Humber and North Yorkshire
Health and Care Partnership

MEETING OF THE INTEGRATED CARE PARTNERSHIP

WEDNESDAY 26 MARCH 2025 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 18 December 2024** To receive the minutes of the previous meeting for approval	Chair	To Approve	Enclosed
14:05	5	**Matters Arising and Actions**	Chair	To note	Verbal
14:10	6	**Notification of Any Other Business**	Chair	To note	Verbal
HUMBER AND NORTH YORKSHIRE STRATEGIC PARTNERSHIP					
14.11	7	**Futures Group Report** To receive a verbal report from the HNY Futures Group	Charlie Jeffery	To note	Verbal
14.30	8	**Local Government Partnership Report** Update on key issues facing Local Authorities	Cllr Owen	To note	Verbal
14.45	9	**Integrated Care Board Report** Update on key issues facing health including an update on the design for the future work.	Pete Thorpe	To note	Verbal

Time	Item	Subject	Led By	Action Required	Paper
HUMBER AND NORTH YORKSHIRE PARTNERSHIP OUTCOMES					
15:00	**10**	**Children's Plan** To receive for approval the proposed Children's Plan for Humber and North Yorkshire	Pete Thorpe/ Michelle Carrington	To discuss	Enclosed
15:40	**11**	**Community Transport**	Karina Ellis	To discuss	Enclosed
15:50	**12**	**ICP Governance**	Karina Ellis	To approve	Enclosed
15:55	**13**	**Any Other Business** To receive any business notified at the start of the meeting	Chair	To note	Verbal
15:58	**14**	**Closing Remarks**	Chair	To note	Verbal
16:00		**Date of Next Meeting:** Wednesday 25 June 2025 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 18 DECEMBER 2024, AT 2.00 PM, HEALTH HOUSE, GRANGE PARK LANE, WILLERBY, HU10 6DT

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MEMBERS PRESENT:

Sue Symington (**Chair**)	Chair of Humber & North Yorkshire ICB / ICP
Cllr Jonathan Owen (**Vice-Chair**)	Vice Chair of Humber & North Yorkshire ICP
Amanda Bloor	Deputy Chief Executive/Chief Operating Officer, Humber & North Yorkshire ICB
Alex Seale	NHS Place Director – North Lincolnshire, Humber & North Yorkshire ICB
Brickchand Ramruttun	Interim Executive Director of Adult Social Care and Adult Services, East Riding Council (via MS Teams)
Cllr Linda Chambers	Chair - Health and Wellbeing Board, Hull City Council
Cllr Michael Harrison	Executive Member for Health and Adult Services, North Yorkshire County Council
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
Mark Bradley	NHS Acting Place Director – North Yorkshire, Humber & North Yorkshire ICB
Peter Thorpe	Executive Director of Strategy and Partnerships, Humber & North Yorkshire ICB
Professor Charlie Jeffery	Vice-Chancellor, University of York / Chair of HNY Futures Group
Sarah Coltman-Lovell	NHS Place Director – York, Humber & North Yorkshire ICB
Simon Cox	NHS Place Director – East Riding, Humber & North Yorkshire ICB

STANDING ATTENDEES PRESENT:

Lucy Phillips (**Minute Taker**)	Executive Business Support Lead, Humber & North Yorkshire ICB

IN ATTENDANCE:

Anja Hazebroek	Executive Director of Communications, Marketing and Media Relations, Humber & North Yorkshire ICB

Katie Brown	Director of Adult Social Care, North East Lincolnshire Council (deputising for Rob Walsh)
Victoria Lawrence	Director, Adults and Health, North Lincolnshire Council (deputising for Karen Pavey)

APOLOGIES:

Alan Menzies	Chief Executive, East Riding of Yorkshire Council
Alison Barker	Chief Executive, North Lincolnshire Council
Ashley Green	Chief Executive, Healthwatch North Yorkshire
Cllr Lucy Steels-Walshaw	Executive Member for Health and Wellbeing, City of York Council
Cllr Richard Hannigan	Deputy Leader, North Lincolnshire Council
Ian Floyd	Chief Executive, City of York Council
Jack Lewis	Consultant in Public Health, Humber & North Yorkshire ICB
Julia Weldon	Director of Public Health and Adult Services, Hull City Council
Karen Pavey	Executive Director for People, North Lincolnshire Council
Matt Jukes	Chief Executive, Hull City Council
Richard Flinton	Chief Executive, North Yorkshire Council
Rob Walsh	Chief Executive, North East Lincolnshire Council
Rob Waltham	Leader, North Lincolnshire Council
Sara Storey	Corporate Director of Adult Social Care and Integration, City of York Council
Stephen Eames	Chief Executive, 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).

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.

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4. APPROVAL OF PREVIOUS MINUTES

The minutes of the meeting held on 25 September 2024 were taken as a true and accurate record and approved subject to one correction to the Members Present.

Outcome:

The minutes of the meeting held on 25 September 2024 were approved and taken as a true and accurate record.

5. MATTERS ARISING AND ACTIONS

The Chair noted there were no matter arising from the previous meeting.

Outcome:

The ICP noted the update provided to the matters arising.

6. NOTIFICATION OF ANY OTHER BUSINESS

No items of Any Other Business were raised.

HUMBER AND NORTH YORKSHIRE STRATEGIC PARTNERSHIP

7. FUTURES GROUP REPORT

Professor Charlie Jeffery provided an overview of the Futures Group, emphasising its role in identifying long-term strategies and projects that could prevent more intrusive and expensive interventions later. The Group aimed to shift the focus to prevention and address the social determinants of health.

Professor Jeffery highlighted two main ideas from the Secretary of State for Health and Social Care's (SoSHSC) speech to NHS leaders which aligned with the objectives of the Futures Group: keep patients healthy and out of hospital, and that resource spent on treatment takes away from resources to spend on prevention.

Updates were provided on two projects:

Connected Humber and North Yorkshire, which focused on harnessing health-related data alongside data from education, housing, social care, and policing to identify drivers of inequality and prevent their emergence. The project had progressed significantly, having transitioned from developmental thinking to application and implementation within the NHS through initial pilot work in special educational needs and disabilities (SEND). Positive engagement and enthusiasm had been noted from involved communities and the project was capturing national attention.

The Healthy Coastal Aging programme aimed to address the unique challenges of coastal communities, particularly the older population. It focused on extending active, independent, healthy life and reducing pressures on public services. The

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initial focus would be on Scarborough, Bridlington, Grimsby, and Cleethorpes, with plans to expand to rural communities. The programme draws inspiration from innovative work in other regions and projects such as the Living Labs in Plymouth, where technology and community engagement have been successfully integrated to support older adults. Collaboration with various partners including within the voluntary sector was underway, including SeeCHANGE Scarborough who have undertaking similar work, and have pre-existing connections with the community.

The proof of concept was to be developed in Scarborough for presentation to the Integrated Care Partnership (ICP) for approval in March 2025. Further plans included expanding the programme to Bridlington, Grimsby, and Cleethorpes, as well as rural communities.

Outcome:

The Partnership supported the Futures Group's proposal to develop undertake coastal-based 'living lab' research in Scarborough which was to be presented to the ICP in Spring 2025.

8. LOCAL GOVERNMENT PARTNERSHIP REPORT

Local Authority (LA) representatives highlighted a number of topics as being central to ongoing work, including devolution, workforce, and Section 75 agreements.

Councillor Stan Shreeve noted both Greater Lincolnshire and Hull & East Riding (H&ER) have achieved mayoral status, with elections scheduled for May 2025. The elected mayors would join the Humber Leadership Board. Cllr Shreeve also provided an update on the Section 75 agreement which was overseen by a Joint Committee to ensure close collaboration between community care, mental health care, and primary care. Positive progress was reported with regards to the product of co-production and integrated working being evident, with tangible results seen in local events and initiatives and better integration with the voluntary sector.

Councillor Shreeve noted some issues specific to North East Lincolnshire (NEL), including significant under-resourcing in children's services, SEND, and public health, and a decrease in life expectancy for males in the region due to deprivation. A regeneration programme has been approved to improve Grimsby town centre.

Pete Thorpe noted the importance of the determination of leadership to work collaboratively and highlighted the shared nature of the approach to improving children's and SEND services.

Councillor Jonathan Owen noted that Section 75 agreements were likely to differ across the six Places, depending on local priorities and partnerships, and noted an overall challenge with public health funding. Councillor Owen also discussed significant pressures on Local Authority (LA) budgets due to the cost of social care and expressed concerns about the sustainability of the voluntary sector in

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replacing some services. The importance of championing prevention and addressing wider determinants of health were highlighted.

Outcome:

The ICP noted the work of, and challenges faced by Local Authorities.

9. INTEGRATED CARE BOARD REPORT

The Chair discussed several key areas of focus for the ICB and noted the Secretary of State for Health and Social Care's (SoSHSC) proposed triple devolution approach of moving from hospital to community care, analogue to digital, and sickness to prevention. This aligned with current ongoing programmes with emphasis on prevention and creating a neighbourhood health service which shifts care closer to home, centring patient voices, and empowering patients to be involved in their care.

Amanda Bloor highlighted several challenges faced by the Integrated Care Board (ICB) at present, including the difficult financial position and winter pressures, with rising cases of COVID, flu, Respiratory syncytial virus (RSV), and norovirus. Vaccinations were being promoted, and there were initiatives to improve patient flow and reduce ambulance handover times whilst focusing on patient safety, quality of care, and maintaining staff wellbeing. There was also a focus on learning from best practice, including work at Hull Royal Infirmary (HRI) with a maximum 45-minute ambulance handover service.

The ICB's commitment to embracing digital transformation was reiterated, with a focus on improving the digital experience for patients and integrating digital solutions into healthcare delivery.

Outcome:

The ICP noted the update of the Integrated Care Board.

HUMBER AND NORTH YORKSHIRE PARTNERSHIP OUTCOMES

10. DESIGN FOR THE FUTURE

Anja Hazebroek provided an update on the Design for the Future public engagement work, which sought input from patients and staff to establish their priorities from their health service and understand concerns. The work took place over October and November and included a survey of nearly 3500 responses and over 50 engagement events, resulting in over 1,100 in-person conversations. Feedback was received from a range of backgrounds.

The feedback showed that the public has expressed a clear mandate for change, with 98% of respondents indicating a desire for changes to the NHS. The top priorities to be addressed from a patient's perspective include long waiting times, retelling stories/poor communication between health services, and understaffing. The public response aligned with ICB aims of a person-centred approach to care. Anja Hazebroek thanked the members of the public who took the time to respond and shared their stories.

The Partnership received an update on the public perspective on transport and travel, with a high expectation for primary care and pharmacy to be highly accessible (including online, or a short walk/bus ride away), but that there was a general trend of willingness to travel further for specialist treatment. Responses suggested most patients would expect to travel less than an hour for most services.

Anja Hazebroek recapped the key emerging considerations as: people's experience of care was broadly good, but the navigation and entrance to the system was broadly poor. Ensuring a person-centred approach and better understanding of the system was key, and a lot of the conversations discussed difficulty in access and a need to build trust in the new models of care. Karina Ellis highlighted that the next steps included a check and challenge process to ensure that there was alignment throughout the ICP's ongoing work. A report was to be published in February 2025 to inform the System Leaders Forum (SLF) of the case for change.

The feedback also suggested that the vast majority of people were trying to improve their health and were willing to use technology to aid with this, especially in areas including ordering medication, telephone calls, and the NHS app, but were more cautious with video calls and health & wellbeing apps. The Partnership discussed the overwhelming volume of apps available and indicated a need for better education and support to build confidence in these tools. Helen Kenyon noted a need to create a distinction between person-centred and face-to-face, and to communicate that person-centred care could still be delivered through digital means.

Simon Cox noted that whilst transport may not be a top priority for the general population, it was a significant issue for certain groups especially those in rural areas and with limited access to transportation. The Partnership discussed the importance of ensuring equitable access to healthcare.

Outcome:

The ICP noted the feedback from the pre-engagement work and supported the next steps of a check and challenge process and establishing the case for change.

11. INTEGRATED NEIGHBOURHOOD APPROACH

The Partnership received an update on the Integrated Neighbourhood approach. Alex Seale explained that the approach aimed to deliver personalised, proactive, and preventative care within local communities, by integrating health and care services at a neighbourhood level, ensuring that care was delivered as close to home as possible and was tailored to the specific needs of local populations.

There are 5 key components of the approach, including improving access to urgent care and generating capacity for proactive management of long-term conditions, ensuring that individuals received consistent and continuous care, and reducing the need for repeated storytelling and improving overall care experience. Further, there was emphasis on utilising data and intelligence to

identify and support individuals with complex needs to enable proactive interventions, as well as working closely with community partners including the voluntary and community sector to mobilise community assets to support health and wellbeing. The development of multidisciplinary teams that work collaboratively and are supported by organisational development and digital infrastructure was raised as crucial to implementing the work.

Councillor Owen raised concerns about the sustainability of integrated working, and emphasised the importance of identifying and addressing gaps that may arise when individuals in pilots return to their regular duties. Alex Seale highlighted that ongoing work meant to address this: the Community Collaborative's work around the core offer and current position across community providers, and a parallel piece of work to understand capacity gaps across neighbourhood teams, as well as mapping work undertaken by the voluntary and community sector (VCS) with regards to connecting intelligence. The Partnership discussed a need for providers to support the change in workforce behaviour which enabled people to focus on establishing better continuity, and noted primary care was a key stakeholder in this.

