Setting the Scene

North East Lincolnshire Trailblazer Programme

The proposal

Develop a sustainable integrated neighbourhood and urgent community care model that identifies need earlier and enables a left shift from reactive hospital-based care towards prevention, proactive neighbourhood support and enhanced care at home, with a strengthened single point of access connecting people to the right support, at the right time and in the right place.

THREE CORE ELEMENTS

Complex INT | most complex 1%	Intensive coordination for people with the greatest complexity and risk, initially informed by analysis of the highest-use 1% cohort.
Core INTs | next 10%	Scale proactive neighbourhood support across the wider rising-risk population.
Community Urgent Care Team	Expand step-up care through CUCT, with community medical cover, weekend SPA capacity, point-of-care diagnostics and virtual ward support, enabling timely assessment and treatment at home.

Five neighbourhoods: one Core INT and one Complex INT for each INT/PCN registered population, operating as two teams within the same service. Model design and co-design are underway with health, social care and VCSE partners, supported by wider engagement.

Neighbourhood Respiratory Specialist Service (NRSS)

A neighbourhood-based model bringing specialist expertise closer to local communities, offering out-of-hospital specialist respiratory assessment, consultant Advice and Guidance, referral management, diagnostic support, multidisciplinary case review, workforce development, education, innovation and research. Delivered through an integrated partnership across Primary Care, Community Services, Community Cardiology, VCSE partners, Northern Lincolnshire and Goole NHS Foundation Trust, and tertiary respiratory services in Hull to support earlier intervention, seamless pathways and improved outcomes.

Six-month development pathway

OCT 2026 Outline business case → **FEB 2027** Clinical + financial model → **MAR 2027** Fully worked-up business case

How social finance could work

Up to £10m investment over 3 years to support delivery of the proposed models. Repayment is linked to agreed outcomes and benefits, subject to the completed business case.

PAYER / COMMISSIONER	To be agreed with partners through the business case and governance process.
POTENTIAL INVESTOR	Macmillan Cancer Support: an internal investment case is expected to follow the NEL business case.
DELIVERY / HOST	Navigo is the Trailblazer site lead on behalf of NEL Health and Care Partnership; the final delivery arrangement remains part of model design.

Social Finance and Macmillan Cancer Support the wider Trailblazer programme; final local roles, repayment measures and terms are to be confirmed through the business case.

INTs, PCN Proactive frailty, NNHIP + PHM: targeted projects, practical learning

We used population data and local insight to identify priority cohorts, then brought partners together to test earlier, more coordinated support.

10489
Frailty interventions

384
Cancer patients supported

21%
fewer GP appointments in WSU

234
Dementia pathway referrals

18%
fewer A&E attendances in early WSU data

4,490
GP capacity minutes released

1 **UNDERSTAND**
PHM, segmentation and local intelligence

2 **PRIORITISE**
Choose cohorts where need and inequality align

3 **TEST**
Co-design pathways, huddles and coordination

4 **LEARN**
Track activity, experience, outcomes and barriers

MERIDIAN | CANCER

WHY Cancer + early diagnosis showed high resource use and fragmented support for people.

WHAT New pathway, risk assessment and dedicated Cancer Care Coordinator roles in support review and assessment.

IMPACT **495 on caseload • 384 contacted • 210 three-month reviews • 449 contacts released c.4,490 GP minutes.**

PANACEA | DEMENTIA

WHY People and families needing earlier, clearer support around diagnosis and memory decline.

WHAT Did: streamlined SystmOne pathway with primary care, memory services, ConnectNEL and Alzheimer's Society.

IMPACT **So far: 234 referred and contacted for follow-up or wider support. Learning now informs a place-wide scale-up plan.**

WHOLE SYSTEM USERS

WHY An identified group of patients/people created disproportionate repeat demand over three years.

WHAT Behavioural analysis, deep-dive case reviews, blue-dot coding, continuity and targeted support enabled.

IMPACT **Early view 21% fewer GP appointments and better continuity, in testing, with early showing c.18% fewer A&E attendances.**

PROACTIVE FRAILTY

WHY Earlier identification, holistic review and coordinated support for people at risk of deterioration.

WHAT Five PCN teams delivering assessments, reviews, MDT coordination and anticipatory care planning.

IMPACT **10,489 interventions in 2025/26 plus 3,150 in Q1 2026/27, showing proactive delivery at scale.**

NNHIP | TEST, LEARN & SCALE

WHY Test & learn to move from pilots to a repeatable, scalable neighbourhood model.

