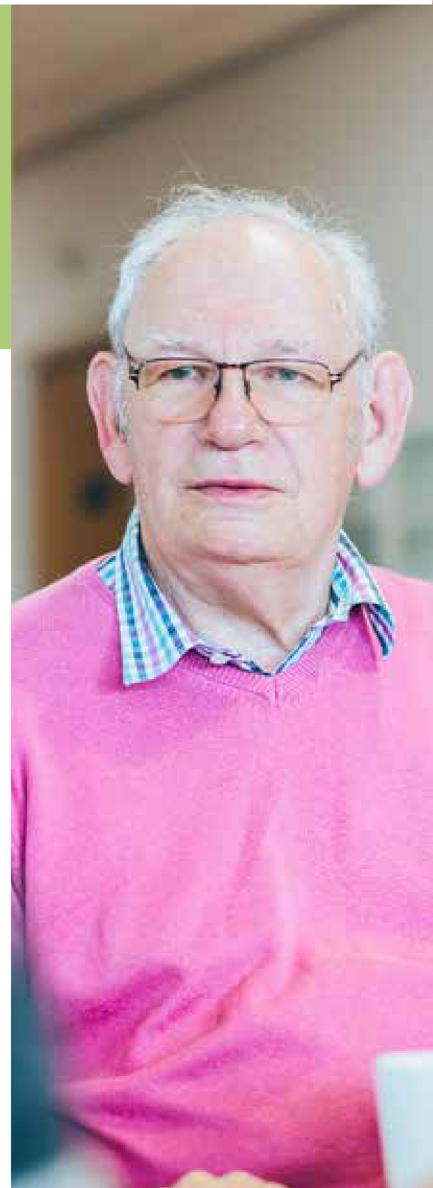
- marketing material in place including logo, Facebook page and website under construction
- introduction pack developed including Quality Standard, basic policies and procedures and guidelines

North Yorkshire Area (co-ordinator appointed January 2023)

- regular steering group meetings (seven members) overseeing progress
- monthly meeting for new and existing Micro Providers (12) in Hunmanby and Filey

East Riding of Yorkshire area (co-ordinator appointed May 2023)

- establishing local contacts, existing businesses and drop in places
- six expressed interest in becoming Micro Providers
- contacting potential steering group members



What we will deliver in 2023/24

We will:

Embed a personalised care ethos

- training and development

Connect with thriving communities

- community based micro support
- digital health hubs
- social prescribing & supported self management
- early Intervention at the Ironstone Community Hub
- children & young people social prescribing - SEND & PHBs / care leavers / York extension
- Community Support Organisation (CSO) capacity to support frail individuals
- proactive social prescribing in York
- Brain Health Café in York
- Scarborough children and young people's social prescribing – Social, Emotional and Mental Health (SEMH)

Enrich personalised care approached across health and care

- maternity
- Local Maternity and Neonatal Systems (LMNS) Gestational Diabetes Pilot
- hospital discharge (oalliative & end of life personalised care & support planning)
- waiting well - HUTH – social prescribing / obesity
- palliative care – care planning
- VCS – PHB knowledge and understanding
- Personalised Joint Care and Support Planning Toolset for Learning Disability - integrating health and care

Addressing the particular needs of **children and young people**

Strategic ambition

The vision for all our Children & Young People is to start well, enabling them to live and age well and if their life is shortened, to end their life well.

The Children & Young People's Alliance meets every two months and membership comprises of multiple stakeholders across the ICS. The alliance oversees the delivery of the service innovation and improvement described in the NHS Long Term Plan and the Children and Young People National Transformation Programme with a specific focus on integration and long-term conditions such as asthma, diabetes and epilepsy.

Population health data and analysis combines feedback with each of our six places across our footprint to inform the strategies required.

This includes addressing health inequalities and inequalities, an example of which is the diabetes poverty proofing projects underway in two of the most deprived areas in Humber and North Yorkshire, the learning from which will be utilised system wide.

Our child voice strategy

The ICB-wide Children and Young People's Engagement and Co-production Strategy will support work to develop and deliver a consistent and effective voice and influence for children and young people across the ICB and ensure those involved are representative of our diverse communities. This will be in place by autumn of 2023.

Children and young people's Core20PLUS5

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

Vulnerable children and young people are being identified as part of all workstreams, with particular focus on those with increased risk including those with protected characteristics.

These include ethnic minority communities, inclusion health groups, people with learning disabilities and autistic people, coastal communities with pockets of deprivation hidden amongst relative affluence and protected characteristic groups.

Specific consideration should be given to the inclusion of young carers, looked after children/care leavers, those in contact with the justice system and LGBT+ people. Learning disability and autism, special educational needs and disabilities (SEND) and children with complex needs and/or disabilities and impact on 'was not brought' rates.

Our priorities

Diabetes

Epilepsy

Asthma

Mental health, learning disability and/or autism - delivered with the sector collaborative

What we will deliver in 2023/24

We will:

- improve access to digital technology to manage diabetes
- roll out to all places the Diabetes Poverty Proofing Project
- benchmark services against core standards for children with epilepsy to identify priority areas for improvement
- deliver and evaluate our pilot programme with specialised nurse practitioners for children and young people with asthma
- embed a pathway between primary and secondary care to deliver national asthma standards
- increase access to dental services and improve oral health
- develop an ICS strategy for palliative and end of life care
- develop our programme for early support and intervention
- use data tracking and local feedback to identify areas of concern and risks for urgent and emergency care attendances
- develop a joint strategy including personalisation planning
- improve access to mental health support for children and young people
- support perinatal mental health enabling improved access and increased offer of psychological interventions
- reduce reliance on inpatient care so that by March 2024 no more than 12 – 15 under 18s with a learning disability and/or autism per million are cared for in an inpatient setting
- with the Mental Health, Learning Disability and Autism Collaborative ensure that 75% of people aged over 14 on GP learning disability registers receive an annual health check and action plan

Addressing the particular needs of **perinatal and neonatal care**

Strategic ambition

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

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

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

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

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

Core20PLUS5 Adult

Inclusive of Maternity Continuity of Carer; evidence based to describe better outcomes particularly in perinatal mental health and safe birthing.

Currently targets are paused nationally; we have teams in North East Lincolnshire and plans to reinstate teams in other areas. Focus on equity of provision means teams planned for more deprived areas and in groups such as younger parents, LGBT+ families, those with disability etc.

Maternity Voices Partnership

The Maternity Voices Partnership local groups are looking to expand in 23/24 to reflect their increased workload; more capacity and resources are required across Humber and North Yorkshire and particularly in areas of pressure including some parts of our cities and coastal communities. We will also be reviewing the scope of these groups around covering Neonatal family engagement and ensuring accessibility to best care.

