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Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Humber and North Yorkshire Health Inequalities

Annual Report

Table of Contents (Interactive)

Prologue: Our Legal Duty on Health Inequalities

The Humber and North Yorkshire ICB has a legal duty to act on health inequalities. This obligation is reinforced by NHS England's Statement on Information on Health Inequalities, which requires ICBs to publish an annual report on health inequalities under section 13SA of the National Health Service Act 2006. The ICB's wider legal responsibilities are set out across several key legislative frameworks, including the National Health Service Act 2006, the Public Sector Equality Duty (Equality Act 2010), the Local Government and Public Involvement in Health Act 2007, and the Health and Care Act 2022. Collectively, these require the ICB to have due regard to the need to reduce inequalities in both access to health services and the outcomes achieved for patients. This report demonstrates how the ICB is meeting these statutory duties through data-driven action, targeted investment, and collaboration with system partners, including VCSE sector, local authorities and communities.

Introduction

Health inequalities remain stark across our ICS; a decade-long gap in healthy life expectancy separates our most and least deprived communities. This report highlights the current health inequalities gaps and demonstrates how Humber and North Yorkshire ICB is driving change through targeted action.

In 2024/25, we:

- Invested in over 60 Place-based initiatives tackling the root causes of inequality.
- Trained 32 Health Equity Fellows, each leading on reducing inequalities gaps in their area of work.
- Embedded lived experience and co-production at the heart of system change.
- Used linked datasets and Population Health Management to deliver precision prevention.
- Achieved measurable impact across Core20Plus5 priorities and Inclusion Health groups.

Upcoming Changes to ICBs

- The ICB Model Blueprint and 10-Year Plan both make extensive reference to prevention and reducing inequalities as cornerstones for ICBs.
- HNY has made a significant impact on local health inequalities to-date for some people but has a ways to go for others. Where the ICB has had success, it has been achieved through a combination of: partnership working, use of health intelligence and evidence, co-producing interventions, dedicated resources, a passionate workforce and above all, intentional effort that recognises inequalities will occur by default if unattended.
- The ICB will aim to strengthen these factors in its remit as a strategic commissioner, reinforcing its commitment to reducing health inequalities for the HNY population.

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Case Studies

Community Blood Pressure Checks in Non-Traditional Settings

Aim:
Improve early detection of high blood pressure in deprived communities by offering checks in optometry and dental settings.

Project Summary:

- **Pilot sites:** 43 optometry & 15 dental practices joined
- **Referrals:**
  - Optometry → high BP referred to **community pharmacy**
  - Dental → high BP leads to **7-day home monitoring**
- **Escalation:** Urgent referrals for dangerously high readings; some led to **life-saving interventions**

Target groups:

- Aged 40+ without hypertension diagnosis
- Younger people with family history (optical only)

Project Outcomes:

- 802 interactions (readings & just screenings)
- 201 readings undertaken
- 62% lifestyle advice provided
- 20% referred to pharmacy
- 8% referred to A&E/urgent GP
- 8% non-urgent GP referrals

Increasing Lung Cancer Screening for People with Learning Disabilities – North Lincolnshire

Aim:

Very low uptake of lung cancer screening among people with learning disabilities (LD) due to access, communication, and support barriers.

Project Summary:

- Identified 46 eligible individuals via GP LD registers
- Introduced LD-friendly adaptations:
  - Easy Read Letters (co-produced)
  - Pre-invited triage calls
  - Verbal booking & flexible appointments
  - Option for same-day CT & smoking cessation
  - Results shared via phone before formal letters

Outcomes:

- 15 Individuals attended screening in Hull (from 0 previously)
- 5 referred for CT scans
- Improved access, dignity, and person-centered support

Withernsea Young Health Champions

Aim:
Train 6–10 pupils at Withernsea High School as RSPH-accredited Young Health Champions

Project Summary

- 9 Year 10 students completed training
- Delivered 5 projects: tutor time sessions, wellness walks, drop-ins, primary school support, employer engagement
- Active role in delivering workshop during the HNY Population Health Celebration event in July 2024

Impacts:

- Boosted confidence, aspirations, and employability skills
- 145 Year 7s supported by peer networks
- Engagement with local GP shaped youth-friendly services

Integration & Influence:

- Collaboration with Holderness Health
- Student voice in community & school Board for Change

Challenges & Learning:

- Importance of student selection & flexible delivery
- Need for strong stakeholder engagement & coordination

Brain Health Café (BHC)
Tackling Cognitive Health Inequalities in Older Adults

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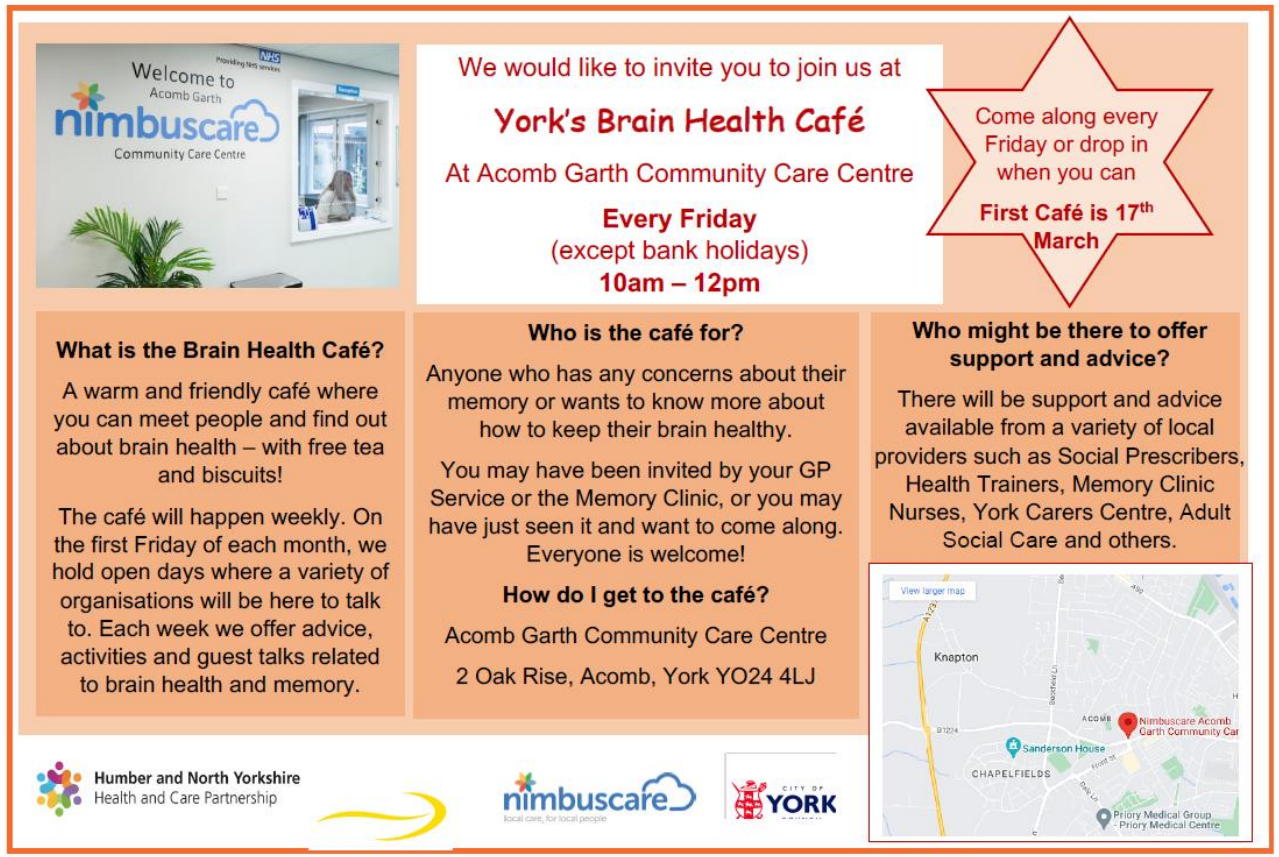
Aim- Foster cognitive well-being and social engagement among older adults through brain-stimulating activities and educational resources.

Project Summary:

- Targeted high-risk, underserved older adults
- Reduced social isolation and emotional distress
- Provided dementia education & early support access
- Reached those not accessing traditional services
- **Outcomes:**
- Filled local gap for suspected dementia support
- Promoted inclusive, proactive outreach in deprived areas
- Venue accessibility and staffing gaps
- Need for inclusive, multilingual outreach



Rainbow GP Drop-in Clinic in Hull

- **Aim**
  - Improved access for families in socio-economically deprived areas
  - Reduced barriers such as language, cultural differences, and logistical challenges
  - Increased participation from fathers towards the end of the evaluation period
- **Project Summary:**
  - Addressed chronic issues like dermatological, gastrointestinal, mental health, and neurodiversity concerns
  - Enabled continuity of care, reducing overtreatment and unnecessary emergency visits
  - Provided holistic, family-centred care without time constraints

Quotes from Participants:

“This is a brilliant idea, Whoever did this needs a statue”

"We kind of feel that NHS is looking after us in a good way now. That we've been heard now. We've been looked after. We've been seen. And cared for. That's what NHS is for, isn’t it?"

"It's just so convenient because the baby can come and play, and I can come and see the doctor at the same time."

(Parent attending Family Hub GP drop-in)

Family Hubs
Hull City Council

Outomes:

- Renewed trust in healthcare services among underserved communities
- Enhanced engagement with healthcare, particularly for those previously overlooked or struggling to access help
- Facilitated early intervention and prevention, improving long-term health outcomes

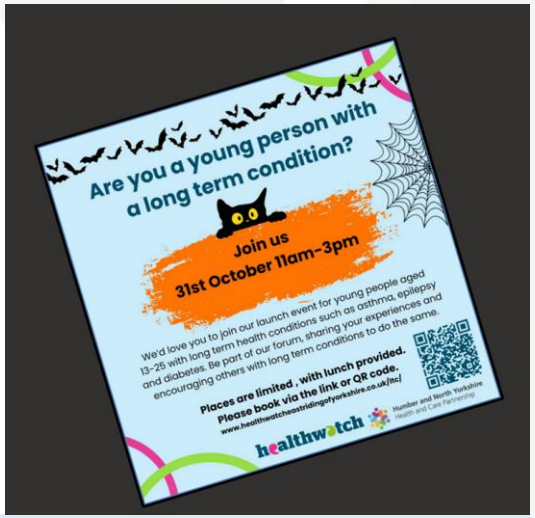
Core20Plus5 Connectors- CYP

Aim

To empower young people (aged 14–25) across Humber and North Yorkshire to shape health and care services by capturing their lived experiences, with a focus on those living with long-term conditions and underrepresented voices.

Project Summary

- Delivered by Healthwatch, the Connectors Programme recruited 28 young volunteers to have peer-to-peer conversations within their communities, schools, colleges, social and hobby groups. Conversations were logged, analysed for themes, and shared with the ICS Children and Young People's Transformation Programme.
- The programme focused on clinical priority areas with limited youth voice, particularly asthma, diabetes, and epilepsy. Each connector aimed to engage 10 peers and recruit another connector, creating a peer-led cycle of engagement. Packs were shared with clinicians to promote the initiative in healthcare settings.