Alex Seale noted that learning was being shared across the country, and the work had been received positively. Helen Kenyon highlighted a need to change the way we record and communicate information across the system to encourage more collaborative reporting, and suggested addressing issues caused by differing national reporting requirements and IT systems which could hinder integrated working. Sarah Coltman-Lovell noted the significant amount of work required to establish clear definitions of 'neighbourhoods' within York Place. From the established 'neighbourhoods', population profiles have started being created, and services could be better aligned. The Partnership discussed the benefits of prioritising dedicated time, space, and governance for neighbourhoods to be established.

Mark Bradley suggested the importance of a strong financial strategy to support the Integrated Neighbourhood approach and emphasised the need for a system mandate to increase the ability to move resources around the system to support local development.

The Chair praised the progress of the work and suggested the creation of a maturity matrix to track the development of the 42 Primary Care Networks (PCNs).

Outcome:

The ICP noted the progress of the Integrated Neighbourhood Approach.

12. CHILDREN'S PLAN FRAMEWORK UPDATE

Peter Thorpe stated that the Children's Plan Framework had been finalised and approved, with the priorities having been socialised through various networks. A well-attended challenge workshop was held recently to assess the ambition of the plan. The plan was to be brought back for approval at the ICP in March 2025.

It was noted that ongoing work aimed to enhance the representation of children's voices within the plan (including utilising existing youth councils and care councils), aligning the plan with the Outcomes Framework and ensuring measures used to assess progress were relevant and effective, and a need to refresh governance arrangements through the Start Well Board (SWB) to ensure effective oversight of priorities and actions and implementation of the plan.

The Partnership discussed the critical importance of early intervention in children's lives as failures in early intervention could have long-lasting effects, and leading to more complex needs in the future. For example, unmet speech and language needs in primary school could lead to behavioural issues in secondary school, which could then escalate to more severe problems such as substance misuse and involvement in the criminal justice system. The insights from a visit were shared to an integrated 'front door' to children's services and the need to support vulnerable children was emphasised. The importance of children and young people (CYP) as a 'golden ambition' was highlighted as a collective responsibility across the system.

Outcome:

The ICP received the update and agreed to receive a plan for approval at the next meeting occurrence.

13. ANY OTHER BUSINESS

There were no items of Any Other Business.

14. CLOSING REMARKS

The Chair concluded the discussion and thanked colleagues for their input. The increasing importance of the ICP was noted.

DATE AND TIME OF THE NEXT MEETING:

Wednesday 26 March 2025 at 14:00 - 16:00.

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Humber and North Yorkshire
Health and Care Partnership

Agenda Item No:	10

Report to:	HNY ICP
Date of Meeting:	26 March 2025
Subject:	Radically Improving Children's Wellbeing, Health and Care: Humber and North Yorkshire Children's Plan
Director Sponsor:	Peter Thorpe, Executive Director of Strategy and Partnerships
Author:	Nicky Lowe, Head of Corporate Affairs and System Support. HNY ICB

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

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

SUMMARY OF REPORT: (*A short summary of the key points set out within the report, with particular focus on **actions** and **outcomes***)

In March 2024, the ICP agreed a simplified version of its Integrated Strategy for Wellbeing, Health Care which lifted and better framed our ambitions, rationalised, and clarified the priorities and described how we would achieve them with a focus on the important and transformative actions. The refreshed Strategy clearly articulates the aims and outcomes as well as the 3 main ambitions; enabling wellbeing, health, and care equity; transforming people's health and care experiences and outcomes and introducing the '**golden ambition' to radically improve children's wellbeing, health and care.** This golden ambition for children distinguishes Humber and North Yorkshire from most integrated care systems in England.

The Start Well Board was established to drive forward the strategy's 'golden ambition' aims to achieve generational change in population health by focusing on children's wellbeing, health, and care. Over the last 6 months the Board has been developing a **Children's Plan** to ensure that resources are directed where they are needed most, fostering a more unified support system that meets children's needs more effectively.

The development of the Children's Plan has emphasised integration across children's social care, public health, education, and health and focuses on the principles of a **child centred approach, prevention and early help, and one system for children** to ensure children are safe, healthy, and ready for school and life. The plan also aims to reduce inequalities and support vulnerable children, ensuring they thrive in their families, schools, and communities.

Following discussions with the Directors of Children Services and Directors of Public Health plus a series of workshops with key stakeholders the framework is built around 3 key outcomes:

- **Children are Safe**: Children will be safe from harm and are supported and protected in their families and communities
- **Children are Healthy**: Children and young people will have healthier lifestyles with better physical and mental health.
- **Children are Thriving**: Children and young people will flourish in environments that support their growth and development and be encouraged to reach their full potential.

Having agreed the outcomes, principles, enablers and success measures for the system the plan is now subject to wider engagement to ensure that it is easily understood, aligns with partner organisation's goals and objectives and is inclusive and respectful, promoting a positive and collaborative approach.

Feedback will be incorporated into the final plan.

Next Steps:
Alongside the finalisation of the Children's Plan detailed delivery plans are being developed to implement the plan, with leadership distributed across the integrated care system to reinforce shared ownership and accountability.

Humber and North Yorkshire is a forerunner ICS in its scale of ambition for children and your people. National prominence and influence are being fostered through our wider partnerships, including work with Baroness Anne Longfield (Centre for Young Lives) and Professor Mark Mon-William (Deputy Chair of the Scientific Advisory Council, Department for Education).

RECOMMENDATIONS: (*Specify the recommendation(s) being asked of the meeting - use additional points as appropriate*):

Members are asked to:

i) To approve the Humber and North Yorkshire Children's Plan subject to further engagement feedback with delegated approval for sign-off for the final plan to the Start Well Board.

ICB STRATEGIC OBJECTIVE (*please click on the boxes of the relevant strategic objective(s)*

Managing Today	☒
Managing Tomorrow	☒
Enabling the Effective Operation of the Organisation	☒

IMPLICATIONS *(Please state N/A against any domain where none are identified)*	
Finance	The delivery of the Children's Plan will be through existing partner resources. The plan aims to encourage organisations to work more collaboratively with various stakeholders, including health, education, and social care services, to create a unified support system that meets children's needs effectively.
Quality	The Children's Plan has a golden ambition which aims to radically improve children's wellbeing, health and care.
HR	The Children's Plan supports culture change by emphasising a fundamental shift in both culture and approach to create meaningful, transformative change for children and young people**.** To support this cultural shift, the framework encourages staff to: • Embrace and drive transformation by adopting a systems thinking approach and fostering a culture of continuous learning and adaptability. • Adopt a child-centred approach, placing the rights and needs of children at the forefront of all decisions. This involves thinking Additionally, the framework includes the I Thrive requirement, which emphasises creating supportive and inclusive environments where children can reach their full potential and achieve positive outcomes. • Use the framework to ensure that resources are directed where they are needed most, focusing on reducing inequalities and supporting vulnerable children.
Legal / Regulatory	When producing the integrated care strategy, the Integrated Care Partnership should consider how the needs and health and wellbeing outcomes of babies, children, young people, and families can be met and improved. The Children's Plan builds on the ICP strategy ambition to radically improve the health and wellbeing of children and young people by setting out key outcomes, principles and priorities.
Data Protection / IG	This report has no adverse implications. The Children's Plan outlines enablers to strengthen our system approach, focusing on: • Digital transformation • Business Intelligence and Population health management • Innovation and Research • Policy Development • Communication and Engagement • Workforce Development Better data sharing will enhance effectiveness.
Health inequality / equality	The Children's Plan supports health inequalities by creating a comprehensive and effective support system that prioritises prevention, early help, and safeguarding, strengthens partnerships, and promotes healthier lifestyles for all children.
Conflict of Interest Aspects	There are no conflicts of interest associated with this report.
Sustainability	There is no adverse impact as a result of this report. The Children's plan seeks to better coordinate resources across the system to deliver more sustainable services.

ASSESSED RISK: (*Please summarise the key risks and their mitigations)*
Several risks need to be managed in the implementation of the Children's Plan, including maintaining quality and consistency, ensuring effective communication and coordination, managing financial resources, and identifying and mitigating potential risks. Addressing these proactively through clear guidelines, robust policies, and regular monitoring via the Start Well Board will help ensure the plan's success and sustainability.

MONITORING AND ASSURANCE: (*Please summarise how implementation of the recommendations will be monitored and the assurances that can be taken from the report)*

The Start Well Board will ensure a shared system oversight, mobilising resources, raising awareness, and fostering collaboration to drive transformative change for children and young people.

ENGAGEMENT: *(Please provide details of any clinical, professional, or public involvement work undertaken or planned. Summarise feedback from engagement and explain how this has influenced your report. If you have not yet engaged with stakeholders include a summary of your plans.)*

The Children's Plan has evolved following a series of discussions with system stakeholders. This included discussions with the Start Well Board, Director of Children's Services, Directors of Public Health and two workshops held in December workshop and February.

The workshops explored the principles required to foster a transformative culture that drives radical changes for children and young people. Participants discussed the importance of a more outcome-focused approach, and the enablers needed to strengthen the system approach to accelerate the focus on prevention and early identification. They also highlighted the need for continuous system learning and adaptability to stay updated with the latest healthcare trends, technologies, and best practices.

The revised plan is currently undergoing system-wide engagement. Initial feedback has been favourable, with organisations identifying synergies with their existing or emerging plans, particularly regarding the emphasis on prevention and early intervention. Consequently, the plan has been updated to incorporate investment from preconception or pregnancy.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No ☒ Yes ☐

If yes, please detail the specific grounds for exemption.

Agenda Item No:	11

Report to:	HNY ICB Board
Date of Meeting:	26th March 2025
Subject:	**Community Transport**
Director Sponsor:	Karina Ellis, Executive Director Corporate Affairs
Author:	Gary Sainty – Head of VCSE – HNY ICB

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

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

SUMMARY OF REPORT: (*A short summary of the key points set out within the report, with particular focus on **actions** and **outcomes***)

Community Transport Report 2025

Following the agenda item in September 2024 to discuss Community Transport, we have released the above report which provides a greater understanding of community transport and the provision available across Humber and North Yorkshire.

The HNY geography is unique and many people in our population rely on community transport, particularly in our coastal and rural areas and those from some of our more deprived communities. Our community transport provides report a significant number of journeys are directly related to health appointments, but many more journeys contribute to reducing ill health by reducing isolation, promoting independent living and creating accessible transport solutions for those who cannot use conventional public transport.

The report provides a number of recommendations to improve working between health and community transport and realise the asset that we have within our system.

Beyond the report, there are many conversations occurring across our system around community transport, these need to be aligned and the VCSE Collaborative is taking a lead on working with our providers to connect the system to the provision available.

RECOMMENDATIONS: (*Specify the recommendation(s) being asked of the meeting - use additional points as appropriate*):

Members are asked to:

i) Consider the recommendations within the report and how we can work in partnership with community transport providers
ii) Respond to the report, at a system and place level, which will influence the actions taken by the VCSE Collaborative over the next 12 months. Health and Wellbeing Boards at place should receive and respond to the report
iii) Develop a system wide understanding of the investment into patient transport including that provided by VCSE organisations. Investment into community transport

comes from different parts of the system (ICB, Place, Hospitals, LA) and there is a lack of consistency. The ICP can advocate for this to be understood at a place level and commitment to pooling resource effectively to ensure appropriate investment into community transport provision

iv) Develop a system wide approach to patient transport whereby the most appropriate transport options are utilised by the system i.e. specialised provision is provided to those that need it through to community transport providing services for those that have no alternative provision but do not require further assistance

ICB STRATEGIC OBJECTIVE (*please click on the boxes of the relevant strategic objective(s)*)

Managing Today	☒
Managing Tomorrow	☒
Enabling the Effective Operation of the Organisation	☐

Finance	Yes – Community transport is not a free service and many operators do not have investment from health. If we are increasing the demand on services, it requires funding, however this can often be cheaper to alternatives and is more around using resource differently as opposed to finding new money.
Quality	Patient experience is noted as positive when using VCSE organisations.
HR	N/A
Legal / Regulatory	N/A
Data Protection / IG	Possibly need to create data sharing agreements to provide patient information to the community transport providers.
Health inequality / equality	Community transport can pick up those who fall out of the non-emergency patient transport (NEPT's) but also provides services to communities who have no alternative provision
Conflict of Interest Aspects	N/A
Sustainability	Investing in VCSE organisations can ensure their sustainability and therefore provision will be in place for longer. Not using the services available could result in them closing down.

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

ASSESSED RISK: (*Please summarise the key risks and their mitigations)*

- Not utilising the services that operate in our patch could result in their closure, which is not able to be re-established. Investment in the services and connecting them as a key part of the system will enable their continued provision that is aligned with the system needs.
- Multiple providers with different criteria. The services available across HNY are different, from car schemes to bus services with different eligibility criteria. If there is a genuine commitment to closer working, over time this can be overcome and greater alignment can be achieved.
- Gaps in provision. It is noted that in our 6 places there is different coverage with some areas not covered by existing provision. Through greater working with community transport we can identify the areas without provision, understand the demand and work collectively to address.

