Welcome

York VCSE Assembly

Health and Care

Wednesday 17 July 2024

Humber and North Yorkshire
Health and Care Partnership

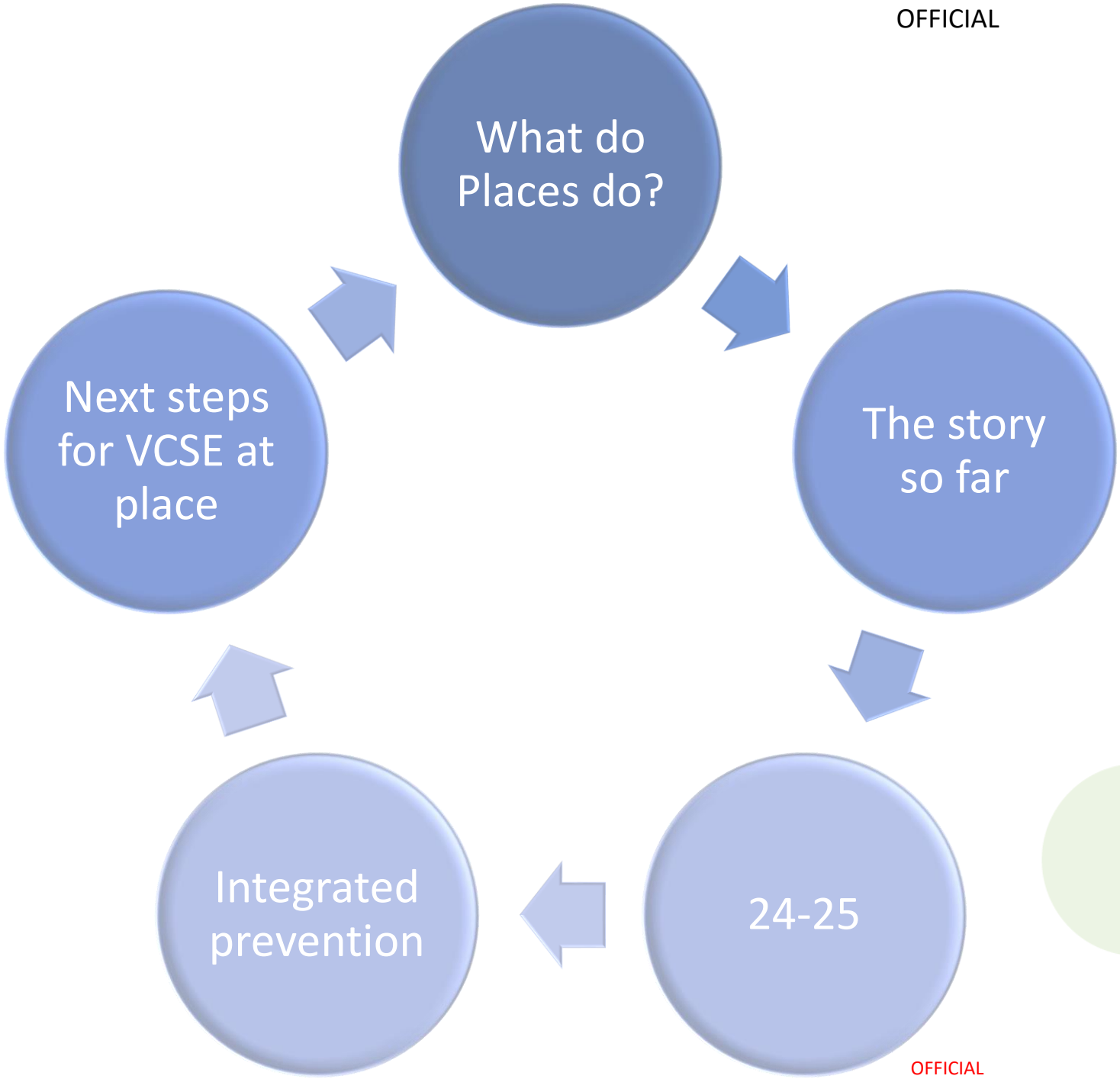
NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

VCSE Assembly

17th July 2024

Sarah Coltman-Lovell

NHS Place Director, York Health and Care Partnership


What do Places do?
The story so far
24-25
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Humber and North Yorkshire
Health and Care Partnership

What Places do

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Places are central to driving our aim in narrowing the gap in health inequalities and increasing healthy life expectancy. They are focused on delivering outcomes for our people and communities that span the life course of start well, live well, age well and die well and the ambitions of enabling equity, improving outcomes and experience of services.

They connect people, communities, democratic leadership, business, public sector partners, educational establishments, voluntary, community and social enterprise, local authorities, the NHS and other providers of health and care to engage, lead and own shared plans that will deliver change and enable people to thrive.

Partners at place work together to reduce social and health inequalities and support the integration of services. They harness the collective leadership to lever the totality of resources at Place and will collaborate and act as one where is makes sense with an emphasis on leading for excellence, prevention and sustainability.

