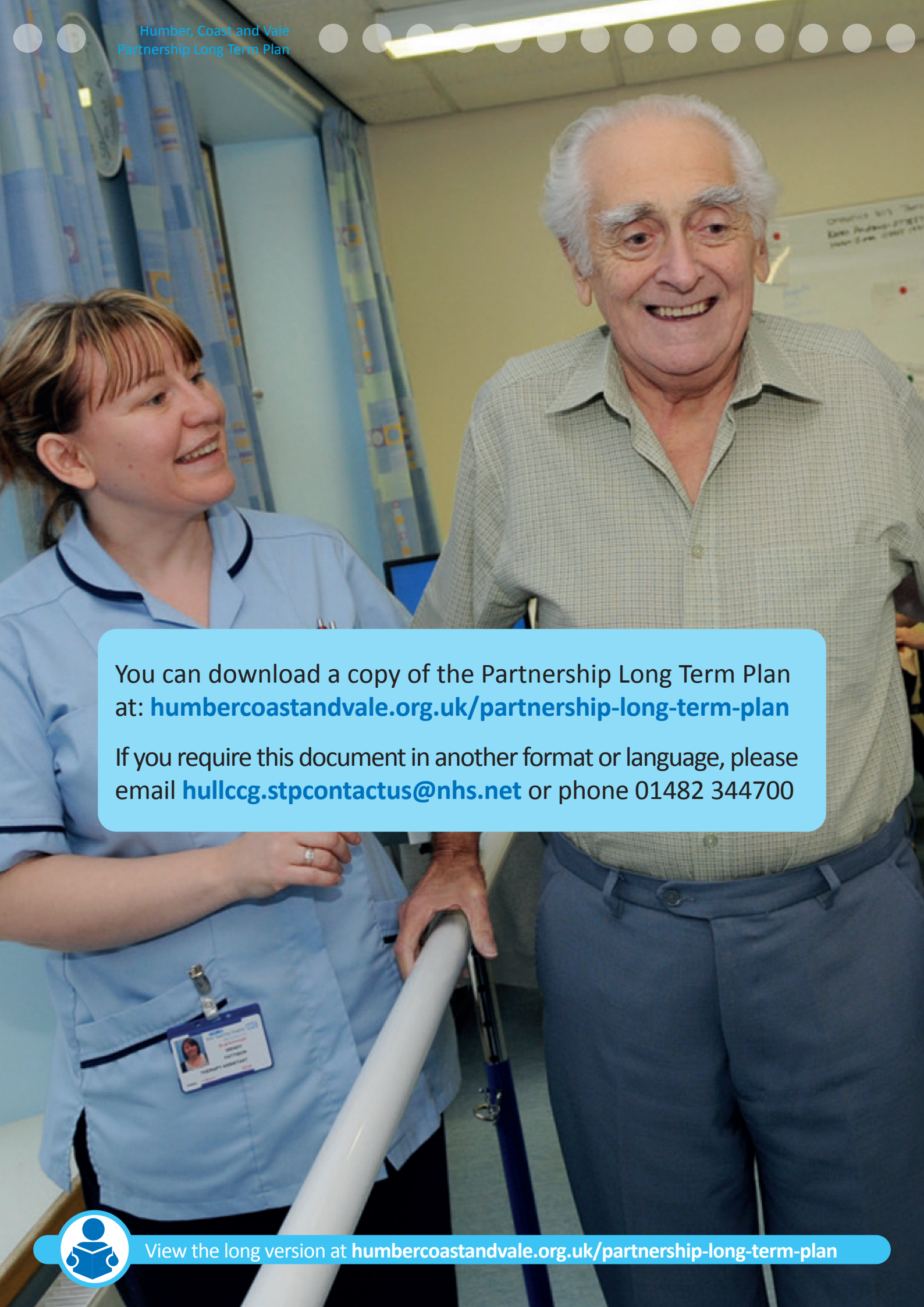
Humber, Coast and Vale Health and Care Partnership