Outcomes

- 274 young people engaged (Jan–May 2024)
- 60 conversations about mental health – the most cited issue
- 28 conversations on oral health – a key Core20PLUS5 focus
- Early insights supported targeted discussions on access barriers and service experience
- Informed quarterly updates to system leadership
- Led to the establishment of a CYP Forum, ensuring continued voice and influence from young people in ICB programmes

From Blues to Bliss: Foresight Celebrates Health and Wellness on Blue Monday

Aim

Reframe “Blue Monday” as a positive wellness touchpoint for vulnerable Foresight beneficiaries.

- **Project Summary**
- 20 Jan 2025 event co-hosted with local health/community partners.
- 50 beneficiaries attended.
- Health corner: BP checks, flu & COVID jabs, cancer awareness (Cervical Cancer Awareness Month).
- Wellbeing/recreation: crafts, table cricket, line dancing, karaoke, mindfulness, therapy dog, choir.
- **Outcomes**
- 20 BP screenings; 4 high readings, all fast-tracked into care.
- Boosted engagement with health services and awareness of cancer/mental health.
- Strengthened community connection and morale.

Bright “Blue” Monday

VOL. 1, NO. 1 — SPECIAL EDITION — 20TH JANUARY 2025

FROM BLUES TO BLISS: FORESIGHT CELEBRATES HEALTH & WELLNESS ON BLUE MONDAY

EMBRACE YOUR EMOTIONS

Cancer Alliance Team

BP Checks

A SMILE IS A CURVE THAT SETS EVERYTHING STRAIGHT

A Life Saved at Home – Tackling Hidden Hypertension in Hull

When Adele Stimpson enrolled on a community blood pressure awareness and skills training course piloted by the HNY ICB, she never imagined the impact it would have so close to home. The training, designed to equip individuals with the confidence and knowledge to support others in checking and understanding their blood pressure, gave Adele the skills to use a home blood pressure monitor safely and effectively.

After the course, Adele decided to practice her new skills by checking her partner's blood pressure. Matthew Cowley, a roofer by trade, felt well, led an active lifestyle, and had no known health issues. But when Adele attempted to take his reading, she was met with repeated error messages; something the training had prepared her to treat with caution. Concerned, they visited their local pharmacy to try again, only to encounter the same issue. The pharmacist recognised the warning signs: the machine wasn't malfunctioning, it simply couldn't register blood pressure that high. They were urgently referred to the Emergency Department.

At Hull Royal Infirmary, the readings confirmed the seriousness of the situation; Matthew's blood pressure was dangerously high at 231/154, placing him in a severe hypertensive crisis with an imminent risk of heart attack or stroke. He was immediately admitted to the cardiology ward and given emergency treatment to bring his blood pressure down. After stabilisation, he was discharged with medication and follow-up arranged with his GP.

Picture caption: Adele Stimpson with partner, Matthew Cowley; and an image of the very high blood pressure reading that was captured once Matthew was in hospital

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Population Health and Prevention Programme

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Population Health and Prevention Programme 2023-28

East Riding Place | **Hull Place** | **North Lincs Place** | **North- East Lincs Place** | **North Yorkshire Place** | **York Place**

Population Health and Prevention Committee

Community, Acute (CAP), VCSE, MH, LD & Autism and Primary Care Collaboratives

Population Health and Prevention Programme Board

Workstream 1 Core20PLUS5 (Adults)
- Maternity
- SMI
- Respiratory
- CVD / Hypertension
- Early Cancer Diagnosis
- Inclusion Health/PLUS5

Workstream 2 Core20PLUS5 (CYP)
- CYP Alliance
- CYP Mental Health Steering Group

Workstream 3 Preventive Risk Factors Delivery Group
- Alcohol
- Tobacco
- Obesity

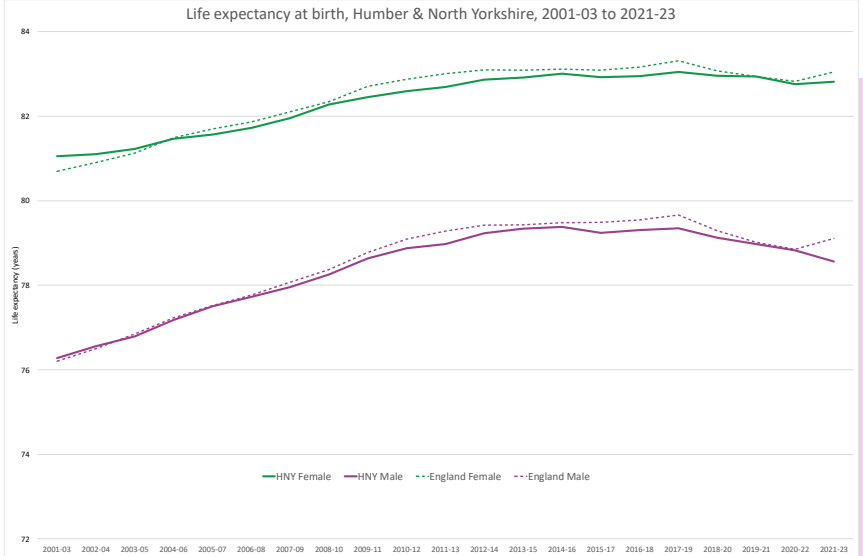
Workstream 4 Public Health Functions
- Vaccinations
- Dental Public Health
- Health Protection

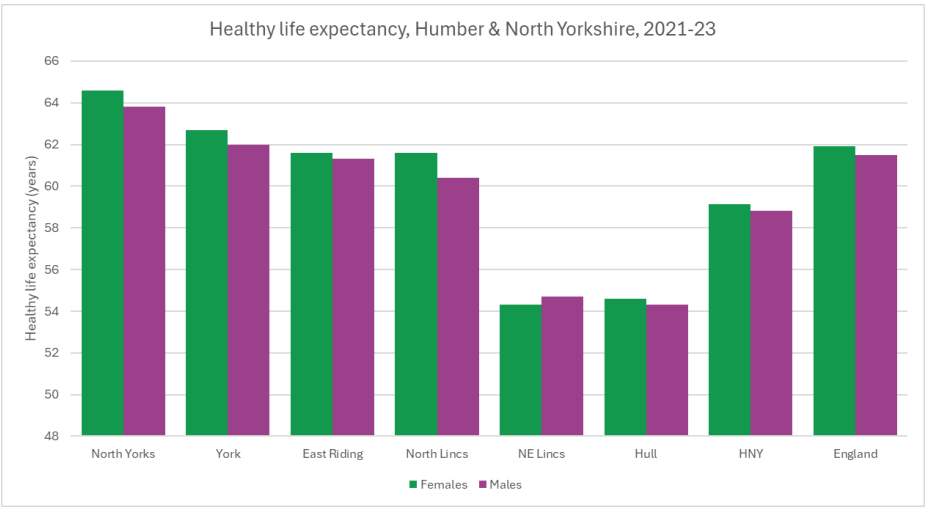
Workstream 5 Population Health Intelligence
- PHM Function
- PHI Collaborative
- ICS Outcomes Framework

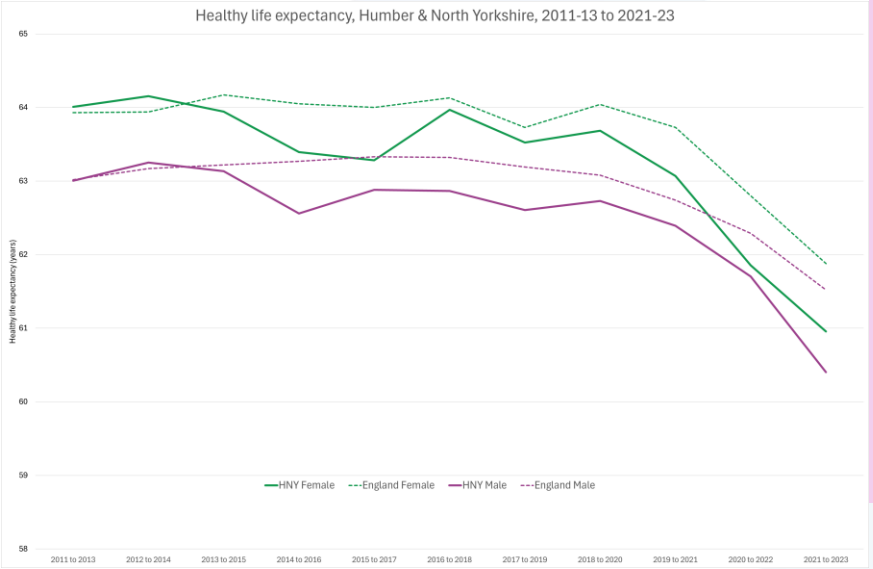
Workstream 6 ICS Building Blocks
- Strategy Support
- Anchor-PHP Academy

