Humber and North Yorkshire
Health and Care Partnership

Report to:	North Yorkshire Health and Wellbeing Board
Date of Meeting:	17 March 2023
Subject:	**Humber and North Yorkshire Integrated Health and Care Strategy**
Sponsor:	Sue Symington, Chair of Humber and North Yorkshire Integrated Care Partnership Cllr. Jonathan Owen, Vice Chair of Humber and North Yorkshire Integrated Care Partnership Wendy Balmain, Place Director, North Yorkshire Amanda Bloor, Deputy Chief Executive and Chief Operating Officer
Author:	Karina Ellis, Executive Director of Corporate Affairs, NHS Humber and North Yorkshire Integrated Care Board

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

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

SUMMARY OF REPORT:

In accordance with the requirements of the Health and Care Act 2022, the Integrated Care Partnership for Humber and North Yorkshire have been undertaking a process to develop an Integrated Health and Care Strategy that cover the area.

This paper sets out the approach taken to develop the strategy which has been informed by the legislative requirements, statutory guidance, policy and a broad range of engagement and discussions with Place at the heart.

A copy of the final draft of the Integrated Health and Care Strategy is attached as appendix A to this report.

RECOMMENDATIONS:

The Members of the Health and Wellbeing Board are asked to:

- Note the update in the paper
- Consider and approve the final draft content of the Humber and North Yorkshire Integrated Health and Care Strategy (appendix A)
- Note the next steps.

Integrated Health and Care Strategy

Introduction and Context

The Humber and North Yorkshire Health and Care Partnership (formally Humber, Coast and Vale) was established in 2016 as a collaboration of 28 organisations from the NHS, local councils, other health, and care providers including the voluntary and community sector. The Partnership covers a geographical area of more than 1,500 square miles and serves a population of 1.7 million people, all with different health and care needs. It includes the cities of Hull and York and the large rural areas across East Yorkshire, North Yorkshire, and Northern Lincolnshire.

The Health and Care Act 2022 that received Royal Assent on 28 April 2022 put Integrated Care Systems (ICSs) on a statutory footing, empowering partners to work closer together to better join up health and care services, improve population health, reduce health inequalities, enhance productivity, and value for money, and help support broader social and economic development. The Humber and North Yorkshire Health and Care Partnership is one of 42 ICSs which cover England.

The Health and Care Act sets out the four core elements of an ICS these are Place, Provider/Sector Collaboratives, Integrated Care Board (ICB) and an Integrated Care Partnership (ICP).

The ICP is a separate statutory committee, which brings together local authorities and the NHS Integrated Care Board as partners to focus more widely on health, public health, and social care. The development of the Humber and North Yorkshire ICP over the spring and summer of 2022 with membership being built from Place and with Place leaders at the very heart. The Humber and North Yorkshire ICP met for the first time in September 2022.

One of the key responsibilities of the ICP is to co-produce with partners an Integrated Health and Care Strategy for Humber and North Yorkshire and guidance was published by Department of Health and Social Care on 29 July 2022 and is available online here: Guidance on the preparation of integrated care strategies - GOV.UK (www.gov.uk)..

The expectation was that Integrated Health and Care Strategies must be built bottom-up from local assessments of needs and assets identified at place level, developed for the whole population using best available evidence and data, covering health and care and addressing the wider determinants of health and wellbeing. The strategy should set out how the assessed needs of the population can be met by upper tier Local Authorities, the ICB and partners and over what timescale. The expectation was that the strategy would be produced by December 2022.

The Health and Care Act 2022, also places a duty on the NHS Integrated Care Board to have regard to Integrated Health and Care Strategy, the Joint Strategic Needs Assessments (JSNAs), and Joint Local Health and Wellbeing Strategies when exercising its functions and developing its Joint Forward Plan and Operational Plans with NHS Trusts and Foundation Trusts.

Process architecture for developing our strategy

Recognising the requirement for a strategy to be developed, early in 2022 and to support the ICP whilst it was developing a strategy design group was established in early 2022 to provide a core function of designing, co-ordinating, developing and overseeing the development of the strategy based on an inclusive approach.

The strategy design group included broad representation from Local Authorities, ICB and Place. It played a key role in analysing data and intelligence and providing the information through which to make sense of where we are and where we want to be.

A number of principles were agreed by the strategy design group which underpinned its development. These were, that the strategy would:

- Be a living and breathing dynamic approach
- Be co-produced and created with the system and its partners, including closely with local government and based on lived experience of our citizens/communities
- Add value and not replicate what is happening in Place
- Enable other emerging strategies to sense check against a set of ambitions and ensure there is a golden thread
- Make use of technology to support the continuing development and engagement so that progress can be seen, feedback given as emerging themes to develop.

The development process has been population health data and intelligence driven, supported by strong clinical and care professional leadership. The work has been a collective responsibility to ensure that the strategy is co-owned, connected to real work and is delivered by a living system which is empowered to act.

There have been and continues to be the opportunity for all members of the wider system to be involved through a networked approach to engagement and open and transparent opportunities to be part of the dialogue. It will be important to continue to provide the opportunity for effective challenge and enable diversity of thought and for the ICP to be prepared to listen to suggested change and keep open minds to evolving the strategy even after approval.

In tandem with this, engagement has taken place with a variety of stakeholders and a number of open sessions have been held. A desktop review of data, evidence and existing policies and strategies and engagement with our communities has also been undertaken. The reviews have considered existing strategies and plans both within the architecture of our system, but also from across our wider system and areas of work through which we come together in partnership.

In addition, the ICP Committee heard the immediate feedback at their meeting on the 26 October 2022 from the workshop that had taken place on the same day, which had focussed on the vision of ‘start well, live well, age well and die well’ and the following questions:

- Where are we now?
- Where do we want to get to?
- How will we get there?
- How will we know when we have got there?

There have been numerous engagement sessions with Place to develop their Place strategic intent.

Where are we now

The information we have gathered from the engagement and document reviews has now been taken to support the development of a strategy document. As previously mentioned, we have set the aim to develop a living and breathing strategy, not a weighty tome document to sit on a shelf. Therefore, the document has been prepared with the view of establishing a strategic intent that is clear and creates the framework for the plans at Place.