Partnership Long Term Plan 2019–2024

Humber, Coast and Vale



You can download a copy of the Partnership Long Term Plan at: **humbercoastandvale.org.uk/partnership-long-term-plan**

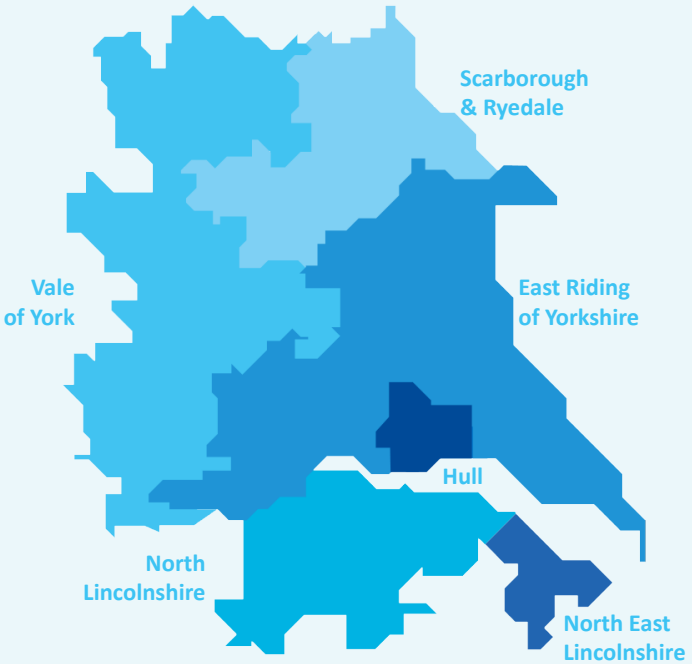
If you require this document in another format or language, please email **hullccg.stpcontactus@nhs.net** or phone 01482 344700

Our Partnership

The Humber, Coast and Vale Health and Care Partnership is a collaboration of health and care organisations who believe we are stronger when working together. We are striving to improve the health and wellbeing of our population as well as the quality and effectiveness of the services we provide.

Our Partnership was established in early 2016, when 28 organisations from the NHS, local councils, other health and care providers and the voluntary and community sector came together to start thinking about the challenges facing the health and care sector over the coming years.

Since then, we have been working together within our six places, as shown on the map, and across wider areas, where it makes sense to do so, to look for ways to join up health and care services and to make them work better for local people.

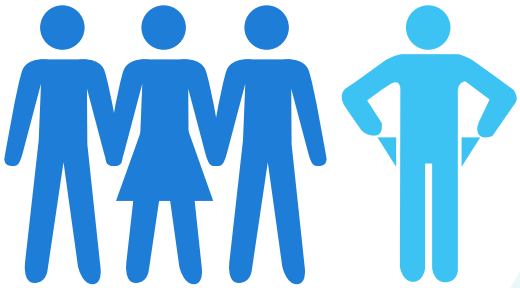


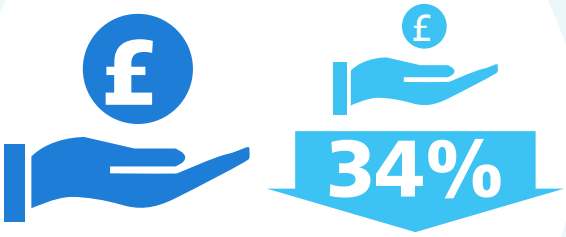
This summary document sets out our Partnership's ambitions and the difference we are seeking to make. You can read the full version of our Partnership Plan on our website.

Our Communities

The population of Humber, Coast and Vale is diverse and this presents both opportunities and challenges. The life chances of our citizens can vary significantly across the different neighbourhoods and places that make up Humber, Coast and Vale.

Nearly a quarter of our 1.4 million people live in areas classed as the most deprived in England.





