

## BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

## Cover

### Health and Wellbeing Board(s)

North East Lincolnshire

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

In addition to sharing the draft plan with key individuals across health, care and housing (including DFG), the plan has also been shared with:

- Health Care Partnership (HCP) leadership group, comprising
  - *Care Plus Group*
  - *Core Care Links (GP out of hours)*
  - *Focus Independent Adult Social Work*
  - *Navigo*
  - *NLaG NHS Foundation Trust*
  - *North East Lincolnshire Council*
  - *North East Lincolnshire Partnership Foundation Trust*
  - *Primary Care Networks (PCNs)*
  - *St Andrew's Hospice*
  - *St Hugh's Hospital*
  - *VCSE (voluntary, community and social enterprise sector)*
- Centre4
- Sector Support North East Lincolnshire Partnership
- Healthwatch.

How have you gone about involving these stakeholders?

The BCF plan is reflective of the Adult Strategy, noted in the previous plan. This Strategy was developed in 2018/19 following an adult services review, which involved significant engagement across key health, care and voluntary sector partners. Progress against Adult Strategy objectives is being reviewed as it nears the end of its life (2022) with involvement from key health, care and voluntary sector partners (for example via 'appreciative inquiry' style interviews and an online survey).

It is likely that the Adult Strategy will be replaced by the Health Care Partnership (HCP) Strategy. To date, the HCP Strategy has been the subject of discussion at the CCG's Community Forum and ACCORD Steering Group (prior to 1<sup>st</sup> July) and at an engagement event with voluntary sector partners, as well as discussion with the HCP partners. These discussions, and the development of the HCP Strategy, are/ is ongoing. The HCP Strategy will aim to align with BCF plans.

Due to the very tight timeline within which a BCF plan must be created, genuine involvement in the BCF plan itself is limited. However, in having input into the Adult Strategy (and its current review) and creation of the HCP Strategy, partners have in effect been involved in development of the BCF plan. The BCF plan has been shared in draft form for comment.

## Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

North East Lincolnshire's (NEL) approach to health and wellbeing, focusing on prevention, putting the community at the centre of service re-design, and supporting people to take more responsibility for their wellbeing, is represented in the 'funnel of transformation' depicted in previous BCF plans (the revised funnel also features on page 19 of this plan). This focus on community-based prevention remains key to current and future planning.

The Adult Strategy (applicable to all adult health and care services) referenced in our 2019/20 plan continues to set out our person-centred, enabling, approach. By focusing on individual and community assets, we aim to increase the likelihood that we will create a resilient population able to thrive on independence and self-care, and reach their maximum potential. The priorities set out in the Strategy continue until the end of year, although it has not been possible to progress in all areas at the speed, or in exactly the same way as, envisaged before the pandemic. Delivery of Strategy aspirations remains challenging due its ongoing impact.

The Adult Strategy is likely to be replaced by a Health Care Partnership (HCP) Strategy currently in development. The HCP Strategy will set out similar objectives in terms of promoting population health and independence, as described in the Adult Strategy and our previous BCF plan(s). The HCP Strategy will be signed off by the NEL Health and Care Joint Committee. This committee comprises representatives of the Council, HCP and ICB (Integrated Care Board), and has been created since submission of our previous plan. The Committee will have oversight of delivery of the HCP Strategy. The HCP Strategy will be implemented by the HCP.

## Governance

As noted in our previous plans, individual schemes are generally subject to monitoring and/ or are monitored by a scheme board or steering group, comprising professionals and community members. This means evaluation is on-going as part of 'business as usual', rather than a one-off activity for the benefit of our BCF plan. Any underperformance is addressed via the relevant board/ steering group or contract monitoring meetings.

BCF governance is part of overall partnership governance set out in the s75 agreement, updated to reflect the move from CCG to ICB. The pooled budget manager is the ICB's Place Director for Finance (South Bank) and the Council's Director of Resources and Governance. The overall lead for the plan is the director of adult services. The plan is developed jointly by Council and ICB. On-going high-level oversight of BCF schemes, and development of BCF plans, is undertaken by the BCF steering group (comprising ICB and Council staff), reporting to the Health and Care Joint Committee. The Committee in turn reports to the Health and Wellbeing Board.

**SIGN OFF OF PLAN:** the draft plan was supported in principle by the Joint Committee on 24<sup>th</sup> August 2022. At that time, it was awaiting regional comments. The final plan was signed off by the Health and Wellbeing Board on 23<sup>rd</sup> September 2022.

Please briefly outline the governance for the BCF plan and its implementation in your area.  
**Overall BCF plan and approach to integration**

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- a) Joint priorities for 2022-23
- b) Approaches to joint/collaborative commissioning
- c) How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

**a) Joint Priorities**

This section of the plan sets out priorities and notes relevant changes when compared with narrative offered in previous BCF plans.

The Adult Strategy sets out how the ambitions of the local outcomes framework, and how the place-based vision for health and wellbeing (also referenced in our previous BCF plans), can be delivered by adult services. This year the ambitions in the Adult Strategy are being revisited, and are likely to appear in the developing HCP Strategy in revised form. At present, the below priorities remain pertinent and have been updated as relevant.

i. Information and advice and the Single Point of Access (SPA)

LiveWell

The LiveWell site (launched on 31<sup>st</sup> March 2021 - <https://livewell.nelincs.gov.uk/>) - which replaced Services4Me, continues to act as our single point of information (referenced in our previous plan). This enables professionals and local people to access low level support to help themselves. LiveWell includes a self-assessment tool which offers specific tailored advice or enables results to be sent to the SPA for follow up contact to be made. In addition, there are specific portals of information relating to dementia, sensory impairment and carers.

To support us in delivering person-centred care, we have developed a new Making it Real (MiR) area on our LiveWell site: <https://livewell.nelincs.gov.uk/adult-social-care/making-it-real-how-to-do-personalised-care-and-support/> This sets out our commitment to the MiR framework which supports personalised care. We intend to build on this over the coming year.

New and revised information has also been drafted in a number of other areas, for example continuing healthcare (CHC), to ensure that it is comprehensive and up to date. New/ revised content is subject to review by a panel of community 'experts by experience' as part of a six-month programme of engagement activity, taking place from July 2022.

As noted in our previous plan, the Livewell site is integrated with another digital platform, Simply Connect - <https://nelincs.simplyconnect.uk/> - which offers advice and information on community resources and activities such as 'knit and natter'. This resource has progressed significantly to include a wide range of community support mechanisms such as: therapists, support groups, care professionals, social groups/ events, childcare, health and fitness classes, outdoor exercise, legal advice, and financial advice.

Single point of access (SPA)

Our 'front door' remains a focus for continuous improvement. The SPA continues to offer integrated health, mental health, social care and therapy access for professionals and the public in NEL. For example, in quarter one (April – June 2022) the adult social care triage team fielded an average of

4,275 calls and the health triage function an average of 7,085 calls. Using the Govmetrics system, SPA is able to secure contemporaneous feedback. For example, 100% of callers to the adult social care triage function that leave feedback, report a positive experience.