As mentioned earlier the requirement of the strategy is that it is developed based on the needs of our population and to do this, we have taken the approach of 'if Humber and North Yorkshire was a community of 1,000 people' what would it look like in terms of it demographics, people's economic, health and wellbeing circumstances. We have also recognised that our communities are also as unique as the people that live in them and provide us with some of our greatest assets whilst acknowledging that they also have very different experiences in their lives.

The ambition set out in the strategy builds on the one we have held for many years as a Partnership which is **for everyone in our population to live longer, healthier lives.** However, we have made it more specific with the addition of 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 this ambition our vision is through a life course approach to ensure that all our people **start well, live well, age well and die well**. And to deliver on both the ambition and vision our intention is to

- **create the conditions** for change, making it easier for our people, communities and organisations to come up with the solutions they think will work best in improving the lives of our people, their neighbours and communities
- **think person** by listening and paying 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.
- **think family** not in the traditional sense but by considering the different way people consider a family, the people who are closest to them, who 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 for all but particularly enable every child to grow, learn and thrive.
- **think community** by recognising the assets in our communities, harnessing the strength and uniqueness, we will 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

The strategy is for everyone to understand our ambition, vision and intentions. To enable us to make this meaningful to a key audience of the strategy our people and communities we have used 'I' and 'we' statements that will resonate with them and have come from different engagement across our system. We will use this as a mechanism for helping to support the evaluation of the progress we are making.

Appendix A to this paper includes a copy of the final draft of the strategy content which the ICP Committee considered and approved on the 14th December 2022.

Next Steps

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.

The most important part of any strategy is turning it into action and we have identified a number of next steps and these are as follows:

- The final content version of the strategy is shared with each Health and Wellbeing Board as the statutory committee for Local Government and the Integrated Care Board for the NHS for approval.
- The strategy is used to prioritise our time, energy and resources 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. An initial plan on a page for each of our six Places is set out in the appendices and these will be developed further during the early part of 2023.
    - Providing the guiding framework for the development of other specific strategies and plans such as the 5-year Joint Forward Plan that the ICB with Providers is required to produce.

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.

- A task and finish group has been established to develop the population health outcome framework to provide the assurance and evidence that we are making the difference we intended
- Continued engagement particularly with our communities as we develop and implement the actions to deliver the strategy – Healthwatch have kindly offered to support this as well as development of communication messages.

Finally, the Communications Plan will be finalised and implemented. This includes for example:

- the production of a professionally designed document,
- the development of an online space which will create the platform to ensure we have a living and breathing strategy, will connect with other strategies, and be a space where we share promising practice

- production of case studies that demonstrate how the ambition, vision and intentions are being delivered in practice with a focus on outcomes and sharing learning.
- A full launch of the strategy will take place over the spring of 2023.

Recommendation

The Members of the Health and Wellbeing Board are asked to:

- Note the update in the paper
- Consider and approve the final draft content of the Humber and North Yorkshire Integrated Health and Care Strategy (appendix A)
- Note the next steps.

Humber and North Yorkshire
Health and Care Partnership

Reimagining Health and Care – An Integrated Strategy

Final Draft

Humber and North Yorkshire
Health and Care Partnership

Contents

Introduction from the Chair and Vice Chair

Humber and North Yorkshire Health and Care Partnership

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….

Sue Symington
Chair

Cllr Jonathan Owen
Vice-Chair

Our **starting point**

Humber and North Yorkshire Health and Care Partnership

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.

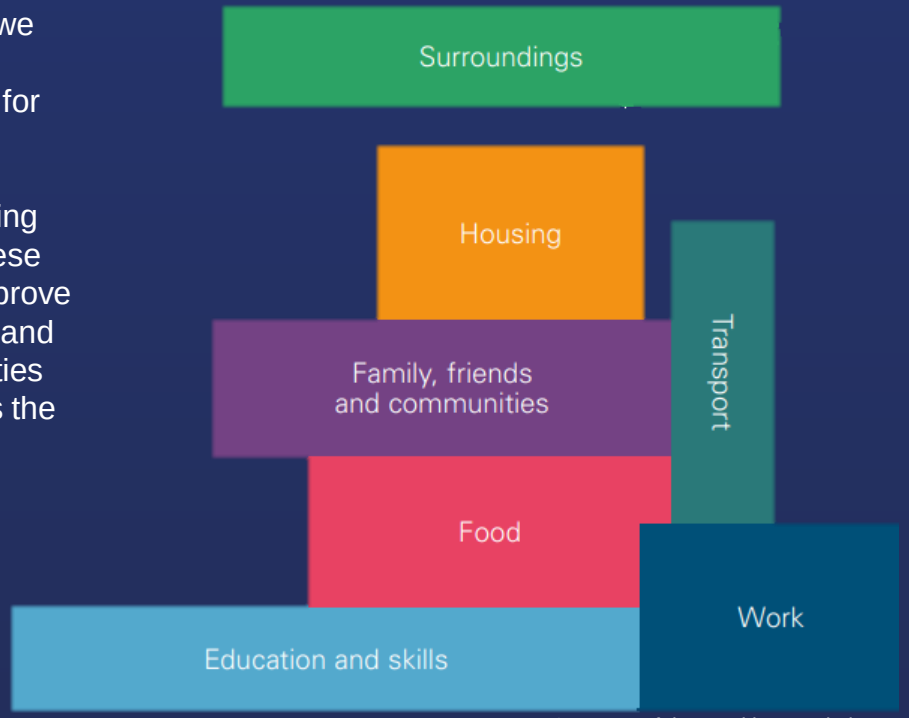
As organisations we share the responsibility for health and care services across the Humber and North Yorkshire. And it is with the people of Humber and North Yorkshire that we share the responsibility for improving health. As we implement this strategy, we will continue to build partnerships with our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



Courtesy of the Health Foundation

Our **strategy** on a page

Our **ambition** is:

Humber and North Yorkshire Health and Care Partnership

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.