Humber and North Yorkshire
Health and Care Partnership

How We Work Together

NHS
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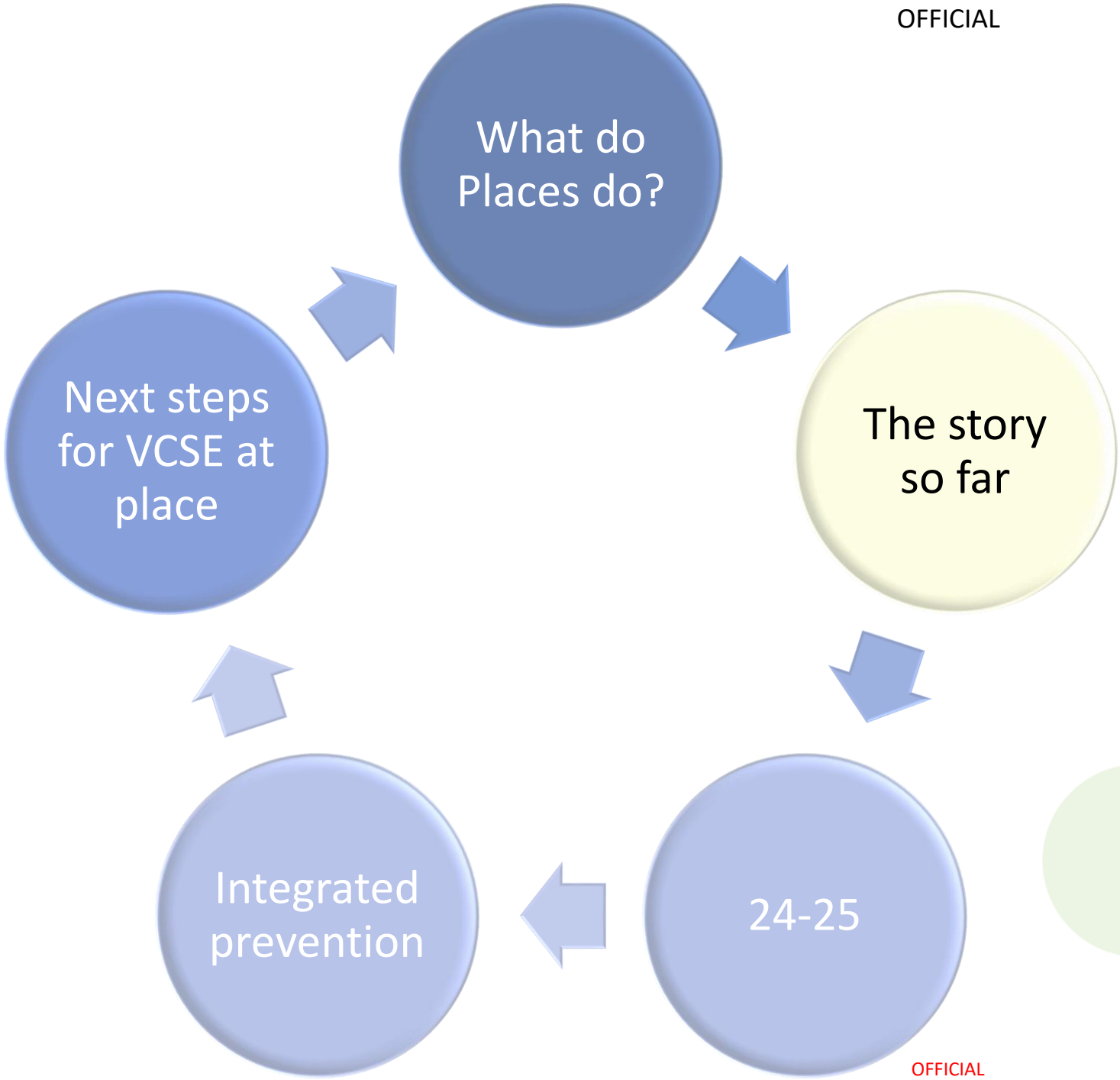
Integrated Care Board (ICB)

Partnership at Place takes many forms and is broader than governance and integration for health and care. This may involve formal legal and budgetary agreements and also a broader range of activities for the common good of our communities. Key aspects are:

In Place – aligning or pooling our budgets, integrating relevant services, understanding our performance and pressures, engaging with our local populations, developing and delivering on shared priorities

Across the 6 places – on major investment, large-scale service re-configurations and government-level actions and influencing

Mayoral Combined Authorities provide new opportunities to scale our shared ambitions – Places will be represented through their elected leaders.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The story so far