Support to ICP

Linked to other ICB Committees



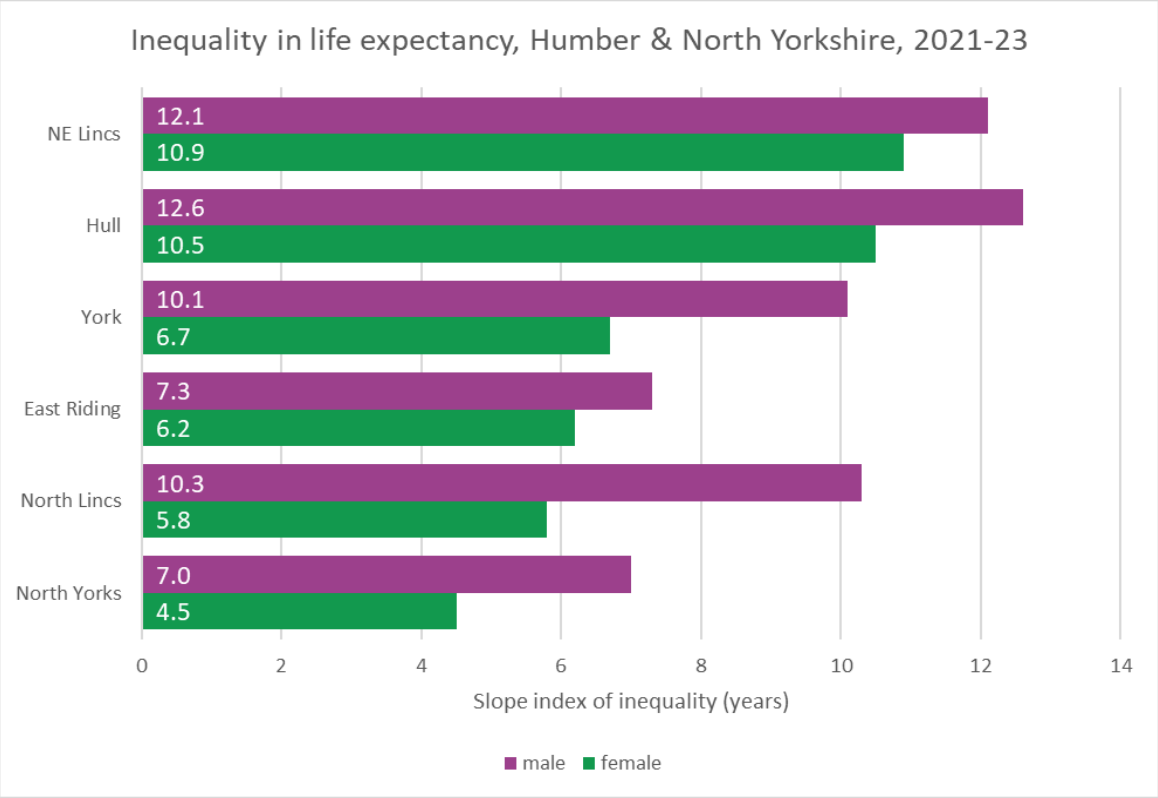


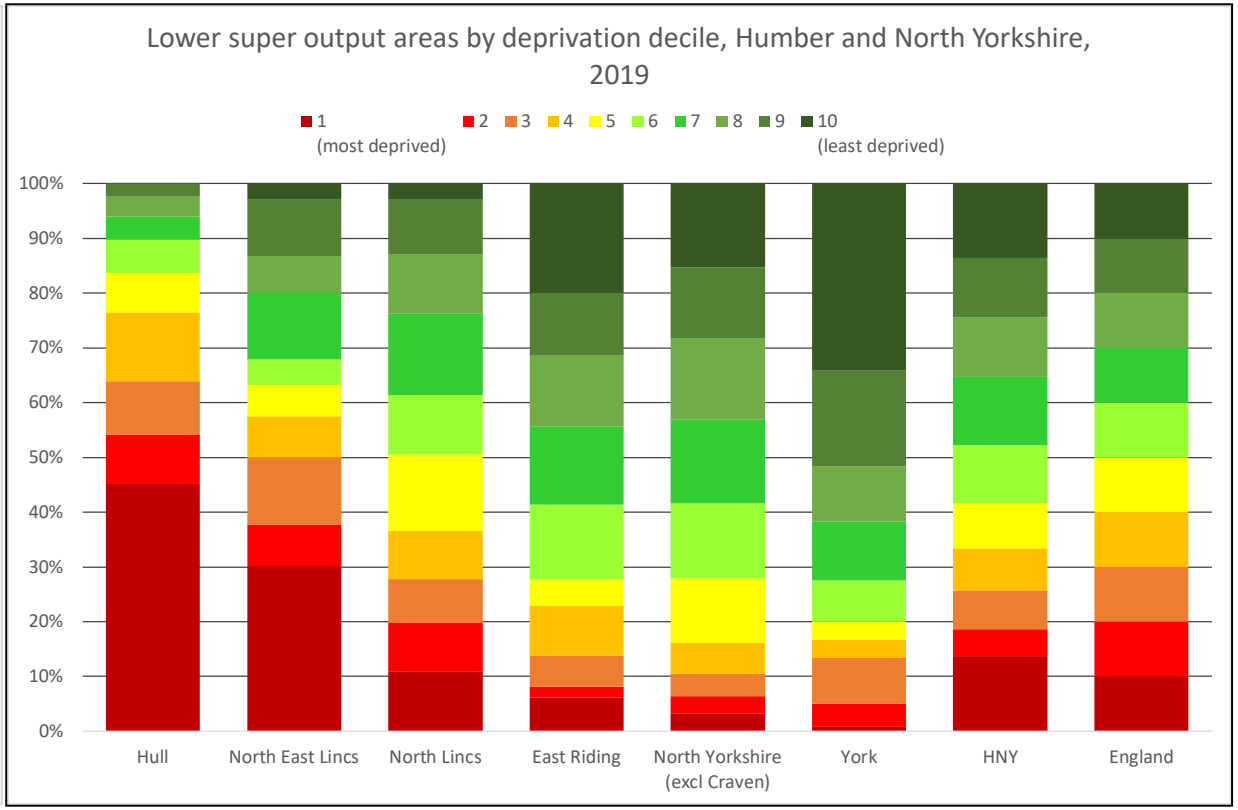


- In 2021-23, life expectancy (LE) was highest in North Yorkshire for females and males and lowest in Hull. LE in HNY tends to be slightly lower than the England average and recent years have seen declines.

- In 2021-23, there is a healthy life expectancy (HLE) gap of over 10 years between North East Lincolnshire and North Yorkshire females and 9.5 years between Hull and North Yorkshire males. The gap in HLE between HNY and England has tended to increase recently, with falling values locally and nationally.

Health Inequalities in Humber and North Yorkshire

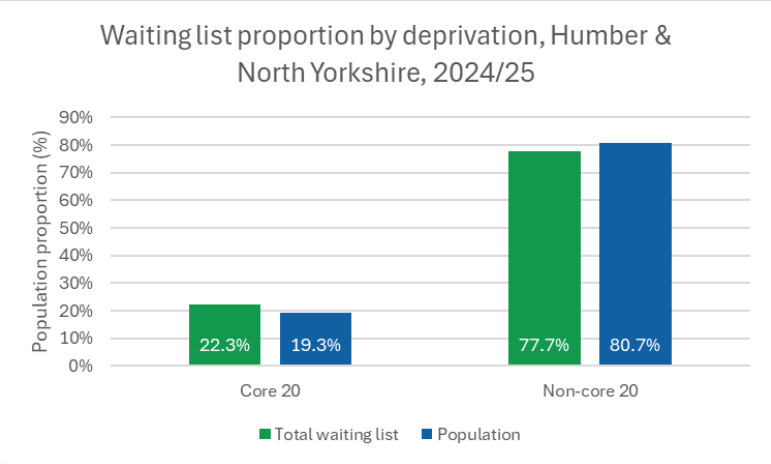


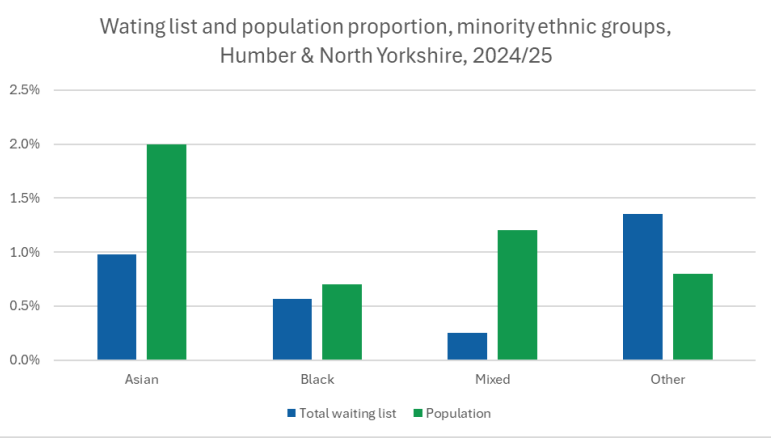


Inequality in life expectancy is higher for males than females in all parts of HNY. Inequalities are highest in North East Lincolnshire and Hull, while North Yorkshire has the lowest inequality in life expectancy.

In Humber & North Yorkshire, 13% of the population live in areas that are among the 10% most deprived in England (shaded dark red). This varies from 45% of people in Hull to 1% of people in York. About 58% of HNY population live in places among the least deprived half of England (green shades).