To deliver the ambition and vision, our **intentions** are to:

Create conditions

to

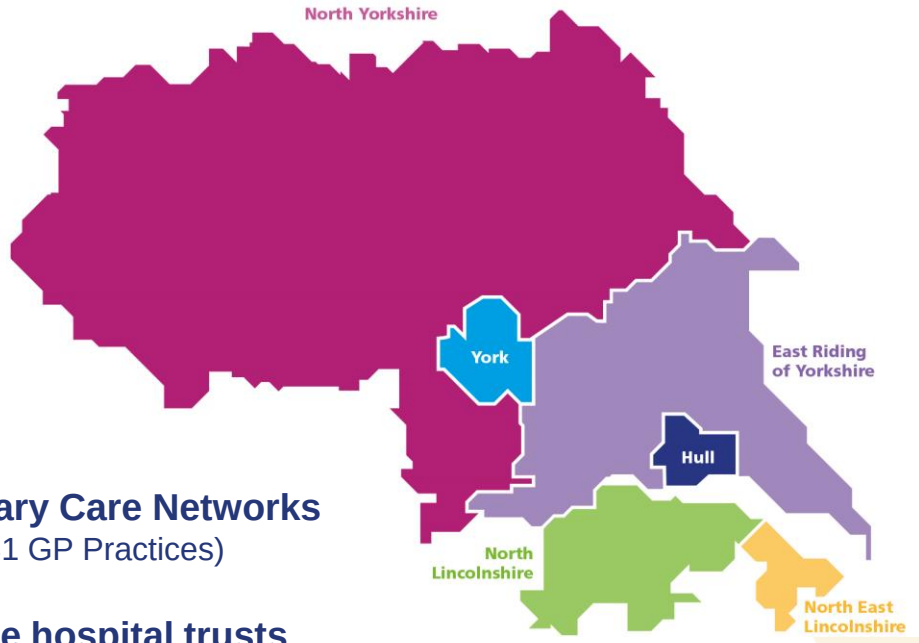
- **Think person**
- **Think family**
- **Think community**

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.



Humber and North Yorkshire Health and Care Partnership

1.7 million people

6 Local Authorities
(upper tier and unitary authorities)

42 Primary Care Networks
(181 GP Practices)

550 care homes

4 acute hospital trusts
(operating across 9 sites)

180 home care companies

3 mental health trusts

10 hospices

4 community / not for profit providers

1000s of voluntary and community sector organisations

2 ambulance trusts

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

Total budget of approx. £3.5bn

City of York Council

North Lincolnshire Council

North East Lincolnshire Council www.nelincs.gov.uk

healthwatch

North Yorkshire County Council

East Riding of Yorkshire Council

Hull City Council

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Our **population in numbers**

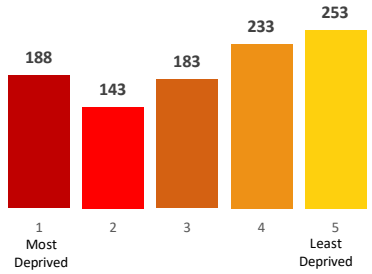
If Humber and North Yorkshire was a Community of 1000 people…….

How to read

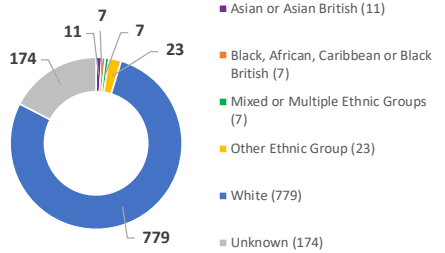
If the population of Humber & North Yorkshire was just 1,000 people then 220 would be aged 65 or over. Of these, 67 would live on their own. That means that 31% of those aged 65 and over live on their own.

Demographics

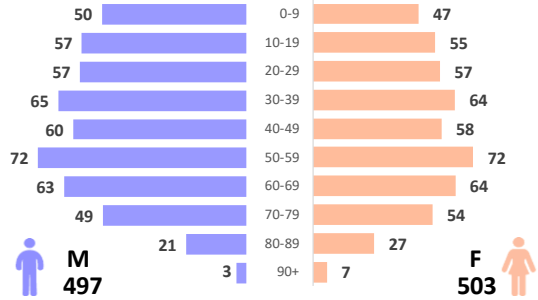
Deprivation



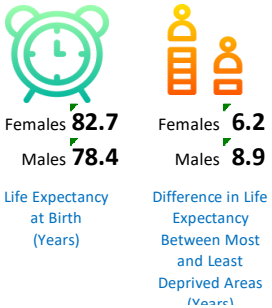
Ethnicity



Population



Life Expectancy



Economic

Education

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

50.6 Average Attainment 8 Score

Employment

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

13 of 615 (2%) Adults Long Term Unemployed

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

Carers

158 of 835 (19%) Adults With a Caring Responsibil-ity

Loneliness

175 of 835 (21%) Adults who Feel Lonely Some, Often Or All Of The time

67 of 220 (31%) Aged 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

8 of 23 (33%) Children in Year 6 Are Overweight (inc. Obese)

4 of 23 (19%) Children in Year 6 Are 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 (25%) 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 (50%) With COPD Received a Flu Vacc 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 House-bound

