Humber, Coast and Vale Health and Care Partnership

Partnership Long Term Plan 2019–2024

Humber, Coast and Vale

You can download a **summary version** of this plan on our website.

It is also available in **Easy Read** on our website.

If you or someone you know would like this document translated or in another accessible format, please contact us via the details below. If you would like to find out more about the work of the Humber, Coast and Vale Partnership, please get in touch.

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Contents

Introduction

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 overall 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. In October 2016, we published an outline plan for the Partnership, which set out our key goals and aspirations. Since then, we have been working together within our six places, as shown on the map, and across wider geographies, 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 document sets out our Partnership's ambitions and the difference we are seeking to make. It provides an overview of the work that we will undertake over the next five years to deliver improvements in health and wellbeing for our population and is aligned with the requirements of the NHS Long Term Plan.

Our Partnership Operating Plan for 2019/20 explains in more detail what we will achieve during the first year of this plan.

Our Context

There is broad agreement that, in order to improve health and care outcomes for our people, we all need to adapt and change the way we do things. For our Partnership, this means working harder to help people in our communities to stay as healthy as possible for as long as possible. It means providing better, more proactive support, to help those with long-term health conditions to manage them well so they don't get worse. It means finding new ways to meet people's needs that are more effective and efficient so that we can continue to provide good quality care for everyone.

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. Some individuals and communities are disproportionately affected by ill-health and premature death for a wide variety of reasons. This includes people with learning disabilities, those without permanent homes, LGBTQ+ citizens, veterans and other individuals and groups who can face barriers to accessing health and care services and wider opportunities to improve their health and wellbeing.

Our region is home to thriving cities, striking coastline and beautiful countryside; yet 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) and unemployment rates also vary across the region from 3.4% in York to 7% in Hull. Access to good quality housing that people can afford is also a challenge, with average house prices in Ryedale and York nine times the average annual earnings.

These differences lead to significant 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. What's more, our population are spending an increasing proportion of their lives with one or more serious health conditions: women living in North East Lincolnshire can expect to live around the last 22 years of their lives in ill-health and men in Hull can expect to live around 19.5 years of their lives in ill-health. Through this plan, we are seeking to remove barriers and address the underlying causes of inequality in health outcomes experienced by people in Humber, Coast and Vale.

As with elsewhere in the country, our population is getting older. Around 20% of our population are aged over 65 (compared to 17% nationally) but this varies across the area. Only 14% of people in Hull are over 65, whereas more than 24% of the population in Scarborough, Ryedale and East Riding of Yorkshire are over 65. Across Humber, Coast and Vale we have some of the worst rates of smoking prevalence in the country: 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). These are just a few of the factors that are contributing to the increasing strain on our health and care services.

The diversity and complexity of the health and care system across Humber, Coast and Vale is, in some respects, a strength but it can also be a barrier to the provision of more efficient and effective care. In order to make the necessary changes to the way health and care services are delivered, it is imperative that we take a collaborative approach to delivering our shared goals.

Our Ambition

As a Partnership, we have an agreed ambition that we want to achieve for our population. In everything we do, we are helping local people to: **start well, live well and age well**.

We want to become a **health improving system** rather than an ill-health treating system. This means shifting the focus of our services 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 and have the support they need for their mental and physical health needs at the earliest possible opportunity. We want to ensure everyone has access to the right care and support that responds to their changing health needs and, wherever possible, support people to be independent and in control. Recognising that it can be difficult to talk about death and dying, we want to create an environment in which people can have positive conversations about dying well. This will help us to give people greater choice and control and provide coordinated, compassionate care for those in the latter stages of life.

Our Priorities

Our vision is extremely ambitious and we recognise that it will not be achieved overnight. We have identified **four priority areas** or key things we want to achieve in order to deliver the vision we have set out.

Helping people to look after themselves and to stay well

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

Improving the care we provide in key areas (e.g. cancer, mental health)

Making the most of all our resources (people, technology, buildings and money)

Our Approach

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**' – these are the areas covered by each NHS clinical commissioning group (CCG) or local council within Humber, Coast and Vale.

Most of the changes described in this plan will be undertaken at place level. This is where local councils, CCGs, health and care providers, voluntary and community sector partners, other public sector organisations and local communities are working together to bring about changes to the overall health and wellbeing of people living in their area. This collaboration at place is, and will remain, the main focus for the work of our Partnership.

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**'. We will work together in three sub systems to help us deliver this plan. In particular, our work at this level will focus on planning levels of activity and undertaking financial modelling within the three sub systems:

- Hull and East Riding
- North and North East Lincolnshire
- York and North Yorkshire

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**'. This plan also covers the areas where we will work together at scale across Humber, Coast and Vale to improve outcomes for our populations.

Priority 1: 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 health and care 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 our extensive engagement with local communities 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 ensure our health and care services are fairer and easier to access for our population, especially those who need them most. By achieving this we will contribute to how long people can expect to live in good health and help to reduce the inequalities in life expectancy that we see in our region.

There cannot be a 'one size fits all' approach to these challenges, which is why in each of our six places we need to work with local people and professionals differently over the coming years.

Whilst the way in which we work will vary from place to place, there are common principles, themes and strategies which we will adopt everywhere. These are:

- Embedding **prevention** into our service models to help people to stay healthy; and where this is not possible, to slow or halt the progression of disease;
- Increasing the **resilience** of our local people and communities, helping them to cope with change better in the future;
- Focusing on particular areas within our Partnership where we have significant **health inequalities**, recognising that these are driven largely by socio-economic factors and therefore we need to work with many partners to address these;
- Increasing **personalisation** of care and support, embracing the fact that none of these challenges can be met if we treat everyone the same, so we need to give people greater control over their own health, care and wellbeing.

Prevention

Many of the diseases affecting people across Humber, Coast and Vale are preventable. Poverty, poor housing, lack of access to good quality employment, exposure to crime, discrimination and other risk factors all affect people's ability to thrive, feel positive and take on healthy behaviours such as eating well, staying active, stopping smoking or drinking within safe limits. Unhealthy behaviours can lead to high numbers of people with heart disease, breathing problems, obesity, cancer and mental ill health. Positive and safe sexual health is also important for both physical and mental health and we will continue to work with public health commissioners, screening programmes and other partners to improve preventative services in this area. In addition, we will work together to increase the uptake of vaccines and screening programmes to prevent illness and identify potentially curable cancers early.

If we are to achieve our Partnership's ambition, we need to find ways of supporting everyone living within Humber, Coast and Vale to recognise the part they can play in ensuring we can all start well, live well and age well. In all of our places, partners are working together with individuals and communities to understand and gain insight into how we can improve the quality and effectiveness of information and preventative messages, as well as putting in place more support to enable people to make positive changes. For example, in East Riding all public sector partners have signed up to a single communications approach to maximise the impact of their campaigns and North Lincolnshire is developing an Independent Living Centre, which will provide a 'one stop shop' to support people with all aspects of independent living. Our work on prevention will continue to focus, in particular, on supporting more people with tobacco dependency to stop smoking and improve their overall health.

As a Partnership we recognise that prevention goes beyond individual responsibility. There is a need to ensure that, where we can, we prevent those with ill-health or existing diagnoses from getting worse by ensuring that they consistently receive the most appropriate treatment, based on evidence. In addition, when our people have reached a point in their treatment that means no further improvements can be made, we will ensure that they can live as fulfilling lives as possible. We will use our local data and a population health approach to ensure that all of our prevention efforts are targeted where they are most needed with the aim of achieving better outcomes for our people.

Our engagement has shown that people think we need to be doing more with children and young people to deliver messages in schools and colleges about healthy lives and wellbeing, in particular in relation to emotional wellbeing and mental health. In all of our six places we will seek to prevent children from experiencing traumatic events, such as witnessing or experiencing violence or neglect, because we know that adverse experiences in childhood can have lifelong damaging impacts on a person's health and wellbeing. We will focus more on supporting children and young people to develop greater resilience so that they are able to cope with change. We will also build on existing partnerships with voluntary and community sector organisations so that we can provide better early support for children and young people experiencing ill health such as anxiety and depression to help prevent them from requiring more intensive medical services.

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, effective training framework that will help staff in all schools 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 jointly 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, knowledge and skills when supporting children and young people with mental health and emotional wellbeing concerns
- Give professionals the knowledge when to refer onto external agencies as appropriate
- Inform professionals of all the training courses and packages available for free to increase their knowledge and skills

Partners have also developed a programme of support through scheduled termly meetings, which will focus on 'hot topics' and train local champions in schools with the appropriate skills to deal with issues (e.g. attachment interventions).

It doesn't just fall to health and council partners to support individuals to live healthier lives. There are many examples of local communities themselves initiating clubs or groups that help people to stay well. Fitmums and friends, which is now spreading nationally as a concept, originated in Hull and started with less than 10 people meeting at one person's house and going out for a run. There are now examples of Park Runs happening every weekend across all of our six places as well as thousands of other community groups that are having a positive impact on peoples' physical and mental health and wellbeing.

Our place-based partnerships will work with their local voluntary and community sector to enable this type of community action to develop and thrive in all local communities. This is part of a wider commitment in each of our six places to support and develop the local voluntary and community sector, and work more closely with them to deliver the aims and ambitions of this plan. What's more, we will play our part as organisations by encouraging our own staff to take part in health improving activities. For example, in Vale of York, GPs have initiated a 'Park Run takeover' whereby every member of staff within a GP practice takes part in some way.

Healthier communities and tackling inequalities

The healthcare services people receive have only a small impact on their overall health and wellbeing. Conversely, many of the services that local councils provide have a significant impact on the health and wellbeing of their residents. This includes looking after parks and open spaces, providing housing and housing support for those who need it, monitoring and improving air quality, growing the local economy in ways that benefit everyone, ensuring every child has access to a good quality education and supporting voluntary and community groups. This is in addition to their role managing social care services and public health.

Each of our places has an established Health and Wellbeing Board whose strategic plans all include an ambition to reduce health inequalities that exist between different groups and communities in terms of their overall health. These plans include addressing a range of issues such as working with schools to raise aspirations and career prospects of young people; improving the quality and availability of social housing and affordable housing; and tackling air pollution, particularly around schools and in more deprived inner-city areas. This is supported by the 'Health in all Policies' approach, which many of our places are adopting. This approach ensures that health and wellbeing issues are considered when public bodies are developing policies whether their subject matter be transport, economic development or housing.

In addition, we have an opportunity to make our contribution to addressing climate change through increasing active travel, eating less meat and improving the energy efficiency of our homes. These actions will have associated benefits of improving health and potentially reducing health and care related carbon emissions through the population being healthier.

We all acknowledge that improving life expectancy and healthy life expectancy will take longer than the five years this plan covers; however, we would expect to see significant improvements in some of the proxy measures that would support this. For example, we know there are particular areas in our Partnership where some people ignore symptoms, struggle to get to an appropriate health service or don't seek out health services when they should, resulting in late presentation and diagnosis of cancer. Diagnosing and treating cancer at an early stage improves the chances of survival. The challenge is determining why late presentation occurs and, more importantly, how we can work at a very local level with people to try to better understand what is behind this and encourage them to seek help sooner.

Work in this area has been underway for some time and we will continue to build on existing successes but increasingly will adopt a more community-based approach, focusing on the assets that exist within communities to improve peoples' life chances. We will improve the way we use data to understand the barriers and underlying reasons for health inequalities. We will also listen to and learn from people with lived experience to ensure our prevention messages are as effective as possible. For example, we will focus on improving information about cardiovascular disease (CVD) prevention for people with a learning disability because we know this is a leading cause of premature death amongst this population. We will design our campaigns with people who have learning difficulties, using their expertise to ensure that our messages are clear and effective.

Our People, Our Place, Hull

The objective of the Our People, Our Place project is to explore, plan and implement a new, place-based way of working for a particular area within the city of Hull. The project concentrates on a single, bespoke geographic area of Hull – the Beverley Road Corridor – and involves agencies working together to deliver cross-cutting, holistic services that protect, support and re-enable people and families by reducing their need for services and improving their lives.

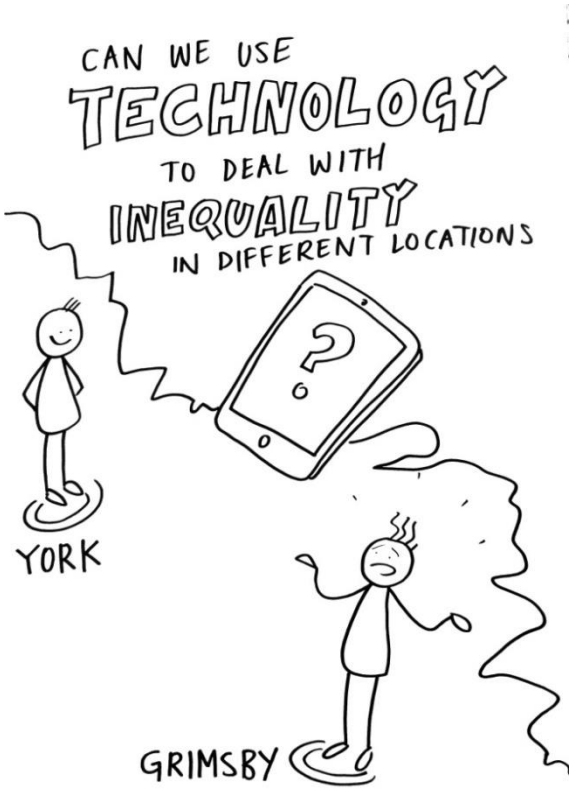
This work is being carried out with the ambition to transform Hull's public sector from traditional silos that are disconnected and often duplicating effort to a smarter system, driven by reliable data and intelligence on what is needed and what works.

To date, eight public sector organisations (including police and fire services as well as NHS organisations and the local council) have shared their data to create an outline of 53 indicators, across all postcodes in the Beverley Road Corridor area. This rich data is enabling partners to identify areas and individuals who need most support and target services accordingly.

Staff and volunteers from public and community organisations are working together to address clearly identified issues within the area. The Making Every Adult Matter approach is being applied to support people identified as requiring high intensity support from the multi-disciplinary team.

Personalised Care

One really important way in which inequalities can be reduced is through introducing more personalised care. Our local communities have told us time and again that they want to have greater control over their health and care. As a Partnership we are responding to this by reshaping the services we offer. Personalised care empowers people by giving them more choice and control over how they interact with professionals, book appointments and access their care records, including through the use of digital technologies.



Fundamentally, personalised care is about a shift in emphasis from a medical focus on treating disease to a more holistic approach that focuses on the individual, their families and carers, and what is important to them. In Humber, Coast and Vale we are already delivering well around providing choice and control through personal health budgets (with 3,031 people expected to receive these in 2019/20), support for self-management and social prescribing.

Personal Health Budgets

Personal Health Budgets are a mechanism to support personalised care by giving people more choice and control over the money that is spent on their health and care package. Budgets are used to pay for care and support that has been mutually agreed between a health professional and the individual; it isn't new money but a different way of spending existing health and care funding. We will build on the good work already taking place in our six places to expand the reach of personal health budgets to more groups of patients. This includes, for example, work to offer personal health budgets for children and young people with learning disabilities or autism where unmet health needs are identified in a child or young person's Education, Health and Care Plan (EHCP). By March 2024, we expect at least 7,200 people in Humber, Coast and Vale to be using a Personal Health Budget.