As of July 2022, a telephone call to the SPA now offers a further integrated option (option 5) which links to Connect NEL (the wellbeing hub referenced in our previous BCF plan, and part of our preventative offer). There are also electronic referral mechanisms via SystmOne, and opportunities for individuals to refer themselves by direct call or email to the wellbeing hub. Connect NEL offers a 24/7 helpful and friendly signposting service created to help people get 'in front of' the services and activities they need faster. It is free to access. It dovetails LiveWell, Simply Connect and Thrive NEL (see below). It provides a conduit to lower-level support provided via the voluntary and community sector and public health teams.

*Priority: further develop our integrated information and advice offer (LiveWell), prevention offer (Connect NEL and Simply Connect), and engagement via the 'front door' (SPA), ensuring it is person-centred, and focused on promoting independence.*

## ii. Housing based help

Care home provision and support to care homes

The COVID -19 Pandemic continues to impact our residential providers, who remain under significant pressure from the risk of outbreaks and loss of staff due to illness. In this challenging time, we have completed our market position statement and we are now in the process of completing our fair cost of care exercise using the national tool kit.

Providers will soon be mandated to complete the Capacity Tracker on a monthly basis which may result in a less frequent level of data being pulled into the adult social care dashboard. To address this, we will soon begin developing our implementation plan for the PAMMS assurance system which should act as an adjunct to our existing assurance processes.

The falls project, run under the Support to Care Home programme, is being reviewed and it is hoped that in the future it may help to develop a pilot of the iStumble App which is supported by EMAS (East Midlands Ambulance Service). This would align with work being considered across the ICB.

Work is continuing to develop support from our five PCNs (primary care networks) to ensure that there is a consistent MDT offer available to all residential providers. The PCN care home clinical leads are also being asked to look at proposals for expanding pilot schemes that are being run in three care homes with the hope that this would be developed further and fully rolled out if possible.

## Extra care housing

It remains our intention, as set out in previous BCF plans, to progress extra care housing (ECH) schemes as part of our accommodation with care offer. We currently have two schemes in the borough – Strand Court and Burchester Court – offering 120 units of modern, adapted, self-contained apartments. Our plans to develop such schemes have generally been behind schedule, but are making progress. We have undertaken a market testing exercise to understand what model best suits NEL and our needs, now and in the future. We are working on the following previously referenced sites:

- Cambridge Road (former Western School site). It is hoped this scheme will offer between 70-90 further units, with work to start in the next 18 months
- Davenport Drive (former Matthew Humberstone school site). This scheme should offer between 70-90 further units. The build for this site will be staggered following commencement of the Cambridge Road site.

Both Davenport Drive and Cambridge Road form part of wider housing development schemes by the Council. Agreement from Sports England has been granted (as these were both old school sites, with playing pitches) to use the land for ECH, and we are now appraising options to seek the best fitting model to support NEL population needs, including a self-delivery option via the Council. The Council, in consultation with Homes England, are developing a business case and are in the process of understanding the viability of this option. This could potentially see an income for the Council through the rents once the capital for the project has been repaid.

*Priority: continue to ensure our housing-based help offer is a) sustainable, b) supported by appropriate professional input, c) sufficiently diverse to meet the needs of local people and enable independence.*

*iii.* Care at home

Our 'teams not times' model continues to be the method for delivering support at home. However, we have also recognised that there is a need for a more enhanced skill set for care workers when delivering care to some residents with ongoing care needs. A pilot has been developed to provide some care workers with additional training to deliver PEG feeds, carry out simple wound care and support insulin dependent residents. It is hoped this will provide data on the amount of training and demand as well as the benefits to the cared for person, and help shape future commissioning specifications.

The just checking scheme referenced in our previous plans, continues to offer additional flexibility to our care at home model – helping to ensure that individuals receive the care they need when they most need it.

We have now secured a lead occupational therapist to deliver the single-handed care project, designed to improve the efficiency and effectiveness of support at home services within phase 1. We will do this by reducing the number of calls for two or more care workers through utilising improved techniques and different equipment suitable for moving and handling with one carer instead of two. The project aims to create a philosophy of reduced care handling; improving techniques for both the individual and the supporting person, and aiding people to be supported by their informal carers and/ or in their home for longer. The project will be delivered over several years across the following phases:

- **Phase 1: Quick wins**

Working with support at home providers - who have already identified individual support packages which may benefit from reassessment with single-handed care in mind - to offer training, support and improvement of knowledge base to staff, informal carers/ formal care workers and the individual. This phase will include general awareness, support and improvement of knowledge base across a number of professionals, including social workers, therapists, and allied health professionals.

- **Phase 2: Wider community providers and complex cases**

Assessing more complex cases in the community for single-handed care, and identifying cases in other services such as supported living, where the individual may benefit from single handed care techniques and approaches.

- **Phase 3: Care homes**

Working with care homes to implement single handed care techniques and equipment. Developing a network of training and support to the staff in these homes to upskill and increase confidence.

- **Phase 4: Whole system**

Developing and embedding a whole system change to implement single handed care-based approaches, from hospital through to the community.

Support at home remains very challenging; providers face extra pressures from the requirement to support hospital discharge, as well as respond to increases in demand from the community. This is especially difficult given the high levels of COVID sickness and spread in the community.

*Priority: appropriately resource and embed new support at home model to ensure personalisation and promotion of independence is maximised (evaluated using the Making it Real Framework).*

iv. Reablement

Creating additional reablement capacity (step up/step down) remains a focus of activity during 2022/23, as well as improving length of stay and outcomes for individuals.

Work continued through 2021/2022 to launch Cambridge Park enhanced recovery unit as the main bed based intermediate care provision (referenced in our previous plans). The plus sized provision (2 ensuite bedrooms) has been completed and utilised continuously since its opening in spring 2022. The service is currently working to reach a capacity of 42 beds with an enhanced service offer to support those with more complex needs.

The reablement improvement programme will run over several years; updated priorities include;

- Increasing the capacity within our intermediate care bed-based facility (Cambridge Park, as above)
- Enhancing the offer in intermediate care to include enhanced nursing functions for e.g., intravenous therapy, PEG feeding
- Developing 10 block booked beds and a spot purchase provider framework to deliver additional enhanced recovery bed capacity to support discharge and avoidable admissions
- Undertaking the re-ablement review
- Working to improve the model, offer and performance of our intermediate care at home service
- Creating a re-ablement culture across NEL
- Delivering the singlehanded care initiative (see care at home section above).

The Council and CCG (now ICB)/ HCP have continued to work with the Assisted Living Centre (ALC) to improve the performance dashboard and financial monitoring of the service. The specification and revised KPIs (key performance indicators) are currently being approved. Demand and capacity work has also commenced to understand the volume and complexities of those presenting to the service. Joint work with the tissue viability nurses, the Council, HCP and the ALC has been progressing to ensure the right processes are in place to provide pressure relieving equipment for those at risk of having, or who have, pressure damage.

