Humber and North Yorkshire
Health and Care Partnership

Reimagining Health & Care – **An Integrated Strategy**

Contents

Introduction from the Chair and Vice Chair	**4**
Our starting point	**6**
Our strategy on a page	**8**
Our partnership	**10**
Our population in numbers	**11**
Our communities	**14**
Create Conditions	**16**
Think Person	**18**
Think Family	**20**
Think Community	**22**
How we will know we have succeeded	**24**
Case Studies	
Start Well	26
Live Well	28
Age Well	30
Die Well	32
What happens next?	**34**
Summary	**36**
Summary of our Patient and Public Involvement and Intelligence	**38**

The aim of this strategy is to describe our shared ambition and set the framework to enable local action to happen. This framework is permissive, not prescriptive – it describes the goals we are aiming for and the values that underpin how we will work together.

Introduction from the Chair and Vice Chair

Humber and North Yorkshire Integrated Care System has big ambitions for health and care!

This strategy captures the aspirations of many partners, including Local Government, Voluntary, Community and Social Enterprise organisations and the NHS, with a practical plan for achieving those big ambitions. Our ambitions are easily understood. We want every single person in our population of 1.7 million people to start life well, to live well, to age well and die well. There are actions that we can take across our whole geography to achieve this, and there are actions which we can take more locally to achieve this: this strategy sets the framework for both.

All Integrated Care Systems have a very clear purpose: to bring together all elements of health and social care in a unique geography, by thinking and working as partners, in order to improve the overall health of the population, by focusing on inequalities in the health of the population and by contributing to the prosperity of our geography. By doing these things together, we believe we can also improve the quality and effectiveness of the services we collectively provide.

Collectively we have resources, a budget of £3.5 billion and more than 50,000 people, to achieve our ambitions, but the most important resources of all, partners who share a deep commitment to making changes that can deliver an improved, joined-up, quality health and social care system for our population.

Our Integrated Care Partnership understands that achieving these ambitions will be challenging: many of us will need to change our ways of working, we will all need to become expert partners across organisations, we must forge new innovative partnerships, we must all embrace technology as an important tool for delivering improvement, we will all need to work at greater pace and we may need to make difficult decisions along the way.

But all of this will be for our vital, shared purpose of investing in the prevention of ill health, enhancing the quality of life of individuals and the health of our Humber and North Yorkshire population at large.

We encourage you to read on to understand what this strategy means for you…

Cllr Jonathan Owen
Vice - Chair

Sue Symington
Chair

Our **starting point**

Of the 1.7 million people who live in Humber and North Yorkshire, more than 200,000 are living in poverty, with more than 60,000 children living in low income families. More than 2400 people each year die from causes considered preventable.

The healthy life expectancy – the number of years a person can expect to live in good health – is just 53.8 years for men in Hull, compared with 67.3 years for men in North Yorkshire. Within North Yorkshire there is a gap of 9.5 years between those from the most and least deprived communities.

For women in Humber and North Yorkshire, the number of years they can expect to live in good health is slightly higher then men but is just 56.4 years in North Lincolnshire, compared with 67.9 years in East Riding of Yorkshire. Within East Riding there is a gap between the most and least deprived of 11.2 years.

The reasons behind these disparities are complex and multi-layered and are as individual as each of the 1.7 million people who live in our communities.

The ways to tackle these disparities are similarly complex and require organisations and communities to work together, to get creative and to have a really clear goal to strive for.

The purpose of this strategy is to set the ambition for our people and communities. To be clear on where we are trying to get to and what will be different if we get it right. It is not a plan or a series of actions but rather a statement of intent. It provides the framework within which strategies and plans will be developed and informs the allocation of our collective resources. The way we prioritise our time, energy and money should be formed by the ambitions in this strategy.

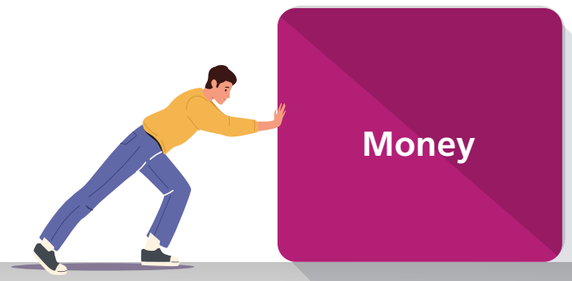
As organisations we share the responsibility for health and care services across Humber and North Yorkshire. And it is with the people of Humber and North Yorkshire that we share the responsibility for improving health. As we implement this strategy, we will continue to build partnerships with our communities to deliver their aims and aspirations for better health and improved lives.

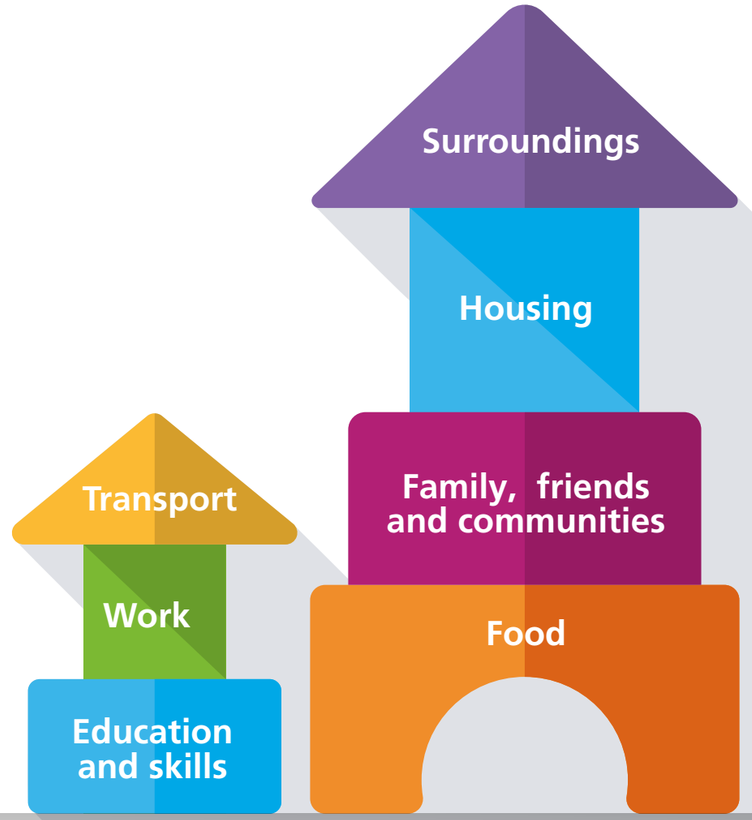
We have extensive assets at our disposal and using our collective power and influence we can use these to put in place building blocks for health; to improve the underlying circumstances that affect the lives and life chances of our people; and provide opportunities for our populations to thrive by helping to address the underlying causes of differences in health.