Dec – Mar 22/23

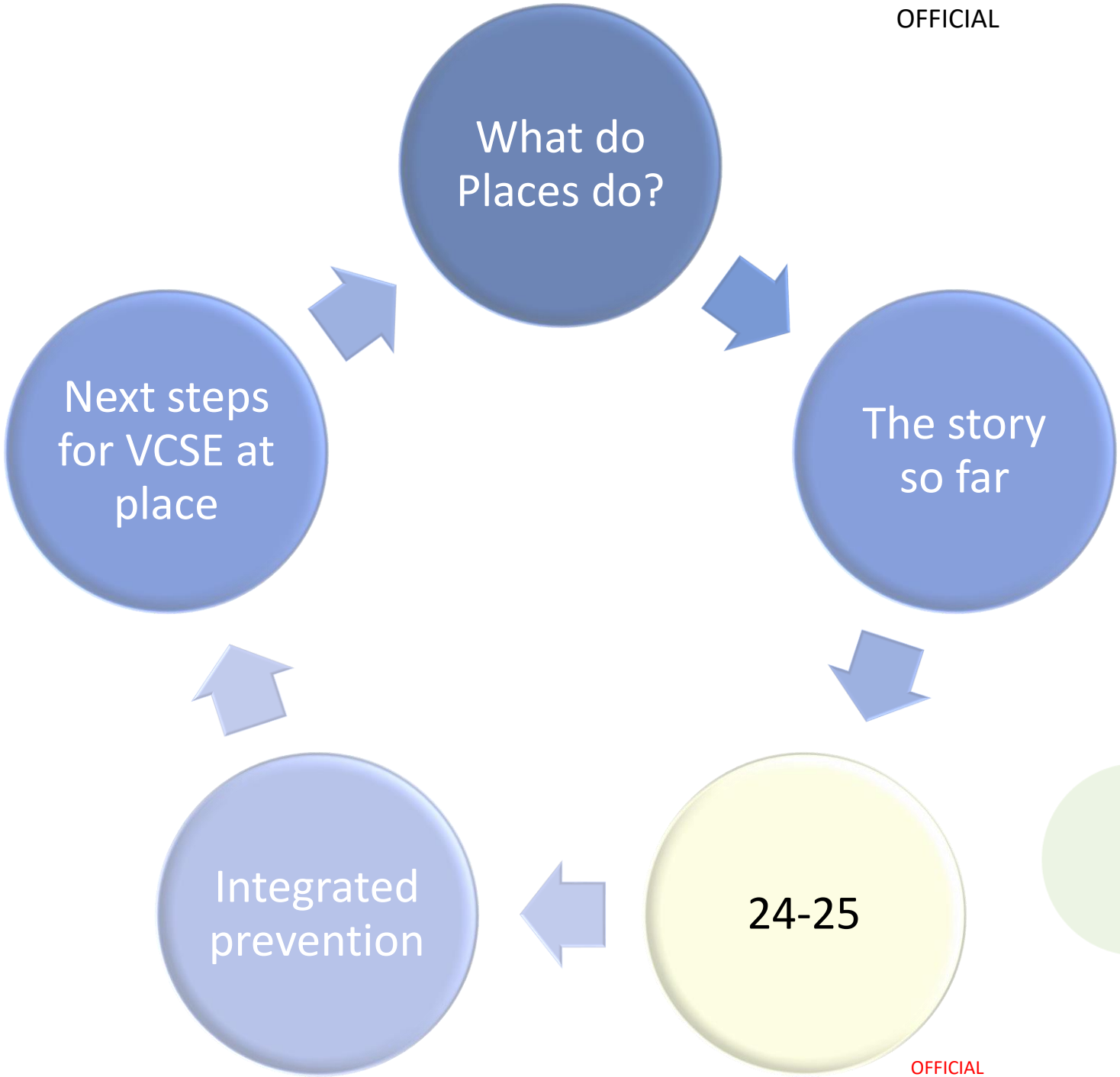
- Place Director appointed
- 6 shared objectives agreed by Place partners to deliver for York's Health and Wellbeing Strategy and Humber and North Yorkshire's Health and Care Partnership Strategy over the next 5 years

Apr – Mar 23/24

- New administration
- New hospital Chief Operating Officer
- New ICB Place Team
- New Director of Public Health
- New Director of Adult Social Care
- New Council Plan 2023-2027
- First joint delivery board established (mental health)

Apr - Sep 2024

- First York Health and Care Partnership annual report
- Places come together to agree what places will do and how they will work
- Decision to initiate dialogue with ICB and City of York Council Executive to transfer responsibilities to Place
- Joint commissioning forum established to oversee transfer programme
- Future service model workshops
- Second joint delivery board established (frailty)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Place in 24-25:
We have agreed our Direction of Travel

YHCP strategic intentions for 2024/25: Signal our intentions to increase responsibility for services organised at Place level, taking a phased approach to deepen collaboration, build from experience, and embed learning.

- Take steps to accelerate delivery of shared objectives through joint planning and formalising integration arrangements that is financially better and leads to better outcomes.
- Enable our front-line teams to work to aligned budgets, plans and outcomes, particularly in services which target broadly the same population groups and outcomes.
- Harness the strength of our strong, independent organisations to pool and direct our collective capabilities to deliver for York and represent York in the wider system.
- Work with the other five Place health and care partnerships and ICB via a Strategic Framework
- Develop a Service Offer which helps to overcome the unprecedented challenges we face and demonstrate the premium of place.
- Strengthen our governance arrangements to make it happen, building shared responsibility for delivery and accountability for outcomes, to shift decision-making to place.