Average weekly wages range from £346 in North East Lincolnshire to £449 in York (compared to £530 nationally).

Average house prices in Ryedale and York are nine times average annual earnings.

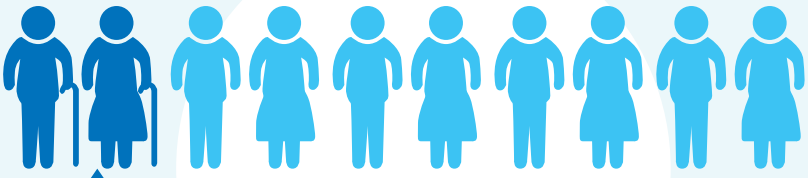
Disparities in life expectancy for those living in our most and least affluent communities of 12.4 years for women and 15.4 for men.

NE Lincs women
22
years of ill health

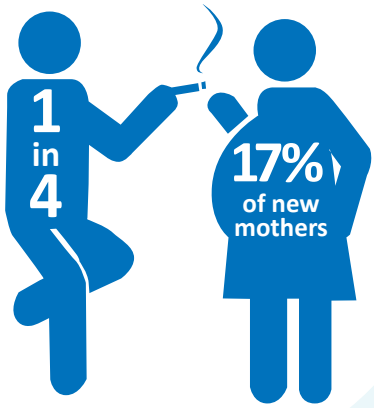
Hull men
19.5
years of ill health

Women living in North East Lincolnshire can on average expect to live the last 22 years of their lives in ill health, while men in Hull typically can expect to live the last 19.5 years of their lives in ill health.

Around 20% of our population are aged over 65 (compared to 17% nationally).



20% aged over 65



One in four adults in Hull are smokers (almost twice the national average) and around 17% of new mothers across Humber, Coast and Vale are smoking at the time of delivery (compared to 10.7% nationally).

Our Ambition

Our Partnership's ambition is for everyone in our area to:

Start well, live well and age well

This means shifting the focus of our work from picking people up when they fall to helping to prevent them from becoming unwell in the first place and supporting more people to manage their health and wellbeing at home so they can get on with living happy and fulfilling lives.

- **We want every child to have the best start in life**
- **We want to ensure everyone has access to the right care and support that responds to their changing health needs**
- **We want to support people to be independent and in control as they age**
- **We want to create an environment in which people can have positive conversations about death and dying, which will help us to give them greater control and provide coordinated, compassionate care**

Our Approach

Most people agree that we need to change the way we do things if we want to see all our people living healthy, happy lives. The sorts of changes we need are significant and won't happen overnight. What's more, they will only happen if we work together.

In our Partnership, we work together at different levels to tackle different challenges.

Most of our work happens at the level we call '**place**' – these are the areas covered by each NHS clinical commissioning group (CCG) or local council within Humber, Coast and Vale.

Where it makes sense to do so, we will join up across more than one place to plan and improve services – we refer to these areas as '**sub systems**'. This is where we carry out much of our financial planning.

There are some areas where we can make bigger and faster improvements by working together across a larger area – we talk about this as '**working at scale**'.

Priority One
Helping people to look after themselves and stay well

The NHS has historically functioned as an 'illness' service rather than a 'health' service. In Humber, Coast and Vale we want to see a fundamental shift in focus of our services from picking people up when they fall ill to helping to prevent people from becoming unwell in the first place. This also means getting better at anticipating when people may need support and being proactive in providing it.

We know from talking to local people that not everyone finds it easy to get the health or the care they need. Sometimes this can mean people don't get the right help, or get it later than is ideal. We want to make sure our health and care services are fairer and easier to access for everyone, especially those who need them most.

How we make this happen will be different in the many different communities that make up our Partnership.

View the long version at **humbercoastandvale.org.uk/partnership-long-term-plan**

There are some common themes, which include:

Prevention

Improving the ways in which we support people to stay healthy and where this is not possible, taking steps to slow or halt the progression of disease.