We each look after a small part of a wider puzzle. By working together with a clear ambition in mind, we are greater than the sum of our parts.

This strategy is not just about making health and care services more efficient or effective – though this is an important priority for our partnership and its constituent parts. Instead it takes a wider and longer view, focusing on what we can change to help people live healthier, happier lives – now and in the future.

Together we can make real change and deliver our vision for the people of Humber and North Yorkshire.





Credit: Health Foundation

Our **strategy on a page**

Our ambition is:

For everyone in our population to live longer, healthier lives **by narrowing the gap in healthy life expectancy between the highest and lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035.**

To reach that ambition our **vision** is to ensure that all our people:

Start Well

We want every child to have the best start in life and enable everyone to be safe, grow and learn.

Live Well

We want to ensure the next generation are healthier than the last and have the opportunity to thrive.

Age Well

We want to ensure people live healthy and independent lives as long as possible by understanding what matters most to them.

Die Well

We want to create an environment in which people can have positive conversations about death and dying.

Our intentions are:

To achieve our ambition and vision, our Partnership through our six Places working with their communities and partners will reimagine health, care and wellbeing services and we will…

Create conditions

Focus on creating the conditions to enable and empower our people, communities and organisations to achieve change.

Change · Empower · Enable

to

Think person

Enable our people to live healthy, independent and safe lives as long as possible by understanding what matters to them.

Secure · Independent · Choice

Think family

Support families and other support networks to enable everyone to be safe, grow and learn and ensure every child has the best start in life.

Safe · Grow · Learn

Think community

Develop an all-inclusive community approach to ensure the next generation are healthier than the last and have the opportunity to thrive.

Work · Healthy · Play

Our partnership

We are the Humber and North Yorkshire Integrated Care Partnership, part of one of 42 Integrated Care Systems (ICSs) established across England.

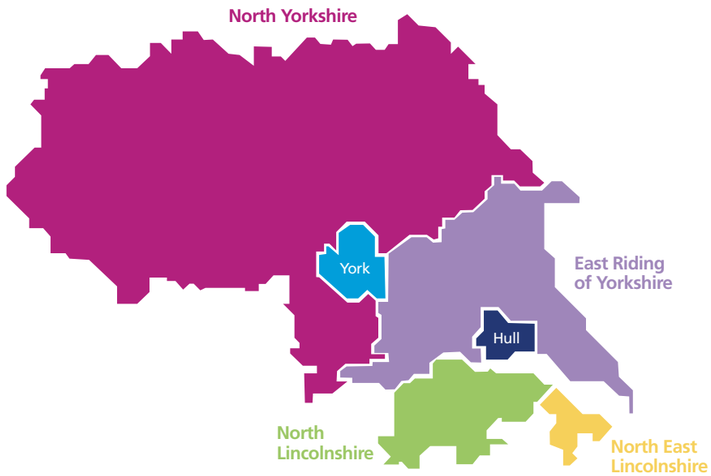
The Integrated Care Partnership (ICP) is a standalone statutory committee between Local Government and the NHS Integrated Care Board (ICB). We are responsible for developing the integrated health and care strategy to address the health, social care and public health needs of our population.

Our focus is on improving outcomes for our population, tackling health inequalities and making the connections between health and wider issues including socio-economic development, housing, employment and environment. We take a collective approach to decision-making and support mutual accountability across the Integrated Care System.

Total budget of approx. £3.5bn

1.7 million people

c.50,000 staff
across health and adult social care



42 Primary Care Networks
(181 GP Practices)

4 acute hospital trusts
(operating across 9 sites)

3 mental health trusts

4 community / not-for-profit providers

2 ambulance trusts

6 Local Authorities
(upper tier and unitary authorities)

550 care homes

180 home care companies

10 hospices

1000s of voluntary and community sector organisations

Our population in numbers

Our vision is for everyone in Humber and North Yorkshire to have equal chances to live long, happy and healthy lives.

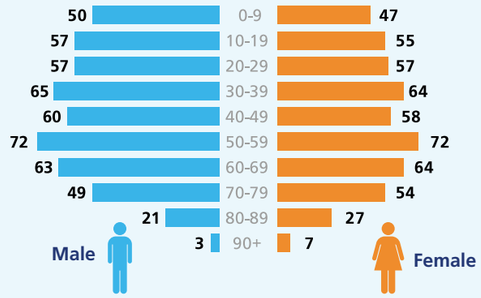
Poverty, unemployment, poor educational attainment, barriers to accessing services and other factors all contribute to the significant gap in healthy life expectancy that exists between those living in our most and least deprived communities. In short, lives are being cut short based on where people live. We must narrow this gap by improving the life chances of those facing the biggest challenges.