Support for Self-Management

In each of our places, we are also looking to introduce more support for people to manage their own health conditions and to improve their health. Our efforts in this area will focus first on supporting women who are pregnant to stop smoking. We will target our support in the areas with the highest prevalence and work with our midwifery teams to support women and their families.

In addition, we will work with people in our communities who live with diabetes, respiratory conditions and heart disease to manage their conditions better. Through our work in this area we expect by 2023/24 to be supporting more than 24,000 of our citizens to manage their own health better.

Social Prescribing

We also have a number of approaches being implemented to social prescribing across the Partnership, which we are seeking to build on over the coming years. The principle of social prescribing is relatively simple: it offers an alternative approach or service to help people who currently access health and care services with social issues for which, a medical intervention is not the right or the whole answer. Most commonly, we see this in general practice where up to a third of GP appointments can be taken by people who do not have a medical condition. A social prescribing service typically involves employing a link worker who receives referrals from healthcare or other professionals and supports the individual to make a personal health and wellbeing plan and get the non-medical help they need to take more control over their health or the issue affecting their health. In many cases these services are delivered by local councils or the voluntary and community sector.

Over the next five years, we will introduce social prescribing link workers into each local community through our Primary Care Networks and expect to around 115 link workers by 2023/24. We will work together across Humber, Coast and Vale to evaluate our existing social prescribing programmes and build on the best aspects of these to enable more people to benefit from social prescribing over the coming years. By 2023/34 we expect to have at least 46,400 people per year benefiting from social prescribing.

Social Prescribing, East Riding

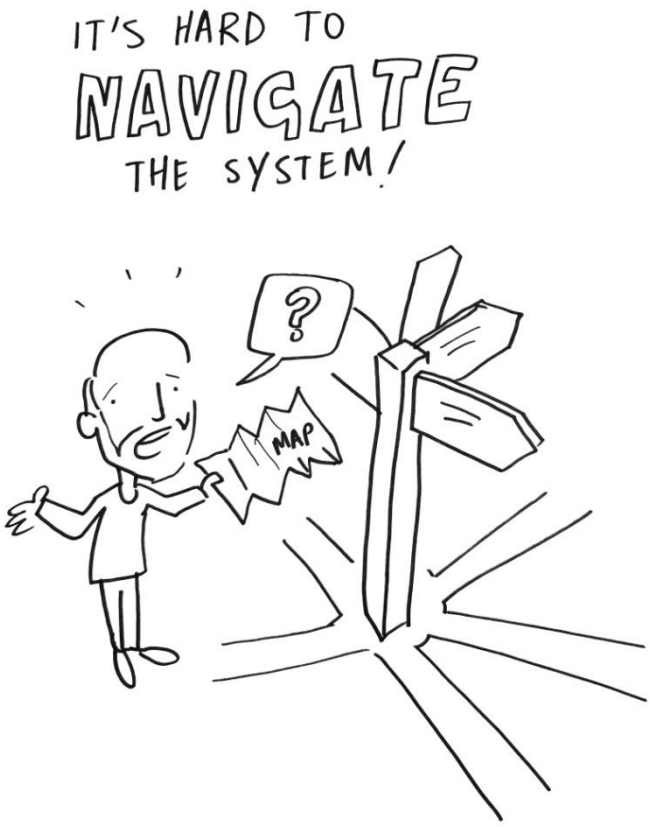
The East Riding has had a social prescribing service since November 2017. The service began as a pilot in the coastal town of Withernsea as part of a wider place-based project. The initial pilot saw approximately 700 people and was welcomed by local residents. The service was extended to the whole of the East Riding in May 2018 and has helped 3773 people to date.

People are helped to access a range of activities and support according to their needs. The majority of referrals are for common mental ill health and financial support. Feedback from those using the service shows that it is improving peoples' lives across the East Riding.

The service is based around an 'Assess, Link and Build' model. The first two aspects are fairly typical but the 'Build' element is less well adopted. The model notes that, critically, there must be something for the link worker to refer to, so the 'Build' element refers to support to develop and sustain the voluntary and community sector infrastructure to ensure they have sufficient capacity to support people being referred on an ongoing basis.

Priority 2: 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 patients 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. The experience of someone who needs care should be 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.



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;
- 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;
- 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;
- 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.

Primary Care

Primary care has been at the heart of our NHS since its inception 70 years ago. The local GP practice is the most common point of contact with health and care services for most of our communities and will continue to be at the heart of local services as we transform our local offer over the coming years. But we know that GPs are under pressure and many people have told us that they are concerned about getting an appointment at their local GP practice when they need it and they would like us to do more to make primary care services more accessible.

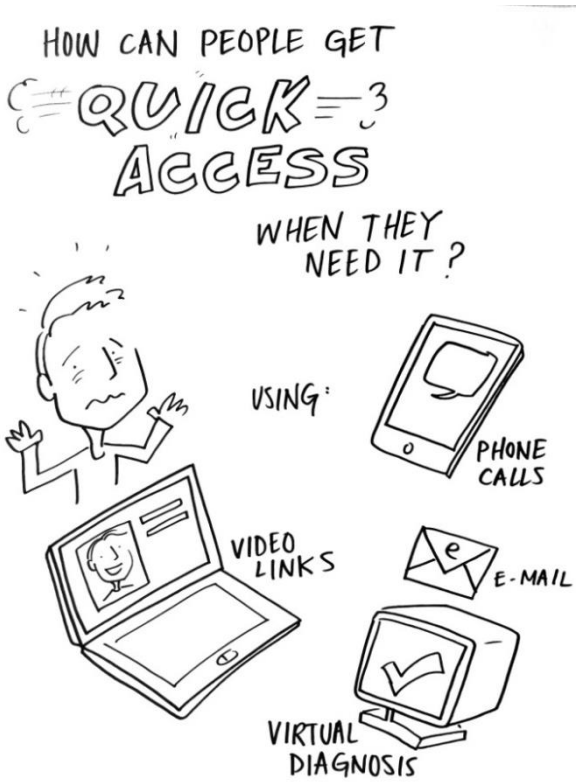
Primary Care Networks (PCNs) are one of the ways in which we will start to transform how primary care is delivered. They will be the building blocks to ensuring services are joined up and able to provide the care and support our communities need in the most effective and consistent way possible.

Primary Care Networks work by bringing together groups of GP practices with other health and care professionals and wider partners to care for a defined population or neighbourhood. Working in this way enables clinicians to move from reactively providing appointments to proactively caring for their whole population. A range of different professionals including paramedics, pharmacists, social workers, therapists and social prescribing link workers will work together with GPs, nurses and administrative teams to provide the most appropriate care for every person. Better data, backed by local knowledge, will support our Primary Care Networks to anticipate the needs of local people and target their services more appropriately.

All our GP practices are now part of one of the 29 established Primary Care Networks across Humber, Coast and Vale. Our immediate priority will be ensuring that each network has secured good working relationships with all the key partners in their respective communities – including voluntary and community sector organisations, community services and mental health providers and local councils. We will also focus on developing clinical leadership within the newly established networks and support the newly appointed Clinical Directors to engage with the broader Partnership.

We will work with our Primary Care Networks over the coming five years to put in place a number of important changes, such as introducing new roles into the primary care workforce and significantly improving digital access and connectivity. We will also support our Primary Care Networks to develop a better understanding of and ability to respond to the health needs of their local population through a population health approach.

In particular, we will improve access to primary care by offering more digital routes for those who wish to use them to get the care and support they need quickly and without having to travel. The NHS App is now available across Humber, Coast and Vale enabling citizens to get advice, order repeat prescriptions and book appointments through their smartphone or device.



Over the period of this plan we will work to expand the digital offer to include virtual consultations and will broaden the range of digital tools to help people to manage their health and long-term conditions. We will also focus our immediate efforts on improving the way GP services connect digitally with hospitals and other providers of health and care services, including ensuring that all referrals and follow-up letters are sent electronically and are accessible to all the relevant professionals involved in a person's care.

Whilst the focus of Primary Care is often on General Practice it does also include dentistry, eye health care and community pharmacy services. These services have played and will continue to play an important role in helping us to deliver the priorities in this plan, in particular, helping people to look after themselves and stay well. We will continue to work with providers of these services to improve the way they join up with the rest of our health and care offer.

Integrated Out-of-Hospital Care

Primary Care Networks will be an important part of a broader 'out-of-hospital' offer for our communities. The intention of this offer will be to provide the care people need at, or close to, home so that our hospitals only provide those things that absolutely need to take place in a hospital.

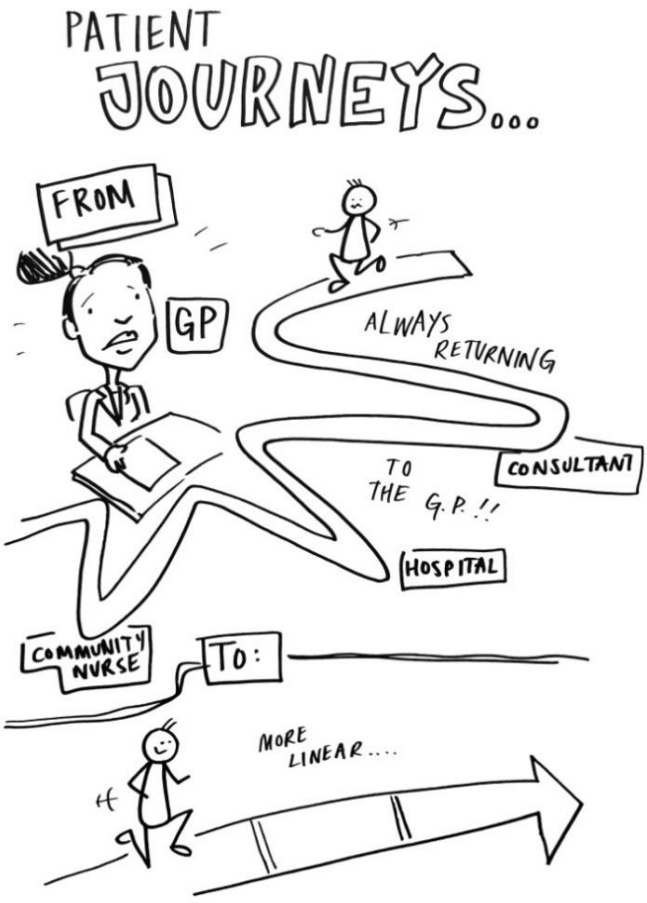
In each of our places, local health and care providers are coming together to enhance the services offered to patients within local communities so that services are more proactive and responsive to the needs of local people. These collaborative arrangements look different in each of our places but are all working towards providing care that is fully integrated from the perspective of the user, regardless of which organisation is providing which element of care.

Our integrated out-of-hospital offer will incorporate both planned and unplanned care and aims to stem the current growth in referrals to hospital services by meeting people's needs better in local communities.

We will achieve this by supporting people to manage their health conditions better to avoid flare-ups and other crisis situations and simplify the way we provide care to avoid people being bounced around from one part of the system to another.

The conditions we will focus on will vary from place to place depending on local circumstances; however, across Humber, Coast and Vale we will focus on supporting people with **diabetes**, **respiratory conditions** and **cardiovascular disease** because these are areas where we know we can make significant improvements by working together at scale.

We will also improve the coordination of end of life care so that more people can be supported to die in their chosen place and not be rushed into hospital unnecessarily.



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. The approach was designed by local community geriatricians and GPs working in partnership with patients and a range of partners. GPs in Hull use the Electronic Frailty Index (eFI) tool to identify patients at risk of severe frailty and invite them to a half-day appointment at the Jean Bishop Integrated Care Centre (ICC) where they receive a number of multi-disciplinary reviews of their care.

Prior to their visit, a member of the clinical team visits each patient in their own 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 experienced GPs, community geriatricians, pharmacists, advanced practitioners, social workers, carer support and therapists who link up with other speciality teams within the community. The team also provide an outreach service to care home residents.

The centre hosts the Humberside Fire & Rescue Service which provides a falls response team and advice and support for those visiting the ICC. 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 on an ongoing basis.

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

Unplanned Care

A key focus of our efforts to join-up health and care services will be ensuring that citizens across Humber, Coast and Vale are able to access advice, care and support in an urgent or emergency situation. Our aim is that, when needed, everyone within Humber, Coast and Vale will have 24/7 access to information, advice and direct care that will meet their needs and that this will be outside of hospital wherever possible.

We have made significant progress already in laying the foundations for a joined-up urgent and emergency care offer; however, our local populations have told us that the system is still too complex and difficult to navigate. Over the coming five years, we will streamline access to care, with a focus on NHS111 and ensuring this is as effective as it can be at directing people to the appropriate service. By offering more joined-up care and directing people to other appropriate services, we will look to reduce the number of people attending our accident and emergency (A&E) departments in our hospitals by 10%.

Humber, Coast and Vale was one of the first areas in the country to launch NHS111 online, which is improving access to urgent advice and support. We will build on this by making digital consultations more widely available in primary care over the coming year. By March 2020, we will have a single multidisciplinary Clinical Assessment Service (CAS) in place, which will include NHS111, ambulance dispatch and GP out-of-hours service. We will also aim to increase direct booking into appropriate settings to ensure our population have either their need addressed in one call or a clear plan of care for their urgent need by the end of their call to NHS111.

By the end of this year (December 2019) we will have Urgent Treatment Centres in all of our places and offer same-day emergency care in each major A&E departments to ensure that people can have their urgent needs treated and get home as quickly as possible. Working with our ambulance providers, we will enable paramedics to treat more people at home or an alternative place of care such as an Urgent Treatment Centre to avoid unnecessary trips to hospital. Where there is a need to transport a patient we will look to streamline the services and use of alternative settings to hospital, where it is clinically safe and appropriate to do so.

We will also respond more quickly to people who are experiencing distress due to mental ill-health by ensuring that a community and intermediate crisis care response is available within two hours, by next year and over the life of this plan we will move to all of our areas having access to mental health crisis care on a 24/7 basis.

We will ensure that those with life threatening and emergency conditions are transported to the most appropriate hospital setting in a timely way to be treated by the appropriate clinicians, in line with the new clinical standards due to be published in Spring 2020. We are already committed to ensuring that health and care services will be available every day of the week, to deliver the 7-day clinical standards. We will also work to streamline the care that is provided in our A&E departments, to ensure that we achieve the A&E waiting time standard over the lifetime of this plan.

For those people that do end up in our hospitals for treatment, we will focus on ensuring timely discharge, either on the day they arrive, if appropriate, or as soon as possible and is safe to do so after treatment. We aim to increase the percentage of people who are treated and discharged on the same day to 33%. We will do this by planning for discharge from the day they arrive and ensuring services are coordinated inside and outside of hospital. By supporting timely discharge we also aim to reduce stays in hospital for people that stay 21 days or longer.

Over the next three to five years, we will work proactively with care homes and other vulnerable residents to prevent emergency admissions to hospital wherever possible. This will include making better use of home-based and wearable technology to support people in their own homes and identify when people are struggling and provide care before their condition deteriorates. We will also be supporting primary care to provide enhanced care into care homes to help prevent care home residents needing to go to hospital. When people return from a stay in hospital we will do more to ensure they don't 'bounce back'.

Urgent Care Practitioners, York

In the Vale of York, the addition of urgent care practitioners to the local service offer is enabling more people to get urgent treatment and advice at home, saving them from having to be admitted to hospital following an accident or other urgent care need.