Our priorities

- Safety and quality
- Choise and personalisation
- Enablers (prevention and workforce)
- Digital

What we will deliver in 2023/24

In 23/24 we will:

- second round of Ockenden/East Kent Peer Review visits; evidence safe, high quality care
- support for CNST adherence, including working alongside providers to achieve Saving Babies Lives v3 – new update includes support for gestational diabetes
- implementation of three year plan priorities including new Pelvic Health Services
- continue improvement against BAPM7 neonatal standards/pre-term birth support
- ensure Continuity of Carer Teams are supported and developed in deprived areas
- continue provision of 'Ask A Midwife' service, LMNS birth plans and supplementary sheets, unit videos, translation & interpretation support, surrogacy guidance etc.
- support LMNS equity & equality and cultural diversity lead work to ensure equity
- continue research work with University of Hull into alcohol support in pregnancy
- work with the Tobacco Control Team to implement a universal incentive scheme
- commence the pilot of heathy weight, diet and exercise support before LMNS rollout
- continue to support recruitment and retention leads in Trusts, maintain links with HEI training, progress international recruitment to maintain required staffing levels
- develop strategy with the Humber and North Yorkshire Midwifery Workforce Supply Planner and HEE
- implement the Maternity Support Worker Scheme to ensure consistent competencies
- support perinatal and maternal mental health schemes enabling improved access
- complete implementation of BadgerNet single maternity IT system across Humber and North Yorkshire
- ensure Yorkshire & Humber Care Record embedded for contextual launch
- review SI/Quality/Performance reporting for true data comparison and learning
- scope e-red book provision with partners

Addressing the needs of **victims of abuse**

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

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

We will work with statutory safeguarding partners to:

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

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

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

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

The LMNS has worked with providers across Humber and North Yorkshire to implement the ICON strategy 'babies cry, you can cope' to reduce the incidence of abusive head trauma.

Midwives, neonatal nurses, health visitors and other partners redirect families to supportive information about when baby crying peaks, what the differences are if babies are born early and how to manage the feelings this brings to parents when they are already stressed and sleep deprived.

Specific care is taken for dads and partners who are often excluded from processes during labour, birth and beyond and hence miss out on key support.

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

We have made a recurrent financial contribution to local services for the last three financial years and this will continue.

We co-produced the North East Lincolnshire Domestic Abuse Strategy with the local authority and all local stakeholders during 2020.

The strategy considers female genital mutilation, so called honour based violence and forced marriage. We are currently working with the local authority to design and implement a commissioning process for local services mandated under the Domestic Abuse Act 2021 which will focus on:

- refuge accommodation
- safe dispersed accommodation
- community outreach support
- Sanctuary Scheme
- MARAC co-ordination
- specialist support for children and young people affected by domestic abuse

New commissioned services will be operational in August 2023 and will deliver a range of outcomes associated with the Domestic Abuse Act. These outcomes focus on the recovery journey for victims/survivors and optimising their resilience and ability to live independently free from violence and abuse.

The overall long term outcome we intend to achieve with this work is the reduction in prevalence of domestic abuse and the reduction of children in care as a result of domestic abuse and sexual violence.

System developments

Delivering today to **transform tomorrow**

Listening to patients' experiences of their care – and to the views of the NHS staff who provide it – plays a crucial part in delivering services that are safe, effective and continuously improving.

Humber and North Yorkshire ICB has a statutory obligation to involve patients and the public in decision making and service development. There are clear standards for public engagement to shape decisions, monitor quality and to set priorities. By giving everyone an equal voice, listening to people who use services and empowering them to be part of the design and decision making about service we become aware of ideas and aspects of service that may not have been considered, enabling us to make positive change.

Insight does not come from a single source: from a single survey, patient story, focus group or public meeting. It's about using a combination of sources to understand a number of different issues and then to ask: "How do we use what we've found out – positive and negative – to improve the quality of every patient's experience?"

Insight can tell us things that other performance data cannot, particularly about how people feel about hugely important issues such as dignity, compassion and respect. We will use continuous engagement models to inform the generation strategic direction as well as specific plans.

We will link with our wider partners to ensure that the collective insight gathered by all organisations is shared, analysed and utilised effectively to build up a full system picture.

All the data and insight we gather and collate will inform future iterations of the Joint forward Plan and other strategies for service delivery. It will also be used to steer our marketing and campaign messaging to ensure our communication resonates with the various audiences it is intended to support. We will support asset-based community development approaches, working with partners (e.g. public health, community teams in local authorities etc.) to help to activate individuals and communities to tackle barriers to good health and wellbeing.

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

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

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

We will launch our programme of work during the first week in July when the NHS celebrates its 75th birthday. This activity will build on initial work undertaken to inform the development of our ICB Engagement Strategy.

Developing our operating model

System wide priorities - doing things once

Integration

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

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

Quality, Efficiency and Productivity Programme

Humber and North Yorkshire Quality Efficiency and Productivity Programme has identified five priority areas to be delivered across the system via the place and collaborative teams, these are:

1. reducing unwarranted variation
2. follow up reduction (including patient initiated follow up)
3. prescribing
4. no criteria to reside (reducing average length of stay universally)
5. continuing health care and Section 117

The programme will realise the scope, scale of system opportunity, impact on quality,

efficiency and productivity by:

- aligning costs to strategy: differentiate the strategically-critical 'good costs' i.e. waiting list reduction / targeted health inequalities funds from the non-essential 'bad costs' i.e. pay growth/contracting costs/locum costs
- harnessing the value of the ICS operating model: do once where makes sense (not just replicating the commissioner provider split at six places)/act as a system facilitator/deliver service transformation through a) place (with local authorities, primary care and social care and community) b) sector collaboratives
- aiming high: use technology, innovation and new ways of working to radically reduce and streamline the cost base/increase capacity i.e. out-patient follow up/addressing clinical variation/one workforce
- setting direction and showing leadership: deliver cost reduction as part of a strategic, business transformation programme = Humber and North Yorkshire Quality Efficiency Productivity Programme
- creating a culture of continuous improvement for our staff: '100 ways ' – no stone unturned, improving efficiency and reducing costs, encourage calculated risk, no blame culture

Acute and planned care

Humber Acute Services Review

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

- shortages and skills gaps in our workforce
- services not meeting clinical and waiting time standards
- buildings, equipment and digital infrastructure not being up to scratch

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

In 2023/24 we will develop a set of proposals to consult with the public on. The decision on which model of care to implement will only be taken after consultation for implementation from 2024 – 2030.

For more information visit our website.

Use the camera on your smartphone to scan the QR code

www.humberandnorthyorkshire.org.uk/our-work/humber-acute-services-review

Community Diagnostics Centres

The National Policy for Community Diagnostic Centres will enable investment to increase diagnostic capacity and reduce elective – especially cancer – waiting list times, reduce health inequalities and deliver a better more personalised experience for patients. This will be delivered through a 'hub and spoke' model.

In Humber and North Yorkshire demand is expected to increase significantly over the next 10 years and so we need to develop our diagnostic service at scale and over an extended period and we will need to maximise the use of national funding.

In 2023/24 we will:

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

Plannced care five year strategy approach

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

- improve access and patient health outcomes
- refocus planned care services with a focus on productive, efficient models
- build an ICS model that is able to meet the demand of the population
- address health inequalities and reduce variation
- improve system resilience
- improve system working
- build on digitally enabled care solutions
- based on place wherever possible
- ensure compliance with national policy and guidance

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

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

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

Pharmacy, optometry and dental services

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

Dental health inequalities

In Humber and North Yorkshire there are approximately 170 general dental service providers for our population.

Oral health inequalities exist in:

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

Data and evidence surrounding oral health inequalities is variable and complex, but we know that they also exist in relation to oral cancer as well as in vulnerable groups with long-standing medical conditions, substance misuse, prisoners/prison leavers and Gypsy, Roma and Traveller communities.