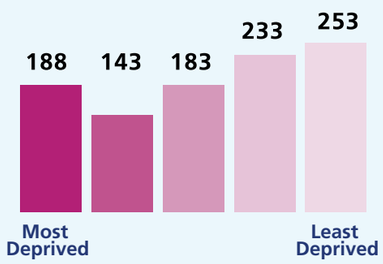
An example of how the read the numbers

If the population of Humber and North Yorkshire was just 1,000 people then 220 would be aged 65 or over. Of these, 67 would live on their own. That means that 31% of those aged 65 and over live on their own.

Demographics

Age





Ethnicity

1.1%	Asian or Asian British
0.7%	Black, African, Caribbean or Black British
0.7%	Mixed or multiple ethnic groups
2.3%	Other ethnic group
77.9%	White
17.4%	Unknown

Life Expectancy

Females 82.7 years
Males 78.4 years

Difference in life expectancy between most and least deprived areas in years:

Females 6.2 years
Males 8.9 years

Our **population in numbers**

Economic

Education

7 of 10 (72%)
'School Ready' at the End Reception

50.6
Average Attainment 8 Score

Employment

2 of 22 (7%)
16-17 year olds Not in Education, Employment or Training

13 of 615 (2%)
Adults Long Term Unemployed

Carers

158 of 835 (19%)
Adults With a Caring Responsibility

Households

16%
Of households in Fuel Poverty

1%
Of households with Children Classed as Homeless

33 of 165 (20%)
Under 16s Live in Low Income Families

Loneliness

175 of 835 (20%)
Adults who Feel Lonely Some, Often or All of the Time

67 of 220 (31%)
65+ Adults over 65 living alone

Risk Factors

Smoking

131 of 813 (16%)
Adults Currently Smoke

13%
Mothers Smoke at Time of Delivery

Alcohol

31 per 100,000
Alcohol Admissions (Under 18)

5
Alcohol Admissions (All Ages)

Obesity

5 of 20 (24%)
Children in Reception are Overweight (inc. Obese)

2 of 20 (10%)
Children in Reception are Obese

4 of 23 (19%)
Children in Year 6 are Obese

8 of 23 (33%)
Children in Year 6 are overweight (inc. Obese)

129 of 813 (16%)
Adults are Obese

Physical Activity

58 of 132 (44%)
5 - 16 Year Olds are Physically Active

517 of 802 (65%)
Adults are Physically Active

201 of 802 (20%)
Adults are Physically Inactive

Core20PLUS5

Children and Young People

7 of 187 (4%)
With Asthma (Age <18)

0 of 187 (0%)
With Diabetes (Age <18)

1 of 187 (0%)
With Epilepsy (Age <18)

1 of 9 (16%)
3 Year Olds with Visually Obvious Tooth Decay

3 of 132 (2%)
Pupils with Social, Emotional & MH Needs

Adults

13 of 813 (2%)
With Severe Mental Illness (Aged 18+)

11 of 23
With COPD Received a Flu Vaccine in Last Year (Aged 18+)

46 of 813 (6%)
With Cancer (Aged 18+)

167 of 813 (21%)
With Hyper-tension (Aged 18+)

Frailty

Housebound/Frailty

9
Housebound

21
Moderately Frail

8
Severely Frail

Our communities

Our communities are the lifeblood of our partnership

Our people are our greatest asset, but many of them live in the most deprived communities in England or face other barriers to living healthy lives.

Of our 1.7 million population 18% live in the 20% most deprived communities and within our six Places this can be significantly higher (as shown by the map). 25% of our population live in the most affluent 20%.

Much of our 4000+ miles is made up of small rural communities with concentrated urban areas of our towns and cities (Hull and York) and a coastline of 297km (185 miles).

We describe below some of the individuals and communities for whom life chances vary significantly across Humber and North Yorkshire with many disproportionately affected by ill-health and premature death.

Many of these are as a result of some underlying circumstances and building blocks such as education, skills and work not being in place.

Digital

14% of our population have unequal access to services where they are provided using digital technology (within Hull this figure is 61%).

Coast

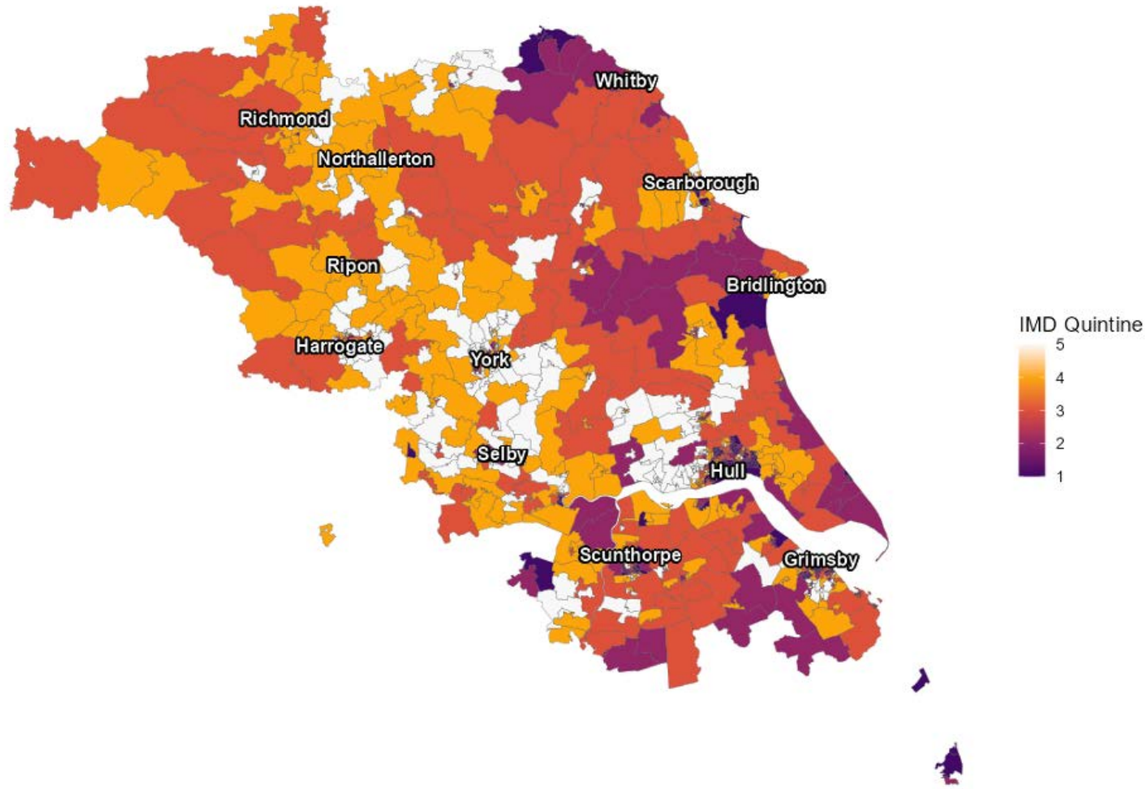
People living in our coastal communities face some of the greatest health and wellbeing challenges as well as poorer access to health care, employment, housing etc. resulting in poorer outcomes.

