Humber and North Yorkshire
Health and Care Partnership

MEETING OF THE INTEGRATED CARE PARTNERSHIP

WEDNESDAY 25 SEPTEMBER 2024 FROM 14:00 – 16:00 HRS

AGENDA

Time	Item	Subject	Led By	Action Required	Paper
14:00	1	**Welcome and Introductions**	Chair	To Note	Verbal
14:01	2	**Apologies for Absence**	Chair	To Note	Verbal
14:02	3	**Declarations of Interest** In relation to any item on the agenda of the meeting members are reminded of the need to declare: (i) any interests relevant or material to the ICB. (ii) that nature of the interest declared. financial / professional / personal / indirect (iii) any changes in interest previously declared.	Chair	To Note	Verbal
14:03	4	**Minutes of the Previous Meeting held on 26 June 2024** To receive the minutes of the previous meeting for approval	Chair	To Approve	Enclosed
14:05	5	**Matters Arising and Actions** 1. Progress update on Children and Young People / Start Well	Chair	To Note	Verbal
14:07	6	**Notification of Any Other Business**	Chair	To Note	Verbal
HUMBER AND NORTH YORKSHIRE STRATEGIC PARTNERSHIP					
14.09	7	**Futures Group Report** To receive a verbal report from the HNY Futures Group	Phil Mettam	To Note	Verbal
14.15	8	**Local Government Partnership Report** Update on key issues facing Local Authorities	Cllr Shreeve	To Note	Verbal
14.25	9	**Integrated Care Board Report** Update on key issues facing health including an update on the design for the future work.	Sue Symington / Stephen Eames	To Note	Verbal

Time	Item	Subject	Led By	Action Required	Paper
14.35	**10**	**Place Update** To receive an update on latest Place / partnership initiatives and latest developments	Peter Thorpe/ Alex Seale	To Note	Enclosed
14:40	**11**	**Design for the Future** To receive an update on the potential future design of services in Humber and North Yorkshire	Peter Thorpe	To Note	Verbal
HUMBER AND NORTH YORKSHIRE PARTNERSHIP OUTCOMES					
14:50	**12**	**Integrated Needs Assessment** To receive an update.	Jack Lewis	To Note	Enclosed
15:00	**13**	**Outcomes Framework** To receive an update.	Jake Abbas	To Note	Presentation
15:10	**14**	**Transport and Travel** Following a brief introduction at the previous ICP meeting to receive and discuss reports on: a) Community transport b) Patient Transport Service	Chair Gary Sainty Chris Dexter	To Discuss	Enclosed
15:55	**15**	**Any Other Business** To receive any business notified at the start of the meeting	Chair	To Note	Verbal
15:58	**16**	**Closing Remarks**	Chair	To Note	Verbal
16:00		**Date of Next Meeting:** Wednesday 18 December 2024 at 14:00 - 16:00			

Humber and North Yorkshire
Health and Care Partnership

HUMBER AND NORTH YORKSHIRE INTEGRATED CARE PARTNERSHIP

MINUTES OF THE MEETING HELD ON 26 JUNE 2024, AT 2.00 PM, FOREST PINES HOTEL & GOLF RESORT, ERMINE STREET, SOUTH HUMBERSIDE, DN20 0AQ

MEMBERS PRESENT:

Sue Symington (**Chair**)	Chair of Humber & North Yorkshire ICB / ICP
Cllr Jonathan Owen	Vice Chair of Humber & North Yorkshire ICP
Stephen Eames (via MS Teams)	Chief Executive, Humber & North Yorkshire ICB
Cllr Michael Harrison	Executive Member for Health and Adult Services, North Yorkshire County Council (via MS Teams)
Cllr Stan Shreeve	Deputy Leader, North East Lincolnshire Council
Erica Daley	NHS Place Director – Hull, Humber & North Yorkshire ICB
Helen Kenyon	NHS Place Director – North East Lincolnshire, Humber & North Yorkshire ICB
Karina Ellis	Executive Director Corporate Affairs, Humber & North Yorkshire ICB
Pete Thorpe	Executive Director of Strategy and Partnerships, Humber & North Yorkshire ICB
Sarah Coltman-Lovell	NHS Place Director – York, Humber & North Yorkshire ICB
Brickchand Ramruttun	Interim Executive Director of Adult Social Care and Adult Services, East Riding Council
Wendy Balmain	NHS Place Director - North Yorkshire, Humber & North Yorkshire ICB
Karen Pavey	Executive Director for People, North Lincolnshire Council
Jane Hazelgrave	Acting Deputy Chief Execuive/ Chief Operating Officer, Humber & North Yorkshire ICB
Professor Charlie Jeffery	Vice-Chancellor, University of York / Chair of HNY Futures Group
Cllr Linda Chambers	Chair - Health and Wellbeing Board, Hull City Council

STANDING ATTENDEES PRESENT:

Emma Jones	Executive Business Support Senior Officer, Humber & North Yorkshire ICB
Lucy Phillips (**Minute Taker**)	Executive Business Support Lead, Humber & North Yorkshire ICB
Michael Napier	Director of Governance and Board Secretary, Humber & North Yorkshire ICB
Nicky Lowe	Head of Corporate Affairs and System Support, Humber & North Yorkshire ICB

IN ATTENDANCE:

Jake Abbas	Deputy Director, Population Health Intelligence, Humber & North Yorkshire ICB
Jack Lewis	Consultant in Public Health, Humber & North Yorkshire ICB
Gary Sainty	Programme Director, Voluntary, Community, and Social Enterprise Collaborative, Humber & North Yorkshire ICB
Yvonne Elliott	Programme Director, Community Health and Care Collaborative, Humber & North Yorkshire ICB (via MS Teams)
Anna Folwell	Consultant Community Geriatrician, Jean Bishop Integrated Care Centre (via MS Teams)
Janet Smith	Public Health Lead for Older People, East Riding of Yorkshire Council (via MS Teams)
Carly Walker	Healthy Ageing Lead, Public Health Team, North Yorkshire Council (via MS Teams)

APOLOGIES:

Alan Menzies	Chief Executive, East Riding of Yorkshire Council
Alison Barker	Chief Executive, North Lincolnshire Council
Amanda Bloor	Deputy Chief Executive/Chief Operating Officer, Humber & North Yorkshire ICB
Ashley Green	Chief Executive, Healthwatch North Yorkshire
Cllr Jo Coles	Executive Member for Health and Wellbeing, City of York Council
Cllr Richard Hannigan	Deputy Leader, North Lincolnshire Council
Erica Daley	NHS Place Director – Hull, Humber & North Yorkshire ICB
Ian Floyd	Chief Executive, City of York Council
Julia Weldon	Director of Public Health and Adult Services, Hull City Council

Louise Wallace	Director of Public Health, North Yorkshire Council
Nigel Wells	Executive Director of Clinical and Professional, Humber & North Yorkshire ICB
Richard Flinton	Chief Executive, North Yorkshire Council
Rob Walsh	Chief Executive, North East Lincolnshire Council
Rob Waltham	Leader, North Lincolnshire Council
Matt Jukes	Chief Executive, Hull City Council
Helen Grimwood	Hull Healthwatch
Alex Seale	NHS Place Director – North Lincolnshire, Humber & North Yorkshire ICB
Simon Cox	NHS Place Director – East Riding, Humber & North Yorkshire ICB

1. WELCOME AND INTRODUCTIONS

The meeting was chaired by Sue Symington, the Chair of the Humber and North Yorkshire Integrated Care Board (ICB) and Chair of the Integrated Care Partnership (ICP). She welcomed everyone to the meeting and gave a special welcome to Dr. Brickchand Ramruttun, who had recently taken on the role of Executive Director of Adult Social Care and Adult Services within East Riding Council.

Those present introduced themselves including the members that had joined virtually via MS Teams.

2. APOLOGIES FOR ABSENCE

Apologies received were noted as above.

3. DECLARATIONS OF INTEREST

In relation to any item on the agenda of the meeting Board Members were reminded of the need to declare:

(i) any interests which were relevant or material to the ICP
(ii) that nature of the interest declared (financial, professional, personal, or indirect
(iii) any changes in interest previously declared.

There were no declarations of interest recorded. Members were reminded of the need to declare any interests relevant or material to the ICB.

4. APPROVAL OF PREVIOUS MINUTES

The minutes of the meeting held on 20 March 2024 were taken as a true and accurate record and approved.

Outcome:

The minutes of the meeting held on 20 March 2024 were approved and taken as a true and accurate record.

5. MATTERS ARISING AND ACTIONS

The Chair highlighted the main matter arising from the previous meeting.

20.03.2024
The ICP was to receive a progress update on a significant programme or work aimed at improving the life chances of Children and Young People (CYP) and the 'Start Well' workstream from the Futures Group. This is contained within Item 9, 'Futures Group Report'.

Outcome:

The ICP noted the update provided to the matters arising.

6. NOTIFICATION OF ANY OTHER BUSINESS

There were no items of any other business to be raised.

HUMBER AND NORTH YORKSHIRE STRATEGIC PARTNERSHIP

7. INTEGRATED CARE BOARD REVIEW

The meeting commenced with a discussion on the ICB review, and the Chair, Sue Symington and Stephen Eames provided an update highlighting the importance of the connections between the ICB and the ICP.

Sue Symington noted the upcoming election, and the effects of the pre-election period on current work. A summary of the challenges faced by the Integrated Care Board was provided, including industrial action by junior doctors, upcoming GP industrial action, Urgent and Emergency Care pressures, and a current cyber incident in London. With regards to the GP industrial action, the BMA have released a ballot of potential actions to be taken into the public domain.

An update was provided regarding the new financial year, with significant contributions from colleagues recognised. Sue Symington highlighted a number of projects regarding the financial targets which created internal pressures, and the creation of medium and long-term strategies to strengthen the process going forward.

There was an update on the development of longer-term work including the Design for the Future, and the 'Start Well' approach through the Futures Group. It was noted that 'Age Well' had been the focus of the Futures Group session which occurred prior to this meeting.

Sue Symington noted that Richard Barker, Regional Director of North East and Yorkshire was to retire, and publicly recognised his work with the ICB.

Stephen Eames noted that James Farrar is taking on the role of Chief Executive of the York and North Yorkshire Combined Authority in support of the newly appointed Mayor.

It was noted that the ICB's AGM was to occur on the 10th July and is to be released in film format.

Outcome:

The ICP noted the current pressures of the ICB and the creation of long-term development and sustainability programmes.

8. LOCAL GOVERNMENT PARTNERSHIP REVIEW

Cllr Jonathan Owen presented a summary of the main issues facing Local Authorities (LAs) emphasising the impact of the pre-election period on work including the devolution proposals in Hull. He also highlighted the challenges in attracting people to work in social care, and recognised the development being done on workforce strategy with LAs, the ICB, and wider organisations.

The financial challenges faced by local governments, with a focus on the balancing of statutory requirements for public and population health with prevention and community development, were highlighted and reference was made to limited public health funding. Cllr Owen noted upcoming funding discussions on continuing healthcare and Section 117 agreements with the ICB.

Cllr Stan Shreeve highlighted the arrangements in North East Lincolnshire, as a Section 75 agreement has been established with the ICB. This is representative of increasing delegation and collaboration, with the Joint Committee comprising of ICB at Place and Local Authority.

Positive progression was shared regarding the outcomes of recent Health and Wellbeing Board 'deep dives' on topics including the cost of living crisis, climate change, and housing. Working groups were forming to support work in these areas.

Cllr Owen welcomed Brickchand Ramruttun as a new member of the Group.

Cllr Michael Harrison highlighted potential upcoming post-election changes in policy and encouraged members to consider issues including care market reform and proposed cap on care costs.

Outcome:

The ICP noted the progress, developments and challenges faced by Local Authorities.

9. FUTURES GROUP REPORT

Charlie Jeffery, the Chair of the Futures Group provided an update regarding the current focus of the Futures Group which, this month, had combined with the Place Leadership Group to explore medium-term issues around 'Start well' and 'Age well'.

It was reported that significant progress has been made within the 'Start well' workstream. The group received an update from HNY Connected which is running proof-of-concept pilots focusing on children and young people (CYP) in North East Lincolnshire and York Places. This involves creating datasets, producing academic research for insights, and deploying with professionals in, with and for communities. Discussions were held on appropriate governance and delivery structures.

The pilot projects were exploring connecting health and education data around autism diagnosis, which included the involvement of schools. A full business case is being developed to assess effectiveness beyond these pilots.

Charlie Jeffrey reported on progress regarding the 'Age Well' programme, noting that workshops highlighted inequality and the links between disadvantage and lifespan as areas of interest, preventative action, employment, coastal populations, and technology access as areas of access and key parameters which influence ageing well. Workshops have been planned to join the work across Places.

The Group had been briefed on the Liberated Method, which takes a person-centred approach rather than service-centred and creates conditions for people

to access their own capability to thrive. The Futures Group agreed that there was significant opportunity in adopting this type of approach across the Partnership and an agreement was reached to explore the Liberated Method to enhance the Integrated Neighbourhood Teams approach.

Outcome:

The ICP Members noted the report from the HNY Futures Group and supported the next steps.

10. SHARED FRAMEWORK FOR EXCELLENCE SUSTAINABILITY AND PREVENTION AT PLACE

Pete Thorpe, Executive Director of Strategy and Partnerships for Humber & North Yorkshire ICB provided an overview of work being undertaken at ICB level to develop a shared framework for Place and emphasised the importance of collaboration in sustaining public services and the ICB's commitment to develop a structure for learning across Place.

It was noted that the delegation of resource and decision-making was still being finalised within the ICB through the Collaboratives and Places, and that the aim was to create efficient working relationships as the ICB operating model matures.

Sue Symington noted the development of governance structures and communication throughout all levels of the organisations to ensure efficiency.

Sarah Coltman-Lovell, NHS Place Director for York, reflected on the positive outcomes of the Place Framework in galvanising action, and highlighted the value of the ICB having a clear framework in place for enabling mechanisms to tackle wider determinants of health.

Outcome:

The ICP supported the draft Place Framework.

HUMBER AND NORTH YORKSHIRE PARTNERSHIP OUTCOMES

11. INTEGRATED STRATEGY FOR WELLBEING, HEALTH & CARE

Pete Thorpe, Executive Director of Strategy and Partnerships for Humber & North Yorkshire ICB, updated on the review of the Integrated Strategy for Wellbeing, Heath and Care following on from the previous meeting. The Strategy had been socialised amongst various stakeholders, committees, and the ICB Board.

It commits to a person-centred approach, listening to the voices of the people we serve, and aims to increase healthy life expectancy and narrow the gap in healthy life expectancy.

It was agreed that the implementation requires a strong partnership approach and system investment to empower collaboration and achieve an outcome-based approach to each of the big four aims: reducing harm from cancer, cutting cardiovascular disease, living with frailty, and enabling mental health and resilience.

It was recognised that the Strategy is based on the health and wellbeing plans of the 6 Places, and system plans will need to be aligned accordingly. The Outcomes Framework (discussed in Item 12) will also assist in signposting where plans may develop, for example through IRIS, and through workforce.

Stephen Eames noted the challenging process of reallocating resource to progress and change current frameworks and highlighted the commitment to providing a generational change for our children. It had also been agreed to seek to allocate 5-10% of resource towards the prevention agenda.

Cllr Owens noted that pressures are similar in the LA sphere, and mutual understanding on mitigating pressures will benefit the system.

Those present approved the final version of the Strategy presented.

Outcome:

The ICP received and approved the final version of the Integrated Strategy for Wellbeing, Heath and Care.

12. OUTCOMES FRAMEWORK

Jake Abbas, Deputy Director of Population Health Intelligence presented the draft Partnership Outcome Framework. There had been revisions to and development of a set of population health measures through which to measure healthy life expectancy and life expectancy in line with the big four health outcomes (reducing harm from cancer, cutting cardiovascular disease, living with frailty, and enabling mental health and resilience), the focus on children and young people, and the emerging Place Framework.

The challenges surrounding selecting the correct measures to use was highlighted, particularly due to the long-term nature of the data being recorded. Work was underway to establish logic models of understanding how to measure

day-to-day work impacts and long-term effects, and how this can lead to implementing evidence-based interventions for outcomes.

Collaborative system-wide work is being prioritised to allocate delivery of interventions, and to establish the analytical function e.g. measuring inequalities at a granular, local level. Qualitative research is being considered alongside quantitative data to centre the patient experience.

A proposal for the deployment of decision support units and strategic intelligence functions will be presented to a future ICP meeting.

Outcome:

The Partnership noted the progress to develop an outcomes framework and agreed to receive a detailed report at a future meeting.

13. AGEING WELL

Population – Demographic Time Bomb

Jack Lewis, Consultant in Public Health, presented an update on the ageing population in Humber and North Yorkshire, and displayed population demographics showcasing the intersectionality of deprivation and other wider determinants of health, explaining the challenges this creates.

It was noted that there have been widening inequalities between Life Expectancy (LE) and Healthy Life Expectancy (HLE) over the past decade, with a decline seen in some areas of our geography for both men and women.

It was highlighted that hospital admission rates from the older populations are drastically increasing as the rate of over 75s in our region grows, and that the changing disease burden must be accounted for with an increase in age-related ailments including dementia.

The Partnership was made aware of the geographical inequalities within the region, and the intersectionality of coastal/rural areas and older populations, and the challenges this provides in accurately assessing the care needs of the whole system in an equitable manner.

Four potential responses to the above challenges were explored: increasing capacity of services, increasing productivity, rebalancing health & care sectors, and focusing on prevention. It was discussed that increasing productivity and capacity alone would delay, rather than dissolve the challenge, and the Partnership agreed prevention and rebalancing the health and care sectors as

favoured responses. There was a recognition of the need for a system-wide approach to addressing the wider determinants of health.

Outcome:

The ICP agreed prevention and rebalancing of health and care as favoured responses to addressing the demand issues.

Frailty – Anticipatory Care?

Yvonne Elliott, Director of the Community Health and Care Collaborative and Anna Folwell, Community Consultant Geriatrician at the Jean Bishop Integrated Care Centre provided an update on the work of the Community Centre of Excellence for Frailty which included distilling 40 principles for ageing well and frailty to 10.

The ageing well and frailty principles support people to live well with frailty and deliver independence, and cover areas including understanding needs of the population, embracing digital technology, and establishing dedicated clinical and strategic leadership. Each Place has been asked to rate itself against the principles, with wide variation across principles and Places found currently.

A Clinical Network had been established to share good practice and a Frailty Strategy is being developed based on the principles underpinned by the Place-Level Framework to provide individual and system outcomes. Other ageing well centres are being contacted regarding research, and the Strategy will examine effective training to increase workforce productivity in this area.