MONITORING AND ASSURANCE: (*Please summarise how implementation of the recommendations will be monitored and the assurances that can be taken from the report)*

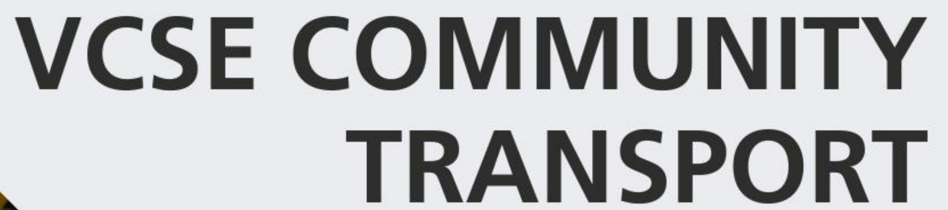
- VCSE Collaborative to manage our work and connection with community transport providers. This will also be reported into the newly established Integrated Primary Health and Care Collaborative (IPHCC)
- Investment into providers will be managed through monitoring and evaluation built into any contracts
- Wider development of system wide approach should be reported back to the ICP where all key partners are already engaged

ENGAGEMENT: *(Please provide details of any clinical, professional, or public involvement work undertaken or planned. Summarise feedback from engagement and explain how this has influenced your report. If you have not yet engaged with stakeholders include a summary of your plans.)*

- Engagement with the VCSE Sector has taken place and will continue through the VCSE Collaborative
- Work taking place with ICB commissioners around NEPT's and a procurement process underway to cover coastal and rural communities who will no longer be eligible for patient transport
- Early engagement with some trusts to understand the patient transport provision, but more should be done

REPORT EXEMPT FROM PUBLIC DISCLOSURE No ☒ Yes ☐

If yes, please detail the specific grounds for exemption.



VCSE COMMUNITY TRANSPORT

Across the NHS Humber and North Yorkshire Integrated Care Board Area

January 2025

*VCSE - Voluntary, Community and Social Enterprise

VCSE Community Transport

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Appendix 6: Permits and compliance Pages 32 - 33

Appendix 7: Method Pages 34 - 35

This report has been produced by charities who provide community transport services themselves, and have the capacity to represent other community transport providers in the area:

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.

Humber & Wolds Rural Action

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 – Jane Evison

A partnership of Goole GoFar & Holderness Area Rural Transport (HART), formed in 2008 and subsequently developed into a purely charitable organisation, which enables the two groups to work together on community projects.

Executive Summary

The Humber and North Yorkshire Integrated Care Board (ICB) extends across a unique geography, covering urban, coastal and significant rural areas, covering North and North East Lincolnshire and East and North Yorkshire and includes the cities of York and Hull. It is acknowledged that lack of transport is an issue for some residents who for a variety of reasons need to access transport not only to attend hospital appointments, but also shopping and day trips. There are without doubt added health benefits associated with the use of community transport (CT) for passengers, providing opportunities to interact socially and reducing social isolation. These wider benefits are linked to health by preventing ill health, reducing social isolation, promoting independent living and keeping people active, all contributing to keeping them out of hospital and better able to reduce their demands for health services.

Changes to prioritisation of criteria for patient transport has resulted in a notable increase demand for CT by some patients who struggle to attend medical appointments because of lack of transport. This increase has put pressure on other areas of work provided by transport groups. This was raised by a representative of one of the CT groups last year and as a result in January 2024 the ICB hosted a webinar for community transport, which was well attended and provided an opportunity for transport groups operating in the ICB geography to meet. In July 2024 the ICB commissioned a piece of work to map the provision of CT and enable a better understanding of where the CT groups are, their size and information about the types of transport they provide.

Purpose of the commission

The Humber and North Yorkshire Health and Care Partnership's (HNY HCP) VCSE Collaborative commissioned a collaboration of 'Community Transport' organisations to support a greater understanding of and the provision of community transport across Humber and North Yorkshire. The aim of this work is to understand the organisations and the services they deliver, the capacity and demand of the services and the opportunities for future growth and connectivity.

The HNY HCP interest is particularly looking at the provision from a health and care perspective, however all community transport has some benefit to the health and wellbeing of an individual. The final report is intended to be shared across the Health and Care system, with health and Local Authority leaders as well as the community transport organisations. It is intended the report will provide a platform to build from and enable collaboration across sectors.

Recommendations

Throughout the exercise to map the community transport provision and associated conversations with partners, the following are a set of recommendations that the system should adopt to provide sustainability to our CT providers, ensure our population has the required services and to ensure that the ICB benefits from having a thriving and sustainable provision:

- Integration. Community transport needs to be embedded in the emerging ‘integrated’ models of working, to ensure accessibility, for those who need it, to health and care

- Sustainability. To enable sustainability, community transport providers need appropriate contracts in place. This should cover multiple years and allow for inflationary increases, which enables planning for the future and so that contracts do not become undeliverable

- Funding. The demand on community transport services is increasing, therefore funding needs to increase as well. Much of the demand is coming from health-related journeys, but there is little health related investment

- Communications between the sector and system needs to be improved. Changes within health and care can have a knock-on effect to providers, if we are more aware of plans and challenges, we have the opportunity to prepare and work collectively on them. This can be achieved through current structures and the VCSE Collaborative providing a mechanism to conduct this through

- Appointment scheduling. The community transport provision is limited and largely reliant on volunteers, therefore we need to make the most of the resource we have. Appointment scheduling is crucial to this and if organisations can work with community transport providers, journeys can carry multiple people creating a more efficient use of the resources

- Partnership working with the system. Time and energy need to be put into partnership working and building relationships between providers and health colleagues at place. The stronger the relationships are, will enable greater collaborative working that means they system as a whole will operate more effectively, and patients will feel the benefit

- Partnership working as a collective. Similar to above, community transport organisations need to build partnerships between organisations. One organisation cannot deliver everything, collectively we can deliver a greater

service and will be more sustainable longer term. Working collaboratively will mean we can maximise the opportunities working with health rather than as many individual organisations, this could lead to a lead provider model which would be more efficient

- Improving data collection. To improve the understanding of how community transport providers operate and where the demand is, we need to have a basic level of data. As shown in this report data collection is inconsistent, we propose as a minimum organisation should record the number of journeys and mileage, a basic profile of the person they are transporting and a reason for their journey

- Forward planning. Community transport is always going to have a place in the community, as a system we need to support the development, for example enabling providers to access training which supports their organisation but also creates a diversity that colleagues in the system can learn from each other. In addition, the system can support with the need to recruit additional drivers and work collectively locally to broaden the reach and encourage more volunteers to come forward

What the opportunities could be

The Government's mission 'Building an NHS Fit for the Future' is the clearest indication on the future direction of the NHS, which will become clearer with the 10 year NHS plan due out later this year.

https://www.gov.uk/missions/nhs#:~:text=First%2C%20from%20'hospital%20to%20community,and%20management%20of%20chronic%20conditions

Community Transport has a role to play particularly with the shifts of 'moving from hospital to community' and from 'treatment to prevention' as mentioned as "big shifts" in the Darzi report:

https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

- Care should be more joined up, or more "integrated". This is to reflect the fact the people living with long-term conditions need the help of a variety of different physical and mental health professionals and often rely on social care too.
- Care should be delivered in the community, closer to where people live and work, and that hospitals should be reserved for specialist care.

Pressures

CT groups have seen a marked increase in demand for transport to medical appointments. This we believe is due to a change in eligibility criteria for patient transport by the ambulance service. The impact these changes have on CT services cannot be overlooked. As of 1st April 2025, more changes to non-emergency patient transport are coming.

Whilst all community transport groups are doing their best to meet demand, in some cases demand outstrips resource and there is a danger that people are turned away. In addition, because vehicles, drivers and volunteer drivers are being requested to cover medical appointments, the other important services which benefit and address health & wellbeing, such as shopping and day trips are restricted.

Budgets and identifying funds are an issue for everyone, but we believe there are opportunities to help each other. There needs to be a better understanding of how community transport is funded and works across the area covered by the Humber & North Yorkshire ICB together with a move to work in partnership to ensure community transport remains able to efficiently deliver patients to their appointments, without neglecting its critical role in wider health and wellbeing. This is particularly important as the recommendations from the Darzi report are implemented, shifting funding from acute to community.

Challenges and Solutions

Community transport groups are challenged by the increase in demand to provide transport for medical appointments, particularly in relation to changes in eligibility criteria for non-emergency patient transport. There is a need for more funding and volunteer drivers to cope with this increase in demand.

Community transport aligns with ICB goals by addressing barriers to access healthcare, reducing missed appointments and supporting patients with mobility challenges. It is particularly relevant for services that need to transport patients to non-emergency medical appointments and providing routine travel for elderly and disabled people to healthcare facilities.

Community transport groups across the ICB work independently, and establishing meetings or other methods of contact to enable collaboration could be productive, although the ability to do this is restricted by capacity.

Consultation and partnership working between the ICB and community transport providers to understand where community transport can support health strategies would enable keeping community transport groups informed of proposed changes that are likely to affect demand for their services. It could also enable collaboration with the ICB on scheduling of transport to hospital appointments, primary care and GP practices and block booking of appointments where possible.

Ideally, this would go beyond simply keeping VCSE community transport providers informed about changes to, say, patient transport criteria, and would assist with opening a dialogue with ambulance services. Community transport providers would welcome the opportunity to explore the development of local agreements around criteria that are based on mobility and need, rather than condition.

In order to do this:

CT can provide the service to meet patient demand, however, there needs to be better partnership working and recognition that an increase in workload comes at a cost to CT organisations.

- Community transport services provide value for money but require sustainable funding, and to allow the services to meet patient needs and provide a reliable service we need agreement of a financial plan over a 3 year period.

Improved communication between health and community transport is essential to providing a service which is sustainable, and patients and passengers can rely upon.

- CT providers collectively to work with the ICB putting systems in place to provide a good transport model and plan for patients' travelling needs
- 6 monthly meetings between community transport providers and ICB, with a named person in the ICB and including a contact person to be engaged with for planning for patients
- Dialogue with Yorkshire Ambulance Service and other ambulance trusts to address the demand to get patients to appointments
- Appointment clustering at hospitals where possible would be of great benefit. The ICB geography covers a very rural and often sparse area, providing transport for such a dispersed population is expensive and time consuming which could be mitigated to some extent by clustering of appointments.
    - Health Inequalities funding through the ICB is being used to develop an appointment-clustering-pilot at one primary care practice, in order to develop a "proof of concept". Please see Appendix 4

There is a need to invest to avoid losing the community transport services that exist. To build stability for the community transport organisations, and to meet the long term needs of residents who will need these services for years to come, this should be a long term investment – a 5 year agreement/contract would deliver better outcomes than short term, last minute decision-making. The VCSE Collaborative could facilitate the work that could come in from the ICB and health providers – commissioners going direct to VCSE organisations can waste time on both sides.

This would enable the local CT sector to engage in regular dialogue with itself, collaborative working where it makes sense and to work collectively work through key contacts/network. CT providers need the capacity to participate in true partnership working with the ICB through engagement in the planning and decision-making, not just informing. This could enable a consistent offer across the ICB area whilst acknowledging there should be some variations due to differences in local areas, and that community transport is one part of the transport options for people of Humber and North Yorkshire region.

The transport challenges residents face will increase with additional changes to non-emergency patient transport imminent, and additional demand for community transport will come from rural and coastal residents who are no longer eligible for hospital transport along with oncology and radiology patients. Reclaiming the costs of hospital transport by those that are eligible to do so is onerous, so many patients are already relying on community transport provision for affordable travel to health appointments.

What is community transport?

Community transport provides flexible and accessible community-led solutions which can represent the only means of transport for many vulnerable and isolated people, often older people or people with disabilities.

Voluntary sector community transport has evolved to fill gaps in transport provision where needs of certain groups are unmet. It is aimed at people who cannot use conventional public transport services, for example due to ill health or disability, or due to their location not being served by other forms of public transport. It 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.

It is important to note that CT is not in competition with public transport – rather, it provides transport services to those who, for a variety of reasons, cannot use public transport. Without community transport services, many residents would not be able to attend medical appointments or have access to shops and leisure activities, as well as day trips, all of which contribute to wider wellbeing, not only giving some independence back but also preventing loneliness and isolation. Some community transport providers provide buses and minibuses for hire to other charities and community groups.

Some of best-known services provided are transport to medical appointments, shopping trips, access to leisure facilities and social outings. The underlying benefit to all these services is it brings people together socially, a shopping trip once a week may be the only time a passenger leaves their home and interacts with others. Public Health suggests that the effects of loneliness and isolation to a person's health can be the equivalent of smoking 15 cigarettes a day.

The Community Transport Association has recently published Mapping England, the first state of the sector survey for Community Transport in England since 2014. This research provides an overview of the scale and breadth of the work delivered by community transport organisations across England.

https://ctauk.org/sites/default/files/2024-09/CTA-Mapping-England-Report-2024.pdf

Key findings

There does not currently appear to be any funding from health for community transport apart from a contribution to North Yorkshire Council for running costs. The amount of this funding varies and was not disclosed to us, but it is a minority contribution. The role of local authority as a source of funding for transport varies across the ICB area (see ‘role of local authorities’ section on page 18).

In the ICB area there are 27 providers in total:

16 organisations running voluntary car schemes
13 running dial-a-ride buses/cars
8 organisations operating community buses

Detailed information from 16 of the 27 providers shows that they collectively have the support of 447 volunteers and over 95,000 individuals have used their services in the last year. Not all organisations count how many passenger journeys they carry out, but those that do completed 261,705 passenger journeys last year.

Community transport services provided

The community transport services provided have been developed locally, around local needs, and therefore they don't always fit neatly into a particular category but, for ease, we have categorised them into three main types below.

For the purposes of this mapping exercise, we have included services that passengers can use to travel to health appointments. We have not included community transport providers that only hire buses/ minibuses to other organisations/voluntary groups and/or day trips and excursions, nor VCS organisations that run minibuses to transport service users to their own activities.