What we will deliver in 2023/24

- understanding current services, effectiveness and risks
- improving access
- prevention with a focus on 2-11 year olds, residents of care homes and inclusion health services
- using data and clinical input to prioritise actions
- focus on workforce - both recruitment and retention
- we will continue to work with our community pharmacy and optometrists to maximise the skills and capacity to support our patients in accessing care close to home

Public health commissioning: screening and immunisation

Commissioning will be central to the NHS meeting the challenges it faces today and in the future, and in ensuring that the NHS delivers the triple aim of improved population health, quality of care and cost-control. In order to deliver the triple aim, commissioning will need to continue to develop as it has since its inception.

There will be a need for commissioners to work more closely together, aligning their objectives with providers and taking a more strategic, place-based approach to commissioning. Integrated Care Systems will all play key roles working with NHS England commissioners to secure the benefit of working together across a system to deliver for patients. Specifically, improving quality of care, reducing inequalities across communities and delivering best value.

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

What we will deliver in 2023/24

In 2023/24 in Humber and North Yorkshire NHS England regional commissioners and the ICB will work together to:

- align the Yorkshire and Humber Screening and Immunisation Health Inequalities Action Plan with ICB priorities
- respond to anticipated national strategies for screening and immunisation for the ICB
- work in partnership to deliver the programme for bowel cancer screening

Specialised commissioning

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

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

We will have greater flexibility to integrate services across care pathways, ensuring continuity for patients and improved health outcomes for the population.

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

What we will deliver in 2023/24

We will:

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

Healthy childhood

Neonatal care – to work with the Yorkshire and Humber Neonatal Operational Delivery Network and Local Maternity and Neonatal Networks (LMNS) to deliver the five-year plans for the implementation of the national Neonatal Critical Care Review to reduce neonatal mortality.

Cardiovascular

Mechanical thrombectomy for stroke - to improve access to mechanical thrombectomy across the region by optimising the use of current in-hours services.

Renal Dialysis - working through the Yorkshire and Humber Renal Network actively reduce the need for renal dialysis by actively focussing on interventional and alternative treatments.

Cancer

Radiotherapy and chemotherapy - to work with providers of paediatric radiotherapy, chemotherapy, oncology services, and cancer alliances to develop new and sustainable service models.

Other

Adult critical care - develop an Adult Critical Care Transfer Service that will support best use of critical care capacity across Yorkshire and the Humber.

Measurable outcomes:

- number of patients accessing thrombectomy service
- stillbirth and neonatal mortality rate
- cancer five year survival rates
- reduced rate of growth in new referrals to renal dialysis units

Mitigating **climate change**

Acting on the climate crisis is a clear, yet still neglected, priority for public health. There is now a large body of work making a clear link between climate change and health.

The impacts of climate change on health can be direct - relating primarily to changes in the frequency of extreme weather (such as heatwaves, drought, fires, floods, or storms) - and indirect, through changes on ecosystems (for example, water-borne diseases, and air pollution) and through effects mediated by human systems (such as occupational impacts, undernutrition, mental health, but also migration and conflict).

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

Integrated system social care strategic leadership forum

The strategic forum has been established to provide a platform where leaders across health and social care and the wider integrated care system can come together to focus on common priorities, sharing insight and intelligence and collectively identify opportunities for improvement and wider system collaboration.

The particular focus is to strengthen the opportunity for senior ICB leaders and directors of adult social care to come together to discuss system-wide issues and challenges with a view to supporting a collaborative approach and collective solutions. The aim is to supplement and strengthen both discussions and actions across the wider ICS geographical footprint.

In 2023/24 the forum will develop an agreed action plan aligned to health and care integration.

The focus will be on the following core areas:

Workforce

- retaining the social care workforce - cost of living crisis
- profile of the sector - changing the narrative
- parity for the social care work force
- link with wider workforce development and new roles e.g. AHP/ARSS - others

Sustainability of the care sector and engagement

- fair cost of care uplifts
- care fee uplifts
- significant inflationary pressures on the sector- energy and fuel
- care provider failure and withdrawals from the market increasing

Sufficiency and sustainability of prevention strategies

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

Creating the conditions for delivery

Our ICS strategy sets out how we will create the conditions to enable and empower our people, communities and organisations to achieve change. This section of the Joint Forward Plan sets out how the ICB will create these conditions in how we work within our organisation and with our partners to embed this way of working in everything we do, and to meet our statutory requirements and obligations.

In this section we will set out:

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

Nursing and Quality **delivering our duty to improve quality**

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

In 2023/24 we will:

- continue to implement our system approach to quality management in accordance with National Quality Board Guidance including managing performance as set out in the guidance. Quality Risk Response and Escalation in ICSs; Guidance on System Quality Groups
- establish the ICB virtual safeguarding hub, to co-ordinate functions to support delivery, provide mutual aid and deliver programmes of work at scale to articulate best clinical practice in safeguarding.

Our ambitions include:

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

Priorities for 2023/24

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

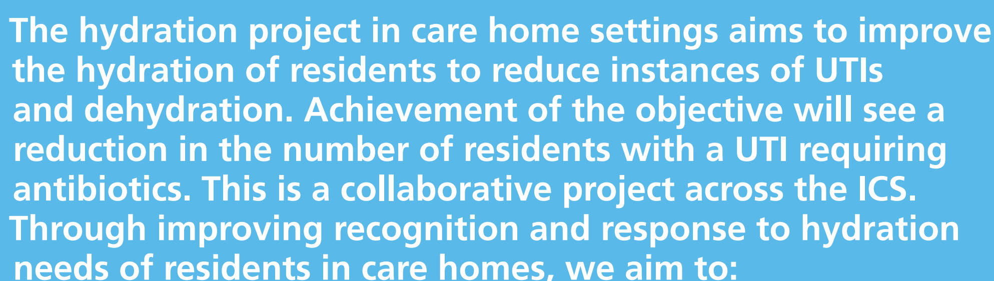
Embed the operational quality systems
To include the range of statutory and regulatory responsibilities

Safeguarding
Provide assurance of system arrangements

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

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

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



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

- **Reduce avoidable harm caused through poor hydration.**
- **Enhance clinical outcomes**
- **Improve experience for residents in care homes.**
- **Improve staff experience/ safety culture.**
- **Improve antimicrobial stewardship.**

Quality: **reducing inequalities**

The Population Health and Prevention Executive Committee oversees the ICB's ambition to improve outcomes in population health and healthcare. It is a partnership between the six local authorities, the ICB, and providers.

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

We will do this by:

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

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

Priorities for 2023/24

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

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

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

Education and training
Introduce health inequalities opportunities to health and care staff and co-ordinate public health training opportunities in the ICB for junior doctors and registrars so that we can upskill the next generation of the health and care workforce with expertise to deliver integrated care that maximises healthy lives

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

Health inequalities funding

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

Humber and North Yorkshire has developed a number of schemes in 22/23 in collaboration with local authority partners which are approved and via the committee and have a quantifiable allocation and measurable impact:

- expanded Tobacco Control and Dependency Treatment Programme
- perinatal weight management project trial
- programme management support to coordinate the CVD prevention pathway
- addressing premature births through a Maternal Wellbeing Programme
- care and support for victims/survivors of domestic abuse
- inclusion health - weight management
- GP Drop-in Service in Rainbow Children's Centre
- family and school links project: support with anxiety related school absence
- GP outreach Urgent Care/Dental Care Service for sex workers
- Cultural Community Café and recreation facilities for asylum seekers – adults and children

Efficiency and sustainability: **financial duties**

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

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

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

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

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

Fair, equitable and realistic financial targets should be established.