It was agreed that the Centre of Excellence for Frailty is an excellent example of sharing best practice and addresses the challenge of Urgent and Emergency Care pressures by focusing on prevention, at-home, and community care.

A Frailty Summit will be held in October to expand upon the work described, including examining different models for different areas. Concerns regarding accessibility and transport were discussed, and it was noted that there needed to be increased access to health services.

Outcome:

The ICP noted the progress and the work to develop the Frailty Strategy.

Age-Friendly Cities and Communities

Carly Walker, Healthy Ageing Lead at North Yorkshire Council introduced the Age-Friendly Cities and Communities concept developed by the World Health Organisation, an effort-based concept which champions a preventative local

response to encourage active ageing. The concept details 8 areas of focus to optimise opportunities for health, participation, and security in order to enhance quality of life as people age. These include outdoor spaces and buildings, civic participation and employment, respect and inclusion, communication and information, social participation, housing transport, and community support and health services.

North Yorkshire and York have signed up to participate, with East Riding of Yorkshire preparing to. The methodology includes aiming for a select few of the 8 domains at once, with the option of supplementing the work with other programmes of work. North Yorkshire have had 4 priorities signed off by the Council's management board.

Janet Smith, Public Health Lead for Older People in East Riding of Yorkshire Council updated on developments within East Riding, which has formed a steering group to establish a baseline profile and intelligence document to identify projects and relevant stakeholders. They are applying for the National Network with a plan to join the Global Network of Age-Friendly Cities in the future.

A number of considerations were highlighted for the partnership including use of age friendly images, ensuring age-friendly workplaces, access to training to support engaging harder to reach older people, loneliness and isolation and reviewing how the voice of older people informs and shapes provision.

Cllr Owens suggested sharing the concept with other organisations within the system to encourage connecting the work up locally.

Outcome:

The Partnership supported the Age Friendly Cities and Communities principles and encouraged all local authorities and other organisations to consider signing up to the Age-Friendly Network and age friendly/healthy ageing partnerships.

14. TRANSPORT AND TRAVEL

Cllr Owens reported on the complexity of travel arrangements for healthcare and community transport due to the current arrangements of contracted transport. Due to the size of the ICS, the issue is difficult to address, and the Partnership was notified that the VCSE Collaborative is undertaking a mapping exercise to assess challenges with community transport. Further details are to be shared at the next meeting of the Partnership.

Gary Sainty, Programme Director for the Voluntary, Community, and Social Enterprise Collaborative, summarised recent discussions with community transport organisations, noting that concerns were raised around a lack of certainty of what is available around the system. The mapping exercise intends to promote opportunities to work alongside LA colleagues to ensure people can access health and wellbeing activities.

Outcome:

The ICP agreed to receive a detailed report at the next meeting.

15. ANY OTHER BUSINESS

There were not items of Any Other Business.

16. CLOSING REMARKS

The Chair concluded the discussion acknowledging the substantial amount of information discussed and asked those interested in contributing to the transport discussion to raise the matter with herself and/ or Karina Ellis.

DATE AND TIME OF THE NEXT MEETING:

Wednesday 25 September 2024 at 14:00 - 16:00.

Humber and North Yorkshire
Health and Care Partnership

Report to:	Integrated Care Partnership
Date of Meeting:	25.9.2024
Subject:	Update on the Developments at Place
Sponsor:	Peter Thorpe, Executive Director Strategy
Author:	Alex Seale North Lincolnshire Place Director

STATUS OF THE REPORT: *(Please click on the appropriate box)*

Approve ☒ Discuss ☐ Assurance ☒ Information ☒ A Regulatory Requirement ☐

SUMMARY OF REPORT:

The Integrated Care Strategy has been reviewed to lift and simplify the ambition of the Integrated Care System. In tandem, the operating model of the ICS is on the journey of maturity to a smaller Integrated Care Board in a flourishing system of five collaboratives and six Places taking on delegated resources and accountability.

This report provides an update on the developments within Place in this context. The report covers a number of areas:

- Progress on the role of Place in driving a number of key priorities within the ICB and wider ICS.
- The progress since the approval of the Place Framework by the ICB and ICP in June 2024.
- Work to develop the future role of Place in the context of the developing ICS operating model of a smaller ICB in a flourishing system.

An update on how Place has engaged in a number of strategic priorities within the ICS is included alongside progress on the development of integrated neighbourhood teams.

In June the ICB signed off the Place Framework which describes how Places will operate to drive our aim of narrowing the gap in health inequalities and increasing healthy life expectancy, and the ambitions of enabling equity and improving outcomes and experience of services across the life course.

A Place Design Group has been established under the authorising environment of the Leaders Forum. The Place Design Group is taking forward the implementation of the Place Framework focusing on system priorities including the socialisation of the Design for the Future Blueprint, working arrangements between Places and Collaboratives in the context of greater delegated resources and accountability and the development of a peer review approach across Places

The Leaders Forum has endorsed an approach for a future proposition for Place and how Place will work with the wider system to deliver the ICS ambition.

RECOMMENDATIONS:

- Members are asked in note the ongoing work to support Place development and the next steps for the progression on Place development

ICP STRATEGIC OBJECTIVE (p*lease click on the boxes of the relevant strategic objective(s)*

Addressing Health Inequalities and improving healthy life expectancy	☒
Delivering the vision – start well, live well, age well, die well	☒
Supporting our strategic intentions – creating the conditions, think person, think family, think community	☒

IMPLICATIONS (*Please state N/A against any domain where none are identified)*

Finance	NA
Quality	Quality impact is identified within the Place Framework
HR	NA
Legal / Regulatory	The Place Framework sets out the operating environment in which the ICB will deliver the 'triple aim' to have regard in making its decisions to; the health and wellbeing of local populations; quality of services; sustainability and efficiency and outlines the underpinning governance approach to support this.
Data Protection / IG	NA
Health inequality / equality	Places are coordinating work to improve population health with partners.
Conflict of Interest Aspects	NA
Sustainability	The Place Framework describes a sustainable approach to support the delivery of the ICB 'triple aim' to have regard in making its decisions to; the health and wellbeing of local populations; quality of services; sustainability and efficiency.

ASSESSED RISK:

Strong partnership working needs to be established to ensure that the ICP can deliver on the transformation and integration requirements. This is being delivered through the embedded Place-based approach set out in this paper.

MONITORING AND ASSURANCE: Monitoring is through Place Committees/Partnerships and reporting to the Integrated Care Partnership

ENGAGEMENT: Engagement has been undertaken through the Place Design Group which includes Local Authority Executive Leadership, Place Director and ICB Executive input.

REPORT EXEMPT FROM PUBLIC DISCLOSURE	No ☒	Yes ☐
If yes, please detail the specific grounds for exemption		

UPDATE ON DEVELOPMENTS WITHIN PLACE

1.0 INTRODUCTION

The operating model of the ICS is on the journey of maturity to a smaller Integrated Care Board in a flourishing system of five collaboratives and six Places taking on delegated resources and accountability.

2.0 DELIVERY AND TRANSFORMATION IN PLACE

Place is a driver of transformational change at the frontline of health and care that delivers on both the ambitions of the ICS and the broader place-based aspirations.

Place has three core functions in the Integrated Care System where this is a unique and specific ability to deliver outcomes, sometimes referred to as the “Place Premium”:

- **Strategic relations and system convener**
- **Support delivery of Integrated health and care**
- **Population health improvement**

Areas of focus in Place include:

Integrated urgent care including discharge for hospital, patient flow and frailty - Leading the Place system approach to discharge and Urgent and Emergency Care (UEC) pressures and delivering transformation of the UEC system with partners in the Place

Population health management and preventative approaches using population health data and focussing the work plans on reducing health inequalities with a specific focus on vulnerable population cohorts e.g. impact of rurality and access to services for inclusion groups and areas of deprivation working closely with partners including the voluntary and community sector

Delivering our integrated community offer Developing out of hospital options that support people in their own home and communities and avoid the need for hospital admissions and deliver effective discharge from hospital

Primary care transformation including development of integrated neighbourhood teams the development and roll out of integrated neighbourhood teams focusing on or more vulnerable populations reducing demand pressures and improving outcomes for people.

Managing our most complex and vulnerable populations complex case management to ensure the best outcomes for our most vulnerable populations, adults and children with more complex needs and high intensity users.

Best use of resources Places are sharing learning to maximise impact and engaging in the 10 identified productivity programmes. Place Partnerships are focused on opportunities for more effective joint working and use of resources across workforce, estates and digital and integration and joint commissions approaches with local authority partners.

A core component of Place is the development of a network of integrated neighbourhood teams which are networks of providers coming together to provide integrated service delivery, focused on local communities (c30-50k populations) and enabled by population health intelligence.

There is an existing programme of successful work that has been done to develop integrated neighbourhood (INT) team working. All Places are developing INT, but some of the INT working is at an earlier stage of maturity and this will be driven at a greater pace and scale. The approach will be through a consistent approach to delivery that is sensitive to the individual Place dynamics (every Place has a unique set of challenges based on population, social, political, environmental and economic & provider market). Enclosed is a case example from Hull Marmot INT. There are a number of similar examples across Places.

The York Health and Care Partnership has embarked on a programme of work to realise the potential of Integrated Neighbourhood Teams. A multi-agency team of professional leaders (PCN Clinical Directors, Public Health, Council, VCSE, Community Health and Mental Health services) is participating in training delivered by The Primary Care Networks Academy working in collaboration with the School of Business and Society, University of York focusing on an approach that understands the differentiated needs specific to the locality.

The North Lincolnshire Health and Care Partnership have tested an approach in the Scunthorpe South Locality. Centred around collaborative learning, the Partnership have taken a "team of teams approach to supporting people with improved health and care interventions. These interventions have impact both at system level and at direct care level. This approach has been co-produced by Primary Care, Hospital Trust, Community Health, Mental Health, Adult Social Care and the VCSE Alliance. The focus area is people with learning disabilities and severe and enduring mental illness. There is now a defined cohort of individual and granular understanding of their issues.

East Riding have recently undertaken a review of their model for integrated team working using a "test and learn" approach. Different evaluation methods have been used including case studies, semi-structured interviews, and quantitative data against measures of population, individual and integration. Integration has been reported as having the greatest impact for professionals to date, highlighting the siloes that currently exist within the health and care system and the lack of knowledge and awareness of what support system partners are able to offer. INTs have created a space for professionals to come together and gain a better understanding of each other and their services, developing direct relationships which have enabled them to overcome connectivity barriers. Services which have previously worked in a reactive way are being given the opportunity to take a proactive and preventative approach.

Challenges that have been identified include sharing information, professional working approaches, communication and ensuring that all professionals are involved fully and understand the concept of INTs as business as usual, rather than an additional task.

North Yorkshire are working with partners to develop INTs as a sustainable approach to integration rather than a structural change to existing services and partnerships, including supporting the sharing of data and population health intelligence to help identify populations and meet the needs of people and communities. The approach has a focus on complexity, not disease pathways and sharing and spreading of learning between localities to promote continuous improvement and learning. Each of the emerging integrated neighbourhood teams has identified a specific population area of focus for integrated working.

Each Place has a plan for roll out and further development of INT working, and plans are under review to see how we can accelerate this to meet the Design for the Future Blueprint ambition.

A key enabler to delivery of this approach is the close alignment of the Community, Primary and VCSE Collaboratives which will enable cross sector integration needed to deliver the model. In addition, progression to closer integrated working with local authorities will further drive this.

3.0 PLACE FRAMEWORK

In June the ICB signed off the Place Framework which describes how Places will operate to drive our aim of narrowing the gap in health inequalities and increasing healthy life expectancy and the ambitions of enabling equity, improving outcomes and experience of services across the life course. The Strategic Framework describes the pivotal role of Place-based health and care partners acting as one and leading for **excellence, prevention and sustainability**.

A Place Design Group has been established under the authorising environment of the Leaders Forum. The Place Design Group which comprises Place Directors and ICB and local authority Executive leadership, is taking forward the implementation of the Place Framework focusing on system priorities including the socialisation of the Design for the Future Blueprint, working arrangements between Places and Collaboratives in the context of greater delegated resources and accountability and the development of a peer review approach across Places.

4.0 PLACE DESIGN FOR THE FUTURE

Places are now moving forward to the next stages of maturity in their form and function. All Places are considering the next steps in terms of moving to more integrated arrangements with local authorities and other partners including establishment of joint committees and extended Section 75 arrangements (pooled funds with local authorities to enable the delivery of integrated care).

In North-East Lincolnshire there is now an ambition to further extend the integration arrangements to create one team, one place, one budget approach, building on the existing Section 75 arrangement. The approach includes the creation of a single leadership team that includes the Director of Children's Services, Director of Public Health and Director of Adult Services and functions such as housing and leisure to more effectively use the broader social and economic factors that determine a person's health. By working differently, this will drive health improvement for the four population groups that have been identified in NE Lincolnshire including improvements in population health and improvements in access and quality.

Places are redefining their working arrangements with Collaboratives, with Collaboratives acting as a focus for system design, and for acute and MHLDA delegated budgets, as well as providing subject matter expertise to inform place-based and sub-geography working.

This will be enabled by the development of the team within and around the Place, ensuring the resource, skills and expertise can be accessed at all levels of the system.

In addition, NHS Place leadership will need to evolve and ensure we have the skills and capacity to deliver each of the three key Place priorities, including effective succession planning and organisational development approaches to develop the skills and expertise to deliver our agenda.

To enable this, a review of the skills and resources needed to deliver the model of team in and around the Place will identify where resource is best deployed in tandem with redesign across Collaboratives and ICB alongside developing a systematised OD approach to develop the skills and business needs to deliver the mandate.

4.0 RECOMMENDATIONS

- Members are asked to note the ongoing work to support Place development and the next steps for the progression on Place development

Humber and North Yorkshire
Health and Care Partnership

HNY Integration Needs Assessment: Findings September 2024

Objectives

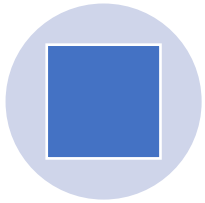
Humber and North Yorkshire
Health and Care Partnership

1. Assess history and current state of health, care, and wellbeing services integration
2. Evaluate effectiveness of integration in various contexts
3. Identify relevant current and projected contextual factors for further integration