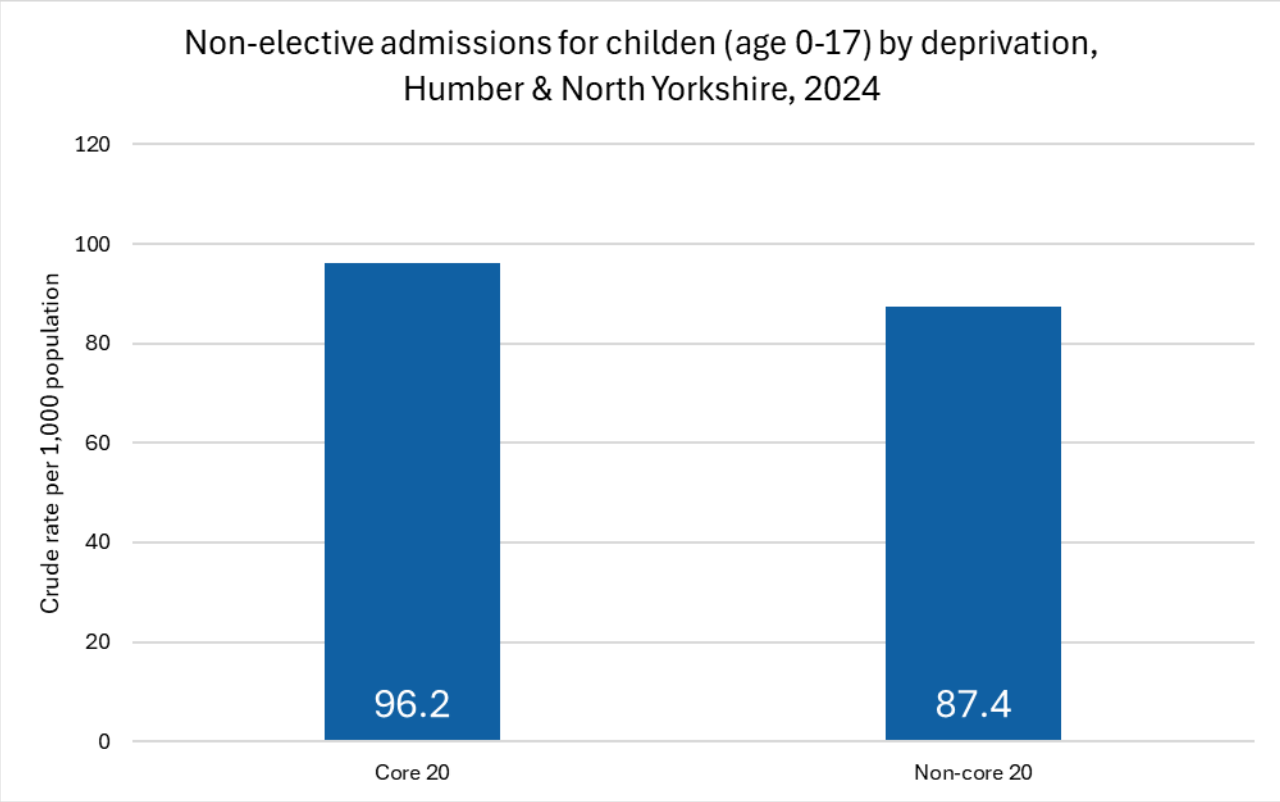
Inequalities in: Elective Recovery





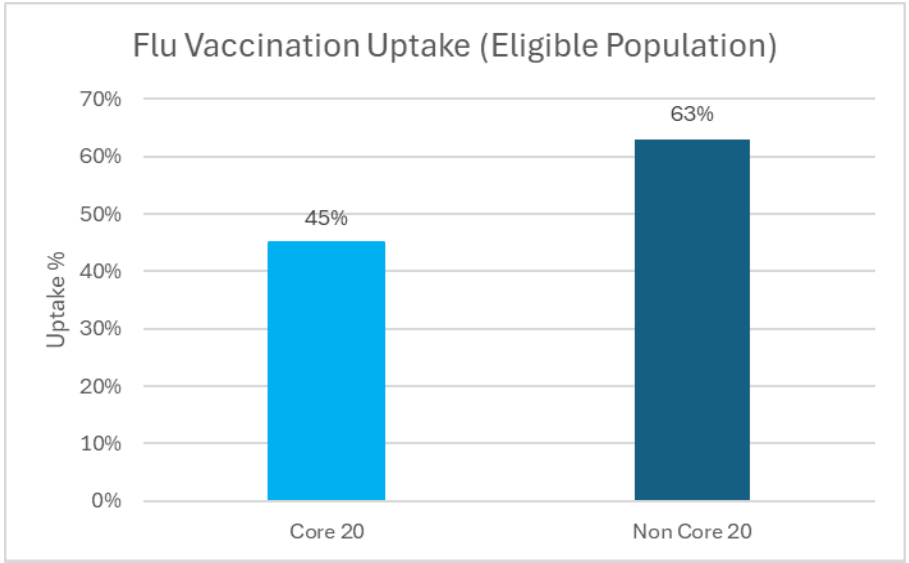
- Elective recovery is going well, with elective inpatient activity up 23.6% from pre-pandemic levels and 4% higher in 2024/25 compared with 2023/24. The waiting list stands at 182,200 (up from167,000 in 20223/24), with core 20 representation (22.3%) slightly higher than their population share (19.3%). 'Other ethnic groups' are overrepresented on the list (1.4% vs. 0.8% in the population) However, data gaps - about 22% lack ethnicity coding - mean these trends are indicative.
- About 39% have waited over 18 weeks, and 2.7% over a year, with a higher proportion of core 20 area residents waiting 18 weeks (40.2% v 38.4%) and >52 weeks (3.2% v 2.6%).
- Emergency admissions are higher in core 20 areas and among Asian, Black, and ‘other’ ethnic groups. The ICB tracks waiting times weekly, broken down by specialty, provider, deprivation, and ethnicity to support equitable care. In 2024/25, prioritisation for people with Learning Disabilities was introduced.

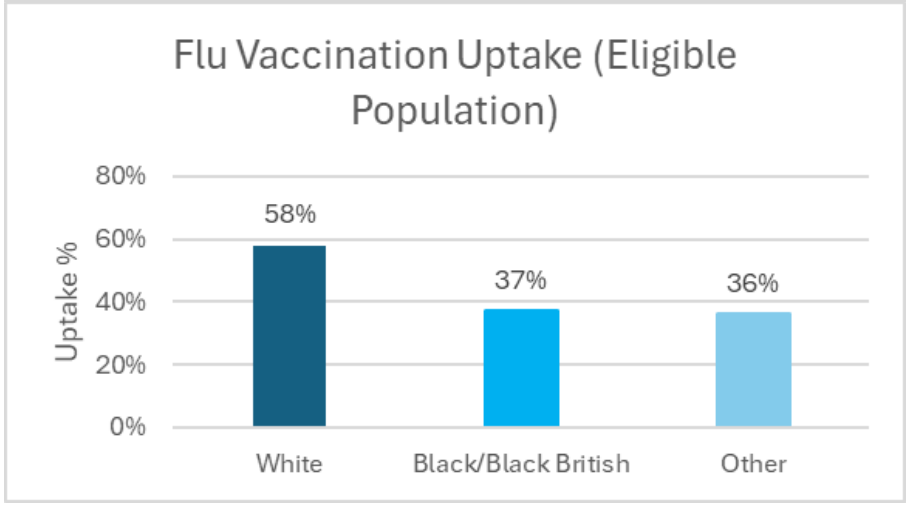
Inequalities in: Urgent and Emergency Care



- There were 30,100 emergency admission for children in HNY in 2024, over 80 per day. Emergency admissions for children and young people are higher in core 20 areas compared with non-core 20. In 2023/24, the rate for children from white ethnic groups (533.1 per 1,000) was much higher than for other ethnic groups and is much lower for children from mixed ethnic groups (31.9 per 1,000).

Inequalities in: Respiratory



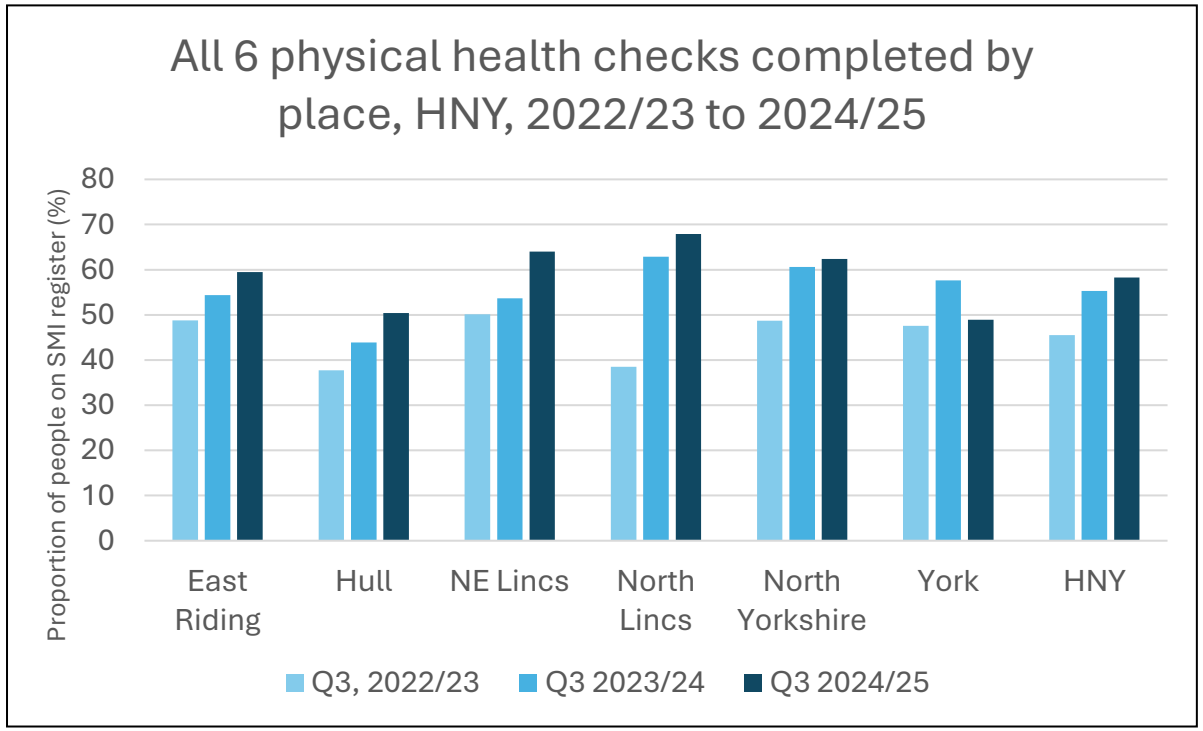


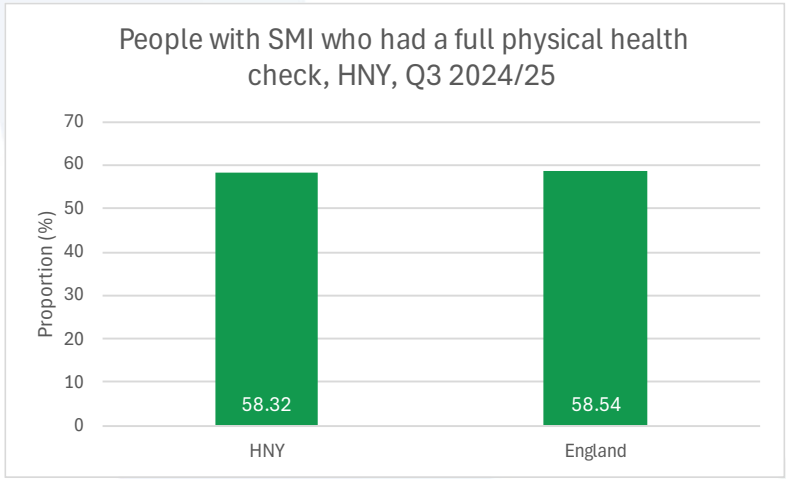
The Public Health Functions workstream within the PH&P programme has a supporting role on the vaccination programmes and is working to reduce inequalities in uptake.

2024-25 Flu programme

Flu vaccination uptake is higher in non-core 20 areas compared with core-20 areas. Overall vaccination uptake appears higher in white ethnic groups, although incomplete ethnic group recording needs to be considered when interpreting these data.

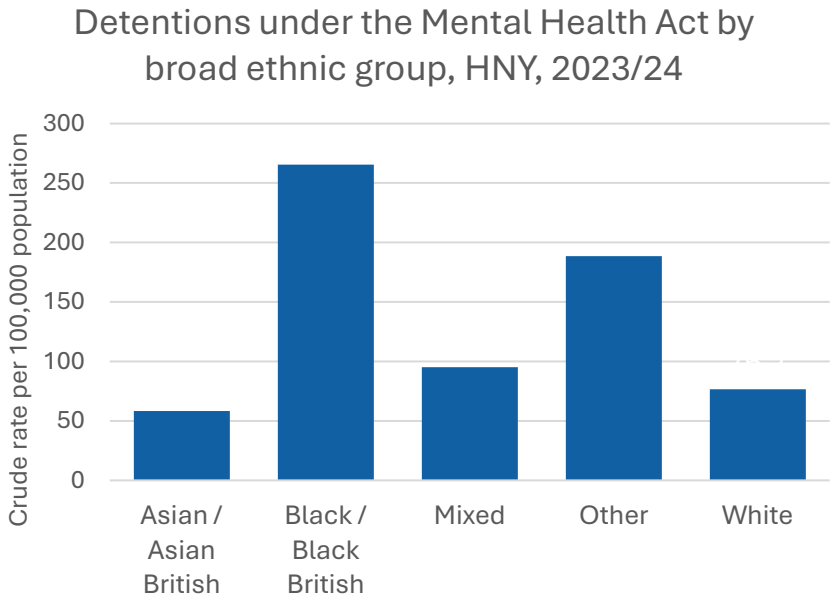
Mental Health- Annual Health Checks for People with Severe Mental Illness





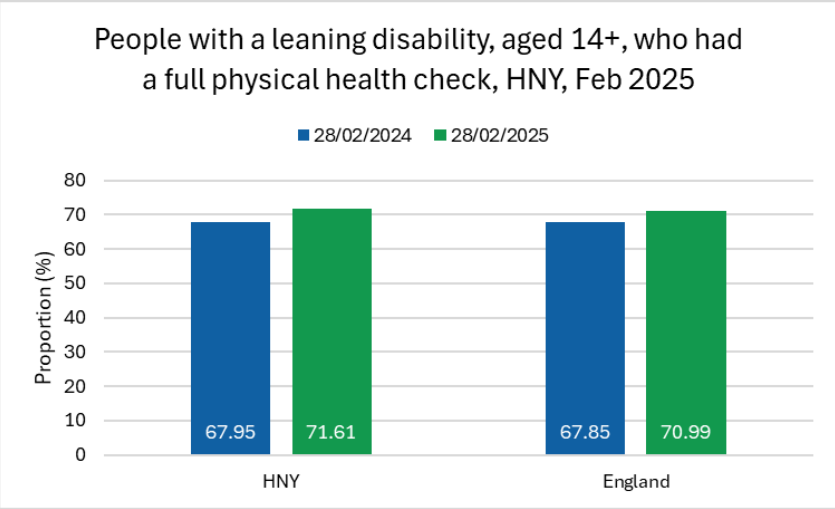
Just over half of people with severe mental illness in HNY received an annual physical health check. For HNY, the proportion of people with SMI who received a full annual physical health check increased from 55.3% (Q3, 2023/24) to 58.3% (Q3, 2024/25). The proportion in HNY is similar to England and varies from 48.9% in York to 67.9% in North Lincolnshire.