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

Guiding principles:

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

Our approach to financial planning

Short term

- quantify our gaps quickly
- explore rapidly in year opportunities
- keep it simple and realistic
- establish our process with place and collaboratives as our prime planning route
- fully exploit the digital agenda
- ensure system rigour
- develop a system lens to demand management

Beyond one year

- describe our three year position and stick to it
- identify our key areas of fragility
- align national and local planning parametres
- keep a strategic focus on capital planning

Our priorities

Embed the ICB approach to driving value and eradicating waste

Develop our systematic approach to planning, ensuring system accountability and transparency

Publish our Joint Capital Resource Plan

What we will deliver in 2023/24

- **align costs to strategy:** differentiate the strategically-critical 'good costs' i.e. waiting list reduction / targeted health inequalities funds from the non-essential 'bad costs' i.e. pay growth/contracting costs/locum costs
- **harness the value of the ICS operating model:** do once where makes sense (not just replicating the commissioner provider split at six places)/act as a system facilitator/deliver service transformation through
  a) place (with local authorities, primary care, social care and community)
  b) sector collaboratives
- **aim high:** use technology, innovation and new ways of working to radically reduce and streamline the cost base/increase capacity i.e. out-patient follow up/addressing clinical variation/one workforce and continued investment in renewable energy
- **set direction and show leadership:** deliver cost reduction as part of a strategic, business transformation programme = HNY Quality Efficiency Productivity Programme
- **create a culture of continuous improvement for our staff:** '100 ways' – no stone unturned, improving efficiency and reducing costs, encourage calculated risk, no blame culture
- establish system wide ICB planning meetings to hold ourselves to account and embed our core principles to planning and accountability

In line with NHS England guidance we will develop and publish a narrative explanation on the full 12 months period from April 2022 to March 2023 making sure that we embed our principles of:

- decisions taken closer to the communities they affect are likely to lead to better outcomes
- collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people
- collaboration between providers (ambulance, hospital, and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity

Efficiency and sustainability: **procurement and supply**

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

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

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

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

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

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

Aims and objectives of the procurement transformation programme

- embed robust procurement and contracting governance and decision making in accordance with the ICB's governance framework through supporting individuals and teams across the ICB to understand processes and know how to access support from the Procurement and Contracting Team
- transform how the Procurement and Contracting Team operates to improve efficiency and reduce duplication while maintaining strategic support for places
- establish a roadmap for the rationalisation of ICB contracts to improve consistency and maximise the efficiency of contract management
- deliver an effective procurement plan for the ICB which balances procurement regulations, legislation and assessed risks
- develop an ICB Contract Management Framework of standardised approach and procedures
- complete the implementation of the single ICB e-contract register

Our priority

Standardise procurement data and systems

What we will deliver in 2023/24

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

Efficiency and sustainability: **duty as to climate change**

The Health and Care Act 2022, the legislation that bought about Integrated Care Boards (ICB) also enshrined in law a commitment by the NHS in England to consider climate change in all decisions.

At Humber and North Yorkshire ICB, we not only recognise our legislative commitments to climate change but aspire to move faster and further becoming recognised as national leaders in responding to the climate emergency through increased mitigation, investment and at the same time ensuring a just and inclusive transition – ensuring on one is left behind.

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

1) **net-zero** – reducing greenhouse gas emissions

2) **climate resilience (adaptation)** – resilient healthcare in the face of a changing climate

3) **nature and biodiversity** – supporting ecosystem recovery

4) **just and inclusive transition** – transitioning to a net-zero carbon economy in a way that is fair and equitable for all

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

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

A three-year strategy based on the aspirations set out in "Delivering a Net-Zero National Health Service" sees our response to climate change woven into all aspect of our ICS ways of working.

In 2023/24 we will continue focus on Green Plans to reduce environmental impact focusing on our priority areas.

Our priorities

Our deliverables

Data and performance

- establish metrics linked to the Greener NHS Dashboard to monitor key performance of the ICS commitments to climate change
- develop a carbon footprint dashboard to establish the carbon account of the ICB

Digital enablers

Digital initiatives can play a key role in supporting a net-zero economy by increasing efficiency, reducing waste, and optimising energy usage including:

- digital supply chain management - procurement of low energy equipment
- research and implementation of “power down” software
- energy-efficient data centres

Estates

There are a number of estate initiatives that will be built into our estates strategy for primary, secondary, tertiary and community care to support the transition to net-zero including:

- costed plans to decarbonise the estate
- increase building energy efficiency
- on-site generation of renewable energy and heat
- optimising building usage

Travel and transport

- collaboration with partners to support modal shift initiatives to public transport and active travel alternatives for staff and patients including walking and cycling
- support the transition to electric vehicles including through staff benefit schemes
- transition of owned and leased fleet to ultra low and zero emission vehicles

Procurement and supply

From April 2023 all contracts above £5m per annum the NHS will require supplies to publish a Carbon Reduction Plan. From April 2024 the NHS will extend this requirement to cover all procurement. More information can be found at the Net Zero Supplier Roadmap, scan the QR code below to view the roadmap.

www.england.nhs.uk/greenernhs/get-involved/suppliers/

Medicines

- decommission desflurane completely given the availability of clinically safe, more environmentally friendly, and cost-effective alternatives
- reduce carbon footprint of inhaler prescribing
- reduce emissions from nitrous oxide and mixed nitrous oxide products in manifold cylinders

Creating an enabling infrastructure: **promoting involvement**

By giving everyone an equal voice, listening to people who use services and empowering them to be part of the design and decision making about services we become aware of ideas and aspects of service that may not have been considered, enabling us to make positive change.

Although we have a legal duty to involve people, we believe local people know their communities best, building relationships and trust by making sure everyone has a voice and that decision making is underpinned by robust evidence, we can make sure that services meet the needs of the local community. Creating opportunities for patients and the public to be involved and contribute, by sharing power and co-producing services and solutions.

The Integrated Care Board has a legal duty to involve patients and the public in decision making and service development. There are clear standards for public engagement to shape decisions, monitor quality and to set priorities. These come from a number of sources, including:

- legislation
- the NHS Constitution
- existing national guidance
- Integrated Care System (ICS) Guidance

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

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

- Be visible honest and open
- Be flexible and dynamic
- Be inclusive and accessible, seeking voices of the seldom heard
- Listen to communities and value contributions
- Learn from each other and feedback
- Involve people in being part of the solution
- Build on trust and ongoing relationships

Find out more about our engagement work

Use the camera on your smartphone to scan the QR code

www.humberandnorthyorkshire.org.uk/our-work/get-involved

Creating an enabling infrastructure: **involving patients and patient choice**

Humber and North Yorkshire Health and Care Partnership recognise that there is a part for us all to play in looking after our health and the health of those around us.

On 1st April 2023 a new website was launched by the NHS in Humber and North Yorkshire to help people start well, live well and age well. Here you can find all the information you need to help live a more healthy and active life whilst learning about the health services in your area.

Let's Get Better brings together lots of health and wellbeing information to support people throughout their lives and helps people choose well and get the care they need when they're unwell.

The Let's Get Talking blog celebrates the people, places and potential that our area has to offer.

The programme is supported by social and digital media, print and online partnerships and health advice videos. Further development is planned including enhancing local content and increasing information on commissioned services, voluntary and community sector and community support in each area, plus specific LGBT+ health information and advice and enhanced accessibility.