Methodology

Humber and North Yorkshire Health and Care Partnership

Part 1:Data Analysis



Part 2: Evidence Review

Part 3: Qualitative Analysis

Humber and North Yorkshire
Health and Care Partnership

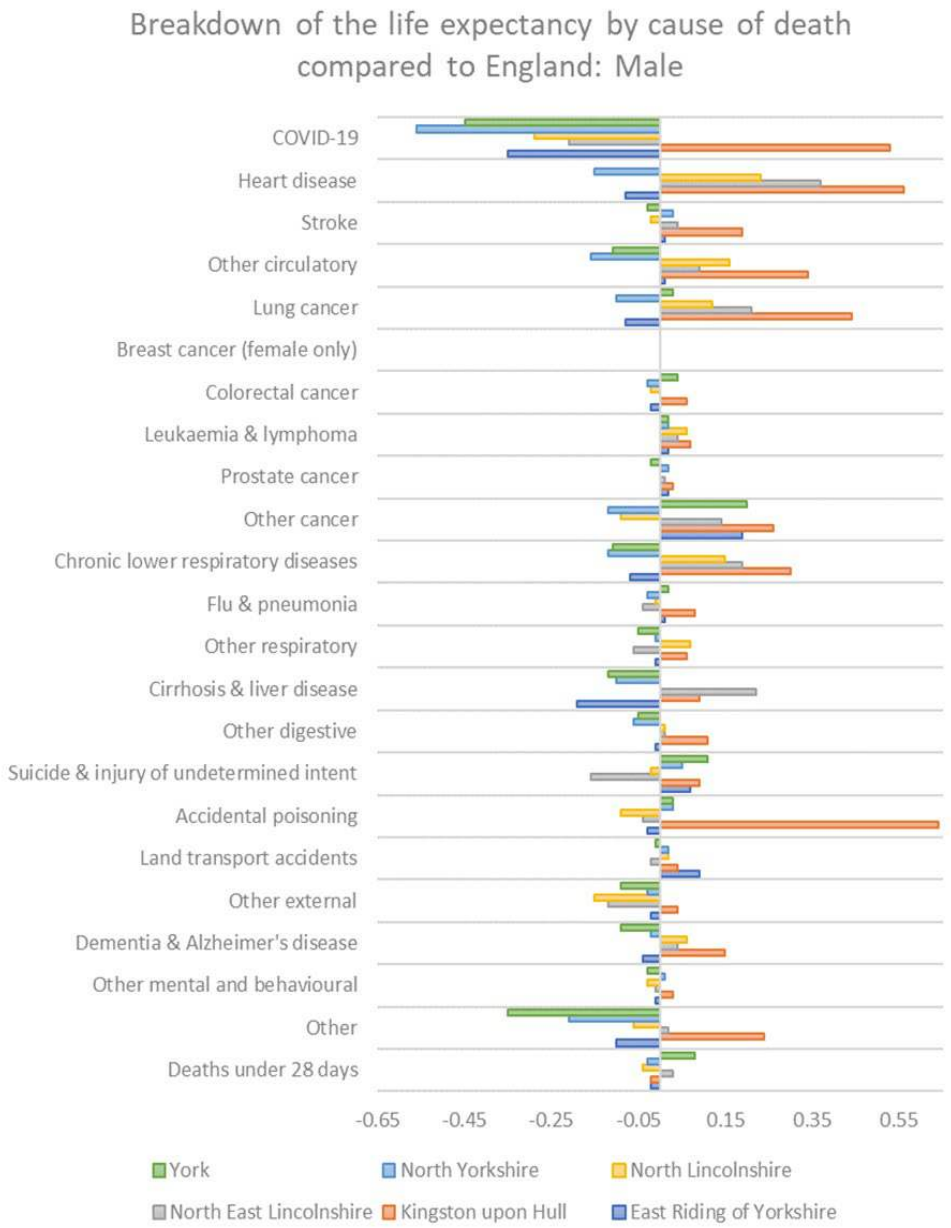
Part 1: Data analysis

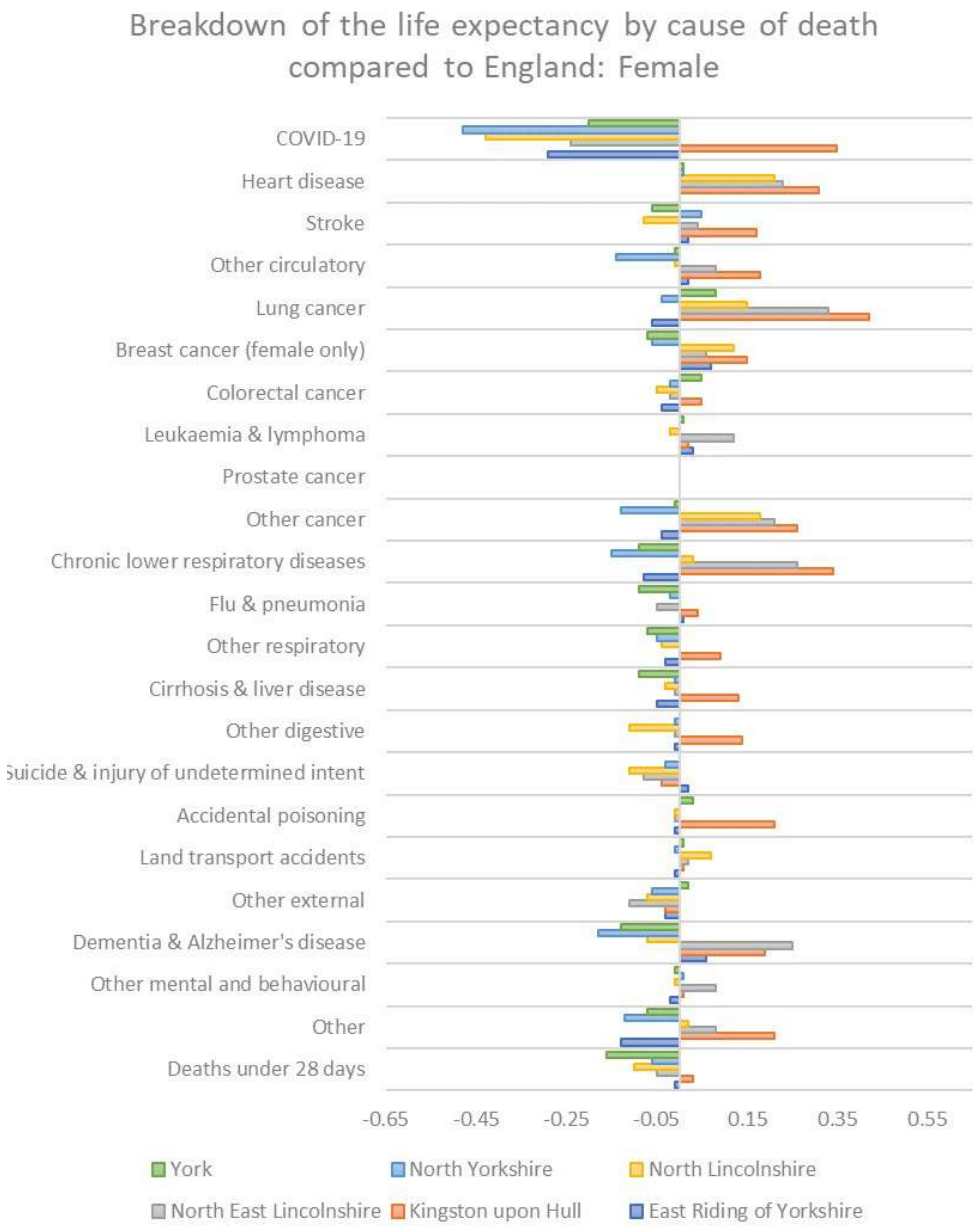
Inequalities

The Office for Health Improvement & Disparities' Segment Tool examines the gap in life expectancy between England and each local authority in relation to the causes of death which have the greatest excess deaths.

These figures compare HNY local authorities with the national life expectancy by the cause of death and gender.

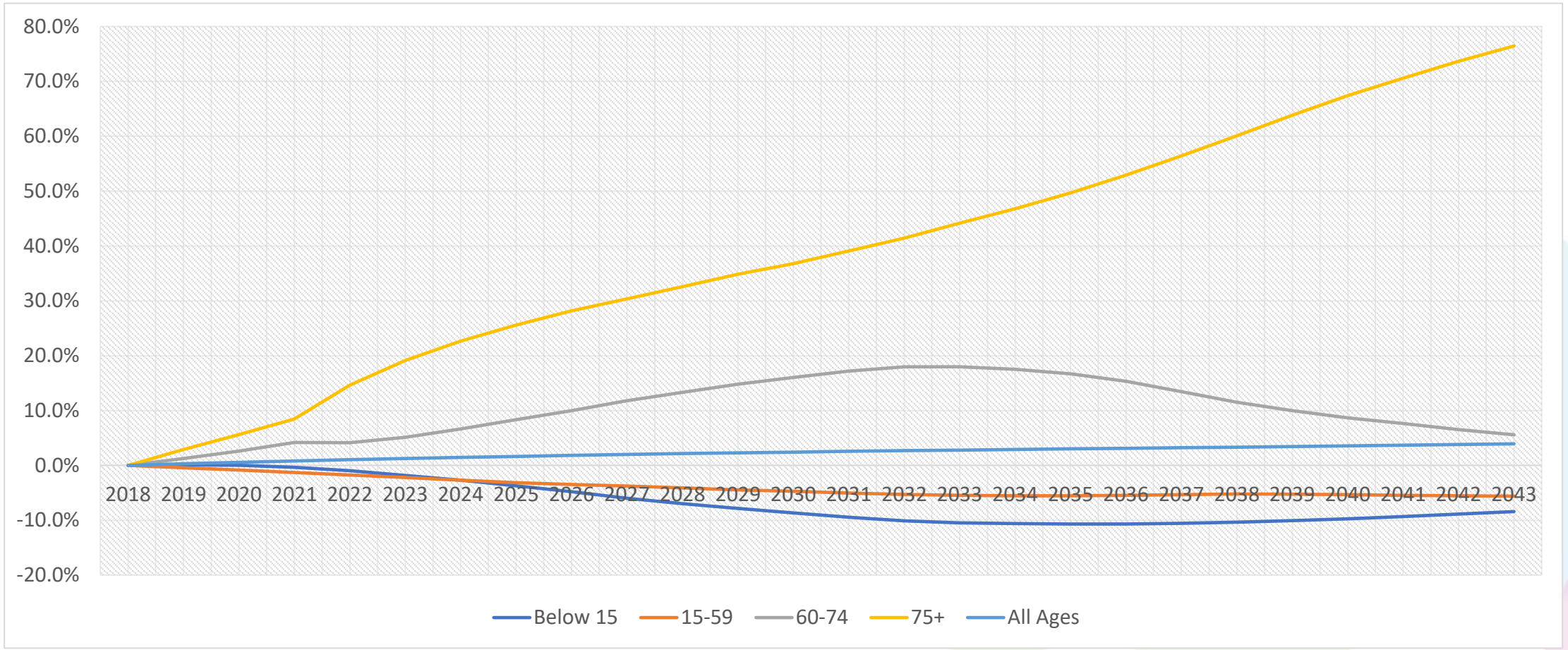
The latest data available is for 2020 to 2021 so is affected by Covid 19. However, there are several causes considered preventable for Hull, NE and North Lincs.





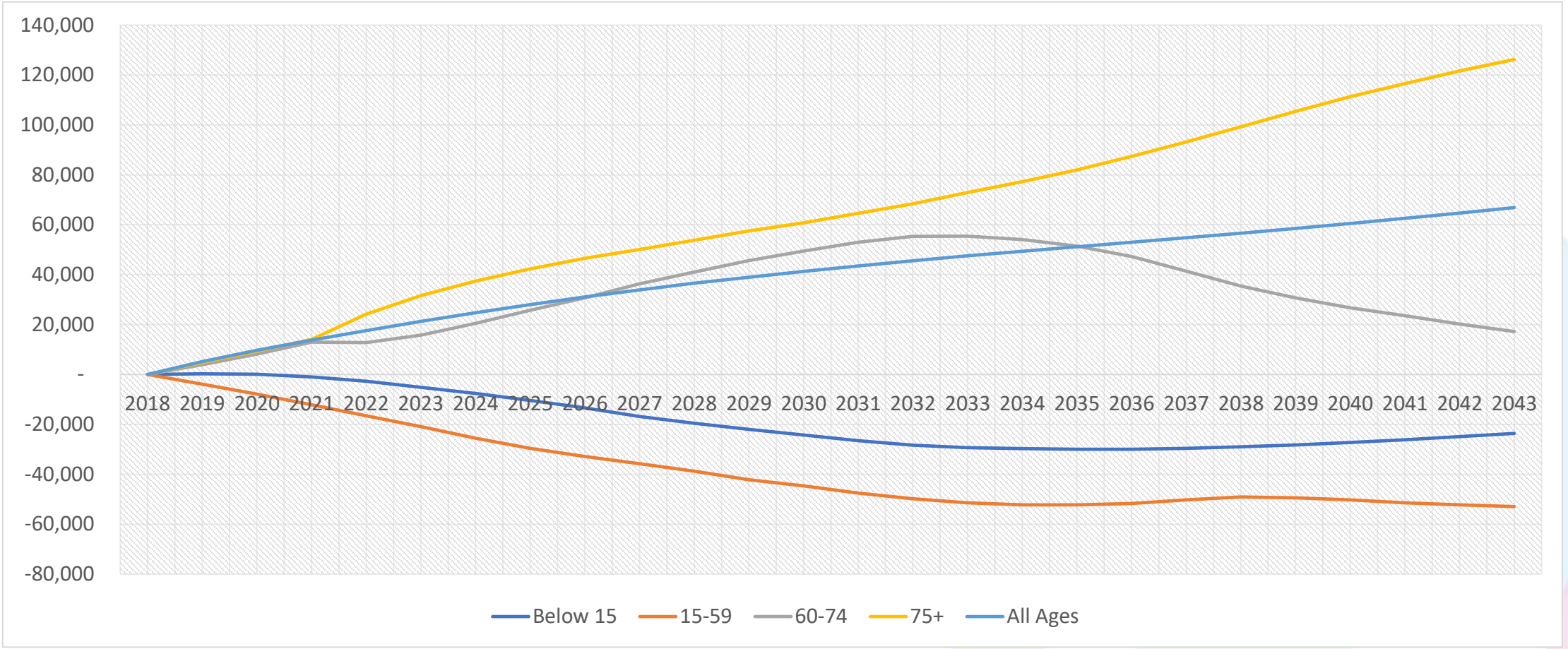
HNY Population Growth

Humber and North Yorkshire
Health and Care Partnership



HNY Population Growth

Humber and North Yorkshire
Health and Care Partnership



Coastal towns

Humber and North Yorkshire Health and Care Partnership

Town Name	Region	Town classification	Income Deprivation / Job Density classification	Total population	Population growth rate
Barton-upon-Humber	North Lincolnshire	Smaller other coastal town	Higher Deprivation Mixed	11,709	8.1%
Bridlington	East Riding	Larger seaside town	Higher Deprivation Residential	35,115	0.4%
Cleethorpes	North East Lincolnshire	Larger seaside town	Higher Deprivation Residential	38,996	-0.8%
Filey	North Yorkshire	Smaller seaside town	Higher Deprivation Residential	6,795	2.0%
Hornsea	East Riding	Smaller seaside town	Higher Deprivation Residential	8,807	4.3%
Withernsea	East Riding	Smaller seaside town	Higher Deprivation Residential	6,458	4.6%
Grimsby	North East Lincolnshire	Larger other coastal town	Higher Deprivation Working	88,565	0.8%
Immingham	North East Lincolnshire	Smaller other coastal town	Higher Deprivation Working	11,037	3.1%
Scarborough	North Yorkshire	Larger seaside town	Higher Deprivation Working	61,892	1.0%
Whitby	North Yorkshire	Smaller seaside town	Higher Deprivation Working	13,014	-2.9%
Hessle	East Riding	Smaller other coastal town	Mid Deprivation Working	14,631	1.0%
Kingston upon Hull	Hull	Coastal city	Higher Deprivation Working	261,048	1.5%

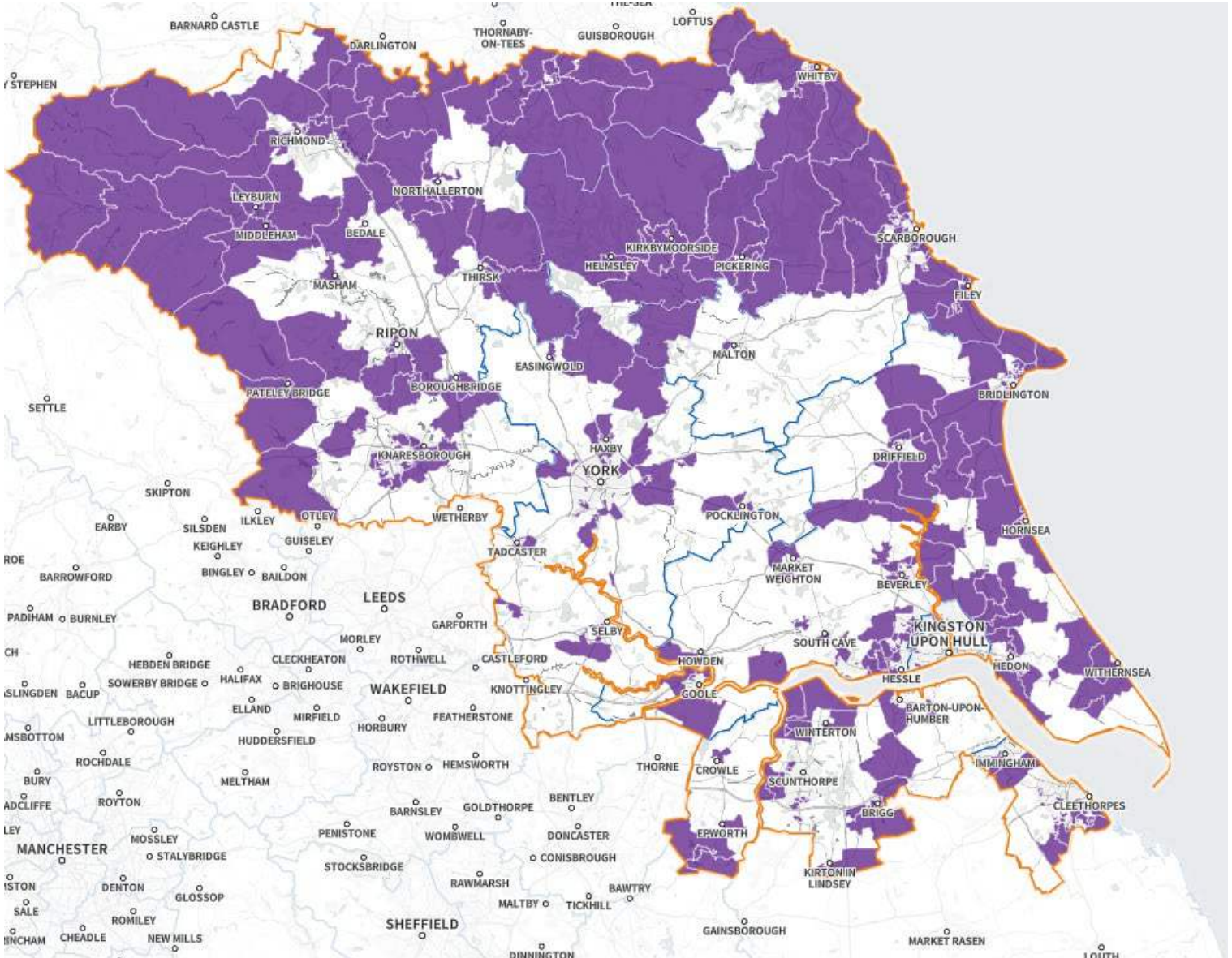
558,000 people live in coastal towns in HNY. Almost 110,000 (20%) are aged 65 plus.

Nationally, 71% of coastal towns had both slower population and employment growth than the England and Wales average over 2009 to 2018 (ONS).

Population growth in HNY coastal towns ranged from 8.1% in Barton-upon-Humber to -2.9% in Whitby.