Justice

Our people within the justice system face poorer health outcomes and face barriers to accessing health and wellbeing services and have often experienced trauma and adversity.

Map showing most deprived areas in Humber and North Yorkshire

(only LSOAs with total population of more than 50 are shown)



Armed Forces

Armed Forces Covenants are in place in each of our Places, recognising our commitment to ensuring current and former service people have their needs met.

Homelessness

People without permanent, secure homes are at higher risk of poor health outcomes and face significant barriers to accessing care.

Ethnicity

6% of our population is from an ethnic group, however we do not know for approx. 17% their ethnicity. We do know that ethnic groups face poorer health outcomes.

Create conditions

Our Integrated Care Partnership is made up of many partners including local government, voluntary community and social enterprise organisations and the NHS. We are collectively responsible for developing and delivering this strategy to address the health, social care and public health needs of our population.

We will focus on creating the conditions to enable and empower our people, communities and organisations to achieve change

In focusing on creating the conditions for change we will make it easier for our people, communities and organisations to come up with the solutions they think will work best in improving their lives and those of their neighbours and communities.

We will work together - with communities and individuals in our Places and across Humber and North Yorkshire – so that their voice is heard in an inclusive and co-ordinated way, and we will use what they tell us to inform how we re-think and integrate health, care and wellbeing services.

We will work with local business, the academic world, the voluntary sector and local and national organisations to encourage the development and implementation of innovative evidence based solutions that support delivery of our ambition and vision.

As the organisations that are one of, if not the biggest employers, in each of our six Places, we are committed to positively contributing to making a difference for local people by:

- Seeking to enable local economic growth by buying local and supporting the creation of a strong infrastructure that attracts and builds businesses in our area
- Creating greater access to work by growing the workforce of the future and providing opportunities for people to develop their skills and giving our people a purpose
- Reducing our environmental impact and making our contribution to the Net Zero Climate targets.

We will develop an approach that enables us to target and use our resources (money, people, technology and buildings) where they are needed, to address issues and challenges that are impacting on the lives of our communities earlier.

Think person

We will focus on enabling our people to live healthy, independent and safe lives as long as possible by understanding what matters to them

By focussing on the person we will listen and pay attention to what they tell us matters most to them which will enable us to remove barriers, and give them greater control over their own lives.

We will maximise the potential for a person to live a longer healthier life by addressing the root causes of health harming behaviour, and making training, education and information available to all; having the **right conversation at the right time;** and enabling people to make **informed choices.** As 1 in 8 people over the age of 18 smoke in Humber and North Yorkshire, tobacco is our most significant challenge to people living healthier and longer lives, this will be an area of focus.

We will ensure that people will be able to access an integrated offer throughout their lives that best meets their needs and circumstances

We will aim for early identification of risk factors and long-term conditions and act early to prevent or delay onset or progression of different health conditions. We will also focus on key areas that contribute most to the years of life lost or lived in ill health, such as cardiovascular disease and cancer.

Through understanding the needs and wants of a person, we will build **proactive, integrated and personalised plans**, that support them to have and maintain greater independence and autonomy over their own lives. Focusing on those with the greatest need first. We will also continue to work together to improve access to health and care services by **reducing the barriers** experienced by people when needing multiple services with the aspiration for this to be seamless for a person.

Whilst the focus is on a person living their healthiest life for as long as possible, we recognise there is a need for people to have positive conversation when they are healthy about death and dying. We will do this by **creating an environment** in which people of all ages feel comfortable talking about death and dying, and developing plans that will help them to have greater control and be provided with the co-ordinated, compassionate care when they need it during a significant change in their life. This will include ensuring there is support to those nearest to them, with their grief and loss.

Think family

We will focus on supporting families to enable everyone to be safe, grow and learn and ensure every child has the best start in life

Families are those people who are closest to an individual, they can include relatives, friends or those who provide a temporary but important relationship or network to support a person. By focusing on supporting families we want to create a safe and nurturing environment that raise aspirations, builds resilience and enables every child to grow, learn and thrive.

We will work together with our partners to ensure everyone but particularly our most vulnerable people are kept safe, with a specific focus on our children and young people and those children in care / care leavers.

We recognise the importance of clear and early health messages to allow individuals to understand and prepare to become a family and we will provide practical and appropriate support for those considering becoming parents and families to ensure the best start in life for the child.

Through supporting the development of a child and by building closer working relationship between health and education, we will focus on key milestones of development in child's life, ensuring they are ready for school, have an ambition to learn and are prepared for employment.

Mental health and wellbeing will be a thread through all that we do, as we aim to reduce the difference in healthy life expectancy between those with mental health and learning disabilities and those without with a specific focus on improving access to children and adolescent mental health support.