*Priority: continue to ensure effective delivery of reablement provision and wider services which support it (e.g., the ALC), whilst working to embed a 'reablement culture' across all levels and types of support.*

v. VCSE (voluntary, community and social enterprise)

Working collaboratively

In 2018/2019, the Council and CCG (as it was then) developed, with community members and representative of the VCSE sector as equal partners, a joint engagement strategy entitled 'Talking, Listening and Working Together'

(<https://www.northeastlincolshireccg.nhs.uk/data/uploads/engagement-strategy/twlt-final-digital->

[a11y-accessible.pdf](#)). This engagement strategy sets out NEL's commitment to routinely involving communities, talking to the public as early as possible and being informed by their experiences, concerns and aspirations. To help ensure communities are included in conversations, we aim to engage with VCSE organisations and seek their support to develop solutions for NEL. Engagement strategy implementation slowed during the pandemic, but plans are being made and implemented to reinvigorate its implementation over the current year. This is happening in several ways, including in respect of the Council/ ICB's relationship with the voluntary sector. Activity includes:

- Creation of an engagement toolkit to ensure that engagement with community and VCSE colleagues drives and informs HCP projects; this toolkit is being consulted on currently
- Reconvening the strategy steering group, which comprises community and VCSE representatives, to consider how best to develop the strategy, given the revised landscape (i.e., the CCG's replacement with ICB)
- Further development of key performance indicators to enable the steering group and others to assess the success of the strategy. Results are published in a 'you said, we did' format
- Creation of a programme of engagement activity, intended to offer a variety of opportunities for community members and VCSE colleagues to contribute to Place development
- Joint working on a number of projects including (for example) an initiative to reduce social isolation in different communities.

Supporting the sustainability of the VCSE sector

The ICB continues to fund Sector Support NEL Partnership (SSNEL)

(<https://www.sectorsupportnel.org.uk/>) jointly with the Council. SSNEL supports not for profit organisations to build their capacity and infrastructure, through voice and influence, and support with funding, governance, and training. SSNEL represents the VCSE sector in the HCP and is the VCSE Lead at system and place. SSNEL is working with us to formalise the Council/ ICB/ HCP's relationship with the system based VCSE Collaborative and place based VCSE Assembly to draw the VCSE sector even closer to planning and delivery. Joint working with the voluntary sector has been crucial in meeting local need throughout the pandemic, and we want to build on that by taking further steps towards integrating the VCSE offer with more formal services. We will continue to explore strengths and assets, partnerships, knowledge sharing, Talking Listening and Working Together, and commissioning and procurement routes.

The BCF funded Preventative Services Market Development Board (PSMDB) continues to support preventative opportunities in the VCSE sector. In light of the pandemic, the PSMDB has successfully concentrated on ensuring that the projects developed have remained sustainable and delivered valuable services. This approach has led to a significant growth in the scale and range of services being delivered and a subsequent growth in the impact delivered.

This year the PSMDB has seen the development of a bike riding for the disabled programme, a new handyman service, a hairdressing service, a food bank, and a programme that will grit the paths of elderly and vulnerable community members to help reduce falls and their consequences.

Although Covid-19 has had a significant impact on the PSMDB's work, and progress has been hampered, work has continued as follows (figures given since PSMDB's inception, to 31<sup>st</sup> March 2022):

Total awards	£485,421
Average Award Size	£23,115
Additional Funds Levered	£1,745,219
For £10 spent by PSMDB, it has attracted an extra £5.95 into the local economy	
Total Combined funds invested in community services*	£2,192.640



Total spend in the local community	£1.9m
Value of that spend (LM3# £2.45 for every £1 spent)	£4,655.000

\*PSMDB grant funding, organisations own contributions and external funding attracted  
 # LM3 measures the multiplier effect of income into a local economy

*Priority: continue to work with VCSE colleagues to ensure coordinated and accessible preventative opportunities, and use existing mechanisms to support projects designed to achieve the same.*

vi. Workforce development, assessments and interface between services

As noted in previous plans, NEL has been promoting and embedding an asset-based approach to practice for some years. All staff micro-commissioning placements (social work, mental health, continuing health care and community nurse practitioners) work to our micro-commissioning policy which advocates an asset-based approach, and is reflective of the national ethical framework published during the pandemic. The asset-based approach is also embedded in the SPA, now strengthened through its links with Connect NEL and Simply Connect. VCSE and ICB teams will further work together with the aim of hosting events that support asset-based approaches, workforce and the interface between formal services and community services.

The programme of engagement on the recently updated micro-commissioning framework is continuing this year, to complement existing programmes of engagement and practice development noted in previous plans. Practice development events this year (offered to all commissioner and provider staff across health and care) include sessions on:

- Deprivation of liberty and the development of the Liberty Protection Safeguards (LPS)
- The Mental Capacity Act 2005 (MCA) philosophy and practice
- The MCA and tenancy
- Using the inherent jurisdiction to protect the vulnerable.

This programme of events also supports us in work to address inequalities (see equality and health inequalities section below). For example, a respected academic will visit NEL's Social Work Forum in September. The Forum is attended by social workers practicing across health, mental health, social care and voluntary sector partners, as well as by nurses. The academic will discuss his latest book and the extent to which systems exacerbate disadvantage. Professionals will be prompted to consider their role in mitigating disadvantage, and developing resilience.

A number of work programmes are in place to improve practice at the interface between services, such as that between adult services and housing. On this there is significant engagement and improved methods of working, pulling together the strategic, enforcement and home options teams in the Council as well as teams in the ICB and wider external partners, including private landlords and social housing providers. This positive interface between services/ partners continues to deliver a sustainable pathway to address homelessness/ housing issues. Work will continue to shape the pathway, supported by agreed principles for shared learning and working. This includes work via the Strategic Housing Action Plan to provide clarity and solutions for key housing challenges, as referenced in our previous plan.

Due to changes of personnel, work on the interface between children and adult services referenced in our previous plan, has not progressed in the way hoped for. This remains an area for further attention and development.

*Priority: continue with the programme of work focused on ensuring staff identify individual outcomes and the progress towards meeting those outcomes, across the life course and across services.*

vii. Collecting information

Following the work of Insights NEL (referenced in our previous plan), a newly formed team 'Strategy, Policy and Performance' commenced 1<sup>st</sup> August 2022. This is a new operating model that is aligned with ICB colleagues in the Contracts and Procurement Team. All work undertaken by this team is intended to benefit the wider Place.

The Data Group working group has completed work to understand which teams work with systems and data; this has led to the creation of a systems administrator group. The group is creating one information directory which will have a central location; this will be a 'yellow pages' of all data held. The group is also developing data quality standards and a data quality training package that will be launched over the next 12 months across the workforce. This group is part of the Insights NEL work that commenced last year. The group comprises Council and ICB representatives. The group has been responsible for mapping business processes across the Council and CCG (now ICB) to understand current processes and where data is held.

A new Customer Service Management Platform is being procured (currently at tender evaluation stage). This new platform offers the capability to integrate business activity with customer engagement in a meaningful way. By creating a central customer database, it will be possible to effectively develop links between service applications, enabling better understanding of customer needs and helping to inform strategy development and service improvement. It will improve the utilisation of applications, reduce application management resource, and improve integration across services. This will also enable evidence-based decisions by using the intelligence held within data sets. Within this platform 'project management software' all information will be captured in one system for all projects that are worked on. This new application will deliver a key commitment to "join up our data and insights capability to make sure we make the best use of all the information and intelligence held across the Place, and that services are delivered in a way that is more efficient and responsive to the needs of our population". The system will be utilised by the Council and HCP.

*Priority: further develop the comprehensive Union approach to insights which allows effective targeting of resources and greater benefits for the residents of NEL.*

**b) Approaches to joint/ collaborative commissioning**

All BCF initiatives are commissioned via the s75 agreement. Governance for joint/ collaborative commissioning is likely to be provided via the Health and Care Joint Committee (referenced in the Governance section at the beginning of the plan).