For example: our work on prevention, in particular, will continue to focus on supporting more people with tobacco dependency to stop smoking and improve their overall health.

Resilience

Helping our local people and communities to cope with change better in the future.

For example: we will do more to support the emotional wellbeing of our children and young people.

Health inequalities

Focusing on the areas in our Partnership with the biggest gaps in health and life expectancy and tackling the underlying reasons for these inequalities, such as poverty, inadequate housing and poor air quality.

For example: we will work together to tackle things that make people unwell, like poverty and poor housing.

Personalisation

Giving people a bigger role in designing their own care and support so that it meets their needs better.

For example: we will give at least 7,200 people control over their own health budgets.

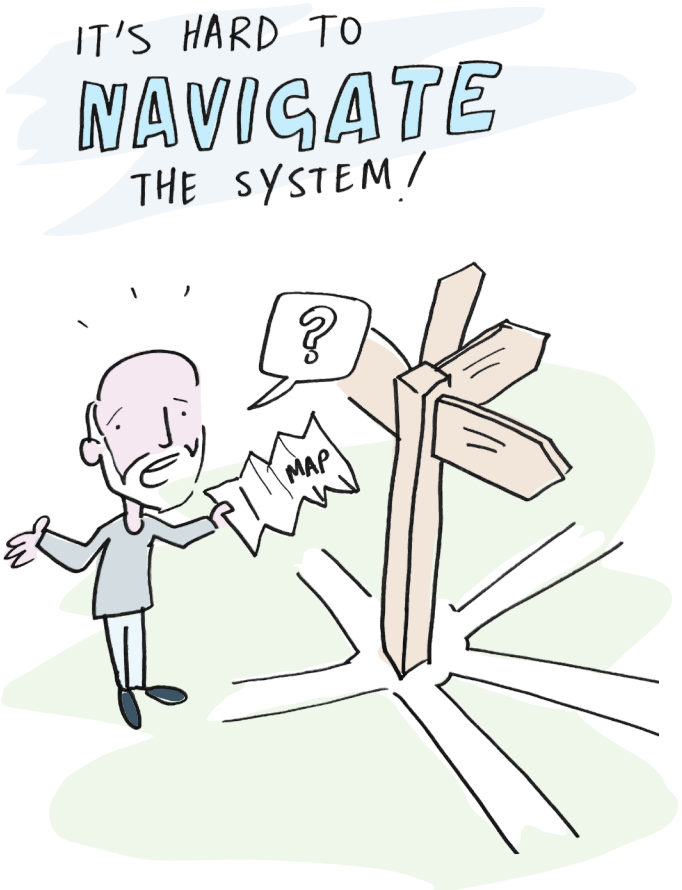
Priority Two

Providing services that are joined up across all aspects of health and care

The complexity of our health and care system can make it difficult for people to navigate between different organisations and services. It places responsibility on individual patients, their families and carers to coordinate between the different organisations and aspects of their care, often when they are least equipped to do so.

Working together, our Partnership offers us the opportunity to fundamentally reshape services so that they are properly joined up and working together based around the needs of individual patients, not the needs of organisations.

Our aim is that the experience of someone who needs care is completely seamless so that the care provided meets all of their needs in the most efficient and effective way possible, regardless of how many different organisations or professionals are involved.



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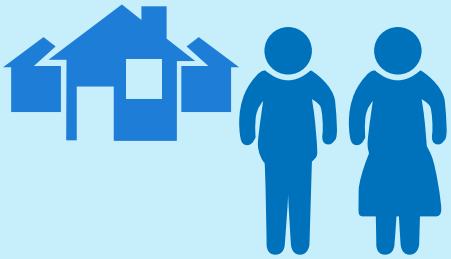
To achieve this outcome, we are working together in a number of areas:

Developing **primary care** – so that every neighbourhood has access to a single team of health and care professionals who can meet a wide range of their needs locally and in a joined-up way.