We will ensure that support is put in place for carers who can often over look their own needs, and in many cases can be young people who experience multiple issues not just health, if not supported well.

We are committed to mitigating the effects of poverty and the cost-of-living crisis for families in Humber and North Yorkshire by undertaking actions that will have a positive impact on the quality of life, prevention of ill health and timely access to health and care services.

Think community

We will focus on an all-inclusive community approach to ensure the next generation are healthier than the last and have the opportunity to thrive

Our communities are as unique and as individual as the people that live in them. We want to harness this strength to help inform the way we plan, design and implement health and care services for people living across Humber and North Yorkshire. We will focus on all our communities, however we will place specific emphasis on working with those with the greatest need, such as our coastal and rural communities.

We will create opportunities that give people p**urpose in all stages of their life** through access to good quality play and work (including volunteering) providing the chance to reduce social isolation and support people to thrive.

Proactive prevention will be at the heart of everything we do. We will connect our communities to the resources that are available to them in their neighbourhood or Place, to enable them to reduce their reliance on professional help and prevent ill-health through services that provide them with opportunities to keep their mind, body and spirit healthy. We will look to actively engage and increase the involvement of children and young people in communities and community activities.

We value and recognise the diversity of our communities and we are focused on making all groups feel included and valued within their communities to improve their health and wellbeing and ensure it is not negatively effected.

We will continue to grow the role of the voluntary and community sector which will see greater involvement of the nearly 14,000 organisations across Humber and North Yorkshire in supporting improving health and wellbeing outcomes for our communities and our people.

How we will know we have **succeeded**

Start Well

We want every child to have the best start in life and enable everyone to be safe, grow and learn.

"It is easy for me to get the support I need for my child."

"I am safe. My family has what they need to look after me."

"I can tell a grown-up if I am feeling sad or worried."

"My mental health matters and I can get help when I'm struggling."

"There are exciting career opportunities for me."

Live Well

We want to ensure the next generation are healthier than the last and have the opportunity to thrive.

"I find ways to stay active and keep healthy that work for me."

"I have meaningful employment, despite the barriers I face."

"I get the care I need and don't get passed back and forth or get forgotten on a waiting list."

"I am on top of my condition and I know what to do if I need help."

"I quit smoking and I feel great."

Age Well

We want to ensure people live healthy and independent lives as long as possible by understanding what matters most to them.

"I am as active as I can be. I enjoy having fun with my friends."

"I can get advice and support for my health at home or nearby."

"When things start to go wrong with my body, I have the care I need to keep living a good life."

"I only go to hospital if it's absolutely necessary."

Die Well

We want to create an environment in which people can have positive conversations about death and dying.

"I feel able to talk about what kind of death I would like before I get sick."

"We are able to talk confidently with patients about their end of life wishes."

"My wishes are known and respected."

"Me and my family can choose how best to say goodbye."

Start Well

“I haven’t been tempted to start smoking or binge-drinking again. I’m just focussing on mine and my baby’s health.”

Kelly, 23, is a first-time mum who lives in a rural area away from friends and family. She smoked since being a teenager and sometimes binge-drank.

“I really wanted to stop smoking and drinking when I found out I was pregnant, but it was difficult to break the habit. I worried about how having a baby was going to affect my mental health and life. I didn’t know anything about being a mum.

I searched on the internet for pregnancy information and went on the Local Maternity and Neonatal System website which was great for finding out what to do when, like referring myself to the midwives.

At my first midwife appointment I told her about my smoking, and she got me set up straight away with nicotine replacement therapy and a referral to the local stop smoking service. She talked to me about drinking and helped me get an app on my phone to start thinking more positively about being pregnant and becoming a mum. She was lovely and reassuring.

I do everything through my phone so found it brilliant that there were so many digital options for me to use. I messaged the Ask a Midwife Facebook page a couple of times when I had questions and registered on BadgerNet so had reminders on my phone for my scans and appointments. I’d have probably missed them if I had to keep checking my hand-held notes!

Because I got such good support through my pregnancy, I got a good start with my baby and my mental health was fine – which was a huge relief. My midwife supported me to breastfeed, which I didn’t plan to do, but it meant I saved loads of money in those early months and felt really bonded with my baby. I felt confident enough to go to baby groups and regularly go to our local family hub. I feel like I have a network where I live now.

I haven’t been tempted to start smoking or binge-drinking again either; I’m just focussing on mine and my baby’s health.”

Live Well

David, 34, lives in a flat near the coast. He struggles to read or write and is unemployed, during the COVID-19 pandemic he became increasingly isolated and as a result found his mental and physical health suffered.

"I was working before the pandemic, but it was a zero hours contract. It's hard to find a job when you struggle with reading and writing and a lot of the places I would've applied to didn't need anyone after we came out of the lockdowns."

When things went back to normal I wanted to get out more, but I didn't have much money so it was just easier to stay in. I started feeling down and lonely and was putting on a lot of weight. My flat was a mess and I couldn't get out of bed in the morning. I just wasn't motivated to do anything.

I ended up making an appointment with my GP Practice and saw the Social Prescriber. I'd never heard of a Social Prescriber but he was a normal bloke like me so I felt like I could be honest with him about how I was feeling and how bad it had got. He helped me find a free exercise and social group that I could get to easily on the bus. I was nervous going at first but recognised a couple of people from the flats when I got there which made it easier.

I'm losing the weight and really enjoying the different exercises. We've been doing things I never thought I'd do like bowls and even croquet in the park. It's a good laugh and gets me out every week.

The group leader helped me and a couple of the other blokes get on an adult learning course to help with our reading and writing. We're all trying to get back into work and meet up to go for a kickabout down the park a couple of times a week.

I didn't want to admit how bad things were but I'm glad I took that first step to talk to someone. I feel so much better about myself and my future now."