The health and social care needs of the service user/patient are not separated. For example, in NEL our CHC team and social care team work collaboratively under one decision making policy – resulting in zero disputes over our funding packages in over a decade. The patient's experience is streamlined to ensure that needs are identified and rapidly supported from all viewpoints. The aim is that:

- Health and social care needs are recognised across teams
- Services share information and alert each other of patient changes
- Services identify any gaps in provision and work together to overcome identified problems
- People only need one assessment with no passing around of responsibility.

**c) How BCF services support integration/ any changes**

The 'joint priorities' section above sets out how BCF services support integration and any relevant changes to date, or planned for the remainder of the year. The remainder of this section focuses on

the enablers of that integration, updating information given in our previous plan on organisational approach, digital developments and workforce.

### Organisational approach

So far as legally possible, the CCG and Council achieved integration via a Union, reflected in updates to the s75 agreement which has been in place since 2007. The s75 has been updated again to accommodate the advent of the ICB. Staff continue to be co-located so that health, care and public health commissioning teams work in the same building and are led by a joint management team and chief executive. This arrangement continues to form the bedrock of integrated activity in NEL.

Prior to the introduction of the ICB, a single Union commissioning plan was developed, underpinned by a set of shared core commissioning principles designed to reflect the findings of the Adult Services Review, aligned with our Adult Strategy. The same principles of shared commissioning against agreed outcomes for NEL still stand and will further develop under the new ICB arrangements. The Union was supported to develop further by FutureGov, via an integration road map which sets the standard for decision making, culture, and organisational design. Local teams will continue to take this work forward, to ensure the Union's vision is realised: "to grow and enhance the place of NEL to improve the health, care and life experiences of our population".

### Digital enablers of integration

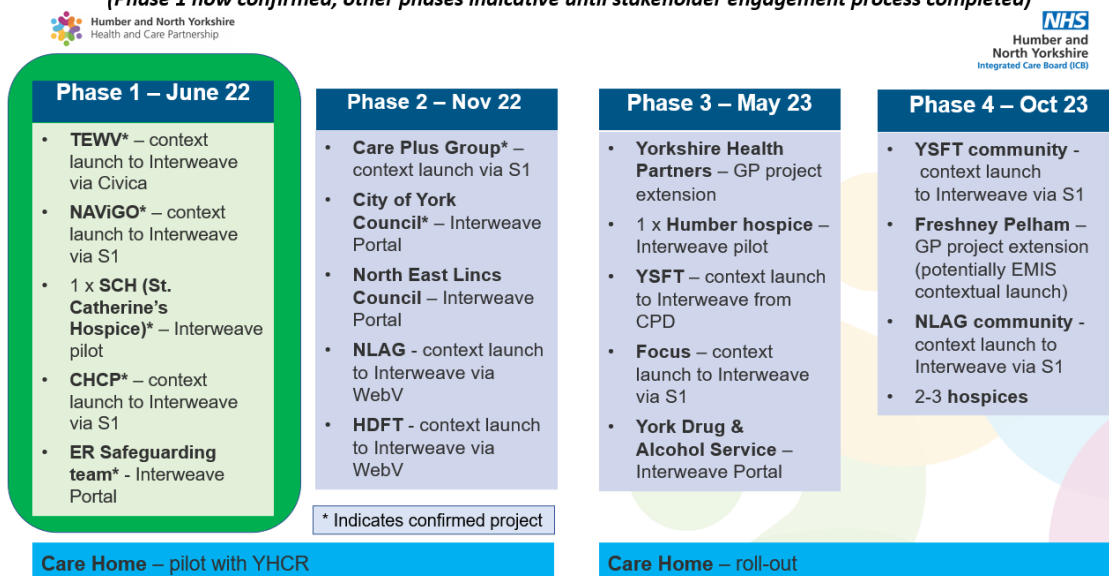
Building on our success and expansion of the initial SystmOne and EMIS integration, we have continued to develop our record sharing technology and ethos with the maturing of our Yorkshire and Humber Care Record (YHCR) and Electronic Palliative Care Coordination Systems (EPaCCS) solution. Several Organisations are now live with data connections into the YHCR including:

- 4 live NHS hospital trusts
- GP practices
- 4 live local authorities
- 2 x 999 providers
- YAS 111 Service
- End of life records.

As we move past the MVS 1.0 Standard into MVS 2.0 we have planned the following 4 phase deployment over the next year.

## Consumer Project Summary – Phases

*(Phase 1 now confirmed, other phases indicative until stakeholder engagement process completed)*



The YHCR system will also support improved Population Health Management toolsets.

Where appropriate we are working towards true electronic patient record convergence to further bolsters professional empowerment.

End of life record sharing has also matured, with a single HCP wide EPaCCS solution now in place. End of life preferences are entered and shared in real time between all partners included in a patient's care; this includes:

- Primary care
- Community care
- GP out of hours (OOH)
- Single Point of Access
- Secondary care
- Hospices
- 111
- 999 ambulance services.

This system ensures that professionals have access to the very latest patient preferences and are fully empowered to make decisions.

We have adopted the NHS APP as our standard front door to patient held records and have integrated the primary care PHR facilities with secondary care records via direct integration with the PKB product. VCSE colleagues have also undertake work to promote the use of the NHS App.

We continue to work with primary care on ensuring best use of public facing digital offerings by providing online and video consultation facilities, along with working directly with Primary Care Networks (PCNs) to ensure that digital maturity of staff and patients is understood. We have also deployed smart patient messaging systems to improve patient knowledge sharing and improve 'did not attend' rates.

We have been the NHSE national pilot site for the production of supportive materials to empower practices to educate practices on the most appropriate access point for them.

We continue the work to support the unplanned and emergency care position by ensuring that appropriate logistics and booking enabling tools are in place. We have provided the ability to:

- Allow 111 to book into emergency departments with a timed slot
- Allow 111 to book into urgent treatment centres
- Allow 111 to book into primary care
- Allow the NEL SPA to book into emergency departments with a timed slot
- Allow the NEL SPA to book into primary care.

We are also starting to provide the ability to book & stream unheralded emergency department walk-ins into the most appropriate location.

To further enhance patient care in the urgent and emergency care setting we are developing a booking and referral system to allow patients to be booked directly from one service into another service, reducing delay and administrative overheads and greatly improving the patient experience. We will also look to extend this facility beyond urgent and emergency care settings.

To ensure quick and secure channels of communication between clinicians we are implementing a dedicated clinical messaging solution across the ICB, which will allow clinicians to communicate with each other to agree the most appropriate care and location for the patient - right care, first time.

We have worked with care home partners to increase the digital maturity of care homes, and ensured that every care home has access to:

- Secure Wifi (which can be augmented with local funds to cover the whole site)
- NHS Mail
- A NHS Laptop
- A 4G enabled tablet for direct remote clinical consultations.

Across the HCP we have formed an (award winning) Care Home Digital Maturity service to assess the digital maturity of care homes and support them to improve the connectivity into the wider care community. This service has been very well received and is making a positive difference.

#### Workforce enablers of integration

NEL continues to battle long standing challenges in recruiting and retaining health and care professionals; these challenges have been exacerbated during the pandemic. Whilst BCF monies are not directly funding recruitment activity, workforce capacity concerns are of relevance to BCF in so far as BCF schemes require staff to deliver them.