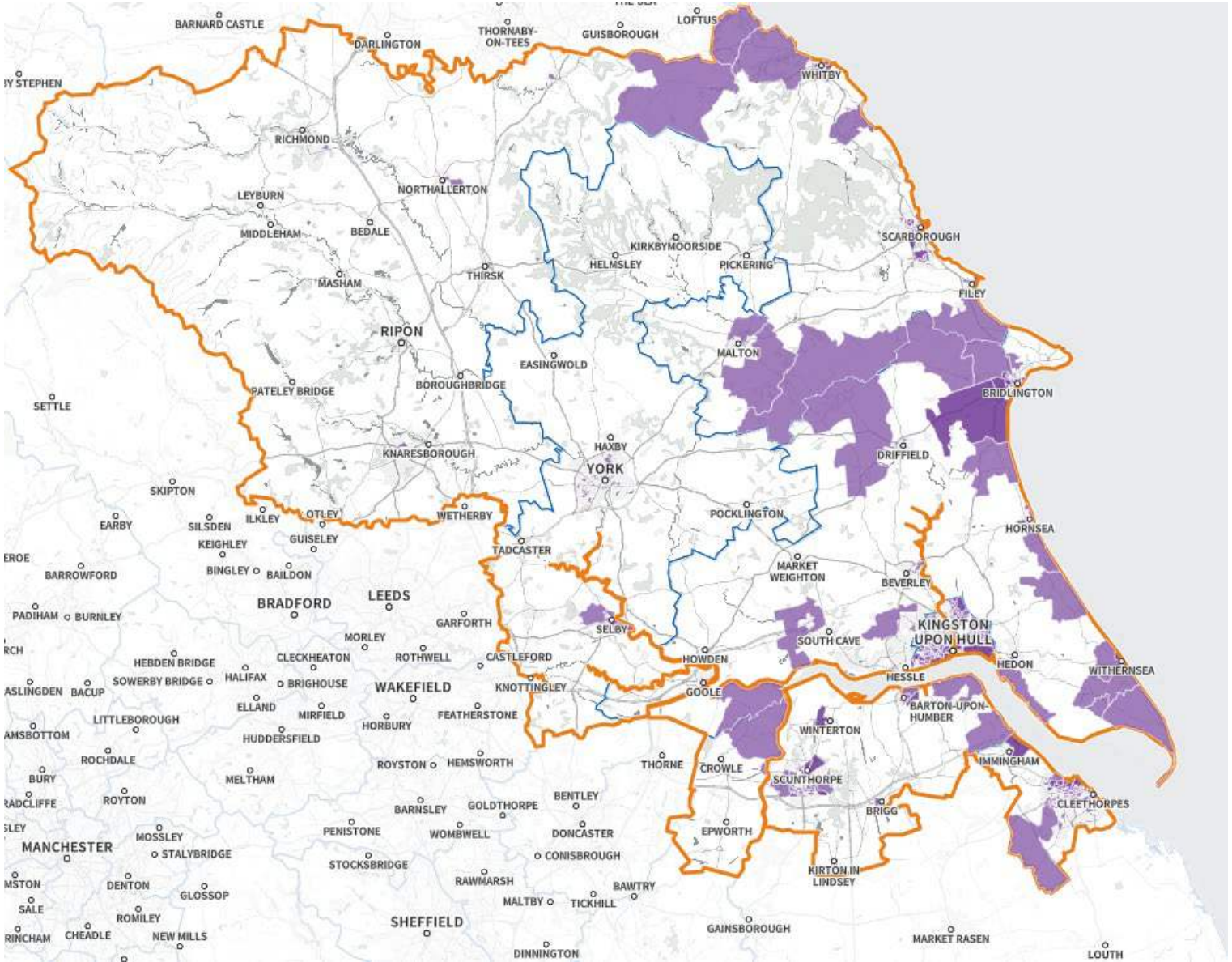
Areas where >20% of population is 70+, and growing

Humber and North Yorkshire Health and Care Partnership

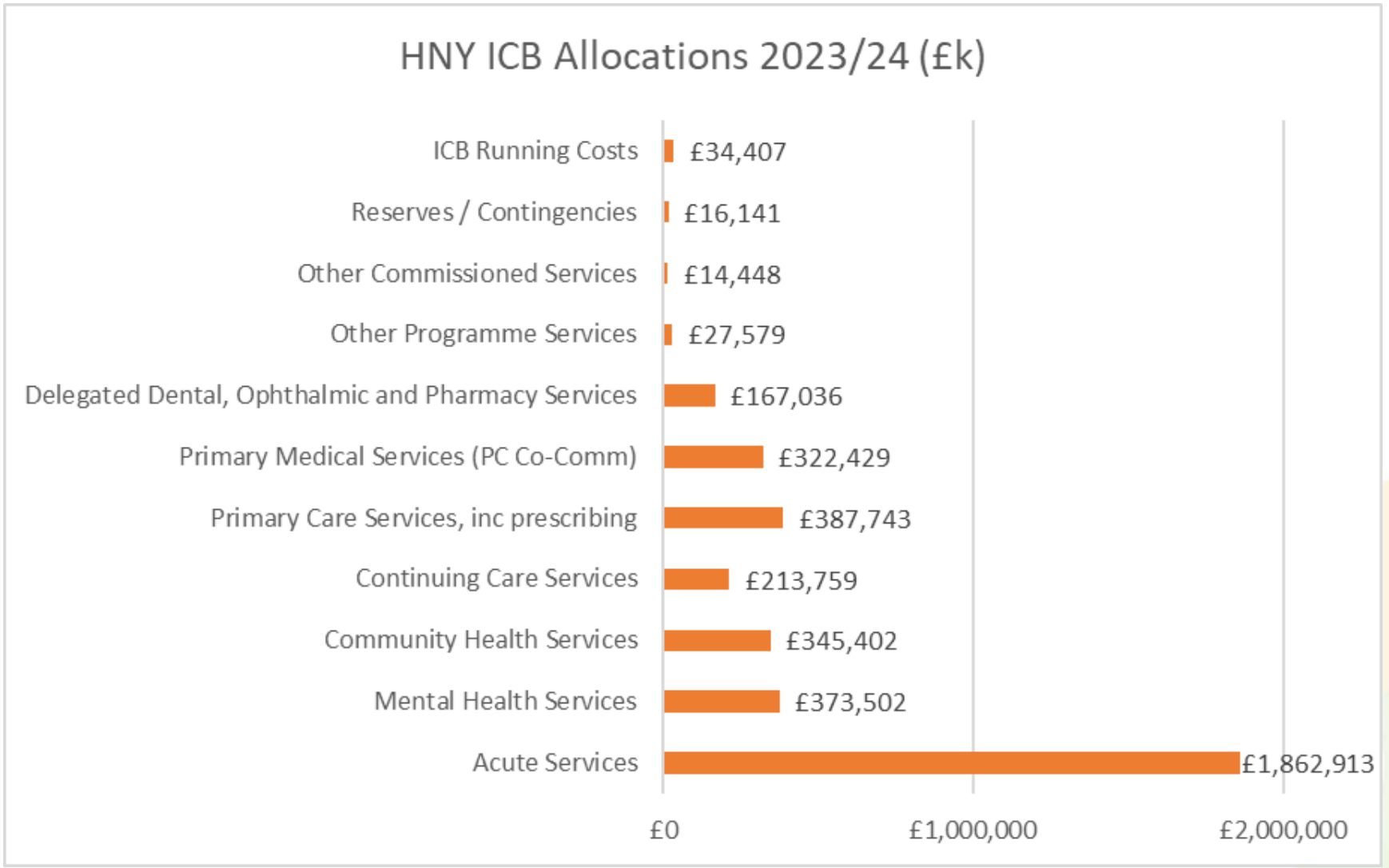


Population in 40% most deprived nationally

Humber and North Yorkshire
Health and Care Partnership



ICB Allocations 2023/24

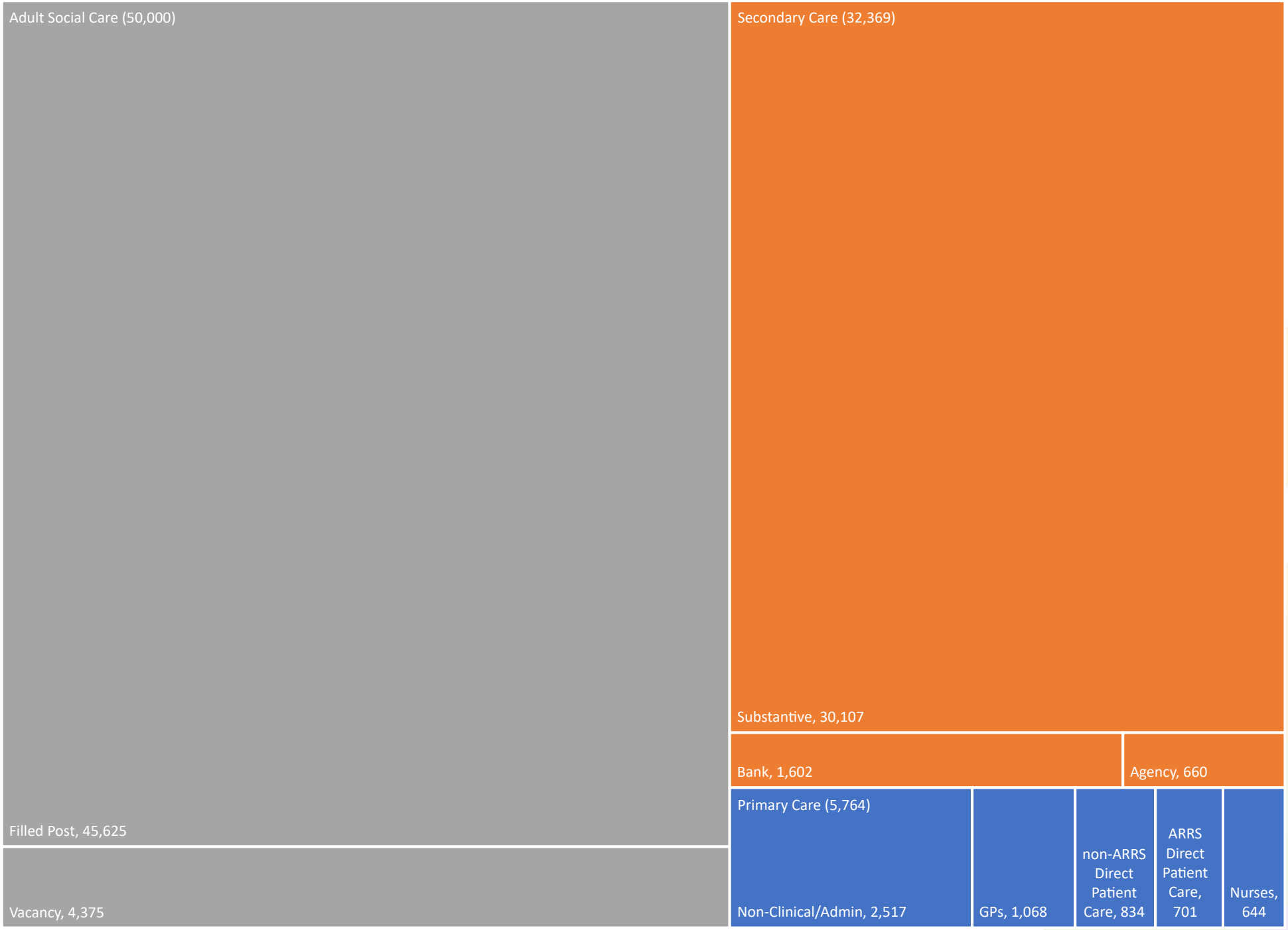


Humber and North Yorkshire Health and Care Partnership

Data has been obtained from Humber and North Yorkshire Board Papers.

£3.76bn is allocated for total expenditure in 2023/24.

Expenditure on Acute Services makes up **49.5% of all allocations** in 2023/24.

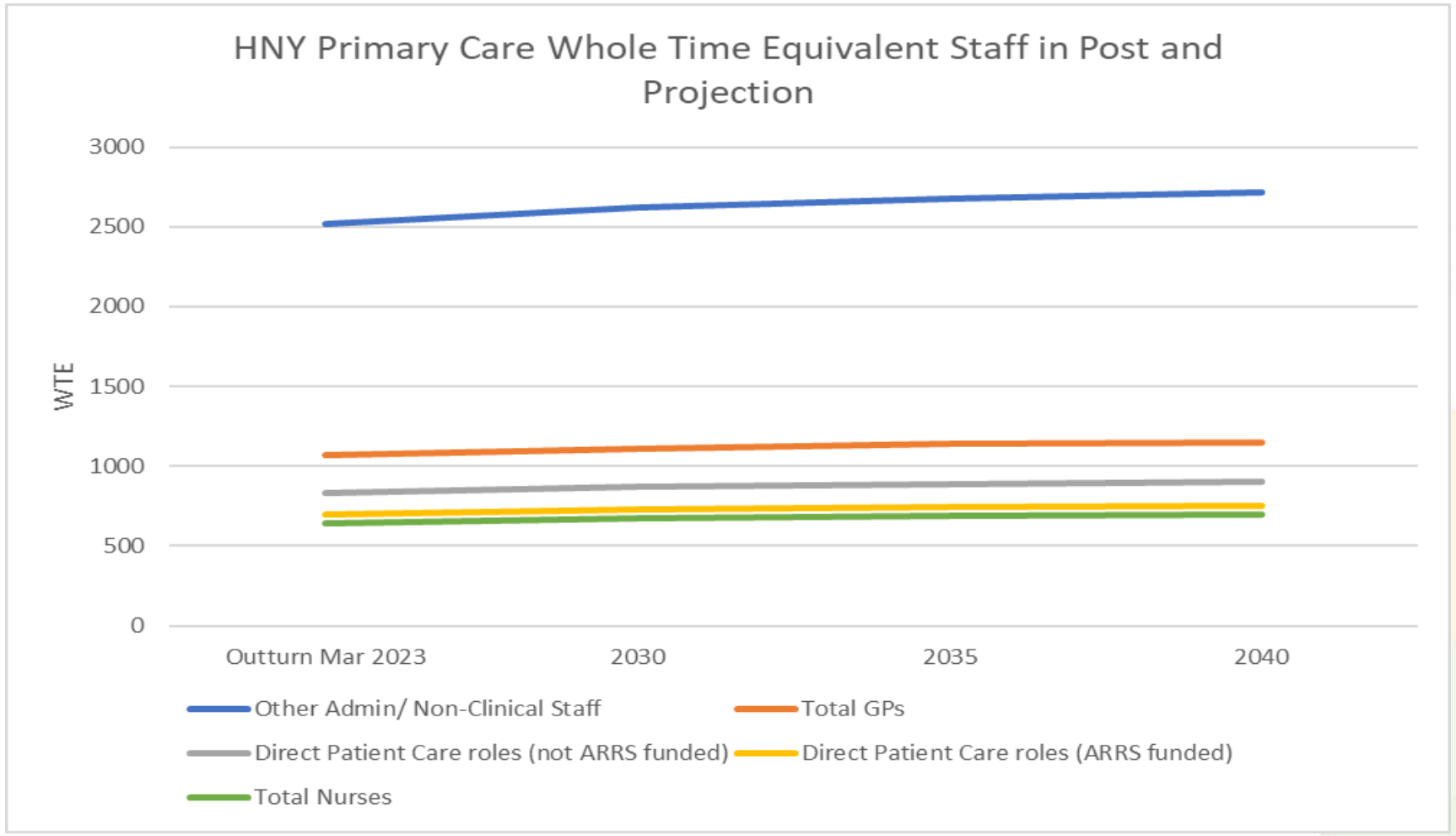


Humber and North Yorkshire
Health and Care Partnership

Current Workforce

General Practice

Humber and North Yorkshire Health and Care Partnership

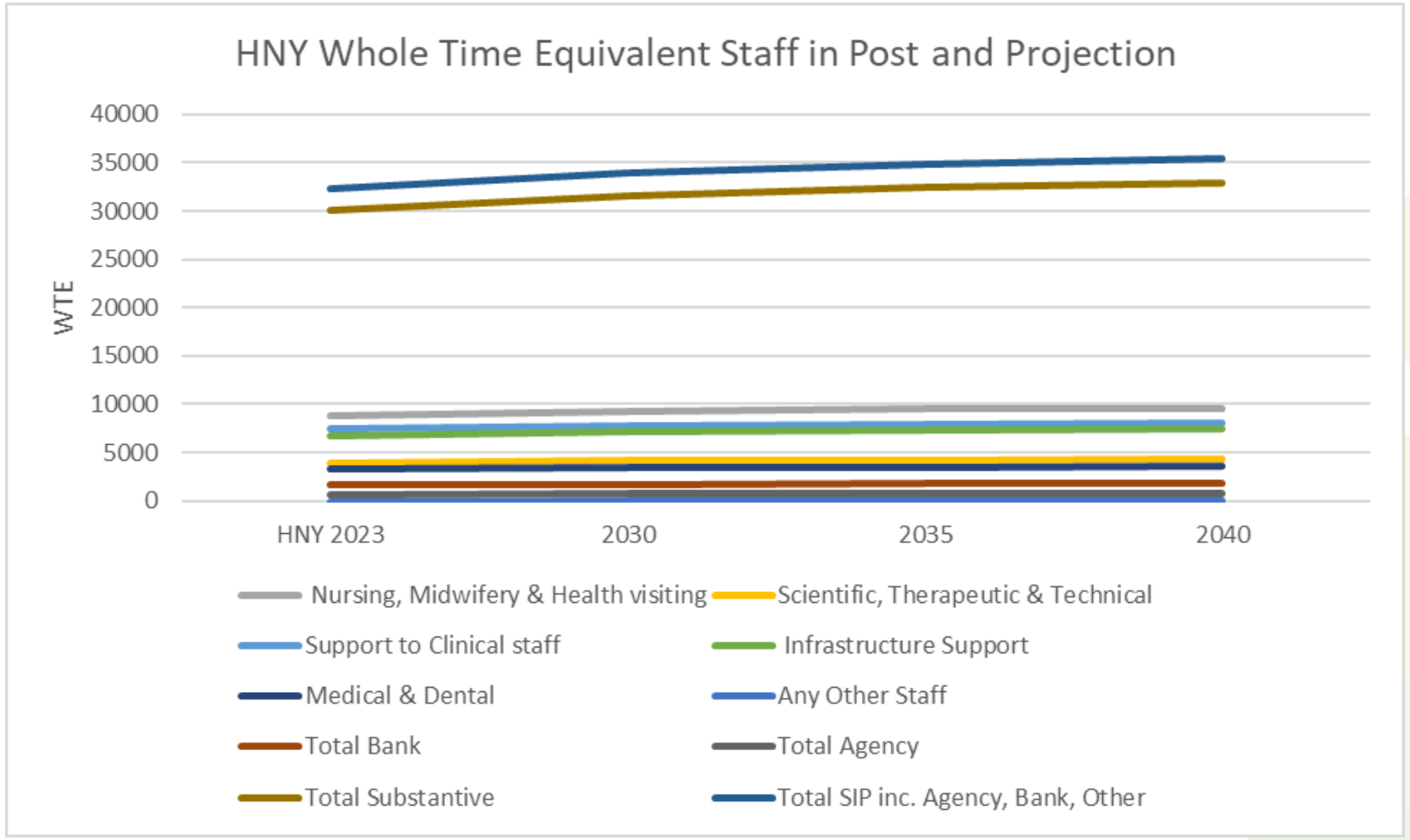


If the workforce increased at the same rate as the projected increase in GP Appointments, would require an **additional 452 WTE employees by 2040**. This includes an **additional 84 WTE GPs**.

Alternatively, if staff levels stay the same as they are now, to support a projected additional 800,000 attendances per year by 2040, would require each GP to support an additional 17 attendances per week.