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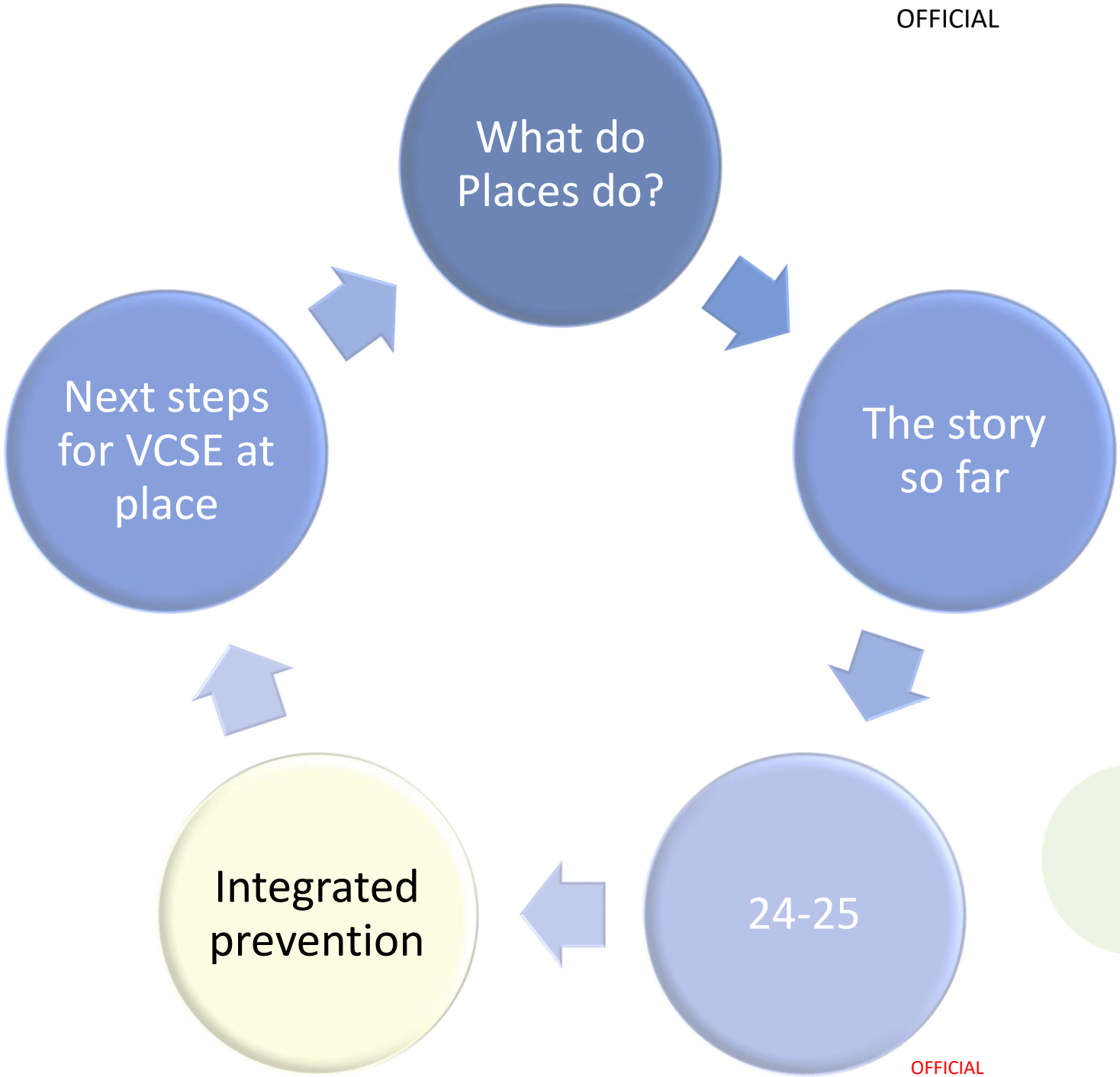
Place in 24-25:
We have agreed our Route to get there

1. **Learn how to do this well by delivering our priorities in 24/25:**
   a. Agree the locality/neighbourhood model which will guide asset-based community development, prevention, and service delivery in and across York for the long term.
   b. Review and design an integrated prevention offer.
   c. Multi-agency design (families, mental health, and frailty hubs).

2. **Formalise integration:**
   a. Align outcomes and resources through joint delivery boards to support partners in place to collaborative, innovate and integrate – aligned to each of our priority areas of prevention, families, mental health, frailty. We already have a model in place for mental health.

3. **Governance:**
   a. Prepare for transfer of responsibilities to Place from April 2025.
   b. Assess the state of readiness as a system to support delegated functions through a mutually agreed Section 75 arrangement.
   c. Work towards a signed Partnership Agreement.

4. **Place Committee Actions: taking account of feedback from the March YHCP and ongoing discussions with partner organisations, it is proposed that we will:**
   a. Develop a shared narrative about what we are doing and why.
   b. Behave as one leadership team and help our workforce do the same, at every level.
   c. Create the bandwidth in our organisations to engage in dialogue that finds better ways of delivering services across physical and mental health, social care, and wider determinants of health.
   d. Enable our communities to shape, participate in, and take ownership of their services.
   e. Conduct quality impact assessments of proposed changes to adopt a consistent approach, hold ourselves to account and promote continuous learning.
   f. Establish a joint commissioning forum (without formal delegated powers in 24/25) to oversee preparations for a Joint Committee and co-opt expertise from ICB/LA as required.
   g. Establish how, by working differently, we can drive out avoidable costs, and shift allocation to support prevention, better care, and sustainability. Start with open communication on how each partner is reducing waste and optimising costs. This is an example of practice from North East Lincolnshire and will support YHCP to create a financially healthier system in readiness for transfer of responsibilities, resources, and decision-making.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What do we mean by prevention?

	LGA definition
Primary Prevention	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.
Secondary Prevention	Systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.
Tertiary Prevention	Softening the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy.

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Prevention in the Labour manifesto

- Labour's reforms will shift our NHS away from a model geared towards late diagnosis and treatment, to a model where more services are delivered in local communities. We will harness the power of technologies like AI to transform the speed and accuracy of diagnostic services, saving potentially thousands of lives. And we will **embed a greater focus on prevention throughout the entire healthcare system and supporting services.**

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Prevention in the Labour manifesto

- To rebuild dentistry for the long term, Labour will reform the dental contract, with **a shift to focusing on prevention** and the retention of NHS dentists. We will also introduce a supervised tooth-brushing scheme for 3- to 5-year-olds, targeting the areas of highest need.
- Prevention will always be better, and cheaper, than a cure. So, we must **take preventative public health measures** to tackle the biggest killers and support people to live longer, healthier lives. That starts with smoking. Labour will ensure the next generation can never legally buy cigarettes and ensure all hospitals integrate 'opt-out' smoking cessation interventions into routine care.
- Labour will **tackle the social determinants of health**, halving the gap in healthy life expectancy between the richest and poorest regions in England.