Workforce capacity remains one of the biggest risks to the local health and care system. For that reason, we continue to work with partners to explore mechanisms to improve recruitment and retention of staff at all levels. For example, we held a workshop to ask our providers for feedback on what they consider to be the main issues in recruiting and retaining staff. We hosted a survey for all care staff to ask them similar questions, and had a very good response rate. We aim to use the survey data and workshop feedback to plan our next steps.

We continue to use events and other methods to promote roles in health and care. For example, we produced inspiring videos with local care staff, which we promote via social media as part of a marketing campaign. We are also working with our providers to support the 'I Care' event in September 2022. This career event will promote the range of roles on offer and encourage people to consider a role in health and social care.

We are working with the Humber wide teaching partnership to consider social worker recruitment and retention across children and adult services. We also have in place close working arrangements between children and adult services in respect of ASYE (assessed and supported year in employment), in line with Skills for Care. This includes children and adult social workers across NEL being subject to the same internal moderation processes during their ASYE.

## Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

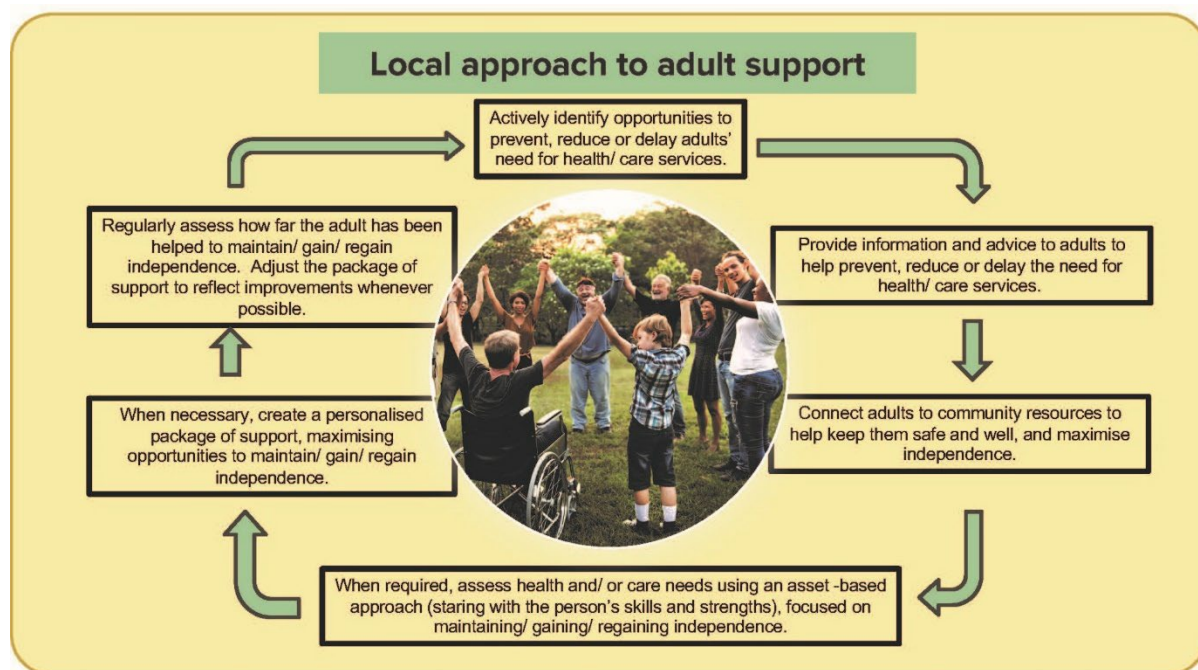
- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Enabling people to stay well, safe, and independent at home for longer

Our Adult Strategy – referenced in our previous plan and throughout this one - is our approach to enabling people to stay well, safe and independent at home for longer. The Strategy's vision is: "Adults in North East Lincolnshire have healthy and independent lives with easy access to joined up advice and support which help them to help themselves". We describe this vision as a 'promoting independence model': our support offer is designed to work alongside the person, to find ways of helping them that maximises opportunities for greater health and independence, and minimises the need for help. Support for adults is intended to be reablement based, challenging people to do more for themselves, and consistently reassessing their ability to maintain, gain or regain skills wherever possible. Success is defined by how far people have been re-abled (helped to maintain, gain or regain their health and independence, as much as this is possible for them).

The Adult Strategy is a Place strategy. All health and care commissioning, whether BCF funded or otherwise, is approached in the same way i.e. for the benefit of Place and intended to enable people to stay well, safe and independent at home for longer. To take one further concrete example (referenced in our previous plan) of joint commissioning, the CCG (as it was then) and Council staff jointly reviewed our day opportunities offer. Engagement with over 200 users of day services, service provider organisations and others enabled us to gather information about current services, and assess the degree to which such delivers on the Adult Strategy's vision. The review's findings are published <https://livewell.nelincs.gov.uk/day-opportunities-survey/>, and are being utilised to inform next steps. A 'you said, we did' document sets out those next steps (available via the same link). In short, day opportunities are being redeveloped to ensure that they are accessible to those who want to use them (regardless of funding responsibility), offering flexible and varied activity to meet a range of needs. A revised offer will aim to promote independence for both users and carers.

We acknowledge that there is more work to do, if we are to make greater progress on promoting independence. The diagram below (headed 'local approach to adult support') sets out that our reablement model is intended to be iterative in that it continues to reinforce the importance of independence – and taking an asset-based approach – at every stage of an individual's 'journey'.



As already largely noted above and in previous plans, this approach is supported in a number of ways including:

- our developing commitment to Making it Real (a step towards promoting personalisation)
- our micro-commissioning policy which underpins an asset-based approach to individual commissioning across CHC, mental health and adult social care
- our collaborative approach to individual commissioning which via a panel comprising representatives from CHC, mental health and adult social care, packages of care are subject to check and challenge i.e., are packages as 'independence promoting' as possible?
- our programme of legal literacy for staff, intended to foster a rights-based approach to delivery across health and care. A rights-based approach means understanding relevant legal frameworks and applying them to individuals in way that fosters personalisation and an asset-based approach.

#### Right care, right place, right time

The offer of extended access to general practice Monday to Friday 8am to 8pm and weekend opening continues and is being slightly amended from October 2022 as it is incorporated as one of the national specifications for PCNs (primary care networks). It continues to be delivered on a collaborative basis by local practices working together within their PCN groupings. The total hours per week that PCNs have to offer will increase slightly from October 2022, as this specification has been combined with a previous practice level extended hours specification. The opening hours for a Saturday are now mandated as 9 am to 5 pm (previously this was locally determined) and there are no requirements for a Sunday unless demand dictates otherwise; previous Sunday demand was extremely low, so local plans do not factor in Sunday opening hours. The local offer will include a mix of face to face and digital support, will be a multi-disciplinary approach, including GPs, nurses, HCAs (health care assistants), clinical pharmacists, physiotherapist, ANP (advanced nurse practitioner) and paramedics, and will include a mix of planned and urgent appointments covering services such as:

- Planned medication reviews / mental health follow ups

- Routine HCA/ nurse appointments for blood tests, health checks/ chronic reviews
- Counselling support services
- Structured medical reviews from clinical pharmacists
- Social worker support services.