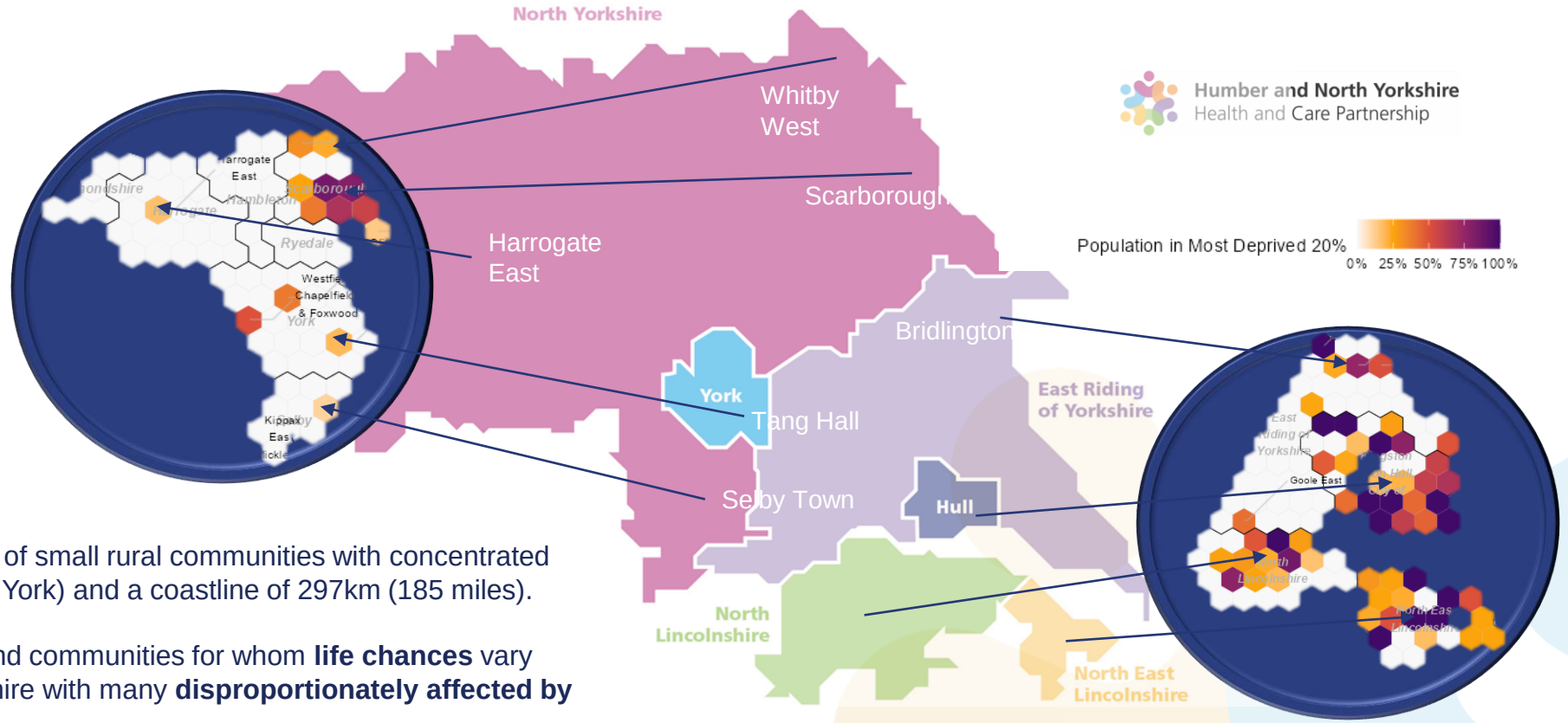
21 Moderately Frail

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 maps). 25% of our population live in the most affluent 20%.



Much of our 1.08 million hectares 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**.

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.

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 that ethnic groups face poorer health outcomes.

Our **intentions**

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 focus on…

Humber and North Yorkshire Health and Care Partnership

Create conditions

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

Change

Enable

Empower

to

Think person

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

Secure

Independent

Choice

Think family

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

Safe

Grow

Learn

Think community

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

Work

Healthy

Play

Create conditions

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

Empower

Change

Enable

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 – 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.

We have conversations with people to discover what they want from life and provide the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments.

We work in partnership with others to make our local area welcoming, supportive and inclusive for everyone.

We see people as individuals with unique strengths, abilities, aspirations and requirements and value people's unique backgrounds and cultures.

We work with people as equal partners and combine our respective knowledge and experience to support joint decision-making

We work in partnership with others to create opportunities for people to work both paid and voluntary and to learn

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

Indepen dent

Secure

Choice

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 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

Grow

Safe

Learn

Family 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 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.

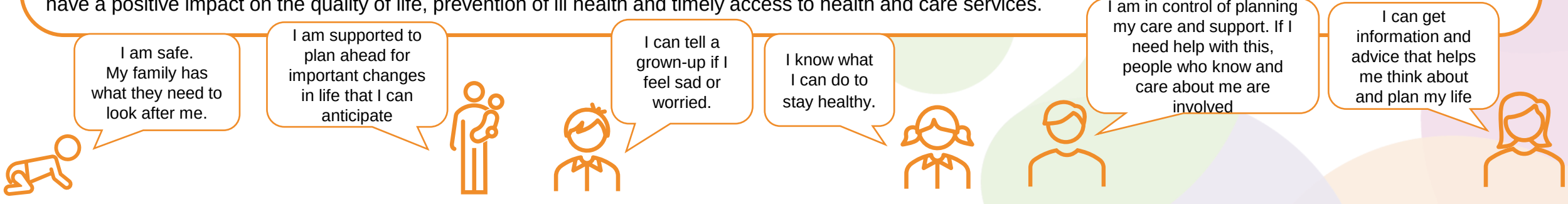
We recognise the importance of **clear and early health messages** to allow individuals to understand and prepare to become a family and we will provide practical and appropriate support for those considering becoming parents and families to ensure the best start in life for the child.

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

Healthy

Play

Work

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 **purpose 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 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.

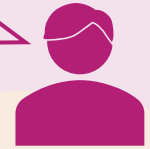
We will continue to grow the role of the **voluntary and community sector** which will see greater involvement of the nearly 14,000 organisations across Humber and North Yorkshire in supporting improving health and wellbeing outcomes for our communities and our people.

We keep up to date with local activities, events, groups and learning opportunities and share this knowledge so that people have the chance to be part of the local community.