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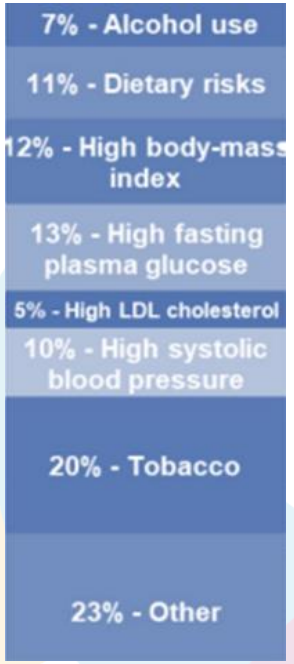
Review and Design an integrated prevention offer

Place Senior Responsible Officer: Peter Roderick

1. The future health of the population, in the context of our ambition to close the gap in healthy life expectancy between the highest and lowest communities by 2030 and increasing healthy life expectancy by five years by 2035
2. Unhealthy ageing isn't inevitable - the life expectancy gap is driven by preventable and manageable diseases
3. Around 42% of the burden of poor health and early death in England is attributable to modifiable risk factors
4. The burden of ill health and deaths fall disproportionately on the most vulnerable
5. Around 25% of health is determined by care, around 50% is made of socio-economic factors like housing, education, employment, living and working conditions.
6. **Our role in Place is to focus on the interventions we know work and have the greatest impact**



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Our role in Place is to focus on the interventions we know work and have the greatest impact

1. **Stroke** is the third most common cause of premature death and a leading cause of disability in the UK. More than a quarter of patients leaving hospital experience moderate to severe disability following a stroke.

2. **Hypertension** is one of the most important modifiable risk factors for CVD, stroke, ischaemic heart disease (such as angina, heart attacks, and heart failure), and renal disease.

3. **Dementia** is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20% at 80 years of age (Alzheimers Research UK).

4. Nationally, around 4.5% of all people aged over 40 live with diagnosed **COPD.** In 2012, 5.3% of all UK deaths were due to COPD (British Lung Foundation).

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	714	1,146	1,379
Kingston upon Hull	386	585	654
NE Lincolnshire	381	602	704
North Lincolnshire	389	632	734
York	705	1,116	1,312
N Yorkshire	1,201	1,921	2,305
HNY Total	**3,777**	**6,002**	**7,089**

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	3,097	4,867	5,933
Kingston upon Hull	1,987	3,036	3,420
NE Lincolnshire	1,160	1,834	2,163
North Lincolnshire	1,622	2,617	3,091
York	2,713	4,206	4,860
N Yorkshire	4,473	7,118	8,729
HNY Total	**15,052**	**23,679**	**28,196**

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	432	698	835
Kingston upon Hull	231	349	390
NE Lincolnshire	183	289	337
North Lincolnshire	205	333	385
York	317	507	600
N Yorkshire	671	1,074	1,278
HNY Total	**2,038**	**3,250**	**3,825**

Increase in cases compared to 2023:			
	2030	**2035**	**2040**
East Riding of Yorkshire	869	1,400	1,679
Kingston upon Hull	911	1,377	1,539
NE Lincolnshire	519	820	959
North Lincolnshire	516	839	971
York	599	954	1,126
N Yorkshire	1,161	1,857	2,219
HNY Total	**4,575**	**7,247**	**8,494**

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Our role in Place is to focus on the interventions we know work and have the greatest impact

1. There is a clear association between increasing age and CKD prevalence; with 1.9% of people under 65 having CKD stage 3-5, rising to 32.7% of people aged 75 plus (OHID **Chronic kidney disease** prevalence model)

2. **Heart failure** accounts for about 2% of all NHS hospital bed-days and 5% of all emergency admissions (NICE, 2018a)

3. Cancer Incidence rates are strongly related to age, with the highest incidence rates being in older people. In 2023, there were 74,067 new cancer cases diagnosed in HNY. By 2040, this is projected to grow by 16% to 85,752 new cases per year.

4. **The burden of ill health and deaths fall disproportionately on the most vulnerable**

5. **All drive the increase in GP and outpatient appointments, planned procedures, A&E attendances, emergency admissions, hospital stays, dependency on care services**

Increase in cases compared to 2023:

	2030	2035	2040
East Riding of Yorkshire	1,492	2,401	2,883
Kingston upon Hull	717	1,085	1,213
NE Lincolnshire	782	1,237	1,446
North Lincolnshire	661	1,075	1,246
York	1,097	1,743	2,054
N Yorkshire	2,426	3,880	4,643
HNY Total	**7,176**	**11,420**	**13,485**

Increase in cases compared to 2023:

	2030	2035	2040
East Riding of Yorkshire	416	668	803
Kingston upon Hull	204	309	346
NE Lincolnshire	134	211	247
North Lincolnshire	167	272	315
York	371	588	692
N Yorkshire	625	999	1,199
HNY Total	**1,917**	**3,048**	**3,602**

in cases compared to 2023:

	2030	2035	2040
East Riding of Yorkshire	1,340	2,145	2,584
Kingston upon Hull	692	1,049	1,175
NE Lincolnshire	503	796	932
North Lincolnshire	594	963	1,121
York	1,115	1,761	2,066
N Yorkshire	1,981	3,166	3,809
HNY Total	**6,225**	**9,879**	**11,685**