- **Voluntary Car Schemes (VCS):**
  Volunteers use their own cars to provide transportation for people who need it, usually for essential trips like medical appointments.
- **Dial-a-Ride or Demand-Responsive Transport (DAR):**
  This service allows passengers to book a ride in advance, often from their doorstep, to a specific destination, such as a medical appointment or shopping trip. These services may operate using buses or cars, which are provided and maintained by the community transport organisation.
- **Community Buses:**
  These are small buses that operate on set routes and schedules, often serving areas with limited or no public transport services. This includes Shopper Services which are regular transport services that take people to local shopping areas.

In the ICB area there are 27 providers in total:

- 16 organisations running voluntary car schemes
- 13 running dial-a-ride buses/cars
- 8 organisations operating community buses

There is very little variation in eligibility criteria between services and areas – some organisations have a membership, although this is often free and where there is a charge for membership it is nominal. Passengers pay for their transport and charges are broadly similar to public transport. Community buses and demand responsive transport charge a fare which is dependent on the journey and any concession available. Passengers of voluntary car schemes pay a mileage rate, usually the HMRC agreed rate, which covers the volunteer driver's vehicle expenses.

16 of these community transport providers have helped us by giving detailed information about their services:

- 447 active volunteers are providing community transport services. The majority of these are drivers but some volunteers also provide cover for bookings and carry out other roles. (Please note, this figure doesn’t include the trustees who provide governance and oversight of these charities.)

- Over 95,000 individuals have used these community transport services in the last year (2023/4).

- Not all of the organisations count how many passenger journeys they carry out, but those that do completed 261,705 journeys last year.

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

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

- Many services are limited by the availability of volunteer drivers, and volunteer recruitment is more challenging now than it ever has been. An additional challenge is a diminishing number of volunteers with a driving licence that allows them to drive a minibus, and MIDAS training can be seen as a barrier.

Organisation name	VCS	DAR	Bus routes
Age UK North Craven	1	1	
Bedale Community Minibus			1
Beverley Community Lift	1	1	1
Boroughbridge Community Charity	1		
Chain Lane Community Hub	1		
Community Works CIO	1		
Easingwold District Community Care Association	1		
East Hull Community Transport		1	1
Esk Moors Active		1	
Goole GoFar		1	1
Grimsby Dial A Ride		1	
Hambleton Community Action	1		
Humber & Wolds Rural Action	1		
Louth Voluntary Car Service	1		
North Holderness Community Transport (HART)	1	1	1
Reeth & District Community Transport		1	
Ryedale Community Transport	1		
Scarborough Dial a Ride		1	
Sherburn Visiting Scheme Supporting Seniors		1	
Skipton Step into Action		1	
Stokesley Community Care Association	1		
Tadcaster Volunteer Cars and Services Association	1		
The Nidderdale Plus Partnership	1	1	1
Up For Yorkshire	1		
Upper Dales Community Partnership		1	1
Upper Wharfedale Venturer			1
York Wheels	1		
TOTAL	**16**	**13**	**8**

The main office location of each of the 27 providers are shown on the map of the ICB area below.

A searchable version of the map can be accessed here https://www.google.com/maps/d/edit?mid=1LFINUEMMlA6iORgy935f57894LE_SVM&usp=sharing

Areas covered

The areas covered by each organisation's journeys are shown in the table below. The majority of organisations cover areas within North Yorkshire, which reflects the size and predominantly rural nature of the area as well as the coordination and investment made by the local authority in the area. The areas stated in the table relate to where the passengers live – in most cases it reflects the location of passengers at the start of their journey. Due to the demand responsive nature of Dial a Ride and voluntary car services, a significant number of journeys will have destinations outside the stated area – for example where passengers travel to hospitals outside the ICB area.

Due to the differing needs for community transport depending on location, some examples are given on the following pages for the East Riding of Yorkshire and North Lincolnshire. In addition, a detailed report relating to community transport in York was prepared for discussion by the Economy, Place, Access & Transport Scrutiny Committee of City of York Council in June 2024 which reviewed York's Dial & Ride service and contains a number of recommendations that members are invited to consider.

Organisation name	NY	ER	NL	NEL	York	Hull
Age UK North Craven	NY					
Bedale Community Minibus	NY					
Beverley Community Lift		ER				
Boroughbridge Community Charity	NY					
Chain Lane Community Hub	NY					
Community Works CIO	NY					
Easingwold District Community Care Association	NY					
East Hull Community Transport		ER				H
Esk Moors Active	NY					
Goole GoFar		ER				
Grimsby Dial A Ride				NEL		
Hambleton Community Action	NY					
Humber & Wolds Rural Action			NL			
Louth Volunteer Car Service				NEL		
North Holderness Community Transport (HART)		ER				
Reeth & District Community Transport	NY					
Ryedale Community Transport	NY	ER			Y	
Scarborough Dial a Ride	NY					
Sherburn Visiting Scheme Supporting Seniors	NY					
Skipton Step into Action	NY					
Stokesley Community Care Association	NY					
Tadcaster Volunteer Cars and Services Association	NY					
The Nidderdale Plus Partnership	NY					
Up For Yorkshire	NY	ER			Y	H
Upper Dales Community Partnership	NY					
Upper Wharfedale Venturer	NY					
York Wheels					Y	
TOTAL	**19**	**6**	**1**	**2**	**3**	**2**

It is difficult to establish the precise level of need for community transport. Individual community transport providers have a sense of whether they are broadly meeting demand. However, this is not collated at place level and it appears no organisation has the overview of what is needed where.

Public transport in the larger towns, and between the bigger towns, tends to be quite good, however, away from these main routes and more heavily-populated areas, public transport varies from sparse to non-existent. Early morning and evening provision is very limited across the rural area. Some villages have a limited number of buses a week, which restricts scheduling for health appointments, and some villages have no public transport at all. Particularly in North Yorkshire, buses are used for school journeys at the start and end of the drivers' working days, and only do "public transport" journeys in between the school runs, so not useful for commuting, appointments at distance, longer appointments or appointments at either end of the day.

Transport Related Social Exclusion is explored in a report by Transport for The North (see Appendix 5) which estimates that 21.8% of the population in the Yorkshire and Humber region live in neighbourhoods with a high risk of social exclusion because of transport issues.

Community transport organisation characteristics

	Total
Registered charity	24
Community Interest Company	2
Limited Company	1
	27

The majority of community transport organisations across the area are registered charities, with two Community Interest Companies and a limited company.

Some of these organisations only provide community transport, for others it is part of their range of services. There is great diversity in size of organisations and the scale of the community transport services provided ranges from small volunteer-run services to larger operators, running services in multiple locations. This diversity aligns with the findings in the Community Transport Association's Mapping England report https://ctauk.org/sites/default/files/2024-09/CTA-Mapping-England-Report-2024.pdf

Running costs of the community transport element of the community transport organisations in the ICB area ranged from £10,000 to £973,000 per year. Their funding comes from a diverse range of sources including local authority grants and contracts, other grants, charges made to passengers for services, direct fundraising and donations from the public. The role of local authority as a source of funding for community transport varies across the ICB as described in the next section of this

report. The move to Mayoral Combined Authorities in York and North Yorkshire in 2024, and in Hull and the East Riding and Greater Lincolnshire 2025 has provided further uncertainty.

All the local authorities are to some extent are providers of transport themselves and in some areas the local authority provides funding for specific services eg demand responsive Medibus transport to health facilities, Mibus (shopping/retail) services under contract to the authority and some Home to School services.

Depending on the type of community transport services provided, some income may come from local authority reimbursement for concessionary fares and/or the Bus Service Operators Grant (BSOG) paid to operators of eligible community transport organisations to help them recover some of their fuel costs.

Community transport providers, like the rest of the voluntary sector are experiencing diminishing sources of funding with high competition for grants. At the same time as sources of funding are reducing, voluntary sector organisations have been experiencing rising costs and this is set to continue with energy costs rising again, and the increase in minimum wage and changes to Employers National Insurance next April. Community transport organisations feel the effects of this even more keenly: rising costs of fuel and vehicle maintenance continue to impact the viability of continuing to provide services.

VCSE community transport providers additionally face some very specific challenges relating to permits and compliance, driver licencing which are described in Appendix 6 of this report. Volunteer recruitment and a retention is a constant task which must be resourced. CT providers use a variety of methods including press releases, advertising on their own websites and social media as well as through volunteer brokerage systems, community outreach and events and word of mouth. Advertising for volunteers also increases awareness of the services available from CT providers, which in turn increases demand.

It is difficult to ascertain what funding, if any, for community transport currently comes directly to CT providers from health. None of the CT providers responding to the questionnaires mentioned health as a source of funding, and it was not apparent from the analysis of annual reports for other providers.

Role of Local Authorities

All the local authorities are to some extent are providers of transport themselves and in some areas the local authority provides funding for specific services e.g. demand responsive Medibus transport to health facilities, Mibus (shopping/retail) services under contract to the authority and some Home to School services.

The role of local authority as a source of funding for transport varies across the ICB area.

North Yorkshire

In North Yorkshire, CT schemes that are part of North Yorkshire Council's provision are funded per completed journey according to a funding formula. The journey payment was recently uplifted to £3 per journey but doesn't cover the full co-ordination costs, and any costs associated with cancelled journeys (which usually involve at least as much staff time) are not recovered. Although community transport is recognised to be integral to the county's transport provision, council staff acknowledge that these services are funded below full cost recovery. Excess costs to the charities to provide the services must be found by the CT provider, either from unrestricted funds, reserves, or through additional charges to clients. This in turn leads to something of a "postcode-lottery" for passengers, with different mileage charges, membership fees, booking costs, etc, and some find themselves entirely ineligible for community transport in their area.

Due to rescheduling of appointments by health and also by patients, a significant number of journeys are cancelled at short notice, mainly because health appointments are cancelled, or changed, or where the client is not well enough to travel on the day. Bookings made, arranged and then cancelled have a disproportionately higher cost to the provider, but are unfunded.

The previous funding formula had been in place for several years, so the likelihood is that the current formula will not see any inflationary increments. Some of the former district councils provided a further subsidy but as this was not consistent across the county, the remaining district payments will cease in this financial year. As an example, in the case of Hambleton Community Action the changes to the funding formula means an annual increase at current journey levels of approximately £7000, but a reduction of £5600 per year of former district council grants.

North Yorkshire Council caps the payment by the passenger for medical journeys at £20, for these longer journeys (often to hospitals, sometimes out of county),

passengers pay £20, with excess costs claimed by the CT provider from the council in order to appropriately compensate the driver's mileage.

In addition, the council has two grant schemes for CT providers - small grants of up to £2500 to improve CT provision, and capital grants for up to 75% of purchase costs for vehicles.

East Riding

East Riding of Yorkshire Council has consistently supported the development of the community transport sector in the local authority area. Some highlights are listed below:

- Supported the creation of two new CT groups in 2002/2003 (HART and Goole GoFar) to ensure all parts of the county had provision
- Established a Community Transport Network to provide developmental support and channel funding opportunities
- Provided annual funding towards vehicle replacement costs
- Funded a range of projects and programmes and supported the sector to write a secure major funding bids
- Tendered a wide range of contract opportunities which CT groups bid for and operate (Medibus, Mibus, Home to School transport and community bus routes)
- Developed and implemented a social value assessment process in procurement of accessible transport.

North Lincolnshire

A grant of £15,000 per year has been made to the CT provider for many years, but that grant has not increased and the cost of the delivering the service is now £38,500. Some small grants are made by Parish Councils although these are ad-hoc. Similar challenges to North Yorkshire, with a significant number of journeys being cancelled at short notice are experienced because health appointments are cancelled/changed, or where the client is not well enough to travel on the day. These have a disproportionately higher cost to the provider.

North East Lincolnshire

Constrained by availability of funding from government for community transport, the information received about funding for community transport from North East Lincolnshire Council is that emergency payments have been made to one CT provider to enable them to continue to operate.

North Yorkshire became a Mayoral Combined Authority in 2024. As North and North East Lincolnshire, and Hull and the East Riding of Yorkshire move into Mayoral Combined Authorities, it is not clear where funding and coordination of community transport will sit for either area.

York

The CT provider ended its Dial And Ride service from 31st December 2023 but continues to provide a voluntary car service. In June 2024 York City Council completed a scrutiny review into the Dial & Ride service which contains a number of recommendations relevant also to this report. The scrutiny review and recommendations can be read here: https://democracy.york.gov.uk/documents/s177195/Dial%20and%20Ride%20Report%20for%20EPAT%20-%20Final.pdf

Hull

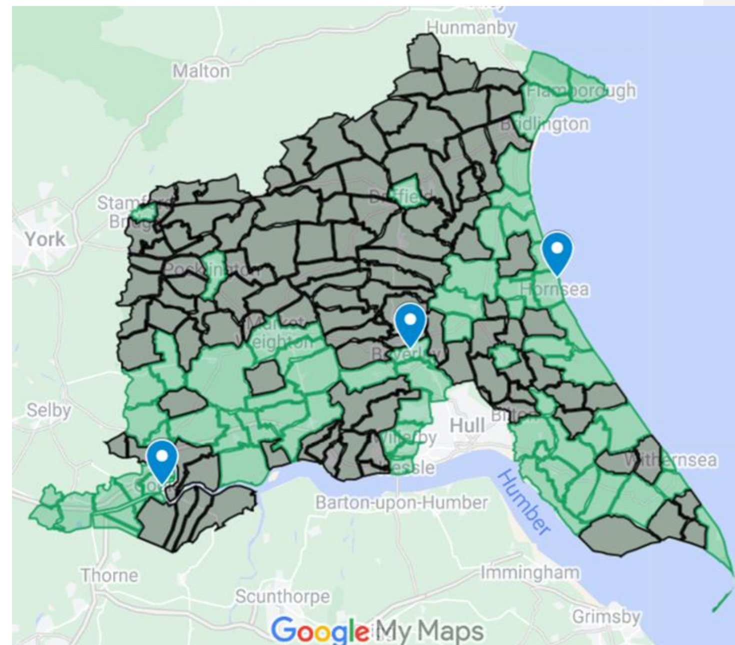
There has recently been a launch of two new pilot CT services by East Hull CT, funded by Hull City Council:

- Marfleet Community Minibus Service carries passengers to shops and medical appointments, runs on a scheduled timetable and is operating twice-a day on Mondays, Wednesdays and Fridays.
- Medibus takes patients to Castle Hill Hospital in Cottingham Monday to Friday, between 07:00 and 17:00.