The joint work with local VCSE organisations to deliver a successful social prescribing programme – Thrive NEL - continues. This was further expanded during 2021/22 through a combination of expansion of the Thrive service including incorporating a broader range of conditions, and additional recruitment to the Social Prescribing Link Workers that are part of the national PCN Additional Roles Reimbursement Scheme. This means that the PCNs can provide a named link person/ lead for the PCN population. Currently around 60 patients per month are benefiting from community support to help them manage their long-term conditions more effectively. A more detailed evaluation of the impact, in terms of the difference the interventions have made to those patients, as well as the reduction in the use of health and care services, is planned for Thrive towards the end of this year.

Primary care continues to deliver its enhanced specification to support residential settings, and this has further been developed to ensure that these standards are met. All PCNs have aligned residential homes and they have established multi-disciplinary teams, although these do operate differently dependent on the PCN and the requirements or preferences of the care homes. Overall, this has led to the development of good relationships with most care homes and effective engagement with the MDT, but there are still areas where further development is ongoing.

Providing the right care in the right place at the right time

The diagram below sets out the HCP's operational model, designed to deliver the right care in the right place at the right time. In particular the model is intended to direct people away from acute care and towards community and home care options wherever appropriate, as depicted in the funnel of transformation on the left of the diagram (and referenced in our previous plans).

Intentions re improving our data collection are referenced above. PCNs will be able to use a wealth of detailed data. Along with their local knowledge, this will give them greater insight into where the significant issues are within their local population. Multi-disciplinary teams, which will include a broad range of professionals linking closely with other health, social care and voluntary services, will be able to identify how to best address health issues within specific communities and support self-care and independent living. The benefit of working with partners outside of health will mean these approaches will not look like traditional health or care delivery. This will support people who might otherwise find it difficult to access care or whose wellbeing difficulties are related to their situation rather than to being poorly.

We plan to create intensive collaboration between different practitioners in the form of Accountable Care Teams. This means we will have teams of practitioners covering different areas of care who will focus on how best to meet the needs of individuals. The functions of the teams will align to the overall priorities of the HCP:

- Each Accountable Team will be responsible, empowered, and supported to deliver changes needed within their area
- Each team will work across organisational boundaries
- Each team will adopt a flexible approach, developing what works and changing what is less effective
- Each team will report to the HCP Professionals Forum for feedback, support, to unblock difficulties, and 'join the dots' so that practice is overseen and evolves over time.

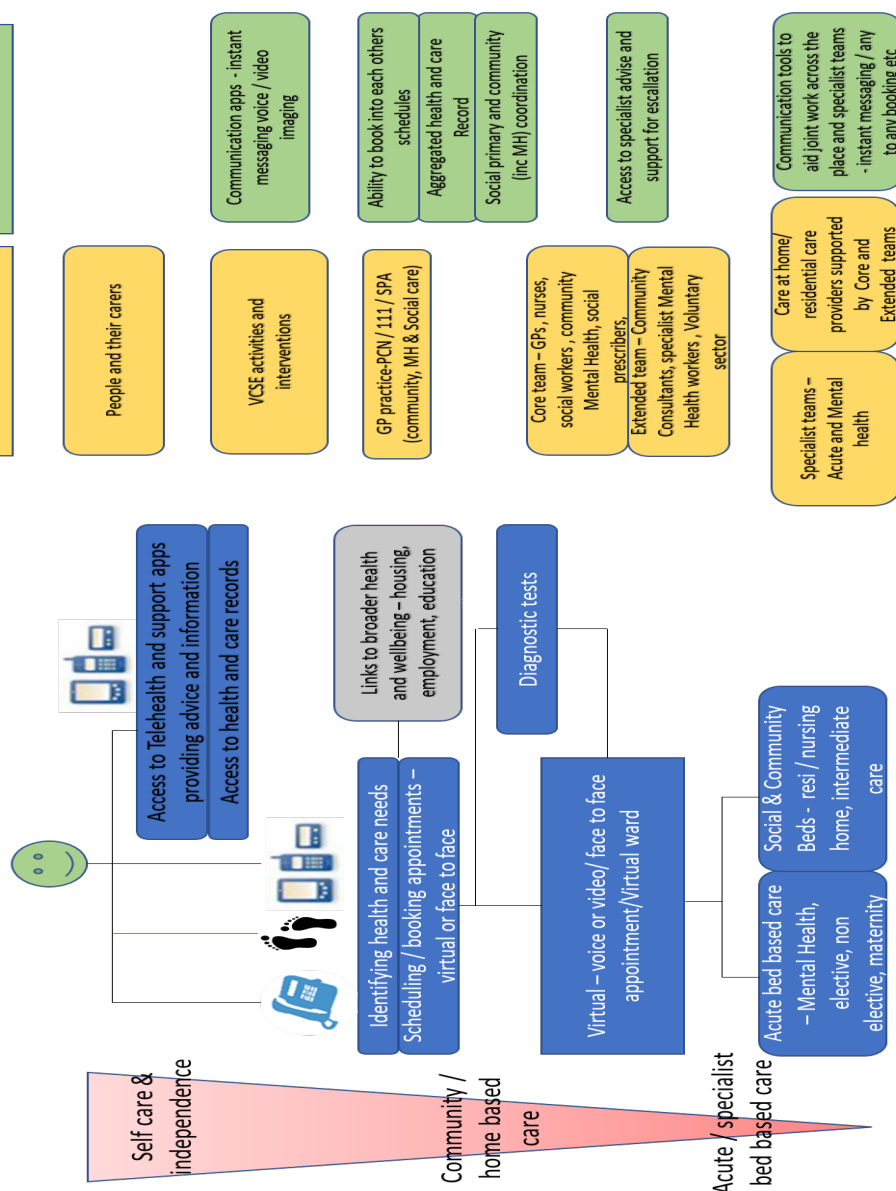


In addition to planning to deliver the right care in the right place at the right time, mechanisms are in place to ensure that problems with delivery are proactively addressed. For example, in addition to ICB contract monitoring and Care Quality Commission regulatory monitoring, provision of commissioned health and care is overseen by the Market Intelligence and Failing Services Group ('the MIFS Group'). The MIFS Group comprises representatives from across health and care, pooling expertise from a range of disciplines. It protects the interests of those with needs in circumstances where providers are finding it difficult to deliver safe and quality services. The Group ensures the regular flow of information about such providers, pooling and analysing intelligence collectively. The Group takes collective action in response to failing or interrupted services; for instance, temporary suspension of referrals until difficulties are remedied, or coordinated action to assess and relocate all residents from their closing care home, regardless of whether they are CHC or social care funded.

The MIFS Group is closely linked with the work of the ICB's quality team. The team facilitates multi-disciplinary professionals to collectively review health and care system intelligence (reported via the shared portal and recorded via incidents and serious incidents). The aim is to seek assurance that problems are properly rectified, share positive practice across the system, and ensure learning is utilised to support wider quality improvements for the system. The team ensures the trends and themes are analysed and followed up, either directly with the provider of care, or for the benefit of all by including items of learning in a widely disseminated bulletin. In conjunction with themes from our shared health and care PALS and complaints function, targeted action helps ensure that the right care continues to be delivered in the right place at the right time.

HCP operational model

### Integrated Place Based Care – 24/7 to meet health and care needs



### Discharge

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

A significant amount of work by all HCP partners (including the hospital trust) has gone into improving the local discharge arrangements and ensuring that we are compliant with national guidance (April 2022).