Mental Health- Detentions and Restrictive Interventions



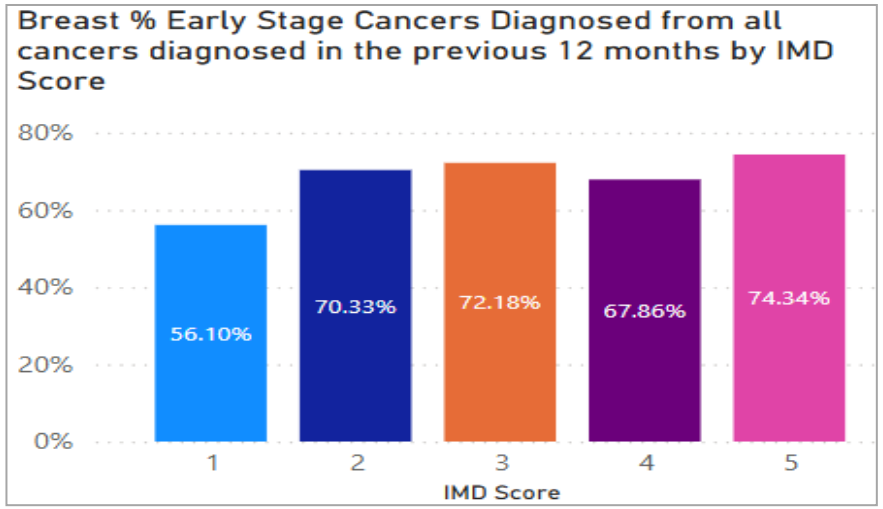
- There were 78.8 Mental Health Act detentions per 100,000 population for the ICB in 2023/24 . The rate was higher in core 20 areas (157.0 per 100,000) compared with non-core 20 areas (73.5per 100,000). The below graph highlights the detentions by ethnicity.
- There were 47 restrictive interventions per 1,000 occupied bed days. Deprivation data is only available by rate and for national deciles, preventing aggregation. However, restrictive interventions are significantly higher in people from Black / Black British ethnic groups (126 per 1,000 occupied bed days) compared with the ICB average. Apart from White categories, rates were lower than average in all other ethnic groups.

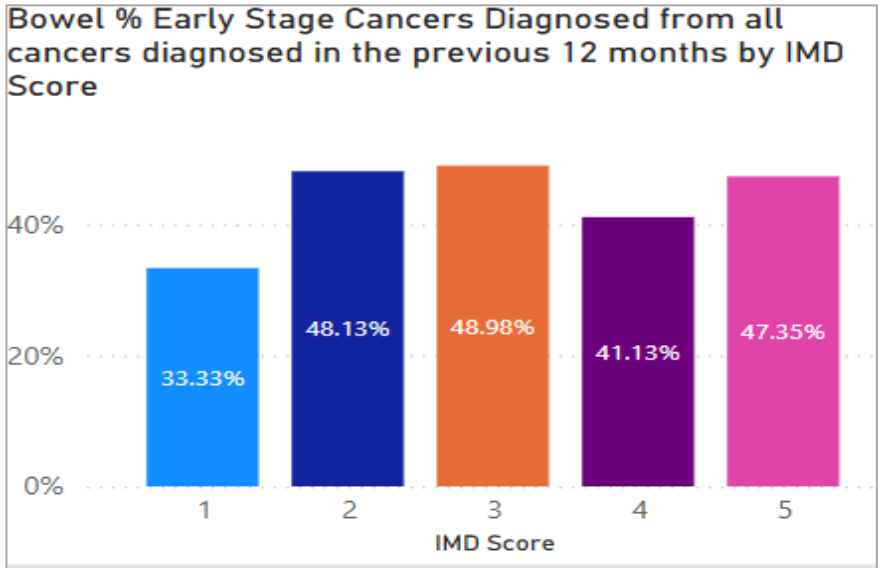
Annual Health Checks- Learning Disability



The national target is for 70% of people aged 14+ with a learning disability to have a physical health check. At the end of February 2025, nearly 7,300 residents in HNY had completed their health check, 71.6% of those eligible. This is an increase on the proportion at the same date in 2024 and remains slightly higher than the England average. An additional 467 physical health checks have been delivered in 2024/25 compared with the same stage in 2024/24.

Cancer and Health Inequalities





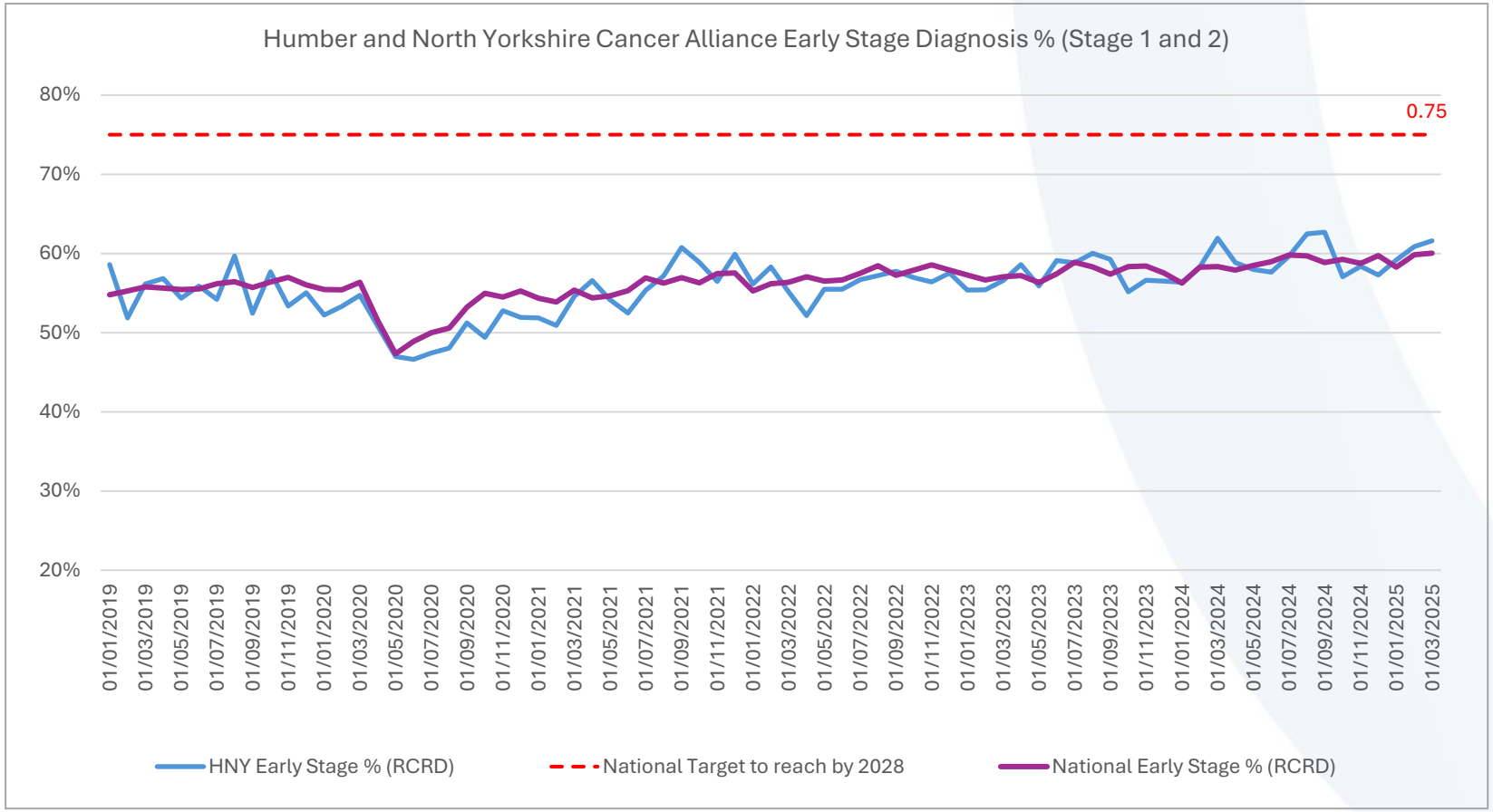
People who live in the most deprived areas of our region are more likely to have their breast and bowel cancer diagnosed at a later stage.

The HNY Cancer Alliance plans awareness raising campaigns and community engagement events in these areas to improve rates of diagnosis in people who are most at need.

They are working with PCNs, Practices and Neighbourhood teams to target those communities with low participation in NHS Screening Programmes and higher incidence of late-stage diagnosis

The data from our Cancer Health Inequalities dashboard informs where we focus our work to ensure we are including the most vulnerable in our population

Improving Cancer Diagnosis for all

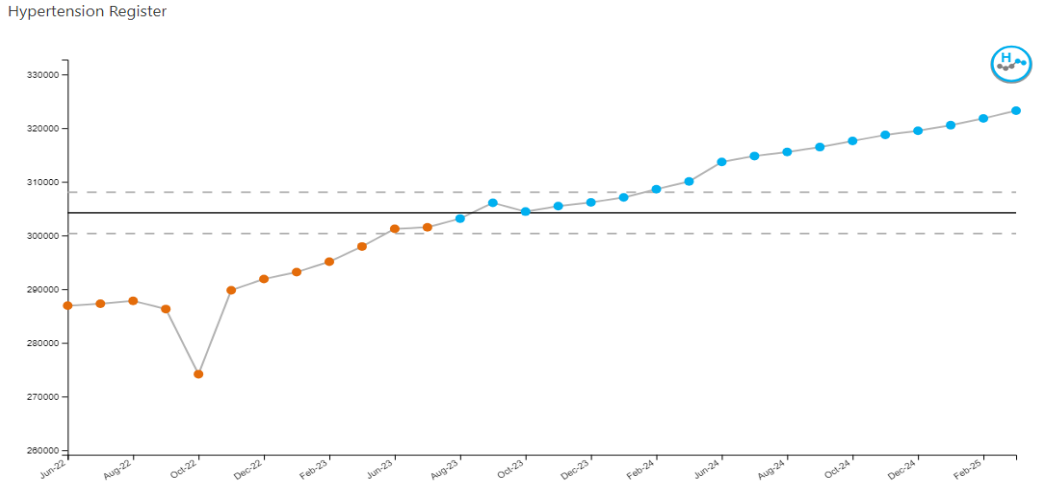


People within the Core20Plus demographic are more likely to have a late-stage cancer diagnosis, and work is focused on reducing the rate within this population.