This aims to provide an essential passenger transport service, however, the long-term viability of the services is uncertain beyond March 2025. commented that the buses would only continue to run beyond next year if there was demand for the services, which would allow further funding from the government's Bus Service Improvement Plan.

Appendix 1: Case Study: East Riding of Yorkshire

Community transport organisations provide services in the parishes in the East Riding of Yorkshire which are shown in green on the map below. Community transport services have developed in these areas in response to demand arising from the lack of other forms of public transport.



Colin Walker, Group Manager for Transportation Services at East Riding Council believes it is essential that the ICB understands the potential contribution that community transport can make to improving access to health and wellbeing for residents and has a clear picture of the constraints the sector currently faces in respect of capacity and resources.

East Riding of Yorkshire Council has a long history of supporting the development of the community transport sector. The Council's Transportation Services team convenes and facilitates a Community Transport Operators Network, which is a forum for sharing best practice, providing strategic and technical support, and identifying opportunities for new service delivery. The Transportation Services Group Manager attends network meetings and supports and advises individual CT groups on major project development.

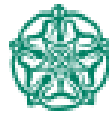
The Council actively seeks opportunities to support community transport delivery through grant programmes and contractual opportunities. Community transport operators deliver demand responsive Medibus (transport to health facilities) and Mibus (shopping/retail) services under contract to the authority and the Council has provided significant funding to support the sector's 'Tackling Loneliness with Transport' project. Community transport operators also bid for and deliver several home-to-school transport services, especially in rural areas.

In the past programmes of support have been established through government funded initiatives such as Local Area Agreements, the Local Transport Fund (during the Covid-19 pandemic), and currently Transportation Services are creating new opportunities for CT operators through the Council's Department for Transport funded Bus Service Improvement programme. This has enabled a significant expansion of the Medibus network, which will enable county-wide coverage.

The East Riding of Yorkshire has three dynamic community transport operators, who make a large contribution to ensuring that the public transport network is inclusive and

accessible. This contribution is recognised and formalised in the East Riding of Yorkshire Community Transport Strategy, which forms a key part of the Council's Local Transport Plan.

The strategy is available at https://www.eastriding.gov.uk/council/plans-and-policies/other-plans-and-policies-information/transport/local-transport-plan/



EAST RIDING OF YORKSHIRE COUNCIL

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Date: 25 July 2024

To Whom it May Concern,

Community Transport in the East Riding of Yorkshire

East Riding of Yorkshire Council has a long history of supporting the development of the community transport sector. The Council's Transportation Services team convenes and facilitates a Community Transport Operators Network, which is a forum for sharing best practice, providing strategic and technical support, and identifying opportunities for new service delivery. The Transportation Services Group Manager attends network meetings and supports and advises individual CT groups on major project development.

The Council actively seeks opportunities to support community transport delivery through grant programmes and contractual opportunities. Community transport operators deliver demand responsive Medibus (transport to health facilities) and Mibus (shopping/retail) services under contract to the authority and the Council has provided significant funding to support the sector's 'Tackling Loneliness with Transport' project. Community transport operators also bid for and deliver several home-to-school transport services, especially in rural areas.

In the past programmes of support have been established through government funded initiatives such as Local Area Agreements, the Local Transport Fund (during the Covid-19 pandemic), and currently Transportation Services are creating new opportunities for CT operators through the Council's Department for Transport funded Bus Service Improvement programme. This has enabled a significant expansion of the Medibus network, which will enable county-wide coverage.

The East Riding of Yorkshire has three dynamic community transport operators, who make a large contribution to ensuring that the public transport network is inclusive and accessible. This contribution is recognised and formalised in the East Riding of Yorkshire Community Transport Strategy, which forms a key part of the Council's Local Transport Plan. The strategy is available at https://www.eastriding.gov.uk/council/plans-and-policies/other-plans-and-policies-information/transport/local-transport-plan/

Paul Bellotti
Executive Director of Communities and Environment

Thank you for participating in this survey, which has been commissioned by the NHS Humber and North Yorkshire Integrated Care Board (ICB). It is essential that the ICB understands the potential contribution that community transport can make to improving access to health and wellbeing for residents and has a clear picture of the constraints the sector currently faces in respect of capacity and resources.

Yours sincerely

Colin Walker
Group Manager - Transportation Services

Appendix 2: Case Study: North Lincolnshire

The only community transport provision in North Lincolnshire is the voluntary car service provided by Humber and Wolds Rural Action. Almost half North Lincolnshire's residents live in rural areas which are not well-served by public transport. The service provides more than just transportation, it helps people maintain an active lifestyle and independence whilst reducing social isolation and many of our passengers tell us how the moral support given by our volunteer drivers has helped their confidence and reduced their worry about the appointment they are travelling to.

Bookings are taken from 9am to 12pm on weekdays to respond to requests for transport and allocate drivers. Passengers are asked to give at least 48 hours' notice of a journey request to enable allocation to a volunteer driver. Membership is currently free and passengers pay 45p per mile for the journey they undertake which is paid to the volunteer driver to cover their vehicle expenses. Volunteer drivers are recruited from the local area, are DBS checked and undertake an induction with ongoing support and training provided.

The Voluntary Car Service has 868 registered passengers of which 448 used the service in the 2024 calendar year. We undertook 1404 journeys in the period October to December taking the total journeys for the 2024 calendar year to 5394. 90% of journeys are for health appointments. The number of volunteer drivers remains stable at 31 but on average, we turn down 6% of bookings because we don't have a driver available. We continue to work hard to recruit new volunteer drivers, although outreach in rural areas to try to recruit drivers also increases awareness of and, in turn, the demand from passengers who need to use the service.

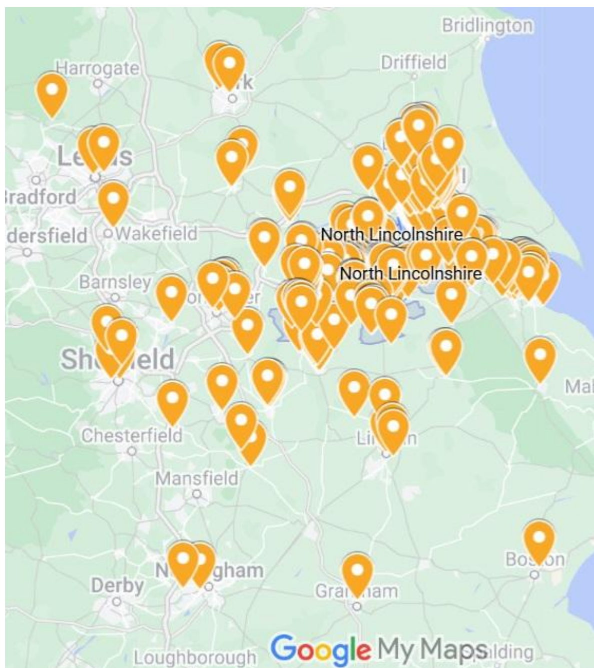
The number of new passenger registrations has more than doubled since 2022/23, and each week sees an average of 5 new passengers. The service carried out approximately 2500 journeys in the year ending March 2023 and now fulfils more than double that number. However, on average 6% of bookings every month are turned down due to driver unavailability.

Feedback from passengers shows the increased demand for the service is primarily due to changes to non-emergency patient transport eligibility criteria. More changes to this eligibility are planned next year, and the current service is above capacity and not sustainably funded. Work at systems level been attempted to liaise with health partners (for example to cluster appointments or adjust times) and thereby make more efficient use of the service, but this in itself is time-consuming and staff capacity is needed to do this work.

The maps below show the location of passengers, volunteer drivers and destinations – all can be viewed on the interactive map here: https://www.google.com/maps/d/edit?mid=1cQcQDJU1VO0RpmN9A8URtmlBQa61AhM&usp=sharing

Drivers

Passengers



Destinations

Appendix 3: Case Study: North Holderness Community Transport (HART)

HART operate a range of services, mostly under a section 19 permit (door to door services) but also section 22 (registered routes to timetables). The operational area covers the length of the East Riding or Yorkshire coastline including Holderness the north Wolds.

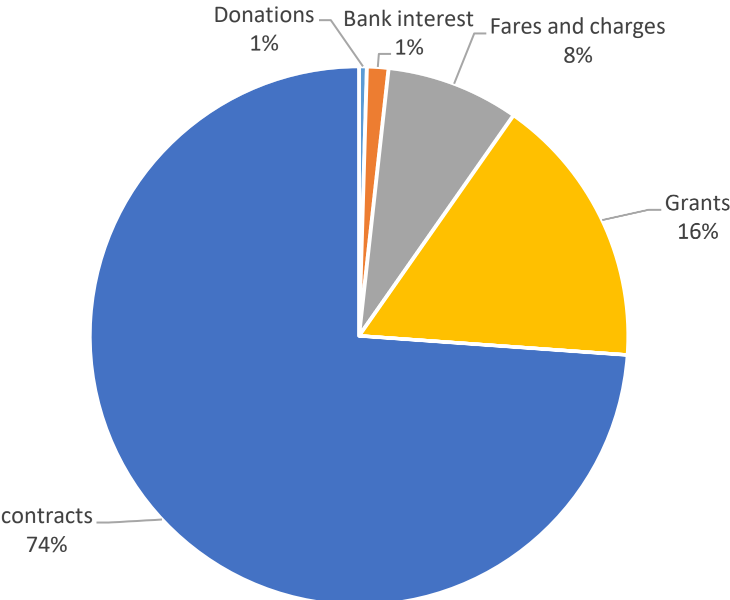
The charity connects rural residents to services such as health facilities and shops, where there is a gap in the commercial public transport network.

We enable people with mobility difficulties, or with a lack of access to transport, whether young or old to live independent lives and participate in their communities. In this way, we reduce rural and social isolation, creating opportunities for residents to venture out of their homes.

We aim to provide high quality, safe, friendly, accessible and affordable transport in local communities. Our services rely heavily upon the generous support of volunteers driving our minibuses and volunteers shaping the development and direction of the charity by becoming a trustee.

The charity delivers the services with 14 coachbuilt accessible minibuses using a mixture of paid and volunteer drivers.

Journey Purpose	**Numer of passenger journeys**
Community Group use	3483
MEDiBUS	3976
Door to door shoppers	11890
School	17100
Town centre services	23048
Totals	59497


North Holderness Community Transport Funding 2024
Donations
1%
Bank interest
1%
Fares and charges
8%
Grants
16%
contracts
74%

Appendix 4

Hambleton and Richmondshire Local Care Partnership Health Inequalities Project (2024-2025)

Exploring appointment clustering to reduce DNAs and improve access to health services.

Hambleton Community Action is leading on a Health Inequalities project funded by the ICB, working with the Local Care Partnership.

As a part of the project, HCA is working with a rural GP practice to explore how appointment clustering could be achieved, and to test this. If we can achieve proof of concept, i.e. a suitable protocol can be developed, this could be cascaded to other practices and into secondary care. Achieving a suitable methodology would deliver:

- Reduced DNAs at appointments and linked reduction in costs associated with cancellations and rearrangements, and improved use of clinician time
- Earlier presentation leading to shorter/more cost-effective treatment cycles, improved health outcomes
- Reduced costs of transport for patients
- Improve quality of journeys (many patients like to share journeys with others where they can)
- More effective use of scarce resources (i.e. volunteers*) increases availability for wellbeing and social journeys that can contribute to reduced demand on health services.

Environmental benefits through fewer “single use” journeys (these journeys often being much longer than would be the case where public transport was available)

*There are widespread assumptions that volunteers are a cost-free, unlimited resource; in practice, there is increasing evidence of a long-term trend away from volunteering, and of volunteers committing to fewer hours. This is because the “traditional” volunteer – affluent, retired, able-bodied, time on hands – is in decline: retirement ages are rising; the value of pensions is falling in real terms; an increase in unpaid caring responsibilities and increased costs of living render people unable to give the time and less likely to run a vehicle. Increased competition for volunteers, including from the NHS itself, means that recruitment and retention costs for volunteers – never £0, have and will continue to escalate.

Appendix 5

Transport for the North report "Transport and social exclusion in the North in 2023/24"

Published February 2024

https://www.transportforthenorth.com/reports/transport-and-social-exclusion-in-the-north-in-2023-24/

At its most basic, TRSE (Transport related social exclusion) means being unable to basic key destinations required for everyday life with the transport options available. This could be through a complete lack of appropriate transport options for a particular journey, through being unable to afford the transport options available, or through feeling sufficiently unsafe or supported when travelling on, to and from parts of the transport network. 17% of respondents agreed that they could not always get to the important places they needed to with the transport options available. Of those who agreed, limited access to GP and hospital appointments was by far the most common element, with 64% of respondents citing this destination.