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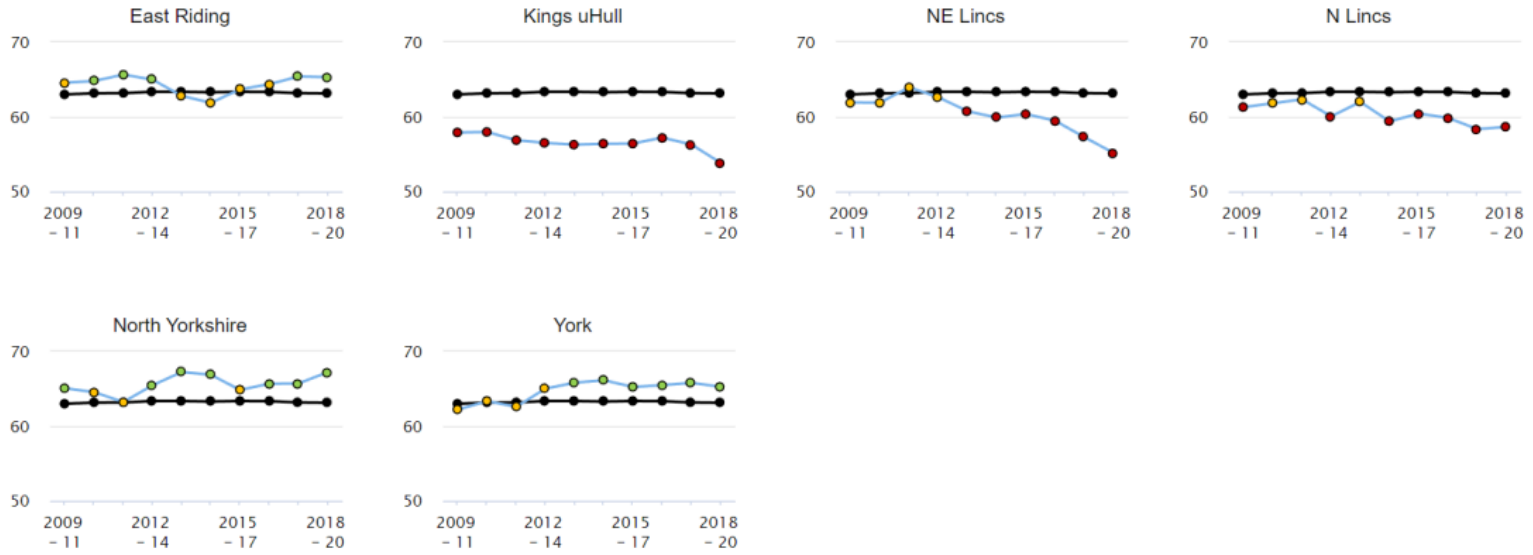
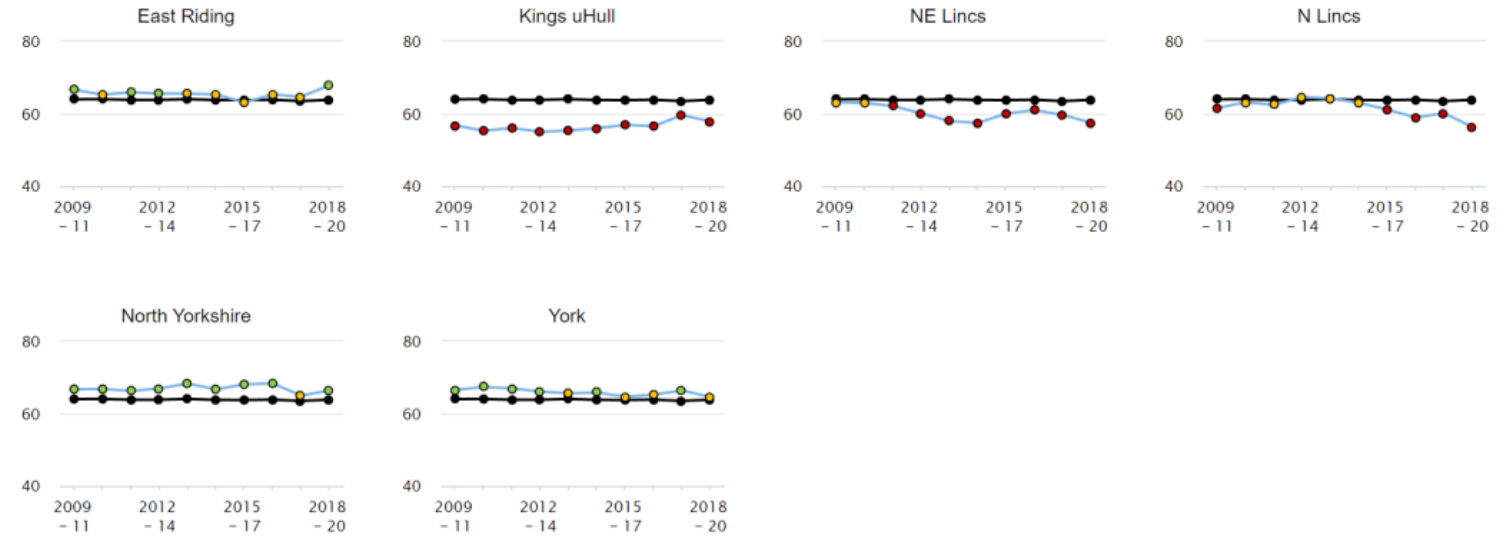
A01a - Healthy life expectancy at birth (Male)



A01a - Healthy life expectancy at birth (Female)



Looks like we're doing ok…

But what about the gaps between communities within York?

Micklegate, Fishergate, Guildhall, Heworth and Hull Road have higher numbers of households with overcrowding than the national average.

1 in 7 live with depression

Hull Road, Clifton, Heworth, Fishergate, Guildhall and Westfield all have high proportions of households in fuel poverty.

York 009D (Bottom 20% IMD)
Clifton Ward
Example street: Kingsway North

York 018B (Bottom 20% IMD)
Clifton Ward
Example street: Crichton Avenue

13% of children are living in low income families (7.7% of children live in a household where a parent or guardian claims an out-of-work benefit)

2 in 3 adults overweight or obese

York 018C (Bottom 20% IMD)
Westfield Ward
Example street: Chapelfields Road

In 2020 there were 13,172 people were living in fuel poverty, representing 14.7% of the population (likely to be much higher now due to COL crisis)

Westfield has the highest number of UC claimants and Heworth Without the least.