Urgent care practitioners are highly skilled paramedics working alongside their Yorkshire Ambulance Service colleagues. They pick up appropriate calls from the 999 emergency and 111 queues; typically those related to falls, minor wounds, patients who have recently been discharged from hospital and those living in care homes. They can prescribe basic medications, treat wounds and provide advice and make referrals for ongoing support. District nursing teams and care homes have a direct dial number to ask urgent care practitioners for advice or to support them with a home visit.

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 having to wait for long periods of time in busy emergency departments, which can be more damaging to their overall wellbeing.

Hospital services for the future

We are working together to carry out two reviews of how acute hospital services are provided in our area: one review is focused on the five hospital sites within the Humber; the other is looking at hospital services for the population of Scarborough and the surrounding areas. Our hospitals face a number of significant challenges, most notably difficulties in recruiting the skilled and experienced clinical staff we need across a whole range of specialties and roles.

Through these reviews we are seeking to make the most of opportunities for our hospitals to work more closely together to share specialist staff, knowledge and expertise and to achieve the scale necessary to provide the best quality of care for patients, whilst enabling as much care as possible to take place as close to home as possible. We want to make working in Humber, Coast and Vale's hospitals an attractive and rewarding career choice to help us recruit the brightest and the best to our area to enable us to provide high-quality services not only now but into the future.

These reviews are ongoing and are tasked with producing recommendations for partners on how to provide the best possible hospital services for the people of Humber, Coast and Vale within the resources (people, technology, buildings and money) that are available. Through the reviews we will continue to develop our understanding of the additional costs associated with operating small and remote hospitals. We will continue to work with colleagues across the country to find new and innovative solutions to these challenges.

We expect both reviews to provide recommendations for a way forward by spring 2020. This will enable us to provide better, more joined-up hospital-based care for those who need to be in a hospital, whilst ensuring those that don't need to be there can get the care they need at or close to home. Ongoing conversations with local people across Humber, Coast and Vale will be critically important to the success of these reviews over the coming years.

Priority 3: Improving the care provided in key areas

We anticipate that, through our efforts to support communities and individuals to take more control over their health and wellbeing, we can improve the overall health of our population and the overall impact of disease and ill-health. Nevertheless, we know that people will continue to need high-quality, safe and effective healthcare services. 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 we get the best possible health outcomes for our population. This will include looking for opportunities to narrow the gap by supporting those with the worst health outcomes in our communities.

Over the next five years we will focus on improving care in the following key areas:

- Cancer
- Mental Health
- Planned Care
- Maternity

In each of these clinical priority areas, we will work together to ensure the population of Humber, Coast and Vale can access the best possible care and have the best possible chance of living a happy, healthy life.

Cancer

Cancer survival is the highest it has ever been in Humber, Coast and Vale. The percentage of people surviving at least one year following diagnosis has increased from 64.5% in 2001 to 71.6% in 2016. However, each week 160 people in Humber, Coast and Vale are diagnosed with cancer; this figure is growing by 2.2% a year, which means there will be an estimated 3,730 additional patients going through cancer diagnosis, treatment and follow-up each year. Too many people in Humber, Coast and Vale have their lives cut short or significantly affected by cancer, with the consequent impact on their families and friends. There are some types of cancer in Humber, Coast and Vale where we fall behind national one-year survival progress, such as lung cancer where our local one-year survival rate is 39.2%, compared with an England average of 41.6%.

Our cancer services are already under enormous pressure and we know that transforming the way we deliver services for our population is the only way to cope with the increase in demand and improve outcomes for our population.

Our Partnership has set a bold ambition to '**deliver world class cancer outcomes for our population**' and accelerate the necessary changes across Humber, Coast and Vale to improve cancer outcomes and quality of life through personalised health and wellbeing support. We will focus our work around four key objectives:

1. Increasing lifestyle choices that minimise the risk of cancer
2. Standardising treatment pathways across Humber, Coast and Vale
3. Improving equity of access to high-quality services for our patients
4. Reducing inequalities in health outcomes through the design of services

More cancers are being diagnosed earlier, which is when treatment is more likely to improve survival. However, in Humber, Coast and Vale in 2017 only 51.2% of cancers were being diagnosed at an early stage and we want to increase this to 60% by 2024.

By working together we will reduce the impact of preventable cancers. We also 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.

However, we know there is significant variation in access to and uptake of screening across our Partnership and we want to improve this. We will work together with local people to design campaign activities that suit the

needs of our local population and ensure that we tailor the approach to reach specific groups, such as people with learning difficulties and those living in more deprived areas where uptake of screening is lower. An example of this is the lung health check pilot programme which is currently under way in Hull. This was identified as the area with greatest need in our Partnership and we intend to expand into other areas where inequalities exist over the next four years.

In addition to increasing screening we also need to transform the way we manage vague but concerning symptoms to ensure patients who do have cancer are diagnosed faster and those who don't get the reassurance they need quickly.

In Humber, Coast and Vale the majority of cancers are still found following a non-cancer specific referral or when an individual presents as an emergency to one of our hospitals. Across the Partnership we are looking to introduce a single point of access to diagnostic services for all patients with symptoms that could indicate cancer. This rapid diagnostic approach would provide a personalised, accurate and timely diagnosis of patients' symptoms by integrating existing diagnostic services with clinical expertise from a wide range of disciplines and information locally. This will build on work we are already undertaking across our Partnership to connect diagnostic services, such as radiology and pathology, which is helping us to make better use of existing resources in our organisations to provide faster responses for our population.

Following diagnosis the majority of our patients are receiving treatment in a timely manner; however, some are still waiting too long. As a Partnership we will continue to deliver improvements with the aim of achieving all the required performance standards by March 2024.

With improvements in survival, more and more people are living with and beyond their initial cancer diagnosis. This is currently the case for around 53,000 people across Humber, Coast and Vale. Many people face long-term difficulties such as worry and depression, concerns about money, family and relationship issues as well as dealing with the physical effects of cancer. Our aim is to provide personalised care and support to people affected by cancer through better coordination and signposting to services already based within communities.

Cancer Champions

One of the ways in which we are helping to ensure more cancers are diagnosed earlier is through our Cancer Champions programme, which is equipping local people to take on cancer in our area. Cancer Champions are a key part of our strategy to share knowledge across our communities, improve screening rates and empower people to seek help early. Since the programme began in September 2018, 1,572 local people from all walks of life have now taken part in the training.

With research showing that four in 10 cancers are preventable, over 1,500 Cancer Champions in Humber, Coast and Vale now have the knowledge to raise awareness about early signs and symptoms, promote healthy lifestyle choices and increase uptake of screening in their communities. The free training supports people to openly talk about cancer with their friends and family, which could minimise the risk of cancer and improve survival rates by helping those with cancer get diagnosed and treated earlier.

Mental Health and Learning Disabilities

We want to change the conversation around mental health in Humber, Coast and Vale. As a Partnership we will work to ensure our local populations know how to manage their own mental health and to know how to access local support when they need it. For people experiencing a mental health crisis, we will develop a system of support that acts quickly, recognises their needs and draws on our collective teams to respond appropriately. Our services will work together more closely than ever before and will focus on the needs of the person they are supporting rather than organisational or geographical boundaries.

By working together in this way, our aim is that:

- People feel more emotionally resilient and recognise the signs when they or a friend/family member may need support with their emotional wellbeing;
- People know how to access support with their mental health locally;
- Stigma around mental health is reduced and people feel able to talk more openly about issues that affect their mental health;
- People can access the support they need within their own communities, without the need to travel long distances.

Investing in mental health services

Historically there has been a lack of investment in mental health services across the country and in the past people with mental health conditions have not always been treated with the same urgency or status as people with physical health conditions. There is now a strong focus, both nationally and locally, on ensuring mental and physical health conditions are treated with the same level of importance. Our plans for mental health will see us significantly increasing investment in mental health services across Humber, Coast and Vale. Over the period of this plan, our investment in mental health care and support will rise by an average of 4% year on year, reaching the required 'Mental Health Investment Standard' in all six of our places in each year of this plan. Investment in children and young people's mental health services will grow fastest as we prioritise our efforts to ensure every young person gets the best start in life and is able to fulfil their potential.

This will be supported by new ways of working, such as a provider collaborative, which will bring together organisations providing mental health services and give them more freedom to innovate and develop new services that will better meet local needs. In Humber, Coast and Vale our provider collaborative will take on responsibility for commissioning and delivery of three specialist services, which are currently commissioned at a regional level. The specialist services currently included are adult secure services, a range of children and adolescent services and specialist eating disorders services.

Prevention and early intervention

We know how important it is that people who experience problems with their mental health receive the right support and guidance at the earliest opportunity. This requires good levels of mental health awareness among staff and the general public but also strong collaboration between system partners to ensure that information is shared across mental health pathways.

In Humber, Coast and Vale we will focus, in particular, on consolidating and embedding our partnership approach to suicide prevention. Through focused community engagement, collaboration with voluntary and community sector partners and effective campaigns, we will enhance the knowledge and skills of our local communities and wider workforce. We will work to reduce the stigma attached to talking about suicide, to support those affected or bereaved by suicide and to promote suicide safer communities. We aim to see a reduction in suicide rates in Humber, Coast and Vale by 2020/21, in line with the national zero suicide ambition. In addition, we will ensure those who are bereaved by suicide are offered timely information and support by an appropriate bereavement service within 72 hours, by next year.

Community support

In line with what our communities are telling us, we are working to simplify access to mental health services so that it is easier for people to get the help they need when they need it. The additional investment in mental health services across the Partnership will enable us to improve services within local communities to make them more responsive and better integrated with our specialist inpatient provision for a wide range of people with mental health needs.

We want to enable as many service users as possible to access the support they require within their own communities and to be able to transition between inpatient and community-based services more effectively. Humber, Coast and Vale has been selected as one of 12 national pilot sites to more closely align community-based mental health teams to our emerging Primary Care Networks. This will connect professionals within our teams better and create a more seamless local service.

By 2020/21, people who require it will receive the appropriate support from Community Mental Health Services within four weeks from referral to treatment across Humber, Coast and Vale.

We will put in place additional support for people with long-term or enduring mental health conditions. Starting this year, we will put in place targeted support to enable people with a mental illness to access employment opportunities and retain employment. In addition, people on our forensic pathways will be able to access support in the community via forensic outreach liaison services (FOLS) as close to home as possible, where clinically safe to do so, by 2020/21.

We are also working to improve support for people living with dementia in our Partnership. We are actively engaging with people with dementia and their families and carers to improve the support we offer and working to increase dementia diagnosis rates by 2020/21 through increasing awareness and improving the support we offer to people following a dementia diagnosis.

Supporting People Living with Dementia, North Yorkshire

In North Yorkshire, local partners have come together to improve the support for people whose lives are affected by dementia, working with local charity Dementia Forward. Following the success of the service in the Vale of York and Harrogate areas, it was made available across the rest of North Yorkshire in April 2019

The aim of the service is to help people living with dementia and their family, friends or carers to feel empowered and informed so that they have choices following their diagnosis. Information, advice and support is provided through a wide range of local services, including a North Yorkshire Helpline; home visits from a trained dementia support advisor; signposting to other sources of help; education programmes and a range of wellbeing and social activities.

One of Dementia Forward's most popular activities is singing. Two members from one of their groups told us: "We started in January. David was diagnosed last year and a Dementia Support Advisor from Dementia Forward came out to see us and she told us about all the different support and activity groups. David loves it and looks forward to it – now he can't drive and you're very restricted when you have dementia. We've never gone out singing or done anything like that but it's really good isn't it?" and "It lifts you up and you look forward to coming."

Help in a crisis

We will make further improvements to care for people who have urgent mental health needs to ensure people have support in a crisis. This will build on the successful implementation of crisis cafes (in York, Scarborough, Hull and Grimsby) and other alternatives to A&E that are already in place across the Partnership, as well as schemes such as the Frequent Attenders Service (in Hull and East Riding), which has shown an overall reduction in A&E attendances of 37% in the identified cohort of patients (during 2018/19). We will expand crisis services and put in place a single point of access in all areas to ensure that everyone within Humber, Coast and Vale will have access to 24/7 urgent and emergency mental health assessment and intensive home treatment by 2020.

Children and young people

We want every child and young person to thrive and so we are working to put in place support that is less rigid and able to respond more quickly to the needs identified by children, young people and their families. Humber, Coast and Vale will be amongst the first partnerships in the country to adopt a new approach to commissioning children and young people's mental health services, which will enable us to secure funding and expertise from all of the different organisations involved to put in place streamlined services that work for our young people.

By working together in this way we will ensure that, by 2020/21, children and young people with mental health issues will be supported by services that are working to a consistent outcomes framework (aligned to the thrive model) that applies to both inpatient and community services, therefore improving transition between care settings.

To ensure every one of our citizens can get the best start in life, we are also investing in supporting new and expectant mums and their families. Working in partnership, we have put in place specialist perinatal mental health services across the whole of Humber, Coast and Vale. Around 4.5% of the relevant population are currently accessing those services; we will seek to increase this to around 7% in 2020/21. In addition, we will build on our recently launched Every Mum Matters campaign, working with local women and their families to raise awareness and increase understanding of perinatal mental health issues to encourage local women and their families to seek help when they need it.

Learning Disabilities and Autism

Our ambition is to ensure that people with learning disabilities and/or autism in Humber, Coast and Vale have the same level of health and wellbeing as the wider local population and that they are not disadvantaged because of their learning disability or autism. We will work with people who are experts – those with learning disabilities themselves – to address the inequalities that exist which lead to people with learning disabilities and/or autism having worse health outcomes overall.

We recognise that we need to ensure the right support is available for people with autism or who have learning disabilities across all of our programmes of work, not just within specific learning disability services; this is reflected throughout this plan.

In Humber, Coast and Vale, we are working together to agree a common set of standards regarding autism and learning disabilities that will be applied in each of our local places and across all of our services to ensure greater consistency in the services we offer. We will do this by working with people who have autism and/or learning disabilities to:

- design, develop, buy and evaluate services alongside professional and clinical staff;
- develop further plans, capturing the voice of local people to describe why and how we are seeking to improve outcomes through participation and involvement in focus groups, to ensure diverse opinions are sought;

- co-facilitate training - for example making reasonable adjustments in health care and raising awareness of the standards expected of all services.

Through the work of the Transforming Care Partnerships, we will ensure we continue to support people with learning disabilities and/or autism to live at home or as close to home as possible and continue to reduce the number of our residents who are living out of area.

We will improve the accessibility of health prevention messages through co-production with people with learning disabilities. This will focus initially on respiratory conditions and cardiovascular disease because these have been identified as the areas that most commonly lead to premature death in people with a learning disability. We will also work to increase uptake of the annual health check and improve support for expectant and new mums who also have a learning disability.

Planned Care

A new model of care

Each year 1.6 million outpatient appointments, more than 200,000 diagnostic scans, and around 220,000 planned surgical procedures take place across Humber, Coast and Vale. That equates to nearly two hospital visits per year for every person in Humber, Coast and Vale.

Our ambition is to completely redesign how we deliver planned health care to improve the experience for patients and make better use of our specialist staff. We will move away from the traditional outpatients' model where patients typically have to make multiple visits to hospital, often over a protracted period of time, to get advice, undergo diagnostic tests, receive test results, discuss potential treatment options and undergo planned treatments or procedures. Many people, such as those with long-term conditions, also attend scheduled follow-up appointments, though not necessarily at the time when they need them most.

Over the next five years we will work to turn this model on its head so that services can respond more quickly to the needs of our local populations, waiting times are reduced and unnecessary trips to hospitals are avoided.