WHAT Established Meridian huddles, governance and PDSA learning; informed the national Scaling INTs cluster; progressed data, digital, estates and evaluation .

IMPACT **85 people supported through an integrated delivery model , with local learning informing the INT scaling blueprint and the next phase of spread.**

MARMOT LENS: target proportionately to need, include wider determinants, work with communities and partners and measure who benefits, who is missed and whether gaps narrow.

NORTH EAST LINCOLNSHIRE TRAILBLAZER

Integrated Neighbourhood, Urgent & Respiratory Care

Earlier identification • coordinated neighbourhood support • care closer to home

1 WHY? THE CASE FOR CHANGE

Persistent inequalities

Frailty, cancer and multiple conditions occur earlier in some communities.

Reactive and fragmented care

Support often follows deterioration or crisis and crosses disconnected pathways.

Concentrated demand

The highest-use 1% comprises 1,735 residents; 1% accounts for 64% of non-elective bed days (36% live in IMD 1 &2 areas).
Rising emergency admission and A&E attendances.

Access barriers

Transport, digital exclusion, confidence and complex referral routes can restrict access.

2 WHAT? THE SERVICE MODEL

INTEGRATED NEIGHBOURHOOD & URGENT CARE

CORE INTs	Proactive support for the wider rising-risk population.
COMPLEX INT	Intensive coordination for people with greatest complexity and risk.
URGENT CARE	CUCT, SPA, medical cover, diagnostics and virtual ward.
RESPIRATORY	Neighbourhood specialist assessment, advice, diagnostics and MDT review.

One SPA • no wrong front door • step support up or down

3 WHO? PRIORITY POPULATIONS

174,000 registered population

Initial focus: highest-use 1% and wider rising-risk cohort

- Moderate or severe frailty
- Multiple long-term conditions
- Dementia
- Cancer with other health and care needs
- Palliative or end-of-life needs
- High or increasing risk of admission
- Escalating use, fragmented care or social risk

Identified through PHM, risk stratification, linked data, professional insight and neighbourhood intelligence.

4 ACTIVATION & INTEGRATION

ACTIVATED STAFF

Build activated teams around shared purpose, autonomy and interdependent roles, supported by consistent leadership, psychological safety, strong team-level management, regular performance review and visible action on staff feedback, so teams can learn, adapt and improve continuously.

INTEGRATED CARE

Develop accountable multidisciplinary teams for rising-risk patients, with shared information, decision-making authority and proactive personalised care. Simplify pathways by removing duplication, hand-offs, unnecessary referrals and fragmented governance, while enabling rapid specialist input.

Expand the service offer from Community Urgent Care Team with increased medical cover, step up, point of care testing and extended operating hours.

Simplify access through a coordinated front door that connects people to the right support, at the right time, through digital and other access routes.

ACTIVATED CITIZENS

Build citizens' knowledge and confidence to manage their health through low-cost population outreach, targeted support for rising-risk groups, personalised digital nudges, scalable virtual group and peer interventions, and strong links to existing services. Apply behavioural approaches and real-time data to refine delivery, improve outcomes and reduce demand.

INTEGRATED COMMUNITIES

Work with communities and partners to improve the conditions that shape health through stronger local leadership, healthier places, social connection, community-led prevention and better links to local support. Use local data to target inequalities, co-design solutions and scale approaches that deliver sustained health, wellbeing and economic benefits.

5 DELIVERY, INVESTMENT & OUTCOMES

DELIVERY	Phased from Q3 2027/28, starting with highest-risk cohorts.
INVESTMENT	In development
OUTCOMES	Earlier intervention; better experience and independence; fewer avoidable admissions, attendances and bed days; narrower inequalities.

A sustainable, evidence-based neighbourhood model built through partnership, co-production and continuous learning.

Trailblazer Programme

Monthly programme overview | October 2026

What we've done

Key Milestone One: Outline Business Case (Oct 26)

Programme and meeting structure developed
Fortnightly Trailblazer Programme Development Group and Delivery Model Design Group, with dedicated workstreams covering stakeholder engagement, activity and finance, community engagement, governance and legal matters,

Additional resource secured
A dedicated budget has been developed with additional resource secured from the Trailblazer Programme to support the development of the Full Business Case. This includes dedicated programme capacity, finance, governance and legal support

Not starting from scratch
Understanding what's already in place so that the model builds on exiting integrated ways of working such as aligned community nursing and mental health teams, INT projects, CUCT, virtual ward and outpatient transformation

Trailblazer model design developments
An emerging model is in development which links core INTs, intensive coordination for the highest-risk cohort, community step-up/step-down care and neighbourhood respiratory pathways.