Secondary Care

Humber and North Yorkshire Health and Care Partnership

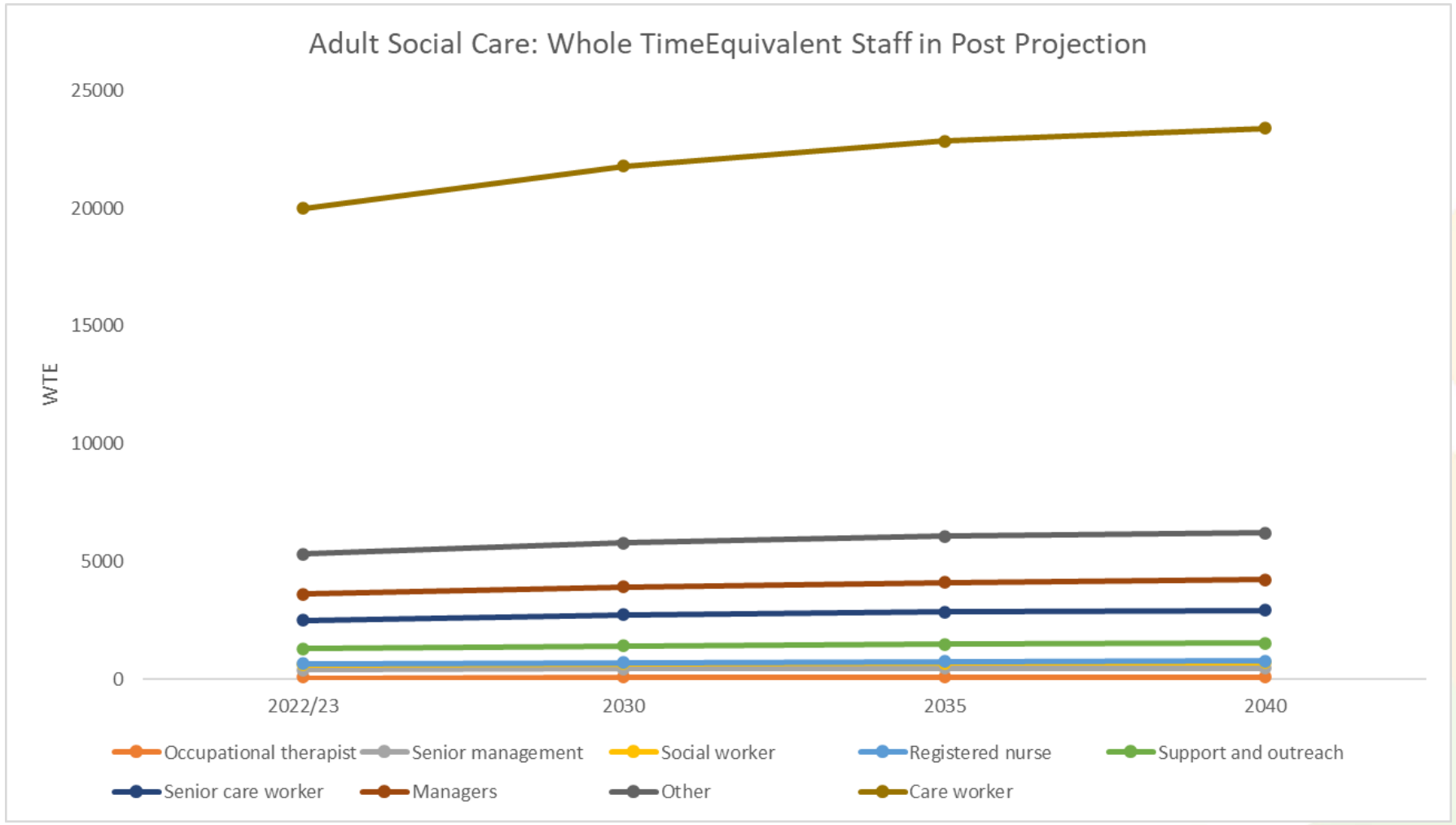


If the workforce increased at the same rate as the projected increase in Secondary Care attendances and admissions, an **additional 3,006 WTE employees would be required by 2040**.

This includes an **additional 301 WTE Medical & Dental staff** and **815 Nursing, Midwifery & Health visiting staff**.

Adult Social Care

Humber and North Yorkshire Health and Care Partnership

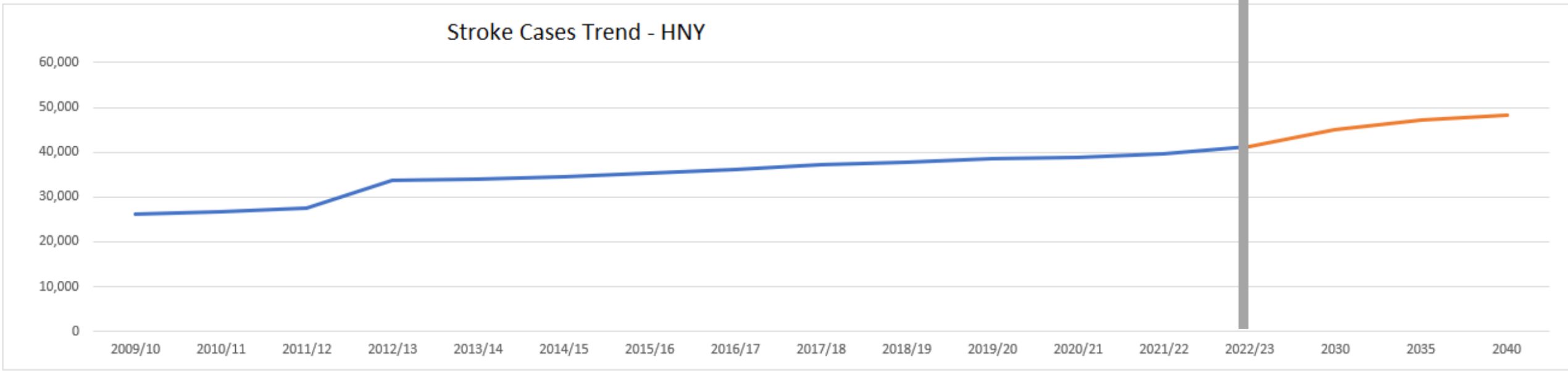


If the workforce increased at the same rate as the projected increase in long term support, an **additional 5,581 WTE employees would be required by 2040**.

This would mainly relate to an **additional 3,400 WTE Care Worker staff**.

Stroke

Humber and North Yorkshire
Health and Care Partnership

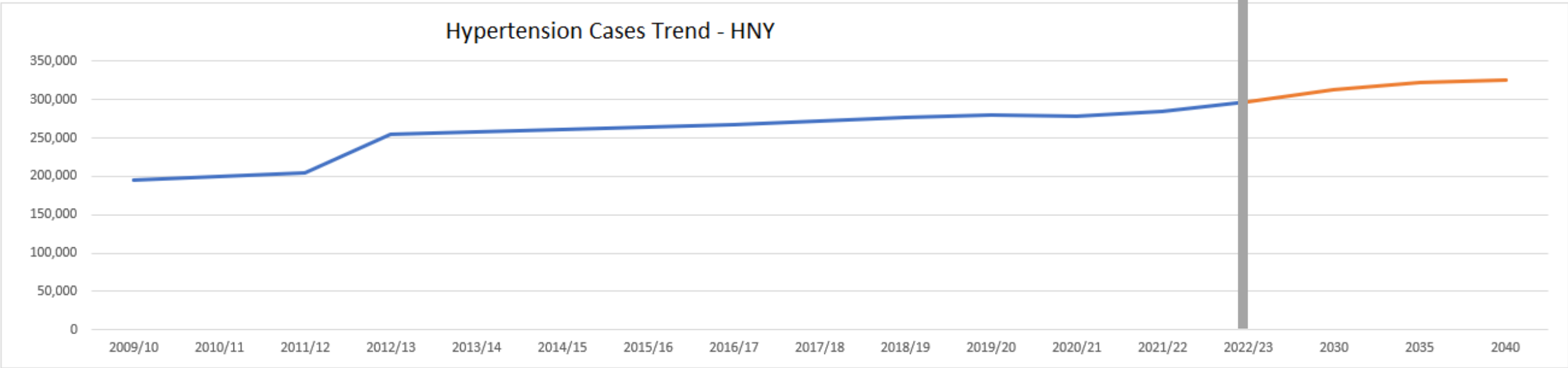


Stroke is the third most common cause of premature death and a leading cause of disability in the UK.
More than a quarter of patients leaving hospital experience moderate to severe disability following a stroke.
By 2040, HNY is projected to be supporting **48,238** patients who have had a stroke or transient ischaemic attack (7000 more than in 2023).
Prevalence in the population will rise from 2.3% to nearly 2.7% by 2040.

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	714	1,146	1,379
Kingston upon Hull	386	585	654
NE Lincolnshire	381	602	704
North Lincolnshire	389	632	734
York	705	1,116	1,312
N Yorkshire	1,201	1,921	2,305
HNY Total	**3,777**	**6,002**	**7,089**

Hypertension

Humber and North Yorkshire
Health and Care Partnership



Hypertension is a highly prevalent condition and is one of the most important modifiable risk factors for CVD, stroke, ischaemic heart disease (such as angina, heart attacks, and heart failure), and renal disease.

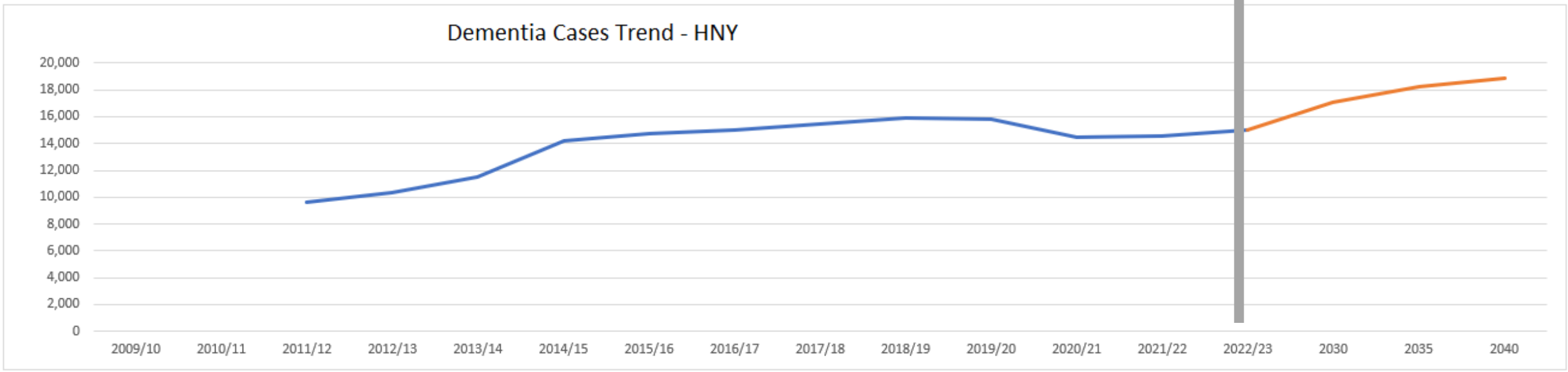
The prevalence of total hypertension increases with age, from 9% of adults aged 16 to 44 to 60% of adults aged 65 and over.

By 2040, HNY is projected to be supporting **326,150** patients with hypertension (over 28,000 more than in 2023).

Prevalence in the population will rise from 2.3% to nearly 2.7% by 2040.

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	3,097	4,867	5,933
Kingston upon Hull	1,987	3,036	3,420
NE Lincolnshire	1,160	1,834	2,163
North Lincolnshire	1,622	2,617	3,091
York	2,713	4,206	4,860
N Yorkshire	4,473	7,118	8,729
HNY Total	**15,052**	**23,679**	**28,196**

Dementia



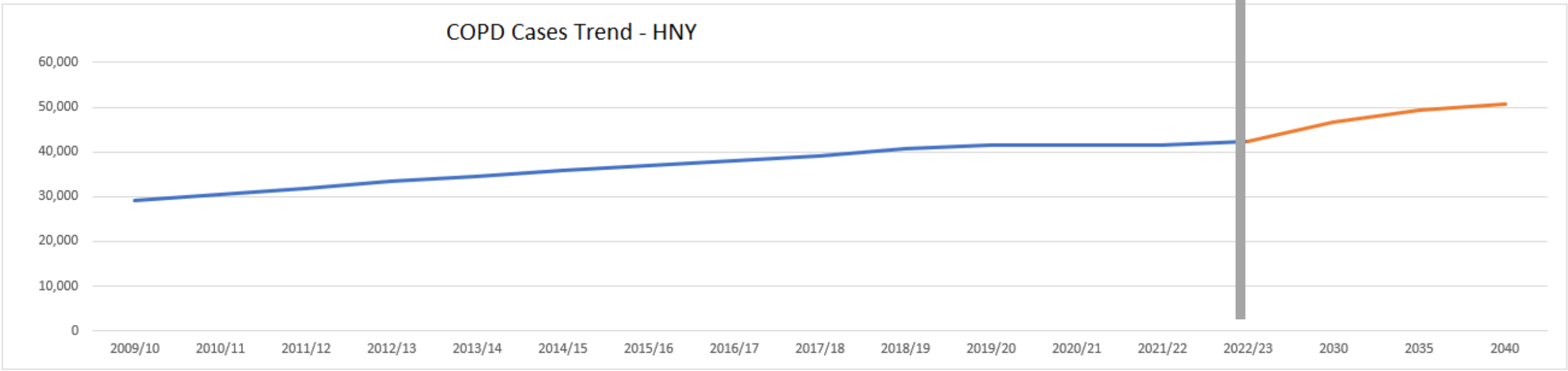
Dementia is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20% at 80 years of age (Alzheimers Research UK). ONS projections suggest that the numbers in this age group could increase by 57% by 2040.

By 2040, HNY is projected to be supporting **18,840** patients with dementia (almost 4,000 more than in 2023).

Prevalence in the population will rise from 0.8% to 1.03% by 2040.

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	432	698	835
Kingston upon Hull	231	349	390
NE Lincolnshire	183	289	337
North Lincolnshire	205	333	385
York	317	507	600
N Yorkshire	671	1,074	1,278
HNY Total	**2,038**	**3,250**	**3,825**

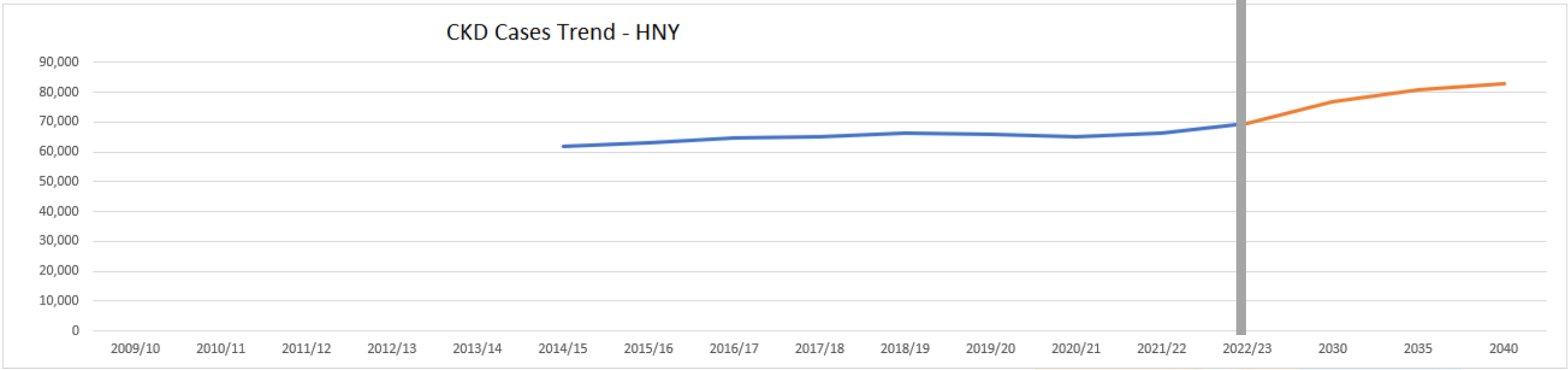
Chronic Obstructive Pulmonary Disease



Nationally, around 4.5% of all people aged over 40 live with diagnosed COPD. In 2012, 5.3% of all UK deaths were due to COPD (British Lung Foundation).
Currently, over 42,000 people in HNY have been diagnosed with COPD. By 2040, this is projected to grow to **50,700**.
Prevalence in the whole population will rise from 2.35% currently to 2.8% by 2040.

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	869	1,400	1,679
Kingston upon Hull	911	1,377	1,539
NE Lincolnshire	519	820	959
North Lincolnshire	516	839	971
York	599	954	1,126
N Yorkshire	1,161	1,857	2,219
HNY Total	**4,575**	**7,247**	**8,494**

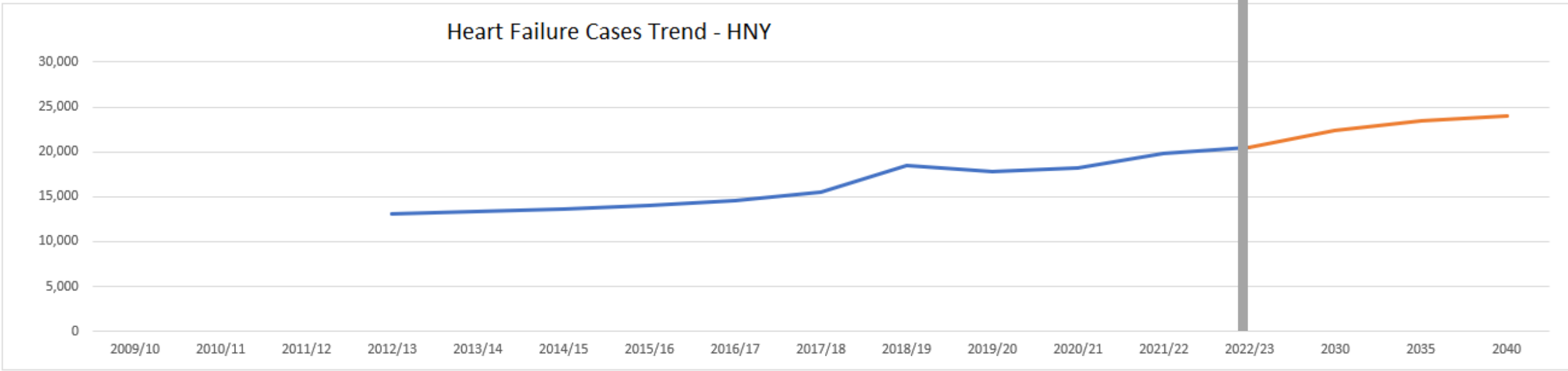
Chronic Kidney Disease



There is a clear association between increasing age and CKD prevalence; with 1.9% of people under 65 having CKD stage 3-5, rising to 32.7% of people aged 75 plus (OHID Chronic kidney disease prevalence model).
Currently, 69,567 people in HNY have been diagnosed with CKD. By 2040, this is projected to grow to **83,052**.
Prevalence in the whole population will rise from 4.8% currently to 5.5% by 2040.