For example: establishing 29 Primary Care Networks across our area - providing joined-up care for our communities.



Joining up **services outside of hospital** - so that care is designed around the needs of the person not the needs of the different organisations providing it.

For example: offering more care outside of hospitals, or closer to home.

Developing our **unplanned care services** – so that appropriate care, advice and support is available to citizens of Humber, Coast and Vale when they need it unexpectedly.

For example: when needed, everyone within Humber, Coast and Vale will have 24/7 access to information, advice and direct care that will meet their needs. This will be outside of hospital wherever possible.

Securing a long-term, **sustainable future for our hospital services** - so that our hospitals are working together to provide high quality care for our populations when they need to be in hospital.

For example: we are carrying out reviews in Scarborough and across Humber to find ways to get the best from our local hospital services.

Priority Three
Improving the care provided in key areas

Over the next five years the Partnership will work together to improve the care we provide for the people of Humber, Coast and Vale in a number of important clinical areas to ensure everyone can have the best possible care.

Cancer

Each week 160 people in Humber, Coast and Vale are diagnosed with cancer and we want to ensure they all have the best possible chance of recovery and that everyone whose life is affected by cancer is supported to live well.

Our work will focus on reducing the impact of preventable cancers and on finding more cancers before symptoms appear. This will help us to ensure a greater proportion of cancers are diagnosed at an early stage, where treatment is more likely to improve survival.

For example: we aim to find more cancers before symptoms appear by increasing uptake of screening and early testing with a focus on bowel, lung and cervical screening. We are already improving screening for bowel cancer, being the first area in the country to offer the new faecal immunochemical (FIT) test for bowel cancer across our whole Partnership.

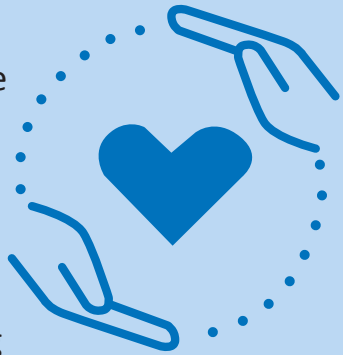
Mental Health

We want to change the conversation around mental health in our area. We will work to ensure all our people, from the youngest to the oldest, know how to look after their mental health and can access support when they need it.

For people experiencing a mental health crisis in need of immediate help, we will develop a support system that acts quickly, recognises their needs and draws on our teams to respond appropriately.

For example: we will expand crisis services and put in place a single point of access in all areas to ensure that everyone in Humber, Coast and Vale has access to 24/7 urgent and emergency mental health assessment and intensive home treatment.

Planned Care



We are redesigning how we deliver planned healthcare to improve patient experience and make better use of specialist staff. We plan to move away from the traditional outpatients' model where patients typically have to make multiple visits to hospital. This will ensure services can respond more quickly to our population's needs, reduce waiting times and avoid unnecessary hospital trips. We will focus on preventing disease and supporting those with long-term health conditions to access treatment early and manage their conditions well.

For example: we will offer more 'one stop shop' appointments where people can undergo tests and discuss treatment plans all on the same day, and will improve health prevention messages by working with experts to ensure they are understandable and effective.

Maternity

We are working to ensure that maternity care is safer, more personalised, kinder, professional and more family friendly. Our ambition is that every woman has access to information to enable her to make decisions about her care and that she and her baby can access support that is centred around their individual needs and circumstances.

For example: we will work to ensure more women experience continuity of the person caring for them during their pregnancy. This will usually, but not always, be the woman's named midwife.

Priority Four
Making the most of all our resources

Within Humber, Coast and Vale we face a number of challenges that mean it is increasingly difficult to continue to provide high-quality, effective care that is keeping pace with rising demand and the changing needs of our local populations.