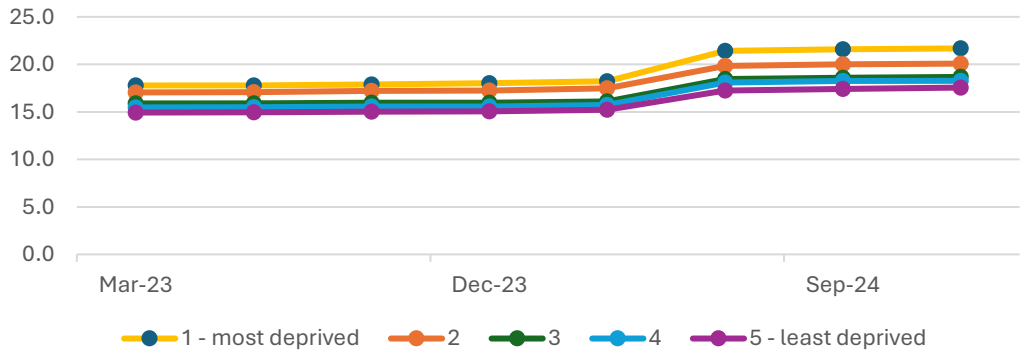
Over the past 12 months, more than half of the cancers in Humber and North Yorkshire (an average of 59.5%) were diagnosed at stages 1 or 2. This marks progress compared to the previous year (an average of 58.0% from April 2023 to March 2024).

The proportion of cancers diagnosed at an early stage in HNY is similar to England.

Inequalities in Hypertension Case Finding



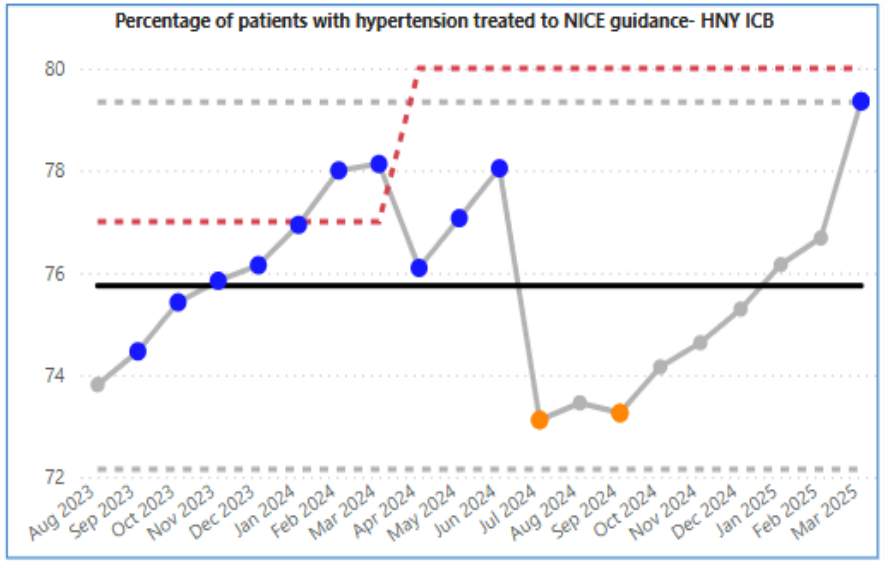
HNY ICB GP recorded hypertension prevalence (% of GP registered population) - deprivation quintiles (age standardised)



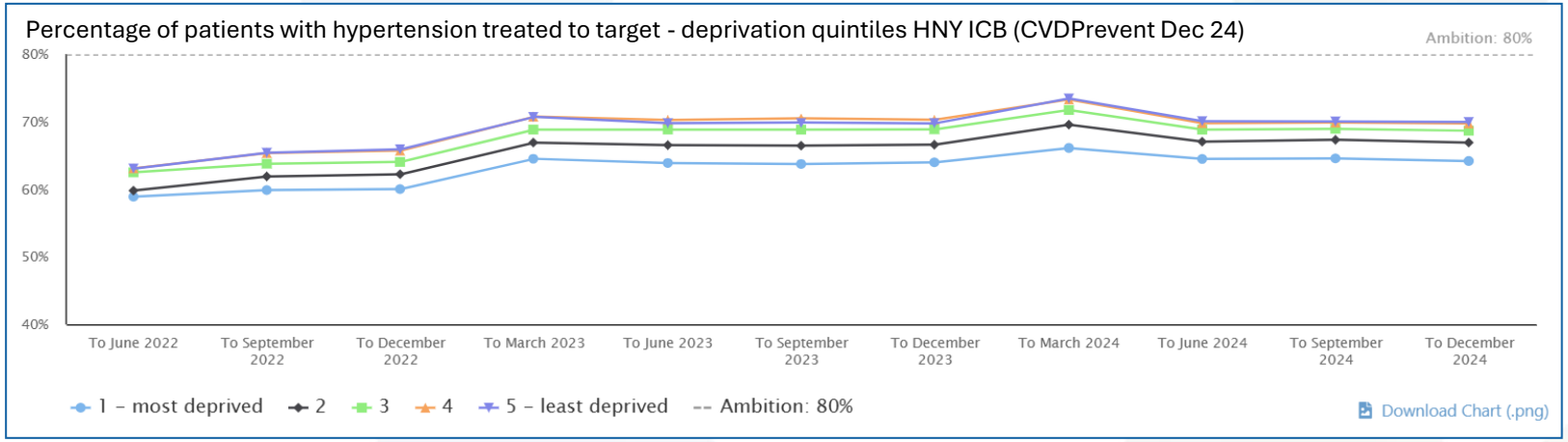
In 2024/25, the focus has been on increasing the diagnosed prevalence of hypertension to reduce the gap between observed and expected rates. As of March 25 the number of diagnosed patients across HNY ICB has risen by 4.3%, an increase of 13,184 new diagnoses compared to March 24. This may be driven by several system-wide initiatives targeting deprived and marginalised populations. As a result of this we have seen an overall increase in registered prevalence across all our populations but a larger increase in our most deprived communities, examples of some of these projects are given below:

- Promotion of **community pharmacy BP case finding service** including recruitment of Community Pharmacy PCN Engagement Leads to enhance collaboration between pharmacies and GP practices.
- Implementation of **innovative BP Check Train the Trainer Model**, supporting local authorities and VCSE staff to accelerate BP checks in the community.
- **Community optometry and dental pilots**: focusing on hypertension case finding in deprived communities and rural areas.
- **Place-based community projects**: Local efforts include community champions in East Coast and Selby, and a CVD outreach project in Scunthorpe focused on hypertension case finding and primary prevention.

Inequalities in Hypertension Treatment

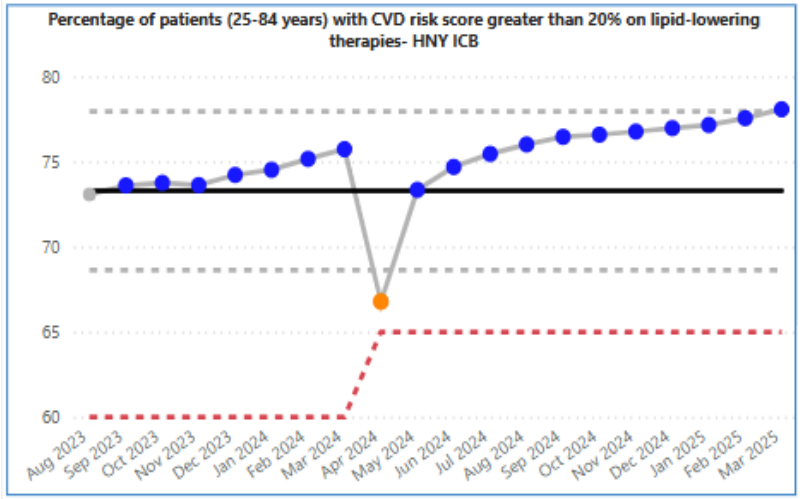


ORGANISATION	LATEST	TARGET	ACTUAL	VAR.	ASS.	PLAN MET
HNY ICB	March 2025	80.0%	79.4%			
NHS East Riding Of Yorks...	March 2025	80.0%	79.6%			
NHS Hull	March 2025	80.0%	74.6%			
NHS North East Lincolns...	March 2025	80.0%	79.0%			
NHS North Lincolnshire	March 2025	80.0%	80.9%			
NHS York	March 2025	80.0%	79.5%			
NHS North Yorkshire	March 2025	80.0%	81.2%			

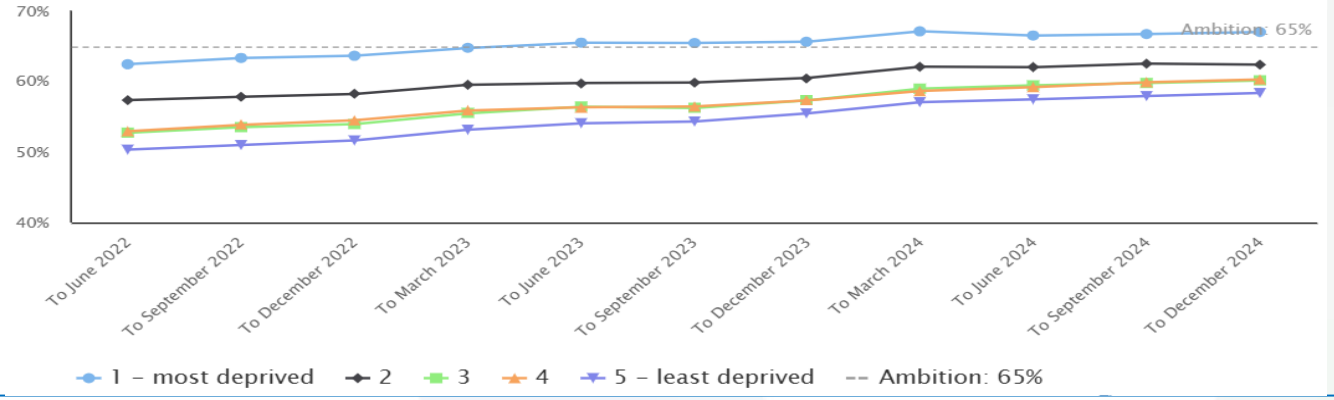


- The percentage of hypertension patients treated to target across HNY ICB in March 2025 was 79.4% (228,869 patients) against a national ambition of 80%. This was an increase of 10,642 patients treated to target from March 24 and equates to a reduction of 85 deaths, 159 strokes and 106 heart attacks over the next 5 years (NNT). All places across the ICB reached the same or improved end of year positions from March 24.
- Practices continue to be supported through dedicated CVD programme support, training sessions and the development of a hypertension toolkit to improve coding and case finding. Innovative hypertension management through Independent Prescriber Pathfinder pilot sites also continues.
- People who live in more deprived areas continue to have poorer outcomes in hypertension management. However, the gap is reducing and is at its lowest value (5.77%) since Sept 22.