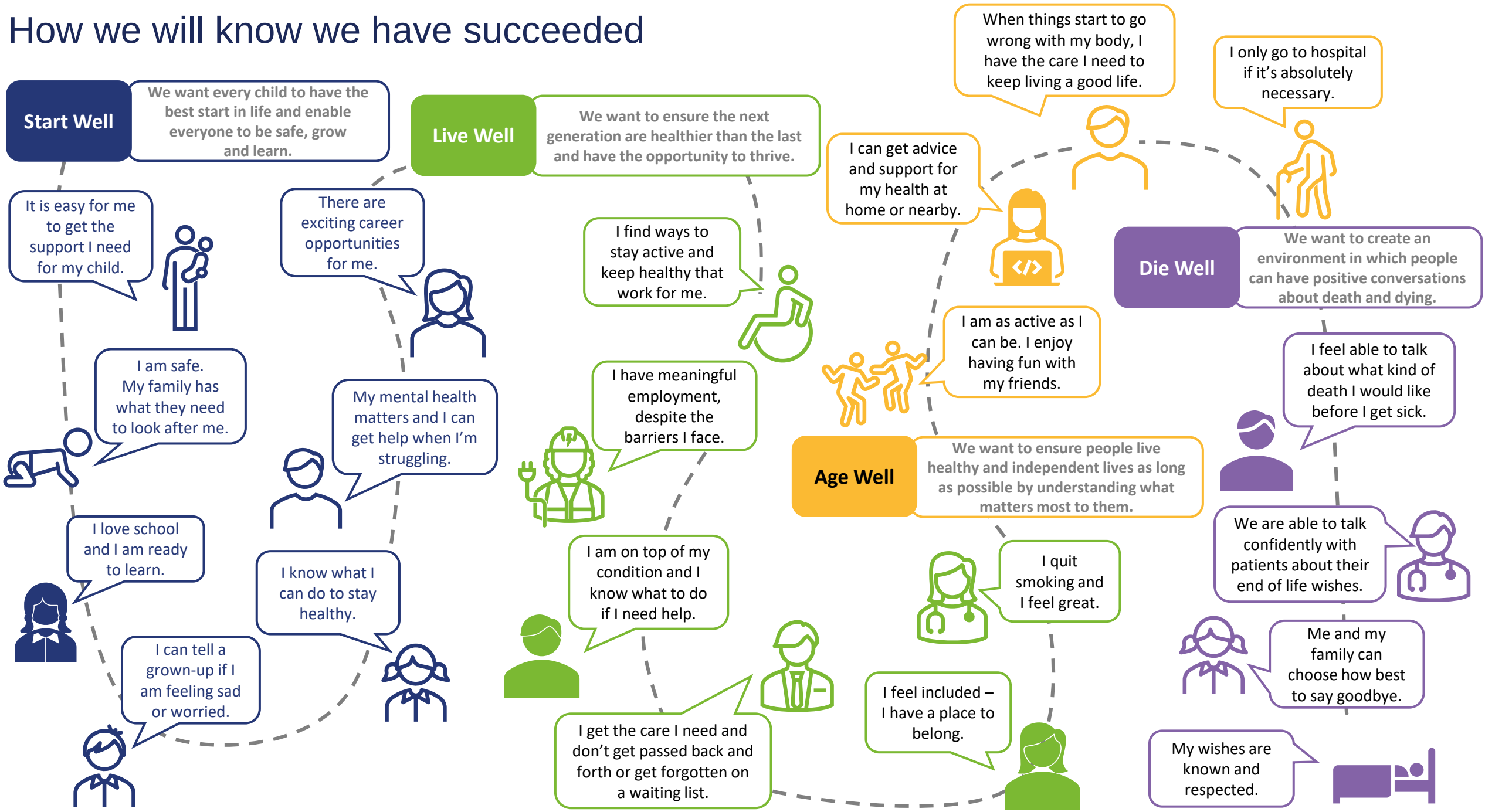
I feel welcome and safe in my local community and can join in community life and activities that are important to me.

I know about the activities, social groups, leisure and learning opportunities in my community, as well as health and care services

I have opportunities to learn, volunteer and work and can do things that match my interests, skills and abilities



How we will know we have succeeded



Humber and North Yorkshire
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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. An initial plan on a page for each of our six Places is set out in the appendices and these will be developed further during the early part of 2023.
- **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

Evidencing 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.

Humber and North Yorkshire
Health and Care Partnership

Appendices

Humber and North Yorkshire
Health and Care Partnership

Place Strategic Intent

Introduction

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.

The following pages are the initial plans on a page for our six Places of:

- East Riding of Yorkshire
- Kingston Upon Hull
- North East Lincolnshire
- North Lincolnshire
- North Yorkshire
- York

East Riding of Yorkshire Place

Humber and North Yorkshire Health and Care Partnership

Aspirations

In support of the vision of the ICS to 'Start well, Live well, Age well and End life well' our strategy at East Riding Place is grounded in the aspirations of the Health and Wellbeing Board, its strategy and improving population health in its widest sense, which includes the wider determinants of health (income, crime, education, work/labour market, built and natural environment, vulnerability). Our current Health & Wellbeing Board Strategy is located at: https://www.eastriding.gov.uk/council/committees/health-and-wellbeing-board/

Our aspiration is to equalise the opportunity for people to live happy, healthy and fulfilling lives through:

- Joining up things in communities
- Avoiding dependency and reducing escalation
- Raising aspirations
- Creating inter-generational wealth

Across 2022-23, we will be refreshing our Health & Wellbeing Strategy to capture the direct and indirect impacts on our population from events including: the pandemic, cost of living crisis, war in the Ukraine and Brexit. We aspire to develop a focussed response to these in terms of supporting residents of the East Riding of Yorkshire.

Concerns / challenges

Our concerns and challenges include:

- The immediacy of the pandemic and cost of living impact and if we can respond quickly enough.
- A significant cultural shift is required which will take time.
- Managing change when there is already pressure on our collective workforce who are dealing with day-to-day operational challenges. Our workforce may have their own personal challenges that we need to support them with (for example impact of the pandemic / cost of living).
- Ensuring a greater emphasis on the conditions of living / wider determinants of health and engagement of partners outside of Health & Social Care.

Plans

The first steps to achieving our aspirations will be to focus on structural priorities including, but not limited to, the following:

- Support the development of 'a movement' underpinned by loose networks and communities of practise to better meet population health needs
- Engage with and hear the voice of local communities
- Use this insight to inform a live intelligence network (Joint Strategic Needs Analysis - JSNA)
- Develop structural responses to meet short and longer term needs - for example Children & Young People
- Empower communities and people at all levels in our system to affect change.

Structural enablers that we have identified as our priorities include:

System Thinking	• Embedding a population health approach across all partners and all staff groups • Enhancing the voice of people and communities and building their intelligence and insight in-to our refreshed strategies
Operational Practices	• Developing the quality of relationships • Empowering operational practitioners to affect service and person-level change
Sector and Partner Development	• Creating 'headspace' / infrastructure for sectors such as Primary Care and the Voluntary, Community and Social Enterprise (VCSE) to be able to equally contribute to system development. • Commitment to a nurturing environment
Enabling Priorities	• Workforce – take an integrated approach to resolving workforce challenges and move to more integrated ways of working • Communications and engagement – develop an effective approach to resident engagement and gathering of insight

While going through considerable change this will also determine how we organise ourselves locally to understand need, co-design and deliver in an integrated model.