Visit Let's Get Better for more information

www.letsgetbetter.co.uk

Patient Engagement Portals

An NHS Patient Engagement Portal is a digital platform that allows patients to access their healthcare information, communicate with healthcare providers and manage their health in a more convenient and efficient manner.

For patients this will mean a more consistent experience that improves access, visibility and control for patients on elective care pathways.

It will enable a single point of entry digital 'front door' to NHS services through the NHS App.

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

Involvement case studies

Customising engagement to make it relevant

In 2021 engagement took place with children and young people across the Humber to hear what they liked and didn't like about coming into hospital and what was most important to them when receiving care or treatment to help them feel better quickly.

To undertake this engagement effectively and ensure young people could respond in a way that was meaningful to them, a child-friendly approach was developed in partnership with play specialists, patient experience leads and paediatric clinical leads within the two hospital trusts.

For young children (0-10 years) a fun activity booklet was developed featuring drawings, matching activities and space to write or leave comments. For older children/young people (11-18 years) a bespoke questionnaire was produced with simplified questions and open space to provide free text or drawings. This booklet was also available to complete online and a URL and QR code was provided to participants. Participation was incentivised with a prize giveaway and parental consent was built into the survey design.

Maternity Voices Partnerships

The Local Maternity and Neonatal System (LMNS) works very closely with Maternity Voices Partnerships (MVPs) based in each place and with a coordinating lead to link into regional and national initiatives.

The MVPs host regular meetings, engage through social media, oversee production of guidance and processes, and support the oversight and assurance processes of the LMNS within their local hospitals to ensure families needs are met.

They also have a cultural diversity lead across Humber and North Yorkshire who supports linkages into different community, faith, racial, LGBT+ and other minority groups to ensure they are effectively represented in these discussions.

The Mental Health Learning Disability and autism sector collaborative

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

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

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

Creating an enabling infrastructure: **appropriate advice**

Clinical and care professionals are the cornerstone of the ICB - a key enabler in delivering the ambitions of the Joint Forward Plan. The ICB has a model of clinical place directors, who have a dual role to provide leadership within their respective places and operate strategically across the ICB.

Each clinical place director collaborates with a virtual team of clinical and care professionals within their respective places. They provide expert clinical advice and facilitate the culture change needed to deliver fully integrated care, across programmes, places, networks and collaboratives.

Alongside this, leading clinical and care professionals from across ICB geographies coalesce on a weekly basis to learn, share and develop clinically led solutions to the various systemic issues facing the ICB.
A core purpose and ambition of the directorate is to drive and facilitate culture change through clinical and professional leadership, at all layers of our complex system.

We will do this through:

Clinical effectiveness

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

Digital

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

Research and innovation

Growing our knowledge and capacity to scale up innovation

Medicines optimisation

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

Our priorities

- **Take forward and agree a way forward for a digital solution to better pathway standardisation to reduce unwarranted variation and support system transformation for patients**
- **Develop clinical leadership to champion and embed clinical transformation within place, collaboratives, and system partners**
- **Develop a structure for clinical networks operating in the ICB which will provide visibility of work and enable the ICB to drive effectiveness and efficiency through agreed network work programmes**
- **Embed streamlined clinical decision making processes for the harmonisation of existing and introduction of new clinical policies**

Creating an enabling infrastructure: **Innovation, Research and Improvement (IRIS)**

Vision

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

Mission

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

What will IRIS do to realises its mission and vision?

Single front door

- for industry, life sciences sector, arms length bodies, academia
- facilitate rapid adoption, spread, scaling up of innovation and best practise

Virtual hub for stakeholders

- harness existing networks, activity, and resources to create a joined-up system that encourages, promotes and enables research, innovation and improvement
- match making function to facilitate new collaborations

Demand signalling

- communicating ICS priorities and 'grand challenges' to researchers and innovators

Culture change

- education, training and upskilling the workforce to provide colleagues with the knowledge and tools that they need to embed research, innovation, and improvement
- promoting research in primary, secondary and social care

A data driven and evidence-based system will enable:

- cultural change and staff empowerment – those who do the work know the solutions
- better outcomes for people
- standardisation of systems and processes
- recruitment and retention of talent
- better use of resources

What will success look like?

- grow local healthcare innovation knowledge and capacity
- support local healthcare innovator and economic development
- fixing our local healthcare 'grand challenges'
- scaling up any local fixes beyond HNY ICS
- be an exemplar health and social care system for research, innovation and improvement

What we will deliver in 2023/24

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

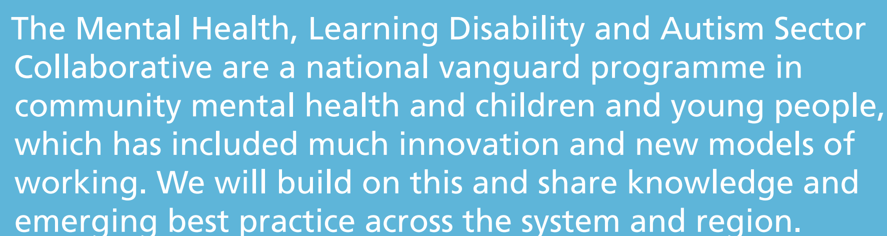
- host a launch event and support ongoing engagement and relationship building
- identify two ICP 'grand challenges' for IRIS to drive activity toward
- create the ICP strategy for research, innovation and improvement
- perform a comprehensive stocktake of what resources exists in the system and develop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

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

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

Adopt NHS impact to create the culture and conditions for continuous improvement across the ICS

- engage with NHSE on the adoption of NHS impact
- learn lessons internally and from other peer ICBs
- engage with global leading vendors to identify opportunities for clinical and operational improvement and sustainable change



The Mental Health, Learning Disability and Autism Sector Collaborative are a national vanguard programme in community mental health and children and young people, which has included much innovation and new models of working. We will build on this and share knowledge and emerging best practice across the system and region.

We will have services in place around community mental health and children and young people's mental health (in particular) that are built on innovative models of care and pathway design arising from the national vanguard sites.

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

Creating an enabling infrastructure: **our digital strategy**

Vision

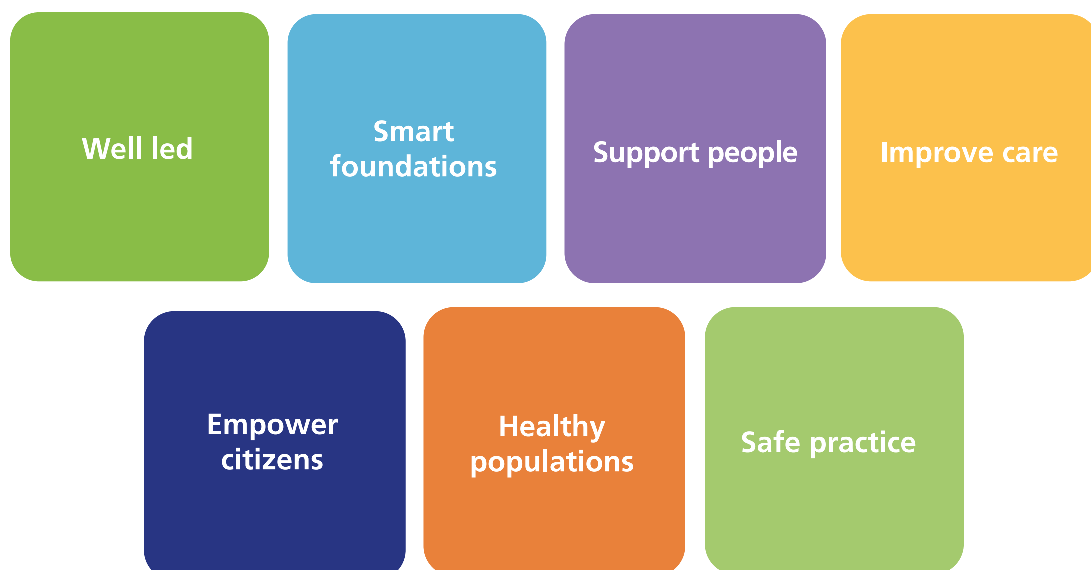
Our digital vision is 'to deliver digital and information services and solutions that enable citizens to Start well, Live well, Age well and End their lives well.'