Despite these challenges, Humber, Coast and Vale is an area rich in assets and strengths. We have a vibrant voluntary and community sector, offering a vast range of opportunities to citizens to improve their health and wellbeing. Our region boasts some of the most beautiful countryside in England, a rich cultural offer including the historic cities of York and Hull, four blue flag beaches and a thriving industrial sector that is home to the largest port complex in the UK and is at the cutting edge of the renewable technology sector.

Advances in technology, alternative approaches to recruiting, training and deploying staff and other new ways of working offer many opportunities to improve the quality of care we provide and improve the outcomes for local people. As a Partnership, we are working together with a broad range of external partners to leverage these assets and resources to ensure we make the most of what Humber, Coast and Vale has to offer so that all our citizens can ***start well, live well and age well***.

View the long version at **humbercoastandvale.org.uk/partnership-long-term-plan**

By working together across the whole of Humber, Coast and Vale we can make a big difference and ensure we are getting the most from all our resources:

People

Supporting and empowering the people who make our health and care system work, including carers and volunteers. This will include tackling workforce shortages, enabling flexible approaches to delivering care and helping staff to work more flexibly and develop their careers.

For example: Hull and York Medical School will train 220 new doctors per year, compared with 130 in 2017. We will continue to develop new roles, such as nurse associates and advanced clinical practitioners, to work alongside our existing workforce.

Technology

Using new technologies to share information and join-up care; to help people manage their health conditions better and to improve access to services.

For example: through the Yorkshire and Humber Care Record we are creating a shared care record that will ensure everyone involved in a person's care – including the patient themselves – will have access to the most up to date information that they need in order to provide safe, effective care.

Buildings

Making best use of our existing buildings and equipment and seeking significant additional investment to enable us to make the changes we have set out in this plan.

For example: funding of £88.5 million has been secured to support the development of urgent and emergency care and diagnostic facilities at four of our hospital sites.

Money

Making the most of every penny in our health and care economy by planning together and spending our money on the things that will make the most difference for our local people.

For example: we have committed to investing more in mental health services and provide additional funding in to primary and community care. These investments will enable us to deliver ambitious plans for the development of services and associated improvements in outcomes.

The difference we're making now

In this section we describe some of the ways we have already made a positive difference in our communities.

Urgent Care Practitioners, York

In the Vale of York, the addition of urgent care practitioners to local services is allowing more people to get urgent treatment and advice at home, saving them from having to be admitted to hospital. Urgent care practitioners are highly skilled paramedics who pick up appropriate 999 or 111 calls; typically those related to falls, minor wounds, patients recently discharged from hospital and care home residents. They can prescribe basic medications, treat wounds and provide advice and make referrals for ongoing support.

This approach is helping more people to stay at home. This is particularly beneficial for frail elderly patients, people living with dementia and others who would potentially be readmitted to hospital, as it saves them from waiting long periods in busy emergency departments, which can be more damaging to their overall wellbeing.

The Ivy Team, Beverley

The Ivy Team introduced a midwifery continuity of carer model in November 2018, which sees them work in a totally different way to support women throughout their maternity journey, incorporating antenatal check-ups, the birth and follow-up care at home afterwards. The team provides midwifery care for women living in a designated geographical area and has birthed almost 200 babies to date.

The home birth percentage of women on their caseload is 10%, compared with the overall hospital percentage of 1.6%. This has been achieved by increasing trust and confidence as they know the women and their medical histories well. They also offer a choice at the time of birth so women can choose a home birth at the point of labour. This increases the choice for women but also allows total flexibility as the midwife will meet the woman at whichever place of birth she decides.

Helping schools to support children and young people's mental health, North East Lincolnshire

In North East Lincolnshire partners have worked together to produce a single training framework that will help school staff develop the right skills and knowledge to be fully confident when supporting children and young people with their mental health and emotional wellbeing. The social, emotional and mental health competency training framework has been developed by a range of experts, including the school links team, educational psychologists and the specialist advisory service.