Evidence and engagement underway
Cohort analysis, service mapping, outcomes work and the draft service-model template have progressed, with VCSE and lived-experience involvement being developed.

What's next

Key Milestone Two: Fully developed clinical, financial and outcomes model (Feb 27)

Develop the programme links
Improve membership and links between the programme group, design groups, finance/activity, BI and neighbourhood health governance. Ensure developments feedback to avoid duplication,

Complete and test the service proposal
Refine the cohort, operating model, intended outcomes, reach, workforce, costs and assumptions through partners and design group, linking to workstreams – Nov 26 – Feb27

Develop the clinical and financial model
Agree baseline, counterfactual, capacity, activity changes, benefits, payer responsibilities and social-finance repayment principles.

Turn INT and respiratory design into operating models
Define team roles, access, hand-offs, care coordination, 24/7 response, digital requirements and movement between services

Co-production, engagement and wider programmes
Use resident, carer, cancer, dementia, frailty, workforce and VCSE insight, while linking Trailblazer delivery to the wider programmes i.e. Pride in Place and Marmot.

Risks & challenges

Partner engagement & commitment
Inconsistent engagement could delay decisions and weaken ownership.
Mitigation: Named leads, clear expectations and early escalation.

Clinical/Operational model agreement
Lack of consensus could delay the design phase or reduce ambition.
Mitigation: Agree design principles and resolve differences early.

Financial model agreement
Partners may not agree how costs, benefits and financial risk are shared.
Mitigation: Agree assumptions and financial principles transparently.

Clinical & financial alignment
The preferred model may not be achievable within the available financial envelope.
Mitigation: Cost options early and agree priorities and trade-offs.

Pace, scope & governance
Complex dependencies and decision routes could cause delay or scope drift.
Mitigation: Clear milestones, ownership and timely escalation.

Key milestone one achieved: Outline Business Case Developed and on track for sign-off at Navigo Board, HNY ICB Exec and Macmillan Social Investment Ops Group

North East Lincolnshire
Health and Care
Partnership

Neighbourhood Health

Healthy Neighbourhoods through neighbourhood partnerships provide the foundations for prevention and wellbeing.

Universal services support the whole population, integrated teams provide proactive coordinated care for those with higher needs, and intensive case management support the small number of people with the most complex needs.

Right support, right time, right place

NEIGHBOURHOOD HEALTH AND CARE DELIVERY

TOP 1% COMPLEX CASE MANAGEMENT

- Intensive MDTs & care coordination
- Personalised care plans
- Wrap-around, high-intensity support
- For the highest need, highest risk

1%

TOP 1% OF POPULATION
People with the most complex needs who require intensive, coordinated, person-centred case management.

TOP 10% INTEGRATED NEIGHBOURHOOD TEAMS
Team of Teams • MDTs • Proactive Care

Risk stratification | Multi-disciplinary teams | Proactive & preventive care | Care coordination | Integrated working

10%

TOP 10% OF POPULATION
People with higher needs who benefit from proactive, coordinated, multi-disciplinary team support.

PRIORITY COHORTS

- First 1001 Days
- Children & Young People's Resilience and Transition to Adulthood
- Health Inequalities
- Ageing and Dying Well

WHOLE POPULATION
UNIVERSAL HEALTH & CARE SERVICES
Population-wide, single organisation services for everyone.

General Practice | Community Services | Mental Health | Social Care | Housing Support | VCSE Services | Family Hubs | Pharmacy Services

100%

WHOLE POPULATION
Universal services available to everyone, delivered using a proportionate universalism approach, with support provided at a scale and intensity proportionate to need.