Inequalities in Lipid Management



ORGANISATION	LATEST	TARGET	ACTUAL	VAR.	ASS.	PLAN MET
HNY ICB	March 2025	65.0%	78.1%			
NHS East Riding Of Yorks...	March 2025	65.0%	78.6%			
NHS Hull	March 2025	65.0%	78.6%			
NHS North East Lincolns...	March 2025	65.0%	80.7%			
NHS North Lincolnshire	March 2025	65.0%	78.3%			
NHS York	March 2025	65.0%	76.3%			
NHS North Yorkshire	March 2025	65.0%	77.5%			

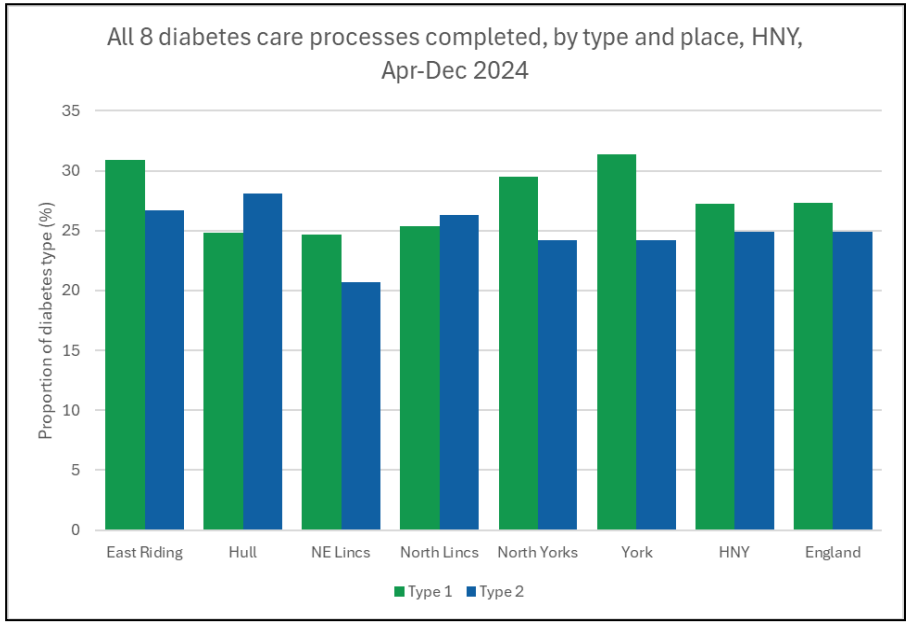


Percentage of patients at risk of CVD, prescribed lipid lowering therapies - deprivation quintiles HNY ICB (CVDPrevent Dec 24)

Cholesterol Management:

- HNY achieved 78.1% of patients with high risk of CVD (Q-risk greater than 20%) on lipid lowering prescriptions in March 25, this exceeds the National target of 65%.
- Whilst there is a higher percentage of prescribing lipids in our most deprived communities inequality remains in achieving target cholesterol levels, especially in deprived areas. Several projects are currently aimed at improving cholesterol management and reducing inequity, including standardising lipid management pathways across the ICB, providing education and toolkit support to GP practices, exploring familial hypercholesterolemia identification through national screening pilots.
- A multiagency behavioural insights project is underway to explore public perceptions of CVD risk factors, with a focus on Core 20 and Inclusion Health populations.

Inequalities in Diabetes



Type 1 Diabetes (Q1-Q3 2024 data):

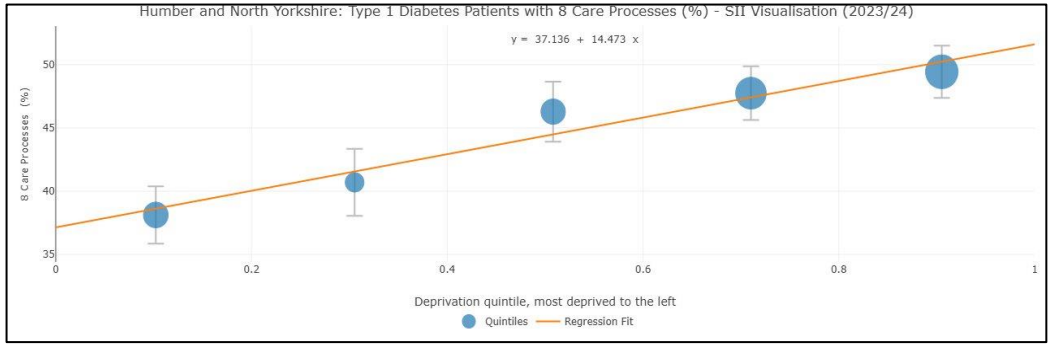
- HNY ICB supports a similar proportion of people with Type 1 diabetes receiving all 8 care processes compared to England (27.2% vs. 27.3%).
- Cholesterol (56.9%) and Urine Albumin (35.9%) care processes are the lowest in HNY, slightly below the national average.
- All 3 treatment targets for Type 1 diabetes are below the England average (28.9% for HNY vs. 30.2% for England)

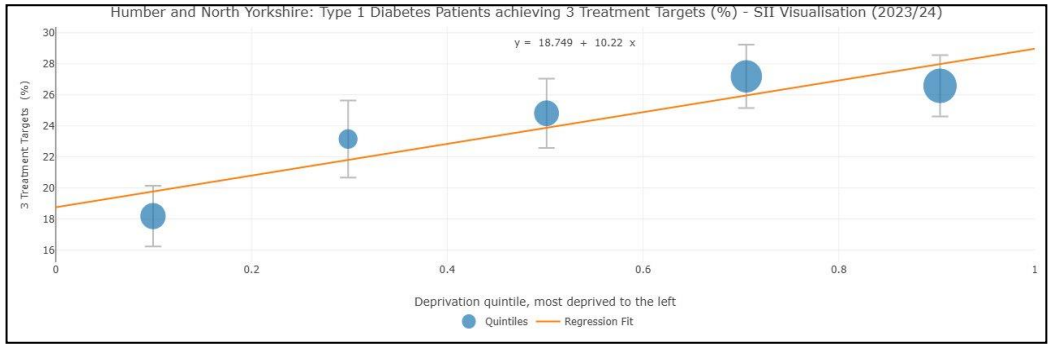
Type 2 Diabetes (Q1-Q3 2024 data):

- Completion rates for Type 2 diabetes 8 care processes and treatment targets are below the national average (24.9% vs. 26.8% for care processes, 42.3% vs. 42.6% for treatment targets).
- Foot checks (59.7%) and urine albumin (50.3%) are the lowest completed care processes.

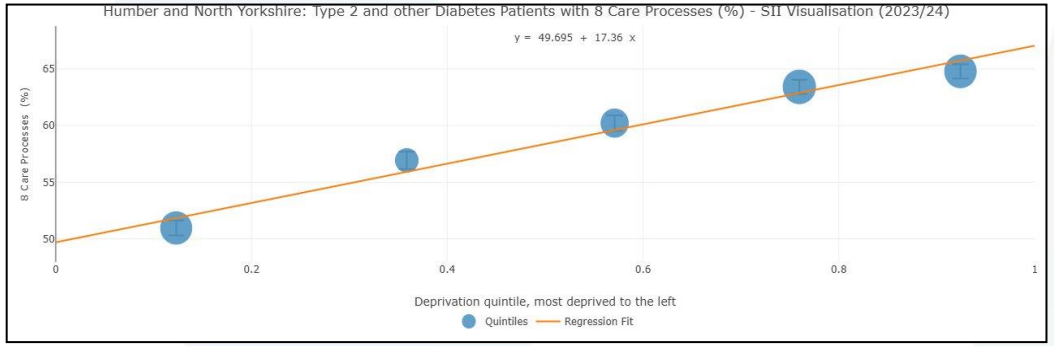
Inequalities in Diabetes

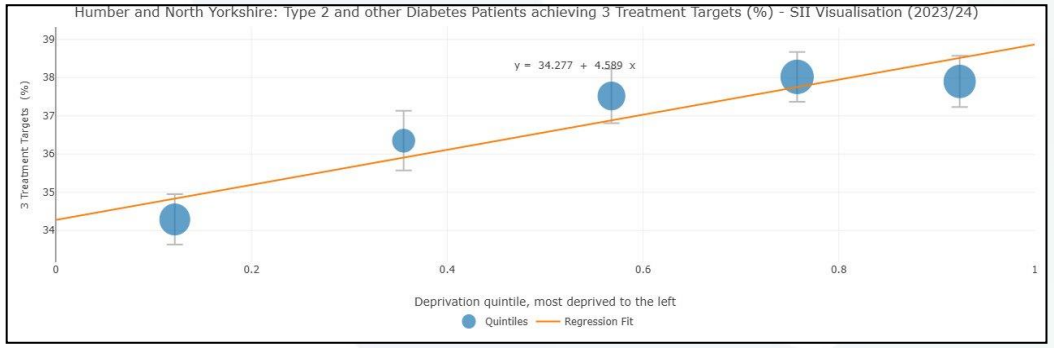
Type 1 diabetes





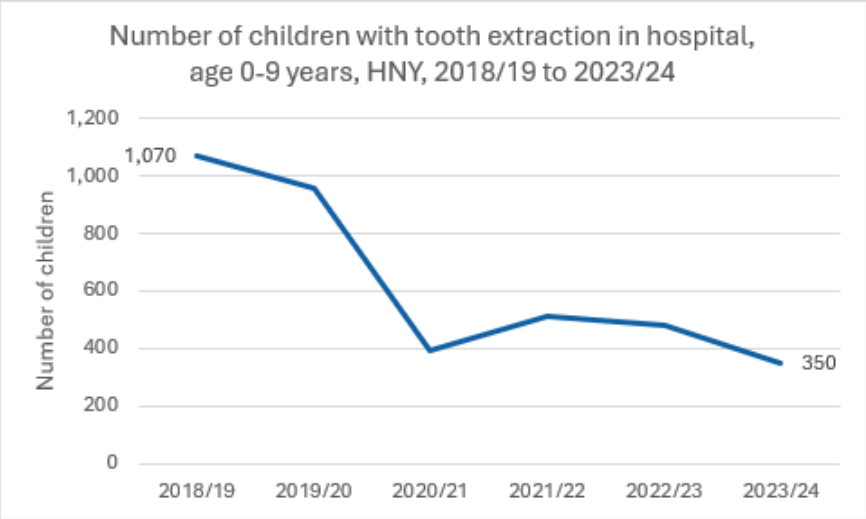
Type 2 diabetes

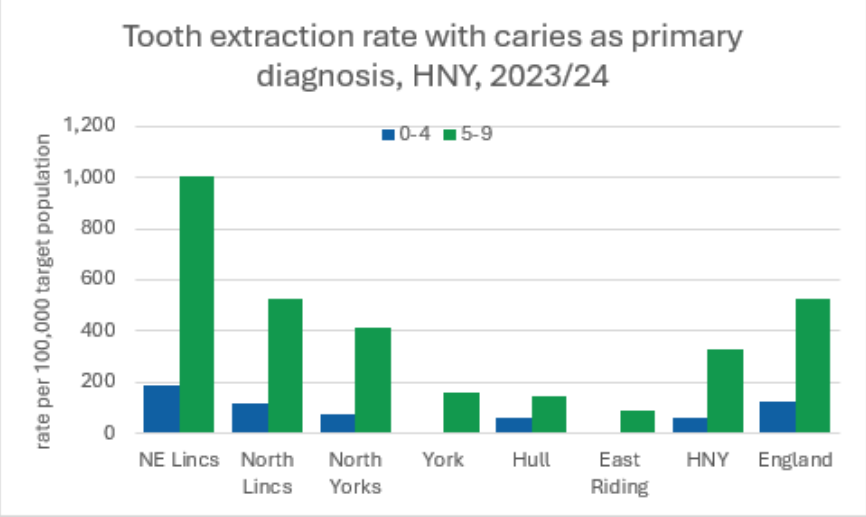




For both type 1 and type 2 diabetes, significantly more people in the least deprived areas received all eight care processes (glucose control, kidney function, heart risk, kidney risk, blood pressure, body mass, foot ulcer risk & smoking risk) compared with the most deprived areas. The same is true for three treatment targets (HbA1c≤58mmol/mol; BP≤140/80; high heart risk prescribed a statin).