We have made minor adjustments to our system to ensure we are aligned to the new discharge guidance (April 2022). The model mirrors the mandated requirements in previous iterations of discharge guidance as we have maintained nurse/ health led discharges with input from social care as required. Twenty-four hours after discharge each individual is followed up by an appropriate professional to undertake a full review of the person's needs and follow them through their recovery, recouperation and re-ablement journey. A full needs assessment is then undertaken if longer term needs are identified. BCF funding has funded additional capacity within the hospital discharge team (nurse led) and the community discharge team (social work) to ensure discharge to assess processes can be followed.

Daily community hub meetings are now common practice. These MDT meetings have been expanded to include representatives from the main onward care routes to ensure there is oversight of each person discharging on pathways 1-3 (circa 35 people/ week), following them through their onward care journey to ensure their needs are met. While the daily hub meetings have been very effective in facilitating discharges, the MDT approach begins when a patient no longer has a criteria to reside. To move to a more proactive approach, we have appointed two new proactive discharge coordinator roles which will ensure that discharge planning commences from the point of admission for those who are or are likely to be on a 1-3 discharge pathway from hospital. The roles and daily community hub meetings enable the delivery of change 1,3,4 and 7 of the HICM.

In NEL we are working wherever possible to the principle of 'home first', supporting individuals with voluntary sector support via the British Red Cross and Friendship at Home for example, which has been funded from existing budgets/ winter surge monies. Plus, the provision of commissioned services via pathway one where necessary. The support at home offer (domiciliary care) has continued to be bolstered through 2021/2022 and into 2022/23 due to increased volume and complexity of individuals. On average 95% of people discharging are going home first. This has helped us delivery against the HICM change four.

In addition, BCF funding has been used to contribute to the continued delivery of Cambridge Park our enhanced recovery unit. As noted above, this service is currently going through a phased implementation. The service - once it has reached capacity - will be 42 beds (with an aspiration of 50 beds in the future). Our intermediate care/ discharge to assess bed-based offer within care homes was increased to support with current demand. Following a review of this a slightly different model is currently out to expression of interest to procure 10 block book enhanced recovery beds and a spot purchase framework, delivering to the enhanced recovery specification. These placements will be available from mid-September onwards (this work links to delivering HICM change 2).

The bi-weekly discharge system improvement group continues to grow and is becoming a driver for change, supported by a weekly operational group to deliver the improvements required. A recent self-

assessment against all of the associated discharge guidance, HICM, 100 day discharge challenge and general best practice has led to a discharge system improvement plan, which has recently been signed off at the discharge system improvement group to address any areas for further development. The discharge executive lead oversees the discharge system across Northern Lincolnshire working with neighbouring authorities as required to ensure blockages/ issues are identified and addressed in a timely manner.

In 2022/23 the areas for development are the full operation of Cambridge Park, launch of the enhanced recovery bed block and spot purchase framework, fully embed the newly appointed discharge planning coordinator roles, launch of a discharge SOP (standard operating procedure) for all HCP partners to sign up to clearly articulating roles and responsibilities, develop an NEL discharge and onward care performance dashboard and work to further develop the home first pathway with the launch of the enhanced support at home offer. The delivery of these areas for further development will help us further our maturity against the HICM in change 1,2,4 and 7.

The BCF has funded many elements of the discharge and onward care process including developments in intermediate care to support a timely discharge from hospital for those without a criteria to reside who require a period of rehabilitation and reablement. The service is already seeing improved outcomes for individuals, with 20% of individuals returning home with no on-going support required.

The BCF also funds additional staff to support with the delivery of 7 day working to facilitate discharges 8am-8pm 7 days a week, meaning that individuals are supported to discharge on the same day wherever possible. The additional staff include increased nursing staff to bolster capacity within the hospital discharge team, additional social workers to support holistic needs assessments within the home environment, additional care staff to support within intermediate care services and support at home provision.

## **Supporting unpaid carers.**

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

NEL offers a number of supportive services which are free to unpaid carers, including (but not limited to) carers' breaks via holistic therapies, activity groups, wellbeing groups, visits and trips for peer support and social inclusion, access to training and learning, and a summer support scheme. There are also free advocacy services, befriending, 1-1 focused support, specialist mental health and dementia support, home support (domestic help and carers' sits), and personal care services for the cared for person (in order that a carer with a more complex care role can access breaks and/or necessary life appointments (e.g., for their own health)).

The current year's action plan builds on the work of previous years and ties in with regional aspirations to improve identification of carers, by increasing the range of options for self-referral, improving the ease of access to referral options for professionals, training professionals to better recognise carers and removing barriers of language for communities so they can recognise their caring role (i.e., via targeted social campaigns, and digital solutions). The plan also covers better integration of carers in service feedback systems (ensuring carers are on panels and boards; for example, a carer has recently joined the hospital board), better recognition of carers in learning settings (e.g., schools), and improved partnership working between the council and HCP to ensure a fairer offer for carers of all ages. There are actions to target working carers, via their organisations, to ensure that working carers are empowered and supported to remain in work while caring (through improved awareness/ cultures, carer policies and carers' passports); a carers' charter is also in progress, which will identify carer friendly organisations, ensuring that carers returning to work will be able to choose environments that are supportive to their carer needs. Ongoing work with the hospital, halted due to covid, has also restarted regarding the flexible visiting scheme for carers of those in hospital, to enable carers to support their loved ones while they are admitted.

BCF supports a significant proportion of our prevention, wellbeing and universal support offer for carers.

## **Disabled Facilities Grant (DFG) and wider services**

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

DFG progress has been severely challenged in the last few years, resulting in increased waiting times, labour shortages, increase in costs, and a reduced supply chain effecting the delivery of materials. All continue to affect performance.

However, despite these challenges, there continues to be a greater focus on the DFG agenda. Operationally, occupational therapy (OT), technical team and commissioners meet on a monthly basis to ensure the delivery of the DFG agenda and support creative ways to reduce waiting times and improve outcomes for people through utilising the DFG budget innovatively. This includes continued application of the local Housing Assistance and Disabled Adaptations Policy (launched late 2019 and referenced in our previous plan). Arrangements have been bolstered with a complete review of the DFG process including a new performance template (from inception to completion of works) enabling all key activities that make up the DFG process to be individually scrutinized, performance assessed, managed and monitored by the Operational Team and Strategic Oversight Group.

The DFG strategic group continue to meet monthly with partners from social care, housing, health and finance from across the local authority and ICB to monitor spend. The group has oversight of the delivery of mandatory and discretionary DFGs, and plans the delivery of wider innovative projects under the Council's discretionary powers to support the people of NEL with their housing needs. Several schemes have started over the last year, including:

- increasing the surveying and OT capacity on site, which includes the recruitment of 5 new employees, focused purely on reducing waiting times.
- The development of an award-winning scheme, Cordage View, which was supported by DFG funding to meet a range of complex needs, future proofed adaptations and infrastructure, and assistive technology to foster independence.
- The formation of a minor adaptation 'handyperson' service to capture those low-level adaptive needs that present within SPA; this could see the installation of lower-level equipment around the home such as grab rails and more; helping to keep people at home and independent for longer.

We are working to develop the scope of the handyperson service to respond to holistic housing needs assessments including thermal warmth, sustainable energy, securing loose carpets, and other repairs and maintenance around the home that may impede an individual in having easy egress around their home or which pose a risk of falls.