"I didn't want to admit how bad things were but I'm glad I took that first step to talk to someone. I feel so much better about myself and my future now."

Age Well

Safiya, 66, is a widow who lives close to her grown up daughter in an urban area. She is retired and has restricted mobility due to a physical disability, high blood pressure and type 2 diabetes.

"I didn't take my diabetes or high blood pressure seriously when I first got diagnosed and I sometimes struggle to control it. I've ended up in hospital a couple of times and regularly need to see my doctor. I take a lot of different tablets every day, some from my doctor and some that the hospital prescribed. I don't really know what they're for."

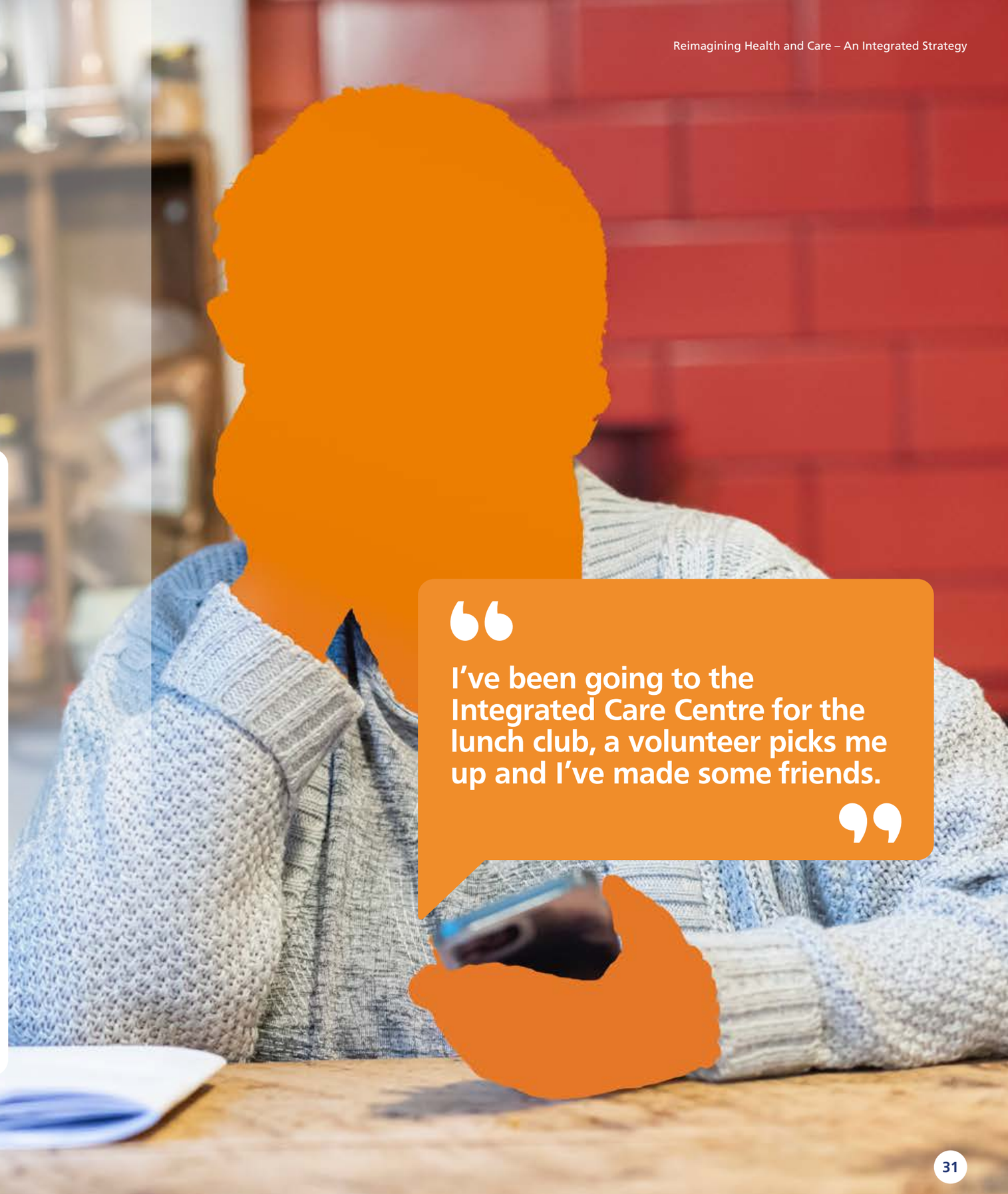
I'm proud to have always worked and only retired when my disability got bad. My daughter and granddaughters visit a couple of times a week and we go on days out together. It can be lonely being a widow but I'm near family so that is reassuring if I get ill.

I don't smoke or drink – I couldn't afford to! I can barely put my heating on in winter never mind splurge on things I don't need. My daughter pays for me to have the internet and gave me an old iPad which has been a lifeline.

I've recently had an appointment at the Integrated Care Centre where they looked at my medicines all together, and all my ailments and disability as one. I felt really respected and not like a burden at all. I'd been worried I wasn't taking my medicines right or they might've been interfering with each other – now I've got the reassurance that everything is working together.

I've been going to the Integrated Care Centre for the lunch club, a volunteer picks me up and I've made some friends. The volunteer has even helped me find some good websites on my iPad to apply for heating help in winter and care for my diabetes, I know the information on them is reliable."

Even though I still struggle I'm glad I'm still independent. I'm managing my conditions much better and haven't needed a doctor's appointment or to go to hospital in a while now which I'm pleased about."



> **"I've been going to the Integrated Care Centre for the lunch club, a volunteer picks me up and I've made some friends."**

Die Well

Ken, 78, lives with his wife in a village. He has terminal prostate cancer and wishes to die at home with his family by his side.