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	1,492	2,401	2,883
Kingston upon Hull	717	1,085	1,213
NE Lincolnshire	782	1,237	1,446
North Lincolnshire	661	1,075	1,246
York	1,097	1,743	2,054
N Yorkshire	2,426	3,880	4,643
HNY Total	**7,176**	**11,420**	**13,485**

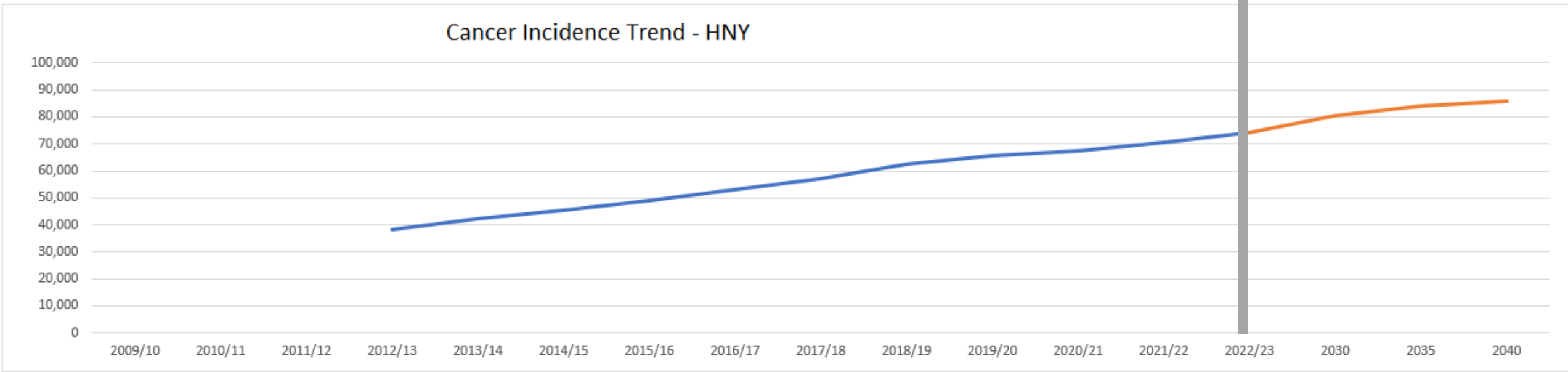
Heart Failure



Heart failure accounts for about 2% of all NHS hospital bed-days and 5% of all emergency admissions (NICE, 2018a).
In 2023, there were 20,431 people in HNY with Heart Failure. By 2040, this is projected to **grow by 17.6%** to **more than 24,000**.
Prevalence in the whole population will rise from 4.8% currently to 5.5% by 2040.

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	416	668	803
Kingston upon Hull	204	309	346
NE Lincolnshire	134	211	247
North Lincolnshire	167	272	315
York	371	588	692
N Yorkshire	625	999	1,199
HNY Total	**1,917**	**3,048**	**3,602**

Cancer



Here, we show Cancer Incidence – the number of new cases per year. This differs from the previous slides which refer to the number of cases of a condition at a particular time point.

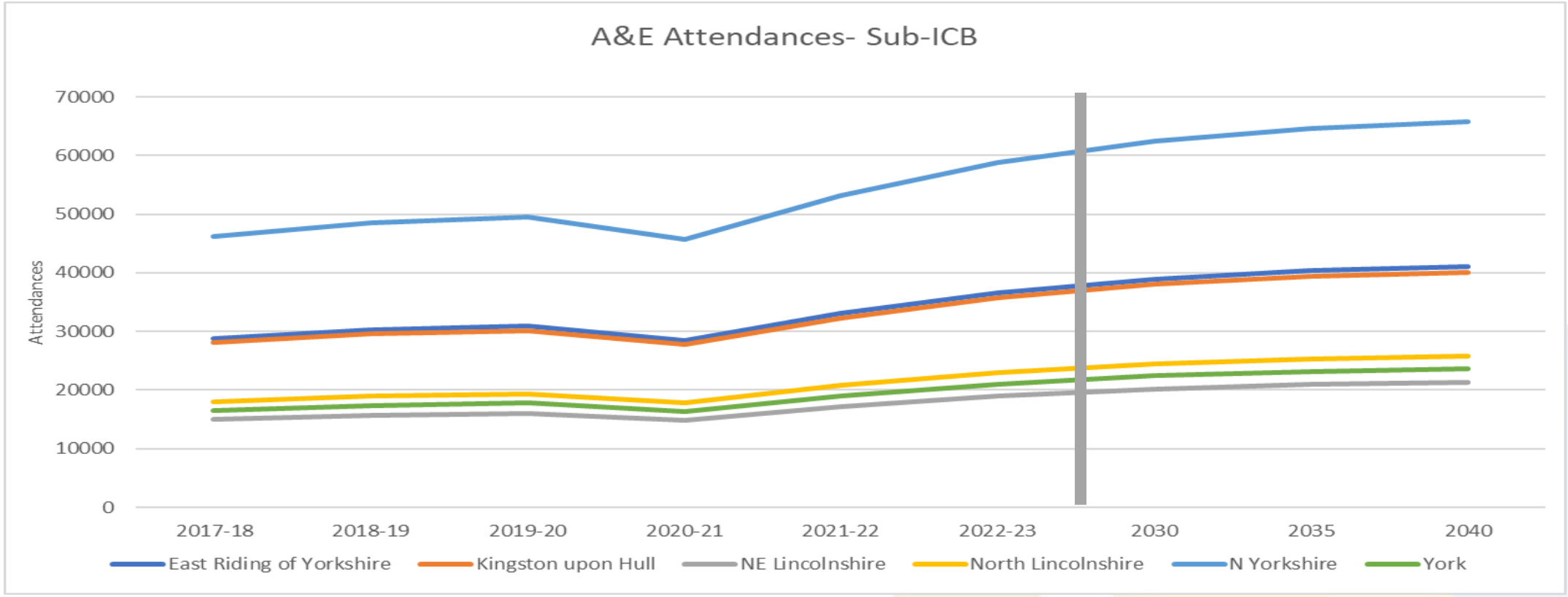
Cancer Incidence rates are strongly related to age, with the highest incidence rates being in older people.

In 2023, there were 74,067 new cancer cases diagnosed in HNY. By 2040, this is projected to **grow by 16%** to **85,752 new cases per year**.

The Incidence rate in the whole population will rise from 4.1% currently to 4.7% by 2040.

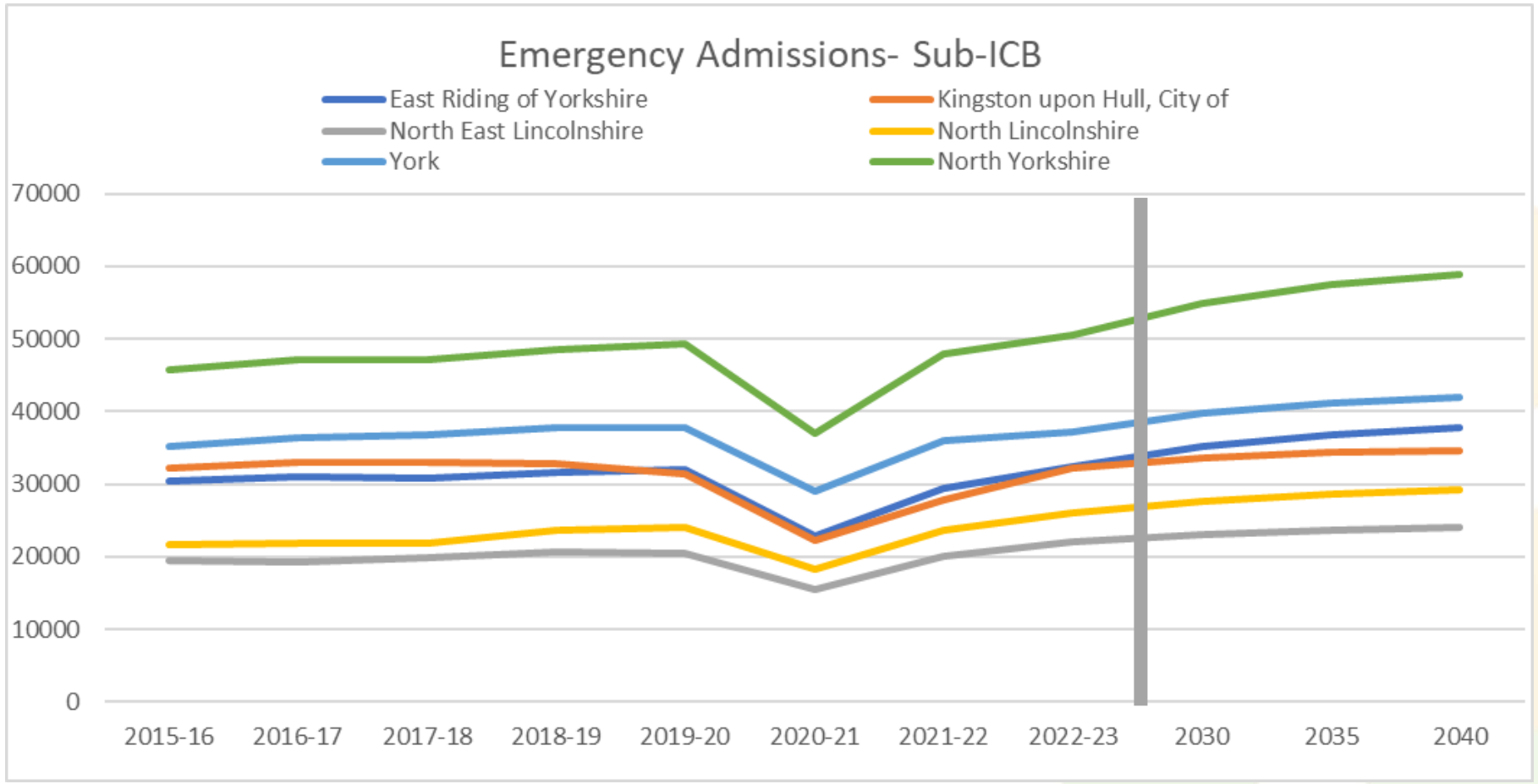
Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	1,340	2,145	2,584
Kingston upon Hull	692	1,049	1,175
NE Lincolnshire	503	796	932
North Lincolnshire	594	963	1,121
York	1,115	1,761	2,066
N Yorkshire	1,981	3,166	3,809
HNY Total	**6,225**	**9,879**	**11,685**

A&E Attendances



Currently, 52% of A&E Attendances in HNY relate to people aged 65 years or above.
Assuming no other changes to policy, capacity or external factors such as GP services, A&E Attendances in HNY are projected to increase by over 23,000 (**12%**) by 2040.

Emergency Admissions

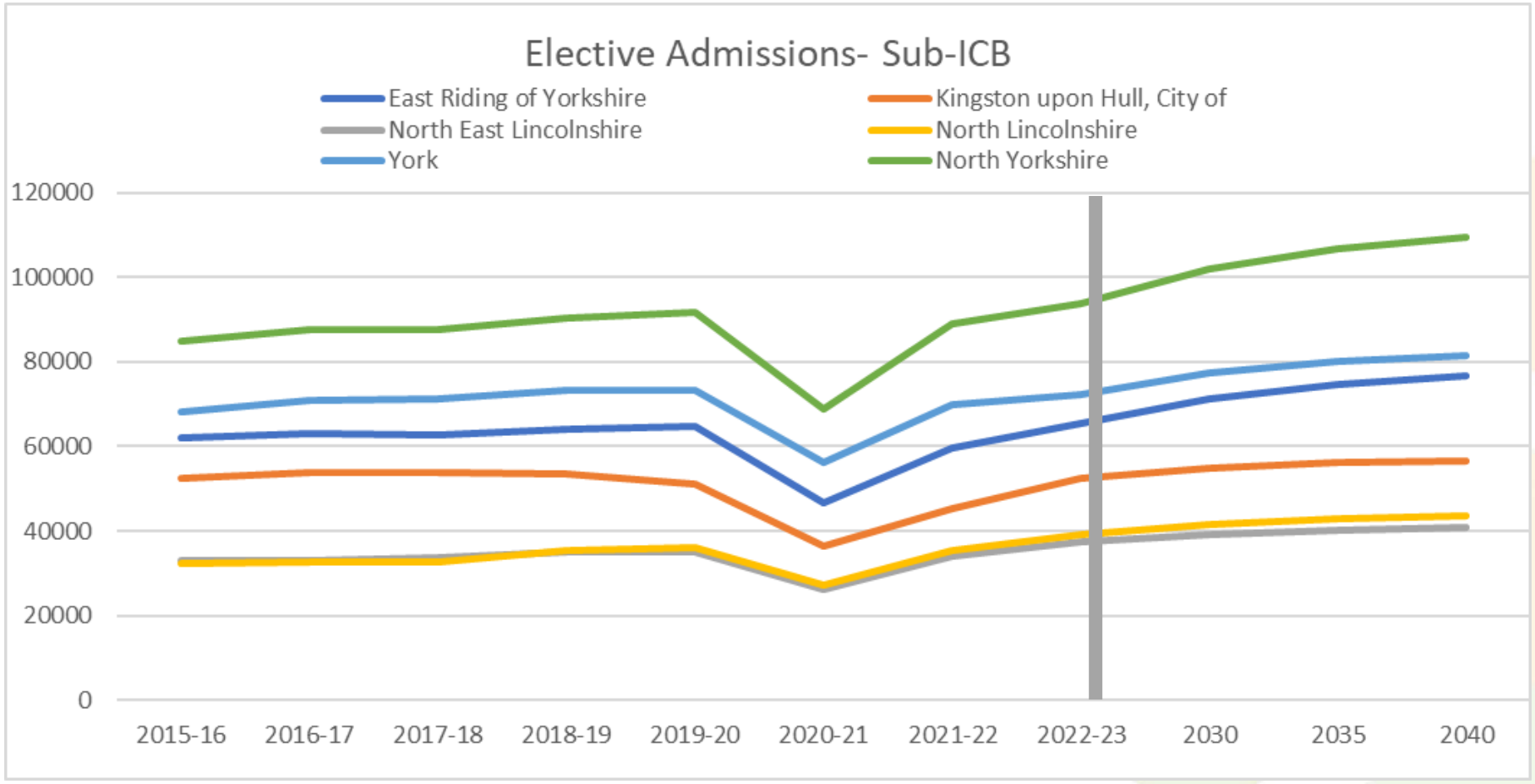


Currently, 57% of emergency admissions in HNY relate to people aged 65 years or above. However, this varies from 46% in Hull to 65% in the East Riding of Yorkshire.

Admissions in HNY are projected to increase by over 25,000 (**12%**) by 2040.

The greatest percentage increase would relate to patients from East Riding & North Yorkshire where admissions would rise by **17%**.

Elective Admissions & Maternity



Elective admissions in HNY **declined by 26% in 2020/21** due to restrictions in place during the Covid 19 pandemic.

Elective admissions in HNY are projected to **increase by over 50,000 by 2040**.

Outpatient Attendances

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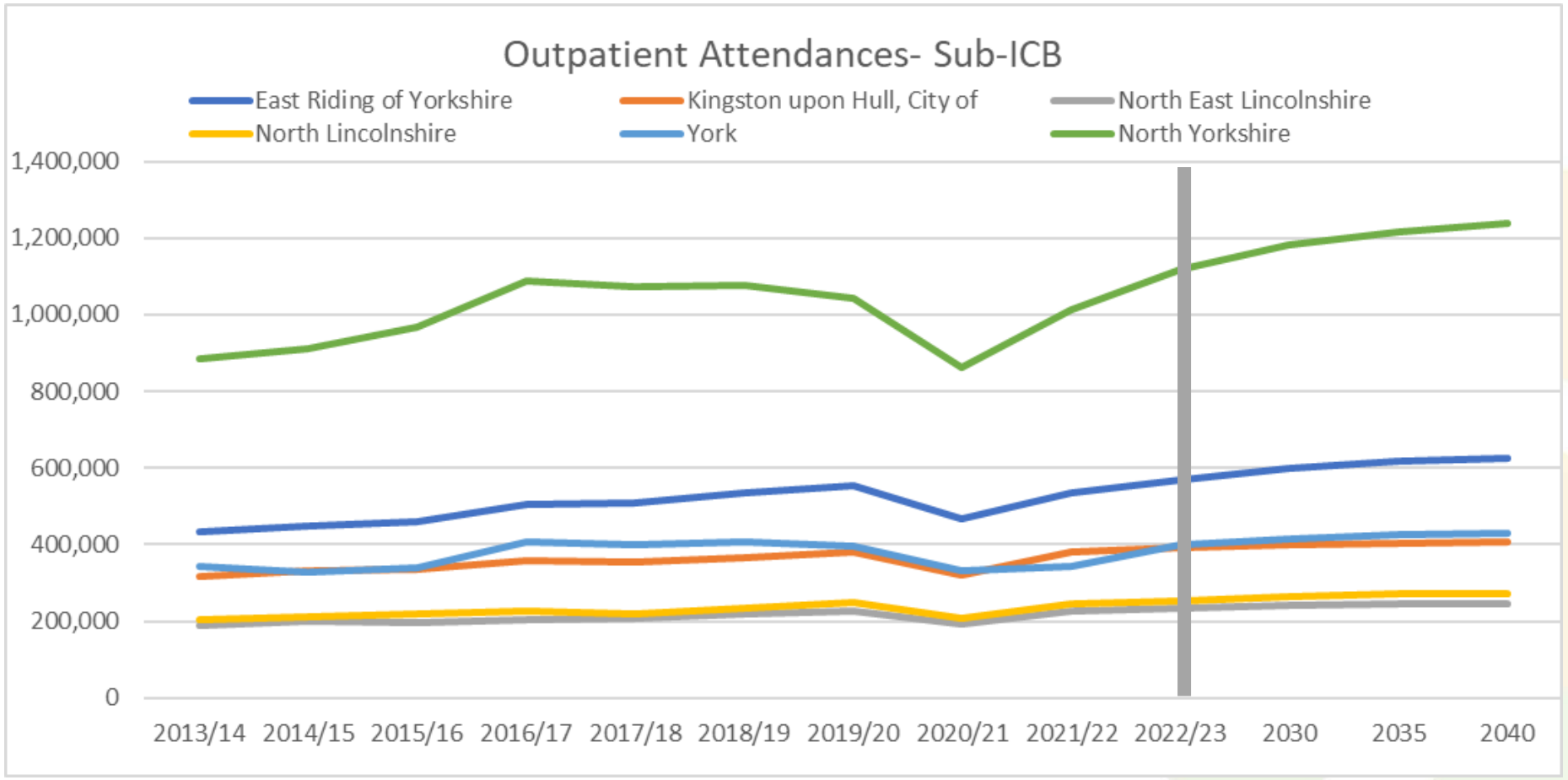
Health and Care Partnership