We will make it easier for people to access expert advice early to help them look after themselves, supported by the use of trusted websites, wearable devices and approved apps. GPs and others working within primary care will be able to request expert opinion and advice from specialists without necessarily having to refer patients to hospital so more people can be treated closer to home. Where specialist referral is required or where ongoing specialist care is needed, more consultations will be available 'virtually' so not all patients have to attend hospital sites. Where patients, such as those with long term conditions, need follow-up care more will be able to request advice when their condition changes rather than waiting for scheduled review appointments. In addition, we will continue to increase the number of procedures done as day cases in hospital and in local clinics so fewer people need to stay overnight in hospital.

Digital developments will support this change by providing shared clinical records so that everyone directly involved in a patient's care will have access to the information they need; increasing the use of apps and trusted websites to allow access to advice and remote monitoring; utilising

technology to support virtual consultations, including video; and using email and text messages to communicate with patients, where that is their preference.

Through this shift our ambition is to reduce face-to-face outpatient appointments by a third (or around half a million appointments), reducing the impact on patients having to travel and freeing up our doctors, nurses and other specialists to respond to their patients when they need advice and reduce waiting times for treatment. Each of our sub systems have identified priority areas based upon local need and identifying the areas where we can make the biggest difference most quickly. Common priorities include cardiology; ear, nose and throat (ENT) services; and urology. We will work together across the Partnership to share the experience and learning as we put changes in place. Changes will include reducing unnecessary follow-up appointments, where they don't add value to patients, switching many more existing appointments to virtual appointments (including phone calls) and increasing the proportion of appointments that are initiated by patients.

We will work proactively to manage waiting lists to ensure than no one within Humber, Coast and Vale waits more than 52 weeks for treatment. Over the next five years we will work towards reducing waiting times including, as guidance is issued, implementing a planned NHS managed choice process for all patients who reach a 26-week wait. In addition, we will focus on areas such as ophthalmology where delays in follow-up appointments can result in a risk to quality and patient safety and impact on patient outcomes.

Musculoskeletal services (e.g. back and joint pain)

One of the areas where we are changing our service model to make it work better for patients is in services for back and joint pain, known as musculoskeletal (MSK) services. We will ensure that our services are following national best practice guidelines (the National Back and Radicular Pain Pathway) across all of Humber, Coast and Vale by 2023/24. This approach provides consistent information and advice, including through digital routes, so that all our residents can access advice they can trust. For those people with existing chronic back pain it aims to support them to become less reliant on pain-relief procedures and long-term analgesia, especially opioid-based painkillers.

This approach is also supported by enabling patients experiencing back or joint pain to go directly to see specialist physiotherapists, known as First Contact Practitioners, within local health centres without having to see a GP first. This service is already in place in parts of our Partnership, including East Riding where services were part of the national pilot in 2018/19. Taking account of local workforce challenges in MSK services, we will work with our Primary Care Networks to ensure everyone across our Partnership has access to a First Contact Practitioner by 2023/24.

First Contact Practitioners, North Lincolnshire

Following on from the success of the national pilot programme in East Riding of Yorkshire, our other places have begun implementing similar approaches for their local populations. North Lincolnshire launched its *First Contact Physio* service in March 2019, which is available to all North Lincolnshire residents by contacting their usual GP practice.

Around one-in-five people book in to see their doctor with a musculoskeletal problem, and often have to wait for a GP referral to get access to physiotherapy advice for such conditions. Now more people are able to access the relevant professional for their care directly, allowing them to start the right treatment sooner so that they are able to stay in work or resume their day-to-day activities. The expertise of physios in these roles means fewer patients are left waiting for a referral or unnecessary tests such as x-rays.

Each appointment with a physiotherapist varies significantly depending on what the issue may be – it could be as simple as discussing lifestyle changes and signposting someone to local exercise providers or referring for diagnostics and potential surgery.

Addressing major health conditions

We will also work to reduce the impact of major health conditions on the quality of life of our populations, with a particular focus on addressing inequalities within and between communities. Over the next five years, our Partnership will make a concerted effort to improve the life chances of our local people by increasing our focus on preventing disease and by supporting those with long-term health conditions to access treatment early and manage their conditions well. This will also reduce pressure on local services by reducing the number of emergency admissions to our hospitals. We will focus on three areas where we believe we can make the biggest difference: diabetes, cardiovascular disease (heart disease and stroke) and respiratory (lung) conditions.

Diabetes

It is estimated that around 8.5% of the adult population of Humber, Coast and Vale is living with diabetes. One fifth of hospital admissions for heart attacks or stroke are in people with diabetes and treating diabetes accounts for around 10% of the overall NHS budget. Reducing the number of people developing diabetes and supporting those who have it to manage their condition well is therefore a high priority for the Partnership over the coming five years.

We will continue to improve our offer of support to those in our communities who are at risk of developing Type 2 Diabetes, through implementation of the National Diabetes Prevention Programme (NDPP). To date 2,775 have taken part in the programme, which supports people at risk of developing Type 2 diabetes to lose weight and improve their general health. We will offer the opportunity to take part in the programme to 2,582 more people by July 2020 and a further 5,221 places will be offered through to August 2023. We will also focus on increasing the number of people who are already living with Type 1 and Type 2 diabetes to achieve the three recommended treatment targets and ensuring they can access specialist advice to support their own care to manage their diabetes and reduce complications (e.g. amputations).

Cardiovascular Disease (CVD)

Public Health England estimates there are 72,530 people in Humber, Coast and Vale with undiagnosed hypertension (high blood pressure), which can lead to heart attack or stroke. We recently launched the Humber, Coast and Vale Healthy Hearts website, which provides information and support for people in our area to reduce their risk of developing CVD. Our focus over the period of this plan will be to build on initiatives such as this to increase awareness and detection of hypertension, atrial fibrillation (irregular heartbeat) and high cholesterol as well as treating tobacco dependency so that we can prevent up to 4,500 CVD events, including 780 strokes and 260 heart attacks. We will also prioritise work towards putting in place consistent access to community cardiology and heart failure services for our population.

Respiratory

Within Humber, Coast and Vale we spend £83 million more than similar areas on admissions and £2.5 million more on prescribing for respiratory conditions and it is one of the leading causes of death in our area. We will focus on improving outcomes for our population by increasing uptake of flu and pneumococcal (PPV) vaccines, optimising the diagnosis and treatment of COPD (chronic obstructive pulmonary disease), improving treatment pathways for patients with pneumonia and those in pulmonary rehabilitation. By supporting people to manage their conditions better, through the use of digital apps, wearable technology and more responsive advice and support from healthcare professionals, we can reduce the likelihood they will need to be admitted to hospital in an emergency.

Medicines usage

The ambitions for planned care are underpinned by ensuring medicines are used in the most effective and efficient way, including supporting patients to use them correctly, to improve patient outcomes and reduce unnecessary prescribing. In particular, this includes working to reduce the number of medicines prescribed to people with learning difficulties and/or autism and supporting GPs, nurses and hospital doctors to reduce the amount of antibiotics and opioids prescribed.

Maternity

In Humber, Coast and Vale 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.

We will continue to offer care that prioritises safety and ensuring a good outcome for mothers and their babies. Through targeted prevention work and, in particular, implementation of the Saving Babies' Lives Care Bundle (Version 2), we aim to reduce the rate of stillbirth by 20% by the end of 2020/21, and by 50% by 2025, the rate of neonatal death, the rate of maternal death by 35% by the end of 2023/24 and the rate of brain injury that occurs during or soon after birth by 50% by 2020/21. We also aim to see a reduction in pre-term birth rate from 8% to 6% by 2025.

In line with what women have told us is important to them, we are working to ensure that many more women and their families will have continuity of the person caring for them during pregnancy, birth and after their baby is born. This will usually, but not always, be the woman's named midwife. Since we began working together as a Partnership, there has been a focus on specific groups of women who need support during their maternity journey and many of these now receive care from the same small team of midwives for the duration of their care. Overall around 15% of women within Humber, Coast and Vale now receive this type of care and we are expanding this across our region. By 2021, we will ensure that more than 50% of women in Humber, Coast and Vale will have continuity of the person caring for them throughout their maternity journey.

We are working with service users through our Maternity Voices Partnerships to improve the quality and accessibility of local information, to ensure that women in Humber, Coast and Vale know about their choices in pregnancy and are able to make an informed choice about where to give birth to their babies. Our aim is that the availability of more choice with respect to local birth place options will result in more women giving birth outside of an obstetric-led unit. By 2020, we hope that around 4% of women will give birth at home (up from 1.1%), 4% of women at a free-standing birth centre (up from 2%) and 20% of women at an alongside birth centre (up from 9%).

In addition to the areas highlighted above, we are prioritising work to reduce rates of smoking in pregnancy, which are significantly above the national average in five out of our six places and above the national target in all six. We will adopt a personalised approach, working through our 'continuity of carer' midwife teams in communities where smoking rates are highest, to provide positive and effective support for women and their families.

In addition it is essential that we work with parents and specifically mothers to support them through healthy pregnancy; prevention work is vital in all areas including increasing breast feeding, reducing alcohol, preventing obesity and linking to existing child health programmes.

Our efforts to transform maternity care will be underpinned by improvements in digital technology with links to the system-wide roll-out of easy access to patients' own digital records described later. We will improve the amount and quality of information available to women, including through online platforms and, by 2023, all maternity records will be digitised and linked to digital red books for children.

The Ivy Team, Beverley

The Ivy Team commenced a midwifery continuity of carer model on 26th November 2018. This meant they began working in a totally different way to support a group (caseload) ofwomen throughout their whole maternity journey, incorporating antenatal check-ups, the birth itself and follow-up care at home afterwards.

They are a team of eight motivated midwives who carry a team caseload based on the Royal College of Midwives guidance. The team provides total midwifery care for women living in a designated geographical area and have birthed almost 200 babies to date.

The home birth percentage of women on their caseload is currently 10%, compared with the overall hospital percentage of 1.6%. They have achieved this 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. They recently supported three babies to be born at home in a five-day period.

Quality

Maintaining and improving the quality of health services for the population of Humber, Coast and Vale remains a priority for our Partnership. Quality means different things to different people. At its simplest, quality is defined as care that is safe, effective and provides a positive experience, wherever possible. The definition of quality includes three key areas:

- **Patient safety:** high quality care, which is safe, prevents all avoidable harm and risks to the individual's safety; and having systems in place to protect patients;
- **Clinical Effectiveness:** high quality care, which is delivered according to best evidence as to what is clinically effective in improving an individual's health outcomes
- **Patient Experience:** high quality care, which aims to deliver positive patient experience ensuring patients are treated with compassion, dignity and respect.

Maintaining and improving the quality of our services continues to be a challenge due to rising demand and the requirement to ensure value for money in the delivery of services. We need to work collaboratively to secure long term quality improvement for the population. Our approach to quality focusses on:

- **Assuring the quality of services** through strengthened governance. This will include: strengthening quality governance boards and quality and safety groups; reviewing board assurance frameworks; undertaking quality impact assessments; consistently monitoring quality, for example, through quality dashboards that focus on deteriorating patients, quality assurance provider visits and utilising national early warning scores.
- **Learning from experiences** by learning from complaints and incidents and ensuring that the voices of patients, carers and families are heard and their experiences shared locally and across our Partnership to improve the quality of services.
- **Collaborative working** within and across organisations to deliver improvements.
- **Focusing on specific areas for improvement** making quality central to service change through the development of improvement plans for areas identified for specific focus.
- **Ensuring quality is integrated** into all aspects of activity.

There are some specific service areas where we know we have more to do to improve quality; these include planned care follow-up appointments, particularly in ophthalmology, and the transfer of patients that arrive by ambulance at our accident and emergency departments. In addition, our three hospital trusts are all rated as 'requires improvement' by the Care Quality Commission (CQC).

We will look to strengthen and improve our approach to and delivery of quality over the period of this plan. Quality and Safety is an area we have identified for further work over the next four months, as set out in the final chapter of this plan. In addition, in Appendix 5 – How we will develop our Partnership, we also set out information on clinical engagement and quality improvement as two key areas we are focussing on. This will enable us to develop further detail around how, specifically, our ambitions to improve quality will be achieved and when certain changes will take place.

Priority 4: 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. For example, it is becoming increasingly difficult to ensure all patients can access diagnostic tests and begin treatment in a timely manner due to ageing diagnostic equipment and shortages in trained staff. Additionally, our dispersed, rural population makes delivering home care more challenging and makes transport to and from healthcare provision difficult for citizens as well as professionals.

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 and communities to improve their health and wellbeing. Our region boasts some of the most beautiful countryside England has to offer, 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 our citizens can all ***start well, live well and age well***.

People

Our people are our biggest asset and we cannot deliver effective health and care services or improve the wellbeing of our populations without them. This includes the huge variety of professionals who undertake clinical, caring and managerial roles within our health and care services as well as the carers, volunteers and community activists who give their time to support loved ones or to make voluntary contributions to the success of local services and community initiatives.

In Humber, Coast and Vale recruiting and retaining sufficient numbers of health and care staff presents a significant challenge. We have an ageing workforce, gaps in skills and workforce numbers and we often find it difficult to attract people to roles in our region. Because of these challenges, supporting, retaining and diversifying our current workforce are key priorities for us.

Across the Partnership we have specific shortages of people with the right skills and experience in a number of areas or staff groups. These include:

- Appropriately qualified care staff
- Experienced social workers
- Diagnostic staff (radiography, endoscopy and sonography)
- Medical staff (doctors) in ED, acute assessment and surgical specialities
- Medical staff in primary care (GPs)
- Paramedics
- Registered nurses (across all settings including social care)

As a Partnership we are working with key partners to make progress with closing some of these gaps by proactively investing in, nurturing, training and educating the current and new health and care workforce to provide flexibility and adaptability as well as and working together to attract new recruits to our area. We are increasing the numbers being trained through our medical school, universities and colleges. For example, we recently secured the single largest increase in medical training places in the country so that, from this year, Hull and York Medical School will train 220 new doctors per year, compared with 130 in 2017. We will continue to increase the training and deployment of new roles, including advanced clinical practitioners, physician associates and trainee nurse associates, to work alongside our existing clinical and professional workforce.

We are developing plans to 'grow our own' by promoting the opportunities that there are to work in health and care with younger people through closer working with schools and colleges, using the apprenticeship levy and by widening participation and encouraging those who would not necessarily have thought of a career in health and or care was possible because of their qualifications to take up education placements. In addition, to attract new and support our existing people we are developing career pathways across health and care with the initial focus on our valuable support level workforce. Similarly, we will do more to improve volunteering opportunities for local citizens who make an invaluable contribution to many aspects of health and care in our area. This work will also be supplemented by a continued focus on international recruitment of doctors and nurses to support teams today.

Our Partnership recognises that, without the contributions of those who provide care and support to loved ones on a daily basis, our services would quickly become overwhelmed. We will do more to support carers and ensure they have the skills, knowledge and help they need to enable them to continue caring for their family members and friends and also to ensure their own needs are met. We will seek to raise the profile of carers and caring to ensure our services and wider communities are more sensitive to the needs of carers and adapt accordingly.

We want Humber, Coast and Vale to be a great place to work for those people currently working in health and care in our area and we want to offer a vibrant employment environment for those considering a career in our area. This also means ensuring that the people delivering health and care services are representative of the people we serve, including ensuring black and minority ethnic staff are represented in leadership roles. In addition, we are working with our Local Enterprise Partnership's to not only promote the places, sub systems and wider partnership area as a great place to work but also in addressing the barriers to employment experienced by those who have health conditions and or disabilities.