Life expectancy difference between wards is a stark 10 years for men and 6 years for women

1 in 10 people smoke

York 018B (Bottom 20% IMD)
Hull Road Ward
Example street: Alcuin Avenue

York 018F (Bottom 20% IMD)
Westfield Ward
Example street: Foxwood Lane

York 018B (Bottom 10% IMD)
Westfield Ward
Example street: Kingsway West

According to statistics released by the End Child Poverty Coalition, in York there are 7,443 children classed as living in poverty.

What about the 9,711 people (4.6% of the population) who live in LSOAs which are amongst the 20% most deprived in England?

What about the 1,680 people (0.8% of the population) who live in an area which is among the 10% most deprived in England?

What about the groups we know experience greater health inequality irrespective of where they live?

Ethnic minority communities

People with multi-morbidities

People experiencing homelessness

Drug and alcohol dependence

Vulnerable migrants

Gypsy, Roma and Traveller communities

Sex workers

Students

Our starting point was to understand the prevention services in York, the gaps, duplication, and areas of improvement.

- Behaviour change – smoking, alcohol, weight, loneliness
- Health champions in community
- Local area resilience and social inclusion
- Tackling determinants of health through social prescribing – loneliness, isolation, financial
- Prevention of disease/delay progression in general practice
- GP list-based searches, optimising health whilst waiting for elective procedures, cardiovascular health
- Clinical health coaching for patients at risk of high intensity emergency care use

Themes

- Some confusion amongst referrers - a single referral point could make the referral / self-referral process easier for all
- Minimal overlap but an MDT approach could help make best use of expertise, where service users are discussed between professionals
- Is there opportunity to maximise efficiency between services by sharing admin function?
- How will services align with localities/integrated neighbourhood teams?
- How will services use PHM to target resources effectively?
- How do services engage under-served population groups, including use of translation services?
- It would be beneficial to adopt an outcomes-based approach, across services, ideally using linked data sets to track induvial level patients.

Our next step is to streamline prevention services and use the totality of existing prevention budgets to maximum effect

Action plan to be developed with prevention services across the system.

Expert steering group convened to oversee integration and improvement activities, including drawing on insight from real people in York most likely to benefit

Use this prevention exercise in shaping future resource decisions around prevention services and Integrated Neighbourhood teams

Use the Population Health Hub as a key asset to supply the undergirding data, insight and population health management input to prevention services, including work on:

- Case-finding (identifying people most at risk / most likely to benefit from prevention)
- Linked datasets (identifying where people are accessing multiple parts of the healthcare system)
- Needs (understanding communities in York affected by health and healthcare inequalities)

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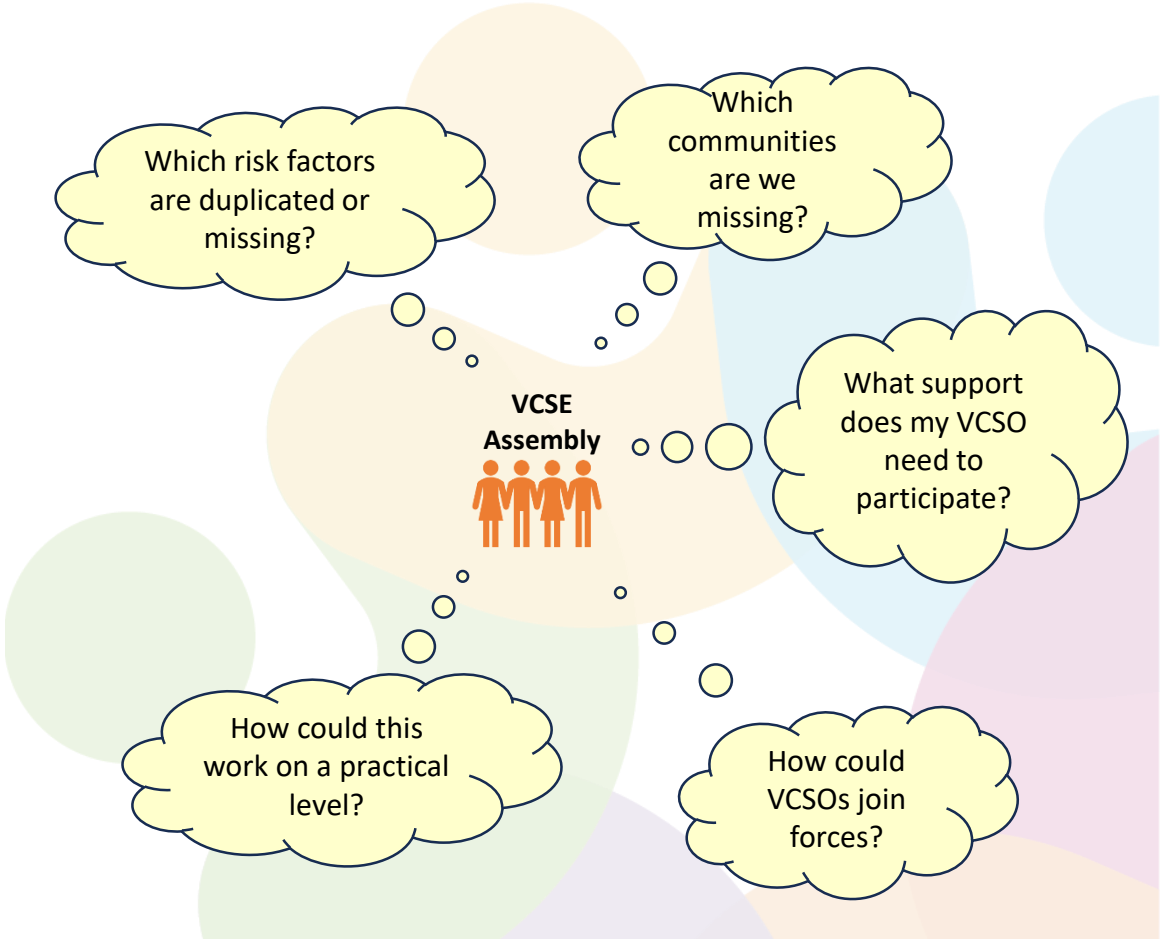
Our role in Place is to focus on the interventions we know work and have the greatest impact