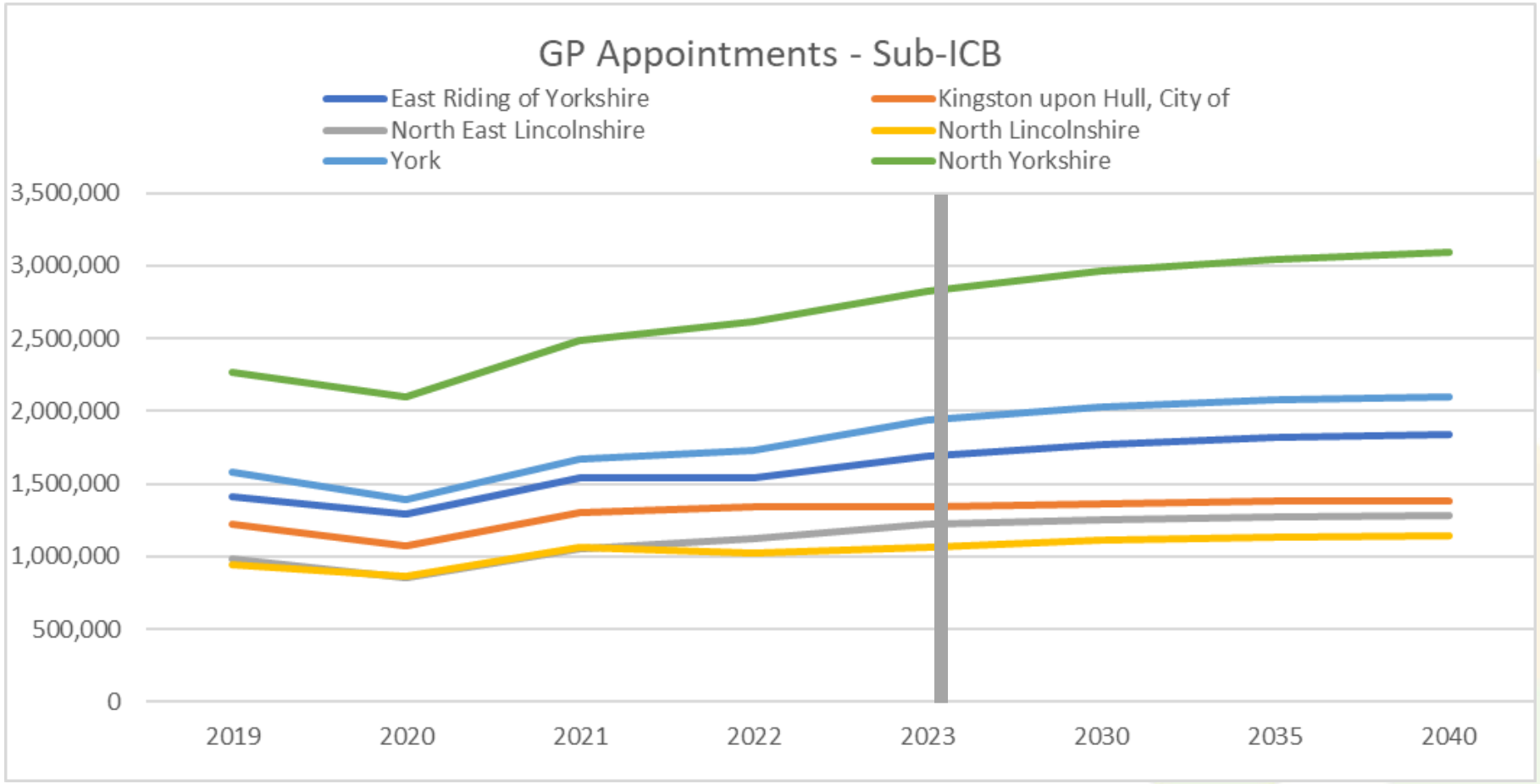


40% of outpatient attendances in HNY relate to people aged 65 years or above. However, this varies from 28% in Hull to 43% in the East Riding of Yorkshire and North Yorkshire .

As a lower proportion of outpatient attendances in HNY relate to people aged 65 plus are projected to increase by a modest **9%** by 2040. However, this represents an **additional 254,000 attendances** per year by 2040.

The smallest percentage increase would relate to patients from Hull (4%) & North East Lincs (5%).

GP Appointments

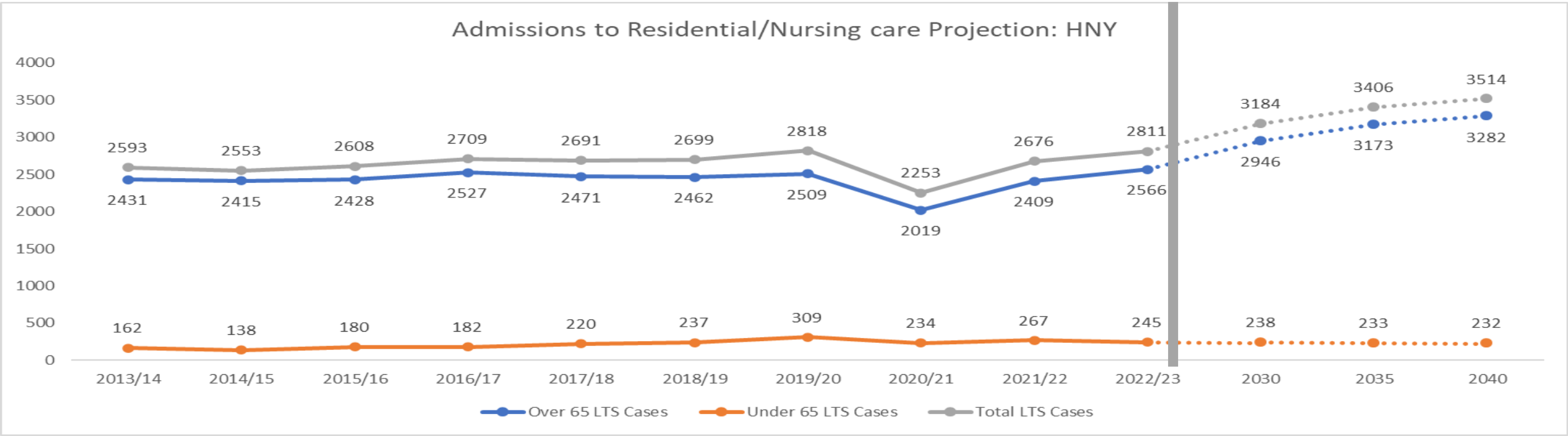


Although the age profile of registered patients is readily available, there is limited published data on the age profile of patients attending general practice consultations. For this reason, the age profile for outpatient attendances has been used to develop projections for GP appointments attended.

An **additional 800,000 attendances** per year are projected by 2040.

Admissions to Residential/Nursing care

Humber and North Yorkshire
Health and Care Partnership



Those admitted to long term residential or nursing care require ongoing, significant health and care support.
The number of people aged under 65 years admitted to long term residential or nursing care is not expected to increase due to limited projected increases in the population overall and policy priorities to enable alternatives to maintain independence.
In 2022/23, there were 2566 older people in HNY admitted to long term residential or nursing care. By 2040, this is projected to **grow by 28%** to **more than 3,282 people**.
The figures above include only those people who are eligible for financial support from the local authority for their residential or nursing care .

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Case for Change

- Ageing population
- Weighted to acute
- Workforce requirements
- Outcome inequalities

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Part 2: Evidence Review

Impact on Outcomes

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Health and Care Partnership

Health Outcomes:

- Larger geographies can lead to inequalities (Health Foundation 2021)
- Can be an accelerant for required changes (ex. IT integration)
- Perceived improved access to care and quality of care
- Does not solve demand and capacity issues

Financial Outcomes:

- No evidence of systematic, sustainable reductions in cost of care (NAO, 2017)
- Caveat: Savings don’t account for rising long term demand (Nuffield 2017)

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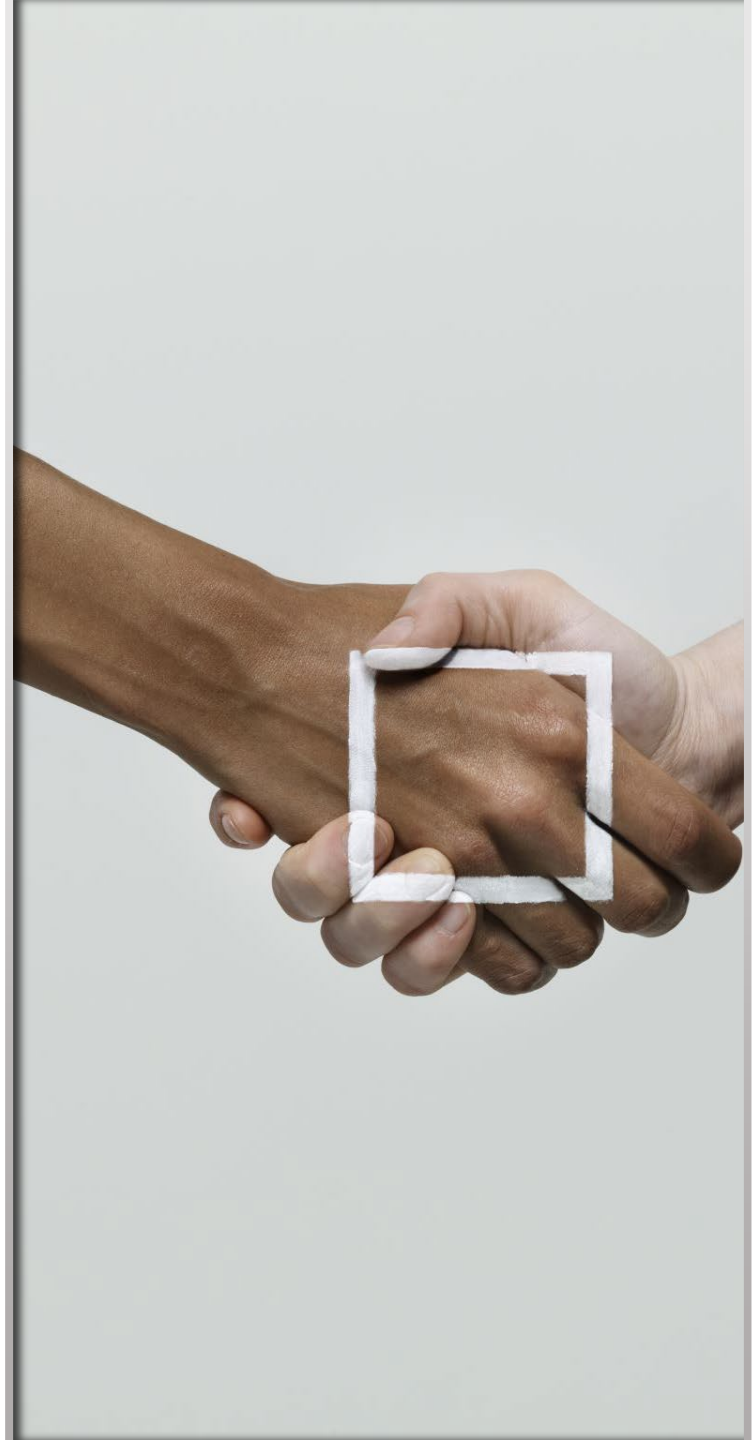
Facilitators:

- Simple changes
- Additional resource
- Strong leadership
- Relevant, accurate and timely data

Barriers:

- Poor engagement
- Governance complexity
- Misaligned incentives between stakeholders
- No KPIs or evaluation from the start



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Evidence Review Recommendations

Shared vision	Adopt a shared vision of what integration means
Transparency	agree on expected barriers and agree mitigations
Simple	Keep changes simple
Long time-horizon	Have a tolerance for no immediate return on investment and allow time to embed

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Health and Care Partnership

Part 3: Qualitative analysis

Interviews and Focus groups

Humber and North Yorkshire Health and Care Partnership

- 25, one hour long, semi-structured interviews and focus groups with a total of 42 participants, representing a wide range of stakeholder groups.
- We developed a thematic coding framework, based on the existing literature into which interview transcripts were systematically coded.
- Interview transcripts were systematically coded into the thematic framework. During the coding process we expanded the framework with a small number of additional themes that emerged specifically from the interview data (e.g. challenges and opportunities posed by the Covid pandemic).

- Interviews complement the evidence synthesis by adding depth and detail relating to the '*how*' and '*why*' from the perspectives of those directly involved.
- Whilst allowing participants to explore areas most relevant to their own experience, role, and perspective, all interviews focused on the following broad themes
  - Understanding of Integration
  - Key factors leading to successful service integration
  - Barriers and risks to service integration and challenges encountered or anticipated
  - Required conditions and resources for service integration
  - Impact, outcomes, and timescales

Stakeholder Summary – Recruitment

Humber and North Yorkshire Health and Care Partnership

		Place Director/ CEO	ICB Place	Primary Care	Acute/ Secondary	Mental Health	Community	Local Authority	Healthwatch	VCSE	Total
York	Invited	1	3	2	3	6	1	1	1	2	**20**
	Interviewed	1	2	1	2	4	1			1	**12**
North Yorkshire	Invited	1	1	5	2	1	2	3	1	1	**17**
	Interviewed	1	1	1						1	**4**
North East Lincs	Invited	1	1	1	1	3	3	2	1	1	**14**
	Interviewed	1	1	1	1	2	2	1			**9**
North Lincs	Invited	1	2	1		1	1	3	1	1	**11**
	Interviewed	1		1		1	1			1	**5**
Hull	Invited	1	1	1			1	1	1		**6**
	Interviewed	1	1	1							**3**
East Riding	Invited	1	1	2	1	2	1	3		1	**12**
	Interviewed	1	1	1		2					**5**
ICB	Invited	2				1				1	**4**
	Interviewed	2				1				1	**4**
Total	**Invited**	**8**	**9**	**12**	**7**	**14**	**9**	**13**	**5**	**7**	**84**
	Interviewed	**8**	**6**	**6**	**3**	**10**	**4**	**1**	**-**	**4**	**42**
	% Interviewed	**100%**	**67%**	**50%**	**43%**	**71%**	**44%**	**8%**	**0%**	**57%**	**50%**

Humber and North Yorkshire
Health and Care Partnership

Key themes

- Understanding Integration
- Culture
- Resources
- Priorities
- Role of the System

Theme 1: Understanding "Integrated Care"

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Whilst interviewees agreed that integration is 'the right thing to do', there is no uniform understanding of the concept itself, nor what implementation should look like.

- Interviews suggest that integration means different things to different people and stakeholder groups across the system.

- Some consider integration in terms of cultural aspects, some believe it is an exercise in resource allocation and demand management responding to (national) policy, and yet others believe integrating services is mostly a question aligning infrastructures with organisational objectives and priorities

"Just to say we integrate doesn't work because everybody forgets about the regulation, everybody forgets about the money, and everybody forgets about the people."
ICB Stakeholder

Theme 1: Understanding "Integrated Care"

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Health and Care Partnership

- To better understand the concept of integration there is, then, a need to:
  - Build common ground by having a shared language to describe integration
  - Acknowledge that different part of the system may have different viewpoints and objectives
  - Respect and work with the different organisational cultures that make up the system and how they shape infrastructures.
  - Realise that there is a cost – financial and interpersonal – to cycles of restructures
- Successfully and sustainably driving the integration agenda forward requires the system to build a shared understanding and culture of integration.

Theme 2: Culture

Humber and North Yorkshire Health and Care Partnership

- Overcoming cultural and political boundaries is considered fundamental for the integration agenda, both from place and system perspective.
- Participants recognise that different organisational cultures – described as “the tribe bit’” by one interviewee when referring to “health and care, health and social care, health and local government dynamics” - is a common obstacle for culture change.
- Interviewees representing place are wary of being “tripped up” by “the nice, rosy view that everybody would come together as a team”, without the ICB recognising that a key element of implementing change is recognising differences in organisational cultures and infrastructures.
- Feedback from the interviews highlights several key factors that are seen to influence the culture and social dynamics, including:
- Communication and engagement.
- Relationships
    - Ownership and buy-in
    - Confidence in change
    - Innovation and Risk-taking

Theme 2: Culture

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Participants mention several areas where communication matters:

- System leadership needs to be consistent, concrete, and supportive in their engagement with different stakeholder groups, something which is seen to be "a little bit vague at times“.
- Mutual understanding of and respect for different organisational cultures and ways of working is raised as a key area of concern. This applies to bridging between health and social care.
- "Upfront conversations" about shared aims and goals of the agenda are required and often shied away from.
- One interviewee identifies middle management as an untapped resource to driving integration forward, stating that both senior leadership and ground/team level staff are "highly motivated", whereas those "in-between and/or from different professional backgrounds" lack the confidence and the clarity of vision to "keep the show on the road“.

Theme 3: Resources – types and definitions

Humber and North Yorkshire Health and Care Partnership

- Transformation needs to be resourced. Interview findings suggest that resources required to implement the integration agenda fall into several different categories:
  - Workforce
    - Capacity, management, and skills of existing staff
    - Recruitment processes, career structures, and staff retention
    - Barriers and challenges posed by, often irreconcilable, organisational cultures
  - Funding and budgets
    - Allocation
    - Legislation
  - Data and Digital
    - Availability and access to relevant data
    - digital infrastructures and support

Theme 4: Priorities

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- Conflicting priorities are cited as an, often challenging, factor in embedding change and pushing forward the integration agenda.
- Particularly important is the tension between national policy/mandate and regional/local service design and delivery.
- There is a concern that different understandings and objectives of what integration means can lead to conflicting priorities. This is particularly pronounced in tensions between system and place as interviewees, particularly at place, are critical of an NHS 'target culture' undermining place-relevant improvements to community-based priorities.
- Setting local priorities - and giving organisations the relevant flexibility and agency - is considered a facilitator to the 'less is more' principle that has been identified as a key strategy to sustainably and meaningfully embedding integration.
- Additionally, different organisations have different sets of targets and ways to measure success and whereas this is accepted as "perhaps a necessary evil", as one participant put it, there is an awareness that this set up creates conflicting agendas.
- Conversely, interviewees note that integration will, in turn, lead to an alignment of priorities.
- Having a shared purpose is described as the backbone of the integration agenda

Theme 4: Priorities

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- Even where priorities within the system may differ, the common goal of integrated services is to

  a) Prevent people becoming patients
  b) Improve service users' access to holistic, and timely health and social care

- Ultimately, interviewees agreed that the premium of integrated services would be "patients and their families experiencing seamless care in the right setting.

- What's more, some participants said that dis-jointed services de facto lead to "blindly trying to find their way around" a system that relies on them providing information they often don't have access to a string of service providers. Single points of access are sometimes cited as a first step towards a solution.

- "Trying to get the best outcomes for people" often described in terms of integrating resources around a person 'from cradle to grave' and should therefore span Early Years education, housing, mental health, technology, debt and finance.