The document aims to:

- Support professionals to improve their confidence and skills when supporting children and young people with mental health and emotional wellbeing concerns
- Give professionals the knowledge when to refer on to external agencies
- Inform professionals of training courses and packages available for free to increase their knowledge and skills

The Jean Bishop Integrated Care Centre, Hull

Partners working together in Hull have developed a new approach to providing anticipatory, integrated out-of-hospital care for Hull's frail elderly population. Patients identified at risk of severe frailty are invited to a half-day appointment at the Jean Bishop Integrated Care Centre (ICC) where they receive several multi-disciplinary reviews of their care. Prior to their visit, a member of the clinical team visits the patient at home to identify any issues about their health, social interaction or day-to-day living they wish to discuss with the team.

The ICC team includes GPs, community geriatricians, pharmacists, advanced practitioners, social workers, carer support and therapists who link up with other community speciality teams. The team also provides an outreach service to care home residents.

After their assessment, a care plan is shared electronically and coordinated by an identified care coordinator. If the patient's condition changes, a model is in place within primary care to ensure patients and their carers receive the care and support they need.

Since opening in July 2018, the Jean Bishop ICC has contributed to a 3% reduction in emergency hospital admissions for patients aged over 80, and to saving an average of £100 per patient per year on medication costs.

How we're listening to you

As we have been developing this plan, we have been listening to the people who use our services and who live in our neighbourhoods and local areas to find out what matters most to them. Your ideas have helped to shape our plans, here's how:

You Said	We Did	We Will Do
Access to Services		
Getting a GP appointment can be really difficult	• Extended GP opening times • NHS App and online booking available • eConsult (online consultations) trialled • Direct access to physiotherapists and other professionals	• Expand availability of online consultations • Expand primary care teams to include new roles • Develop primary care networks
Travel and transport can be a challenge, especially in rural areas	• Made more appointments available for advice over the phone • Launched NHS 111 online and eConsult	• Expand the use of virtual consultations and remote monitoring • Develop out of hospital services to avoid unnecessary trips to hospital
Communication and Disjointed Care		
Communication between patients and healthcare providers, and between different parts of the health and care sector, is not always effective	• Improvements made to IT and digital systems • Improved record sharing • Stronger join working between organisations	• Introduce digital patient-held records and single patient record across all organisations • Offer more text reminder systems • Provide more joined up services

You Said	We Did	We Will Do
Meeting People's Broader Needs		
When community and family support is available, people feel healthier and happier	• Introduced social prescribing • Support for carers in local areas	• Embed voluntary sector partnerships • Expand social prescribing
Choice and Control		
People have told us they can manage their own conditions better when they have more knowledge and access to advice and support when they need it	• Launched Humber app store, to help people find the best health apps • Developed a Healthy Hearts website • Maternity website launched • Diabetes Prevention Programme in place	• Transform how we offer outpatients appointments • Offer more digitally-enabled care and management of conditions (e.g. wearable devices) • Expand availability of trusted advice and guidance online
Involving People		
You would like more opportunities to get involved in decisions about your care	• Extensive involvement in developing this Plan • Ongoing engagement programmes across the Partnership • Maternity Voices Partnerships (MVPs) established	• Develop a cancer patient network • Continue to develop MVPs • Ongoing engagement on acute services reviews and other service developments

We are committed to working with our communities as we put in place the changes set out in our Partnership Long Term Plan.

The ambitions we are seeking to achieve will involve every individual and community within Humber, Coast and Vale taking an active role, helping to ensure we can all start well, live well and age well.

To find out more about how we engaged with our communities about our plan, read the full version of the Partnership Long Term Plan.

We believe we are stronger together and can only really make the improvements we want to see if every one of us plays our part.

In everything we do, we seek to enable our local people to: start well, live well and age well and break down barriers that stop people from living happy and healthy lives.

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