(Page 24)

Based on datasets from 2019, in the Yorkshire and Humber region, 1,199,000 people (21.8% of the population) lived in neighbourhoods with a high risk of social exclusion because of transport issues. These neighbourhoods have poor access to key destinations with the transport options available, significant transport inequalities, and high levels of deprivation.

(Page 10)

The updated research carried out for the report focuses on three population groups:

- Those with low a household income or in insecure work
- Those with a disability or long-term health condition
- Informal unpaid carers

found to be at relatively higher risk of TRSE because they face greater:

- constraints on their transport choices, such as through cost, safety concerns, and inaccessible place design.
- consequences when transport systems fail to work in the way they should, such as being unable to afford alternatives when a bus or rail service is cancelled, and therefore facing longer delays.
- needs to travel in ways that are not well served by the transport options available, such as travelling outside of peak times for shift work, or for work on peripheral industrial sites.

The combination of these constraints, consequences, and needs means that transport issues do not just cause inconvenience, they have a fundamental impact on the ability

to take a full and meaningful part in society. This could mean being stuck in poverty, facing social isolation and loneliness, or worsening physical and mental health. Transport issues may not be the only cause, but have a significant role in causing or exacerbating these elements of social exclusion.

Appendix 6

Permits and compliance

Normally, an organisation operating in Great Britain (GB) that accepts any sort of payment for providing transport to passengers must hold either a PSV 'O' licence or a private hire vehicle (PHV) licence. However, not-for-profit organisations can apply for permits under section 19 or section 22 of the Transport Act 1985 to allow the holder to operate transport services for hire or reward without the need for a full public service vehicle operator (PSV 'O') licence.

The permit system is quite complicated see guidance https://www.gov.uk/government/publications/section-19-and-22-permits-not-for-profit-passenger-transport/section-19-and-22-permits-not-for-profit-passenger-transport

A permit holder has a responsibility to make sure that their services are operated within the law, with vehicles properly maintained and that they use drivers with the appropriate qualifications.

In addition to the servicing of the vehicle and the MOT test, vehicle safety inspection and routine maintenance inspections must be carried out at set intervals on items which affect vehicle safety, followed by the repair of any faults. Each vehicle must also have a daily walkaround check.

https://www.gov.uk/government/publications/section-19-and-22-permits-not-for-profit-passenger-transport/section-19-and-22-permits-not-for-profit-passenger-transport#annex-2-recommended-maintenance-arrangements

Driver licensing

Rules covering driver licensing requirements are complex and depend on the size of vehicle and when the driver passed their test. https://www.gov.uk/government/publications/section-19-and-22-permits-not-for-profit-passenger-transport/section-19-and-22-permits-not-for-profit-passenger-transport#drivers-of-permit-vehicles

CTA guidance https://ctauk.org/wp-content/uploads/2022/01/How-to-Driver-Licensing-in-GB-1.pdf

It is becoming more difficult to recruit volunteers due to driver licensing changes. This issue arises due to changes in national legislation, and local community transport organisations can only influence these through engagement with, for example, the Community Transport Association. There is a decreasing pool of volunteers that meet the criteria below, who are aging.

- Drivers of vehicles operated under a permit must be 21 or over.
- Drivers who passed their car test on or after 1 January 1997 may drive a small bus but only if certain conditions are met.

- On reaching the age of 70 a driver will need to renew their car licence and can also apply to renew their D1 entitlement but will need to take a compulsory medical examination as they must meet required health standards.
- If drivers want to drive a minibus with a GVW of over 3.5 tonnes (or 4.25 tonnes with the allowance for specialist equipment), drive abroad, tow a trailer or be paid to drive a minibus, under a Section 19 Permit, they need D1 entitlement and this is only as standard on licences issued before January 1997.

Under a Section 19 Permit drivers must meet certain conditions to drive a minibus on a standard B car licence.

- They are over 21 years of age
- They have held a full category B car licence for at least 2 years
- They receive no payment or other consideration for driving other than out-of-pocket expenses
- The vehicle has a maximum gross weight not exceeding 3.5 tonnes (4.25 tonnes including specialised equipment for the carriage of disabled passengers)
- For drivers aged 70 or over, that they don't have any medical conditions which would disqualify them from eligibility for a D1 licence
- No trailer is being towed
- Where the driver's licence only authorises the driving of vehicles with automatic transmission, that only a vehicle with automatic transmission is used
- Drivers aged 70 or over who don't meet the higher medical standards are not authorised to drive small buses. They can drive small vehicles being used under a permit, provided they have renewed their car licence.

Note: voluntary car schemes

Car sharing is exempt from the requirement to operate under a permit. Car sharing is when prearranged payments are made to the driver and the aggregate of all payments received does not exceed the running costs of the vehicle for the journey. Section 19 permits or private hire licences are therefore not required. Section 19 permits may be appropriate only where cars or MPVs are owned by the organisation.

See Definitions https://www.gov.uk/government/publications/section-19-and-22-permits-not-for-profit-passenger-transport/section-19-and-22-permits-not-for-profit-passenger-transport#definitions

Pay and recruitment

Anecdotally, recruitment of paid drivers is also currently challenging. Both community transport and commercial providers report that they are struggling with driver recruitment and retention because haulage and other alternatives pay significantly more. Rises in National Minimum Wage and Employers National Insurance contributions have an impact on the organisations who employ staff.

Appendix 7

Method

This piece of work has been undertaken by representatives from three of the CT groups in the area who are involved in delivering a service getting passengers to medical appointments. With our knowledge of CT, we believe we are well placed to gather relevant information and provide a useful document to base further discussion on.

All of the voluntary and community sector providers of CT across the ICB geography were contacted and a survey was circulated. From the survey and additional research, we identified 27 providers, 24 of which are charities, 2 community interest companies, 1 limited company and 1 informal. Some only provide community transport, for others it is part of their range of services. 16 organisations run voluntary car schemes, 13 dial-a-ride services and 8 organisations operate other bus services.

Survey questions:

1. Organisation name
2. Please select the option that best describes your organisation
   - Registered charity
   - Constituted community group
   - Limited company
   - Community Benefit Society or Industrial and Provident Society
   - Informal group
   - Community Interest Company
   - Other
3. What type of community transport services do you provide?
   - Bus with paid driver (employee)
   - Bus with volunteer driver
   - Car with paid driver (employee)
   - Car with volunteer driver
   - Other
4. Which areas do you operate your transport service in?
   - North Yorkshire
   - East Riding York
   - Hull
   - North Lincolnshire
   - North East Lincolnshire
5. Do you provide any other services apart from transport? If so, please tell us what other services you provide.
6. Is there any eligibility criteria that passengers must meet to use your services? If your eligibility criteria is stated on your website, you can give us a link here.

7. Is there a notice period that passengers must give you before they wish to travel? If so, please let us know here.
8. Do you use any software to book journeys? If so, please tell us the software that you use.
9. How many passengers have travelled with you in the last 12 months?
10. How many passenger journeys has your service completed in the last 12 months?
11. Do you have any data about the length (mileage) of the passenger journeys that your service makes? If so, please tell us here.
12. Do you have any data on the reasons why your passengers travel? Please let us know here. We would like to establish whether journeys are social or for basic needs such as shopping, health appointments etc. or any other reasons.
13. How many paid drivers does your organisation employ? Please state if they are full or part time.
14. How many volunteer drivers does your organisation have?
15. Please select the answer that best describes the capacity of your service
    - We have more demand than we can meet with our current resources
    - We can meet current demands for services with the resources we have
    - We have spare capacity and could carry out more journeys if there was demand
    - Other
16. Please tell us the annual cost of running the community transport aspect of your organisation. If your organisation only provides community transport, please tell us the total annual running costs of your organisation.
17. Please tell us where your funding has come from in the last 12 months (select all that apply)
    - Local authority grants
    - Local authority contracts
    - Grants from other sources (eg trusts and foundations, National Lottery Community Fund, etc)
    - Fees charged to service users (fares, expenses, etc)
    - Donations from the public including service users
    - Parish councils
    - Government funding
    - Your own fundraising (events etc)
    - Other
18. Is your organisation involved in any networks, for example specific networks for providers of community transport or wider networks for community organisations. If yes, please tell us the names of the networks.
19. Would you like to be involved in a network for community transport providers? (Either local or regional)
    - Yes
    - No
    - Other
20. What have we missed? Is there anything else you want to say?

Humber and North Yorkshire
Health and Care Partnership

Agenda Item No:	12

Report to:	**Integrated Care Partnership**
Date of Meeting:	**26th March 2025**
Subject:	**Q4 Integrated Care Partnership Governance Review**
Director Sponsor:	Karina Ellis, Executive Director of Corporate Affairs
Author:	Governance and Compliance Team

STATUS OF THE REPORT:

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

SUMMARY OF REPORT:
Good governance is central to the running of Humber and North Yorkshire System. It ensures the system partnership arrangements are meeting the legislative responsibilities and provides assurance that specifically the ICB is conducting the duties required of a public body in an efficient and effective manner.

The ICB and system governance processes are there to demonstrate clear accountability, transparency, that we are operating ethically and that we are well-led. It not only gives our communities, staff and partners confidence in the ICB but also provides assurance to NHS England and the Government in the ICB and system decision-making processes.

RECOMMENDATIONS:
Members are asked to:

i) Discuss and agree the annual review of effectiveness for 2024/25, noting any areas to address for 2025/26.
ii) Discuss and approve the ICP Annual Report for 2024/25 and agree to delegate authority to the Chair and Executive Director Leads to make any additional amendments as required due to timing issues.
iii) Discuss and agree any minor updates to the terms of reference and note the intention to undertake a full review prior to ICB Board and Health and Wellbeing Board approval.

ICB STRATEGIC OBJECTIVE

Leading for Excellence	☒
Leading for Prevention	☐
Leading for Sustainability	☐
Voice at the Heart	☐

IMPLICATIONS

Finance	The Finance, Performance and Delivery Committee is a Committee of the ICB Board and is required to undertake compliance reviews for year-end alongside all other ICB Board statutory and non-statutory committees.

Quality	The Quality Committee and the Clinical and Professional Committee are Committees of the ICB Board and are required to undertake compliance reviews for year-end alongside all other ICB Board statutory and non-statutory committees.
HR	The People Committee and Remuneration Committees are Committees of the ICB Board and are required to undertake compliance reviews for year-end alongside all other ICB Board statutory and non-statutory committees.
Legal / Regulatory	The HNY ICB Constitution states that the ICB Board and its Committees have a duty to carry out a review of effectiveness annually and report findings within the Annual Governance Statement.
Data Protection / IG	The Audit Committee is responsible for compliance in the areas of IG/Data Protection and will include information on this area with year-end reporting.
Health inequality / equality	All committees of the ICB Board have a role in ensuring we enact our duties in relation to equality and health inequalities.
Conflict of Interest	No conflicts of interest have been identified prior to the meeting. Conflicts of interest compliance will be considered within the review and detailed within the Committees annual reports.
Sustainability	There are no sustainability implications relating to this paper, however sustainability controls and mitigations will be considered on a case-by-case basis, as appropriate.

ASSESSED RISK:
The ICB has a statutory and regulatory obligation to ensure that systems of control are in place, to minimise the impact of all types of risk.

There are no significant risks aligned to this paper; however, it should be recognised that the Quarter 4 Governance Review is a significant programme of work and slippage may impact on the delivery of the Annual Report and Annual Governance Statement.

MONITORING AND ASSURANCE:
The ICB Board is required to monitor the effectiveness of its governance arrangements, including its committees. The outcome of this is reported to NHS England via the ICB Annual Report.

ENGAGEMENT:
A wide variety of ICB subject matter specialists, senior officers, committees and the ICB Board will be engaged in this work, as required.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No ☒ Yes ☐

Humber and North Yorkshire
Health and Care Partnership

1.0 Introduction and Purpose

1.1. The ICB is required to conduct governance reviews of its committees on an annual basis. This year's approach draws upon the same multi-faceted methodology used in 2022/23, and 2023/24, where any actions identified from the previous reviews will be checked as well as any further learning from the current year. The review comprises three elements:

i) Committee effectiveness review 2024/25
ii) Committee annual report 2024/25
iii) Committee terms of reference

1.4 The purpose of this report is to present the above documents to the Partnership and seek recommendations that will satisfy year end requirements.

1.5 It should be noted that each committee has been assigned a 'governance lead' to support the secretariat and 'heads of/leads' of the committee to complete this work. The Chair and Executive Director lead/s have also been engaged with in this process before the reports have been reviewed by the Partnership.

1.6 In preparation for the Q4 review, each committee secretariat has ensured that a decision register has been kept up to date throughout the financial year.

2.0 Committee Effectiveness Review 2024/25

2.1 NHS England guidance, the Insightful ICB Board, outlines key indicators for evaluating the effectiveness of integrated care boards (ICBs) and their committees. The reviews the ICB conducts, utilising industry standards outlined in the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook alongside the committees' annual report, focus on compliance with statutory duties, early warning signs of issues, continuous improvement, effective leadership, risk management, insightful use of information, and effective decision-making. Together this ensures consistency, transparency, and accountability, supporting robust governance and continuous improvement.

2.2 The Committee effectiveness review for 2024/25 has been completed based on available evidence and is included in Appendix A, and the Partnership can be confident in its effectiveness for 2024/25.

2.2 The outcome of all committee effectiveness reviews will be discussed at the ICB Board meeting as part of the year-end processes.

3.0 Committee Annual Report

3.1 The draft Committee Report **2024/25** is attached at appendix B for discussion and approval.

3.2 It should be noted that depending on the date the report has been received by the Partnership, that there may be some gaps where additional input will need to be made following the meeting but before year-end. If this is the case, we will ask that the Partnership delegates authority to the Executive Director and Chair to approve any minor updates made in respect of this, due to timing issues.