In November 2018, through working with partners and wider stakeholders, we produced our Partnership Workforce Plan. It set out our Partnership goal which is to have **resilient people working across health and care** in Humber, Coast and Vale, that feel sufficiently motivated, supported, empowered and equipped to deliver safe and effective services, drive sustainable improvements and positively influence the health and wellbeing of the population.

If we are to achieve this ambition we need to work together and take the opportunity given to us in the interim NHS People Plan to take greater ownership and leadership of our people agenda as a Partnership. This will require us to look at our investment and undertake planning in a way which has never been done before in Humber, Coast and Vale to ensure that our biggest asset, our people, are aligned to the ambitions set out earlier in this plan. Some of this work has commenced in our six places and three sub systems and we will look to build on this over the next four months alongside our priority programmes to further develop our people plans.

The Workforce of the Future

Over the last 18 months, we have been working together to develop new roles within our workforce to support existing doctors, nurses and therapists and provide care that meets the needs of our population. In particular, we have supported the training and recruitment of 159 advanced clinical practitioners and 40 physicians associates into Humber, Coast and Vale, with a further 43 positions currently being recruited to.

Both roles are relatively new to the health and care workforce but in Humber, Coast and Vale our new recruits are already making a huge difference and enabling more people to access care and support more quickly. The roles are deployed in the delivery of services in our hospitals, primary care, community care and mental health providers and have in some places in our partnership been established on a rotational basis across providers.

The following passage is written by one of our physician associates.

“Being one of the first qualified physician associates to work in Hull, I wondered how people would react to this new role. It was pleasing to see the warm reception from patients and staff alike. During our training, we rotate around different specialities including paediatrics, surgery, and acute medicine to name a few. This exposure, combined with our transferable skills we acquired in academic life, equip us to complement existing multi-disciplinary teams to provide patient-centred care. We are not prescribers, but can complete all aspects of patient care in collaboration with a doctor.

“Physician associates are able to provide continuity in our care, be it on a ward or in general practice. The immense trust that we are able to develop is hugely gratifying and fuels my ambition to succeed in my career.”

Technology

Digital technology and innovation offers incredible opportunities to improve the health and wellbeing of our population as well as to improve the efficiency and effectiveness of the services we provide. Better digital infrastructure will be critically important to enable many of the changes set out in this plan, such as improving digital access to primary care and transforming how we deliver outpatient clinics. New technology can also be deployed to help people to improve their own health and wellbeing and to treat ill-health in new ways.

To make the most of these opportunities over the next five years, we will focus on:

- Sharing information and ensuring our digital systems talk to one another;
- Upgrading basic infrastructure to support the changes set out in this plan;
- Using technology to increase access to care and support wider wellbeing;
- Fostering innovation to tackle challenges in new ways.

Sharing Information to Improve Care

We know from engagement with patients, particularly those with long-term conditions or ongoing healthcare needs, that their experience of treatment and care would be significantly improved if up-to-date information about their treatment was available to all the professionals involved in their care. Addressing this challenge will be the top priority for our Partnership over the period covered by this plan. We have made significant progress already by joining up some key clinical systems and increasing the use of the enhanced Summary Care Record, which enables sharing of some basic information across all care providers.

We have an ambitious plan, working with partners across Yorkshire and Humber, to develop the **Yorkshire and Humber Care Record** over the next five years. Our vision is for all our health and care services and teams in Humber, Coast and Vale to have secure and role-appropriate access at the point of care to the Yorkshire and Humber Care Record. This will provide a single point of truth about the full spectrum of care delivered to our patients.

Yorkshire & Humber Care Record

Over the last 10 months we have made significant progress in a very short space of time. We have connected 57 GP practices to the technology enabling them to share information through the Yorkshire and Humber Care Record. Over the next year our focus will be on connecting our three main acute hospital providers and continuing to link up the remaining GP practices. We have also recently put in place an Electronic Palliative Care Coordination system to support the sharing of end-of-life care plans and preferences across all provider organisations in the York and Scarborough area. End of life records will be able to be viewed within the Yorkshire and Humber Care Record, which will provide a single point of truth and seamless care across GPs, hospitals, hospices, ambulance service and specialist services.

The Yorkshire and Humber Care Record will also enable us to do more to understand the health needs of our population. We are investing in the latest technology to enable us to make sense of the vast amount of anonymised data our organisations currently hold in order to plan services that more closely match the needs of local people. This work will be underpinned by a robust approach to data protection and cyber security.

Linking Systems and Sharing Information

As a key building block for the wider Yorkshire and Humber Care Record, local organisations came together to improve record-sharing within the Humber area. The Supplier-Led Interoperability Pilot (SLIP) was launched across the Humber area in February 2019. This project enables the two main patient record systems used within primary, community and end-of-life care settings across the region (EMIS Web and SystmOne) to share information for the first time. This improves the safety and the quality of care for people accessing a number of services, including out-of-hours GP appointments, community nursing and end-of-life care.

This development makes Humber, Coast and Vale the first region in the country to successfully link these two widely used clinical systems. This project has enabled the sharing of the records of 275,000 citizens (around 30% of the Humber population) that were previously not able to be shared with any other systems. This will not only improve the standard of care for our patients, but will also make better use of our clinicians' time. It's the first step towards a wider ambition to provide a fully-joined up digital care record across all health and social care providers.

This sharing capability will, in time, be integrated into the broader Yorkshire and Humber Care Record which will give citizens, clinicians and other professionals appropriate access to a single, accurate and up-to-date health and care record.

Improving Access

As set out in earlier sections of this plan, improvements in digital technology will be a vital enabler to ensure we can improve access to primary care and outpatient services, making more effective use of clinicians' time and enabling greater flexibility in the services offered.

New technology, such as wearable devices and clinically-approved apps, can support people within Humber, Coast and Vale to manage their health conditions and improve their overall health

and wellbeing. For example, the Moodbeam wearable mood tracker, which has been developed by a local tech start-up in our area, is being trialled by some of our partners. The wearable device focuses on capturing and making sense of mood, in an effort to support people to better understand how they feel and have more meaningful conversations with loved ones. We recently launched the Orcha app store across the Humber region. This resource enables our doctors to recommend the most effective, clinically-approved apps to local patients and is widely available to the public; enabling them to select apps they know they can trust.

Over the next five years, more people will be using technology to help them stay well and independent at home. With more and more technology we need to be careful to also ensure that people feel comfortable with this change and are able to share in the benefits it brings. We will aim to make digital as easy as possible for everyone whilst recognising the importance of maintaining face-to-face interactions.

Fostering Innovation

We will work hard over the coming five years to create permission and space for new ideas to be developed in order to tackle the significant challenges we face. Innovation goes far beyond just technological change and in all aspects of our work we will seek to foster new ideas and innovative ways of tackling challenges. In particular, we will support digital innovation through initiatives such as the Humber Care Tech Challenge and the Propel@YH programme, which is supported by the Yorkshire & Humber Academic Health Sciences Network. Working with colleagues across Yorkshire and Humber we are also seeking to become one of the UK's first Digital Innovation Hubs.

Collaboration across Yorkshire and Humber

Our Partnership recognises that there are benefits to working on a large scale when it comes to digital technology and we are therefore are working closely with neighbouring Partnerships in West Yorkshire and Harrogate and South Yorkshire and Bassetlaw to maximise the impact of our investments.

We have agreed that we will work together on the following areas that are common priorities to all three of our Partnerships:

1. Develop our health and care, business and professional leaders to understand how digital enables transformation;
2. Support all our citizens to benefit from digital innovation, ensuring we design for inclusion;
3. Enable our workforce to effectively use digital services to do their jobs;
4. Integrate with, use and leverage maximum benefit from the Yorkshire and Humber Care Record;
5. Adhere to a common set of digital principles and standards.

In particular, we have committed to making the most of the Yorkshire and Humber Care Record technology by agreeing to a common set of principles and standards that all future digital investments will have to comply with. This will help to ensure that all future digital systems are compatible with the connected infrastructure we are developing through the Yorkshire and Humber Care Record programme.

Buildings

This plan sets out our ambitious plans for improving local services through transformation and working together. However, the condition and design of some of our buildings and infrastructure is holding us back from delivering the scale and pace of change that we aspire to. Over the next five years and beyond, we will be seeking significant additional investment in buildings and equipment to enable us to make the changes we have set out in this plan.

Our Partnership Estates Strategy was developed in July 2018 and refreshed earlier this year. It sets out our ambitions in three key areas:

- Making better use of existing buildings, including reduced running costs and increased sustainability;
- Rationalisation of the estate and commercial disposal of surplus land and buildings;
- Development and replacement of our buildings and equipment to ensure business continuity and facilitate service transformation.

Making best use of our buildings

Over the last 12 months we have reduced our overall estates running costs and reduced the proportion of our buildings that are either unoccupied or used for non-clinical purposes. Our ambition is to achieve or improve upon the Carter metric targets in these key areas over the coming years.

Sustainable Development Management Plans have been drawn up and are being implemented at sub system level. In accordance with these plans, new combined heat and power plants have been installed at six hospital sites across Humber, Coast and Vale. These investments are delivering both recurrent revenue savings and reductions in CO_2 emissions that are enabling host Trusts to meet environmental targets. Further developments of this type have been planned and will go ahead subject to business case approval and confirmation of financing arrangements.

Rationalising our estate

Our Partnership is making good progress in implementing its plans to dispose of land and buildings that are no longer required, with over 32% of scheduled disposals having already been completed. On the basis of the progress made and new opportunities that have been identified, we have increased our targets for commercial disposal of land (an extra 14.96 hectares at a value of £1.28 million) and provision of additional housing (247 extra units). Further opportunities are being explored including one large plot of surplus land that would support the provision of 400 additional houses and generate a significant additional financial receipt.

Backlog Maintenance

The age and condition of many of our buildings continues to present major challenges for the Partnership. Some of our larger buildings are nearing end of life and will need to be re-provided during the period of this plan. In addition, key infrastructure in important clinical areas is also

nearing end of life and will require large scale re-provision. Despite the investments that are being made using provider capital allocations and realisation of benefits associated with the disposal of surplus buildings, our overall backlog maintenance value increased by £19 million in 2018/19 to a total of £127 million. A significant proportion of this (£65 million) represents high-risk maintenance requirements. Over the coming years these figures need to be reduced significantly to address the risks that we are carrying in relation to service quality, safety and business continuity.

Base Case Capital Investment Plan

Partner organisations have developed base case capital investment plans that are aligned with confirmed or anticipated capital funding allocations. These plans focus on essential investments into statutory compliance and backlog maintenance works, replacement of essential items of medical and scientific equipment and re-provision of basic IT infrastructure. Our confirmed and anticipated capital funding allocations are limited and there is very little scope to increase these over the next few years through additional provider borrowing. As a consequence, some essential larger scale developments are not covered in our base case capital investment plan.

Current Developments

Our Partnership has been successful in securing capital funding through the Wave 3 and Wave 4 STP capital bidding exercises. Under Wave 3, funding of £8.2 million was secured to support the development of a new Tier 4 children and adolescent mental health inpatient facility in Hull. Building work is nearing completion and the new facility will open before the end of the calendar year.

Under Wave 4, funding of £88.5 million was secured to support the development of urgent and emergency care and diagnostic facilities at four of our hospital sites. This programme of development is critical to the successful implementation of our plans to transform urgent and emergency care services and improve our performance against national cancer targets. This includes the expansion of same-day emergency care models as well as our ambitions to reduce waiting times for a range of diagnostic procedures, including CT, MRI and endoscopy. Planning work on the Wave 4 programme is ongoing. Subject to satisfactory progress being made with the preparatory planning and business case approvals process, it is anticipated that construction work on the Wave 4 schemes will start in the latter half of 2020.

Additional Capital Investment Requirements

Our Partnership has identified a number of essential, large scale developments that cannot be managed as part of our base case capital investment plan because of the size of the investment required. Two of these developments will require capital investment in excess of £100 million and were therefore referenced specifically in our refreshed Estates Strategy earlier this year:

- A large scale investment (around £140 million) is required to enable the re-provision of clinical accommodation (including inpatient wards and theatres) from the Coronation Block at Scunthorpe General Hospital. This building is now beyond repair and needs to be

replaced as soon as possible. This development would allow for the overall hospital site to be reconfigured onto a more efficient footprint.

- A further large scale investment (ca £160m) is required at Hull Royal Infirmary to enable the re-provision of 20 inpatient wards that are currently accommodated on the 10 upper floors of the 13-storey tower block. These wards do not comply with all current standards in relation to control of infection, privacy and dignity and the efficient provision of high quality care. The age and layout of the tower block precludes refurbishment or reconfiguration of the ward accommodation in situ. Re-provision is therefore proposed as part of a wider redevelopment plan that will optimise efficient future use of the site.

Other essential developments that cannot be managed as part of our base case capital investment plan include:

- Refurbishment of inpatient wards and operating theatres, including re-provision of associated services infrastructure;
- Replacement of clinical information systems and upgrade of major IT infrastructure;
- Development of facilities to support transformation and the provision of integrated health and care services at locality level;
- Development of facilities to support transformation and improvements in quality, performance and efficiency in key clinical service areas (including specialist rehabilitation, perinatal mental health, day surgery, renal medicine and pathology).

Our Partnership is keen to continue discussions with the NHS England and Improvement Regional Team and with national bodies regarding our additional capital investment requirements. In the first instance, we will be seeking approval to undertake initial planning work to scope out these developments more fully. We would then wish to engage in further discussions with the Regional Team and the national bodies to agree potential financing models and indicative timescales for these key developments.

Money

The growth in funding for the NHS is forecast to increase to an average of 3.3% in real terms for the next five years, following the announcement by the Prime Minister in June 2018 of additional funding for the NHS. In recent years demands on our resources have grown faster than the funding that has been available, putting services under ever increasing pressure and resulting in organisations finding it difficult to deliver care within what they have available. Across Humber, Coast and Vale there are still organisations which have underlying planned deficits going into next year and beyond, so while increases in funding are very welcome, much of it is likely to be needed to help restore financial balance.

Council budgets have fared significantly worse over this decade. Public health grants have fallen significantly since 2012. Despite recent increases, public spending on adult social care in England is still 2.1% lower than it was in 2009/10 and the percentage of overall council budgets that is now spent on adult social care has continued to rise over the same period. The government has yet to set out long-term funding plans for social care (accurate at November 2019).

Our Partnership has developed a financial strategy for the next five years that will enable us to meet our notified financial targets (Control Totals) and deliver significant financial improvement towards financial balance by 2023/24, whilst supporting the improvements in health and care services for the people of Humber, Coast and Vale that are set out in this plan.