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

We will

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

Our priorities



What we will deliver in 2023/24

- development of a unified approach to digital based on a distributed leadership model with the intention of a refreshed system wide approach
- continue to deploy the Yorkshire and Humber Care Record across all areas of health and social care
- collaborate to rationalise and develop our electronic patient record systems, delivering the required elements of the programme
- continue to implement the actions set out in the Digital Inclusion Strategy and Plan
- develop and implement a self-sustaining, system-wide, multi-disciplinary data and analytical collaborative model – that produces high-quality, locally-relevant intelligence to enable leaders at all levels to make decisions informed by evidence

The Humber and North Yorkshire Digital Inclusion Steering Group continues to ensure that services across the health and care system are designed to be as inclusive as possible.

For example, East Riding of Yorkshire Council are working with the LGA to create a digital inclusion tool to support service users to find the right digital support to suit their needs. The project started in January 2023 and will run until December 2023.

The Holderness ward within East Riding of Yorkshire will be used as a test area for the project. East Riding of Yorkshire Council Services, GP practices and community groups will test and evaluate it before wider rollout.

The Digital Inclusion Steering Group continues to grow and support the ICB to expand and support stakeholders in knowledge sharing and networking in 2023/24.

Creating an enabling infrastructure: **our people strategy**

Our People Strategy

Be the best place to work	Grow and train our workforce	Demonstrate system leadership
• supporting staff health and wellbeing • supporting inclusion and belonging	• growing the workforce of the future and ensuring adequate workforce supply • educating, training and developing people and managing talent	• valuing and supporting leadership at all levels • supporting system design and development

Our priorities

- Inclusive health and care careers
- Flexible workforce: agency and bank
- Leadership, talent and succession
- Stay and thrive: retaining our staff
- OD lab for system effectiveness

Our Workforce Transformation Programme

We will deliver our strategy through an iterative transformation programme delivered in phases to enable sustainable workforce transformation and drive system development. Our innovative methodology for workforce transformation is built on distributed leadership and open participation.

Case study: 180 Days of Action on Workforce Sept 2022 – March 2023

Read about the success of the first phase of our transformation programme – 180 Days of Action on Workforce - in our 180 Days storybook and watch our 180 Days partnership film to hear about how our innovative approach to change design and leadership is changing the way partners work together.

What we will deliver in 2023/24

Inclusive health and care careers

- careers support menu in deprived schools
- work experience placements bank, employer toolkit and virtual offer
- disability confident
- veterans

Flexible workforce: agency and bank

- design Humber and North Yorkshire (HNY) system collaborative bank
- deliver 23/24 NHS England bank and agency objectives
- create HNY bank and agency dashboard

Leadership, talent and succession

- create best practice programmes for leaders at all levels
- explore common induction

BREAKTHROUGH HNY
Our Workforce Transformation Programme 2023/24

Our People Strategy sets out a long-term architecture for the people challenge and explains how our leadership community is organising its collaborative thinking and planning around people and workforce.

Our System Workforce Board and its committees will oversee the development and implementation of medium-term strategic plans, ensuring partners from all sectors are involved and share control.

Embrace new ways of working

- all sectors workforce transformation including VCSE
- carers and volunteers

Building strong foundations

- transforming people services and supporting the people profession
- leading co-ordinated workforce planning using analysis and intelligence

Care at home workforce redesign | Children and young people's workforce redesign | Oral health workforce redesign | Volunteers at the heart of the system | Enabling colleague movement | One system, recruiting together

- deliver career progression curriculum
- work with region 4+1 on senior level talent

Stay and thrive: retaining our talent

- co-design and launch flexible working strategies
- new starter attrition prevention tools
- exit intelligence
- stay conversations

OD lab for system effectiveness

- create cutting edge OD toolkit to support system effectiveness, involving and developing place, collaborative and function leaders and teams

Care at home workforce redesign

- map VCSE care at home workforce at place
- streamline care at home roles
- amplify direct care provider voice
- care at home digital vision

Children and young people's workforce redesign

- to be developed with directors of children's services

Oral health workforce redesign

- to be developed with dental commissioners and profession leaders

Volunteers at the heart of the system

- apply 180 Days research findings
- design and progress HNY volunteer hub
- research volunteering in social care

Enabling colleague movement

- define and negotiate portability agreement and process
- employee passports

One system, recruiting together

- HNY attraction campaign and front door
- shared recruitment charter and principles
- pilot joint recruitment campaign and recruitment innovation

Creating an enabling infrastructure: **supporting wider social and economic development**

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

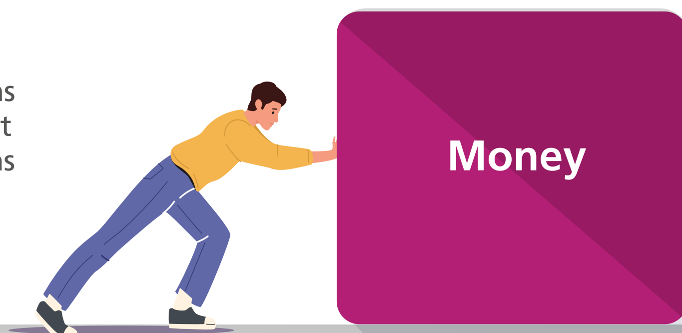
Utilising our partnerships and our history of working with our communities, we will look to optimise the arrangements to impact positively on our communities and support through our actions addressing the gaps in the building blocks of health, to deliver the aims and aspirations for better health and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