3.3 All committee annual reports will form part of the Annual Governance Statement, published within the ICB Annual Report as part of the year-end processes.

4.0 Partnership Terms of Reference

4.1 The terms of reference have been updated to include revisions to the conflicts of interest paragraph, inclusion of the Freedom of Information (FOI) paragraph, and modifications to the reporting arrangements paragraph.

4.2 There is an intention to conduct a thorough review of the ICP's terms of reference requiring further engagement with ICP members.

4.3 All committee terms of reference will be taken to the ICB Board and Health and Wellbeing Board for formal approval, as part of the year-end processes.

5.0 Recommendations

The Partnership is asked to:

- Discuss and agree the annual review of effectiveness for 2024/25, noting any areas to address for 2025/26.

- Discuss and approve the Committee Annual Report for 2024/25 and agree to delegate authority to the Chair and Executive Director Leads to make any additional amendments as required due to timing issues.

- Discuss and agree any minor updates to the terms of reference and note the intention to undertake a full review prior to ICB Board and Health and Wellbeing Board approval.

END.

APPENDIX A

Integrated Care Partnership – Annual Review of Effectiveness 2024/25

Issue	Yes	No	Comments / Action
Composition, Establishment and Duties			
Does the Committee have written terms of reference that adequately define the Committee's role?	X		There is a section that defines the purpose and responsibilities of the Committee
Have terms of reference been ratified by the ICB Board?	X		May 2024
Does the Committee report to the ICB Board in accordance with its ToR?	X		The Committee submits an escalation and assurance report to the Board following each meeting.
Does the Committee receive the appropriate level of input from its Members?	X		There is strong engagement in the work of the committee. Members freely input into discussions and engage with speakers on topics being discussed. The Chair regularly meets with Health and Wellbeing Board Chairs, particularly the Co-Chair to develop the agenda. The Futures Group Chair also contributes to the agenda.
Does the Committee prepare an Annual Report on its work for the ICB Board?	X		The annual report for 2024/25 is complete and attached.
Has the committee been quorate for each meeting this year?	X		Quoracy was achieved for 3 out of 4 meetings so far for 24/25. The meeting on 20th March was not quorate due to the absence of a Director of Public Health.
Administrative Arrangements			
Are agendas and reports circulated in good time for Committee Members to give them due consideration?	X		Agendas and papers circulated a week in advance of each meeting in line with the Standing Orders
Are the minutes and actions circulated in good time for Committee Members to give them due consideration?	X		In line with Standing Orders and Terms of Reference.
Has the Committee met the appropriate number of times this year?	X		The Terms of Reference currently states the committee will meet no less than 4 times per year. This was achieved in 2024/25.
Have all Committee Members attended meetings on a regular basis; is the level of attendance satisfactory and in line with the ToRs?	X		All members or agreed deputised colleagues have attended on a regular basis.
Governance, Scrutiny and Assurance			
Can the Committee demonstrate that it has provided the ICB Board	X		The Committee submits an escalation and assurance report to the Board following each meeting.

with assurance in respect of the Statutory Duties as per the ToRs?			
Can the Committee demonstrate that it has provided ICB Board with assurance in respect of the BAF / Corporate Risks?	N/A	N/A	Not applicable to the ICP.
Has the Committee sufficient time to give appropriate consideration and scrutiny to its business and agenda?	X		Meetings have generally run to time and all agenda items covered as scheduled
Does the Committee receive sufficient Reports to enable it to fulfil the Terms of Reference?	X		A forward plan was agreed by the committee for 2024-25 to ensure topics are covered systematically, with the relevant amount of detail. The committee has received a broad range of reports that cover its remit.
Do the reports presented to the Committee provide the quality and detail required to enable the Committee to provide assurance and carry out the ToR?	X		Attendees include subject matter experts who are invited to provide significant assurance on reports. Papers that require a decision have been detailed
Does the Committee understand the risks / issues, make decisions and provide assurance?	X		As part of its decision-making risks and issues are considered. The ICP is regularly assured on areas under its remit.
Has the Committee approved the ToRs and Work Plans to any subordinate groups?	X		The ICP receives and agrees the objectives for the Futures Group.
Has the Committee received regular progress reports from subordinate groups and been advised of any significant issues/risks?	X		The ICP receives feedback from the Futures Group as part of its agenda.
Has the Committee effectively managed Conflicts of Interest in line with the ICB Conflict of Interest Policy and the Committee's ToR?	X		There is a standard agenda item and conflicts declared are evidenced within minutes. The Committee annual report provides more detail.
Work Plan			
Has the Committee established a workplan for the year and has been adhered to?	X		The ICP agreed a workplan for 2024-5 and this has been adhered to.
Does the Committee review its Work Plan at least quarterly?	X		The Chair and H&WB Chairs regularly review the workplan.
Has the Committee achieved its agreed Work Plan?	X		The committee's work plan has been used to agree the agendas for meetings during the year.
Does the Work Plan reflect all of the duties and responsibilities set out in the ToR?	X		The work plan reflects the duties and responsibilities set out in the ToR. A new work plan for 2025/26 has been drafted to reflect how the work of the committee has evolved in year.
Are there any areas of the ToR which require additional focus or a change in approach? Have any	X		The Terms of Reference have been reviewed and updates proposed for 2025/26. The Secretariat will ensure that the

necessary changes been made to the Work Plan to achieve this?			workplan is regularly updated according to the Committee's objectives and associated risks.

Integrated Care Partnership – Annual Report 2024/25

INTEGRATED CARE PARTNERSHIP (ICP) – Annual Report 2024/25

This report covers the work of the Integrated Care Partnership of the Humber and North Yorkshire for matters relating to the year 2023/24.
This report provides the HNY ICB Board with a summary of the work done and how the Committee has discharged its responsibilities in supporting the ICBs Annual Governance Statement (AGS) and Assurance Framework.

Committee Membership

The committee consists of the following members:

- The Chair of the ICB (who will also be the co-chair of the ICP)
- Co-Chair of the ICP (usually an elected member, nominated by the councils)
- The Chief Executive of the ICB
- The Deputy Chief Executive / Chief Operating Officer of the ICB.
- 6 Place Leaders (Usually Local authority Chief Executives or their nominated deputy)
- 6 Elected Members, (Usually Health and Wellbeing Board Chairs or holders of other relevant portfolios).
- 6 NHS Place Directors
- 2 Directors of Public Health (ideally one from the Humber area and one from North Yorkshire and York)
- A representative of Healthwatch (who will support the committee in respect of the voice of lived experience)

Attendance records are detailed within the minutes and show that there was a good level of attendance from all member organisations throughout 2024/25.

Numbers required for quorum and any instances where the Committee was not quorate

The Partnership Committee is quorate when at least nine members of the Committee are present to include at least:

- One of the Co-Chairs
- Two Place Chief Executives or their nominated deputy
- Two Elected Members (in addition to the Elected Co-Chair if they are chairing the meeting)
- Two NHS Place Directors (ideally representing a different Place to the Place Chief Executives)
- One Director of Public Health
- Chief Executive or Director of the ICB

Nominated deputies may speak and vote on their behalf and where applicable will form part of the quoracy and Members will count towards the quorum if attending remotely.

This was achieved for 3 out of 4 meetings so far in 2024/25.

20th March 2024 – This meeting was not quorate due to the absence of a Director of Public Health. It was decided by the Chair that a consensus would be sought on matters requiring a decision from those present.

Conflicts of Interest

No conflicts of interest were identified during 2024/25.

Date of approval of terms of reference

The Partnership Committee reviewed its Terms of Reference in March 2024, and these were presented and approved by the ICB Board in May 2024 and the Health and Wellbeing Boards in each Place.

Key Role of the Committee

The Partnership has the responsibility of creating an Integrated Care Strategy that outlines how the diverse health needs of the local population will be addressed. This strategy takes into account any relevant joint strategic needs assessments produced by Health and Wellbeing Boards in the Humber and North Yorkshire area. The Strategy identifies the main priorities and factors that will enable the health and care system to focus on integrating efforts to support the joint health and wellbeing strategy.

To ensure effective implementation, the strategy is supported by six Place Health and Care partnerships. These partnerships will facilitate collaboration among different Places to streamline processes across the larger geographical area.

In addition, the ICP oversees population health strategies and adopts a system-wide approach to reducing Health Inequalities. It actively encourages and supports the development of key anchor organisations and promotes collaboration in socio-economic development.

The ICP also plays a key role in fostering innovation, research, and improvement across the ICS footprint. Furthermore, it nurtures and sets an example of an open and inclusive approach among its partners.

Strategic risks delegated to the Committee for scrutiny as per the Assurance Framework

As per the ICB Board Assurance Framework, no risks are assigned to the ICP. Any risks associated with the delivery of the Partnership Strategy will be managed through the lead partnership organisation with responsibility for the specific area.

Main Responsibilities of the Committee

The Partnership Committee provides the formal leadership for the Integrated Care Partnership. The Partnership Committee is responsible for

- Developing and agreeing an integrated care strategy across Humber and North Yorkshire- and tracking progress against the key objectives.

- Making recommendations to the ICB on delivery of integrated care strategy and on matters that span more than one place such as major service reconfiguration, capital investment, collective action and campaigns.
- Having oversight of delivery of the integrated care strategy, including tracking progress and review.
- Working effectively, collaboratively with partners with shared accountability.
- To be responsible for the oversight, monitoring, and implementation of remedial actions in relation to any risks which are aligned to the committee and managed within the respective organisations.

The partnership Committee comprises of:

- Futures Group
- Place Leaders Group
- Formal ICP Board

Special responsibility of the ICP – Twice Yearly Symposium
The ICP also invited the wider leadership community across our ICS to come together in a symposium format. The purpose of the symposium is to:

- Share knowledge, promote learning.
- Build partnerships and create an opportunity for networking.
- Communicate - sharing progress and challenges.

Summary of the key outcomes of the Committee

The Integrated Care Partnership (ICP) is a statutory committee jointly convened by Local Authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.

Improvements have been made to the ICP to reflect a system approach to reducing health inequalities and promote partnership working and the development of an outcomes framework. This includes a life course approach, highlighting 16 high-level metrics, and plans for further data collection and segmentation to assess inequalities.
In discharging its duties, the Partnership Committee have agreed several standing items including strategic partnership reviews/ updates from

- Chairs Partnership Reviews
- Local Government Partnership Reviews
- Futures Group Reports
- ICB Chief Operating Officer Place reports

The Partnership Committee has covered various topics during 2024-25:

April 2024 – ICP Symposium

Ageing Well: Harnessing the Opportunities and Challenges of a growing population of older people in the UK

- In April 2024, the Humber and North Yorkshire Health and Care Partnership held a symposium in York to address the challenges and opportunities of an ageing population.

- The keynote speakers were Professor Sir Chris Whitty, Chief Medical Officer for England, and Tina Woods, founder and CEO of Collider Health. The speakers emphasised the need for prevention, innovation, and collaborative approaches to support healthy and independent ageing.
- The event highlighted initiatives like the Jean Bishop Integrated Care Centre in Hull, which has successfully reduced emergency hospital admissions for elderly patients. Building on this success, a new Frailty Centre of Excellence will ensure equitable, high-quality care across the region, fostering vitality and resilience in later life.

June 2024

- An overview was provided 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.
- The final version of the Integrated Strategy for Wellbeing, Heath and Care was approved. The Strategy is based on the health and wellbeing plans of the 6 Places, and it was agreed that system plans will be aligned accordingly.

September 2024

- Futures Group Report – the Future Group's has a focus on healthy ageing and longevity. The intent is to focus on coastal towns that are often harder to create impact in due to the location and quality of life The Partnership supported the Futures Group approach to develop a proposal for coastal based 'living lab' research which is to be presented to the ICP in Spring 2025.
- Local Government Partnership Report – It was noted that work involving public engagement with a focus on prevention and ensuring fair access to healthcare is underway and that preparation for devolution is a major focus. The Partnership discussed how resources can be spread in a cross-geographical manner, including Section 75 agreements with the potential to direct resources towards local authority areas.
- The Partnership received an update on Integrated Neighbourhood Teams as an example of the use of collective resources within defined localities to seek consistent patient outcomes. The concept includes aligning resource mechanics and governance to avoid over-medicalisation and support care as close to home as possible.
- Outcomes Framework – It was noted that measures will be both quantitative and qualitative and will primarily focus around 5 priority outcome themes (cardiovascular disease (CVD), Children and Young People (CYP), frailty, cancer, and mental health). The focus is on developing high-level outcomes in the four major health areas, along with a golden ambition around children's health. They will also consider the life course themes, as per the ICB's Strategy.

November 2024 - Symposium

A digitally enabled health and care system - Humber and North Yorkshire Health and Care Partnership held its third symposium on 6 November, focusing on the transformative potential of a digitally enabled health and care system. The event, which was held as an online webinar, aimed to inspire curiosity, foster innovation, and introduce pioneering thought-leaders in digital health.

Speakers included Mark Davies (IBM), Professor Daan Dohmen (Luscii), Dr Simon Wallace (Microsoft UK), and Rachel Dunscombe (OpenEHR), and each speaker was charged with answering the same question:

"Looking ahead to the next 5-10 years, how can we ensure that emerging digital technologies are successfully integrated into health and care systems to improve patient outcomes, while also making sure that digitally enabled care remains equitable, accessible, and sustainable for everyone?"

In a world where the NHS faces the most challenging of times, this event provided a compelling vision for the future of health and care, shining a bright light of optimism on the emerging use of digitally enabled healthcare.