"It's just been me and the wife at home for years now, but the kids still visit all the time. They've got their own families but we're very close knit. I know my cancer diagnosis has hit them hard.

I wish I had thought more about what I would want at the end of my life before I had to face the reality of it. There's a lot of paperwork to do when you're dying! I'm glad I've had the support of my palliative care nurse through it all. I didn't envisage spending my last months 'getting affairs in order'. Some of the paperwork has been quite sobering but I understand it's a necessary task.

I want to die at home, which my wife supports. I hadn't thought about the impact this would have on her and she didn't like to say. Luckily my nurse recognised it would be hard and has arranged for us to have some external carers as things progress.

My wife has been my rock. She's got the support of the palliative care team as well who have offered her counselling and they've found a friendly coffee group who meet at our local hospice. She hasn't gone yet but says she will in her own time.

We've had the same few professionals involved from the start. It's been good to not have to relay everything every time we've had a nurse or doctor come to the house or get involved in my care.

I'm trying not to waste time worrying about dying. I've made a bucket list so I can make sure my family have some happy memories before I go. I'm in good spirits but know my family are struggling.

We're working together with the district nurse, my doctor and palliative care team to make sure everyone is supported in a way that suits them. When the time comes that I can't look after my family anymore, I know there is bereavement support available to make sure they're doing okay."

My wife has been my rock. She's got the support of the palliative care team as well who have offered her counselling and they've found a friendly coffee group who meet at our local hospice.

What happens **next?**

Whilst the purpose of this strategy is to set the ambition and vision for our people and communities with some description of our intentions of how we will achieve this, it is only the framework from which other specific strategies and plans will be developed and the allocation of our collective resources will be informed.

In addition, we also want to understand the difference that is being made and whether we need to adjust our ambition, vision and intentions by keeping the strategy as a living and breathing document.

Turning strategy into action

The way we prioritise our time, energy and resources will be informed by the ambitions in this strategy and actions will be developed through:

- **Place** engaging with their communities, neighbourhoods and partners building with communities to develop integrated delivery plans – aligned also with local health and wellbeing strategies.
- **Integrated Care Board** engaging with partners to develop a 5 year Joint Forward Plan which will use the strategy as a framework and an annual operational delivery plan.
- **Other Strategies, Plans and Programmes** e.g. People Strategy, Digital Strategy, Children and Young People Alliance.

Strategies, plans and further information about our programmes are available on our website **www.humberandnorthyorkshireicb.nhs.net**

To evidence we are making a difference we will:

- Develop a population health outcome framework to provide the assurance and evidence that we are making the difference we intended.
- Ensure we have continued engagement with our communities and receive their feedback on the delivery, working closely with Healthwatch.
- Share case studies of our promising practice to promote learning and enable others to adopt and implement new ways of working.

Summary

This strategy has been developed by working with, and building up from, each of our six Places in Humber and North Yorkshire.

During the development of the strategy, each of our six Places has been engaging with their communities and partners to describe their initial intent of how they will deliver the ambition and vision set out in the strategy. Each Place has developed its own plans and these are all available on: **humberandnorthyorkshire.icb.nhs.uk**

The engagement exercises have used a broad range of methodologies and have largely focussed on service areas and service specific commissioning projects. The findings from these exercises have been aligned to the following areas:

- All services
- Start Well
- Live Well
- Age Well
- Die Well

The findings from this initial work to support the strategy is summarised on the following pages but as patient and public involvement is a dynamic process that continually gathers intelligence, our most up to date information can be found on our website **humberandnorthyorkshire.icb.nhs.uk**

Summary of our **Patient and Public Involvement and Intelligence**

These are the key themes that emerged from our engagement activities.

All Services – Making Lives Better

Involving people

- More co-production and working together with health professionals to develop personalised care plans.
- Being listened to and involved in decisions about my care (or the person I care for) is important.
- People need easy access to accurate information and support in order for them: to engage in lifestyle change, access treatment early (prevention, screening and early diagnosis) effectively manage their condition.
- Better advocacy and support for people going through the continuing healthcare assessment
- Listening to patient feedback on an ongoing basis and using this to improve services provided in the future.

Choice and control

- Person-centred care in end-of-life services really matters – thinking of the patient and their family and providing care around the needs of the patient.
- Being able to choose who visits postnatal wards is improving peoples' experiences of care.
- Where people have long-term conditions, understanding their condition and being confident enough to manage it improves their overall health and wellbeing.
- Being able to self-refer into services without having to go through a GP has been identified as a positive change to current services (e.g. to see a physiotherapist for muscle problems, or go directly to talking therapies for depression and other mental health problems).
- Including families and carers in a person's treatment, offering extended visiting times to give people more opportunities to choose who supports them, is important.

Caring and compassionate staff

- Having a person-centred approach to care, where staff separate the person from the illness, supports recovery.
- The diversification of roles within GP surgeries, is having a positive impact according to local people.
- Feeling listened to and cared for by non-judgemental, professional staff at all levels.

Community and family support

- Support from voluntary and community sector organisations and/or projects in the local area is important.
- Involving families and carers and considering their needs as well as the needs of those they care for is important.
- Social prescribing has been highlighted as having a positive impact on peoples' health and wellbeing and is connecting them to their communities and the many activities they can get involved in to improve their health and wellbeing.
- The introduction of alternatives to A&E for those in mental health crisis across the region is enabling people to access support from the right people, at the right time, and in a more appropriate environment.
- Peer support was identified as important by many people we engaged with. Meeting people in similar situations and learning from one another has a positive impact.

Responsive and accessible services

- Care closer to home. Availability of specialist support so that people can recover at home rather than in a hospital bed.
- Easy access to services, by using online (preferred by about half of people) i.e. being able to access services online at a time and place that suits the individual, and single point of access
- Extended opening hours and reduced waiting times
- Fast referral for life changing diagnosis/ treatment.
- The importance of the physical environment where care is provided being appropriate and pleasant has an impact on peoples' experience of the services they access.