Our ambitions and plans are subject to change as we consult and gain insight into our populations needs through the refresh of the East Riding Health and Wellbeing Strategy.

Kingston Upon Hull Place

Humber and North Yorkshire Health and Care Partnership

Vision

We have a single unified vision for the City of Hull

Working together to create a fairer Hull where everyone benefits from real and sustained improvements in health and wellbeing

Values

These values will underpin how our system leaders work together to do the best for Hull and to unlock solutions that we cannot do when thinking only as individual organisations.

Co-ordination at Place
Intelligence based decisions
Communities driving change
Collective accountability

Aims

- **Proactive prevention** – work to address root causes of poor health and inequality. This will involve education, making sure people have access to resources, supporting recovery and providing early help.
- **Reducing health inequalities** – this area is about prioritising targeted work in Hull communities which experience the highest levels of inequality. This includes supporting broader social and economic development.
- **System integration** – we will transform the way we provide services across organisational boundaries.

What will be different?

- A new model of care will be in place which will wrap care around people who are at home, supporting them to stay well in their homes. This will be underpinned by a pooled budget managed via an alliance agreement.
- We will work with our staff and teams to provide person centred services and a foster a culture where staff work across organisational boundaries.
- We will manage a single account for the city resources through open and transparent decision making.
- We will tackle health inequalities head on through robust and systematic approaches and building on our new partnerships established through the Poverty and Truth Commission and the Financial Insecurity Network.
- We will support those communities most in need and with a particular focus on children and young people.
- We will use a digital platform to develop an integrated care record across Hull.
- We will actively engage with the people of Hull in a coordinated way and use what they tell us to inform how we develop our services.
- We will learn together as a local system and ensure that quality improvement is at the heart of everything we do.

What happens next?

- We will commence a co design process with our people to develop a new model of care for the city.
- We will formally establish our Health and Care Partnership, working towards becoming a Joint Committee to transform how we make decisions.
- We will develop our integrated financial plan so it becomes a plan for the city.
- We will mobilise our cross partnership workstreams to support how we deliver.
- We will mobilise our health inequalities workstreams to target our support to where it is most needed.
- We will keep our people regularly updated on what we are doing

We already have some innovative, partnership wide and forward thinking programmes which we will build on.

Integrated Care Centre Team
We will build on our existing ICC Team which has been established and now combines a proactive assessment service with a response line as part of an urgent 2-hour community response. The impact of this is that ED attendances and admissions are performing below the 2019/20 baseline position.

Supporting primary care
Our PCNs have developed health inequalities plans – as being at the front door for many of these issues particularly given the cross city levels of deprivation. To support delivery of these plans we have invested directly to practices to enable the delivery of improved outcomes in those areas associated with high deprivation.

The Building Forward Together programme
This provides a pro-active opportunity to rethink and shape the role of the local voluntary and community sector in place based working. The key principles underpinning this work are:

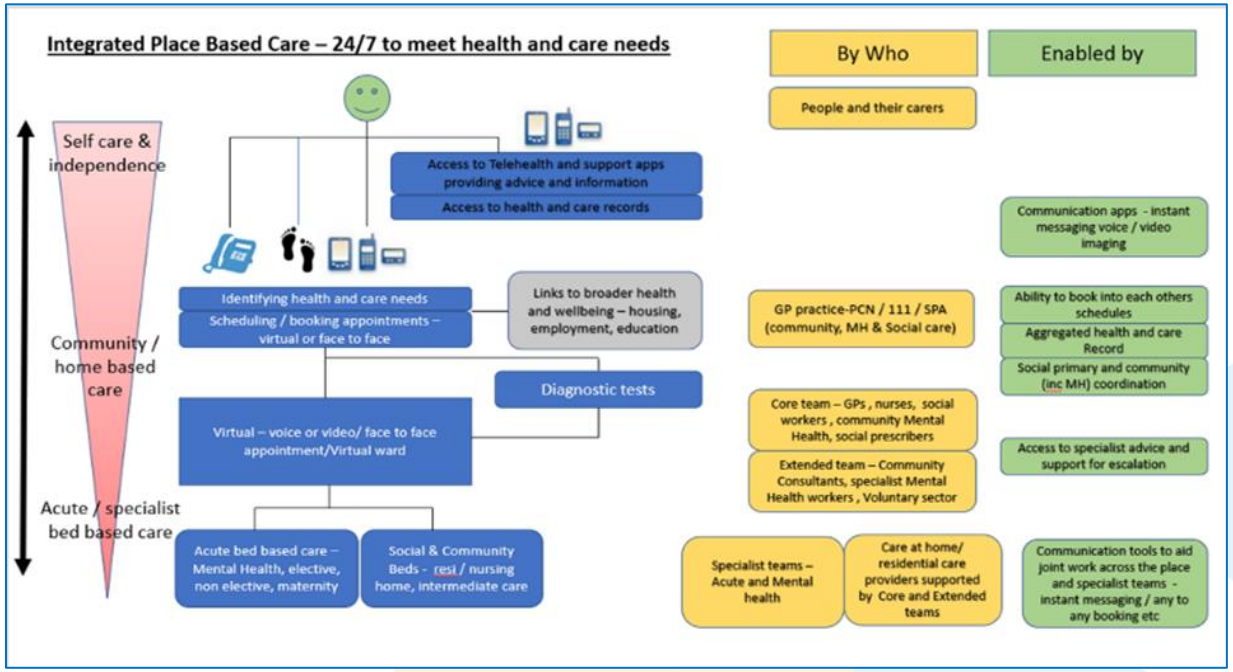
- partnership and collaboration
- social inclusion
- a shared approach to tackling health inequalities and
- developing a better understanding of what the voluntary and community sector does now and what it could do in the future