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

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

What we will deliver in 2023/24

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



Case study

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

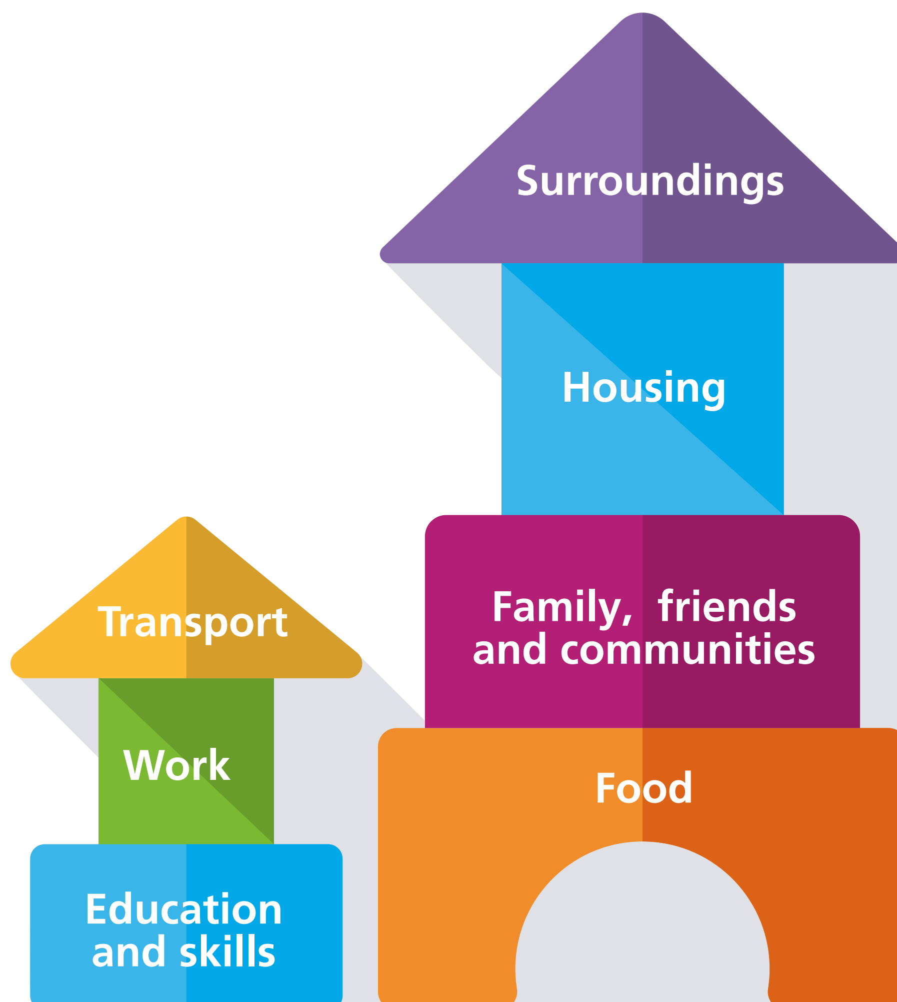
One of our key priorities is workforce development and this is being facilitated through the North East Lincolnshire Health and Care Partnership and involves partners from across health and care.

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

In addition to this the workforce group will:

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

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



Credit: Health Foundation

Appendix

Appendix A:
What will success look like

How we will know we've succeeded

Start Well

Strategic outcomes	JFP Outputs	Operational plan deliverables
I am safe. My family has what they need to look after me	Complete a serious violence needs assessment and develop a partnership response strategy Respond to the findings of the national audit of domestic abuse support in healthcare settings Map models of intervention for domestic abuse and adopt and spread best practice develop pathways for non-fatal strangulation, honour and faith-based abuse FGM and forced marriage Respond to children who are experiencing low levels of domestic abuse Ensure meaningful data collection to contribute to developing a better system understanding of domestic abuse Develop an ICB wide learning culture and ensure safeguarding training is of a high quality	
I know what I can do to stay healthy	Pilot health weight, diet and exercise support before LMNS roll out Develop our programme for early support and intervention	
My Mental health matters and I can get help when I'm struggling	Build on Trauma Informed Care Programme to provide early intervention and prevention to support vulnerable children and young people Support perinatal mental health enabling improved access and increased offer of psychological interventions Improve access to mental health support for children and young people	Improve access to mental health support for CYP in line with the national ambition Improve access to perinatal mental health services

Strategic outcomes	JFP Outputs	Operational plan deliverables
My Mental health matters and I can get help when I'm struggling	Support perinatal mental health enabling improved access and increased offer of psychological interventions Reduce reliance on inpatient care so that by March 2024 no more than 12-15 under 18s with a learning disability and/or autism per million are cared for in an inpatient setting Ensure that 75% of people aged over 14 on a GP learning disability register receive an annual health check and action plan	
There are exciting career opportunities for me	Introduce health inequalities opportunities for health and care staff in HNY	
It is easy for me to get the support I need for my child	2nd round of Ockenden peer review visits - evidence of safe, high quality care CNST adherence including working to achieve Saving Babies Lives and support for gestational diabetes Implementation of 3 year plan including new Pelvic Health services Continue improvement against BAPM neonatal standards pre-term birth support Continue research work with University of Hull research work into alcohol in pregnancy Support LMNS equality and diversity programme to ensure equity Continue to support recruitment and retention in trusts to maintain required staffing levels for maternity services Develop strategy with HNY wider workforce supply planner Implement maternity support worker scheme to ensure consistent competencies Complete implementation of BadgerNet single maternity IT system Ensure Yorkshire and Humber Care Record embedded for contextual launch Review SI and quality performance for true data comparison and learning	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury Increase fill rates against funded establishment for maternity staff

Strategic outcomes	JFP Outputs	Operational plan deliverables
It is easy for me to get the support I need for my child	Scope e-red book provision with partners Use a data driving approach to identify inequalities in access and experience for children and young people in mental health services Trial the risk stratification tool for action for children and young people with asthma Improve access to digital technology to manage diabetes Roll out to all places the diabetes poverty proofing project Benchmark services against core standards for children with epilepsy to identify priority areas for improvement Deliver and evaluate our pilot programme with specialised nurse practitioners for children and young people with asthma Embed a pathway between primary and secondary care to delivery national asthma standards Increase access to dental services and improve oral health Use data tracking and local feedback to identify areas of concern and risks for urgent and emergency care attendances Develop a joint strategy including personalisation planning Ensure Continuity of Carer teams are supported and developed in deprived areas Continue provision of ‘Ask a Midwife’ service including birth plans, translation and interpretation support, surrogacy guidance	

Live Well

Strategic outcomes

I am on top of my condition and I know what to do if I need help

JFP Outputs

Improve diagnostics for cancer - focussing on liver surveillance and cytosponge delivery

Support awareness and diagnosis of cancer - targeting the 20% most deprived areas

Deliver our programme of Living with and beyond cancer

Build on the early implementer site for Community Mental Health Transformation to continue to increase access to mental health support in the community

Develop a 3 year plan for inpatient services across Mental Health, Learning Disabilities and Autism

Develop working arrangements with transforming care partnerships to deliver key priorities across learning disabilities and autism

For people in MH crisis expand the use of MH response vehicles following successful implementation on our patch via the Yorkshire Ambulance Service (YAS)

Ensure sustained improvement for the delivery of annual health checks for people with serious mental illness

Work with maternity programme to support perinatal mental health enabling improved access an increased offer of psychological interventions

Continue to invest in Health and Wellbeing programmes

Operational plan deliverables

Meet the cancer faster diagnosis standard by March 2024

Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the early diagnosis ambition by 2028

Increase the number of adults and older adults accessing IAPT treatment

Achieve a 5% on year increase in the number of adults and older adults supported by community mental health services

Work on eliminating inappropriate adult acute out of area placements

Reduce reliance on inpatient care, while improving the quality of inpatient care for adults with a learning disability and/or who are autistic

Ensure 75% of people aged over 14 on GP learning disability registered receive an annual health check and health action plan by March 2024