Healthy Neighbourhoods – Community-Led Neighbourhood Partnerships

Community Leadership | VCSE Partnerships | Community Voice | Local Action & Social Capital | Prevention & Wellbeing | Asset-based Communities

COMMUNITY-LED NEIGHBOURHOOD PARTNERSHIPS (COMMUNITY PLANS EMBEDDED IN EVERY WARD)

1. East Marsh
2. West Marsh
3. Sidney Sussex
4. South
5. Heneage
6. Fresheey
7. Croft Baker
8. Yarborough
9. Park
10. Immingham
11. Wolds
12. Humberston and New Waltham
13. Scartho
14. Waltham
15. Haverstoe

ENABLING & GOVERNANCE – RUNNING ACROSS THE WHOLE MODEL

Strategic Leadership & Oversight | Integrated Governance & Accountability | Data & Insight Driven | Shared Resources & Investment | Continuous Learning & Improvement | Joint Health and Wellbeing Strategy

DELIVERY PRIORITIES 2027-2030

1. Scaling Integrated Neighbourhood Teams (including children and young people)
2. Planned Care and Outpatient Transformation
3. Urgent Care and Hospital Avoidance
4. Neighbourhood Health Centre Developments

HEALTHIER Together
North East Lincolnshire

Better Health • Fairer Outcomes • Stronger Communities

NEIGHBOURHOOD HEALTH AND CARE DELIVERY

How our top 10% and top 1% teams work

One team for everyday complex care, plus a data-led team for those at greatest risk

1% COMPLEX CASE MANAGEMENT

WHO

The 1% at highest risk, proactively identified from population health data

TEAM

GP
Care co-ordinator
VCSE partners

HOW

Through a holistic approach uncover wider needs not currently being met and coordinate a personalised response

AIM

Fewer non-elective admissions & A&E attendance through earlier, proactive support out of hospital. Better outcomes, quality of life, experience, independence and confidence to manage health.

Step up for intensive coordination · Step back to the INT when stable

10% INTEGRATED NEIGHBOURHOOD TEAM

ONE TEAM

- Joint leadership role
- PCN practice teams
- Integrated community nursing
- Integrated community mental health
- Social care
- VCSE partners

WHO WE SUPPORT

- Frail
- Housebound
- Palliative and end of life
- Multiple LTCs (including cancer)
- Care home residents
- At risk of admission

HOW WE WORK

- One team around the person
- Shared accountability for neighbourhood outcomes
- Direct professional-to-professional communication wherever possible
- Working at the top of competence
- No wrong front door
- Reducing unnecessary duplication, referrals and hand-offs
- Shared decision-making and collaborative problem solving

Right support, right time, right place

URGENT CARE AND HOSPITAL AVOIDANCE

Intermediate urgent care: what we need

Building on CUCT with the medical cover, weekend capacity and diagnostics to step care up at home

TODAY: WHAT WE HAVE

SPA clinical assessment team
Takes calls from the public and HCPs

CUCT
ACPs, acute social care and acute therapies

Step-down virtual ward
Virtual consultant support from the acute trust for patients leaving hospital

WHAT WE NEED TO ADD

Community medical cover

GP, frailty GP or community geriatrician

- Medical support for the CUCT
- Medical cover for step-up virtual ward beds to prevent admission

Weekend SPA cover

More clinical assessment capacity at weekends

Point of care testing

Blood tests · Chest X-ray · Bladder scan

Goal: step up as well as step down, so more people are treated safely at home instead of being admitted

NEIGHBOURHOOD HEALTH AND CARE DELIVERY

Neighbourhood Operating Model

A consistent set of principles and outcomes, delivered through locally agreed arrangements

CORE OPERATING PRINCIPLES

1 ONE TEAM
One team around the person

2 SHARED
Accountability and decision-making

3 DIRECT
Professional-to-professional communication

4 PROACTIVE
Prevention, early intervention and top of competence

5 SIMPLER
Less duplication, referrals and hand-offs

LOCAL FLEXIBILITY • CONSISTENT FUNCTIONS • SHARED NEIGHBOURHOOD OUTCOMES

4 CONNECTED COMPONENTS

Sustainable improvement across workforce, care, citizens and communities

1 ACTIVATED STAFF
Trust and shared purpose
Leadership development
Psychological safety
Continuous improvement

2 INTEGRATED CARE
Multidisciplinary working
Priority cohort management
Streamlined pathways
Coordinated planning

3 ACTIVATED CITIZENS
Understanding health needs
Supported self-management
Shared decisions
Prevention and wellbeing

4 INTEGRATED COMMUNITIES
Residents as partners
VCSE collaboration
Wider community assets
Local test and learn

CORE FUNCTIONS

- Demand & capacity
- MDT case review
- Population health
- Care coordination
- Escalation
- Advice & guidance
- Information sharing
- Workforce & improvement