North East Lincolnshire Place

Humber and North Yorkshire Health and Care Partnership

Overall Approach

- North East Lincolnshire – erasing lines in the system
- Our local community, health and care system is currently building on a lengthy. proud and powerful history of collaborative and integrated working ensuring our community, health and care organisations work hand in glove which has benefitted local people for many years. Our Health and Care partnership enables partners to work together where a multi agency approach is required to tackle and deliver local priorities whilst still undertaking their own functions and service delivery
- Our local community, health and care system is becoming more holistic – bringing together and delivering mental, physical and social care together. for both children and adults. We are redesigning prevention and care locally, including reflecting the outcomes of the Acute Services Review and Out of Hospital services. Its 'all age' mandate will mirror the 'start well, live well and age well' vision of Humber and North Yorkshire ICS.
- We recognise that there is still work to be done to take full advantage of the opportunities presented by the new structures emerging as part of the integrated care system, however we are starting from a place of mature and effective working relationships which have already delivered a range of innovative and integrated solutions which will be scaled to further benefit



Approach to Integrated Care

- Our core model of care will be the Accountable Teams model, embodying teams working together to meet the health and care needs of people, their carers and families. Rolling this model out erases the 'lines in the system' created by organisational needs and boundaries, and will be founded upon:
- One referral to the right person at the right time
- "Accountable Care Teams' – avoiding often complicated and time-consuming transfers between services, professionals and organisations
- Shared data; digitally enabled; capable and empowered staff; and tailored care
- Delivering home first and virtual wards
- We have already successfully delivered the Connected Health model in Cardiology, breaking down barriers between primary and secondary care to eliminate waiting lists for this specialty – we will roll this out for other pathways of care and other specialties.

Our Priorities

Smoking – reducing our smoking in pregnancy rates to ensure children get a better start to life
Children - Improving experience and outcomes for Children and Young People
Mental Health – reducing our life expectancy rate differential between those with MH and those without
Skills – support life long learning / supporting people into H&C roles for the future – increase in no of people with level 3 qualifications

North Lincolnshire Strategic Intent

Our Ambition

Our ambition is for North Lincolnshire to be the best place for all our residents to be safe, well, prosperous and connected; experiencing better health and wellbeing

People will;

- enjoy good health and wellbeing at any age and for their lifetime.
- live fulfilled lives in a secure place they can call home.
- have equality of opportunity to improve their health and play an active part in their community and enjoy purpose within their lives.

Our community first approach

Our transformation approach empowers and facilitates individuals of all ages including children and young people to participate in their own communities, putting people and communities at the heart of health and care. People will have personalised care, be enabled to self care and have control over their lives. People will get the best care closest to home. We will use our collective resources to improve outcomes for people and be informed by the voices of our diverse communities. We will use our Place assets and resources to strengthen prevention and community support, reducing the need for higher levels of care which is safe, effective and high quality in the right place at the right time. We will use the North Lincs £1 wisely and with integrity. We will ensure participation and prevention threads through all that we do. We will foster a culture of one team, enabling our workforce to achieve great outcomes for people and support the workforce to be well. We will ensure we have the most effective systems and enablers of change.

The ICS and Place Partnership will invest locally to deliver this strategic intent ensuring the community health and care system is the right size for the population, is organised to meet levels of need and inequalities; focuses on prevention at every level and opportunity; and is high quality. The Partnership will utilise digitally enabled care to support the individual and integration of the workforce. We will prioritise those most in need. We will enable partners to manage risk effectively, to work together to promote positive risk taking to improve the outcomes we aspire to.

Priorities for Collective Investment

328 square miles

Mental health and wellbeing will thread through all that we do across all age

Asset based community development will identify and work with the strengths of communities to level up North Lincolnshire

Innovation will be supported including digital tools that enable individuals to maximise their health and wellbeing

The health inequalities gap will reduce across our wards

Access to health and care will take account of rural challenges

Healthy life expectancy will improve for our population

People with long term conditions such as lung and heart disease, will improve experience proportionately good health

There will be a single workforce strategy covering; leadership and management, recruitment and retention, reward and recognition, career pathways, and talent development

The integrated practise model will be person centred

North Yorkshire Place – Our Strategic Priorities

Humber and North Yorkshire Health and Care Partnership

A comprehensive and integrated health and social care model

WHAT DOES GOOD LOOK LIKE

- Increase in people living independently or managing safely at home/care setting.
- Increased care provided closer to home, with a sufficiency of supply of community health and social care services.
- Reduced need for acute beds for urgent care and for 24/7 residential and nursing beds.
- Significantly reduced delayed discharges into community care (whether nursing, residential or domiciliary care).
- Acute delivery operating much more in the community, coexisting with primary and social care.
- Partnerships that understand and respond jointly to the needs of their communities.
- People are supported to live in a broad range of housing that meets their circumstances.

KEY ACTIONS

- Ensure a greater emphasis on self-help, prevention and population health management (PHM).
- Develop a model for community health and social care which addresses sufficiency, comprehensive-ness and skill mix, as well as integration.
- Develop a consistent model for intermediate care.
- NHS, local authority and other partners to develop integrated models of care, e.g. strong multi-disciplinary teams and consistent 'any door' access.
- Develop alternative services in or near Emergency Depts – urgent community response, virtual wards
- Strengthened role for the VCSE.
- Supporting Enhanced Health in care homes and joint work through the Quality Improvement Team to improve responsiveness and quality.

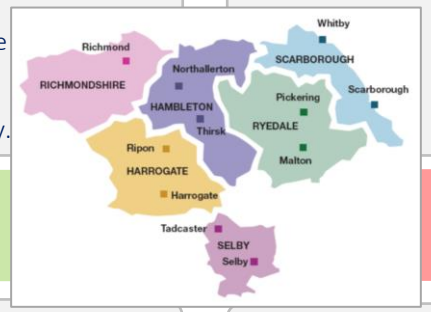
A high quality care sector, with sufficient capacity to meet demand

WHAT DOES GOOD LOOK LIKE

- Increase in people living independently.
- Higher recruitment and retention levels across health and social care.
- A care market sustainable for providers and affordable for commissioners and service users.
- Reduced reliance on acute beds and 24 hour nursing/residential care – Home First approach.
- Enhanced community capacity that can flex to prevent avoidable hospital admissions and facilitate timely hospital discharge.

KEY ACTIONS

- Shaping the care market through the trans-formation of Approved Provider Lists – consider impact of social care funding levy and cap.
- Recruitment and retention of care staff through attractive pay, training and career development.
- Develop innovative models for domiciliary care.
- Undertake fair cost of care exercises for domiciliary care and implement actual cost of care for residential /nursing care to deliver a sustainable care market.
- Work with care providers to implement the national charging reforms for adult social care and the next phase of the NHS discharge pathway.