Strategic outcomes	JFP Outputs	Operational plan deliverables
I am on top of my condition and I know what to do if I need help	Work with partner organisations to get closer to people suffering from health inequalities Support more people and communities directly to increase digital access and support a digital strategy Develop approach to addressing multi-morbidity starting with our cardiovascular disease detection and prevention plan Develop strategies that focus on prevention for people with 1 long term health condition Support investment at place including local authorities to target inequalities Increase percentage of patients with hypertension treated to NICE guidance Increase percentage of patients aged between 25 and 84 years old with a CVD risk score greater than 20% on lipid lowering therapies Address health inequalities and make every contact count through our Winter Vaccination Board Roll out the spring COVID booster campaign and plan for an anticipated COVID autumn booster campaign	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 Increase number of patients on lipid lowering therapies
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Planning, delivering and transforming services together with the planned care strategy Work with clinical networks to share best practice and reduce unwarranted variation The electronic patient record programme to support digital modernisation Work together to ensure the clinical sustainability of fragile services Implementation of prioritisation of people with learning disabilities on the waiting list Improve treatment pathways including a stocktake of non-surgical oncology Increase uptake and expansion of the Lung Health Checks programme	Continue to reduce the number of patients waiting over 62 days

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

Strategic outcomes	JFP Outputs	Operational plan deliverables
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Improve ambulance handover times within emergency departments	Improve CAT 2 response times across 2023/24
	Reduce overcrowding in Emergency Departments	Improve A&E waiting times by March 2024
	Support the reduction in >12 hour waits in emergency departments	Improve A&E waiting times by March 2024
	Undertake a full review of all urgent treatment centres	
	Improve type 3 performance reported and subsequent overall 4 hour standard support reduction in emergency department crowding and time in department	Improve A&E waiting times by March 2024
	Ensure urgent treatment centres are compliant with national standards	
	Increase direct conveyance to urgent treatment centres supporting reduction in ambulance handover times and CAT 2 response	Improve CAT 2 response times across 2023/24
	Minimum opening hours of 12 hours a day 7 days a week to support same day emergency care	
	Align same day emergency care opening times to peak demand times	Improve A%E waiting times by March 2024
	Increase direct access to same day emergency care for 111, 999, crews on scenes and GPs without the need for ED assessment first	Reduce adult general and acute bed occupancy
	Implement referral based on exclusion criteria to maximise same day emergency care opportunities	Improve A&E waiting times by March 2024
	Increase 0 day lengths of stay	Improve A&E waiting times by March 2024
	Reduce emergency department crowding and wait times - improving 4-hour standard	Reduce adult general and acute bed occupancy
	Co-ordinate an integrated high intensity user programme across the ICS	Improve A&E waiting times by March 2024
	Reduce the number of patients classed as high intensity users	Reduce adult general and acute bed occupancy
	Reduce re-attendance rates	
	Increase the number of alternative care pathways available to patients which avoid emergency department and hospital	

Strategic outcomes	JFP Outputs	Operational plan deliverables
I get the care I need and don't get passed back and forth or get forgotten on a waiting list	Develop the peri-operative business case Submit business cases for the hub and spoke model for Community Diagnostic Centres Implement the Scunthorpe Community Diagnostic hub Undertake detailed modelling and engagement on our planned care 5 year strategy and approach Consult on a set of proposals for the Humber Acute Services Review Understand current services, effectiveness and risks for pharmacy, optometry and dental services Align the Yorkshire and Humber screening and immunisation health inequalities action plan with ICB priorities Work on identified clinical pathways to test out new ways of working for specialised services	
I feel included - I have a place to belong	Improve data quality and reporting on health inequalities and develop a health inequalities plan across acute care Continue to develop our Core20PLUS5 ambassadors to promote health and wellbeing and reduce inequalities Focus on digital inclusion, increasing the number of eligible population registering for the NHS App Continue to embed a personalised care ethos Connect with thriving communities through personalised care Enrich personalised care approaches across health and care Increase the numbers of organisations engaged, increasing levels of diversity Track the reach of communications and public engagement Support co-design within communities to ensure a diverse perspective on development and planning	

Strategic outcomes	JFP Outputs	Operational plan deliverables
I feel included - I have a place to belong	Work through VCSE organisations to engage with people in coastal communities to understand their specific health and wellbeing needs	
	Increase utilisation of the VCSE sector to promote, engage and advocate for peoples' voice	Continue to address health inequalities and deliver on the Core20PLUS5 approach
	Support greater understanding of communities across HNY and what matters to them	Continue to address health inequalities and deliver on the Core20PLUS5 approach
	Embed Core20PLUS5 into integrated neighbourhood teams, starting in our coastal areas	Continue to address health inequalities and deliver on the Core20PLUS5 approach
	Address asylum seeker health needs	
	Scope out an inclusion health service that reaches all parts of the system	
	Provide tools to improve population health and reduce variation through roll out of PHM support across primary care networks	
	Integration Needs Assessment to make recommendations of where further integration should take place	
	Develop strategy to address health inequalities in coastal and port communities	Continue to address health inequalities and deliver on the Core20PLUS5 approach
I find ways to stay active and keep health that work for me	Utilise our Additional Roles Reimbursement Scheme to recruit an additional 217 individuals across Primary Care Networks	
	Develop a consistent approach to the management, recruitment and development of volunteers	
	Ensure that the wider determinants of ill health are considered in ICB planning	
	Influence and shape future investment in the VCSE sector to increase sustainability	

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

Age Well

Strategic outcomes	JFP Outputs	Operational plan deliverables
I only go into hospital If its absolutely necessary	Reduce unnecessary admissions and conveyance to Emergency Departments through understanding alternative pathways that would support wider admission avoidance Improve data quality and implement faster data flows in community to support admission avoidance Complete waiting list audit to ensure we give visibility to the total waiting list and support a reduction in the overall waiting list Provide system wide support to clinical networks to support a reduction in inequalities and improve health outcomes Utilise our Additional Roles Reimbursement Scheme to recruit an additional 217 individuals across Primary Care Networks	Continue to recruit ARRS roles by the end of March 2024

Strategic outcomes	JFP Outputs	Operational plan deliverables
I only go into hospital If its absolutely necessary	Make it easier for people to contact a GP practice so that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently as assessed the same or next day according to clinical need Increase access to primary care by providing additional appointments and increasing the number of appointments available Continue development of our neighbourhood teams	
I can get advice and support for my health at home or nearby	Increase the number of crisis first care contacts to reduce admissions to hospital Increase the number of crisis first care contacts to reduce admissions to hospital Better understand the value of virtual wards to help inform their utilisation	Consistently meet or exceed the 70% 2 hour urgent community response standard Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
I can get advice and support for my health at home or nearby	Complete system wide programme of support for a new model of intermediate care to support discharge and increase bed capacity through reducing 'no criteria to reside' Improve discharge pathways to reduce the number of bed days lost and improve patient flow Roll out OPTICA and virtual ward automation digital applications to support urgent and emergency care bed occupancy	

Strategic outcomes	JFP Outputs	Operational plan deliverables
I can get advice and support for my health at home or nearby	Utilise remote monitoring funding to purchase and deploy equipment in the pathways and places most challenged Focus on levelling up delivery against the dementia diagnosis targets across HNY so that resource is directed to places where the biggest improvements are needed	Recover the dementia diagnosis rate to 66.7%
I am as active as I can be	Continue to invest in Health and Wellbeing Programmes in Primary Care	
My wishes are known and respected	Increase the use of rehabilitation and reablement and support at home for palliative care	
We are able to talk confidently with patients about their end of life wishes	Develop an ICS strategy for palliative and end of life care for children and young people	
My wishes are known and respected	Develop the ICB strategy and delivery plan, responding to the priorities identified in the stocktake	

Humber and North Yorkshire
Health and Care Partnership

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