December 2024

- The ICB's focus on prevention, digital transformation, and addressing winter pressures was discussed. Challenges included financial difficulties and rising cases of COVID, flu, RSV, and norovirus. Initiatives to improve patient flow and reduce ambulance handover times were also mentioned
- Design for the Future: an update was provided on public engagement work, which showed a clear mandate for change in the NHS. Key priorities included reducing waiting times, improving communication between health services, and addressing understaffing. The feedback will inform the System Leaders Forum's case for change.

APPENDIX C

Humber and North Yorkshire Integrated Care Partnership

Terms of Reference

Terms of Reference:	Humber and North Yorkshire Integrated Care Partnership
Authorship:	Corporate Affairs
Board / Committee Responsible for Ratifying:	ICB Board Health and Wellbeing Boards
Approved Date:	~~March 2024~~TBC
Ratified Date:	~~May 2024~~TBC
Review Date:	March 2026~~5~~
Version Number:	~~v~~V~~3.0~~4.0
The online version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.	

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1.0 Parties to the Terms of Reference

The Integrated Partnership is a statutorily equal partnership between the NHS and local government to work with and for their partners and communities. The members of the Humber and North Yorkshire Integrated Care Partnership (the Partnership), include:

Local Authorities

The following are Local Authorities (the Councils) within Humber and North Yorkshire:

- East Riding of Yorkshire Council
- Hull City Council
- North Lincolnshire Council
- North East Lincolnshire Council
- North Yorkshire County Council
- City of York Council

National Health Service

NHS Humber and North Yorkshire Integrated Care Board (the HNY ICB)

As members of the Partnership all organisations subscribe to the vision, principles, values, and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in these Terms of Reference.

Definitions and Interpretation

These Terms of Reference is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

These Terms of Reference shall commence on the date of approval of all Parties. It will be subject to an annual review by the Partnership Committee to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System and will be published on the Humber and North Yorkshire Integrated Care Partnership website.

2.0 Introduction and context

This Terms of Reference (ToR) is an understanding between the Councils and Humber and North Yorkshire Integrated Care Board ("the Statutory Organisations"), established in accordance with Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022).

("the Statutory Organisations"), established in accordance with Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022
It sets out the details of our commitment to work together in partnership to realise a shared ambitions to improve the health and wellbeing of the circa 1.7 million people who live and work in Humber and North Yorkshire.

The Integrated Care Partnership is a statutory committee jointly convened by six Local Authorities and the NHS Humber & North Yorkshire Integrated Care Board and comprises of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.

The Partnership will act as the ‘guiding mind’ of Humber and North Yorkshire Health and Care Partnership (Integrated Care System (ICS)) and is authorised to operate within these Terms of Reference, which set out its purpose, membership, authority, and reporting arrangements.

The Partnership is one of the four core elements of an Integrated Care System along with Place, the Integrated Care Board, and the Sector Collaboratives. The Partnership will not duplicate the work of the Local Health and Wellbeing Boards. Members of the Partnership Committee will champion and act as ambassadors of effective partnership working for local population benefit.

2.1 Purpose

The ICP will create the space for partners to develop joint strategies that better serve local populations, based on population health management approaches. They will enable partners to plan for the future and develop strategies for using available resources creatively to address the longer-term challenges which cannot be addressed by a single sector or organisation alone.

There is a statutory requirement for the Partnership to produce an Integrated Care Strategy. This will be informed by both Health and Wellbeing Boards (HWB) and Joint Strategic Needs Assessments (JSNA) and will shape the priorities for the ICS to improve the health and care of the circa 1.7 million people we serve. Our mandate is to:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience and access.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development.

We believe that many of the needs and health aspirations of our population are best met locally, in the six places we have identified in our partnership geography.

With patience, respect, and a willingness to work together, the ICP will drive the direction and policy of the ICS, by:

- Being rooted in the needs of the population and communities it serves at place, and collectively across Humber and North Yorkshire.
- Overseeing population health strategies.
- Overseeing the system approach to reducing Health Inequalities.
- Overseeing and promoting partnership working in respect of the socio-economic development.
- Encouraging and supporting the development of key anchor organisations and their role in supporting local prosperity.
- Encouraging and supporting Innovation, Research, and Improvement across the ICS footprint.
- Enhancing productivity and value for money by supporting integration and subsidiarity locally and regionally where it is appropriate and effective to do so.
- Nurturing and role-modelling an open and inclusive approach between partners.
- Taking a person centred, strength-based approach; Think Person, Think Family, Think Community.

3.0 How we work together in Humber and North Yorkshire

3.1 Our shared vision and objectives

Our Aims

We aim to narrow the gap in healthy life expectancy by 2030 and increase healthy life expectancy by five years by 2035.

Our outcomes are to ensure that our population can:

Start well, live well, age well and die well.

Our ambitions

- Enabling wellbeing, health and care equity.
- Transforming people's health and care experiences and outcomes.
- Radically improving children's wellbeing, health and care.

3.2 Our shared values and behaviours

We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values and have aligned these to the Nolan Principles which define the standards of conduct expected by a person or people in public office:

a. **Selflessness -** act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
b. **Integrity -** not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
c. **Objectivity -** in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
d. **Accountability -** are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
e. **Openness -** be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
f. **Honesty -** a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
g. **Leadership -** promote and support these principles by leadership and example.

4.0 Partnership Committee

Whilst the ICP has no formal delegated powers from its constituent organisations, it will provide an authorising environment through a leadership, oversight, and support for system-wide activities, playing a key role in ensuring joint accountability to our population. The ICP will also continue to evolve in the way it works in response to the changing priorities of the partnership.

The Partnership does not replace or override the authority of the Councils or HNY ICBs Boards and Committee. Each of them remains sovereign and Councils remain directly accountable to their electorates.

4.1 Responsibilities

The Partnership Committee provides the formal leadership for the Integrated Care Partnership. The Partnership Committee is responsible for

- Developing and agreeing an **integrated care strategy** across Humber and North Yorkshire- and tracking progress against the key objectives.
- Making recommendations to the ICB on delivery of integrated care strategy and on matters that span more than one place such as major service reconfiguration, capital investment, collective action and campaigns.
- Having **oversight** of delivery of the integrated care strategy, including tracking progress and review.
- Working effectively, collaboratively with partners with **shared accountability**.
- To be responsible for the oversight, monitoring, and implementation of remedial actions in relation to any risks which are aligned to the committee and managed within the respective organisations.

4.2 Membership and attendance

The ICP membership shall be agreed by the ICP and appointed by the relevant organisations.
The membership of the Partnership Committee is comprised of the following:

- 6 Place Leaders (Usually Local authority Chief Executives or their nominated deputy)
- 6 Elected Members, (Usually Health and Wellbeing Board Chairs or holders of other relevant portfolios).
- 6 NHS Place Directors
- 2 Directors of Public Health (ideally one from the Humber area and one from North Yorkshire and York)
- A representative of Healthwatch (who will support the committee in respect of the voice of lived experience)
- Chair of the ICB (who will also be the co-chair of the ICP)
- Co-Chair of the ICP (usually an elected member, nominated by the councils)
- Chief Executive of the ICB
- Deputy Chief Executive / Chief Operating Officer of the ICB.

4.3 Chair and Vice Chair

Meetings will be chaired by either of the co-chairs.

The Co-Chairs will be selected from HNYICB and one selected from the Elected Members, nominated by the councils.

Note: Co-Chairs, on behalf of the Partnership Committee or at their own discretion, may establish specific reference groups or challenge groups from the wider leadership community to inform their own thinking and understanding.

The Co-Chairs will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR. A forward plan will be developed to support the setting of the agenda.

4.4 Deputies

Members are permitted to nominate a suitable deputy to attend a meeting of the Partnership Committee on their behalf should they be unable to attend themselves.

Members are responsible for fully briefing any nominated deputies.

Deputies need to be confirmed in writing to the Chair of the ICP ahead of the meeting.

4.5 Attendees

- The Partnership Committee may invite members of the broader Leadership Community to their meetings as needed/required.
- Executive Directors/Officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.
- Other individuals may be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.

4.6 Quoracy

The Partnership Committee will be quorate to include at least:

- One of the Co-Chairs
- Two Place Chief Executives or their nominated deputy
- Two Elected Members (in addition to the Elected Co-Chair if they are chairing the meeting)
- Two NHS Place Directors (ideally representing a different Place to the Place Chief Executives)
- One Director of Public Health
- Chief Executive or Director of the ICB

Nominated deputies may speak and vote on their behalf and where applicable will form part of the quoracy and Members will count towards the quorum if attending remotely.

If any member of the ICP has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

4.7 Decision Making Arrangements

The Partnership Committee will ordinarily reach conclusions by consensus. Any decisions taken will be recorded in the minutes of the meeting.

If consensus cannot be reached and if timeframes allow, then the item will be re-scheduled for discussion at the next meeting of the ICP. Otherwise, decisions will be taken by majority.

Only members (or nominated deputies) of the Partnership Committee may vote. Each member is allowed one vote, and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Co-Chairs of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Co-Chairs may conduct business on a ‘virtual’ basis using Microsoft Teams.

4.8 Conflicts of Interest

In advance of any meeting of the ICP, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed.

At the beginning of each meeting of the ICP members will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any interests which are declared at a meeting must be recorded within the minutes of the meeting. ~~Any such declarations will be formally recorded in the minutes for the meeting.~~

The Chair of the ICP will determine how any declared interests should be managed.

Individuals (including those employed by other organisations) must also ensure that they comply with both the ICB's and their employing organisation's policies / professional codes of conduct with regard to the recording of declarations. ~~ICP members must ensure that they always comply with their organisational policies/ professional codes of conduct.~~

4.9 Freedom of Information Act 2000

The minutes and papers of this Committee are considered public documents, except where matters are specifically deemed to be unsuitable for publication. This will usually be due to draft work in progress, issues of confidentiality, or commercial sensitivity.

4.10 Meeting Arrangements

The Partnership Committee will meet no less than four times per year and face-to-face.

Note: Extraordinary meetings may be called for a specific purpose at the discretion of the of the Co-Chairs. At least five clear working days' notice will be given when calling meetings.
The quarterly meetings of the Partnership Committee will be held in public via an electronic livestream.

4.11 Sub-Groups of the Integrated Care Partnership

The **Futures Group** will report to the Integrated Care Partnership Committee quarterly.
The purpose of the Futures Group will be to pursue partnership working that increases the capacity and effectiveness of the ICS in delivering on its long-term ambitions. This will go beyond the existing health and care partnership (NHS, local authorities, patient voice, voluntary sector) and harness the capabilities of universities, colleges, the private sector, and health charities.

The intention is to position the Futures Group as a 'first mover' (thought leader and innovator), generating multi-sector partnerships producing scalable transformative change that can be adopted more widely. The group will focus on the medium to long term only and will working across four main themes – research, workforce, technology, and population health. The Group will:

1. Work together with clear focus on our strategic organisational objectives, which can deliver system change and system sustainability.
2. Create 'joined up' thinking and avoid silos.
3. 'Make things happen'. A committee which enables change and transformation.
4. To ensure that transformation and innovation are at the heart of our health and care system.
5. Create a 'team' of multi-disciplinary leaders who share a commitment to the transformation agenda- and by bringing this work together can find the ways in which their work overlaps improving connected working and avoiding duplication.
6. Develop a generation of innovative system leaders- supporting our talent and succession objectives.
7. Bring rigour and challenges from an academic setting.
8. To report to the ICP in respect of development and progress.

The Futures Group will have an external chair and independent members, along with executives from across the ICS. The minutes of the meeting will be shared with the ICP.

The **Place Leaders Group** will report to the ICP quarterly.

The purpose of the Place Leaders Group is to strengthen partnerships at Place. Meeting alongside the Futures Group the intention is to share best practice and learning from Places and explore scalable opportunities arising from current Place, regional and national initiatives, which best meet the objectives of the Partnership Strategy and address the wider determinants of health.

4.12 Special responsibility of the ICP – Symposium

At least once a year, the ICP will invite the wider leadership community across our ICS to come together in a symposium format, where they will welcome guests from the wider health and social care population, along with other partners including education, business, and other public sector organisations.
The purpose of the symposium will be:

- Sharing knowledge, promoting learning
- Building partnerships and creating an opportunity for networking
- Communication- sharing progress and challenges.

4.13 Reporting Arrangements

In addition to the Futures Group and the Place Leaders Group the ICB will receive a regular report from the Population Health committee, Start Well committee and Place Health and Care Partnerships.
~~The minutes of the meetings shall be formally recorded by the secretariat and the Co-Chairs will provide the agreed key messages of each of its meetings, for information, to the ICB Board, Health & Wellbeing Boards, and Place Committees~~

~~The Co-Chairs will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.~~

The minutes of the meetings shall be formally recorded by the secretary. The Co-Chair will provide assurance and escalation reports to the Board at each meeting, as appropriate, and shall draw to the attention of the Board, Health & Wellbeing Boards, and Place Committees, any issues that require disclosure to the Board or require action

4.14 Secretariat and Administration

The Committee shall be supported initially by the Executive Director of Corporate Affairs, and with the Secretariat provided by the ICB Corporate Affairs function. The secretariat function which will include ensuring that:

- All meeting venues are fit for purpose.
- The agenda and papers are prepared and distributed 5 days in advance having been agreed by the Chair.
- Quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Committee.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.
- The secretariat is responsible for ensuring that the annual programme of business is regularly updated according to the Committees objectives and associated risks.

4.15 Review

The Partnership Committee will review its effectiveness at least annually.

END