	Current position in York	Impact on the system in York	E.g. preventive Interventions
Falls (over 65s)	2000 falls-related admissions per year	• £252 ambulance call out • Average 12 days LOS • Average £5200 cost per admission	• Strength and balance exercises • Medication reviews • Tackling hazards
Loneliness	25% (over 44,000 adults) feel lonely all or most of the time	• Loneliness is the equivalent of smoking 15 cigarettes a day	• Local Area Coordination • Befriending • Community development
Smoking	14,000 regular smokers	• 200 deaths p.a. • £3m cost to social care p.a.	• Cessation services
Alcohol	36,000 people drinking over recommended amount	• £91.7m p.a. cost to society in York • 3,753 alcohol-related admissions p.a.	• Brief advice • Treatment
Condition management	1,791 admissions to hospital for ambulatory care sensitive conditions in 2023	• Combined acute costs of ACS admissions c £8m	• COPD control e.g. MyCOPD • Condition reviews • Self-management / peer-led
Cardiovascular events	100 strokes p.a. 600 new BP cases p.a.	• New onset strokes cost £45 k in the first year & £25 k in subsequent years	• Blood Pressure monitoring • Physical activity interventions

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Next steps for VCSE at Place

Aligning commissioning budgets

- Visibility of NHS and Council budgets
- Enabler to provider integration
- Outcomes-led approach

York Health and Care Collaborative

- Mutual respect, trust, and open communication
- All partnership work passes through here
- The driving force of health care and prevention in the York Health and Care Partnership
- Address inequalities, equity and promote prevention
- How would representation work?

Joint Delivery Boards

- Formalise integration between providers with as little structural reorganisation as possible
- Mental Health and Frailty - multi-agency provider representation
- Common set of a few measurable outcomes.
- Demonstrate added value from combining resources including shift to non-statutory
- Facilitates joint governance, workforce and estates planning

Group Discussions:

How can the VCSE sector support York's health priorities?

How can we 'get ready' for opportunities that might arise to design and deliver these health and care priorities?

Health and Care Update / York VCSE Assembly Survey Results

Alison Semmence

Chief Executive, York CVS

VCSE Assembly Survey 2024

Topics and themes to explore at future meetings:

- Transport
- Inequalities in York
- Improving commissioning processes
- Adult wellbeing
- Young People
- Digital inclusivity / digital access
- Public access to health and care partnership meetings
- Preparing ‘over ready’ proposals
- Health and social care developments

Timing, frequency and method of VCSE Assembly meetings:

- General consensus that a combination of face to face and online meetings would be the preference

Comments:

- Dedicated time for networking during face to face meetings
- Face to face is important for networking
- Online opens up the meeting to more people

VCSE Assembly Survey 2024

Other comments / feedback:

- More clarity about how the system works – for those who attend the meetings and for those who don't
- Sometimes information is received a little late but it is relevant
- Talk about impact and share case studies to show the amazing work the sector is doing

Share your feedback:

- Complete the survey here – https://www.surveymonkey.com/r/York-VCSE-Assembly-May24
- Email: anna.boad@yorkcvs.org.uk

VCSE Collaborative Communications Update

Anna Boad

VCSE Collaborative Communications Lead

Anna.boad@nhs.net

Events and learning opportunities

Humber and North Yorkshire Health and Care Partnership

- 23 July (12:30pm) – Menopause Awareness at Work
- 11 September (12noon) – Domestic Abuse Awareness webinar
- 26 September (5pm) – Breath work for stress, anxiety and overwhelm
- Click on the follow links to find more information and tools Ambassador toolkit, Ambassador Programme plus our resources page where you can find lots of helpful and inspiring information!
- View all events here: Humber and North Yorkshire Health and Care Partnership - Booking by Bookwhen

- NHS Humber and North Yorkshire Integrated Care Board (ICB) held their AGM on 10 July 2024. This was streamed via YouTube and can be watched back at: www.youtube.com/watch?v=kbpTNB1cX0A.

VCSE Collaborative Communications

Humber and North Yorkshire
Health and Care Partnership

VCSE Collaborative communications aims to showcase the sector's work, knowledge and experience, and to share opportunities and connect the VCSE sector with the wider Humber and North Yorkshire Health and Care Partnership.

Bi-monthly e-bulletin: View the latest issue here
Website: Find out more about our programmes of work here

Share your updates with us – submit your case study here

Comms email: anna.boad@nhs.net | **VCSE Collaborative email:** hnyicb-ery.vcseteam@nhs.net

Sign-up to our mailing list here

Shaping York Community Fund

Thomas Waring

Head of Grants, Two Ridings Community Foundation

Shaping York Community Fund

The York Community Fund is a new independent fund, administered by Two Ridings Community Foundation. It has been created for the people who live, work and study in York, to support vibrant and purposeful community action that actively improves the wellbeing of everyone in the city. It also provides a point whereby donors can collectively contribute into a fund specifically for York people and communities.

What are the needs and opportunities you are seeing / experiencing in York's communities that could benefit from resource and support through this funding?

Complete the survey here

Thank you and close

Next Meeting:

24 September, 1pm – 3pm, Denham Room