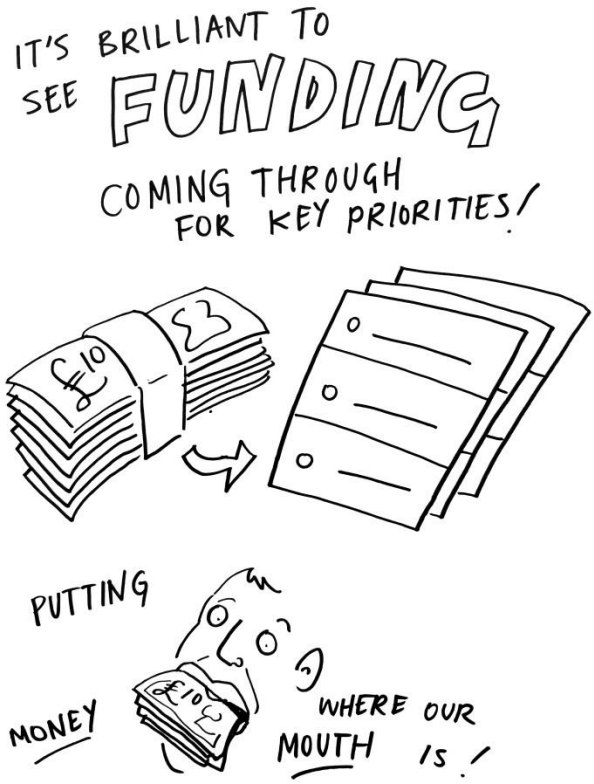
We recognise that improving our financial performance at the required scale will be a significant challenge, with efficiency gain requirements in the short term exceeding 3% for some partner organisations. Our Partnership Plan for 2019/20 has an overall planned of deficit £79m; however we believe there is an underlying, recurrent deficit closer to £96m. Whilst action is being taken to manage and mitigate in-year financial pressures, our underlying financial position and therefore our starting point for the next four years is an overall deficit which is well in excess of the starting point used by NHS England and Improvement to set the financial targets.

Partner organisations in our three sub systems have been working together to develop plans that will achieve the triple aim of enhancing health and wellbeing, improving the quality and safety of our services and increasing productivity and efficiency, enabling us to provide financially sustainable health and care services for the people of Humber, Coast and Vale.

Over the next five years our Partnership is looking at delivering continuous improvement in financial performance in all three sub systems by:

- Collectively agreeing and working to a financial Control Total in each of our sub systems; early work has commenced in 2019/20 to ensure we make progress.
- Continuing to establish alternative payment mechanisms that focus on managing activity levels and reducing cost.
- Developing and integrating out of hospital care with a focus on keeping demand for hospital services under control.

Across the Partnership we have committed to investing more in Mental Health Services and complying fully with the Mental Health Investment Standard. We have also committed to providing additional funding into Primary and Community Care. These investments will enable us to deliver the ambitious plans for the development of services in these areas and the associated improvements in outcomes, as set out in this plan.



Although our plan anticipates the development of primary care, community care and mental health services and a range of other initiatives that will reduce projected increases in demand for acute hospital services, some targeted investments in acute hospital services will also be required. Within our financial strategy, provision has been made for investment in urgent and emergency care services that will support the service developments associated with our Wave 4 capital programme, including the expansion of Same Day Emergency Care services. Provision has also been made for investment in planned care services. This will help us to address service specific pressure points in our three sub systems over the planning period.

Our Partnership has identified a number of key areas where we are collaborating to deliver efficiencies aligned to long term transformation priorities. These include:

- Transforming outpatient services
- Comprehensive and structured review of acute service provision in the Humber and Scarborough areas
- Development and utilisation of the Yorkshire and Humber Care Record
- Medicines optimisation
- Estates utilisation
- Pathology collaboration

The acute services reviews that are being undertaken in the Humber and Scarborough areas have not yet progressed to a stage that would enable any proposed or potential service developments to be included in the plan. On that basis, the current financial plan does not include any projected financial implications or assumptions in respect of the two acute reviews. Work in this area will continue over the coming months and will inform our ongoing financial planning. In addition, it is our intention to continue to develop our understanding of the additional costs associated with operating small and remote hospitals, working with colleagues across the country to find new and innovative solutions to these challenges.

In respect of capital expenditure, our financial forecasts are currently based on confirmed allocations with only a very modest set of aspirational requirements included. As set out in the Estates and Capital Investment Strategy section of our plan (see above), this will only allow us to implement a base case capital investment plan that covers an element of the essential investments into statutory compliance and backlog maintenance works, replacement of essential items of medical and scientific equipment and re-provision of basic IT infrastructure. Financing arrangements will need to be agreed for a number of additional large scale developments that are essential to continued clinical service delivery that cannot be managed as part of our base case capital investment plan.

The planning assumptions that underpin the figures that we have submitted via the planning tool and metrics tool are summarised in Appendix 4. This includes our assumptions regarding projected future workloads, workforce numbers, performance against key targets and metrics and deployment of financial resources.

In April 2020, the geography covered by the current Hambleton, Richmondshire and Whitby Clinical Commissioning Group will join the Partnership from the North East and Cumbria Integrated Care System. Therefore over the next four months we will work with colleagues to understand the impact of this transfer on our financial plan. We currently understand that this may add a further deficit of around £4.8m to our Partnership financial position.

How we take our plan forward

As set out in the introduction to this plan, the aims and ambitions of our Partnership will primarily be delivered through the work in our six places and three sub systems. Where it makes sense to do so, we will work at scale across the Partnership.

In developing this plan, we have undertaken a collaborative planning process that has involved all partner organisations and a broad range of wider stakeholders in each of our six places as well as through our collaborative programmes. This plan describes our ambitions and sets out what we, as a Partnership, want to achieve during the next five years and beyond. We recognise that it does not go into a significant level of detail around how, specifically, some of the ambitions will be achieved and when certain changes will take place. Much of this detail is set out in other documents, strategies and plans, which are already available (see Appendix 2). In some areas, however, the detailed plans are still a work in progress and require further development. Over the next four months we will continue our collaborative approach to developing our supporting plans working alongside colleagues from NHS England and Improvement Regional Team, Public Health England and Health Education England, where appropriate. In addition, we will look to align this work with our operational planning for 2020/21.

We have identified a number of areas where we will work together with colleagues from within and beyond the Partnership to develop these more detailed plans further. These areas include:

- Cancer
- Mental Health
- Primary Care
- Quality and Safety
- Digital Technology
- People

To help us to make our plans a reality, we have established a framework within which we will operate and enable us to work together to make the changes set out in this plan. The leadership and distributive resourcing arrangements we have established as a Partnership are set out in Appendix 4. In addition, we will continue to develop the strength of our Partnership over the coming months as we work towards our ambition of achieving Integrated Care System status by summer 2020. Further detail of what this includes is set out in Appendix 5.

Finally, during the period of this plan there will be some minor changes to the geography covered by our Partnership and our neighbouring systems of North East and North Cumbria and West Yorkshire and Harrogate. This is linked to the merger of three Clinical Commissioning Groups (CCGs) in North Yorkshire: Hambleton, Richmondshire and Whitby, Harrogate and Rural District and Scarborough and Ryedale. With effect from 1st April 2020, when the three CCGs will become one called North Yorkshire CCG, the geography currently covered by Hambleton, Richmondshire

and Whitby and Harrogate and Rural District will join our Partnership for planning and reporting purposes, simplifying arrangements.

Harrogate and District NHS Foundation Trust is a fundamental part of the Harrogate and Rural District system. It delivers most acute hospital and community services to local people and for planning and performance reporting will also be a part of the Humber, Coast and Vale. However, to ensure that the benefits accrued over the last four years in the way in that the Trust has worked with West Yorkshire colleagues, it will continue to work closely with West Yorkshire and Harrogate Health and Care Partnership around key programmes of work as a member of West Yorkshire and Harrogate Health and Care Partnership and the West Yorkshire Association of Acute Trusts (WYAAT). This includes, for example, around the 'Hospitals Working Together' programme, the Cancer Alliance, and other areas of work where it makes sense to the care provided for local people. It's important to note that this will not actively change

These change means our Partnership will be covering a larger geography, extending across the more rural and remote parts of North Yorkshire and expanding the size and scope of the York and North Yorkshire sub-system. Over the next few months we will work through the relevant processes and make the appropriate changes, to ensure a smooth transition.

All of these practical changes and developments will be focused on supporting the Partnership to achieve the aims and ambitions set out in this plan. We are committed to the principle that 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 the barriers that stop people from living happy and healthy lives.

Appendices

1. Our partner organisations

- Care Plus Group
- City Healthcare Partnership CIC
- City of York Council
- East Midlands Ambulance Service NHS Trust
- East Riding of Yorkshire CCG
- East Riding of Yorkshire Council
- Focus CIC (Independent Adult Social Work)
- Hull University Teaching Hospitals NHS Trust
- Hull CCG
- Hull City Council
- Humber Teaching NHS Foundation Trust
- NAViGO
- NHS England and Improvement
- North East Lincolnshire CCG
- North East Lincolnshire Council
- North Lincolnshire CCG
- North Lincolnshire Council
- North Yorkshire County Council
- Northern Lincolnshire and Goole NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Scarborough and Ryedale CCG
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Vale of York CCG
- York Teaching Hospitals NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

2. Our underpinning strategies and plans

This plan describes our ambitions and sets out what we, as a Partnership, want to achieve during the next five years and beyond. We recognise that it does not go into a significant level of detail around how, specifically, some of the ambitions will be achieved and when certain changes will take place. Much of this detail is set out in other documents, strategies and plans, listed below.

You can view or download copies of the strategies and plans listed below on our website. These will be updated, as necessary, over the lifetime of this five year plan.

General Information

- Humber, Coast and Vale Health and Care Partnership 2019/20 Operating Plan

Engagement reports (that have influenced this plan)

- Humber, Coast and Vale Partnership Engagement Mapping Report
- What Would You Do? Healthwatch Report to inform the Partnership Long Term Plan
- Capturing the voice of people with a learning disability or autism living in Humber, Coast and Vale: Summary report of research and feedback
- Moving Forward with the NHS Long Term Plan: No One Left Behind

Priority 1: Helping people to look after themselves and to stay well

- City of York Health and Wellbeing Strategy
- East Riding Health and Wellbeing Strategy
- Hull Health and Wellbeing Strategy
- North Lincolnshire Health and Wellbeing Strategy
- North East Lincolnshire Health and Wellbeing Strategy
- North Yorkshire Health and Wellbeing Strategy
- Personalised Care: 5 year ambition – Humber, Coast and Vale

Priority 2: Providing services that are joined –up across all aspects of health and care

- East Riding Health, Care and Wellbeing Plan 2018 - 2023
- Hull Place-Based Plan
- Scarborough Place Plan (Ambition for Health)
- North East Lincolnshire Place-based Plan
- North Lincolnshire Place Plan
- Vale of York Place Plan
- Humber, Coast and Vale Primary Care Strategy
- Humber, Coast and Vale Unplanned Care Plan
- Humber Acute Services Review
- Scarborough Acute Service Review

Priority 3: Improving the care we provide in key areas

- Humber, Coast and Vale Cancer Alliance Long Term Plan
- Humber, Coast and Vale Mental Health Long Term Plan
- Humber, Coast and Vale Planned Care Plan
- Humber, Coast and Vale Local Maternity System Plan

Priority 4: Making the most of all our resources

- Humber, Coast and Vale Workforce Plan
- Humber, Coast and Vale Partnership Digital Strategy
- Humber, Coast and Vale Estates Strategy

In some areas, the detailed plans are still a work in progress and require further development. Over the next four months we will continue our collaborative approach to developing our supporting plans, working alongside colleagues from NHS England and Improvement Regional Team, Public Health England and Health Education England, where appropriate. In addition, we will look to align this work with our operational planning for 2020/21.

3. How we have engaged on our plan

The partners within Humber, Coast and Vale have taken time over recent months and years to listen to the people who use our services and who live in our neighbourhoods and places to find out what matters most to them. We have been listening to what people are telling us about the changes they would like to see in their local areas and with their health and care services. We have also been listening to what people are telling us is good about health and care in their neighbourhoods and talking to them about how we can share these good ideas across our Partnership. This listening and engagement is part of an ongoing process that will continue as we implement our Plan over the coming five years.

In addition to ongoing engagement that is being undertaken within each of our partner organisations, places, sub-systems and our collaborative programmes, an extensive programme of engagement with stakeholders has been undertaken to enable a range of voices and perspectives to inform this plan and the priorities identified within it. The programme of engagement and involvement that has been undertaken to produce this plan comprises the following three elements:

1. Mapping of engagement activity to date (March to May 2019)
2. Engagement in the development of the plan (April to June 2019)
3. Engagement on draft plan (July to September 2019)

Engagement mapping

Each of our partner organisations within Humber, Coast and Vale regularly engages with local residents or citizens, including those who use local health and care services, in a variety of different ways. Over the past 18 months, as a collective, we have engaged with tens of thousands of people across the Humber, Coast and Vale area in a variety of different ways. This engagement has taken many forms, including face-to-face conversations, paper, online and telephone surveys, focus groups, listening events, public meetings and visits to health and care facilities. It has covered a range of service areas, patient groups and local issues, according to local need and the programmes of work being undertaken by partner organisations.

To support the development of this Partnership Long Term Plan, an engagement audit was undertaken to bring together existing intelligence from engagement and involvement work that has been carried out since the publication of the HCV Partnership STP submission in October 2016. An Engagement Mapping Report was produced which highlights some of the key themes emerging from that engagement and some of the things that people in the Humber, Coast and Vale area have told us about their health and wellbeing. These themes are drawn from more than 36,000 instances of engagement and involvement with the public and were summarised by partners in their submissions for the report.

Engagement in plan development

A broad-based engagement exercise with the public took place throughout Spring 2019 to gather views and perspectives on the NHS Long Term Plan to inform the development of this Partnership

Long Term Plan. This engagement work was nationally commissioned by NHS England but led by local Healthwatch across Humber, Coast and Vale and gathered the views of over 2000 local people through a variety of means including online surveys, face-to-face conversations and focus group discussions. This included a specific focus on 'hard to reach' groups and those less likely to participate in traditional engagement opportunities.

The work undertaken by Healthwatch provided the Partnership with a wealth of information about the preferences and priorities of local people. It highlighted what matters most to those they spoke with for their health and care in the future and sets out, in particular, views about how they would like to be involved and kept informed as services change over the lifetime of this plan. As far as possible, these aims and wishes expressed in this report have been taken into account in the drafting of our Partnership Long Term Plan.

In addition, each of the Partnership's collaborative programmes has undertaken engagement with their key stakeholders in the development of their draft plans. They have focused, in particular, on clinical engagement and ensuring a range of clinical and professional leaders from across the different partner organisations has been involved in identifying and agreeing their priorities.

Engagement on the draft plan

Throughout the summer, engagement events have taken place with a wide range of stakeholders across Humber, Coast and Vale to review and refine the plans and priorities identified within each of our places, sub-systems and programmes that are working at scale across Humber, Coast and Vale.

This engagement programme began with a Health and Care System Leaders Event in June 2019, where over 100 senior leaders (including executive and non-executive directors, elected and lay members and clinical leads) came together to contribute to and review emerging plans across the Partnership's collaborative programmes. Interactive discussions took place covering a range of topics such as workforce, digital, mental health and primary care.

This was followed by a series of five stakeholder engagement events that took place throughout August and September, including one event dedicated to clinical engagement. In total more than 300 people from a wide range of backgrounds participated in the engagement events. For those who could not attend in person, a range of written materials and video clips were made available to view online, together with an opportunity for them to leave comments and make suggestions. Feedback gathered through these events has been incorporated into plans in an iterative manner, which will continue throughout the period from submission of the draft plan on 27th September 2019 to submission of the final plan on 15th November 2019. The drawings that are featured in the Plan document were produced at these engagement events and reflect the ideas, comments and suggestions of the public and other stakeholders who attended.