- “Multi-professional support" is seen to not only be beneficial to individuals and their families, but also enable systems to more efficiently use their resources.

- Some interviewees would like to more direct input from service users in designing and advancing service integration.

“I think often when we talk about integration and trying to get the best outcome for people we think about integration around the person. So, what does that look like in terms of that person, enabling that person, to have access to the resources and assets which they need to help them have the best kind of life”.- Social care stakeholder

Theme 5: The role of the system

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Health and Care Partnership

- Alongside changing the system's geographies, the introduction of ICSs has influenced, often long-established, working relationships and networks.

- How well received the move into an ICS is differs between stakeholder groups.
  - Representatives of the Voluntary and Community sector tended to be more positive as they feel it has increased their visibility and integration with the wider system.
  - Primary Care representatives tended to be less certain about this structural change and are more inclined to mourn the 'good old days when they operated within CCGs.

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Summary

What does successful integration look like?

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- It is person-centered, not target-focused and understands which (health and social) outcomes matter most to different people at different places.
- It provides patients and their families with seamless care where the notion of ‘referrals' and 'discharge' are redundant.
- It avoids duplication - of efforts as well as data and information - and facilitates contact with and access to multi-professional support
- It provides staff with a single set of data, connecting secondary care, community, primary, and social care
- It provides service users with an integrated digital virtual record
- It is built on an agile workforce and capacity that can flex and adapt to population needs and service demands
- It works with flexible budgets and recognises that the premium of integration is increasing 'health value', rather than reducing 'health cost'.
- It resists an imposed target culture and recognises that pace of change relies on many factors
- It is built from the ground up, fosters, and recognises place-based, concrete activity and outcomes.
- It prioritises and normalises cycles of reflection and evaluation as fundamental and integral components of transformation.
- It is opportunistic, building, often in specific, concrete ways, from the ground up and expanding on resources, structures, and momentum already present.
- It recognised the hearts and minds piece at its center and reaches for culture change over re-structure.

What does successful integration look like?

Humber and North Yorkshire Health and Care Partnership

These measures of success seem to be present wherever interviewees cite examples of successfully working in an integrated way. Examples include:

-**Navigo mental health service**

- Holistic, person-centred approach with a focus on enablement, long-term goals and outcomes, flexible workforce and a focus on job satisfaction, reaching across sectors, learning cycles based on sharing of good practice, an ethos of feeling part of something bigger

-**Frailty hub York**

- Collaborative ethos, strong integration of health and social care, strong presence of voluntary sector, local authority, and primary care, benefits of multi-agency co-location, workforce knowing each other, shared vision and objective of safely keeping frail elderly at home.

-**The Jean Bishop Centre in Hull**

- “Integration benchmark". Relationships-based approach and focus on culture, specific and targeted, bringing together "different organisations, different skills, to deliver a specific service". Staff seamlessly transition from one service real to another whilst having secure employment by their own organisation

Summary of obstacles

Humber and North Yorkshire Health and Care Partnership

Obstacles, or barriers, to advancing integration broadly fall into two themes in HNY.

- Relationship
  - Risk-averse
  - NHSE mandate vs local priorities
  - Territorial ways of working
  - Reliance on the 'usual suspects' to drive change
  - Fear of loss of control over budgets, workforce, agency
  - Some sectors feeling external to discussions

- Process
  - Organisational conflicts – different demands and legislative requirements creating a disconnect such as funding.
  - Workforce challenges (recruitment, retention, skills and capacity)
  - Pace of change and time-frames
  - National – system – place targets and required outputs
  - Conflicting priorities between organisations

Summary of Opportunities and Enablers

Humber and North Yorkshire Health and Care Partnership

Interviewees identified several opportunities and factors that positively influence integration:

- Focus on people and place/communities - already have a good baseline.
- Data – connecting across sectors and places avoiding duplication e.g. single digital virtual record.
- Workforce flexibility and alignment.
- Culture and engagement over restructure, resisting imposed targets.
- Momentum – already present, opportunity to build on this learning on previous experience and what is already present e.g. COVID.

Covid pandemic: an "incubator for innovation"

Humber and North Yorkshire Health and Care Partnership

- Working inside the Covid-pandemic introduced a crystal clear, shared common goal, which, in turn lowered people's risk-taking threshold. Inadvertently, this gave permission to try ways of working that would otherwise have seemed unattainable, too arduous, or too risky.

”There’s so much stuff that we did in COVID we just wouldn’t have tried it because we all wanted to be safe, and actually, being safe in COVID was doing something very different”- Secondary care Stakeholder

- The Covid pandemic was described as a lever for "forced and accelerated integration" and therefore an unexpected experiment in system change.

- Fostered virtual team working “has changed the culture of how the managers work together”.

“It opened up opportunities that say, in order to do stuff well, you don’t have to all be in the same room”-ICB Place Stakeholder

Covid pandemic: an "incubator for innovation"

Humber and North Yorkshire Health and Care Partnership

- Resource allocation and easing up of bureaucracy meant a (temporary) shift from governance focused to outcomes focused ways of working.

"Showed that "if we just find a way of not worrying about the money or managing the money in a different way, we can do stuff more easily and more quickly"- Primary care stakeholder

- Shifted focus towards local authorities and social care skills and expertise.
- Facilitated data sharing and access, raising again questions around common and persistent barriers that often prevent data sharing and digital integration.

"The pandemic was really useful for the voluntary sector. I think it shone a light on what people did"- VCSE Stakeholder

- Working inside the Covid-pandemic introduced a crystal clear, shared common goal, which, in turn lowered people's risk-taking threshold. Inadvertently, this gave permission to try ways of working that would otherwise have seemed unattainable, too arduous, or too risky.

"Stopped people feeling they have to protect their resources"- Secondary care stakeholder

- The Covid pandemic was described as a lever for "forced and accelerated integration" and therefore an unexpected experiment in system change.

What does successful integration look like?

Humber and North Yorkshire
Health and Care Partnership

"Coming at it from an idealist's perspective, I'd like to get away from talking about primary care, and stop talking about secondary care, and stop talking about social care, and stop talking about mental health steps, and just think more broadly around care, because patients don't care. They want their problem dealt with, and I guess a truly integrated system would allow people to flow through that and be put into the right box without a them and us silo mentality"

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VCSE Community Transport

Jane Owen Chief Executive Humber and Wolds Rural Action	**Jane Evison** East Yorkshire Community Transport	**Liz Lockey** Chief Officer Hambleton Community Action	**Gary Sainty** Head of VCSE Humber and North Yorkshire health and Care Partnership

Wednesday 25th September

Organisations

Humber and North Yorkshire
Health and Care Partnership

Humber and Wolds Rural Action – Jane Owen
Community support to address rural issues including social isolation, access to services, affordable housing, local economy, and impact on the environment
Provider of voluntary car service in Northern Lincolnshire

Hambleton Community Action – Liz Lockey
Reducing transport and access challenges, building confidence, social connection and resilience and supporting volunteers and organisations
Hosts of the Hambleton & Richmondshire Rural Transport & Access Partnership

East Yorkshire Community Transport
"EYCT is a partnership of Goole GoFar & Holderness Area Rural Transport(HART). The company was formed in 2008 and subsequently developed into a purely charitable organisation, which enables the 2 groups to work together on community projects".

Context

Humber and North Yorkshire Health and Care Partnership

- Community transport is vast, lots of variance across all 6 places
- Webinar held February 2024 – Community Transport Providers
  - Opportunities and Challenges
  - Many provide health transport but also wider wellbeing
  - Investment is mixed
  - Lack of knowledge on what the offer is
  - Lack of connectivity between health and providers
- VCSE Collaborative have a priority to support and develop the connection of community transport to health
- Wider conversations – Ophthalmology, Winter, Hospital Discharge, Non-Emergency Patient Transport, Social Prescribing, Prevention agenda
- VCSE Collaborative commissioned some mapping work

Community Transport Video

Humber and North Yorkshire
Health and Care Partnership

Community Transport overview

Humber and North Yorkshire Health and Care Partnership

Transport which is designed, specified and developed by the communities it services and provided on a not-for-profit basis in direct response to the identified needs of those communities

For people who cannot use conventional public transport services
- not in competition with public transport
- provides transport to medical appointments, access to shops and leisure activities, day trips

In scope for this mapping exercise:
CT services that passengers can use to travel to health appointments
- Voluntary Car Schemes
- Dial-a-Ride or Demand-Responsive Transport
- Community Buses

In the ICB area there are 27 providers in total:
- 17 organisations running voluntary car schemes
- 12 running dial a ride buses
- 7 organisations operating regular bus routes

Humber and North Yorkshire Health and Care Partnership

27 providers in total;

- 24 registered charities
- 2 CICs
- 1 limited company
- 1 informal group

North Yorkshire 19
York 3
East Riding 6
Hull 2
North Lincolnshire 2
North East Lincolnshire 1

Mapping Community Transport

Humber and North Yorkshire Health and Care Partnership

Some only provide community transport, others it is part of their range of services.
Range of different sized organisations from smaller volunteer-run groups to larger operators, running services in multiple locations.
Running costs ranged from £10,000 to £973,000 per year.

16 of the CT providers have helped us by giving detailed information:

- 447 volunteers
- Over 95,000 individuals have used these services in the last year
- Not all organisations count how many passenger journeys they carry out, but those that do completed 261,705 journeys last year

10 have more demand for services than they can meet, 4 can meet demand with their current resources and 2 have some spare capacity.

14 organisations record why their passengers travel – all stated health appointments were a main reason and 9 organisations cited it as the primary reason

Not much variation in eligibility criteria – some have a membership (often free)

Challenges and opportunities

Go Local is an overarching brand for community transport in North Yorkshire

Jointly designed by community transport organisations and North Yorkshire Council Go Local Website

Potential to link to other types of transport (i.e. journey planning) has been suggested but has yet to be explored

Challenges include but not limited to:

- Funding
- Need for more volunteer drivers
- Increase in demand across the area for transport to medical appointments
- Community Transport groups working independently in some areas
- Collaboration with health providers

A Chance to Make a Difference

Humber and North Yorkshire Health and Care Partnership

- Working together we can achieve so much more for patients and passengers
- We have an opportunity to make things easier for everyone
- We all want the same outcome
- Better communication means better outcomes for everyone
- A glimmer of hope

Thoughts on Next Steps

Humber and North Yorkshire Health and Care Partnership

Community Transport

- HNY Network of Community Transport – quarterly place to come together discuss and share challenges and priorities and what is happening across HNY
- Think collaborative – providers can be siloed, need to start thinking system and what could we do collective
- Showcase the impact of the community transport offer
- Proactively make connections with Health providers

Health – NHS

- Investment – the services are essential but underfunded. There is a need for longer term funding to enable sustainability
- Data sharing – to enable greater connection and patient experience
- Connect health to providers and work collectively on appointment setting
- Within the ICB the VCSE Collaborative will work with providers to develop the offer and connection

Wider System

- Collaborative commissioning – remove competition from funding and support collaborative working
- Create framework of transport – enable the right transport for the right person
- Smaller group to design what the offer is and how to access it
- Develop understanding of what is required across the system and at place

NHS
Yorkshire
Ambulance Service
NHS Trust

Patient Transport Service
ICP Overview of services

Chris Dexter Managing Director - PTS
25 September 2024

YAS PTS facts

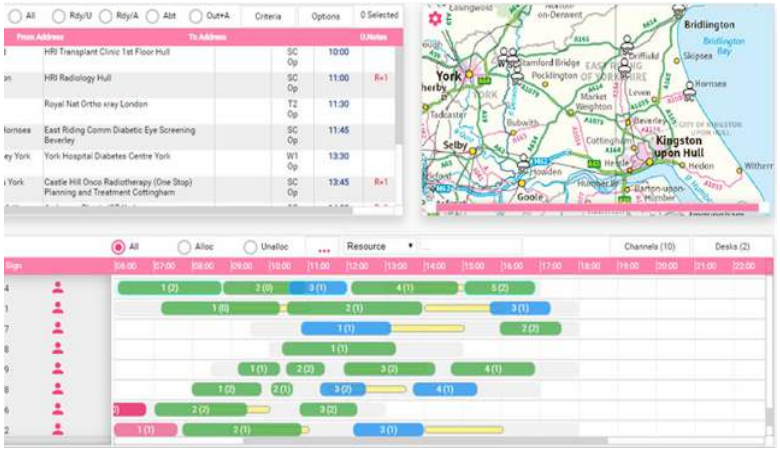
926,374* Patient Journeys
320,629 of which are HNY registered patients

494,184* telephone calls
172,964 were HNY patients or HCP's

94.6%* of patients had a "good" or "very good" experience with YAS PTS

350 YAS owned/leased PTS vehicles

YAS is one of the largest providers of PTS in the UK



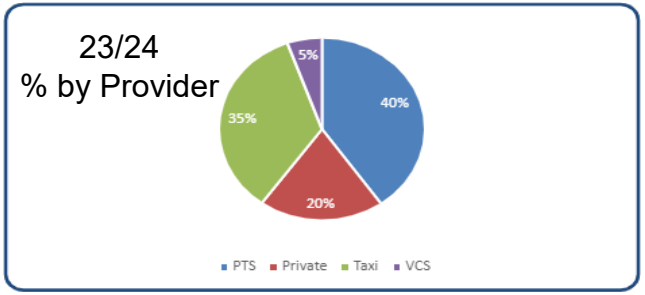
*full year figures for 2023/24 for Eligible patients under the NHS E criteria for NHS funded transport

Background – Service model

- YAS PTS operates on a lead provider model, contract costs assume:
  - Patient journeys with substantive YAS PTS crews 460 front line staff (typically specialist - supporting higher mobility needs) & Volunteer drivers
  - Patient journeys through sub-contracted frameworks (Taxi, Flexible on-day capacity)
  - Frameworks & Sub-contractors overseen by a robust governance framework to ensure quality and control costs
- Lead provider model allows PTS service to maintain quality while operating flexibly and cost effectively
- Specialist Transport Provider requirements, and legal/CQC registration requirement for many of the NEPTS patient journeys.

How we allocate our resources

Patient/Journey Type	Resource
Outpatient PTS journeys	• 1st rule →Maximise YAS PTS resource (Substantive YAS PTS Crews) • 2nd rule → Maximise VCS for suitable mobility patients • 3rd rule → any remaining journeys plan up-to private resource, taxi
Complex mobility patient transfer	Pre-plan to YAS crew(s)
Out of Area (ECR's)	Pre-plan to Private Provider or VCS
Renal Patient transport services Mini-tender, market-test best value	Taxi and Private Provider Frameworks
Fixed-term services Mini-tender, market-test best value	Private Provider framework



PTS Contracts

Yorkshire Ambulance Service NHS Trust

- YAS provides NEPTS across HNY, with exception of NE Lincs
- Services aligned to HNY place-boundaries; but historic differences in Place-level specs can create barriers & challenges to access
  - i.e. Different rules, operating hours and access criteria between places – source of confusion for Acutes and Patients. Joint work underway to review
- National Eligibility Rules apply to access NHS-funded NEPTS, patients must have medical need for transport as defined by national criteria
  - National Eligibility rules updated in 2022, each ICB now undertaking a programme to confirm how the new criteria will be applied in their area
- Key standards: (note: % thresholds & metrics vary by place)

Pick up	Patients picked up from home no more than 120 mins before appt
Arrival	Arrival at clinic no more than 120 mins before appt
Pre-planned Discharge	Pick up within 90 mins of patient booked ready time
Same-Day Discharge	Pick up within 120 mins of patient booked ready time

NHS E review

Yorkshire Ambulance Service NHS Trust

Eligibility criteria, haemodialysis and mobility categories

Support for wider transport planning and journeys for all patients

Increased transparency

This Review has a vision of patients at the centre of a responsive, fair and sustainable service which embraces innovation and technology

A net zero NHS patient transport sector

Better procurement and contract management

The updated non-emergency patient transport services (NEPTS) eligibility criteria was published by NHS E/I on 31st May 2022 together with the full consultation response document.

*NHS Futures

Net Zero Travel & Transport

NHS Yorkshire Ambulance Service NHS Trust

The NHS E ambition is that all NEPTS vehicles should be zero emission by 2035

*Total order size 140 vehicles

NHS E Fleet lead say '*YAS will be largest EV "Ambulance" fleet of any Ambulance Service*'

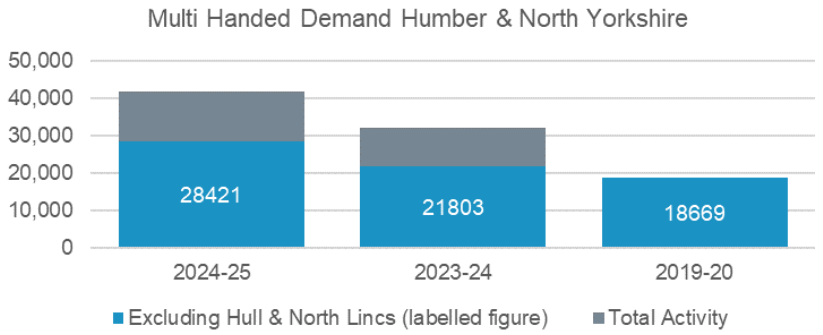
2023-25 YAS 2 year PTS Fleet replacement programme Includes 35 Electric Ambulances – Sept/Oct 24 roll-out, charging infrastructure across YAS estate in place

Patient Transport Recurrent Demand & Service Changes Summary 24/25

NHS Yorkshire Ambulance Service NHS Trust

Economic Impact (non-pay)	**Compound Cost-Inflation, Transport Sector Market rates, Fuel 'Crisis', "Cost of Living" & Volunteering, workforce**
Planned Care & System changes	Demand, 24/7 NHS, places/choice, waiting lists, diagnostic targets
Discharge & Patient Flow	D2A, A&E Hand-over and flow, discharge delays
Patient Mobility shift	Less single crew → double/multi crew
Call Handling / Booking	IP&C increased AHT, increased demand
YAS PTS/Ambulance/VCS Staffing	Shortfall → Taxi/Private Increased usage.

	Total Activity		Variance
	2024-25	2023-24	2023-24
Hull	18,552	16,631	11.6%
East	26,192	22,186	18.1%
North Lincolnshire	17,622	16,824	4.7%
SCAR & VOY	37,211	31,629	17.6%
HRW & Harrogate	17,083	15,366	11.2%



Reflections and recommendations for the system leaders on the ICP

- To share a commitment for a system partnership and collaborative approach to patient transport, sign posting and aligning to transport plans across partnership; as well as to support the work of the ICB's Executive Leadership Board