A strong workforce

WHAT DOES GOOD LOOK LIKE

- Sufficient trained and motivated staff to meet demand through:
  - Positive narratives about the various different roles and professions.
  - Increasing numbers of people being recruited.
  - Range of innovative, possibly even joint funded, posts to help bridge gaps and/or break down silos (e.g. part primary care / community, or part health / social care).
- High recruitment and retention levels of all care staff.

KEY ACTIONS

- Develop more balanced/varied roles and better work/life balance, wellbeing support, appropriate rewards.
- Develop innovative approaches to recruitment.
- Develop innovative workforce models.
- Innovative use of technology to support staff.
- Identify opportunities for cross sector working and roles.
- Support international recruitment across sectors.

Prevention and public health: adding life to years and years to life

WHAT DOES GOOD LOOK LIKE

- Narrowing of the gap in health inequalities between the least deprived areas compared with the most deprived areas across North Yorkshire.
- Increase in overall healthy life expectancy across the County.
- Narrowing of the gap in healthy life expectancy between the people in the least deprived areas compared with those in the most deprived areas across North Yorkshire.
- Having a clear, resourced strategic plan with dedicated staff to implement.

KEY ACTIONS

- Commission and provide high quality, accessible prevention and primary care services.
- Support people to maintain good mental health with timely access to effective primary, secondary and specialist services when needed.
- Support people to be physically active across all ages and stages of the life course.
- Influence through the strength of the partnership the wider determinants of health with a particular focus on coastal communities.
- Promote and invest in stronger communities and strategic commissioning of the VCSE.
- Engage with people in a dialogue about self-care, early help, loneliness and using digital tools.

York Place

Our place intention

…is to collaborate better and integrate further, to redesign and deliver services that meet population need. Working with our citizens and stakeholders we have developed a York 'Prospectus' which describes the state of our system in 2022, the changes we are currently putting in place, and what people have told us they would like to see in future years.

Our health needs (JSNA)

Preventable ill-health 1 in 10 smoke 2 in 3 adults overweight or obese 1 in 7 live with depression	**Widening inequality gaps** Healthy Life Expectancy Health of those with a learning disability School readiness	**York's 'red flags'** Alcohol consumption/admissions, multiple complex needs, drug related death, student health
Economic factors Lower than average income 10% of children living in poverty Housing affordability gap	**Changing Demographics** Aging & growing population 4% ↑ hospital use (annual), 10% social care, 2.5% ↑ in GP (over 5yrs)	**Mental Health** u18s admissions for mental health need High prevalence of common MH illness High suicide and self-harm rate

Strengths for health and care in York

Improved links between primary care and wider social interventions, e.g. through social prescribing	Many wonderful NHS and care **staff,** and commitment shown in e.g. the vaccination rollout	An abundance of **health assets** – green space, access to culture and heritage, community venues
An emerging aligned set of **prevention services** / practitioner networks	**Research and innovation** – the potential from clinical trials and operational insight	Use of **technology** to enable care and improve ways of getting help (but guard against digital exclusion)
The depth and togetherness of the **voluntary sector**	The power of **involvement** – seen in several 'coproduced' initiatives	Geography, in terms of our **aligned** providers, VCSE and council

Challenges for health and care in York

An overstretched, tired and burdened **workforce** where morale is low	**Demand** for healthcare seems to only ever head in one direction (upwards)	People often report ending up in the **wrong place** for too long, be it a hospital bed or the wrong service	A challenging **financial** situation for all providers of care in York
Limited **resilience** in a number of smaller voluntary sector organisations	The long shadow and collective trauma of **COVID**	A reversal of **inequality** gains - people in poorer parts of York are dying earlier than they should	**Access issues** to several services, including urgent care, primary care and dentistry
Huge **backlogs** in care and long waits, across hospital care but also GP, community and social care.	A young **people's mental health crisis**, apparent even before the pandemic made it worse	A '**crisis management**', system, not a 'preventative' system	Labyrinth **systems** – people feel they bounce from one gatekeeper to another

Our priorities

Overarching goal: Delivery of the York Health and Wellbeing Strategy

- **Quality of services:** quality, safety, experience of care
- **Population health:** health generation, prevention, early intervention
- **Access to services:** general practice, dentistry, planned care
- **Resilient community care:** preventing admissions, in-and-out-of-hospital care, effective discharge
- **Urgent and emergency care:** capacity, resilience, responsiveness

How will we achieve our ambitions?

- Strengthen **foundations**, governance and joint decision making in our place partnership, to demonstrate the behaviours agreed in our 'Charter'.
- **Coproduce** plans with communities, staff groups and partners.
- Develop and embed a **population health** approach using the CORE20PLUS5 framework.
- Lead the health and care sector response to the three City Strategies.
- Join up health and care **research and innovation** potential in York.
- Produce a realistic future **workforce** strategy based on the concept of an integrated York 'health and care team'.

Our framework for a health generating city

Humber and North Yorkshire
Health and Care Partnership

Summary of our Patient and Public Involvement and Intelligence

Introduction

This summary has been drawn from engagement activities from across the Humber and North Yorkshire Integrated Care Board, using a broad range of methodologies. Patient and Public involvement is a dynamic process that continually gathers intelligence, and so this summary will continue to be updated.

The engagement exercises have largely focused on service areas and service specific commissioning projects. The findings from these exercises have been align to the following areas:

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

Additional engagement with patients, carers and the public, aligned with the life course areas above, will take place to inform the ICP Strategy

All Services – Making Lives Better

Humber and North Yorkshire Health and Care Partnership

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.

All Services – Making Lives Better

Humber and North Yorkshire Health and Care Partnership

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, using online (preferred 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.

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Health and Care Partnership

In addition to the general insights already outlined,
the following slides highlight elements that are specific to the key areas:

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 duel diagnosis of SEND and Mental Health, one can preclude the other

Live Well

Humber and North Yorkshire Health and Care Partnership

- 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.

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 unnecessarily.

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.


Humber and North Yorkshire
Health and Care Partnership
Thank You