As indicated in our last plan, we continue to foster an innovative approach (delivered by the DFG Operational Group, which reports to the Strategic Oversight Group) to ensuring the DFG is used to support people to live as independently as possible in their own homes, including:

- Working to support those who have waited for suitable adapted housing on our home choice links register by acquiring stock from social landlords
- Improving the thermal comfort of those who have health conditions which are exacerbated by damp and cold environments

- Utilising existing housing providers across the borough to support DFG adaptations to reduce the DFG waiting times for those in supported living, allowing works to be completed more quickly to support complex needs.
- Developing a trusted assessor approach to minor adaptations, delivering a more direct service and reduced waiting times.

DFG work is undertaken by the Council, ICB and wider partners.

Housing and the DFG lead have been engaged in the development of this BCF plan.

## Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

NEL's approach to tackling health inequalities remains broadly as set out in our BCF plan 2017/19 (pages 14/15) and reiterated in subsequent submissions. As summarised in our last plan, schemes are intended to address inequalities by being accessible to/ reaching out to local people in their communities in a way more likely to tackle disadvantage and increase resilience.

The NHS 2021/22 Priorities and Operational Planning Guidance: Implementation Guidance ('the Guidance') states that the pandemic has highlighted an urgent need to address inequalities. Similarly, the pandemic has amplified existing health inequalities in NEL and continues to impact on provision and planning. The conclusions of the 2020 Director of Public Health's annual report, focused on tackling health inequalities and referenced in our previous plan, remain pertinent. For example, it remains true, as the report highlights, that individuals living in deprived communities are less likely to consume preventative NHS care, to identify risk factors, and to present to healthcare services at an early stage of illness. Such communities are therefore more likely to be admitted to hospital as emergencies and at a later stage of illness, and to suffer worse outcomes. Connect NEL is supporting reduction in inequalities by providing an alternative, non-statutory route to access support and services. Where necessary it builds individuals' confidence through access to other help which supports them to engage with the services they require. By supporting people in this way, we hope to provide inclusive services and proactively engage those at greatest risk of poor outcomes (Guidance priorities one and four).

Changes in the delivery of healthcare during the pandemic, with a focus on more remote methods of delivery for appointments, may have exacerbated inequalities in access, with some groups potentially facing digital exclusion due to factors such as age, skill, income, or lacking devices, data, Wi-Fi and/ or a safe, calm space to engage in digital appointments. Work on digital inclusion and inequality within the system, and at place, is in development. Projects have and are being piloted within the VCSE sector to respond to digital barriers with a view to growing, duplicating and evolving successful projects in the future. Efforts to mitigate digital exclusion support us in addressing Guidance priority two.

ICB and public health colleagues continue to work across the HCP in a range of ways to tackle inequalities in the broadest sense and in ways which are reflective of the CORE20PLUS5 approach; some non-exhaustive examples include:

- Responding to the digital barriers that those with serious mental illness can face (e.g. limited access to technology), there has been a re-focus on annual physical health checks for this population. These can be delivered in person, in people's homes
- Recognising that people with learning disabilities have been adversely affected by both Covid-19 and the social restrictions imposed in the management of it, there has been a



campaign to increase the number of annual health checks completed for this group, and a bowel cancer screening programme, reasonably adjusted to the needs of those with learning disabilities, has commenced. This has involved working with the Learning Disability Wellbeing Team, who can support patients with learning disabilities to explain the health check/ screening, and work with practice staff to ensure that they understand any reasonable adjustments required by those with learning disabilities

- As access to mental health support has been challenging for many, including those who are or were looked after children, the ICB is seeking to introduce a more trauma informed approach via training. Workers have been introduced in several primary care networks (PCNs) which can connect people into VCSE support or into primary or secondary care services as appropriate, stopping people being passed 'from pillar to post', and helping respond to any social issues which may contribute to or exacerbate mental ill-health
- Partnership working between local authority, ICB, and adult mental health provider (Navigo) has seen development of dedicated mental health nurse to jointly support rough sleepers, who often suffer significant disadvantage
- In response to falls in diagnosis rates for dementia, due to reduced referrals into and out of primary care during the pandemic, information and support campaigns have successfully been established meaning referrals to the Memory Clinic are now nearing pre-pandemic levels.
- Creating population data packs for each of our PCNs that identify each PCN's 20% most deprived to facilitate starting conversations about areas/patient cohorts PCNs want to focus their CORE20Plus5 approach on. The intention is to surface "hot spots" of health inequalities and provide a very localised approach to tackling them.

Following the establishment of ICB and HCP, the Union Equality & Diversity Core Group mentioned in our previous BCF plan will become a HCP Equality, Diversity & Inclusion (EDI) Group. The EDI Group will build on the work of the Union E&D Group and continue with Equality Impact Assessment paperwork. The Group's membership will be broadened to include all local partners, and will work to ensure the HCP:

- takes into account the National Healthcare Inequalities Improvement Programme and the CORE20PLUS5 approach
- meets the Public Sector Equality Duty as outlined in the Equality Act 2010 in our direct service delivery and commissioned activities
- works to ensure equitable and inclusive health and care services in NEL,
- works together and with other partners to reduce health inequalities across NEL
- promotes equality, diversity and inclusion across our workforce and communities.

The EDI Group aims to contribute to strengthening leadership and accountability for tackling health inequalities at Place, in support of the Guidance priority five. Local leaders have expressed the intention to develop a Place based EDI strategy and to ensure that work on this topic is directed by and fed into the Health and Wellbeing Board.

The revised Group's key tasks will include:

- monitoring the quality of Equality Analysis and Impact Assessment for service development, strategies and policies
- ensuring procurement processes and ongoing contract monitoring promotes equality and diversity
- participating in the monitoring of equality, diversity and inclusion in the delivery of NEL's engagement strategy (the NEL Commitment to 'Talking, Listening and Working Together')

- overseeing the development and delivery of a joint resource for EDI training, ensuring it incorporates equality impact assessments for staff and volunteers.

As inequalities exist in NEL for those grouped by factors other than protected characteristics, the following groups have also been considered in the work of the Union E&D Core Group (and will continue to be considered by its successor, the EDI Group):

- those with Veteran status
- those living in areas of deprivation
- unpaid carers
- care leavers
- Looked after children.

We referenced earlier in our plan (see page 10) the importance of drawing on accurate data to help us assess whether our efforts to deliver effective services and tackle inequalities are successful. The planned information directory acting as a ‘yellow pages’ of all data held, in conjunction with the new platform to enable evidence-based decisions using data intelligence, will support the work of the EDI Group. Such is also reflective of the requirements of the Guidance priority three.

To ensure that health and care services are designed and delivered in a way which promotes equity of access, we must ensure that engagement and communication methods take into account the needs of people with a protected characteristic, so that those with a protected characteristic are able to fully participate. Communication and engagement activity is monitored. The latest published report can be viewed here:

<https://www.northeastlincolnshireccg.nhs.uk/data/uploads/equality/nelccg-engagement-equality-monitoring-report-20-21.pdf>

More information can be found here: [Equality and diversity - NELC | NELC \(nelincs.gov.uk\)](#) via which a report made in April and updated in June 2022 is available, setting out further detail on local plans (<https://www.nelincs.gov.uk/assets/uploads/2022/07/Equality-Report-June22-a11y.docx>) .