Ongoing engagement

The engagement we have undertaken in developing this plan should be seen as the starting point not the end of our conversations with local stakeholders. It was clear from the engagement report

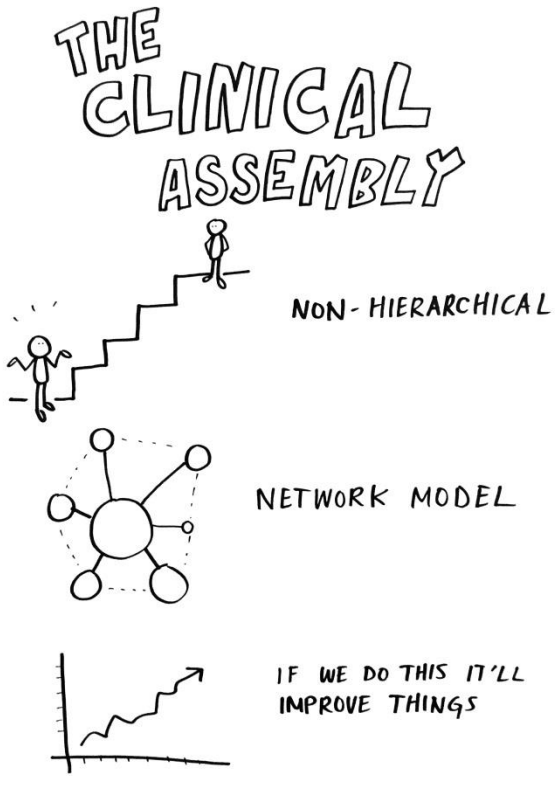
produced by Healthwatch that local people are keen to be involved in designing and developing future changes to health and care in their areas. We are committed to continuing this engagement through our existing networks and developing new ones where these are required, adopting the approaches suggested in the Healthwatch report.

Across a number of our clinical priority programmes, the Partnership has been actively putting in place additional engagement mechanisms to ensure the people who use local services are able to help shape those services for the future. For example, the Humber, Coast and Vale Local Maternity System has developed a network of five Maternity Voices Partnerships (MVPs), led by lay chairs. MVPs create opportunities for local service-users to shape the way in which their maternity services are delivered, by sharing their experiences and feedback about their care and co-producing new and developing services. The Humber, Coast and Vale MVP network conducted a recent survey of over 500 expectant and new parents. The responses to this survey will help determine how information about choices to be made in pregnancy is shared in the future as the Local Maternity System develops personalised care plans and the digital offer.

It is important to note that the focus of the Partnership Long Term Plan is to set out high-level ambitions and outcomes that partners across Humber, Coast and Vale will work towards delivering over the coming five-year period. Specific service change elements will still be subject to the same requirement to involve patients and the public, which remains the duty of the relevant organisation(s) responsible for implementing that particular change.

Health and social care professional engagement

As set out above, engagement with clinicians and frontline professionals from all disciplines has been an important part of developing this plan. Ongoing engagement with our frontline staff will be particularly important over the coming years as the plan is implemented to ensure they are fully involved in the changes we will be making.



As part of our work through the ICS Accelerator Programme (see Appendix 5), our Partnership is reviewing and strengthening our Health and Social Care Professional Engagement strategy. This work will ensure we have embedded clinical and professional engagement and effective clinical and professional leadership at all levels of our Partnership.

We are building on the Clinical Assembly model which we have been developing over the past nine months, which is enabling broad-based engagement with clinicians in a whole range of Partnership programmes.

You Said, We Did, We Will Do

We have undertaken extensive engagement in order to develop this Plan. The table below provides a very high level summary of some of the key issues and suggestions that were raised by local people in the course of our engagement. It also highlights some of the innovations and changes set out within our Partnership Long Term Plan and how these relate to the challenges that we have heard from our local populations.

This is by no means an exhaustive list but is intended to highlight some of the ways in which our plans are responding to the needs and desires of our local populations. We are committed to continuing the dialogue and working with our communities as we implement the changes set out in our Partnership Long Term Plan. The ambitions we are seeking to achieve will involve every one of the 1.4 million people within Humber, Coast and Vale taking an active role in improving the health and wellbeing of the people of Humber, Coast and Vale.

You Said	We Did	We Will Do
Access to services		
You told us: Getting a GP appointment can be really difficult	We have: • Increased availability of appointments through extended access (evenings and weekends) • Introduced the NHS App and online booking • Trialled EConsult (online consultation) in some GPs • Provided direct access to physiotherapists and other professionals	We will: • Expand opportunities for online consultation • Expand primary care teams to include new roles and a wider range of professionals • Develop Primary Care Networks, which will provide more joined-up care in local communities.
You told us: Waiting times for some services are too long, in particular: – mental health services for children and young people (CAMHS) – autism services – outpatients	We have: • Extended the availability of talking therapies in all places • Significantly reduced the numbers of people waiting over 52 weeks for treatment	We will: • Increase funding for mental health services to improve access • Ensure no one waits 52 weeks for routine surgery • Transform outpatient services to reduce unnecessary appointments and make services more responsive
You told us: Travel and transport can be a challenge, especially in rural areas	We have: • Extended the use of phone consultations, • Introduced NHS111 online and EConsult in some GPs	We will: • Expand virtual consultations and remote monitoring • Develop out of hospital services to avoid unnecessary

		trips to hospital
You told us: Certain services are available in some communities and not others	We have: • Standardised commissioning policies for a range of areas	We will: • Reduce variation by working together to put in place standardised approaches in different areas • Continue standardising commissioning policies
You told us: You are worried about workforce shortages and the impact these might have on the care that is available	We have: • Developed new roles to complement existing workforce • Secured the expansion of medical school training places • Introduced a nursing course in Scarborough	We will: • Continue to recruit to new roles • Develop apprenticeships • Expand volunteering opportunities • Put in place more joined-up career pathways to enable people to progress • Make jobs and working environments more attractive for current and future staff
Communication and Disjointed Care		
You told us: Communication between patients and healthcare providers is not always effective (e.g. letters go missing, results are delayed)	We have: • Made ongoing improvements to our IT infrastructure	We will: • Introduce digital patient-held records • Introduce text reminder systems across a range of services
You told us: Communication between different parts of the health and care sector are sometimes poor and care can become disjointed	We have: • Improved record sharing between organisations • Strengthened collaboration amongst partners	We will: • Put in place a single patient record (Yorkshire and Humber Care Record) • Provide more integrated out-of-hospital care and develop Primary care networks
You told us: People don't always know the right place to go to for advice. Services are changing a lot and quickly – people find it hard to keep up	We have: • Improved NHS 111 service • Launched NHS 111 online • Launched joint information campaigns	We will: • Expand direct booking through NHS111 • Put in place a Single Clinical Assessment Service to direct patients to the appropriate care

Meeting people's broader needs		
You told us: People would like more support following diagnosis (e.g. cancer or other long term conditions)	We have: • Introduced Cancer Care Review pack • Post-diagnosis support for dementia	We will: • Improve mental health support for all, especially those with long-term physical health conditions • Expand dementia support
You told us: When community and family support is available, people feel healthier and happier	We have: • Introduced social prescribing in all local areas	We will: • Embed voluntary sector partnerships • Expand social prescribing
You told us: Carers need to be supported to care for their loved ones	We have: • Put in place carers strategies in many of our places	We will: • Ensure the needs of carers are explicitly considered within our plans and included in 'workforce' considerations
Choice and Control		
You told us: People would like more choice and control over their care, especially: - end of life - maternity	We have: • Developed End of Life strategies in many of our areas	We will: • Enable joined up End of Life Care through better technology (ePACCs) • Improve choice in maternity services
You told us: Patients have told us they can manage their own conditions better when they have knowledge and access to advice and support when they need it	We have: • Launched Orcha app store to direct people to the most effective health and care apps	We will: • Transform outpatients • Digitally-enable care and management of conditions (e.g. wearable devices) • Expand availability of trusted advice and guidance online
Involving People		
You told us: You would like more opportunities to get involved in decisions about your care	We have: • Undertaken extensive engagement in developing our Long Term Plan and work of the Partnership • Established Maternity Voices Partnerships (MVPs) and a Citizen's Panel	We will: • Continue to develop MVPs • Develop a cancer patient network • Continue our ongoing engagement programmes for the acute services reviews

4. How will we deliver our plan

Our approach to delivery

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'. Collaboration at place is and will remain the main focus for the work of our Partnership.

Sometimes, where it makes sense to do so, we join up across more than one place to plan and improve services – we refer to these areas as 'sub systems'. In particular, our work at this level will focus on planning levels of activity and undertaking financial modelling within the three sub systems: North and North East Lincolnshire; Hull and East Riding and York and North Yorkshire.

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'.

The diagram below sets out the different ways in which the Partnership operates:

Over the last 12 months, we have strengthened the approach to our collaborative programmes and established robust governance arrangements for the Partnership, as set out in the diagram below. The clinical and managerial leadership of some of these programmes has been enhanced as well as representation on the Executive Group and other Boards. Our Partnership objectives will be delivered using this framework, which will continue to be reviewed as part of our journey towards achieving Integrated Care Status, as described below.

Leadership and resourcing

The following table identifies our Partnership Leaders who will provide the leadership and managerial direction for the Partnership and Collaborative Programmes as well as holding each other to account for delivery through the Executive Group. Leadership arrangements will change and flex as required to deliver the wide-ranging aims and ambitions set out in this plan.

Our Partnership has chosen to support delivery using a distributive model and the leaders are supported, in the main, by existing resources from within our system. This is also underpinned by the use of transformation funding and some aligned resource from NHS England and Improvement.

Our Partnership Team		
Partnership Chair and System Lead		Stephen Eames
Deputy Chair and Executive Lead		Andrew Burnell
Clinical Lead		Peter Melton
Finance Lead		Lee Bond
Public Health Lead		Stephen Pintus
Partnership Director		Chris O'Neill
Assistant Director – Partnership Development		Karina Ellis
Head of Communications and Engagement		Linsay Cunningham
Strategic Priority Areas		
Humber Acute Review	Chair	Emma Latimer
Scarborough Acute Review	Chair	Maddy Ruff
Clinical Priority Areas		
Cancer	SRO	Phil Mettam
	Clinical Lead	Stuart Baugh
	Managing Director	Vacant
Mental Health	Executive sponsor/SRO	Michele Moran
	Clinical Lead	Steve Wright
	Programme Director	Alison Flack
Urgent & Emergency (unplanned) Care	Chair/Clinical Lead	Andrew Phillips
	SRO	Helen Kenyon
	Programme Director	Sue Rogerson
Elective (planned) Care	SRO	Alex Seale
	Clinical Lead	Several aligned to workstreams
	Programme Director	Caroline Briggs
Primary Care	SRO/Clinical Lead	Dan Roper
	Programme Director	Geoff Day
Maternity	SRO	Chris Long
	Clinical Lead	Kevin Philips
	Commissioning Delivery Lead	Sarah Smyth
	Programme Director	Becky Case
SRO for Antimicrobial resistance		Beverley Geary
Executive Lead for system resilience (including EU Exit)		Peter Reading
Strategic Resourcing Boards		
Strategic Digital Board	Chair	Chris Long
Estates Board	Chair	Simon Morritt
Workforce Board	Chair	Rob Walsh
Places		
East Riding		John Skidmore
Hull		Matt Jukes
North East Lincolnshire		Jane Lewington / Jane Miller
North Lincolnshire		Denise Hyde / Emma Latimer
North Yorkshire		Amanda Bloor
York		Phil Mettam / Simon Morritt

5. How we will develop our Partnership

Journey to an Integrated Care System (ICS)

Accelerator Programme

Following our Partnership review meeting with NHS England and Improvement in November 2018 it was recognised that we had made demonstrable progress over the previous year and were now considered to be an aspirant Integrated Care System (ICS).

As a result, our Partnership set an ambition in our 2019/20 Operating Plan to achieve ICS status by the summer of 2020. This was further supported by NHS England and Improvement and as a result the Partnership is now receiving additional support to develop and mature, in the expectation we can achieve this ambition.

The main support is being provided through the **ICS Accelerator Programme,** an intensive programme of hands-on support structured around core components of system development as set out in the ICS maturity matrix. The programme includes a scoping phase with the Partnership to identify priority areas of focus for a 16 week programme of delivery that will include access to dedicated subject matter experts, both from NHS England and Improvement and other partners.

Support will be delivered through a combination of workshops, sharing best practice, and work on key documents and strategies with the expectation that progress will be made in the development of the Partnership maturity with a roadmap to achieving ICS status. Whilst completing the Accelerator Programme will not guarantee our Partnership is granted ICS status, partners are committed to ensuring the programme is as successful as possible.

We have completed the scoping phase of the ICS Accelerator Programme, which included two diagnostic sessions with Executive Group members and with a small group of Non-Executive Directors, Elected Members and Chairs. These were focussed on understanding the Partnerships strengths and areas for development against the ICS Maturity Matrix. The key messages from the assessment undertaken through the diagnostic sessions were that across the four domains our Partnership is mainly in the developing maturity level and there are a number of strengths on which to build at place level and across our Partnership. There are strong arrangements established that require reaffirming, clarifying and documenting so there is a collective understanding of leadership and governance. Local leaders have demonstrated a readiness and commitment to operate as an Integrated Care System. In addition, it is acknowledged that impact can be achieved on current delivery and performance across our Partnership.

This diagnostic phase has led to the identification of three priority areas for the delivery phase of the programme which include:

- **Collective Partnership Working -** Reaffirming a collective commitment to subsidiarity, collaboration, partnership working, trust, common vision, values and priorities and

improvement – hearts rather than minds and documenting these in a shared, collective narrative that everyone supports.

- **System Operating Arrangements -** Reaffirming and clarifying the Partnership governance, mutual accountability and roles and responsibilities at all levels linked to the delivery and oversight and assurance of the Partnership vision and priorities as set out in the Partnership Long Term Plan.
- **Stakeholder Engagement** – Exploring and understanding what effective and good engagement with key stakeholders including Clinical, Non-Executive Directors and Elected Members looks like, with a particular focus on engagement with clinicians and frontline health and social care professionals.

Population Health Management

In addition to the three priorities above, we are also undertaking additional work around Population Health Management, which will be focussed around raising the awareness of the approach and providing support to the development of the Humber, Coast and Vale approach. This will be supported by the recent announcement that our Partnership will be one of the 12 in the next wave of the National PHM Pilot Programme facilitated by Optum and NHS England and Improvement.

Executive and Non-Executive Leadership Development

In addition to the Accelerator Programme, our Partnership will continue to work with the Leadership Academy to develop a leadership development programme for the Executive Leaders focussed around them as individuals and with the NHS Confederation to support the development of the Non-Executive Directors.

As set out in the plan, we will also focus on supporting our newly appointed Primary Care Network Clinical Directors. In particular, ensuring that they are able to quickly establish their role within their locality and also enable them to make strong links with other Clinical Directors to offer peer support and opportunities to share learning.

Quality Improvement

Each organisation currently has its own approach/methodology to quality and service improvement. Our Partnership believes that this is an area for further development and is currently exploring the possibility of implementing a Partnership-wide approach to quality improvement. We recognise that this is a significant task and we are working with NHS Improvement to learn from others who have taken a system wide approach.

Our Partnership approach to quality and service improvement will depend on our starting point, the level of adoption required and the resources available. Any implementation will require senior leadership buy-in and representation from all the organisations within our Partnership to ensure a collaborative endeavour.