In addition to the general insights already outlined, the following elements are specific to the key areas of Start Well, Live Well, Age Well, Die Well.

Start Well

- Children and young people want:
- Positive experiences, positive relationships with family and friends.
- To feel cared for and safe
- Mainly associate living well with healthy eating and exercise.
- Biggest concern is transition between schools.
- Prefer a variety of ways of accessing services that improve convenience and anonymity.
- Experience issues with dual diagnosis of SEND and Mental Health, one can preclude the other.

Age Well

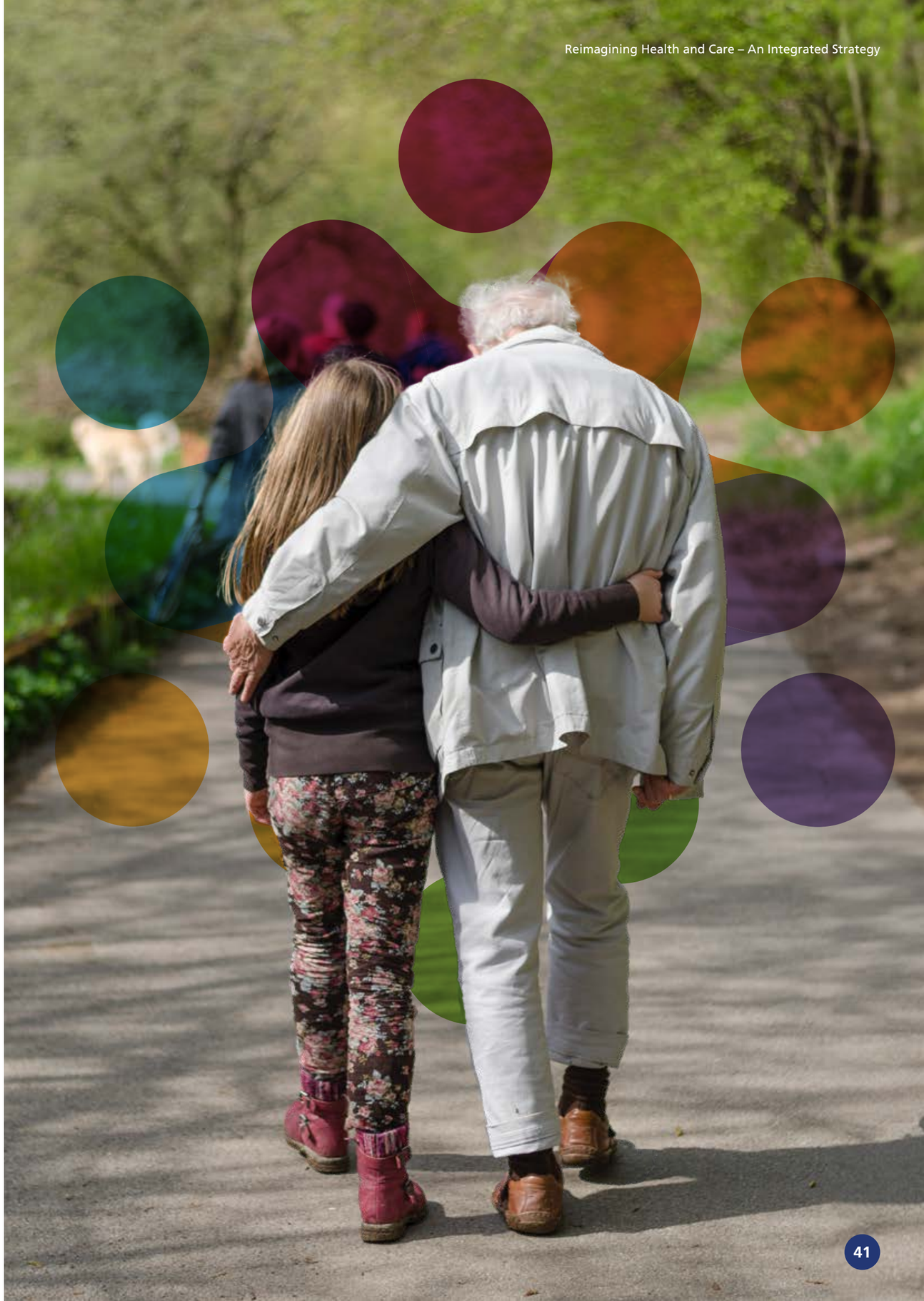
- Information leaflets could be provided to patients about how to effectively manage their condition.
- A range of condition-specific support groups were also highlighted in our engagement as having a positive impact on peoples' lives and helping to support them to manage their condition and live fulfilling lives (e.g. Macmillan, MS Society, Alzheimer's Society).
- Care home liaison teams are having a positive impact by helping people to stay in their own home and avoid going into hospital.

Live Well

- People need easy access to accurate information and support in order for them to engage in lifestyle change. They would like more information about how to lead a healthy lifestyle.
- Increase information about prevention, screening and early signs and symptoms so that people can access treatment early.
- Social prescribing has been highlighted as having a positive impact on peoples' health and wellbeing and is connecting them to their communities and the many activities they can get involved in to improve their health and wellbeing.
- The introduction of alternatives to A&E for those in mental health crisis across the region is enabling people to access support from the right people, at the right time, and in a more appropriate environment.
- Peer support was identified as important by many people we engaged with. Meeting people in similar situations and learning from one another has a positive impact.

Die Well

- Person-centred care in end-of-life services really matters – thinking of the patient and their family and providing care around the needs of the patient.
- Support carers in all aspects of their life, not just health.
- Carer-friendly education and employment is vital. Access higher-level training about the conditions of those they are caring for so they can support them more effectively. Resilience training for carers to help them to cope with difficult situations.



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