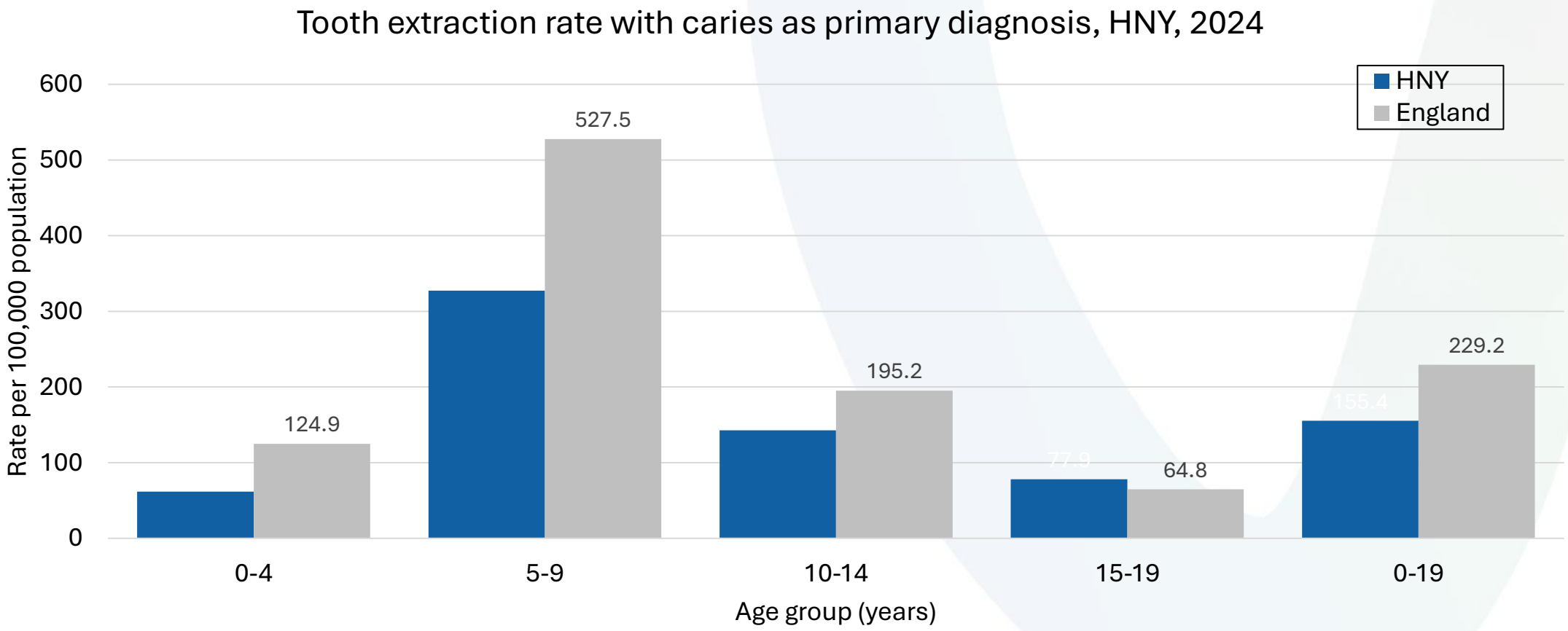
Inequalities in Oral Health



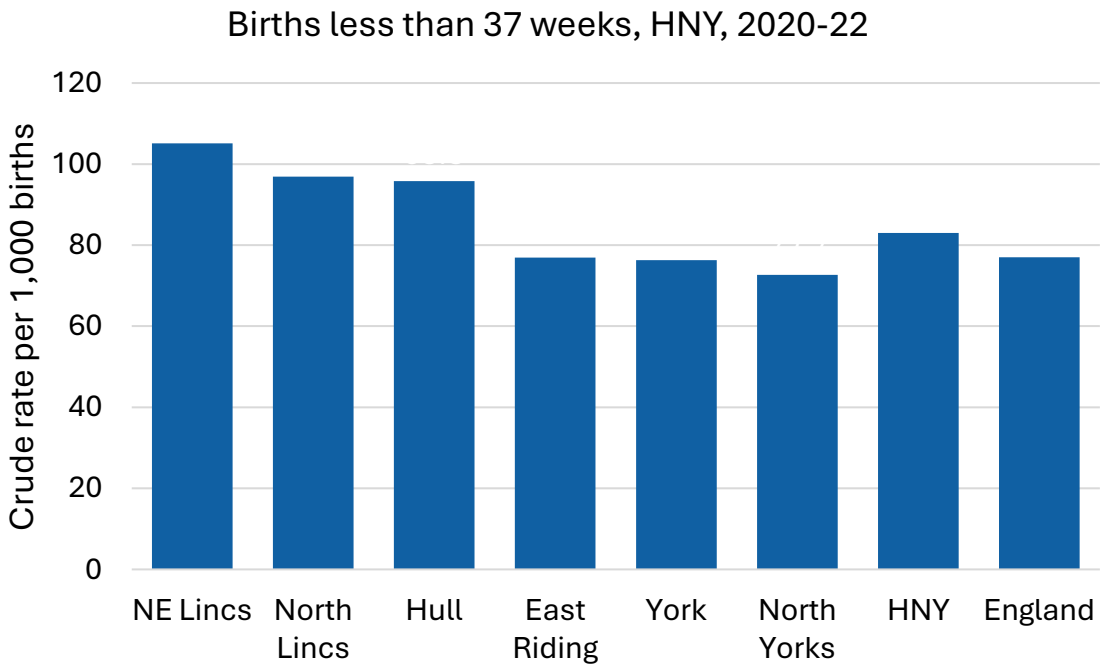


Although overall number of hospitalisation for dental extraction has had a decreasing trend in the past years, variation is being observed across the six ICB Places. Some of this variation is due to increased community extractions, particularly in Hull and East Riding. Such extractions are not captured in hospital admissions data.

Inequalities in Oral Health



Inequalities in Maternity: Premature births



- In Humber and North Yorkshire, there are around 1,300 premature births annually (2020-22), up from 1,200 and accounting for 8.5% of all births (up from 5.7% in 2019-21). Smoking in pregnancy is high in certain areas, with negative outcomes like low birth weight, heart defects, and stillbirths being more common. The region also has higher-than-average rates of heavy drinking and obesity in pregnant women, which increases risks like Type 2 and gestational diabetes.
- Premature births are higher in HNY in our more deprived Places.
- To address these issues, the Local Maternity & Neonatal system works with partners to support individuals with these challenges before, during, and after pregnancy. Efforts include promoting smoking cessation, offering additional training for healthcare professionals, and improving access to alcohol support services. A weight management project in North and North-East Lincolnshire has helped women manage their weight, with positive results.
- A new scheme is also linking women with gestational diabetes to the National Diabetes Prevention Programme (NDPP), with referral rates increasing from 0.2% to 42% in some areas.

Inclusion Health/ Plus

- This year, we took major steps to address health inequalities faced by inclusion health groups and our Plus populations. A comprehensive Health Needs Assessment revealed widespread unmet needs and data gaps, reinforcing the urgency of targeted, data-driven action. In response, we co-developed a System-wide Inclusion Health Strategy and Action Plan for 2025–2028 (Please see the next slide), rooted in cross-sector collaboration, lived experience, and NHS England's national framework.
- Our Inclusion Health Register Pilot in York introduced a standardised primary care coding system, increasing formal identification of patients by 14.23% (1,179 people) in just three months. With strong GP participation and scalable learnings, this initiative will inform better commissioning and more equitable care across the ICB.

We Care
We Connect
We Innovate

Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

HNY Inclusion Health Action Plan

Inclusion Health: The PLUS focus

Humber and North Yorkshire ICS Inclusion Health Strategic Approach 2025-2028

The **NHS CORE20PLUS5 framework** is designed to reduce health inequalities by targeting the **most deprived 20% of the population (CORE20)** and ensuring focus on **socially excluded groups (PLUS)** while addressing key clinical priorities. **Inclusion Health** is focused on these groups experiencing multiple disadvantage and extreme health inequalities.

Four Guiding Principles

Our shared vision:

In Humber and North Yorkshire, individuals of all ages from inclusion health groups will live longer and healthier lives in communities which enable them to thrive

Four Strategic Priorities

- **Understanding the characteristics and needs of inclusion health group**
- **Develop a confident and competent workforce by embedding a trauma-informed and culturally competent approaches**
- **Enhancing prevention and early intervention**
- **Ensure services are integrated, accessible and inclusive**

Why This Matters?

Staff	Service users	System	Partnerships
More tools and increased confidence to address unmet needs, leading to best practice, improved job satisfaction and workforce retention.	Better experiences of care, access to person-centred, inclusive and high-quality services, and health outcomes.	Coordinate and support strategic commissioning of models of care for people facing multiple disadvantage and barriers to mainstream services	Better use of resources, unifying efforts across health, social care and community organisations

Areas of focus	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Priority 1			
Working in partnership with Lived Experience	Established sustainable mechanisms and structures to facilitate co-production	Improved use of qualitative approaches	Improved understanding of health disparities, intersectionality, and unmet needs, to inform interventions and prevent ill-health
Data integration and insights	Established qualitative data collection mechanisms, improving analysis of health inequalities	Services are designed and delivered in partnership with people with lived experience, ensuring co-production principles are fully embedded	
Establish standardised primary care coding system	Enhanced identification and recording of inclusion health status in GP practices improves health data for inclusion heath	Enhanced understanding of health inequalities informs targeted interventions, resource allocation, and effective outreach strategies.	
Priority 2			
Health promotion	Improved engagement with community services	Improved early detection of health conditions, preventing ill-health and early mortality	Sustainable physical and social environment supporting good health
Equitable access to community services	Higher uptake of vaccination and screening programs	Individuals are empowered with accessible, inclusive, and sustainable prevention initiatives	
Safeguarding & Trauma-Informed Support	Improved service user experience and service response to trauma	Provision across health, social care, housing, and other sectors use principles and standards that protect inclusion health groups	
Priority 3			
Workforce development and training	Staff demonstrate increased awareness and confidence in addressing unmet needs and challenging discrimination	Trauma-informed and culturally competent workforce	Inclusion groups have increased confidence that services will meet their needs, recognise their strengths and treat them with respect and dignity
Organisational culture, attitudes and behaviours	Established feedback and reporting mechanisms for inclusion health groups and advocates	Inclusion health groups experience fewer barriers and delays in accessing services	
Priority 4			
Commissioning	Enhanced equity focused commissioning	Integrated services are embedded across the system	Enable people of all ages to access holistic care and services at the point of need
Access and Engagement	Reduced access barriers ensuring timely and appropriate support.	Inclusion health groups experience fewer barriers and delays in accessing services	
Enhanced and integrated services	Enhanced primary care and specialist service provision	People experience better outcomes, with evidence of improved health and cost-effectiveness	

For any queries about this report, please contact Population Health and Prevention team , mina.fatemi@nhs.net or hnyicb-ery.populationhealthandprevention@nhs.net.