We will look to commence the development of our approach to quality improvement using the following five phases:

- Phase 1 readiness and the case for change – determine board level understanding, organisational readiness to change, cultural maturity and level of commitment
- Phase 2 diagnostic – baseline assessment of current individual approaches and capacity in individual organisations, cultural assessment
- Phase 3 planning - development of strategic approach and alignment/ agreement with existing system priorities and OD/ workforce strategies
- Phase 4 development – training, capability building and awareness
- Phase 5 application and refinement – application/ testing/ refinement/ adoption.

6. How we have developed our plan

Planning assumptions underpinning the NHS activity and financial planning

As set out in the introduction of this plan, the key emphasis for delivering the aims and ambitions of the Partnership will be through the work in our six places and three sub systems, focusing on integrating out of hospital services to ensure more responsive, joined up care is available.

In developing this plan, we have undertaken a robust collaborative planning process involving all partner organisations and have agreed planning assumptions at sub system level. This collaborative approach has ensured that we have achieved full alignment between commissioners and providers in relation to activity, capacity, the availability and use of financial resources and the available workforce in all three sub systems. The assumptions made as part of the planning in each sub system are set out in greater detail below.

It is also important to understand the starting positon of our Partnership in developing this plan. Notwithstanding the significant progress made that has been made over the past three years, the Partnership faces a number of challenges in some key areas, which impact upon our overall financial and performance position, specifically:

- Delivery of the NHS Constitutional/Access standards for planned and unplanned care;
- Workforce gaps across health and care, resulting in a greater reliance on temporary and agency staff;
- The financial position, both at organisation and Partnership levels, is challenging;
- The level of demand, given both the extent of health needs and expectations, often exceeds the supply in terms of capacity and availability, further limited by a lack of independent providers;
- Historically large and unsustainable waiting lists and backlogs for both routine and follow up appointments. However, these have been improving over the last year.
- Quality challenges as demonstrated by all three acute providers being rated 'requires improvement' by the Care Quality Commission (CQC). In addition, Northern Lincolnshire and Goole Hospital has been in both quality and financial special measures since 2017.

Therefore, in each of our three sub systems the planning assumptions have considered the need to balance off the following:

- Current delivery and performance against the 2019/20 Partnership and organisational operational plans, including the distance away from the numerous NHS Constitutional/Access Standards;
- Current and anticipated challenges across both planned and unplanned care in terms of demand, capacity and workforce;
- The financial assumptions and availability of resources for 2020/21 to 2023/24;
- Quality considerations for both planned and unplanned care and ensuring waiting lists are safe;
- Capital and estate plans and their timescales for delivery.

The changes outlined within this Plan are underpinned by a number of assumptions relating to finance, workforce and the levels and types of activity that will be undertaken over the coming four years. For finance and each of our sub system, the planning assumptions are set out below.

Finance

The assumptions that support our financial plans are extremely ambitious for each of our three sub systems. Whilst there is no material misalignment of financial expectation between commissioners and providers, there are significant efficiency assumptions in all but one of our organisations. The efficiency assumptions are in some years and for some organisations greater than the 2.0% assumed by NHS England and Improvement in setting the Control Totals. This is particularly evident in the early years of the plan. The assumptions that have been made around efficiencies reduce over the four years such that the underlying financial position of our Partnership by March 2024 is much more in line with those of NHS England and Improvement. In addition, the plan assumes an element of historic commissioner surplus of around £12.3m will be made available over the period of this plan to support transformation and deliver the ambitions we have set out.

Hull and East Riding

Performance across the Hull and East Riding sub system in delivering the A&E 4 hour standard has been challenging in the past 12-18 months. This is due to a variety of factors including variations in demand, workforce and other challenges, patient flow issues and difficulties in terms of discharge and flows out of hospital in community and care settings. A recovery plan is currently in place to try to improve the position and this is starting to have an incremental impact, though this needs to be sustained. Particular issues relate to weekend discharge, length of stay and primary care streaming, all of which are subject to monitoring and review. The plan is to improve performance against the 4 hour standard and deliver the 95% standard during 2020/21.

The planning assumptions for Hull and East Riding are based on a 2.4% 3 year average growth for emergency department attendances, with an assumption of a flat overall growth in non-elective admissions. The latter is premised on continued investment in the assessment and ambulatory care models along with the work of the Frailty Intervention Team and a surgical assessment facility. The Urgent and Emergency Care Wave 4 Capital Funding Business case is part of this solution, and has been built into the financial modelling, as well as the proposed model for the Community Respiratory Service. These proposals will have a more substantial impact in the latter part of the next 4 years.

Improvements are also planned in delayed transfers of care and the time patients are staying in hospital, especially those currently staying beyond 21 days. The planning assumption for those waiting beyond 21 days is to deliver the 55% target reduction in 2019/20 from 126 to 55 and then sustain this level of performance throughout the next 4 years.

Planned care has also experienced some challenges, despite some reductions in demand from the main Commissioners. There has, however, been a growth in 2 week referrals from GPs, mainly around Cancer, as well as growth from outside of the Hull and East Riding area. There remains a

high residual waiting list at Hull University Teaching Hospital Trust, 53,495 as at August 2019, with a plan to get this down to 52,800 by March 2020. However, a more sustainable list size is felt to be 38,440, so significant work is required to reduce the overall waiting list from current to more sustainable levels.

The planning assumptions are based on no people waiting 52 week in 2019/20. There are pressures in gynaecology and the risk of late transfers from other providers. Other specialities where challenges exist include ENT, Ophthalmology and Cardiology.

The assumption for Cancer 62 day is to meet the standard by March 2024 and diagnostics by the end of March 2024, both of which will be ambitious from the current baseline performance.

North and North East Lincolnshire

The planning assumptions for the North and North East Lincolnshire sub system reflect both the substantial challenges that have been, and continue to be faced, but also the incredible hard work and joint working between commissioners and providers that has taken place as part of a strong ambition to move things forward for the local population.

Significant underlying challenges exist in terms of workforce, capacity, the financial context and the limited supply of independent sector providers, compounded by additional activity flows from central and southern Lincolnshire. These factors make the starting point, and associated planning assumptions, quite distinctive from most other sub systems. Nevertheless, there remains a strong commitment to build on the progress made during 2018/19 and so far in 2019/20.

For urgent care, performance across the A&E standard and associated measures has been variable in recent years, with the past 18 months including additional activity and ambulance diverts. Northern Lincolnshire and Goole NHS Foundation Trust agreed a boundary divert to support pressure at Boston Hospital, part of United Lincolnshire Hospitals. This doubled their urgent and emergency care footprint and led to a step change in activity from East Lincolnshire. Length of stay, delayed transfers of care and ambulance handovers have deteriorated in recent months and are the subject of an improvement plan.

For elective care, building on the substantial progress in reducing the numbers during 2018/9, there is a strong commitment to ensuring that there are no people waiting more than 52 weeks for planned care, as well as reducing the waiting list size to circa 21,000 by March 2024 and meeting the 92% Referral to Treatment standard by the same timescale.

The Trust has experienced a number of coding errors that has effected circa 14,000 patient pathways. All have gone through a validation process which has identified a number of people who have waited more than 52 week. Whilst the majority of these have been treated there are a small number that are still impacting on the monthly performance in 2019/20.

Substantial work is required in relation to outpatient activity where growth figures for Year 2 will continue at the 2019/20 plan and then match the national 3 year rolling average. Outpatient follow up appointments requires a significant ongoing focus to ensure that a further reduction is

achieved to meet the necessary one third reduction since 2018/19 given the backlogs prior to that point.

The trajectory timescales to meet the standard for diagnostic waiting times is March 2021, and progress will be made towards achieving the 62 Day Cancer waiting time with a plan to achieve 82% by March 2024. Both of these are stretching trajectories given the current position and the diagnostic trajectory will be dependent upon all capital schemes being in place to create the much needed additional scanning capacity.

York and North Yorkshire

Delivery of the A&E standard has been a challenge, in particular on the Scarborough site that experiences a peak in activity in winter as well as in summer when the population increases fourfold. This has been further compounded by an increase in emergency attendances at both York and Scarborough sites, which has been assumed to continue as part of the planning assumptions for the next four years. Non-elective admissions are projected to increase by around 3% per annum driven predominantly by demographic growth. Within this overarching increase, there is the growth in zero length of stay at 2.1% and 1 day length of stay at 1.3%. Substantial work is also required to tackle the challenges in relation to delayed transfers of care and stranded and super stranded patients.

A key consideration for the delivery of safe urgent care services at the Scarborough site is quality and safety, especially around safe staffing levels, as flagged as part of the CQC visit in July 2019. Additional staffing has been put in place to help mitigate this but further work is taking place as part of a York and North Yorks sub system action plan to address the various issues and risks that result in ambulance handover delays, 12 hour trolley waits and patients breaching the four hour standard.

For elective care, there is a commitment to reduce the waiting list and deliver the RTT standard during the next four years, but the starting point indicates that this will be a challenge given that the waiting list is ahead of the plan for 2019/20, though there are signs of a reduction in GP referrals in recent months. Recovery actions are in place to address the waiting list position, though there are a number of specialities where this is causing some difficulties, namely General Surgery, Orthopaedics, Maxillo-Facial Surgery, Gastroenterology, Anaesthetics and Ophthalmology.

For Cancer, the ambition is to deliver the targets for Cancer 62 Day and Cancer 2 week waits by March 2020 and sustain this thereafter. The pressures from 2 week waits referrals creates some risks around capacity to deliver routine reporting and waiting times and subsequent impact on diagnostics could contribute to further challenge in delivering these targets.

7. How we will measure success

In developing this plan, we asked our stakeholders – clinicians, patients, partners and the public – what they would like to be different in five years' time. Throughout the plan, we have tried to focus on outcomes, rather than outputs, when we are describing what it is we are seeking to change. We face challenges, however, in measuring these outcomes as they are often more difficult to count and find definitive measures for.

There is a range of performance measures, set out below, which will be monitored by our Partnership as well as NHS England/Improvement as proxy measurements for the progress we are making in delivering this plan. In addition to these measurements, we will continue our ongoing engagement with patients, the public, staff and other stakeholders to find out what difference our work is making to them. These are the sorts of things we want people in Humber, Coast and Vale to be able to say as a result of the changes we are making in this plan; these have been informed by our engagement work and what people have told us they want to see different in five years' time.

- I know what I need to do to live a healthier life and can get advice and support in my area;
- My mum can keep living at home because everyone is working together in her community to look after her *before* she falls or her condition gets worse;
- It is really simple to get advice and treatment when I need it unexpectedly;
- I can book my appointments online and see a doctor or nurse when it suits me;
- My children know about looking after their mental health and can talk to someone if they are worried about themselves or a friend;
- If I have symptoms that might indicate cancer, I will get tested quickly;
- My GP and her team can get advice directly from hospital doctors and order tests themselves to save me making unnecessary trips to the hospital;
- I can monitor my diabetes on my smartphone and I can get in touch with my nurse if I'm worried;
- I have a single health and care record that everyone involved in my care can see and update, including me.

Performance measures

The following set of performance measures will be used to measure our progress as a Partnership against delivering key aspects of the NHS Long Term Plan. Many of these measures are still to be confirmed at a national or regional level. The Strategic Planning Metric Tool that accompanies this plan sets out the measures and, where relevant, identifies the ambition we have set within this plan.

Agreed Headline	Measure description
Primary and community services: annual implementation milestones for 5 year GP contract; new community services response times	Percentage of overall NHS revenue spent on primary medical and community health services
	GP contract / Primary Care Network Patient reported access measure – measure to be confirmed*
	Community rapid response 2 hour/2 day measure to be confirmed
Comprehensive ICS coverage	Percentage of population covered by ICS
Emergency care: on agreed trajectory for Same Day Emergency Care	Percentage of non-elective activity treated as Same Day Emergency Care cases
Prevention: increase uptake of screening and immunisation;	Population vaccination coverage – MMR for two doses (5 years old)
	Bowel screening coverage, aged 60-74, screened in last 30 months
	Breast screening coverage, females aged 50-70, screened in last 36 months
	Cervical screening coverage, females aged 25-64, attending screening within target period (3.5 or 5.5 years)
Inequalities: inequalities reduction trajectory	Measure that reflects the inequalities focus of local plans – measure to be confirmed

Agreed Headline	Measure description
Prevention: Alcohol care teams, tobacco treatment services, and diabetes prevention programme	Coverage of ACTs – percentage of hospitals with the highest rate of alcohol dependence-related admissions with ACTs in place
	Number of people supported through the NHS Diabetes Prevention programme
	Percentage of people admitted to hospital who smoke offered NHS funded tobacco treatment services
Maternal and Children's health: On agreed Trajectory for 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025	Reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury, based on MBRRACE data
Improve cancer survival: on agreed trajectory so that 75% of cancer patients diagnosed at stage 1 or 2 by 2028	Proportion of cancers diagnosed at stages 1 or 2
	Proportion of people that survive cancer for at least 1 year and 5 years after diagnosis
Learning disability and autism: on agreed trajectory for halving inpatient rate by 2023/24 and increasing learning disability physical health checks to 75% of people over 14	Reliance on specialist inpatient care for people with a learning disability and/or autism
	Proportion of people with a learning disability on the GP register receiving an annual health check
Mental health: on track for locally agreed service expansion, and increase in investment for mental health	Number of people accessing IAPT services

Agreed Headline	Measure description
services as a share of the NHS budget over the next five years, worth in real terms at least a further £2.3 billion a year by 2023/24	Number of children and young people accessing NHS funded mental health services
	Mental health access standards once agreed
	Percentage of overall NHS revenue funding spent on mental health services
Implementation of agreed waiting times (new clinical standards for urgent and emergency care, elective care, cancer and mental health from April 2020)	Percentage of patients in A&E transferred, discharged or admitted within four hours
	Percentage of patients starting cancer treatment within 62 days of GP referral
	Percentage of patients with incomplete pathway waiting 18 weeks or less to start consultant led treatment
	Patients waiting more than 52 weeks to start consultant-led treatment
	Elective waiting list size
Workforce metrics will be agreed through development of the NHS People Plan. Interim placeholder metrics to support development of local plans will be:	Staff retention rate
	Proportion of providers with an outstanding or good rating from the CQC for the “well led” domain

Agreed Headline	Measure description
	Workforce diversity measure to be agreed
	Number of GPs employed by NHS
	Number of FTEs, above baseline, in the Primary Care Network additional role reimbursement scheme
	Nurse vacancy rate
	Staff well-being measure to be agreed as part of the People Plan
	Sickness absence
Outpatient reform: Avoidance of up to a third of outpatient appointments (including outpatient digital roll out)	Percentage reduction in the number of face to face outpatient attendances
Empowering People: Summary care Record roll out, EPR roll out	Proportion of population registered to use NHS App
Access to online/telephone consultations in primary care	Proportion of the population with access to online consultations
	Access to general practice appointments

Agreed Headline	Measure description
The NHS will return to financial balance: NHS in overall financial balance each year	Percentage of organisations in financial balance
	Aggregate forecast end of year financial position of providers, commissioners and NHSE central budgets against agreed budgetary limits
The NHS will achieve cash-releasing productivity growth of at least 1.1% per year	Total Cash releasing productivity growth (covering acute, mental health and community providers initially)
The NHS will reduce growth in demand for care through better integration and prevention	Cost weighted non-elective activity growth
The NHS will reduce variation in performance across the health system	Measure on reduction in unwarranted variation achieved by the NHS
The NHS will make better use of capital investment and its existing assets to drive transformation	[Metrics to support this test to be confirmed following the Spending Review and the development of the new NHS capital regime]