Annex A

Report of York Health and Care Collaborative; Update March 2021

1. Introduction

This report provides update on the work of the York Health and Care Collaberative (YHCC); briefly outlining the scope of each priority workstream and progress that has been made since the initial report to the Health and Wellbeing Board in October 2020.

2. Progress on Priorities; 2020/2021

As would be expected, the Covid-19 pandemic has influenced our ability to make progress, this was particularly marked over December, January, and February, as organisations and professionals again focused on tackling the impact of Covid-19 as well as dealing with the additional workload associated with the winter months and in implementing the vaccination programme. However, progress has been made in each of the YHCC priority workstreams;

- Prevention
- Ageing Well/Frailty
- Multi-morbidity
- Mental Health
- Covid-19 Preparedness and Resilience.

2.1 Prevention

The responsibility for leading health promotion and prevention activities across the city is with City of York, Public Health directorate, although prevention is the business of all partners represented at YHCC. YHCC provides a forum to share population health intelligence and identify where a collaberative approach can increase the impact and effectives of interventions. Given the potential broad scope of this work the approach has been to identify three main areas of focus (which are then considered by YHCC each month on a rolling basis);

a) **Smoking**; in November YHCC received the City of York Tobacco Control Plan, and identified areas for opportunity for cross-system collaboration, particularly in targeting vulnerable groups by applying the 'every contact counts' principle e.g. linking up with existing initiatives such as SMI Heath Checks and improving links between the Health Trainer Service, who offer smoking cessation support and other health and social care staff. The Tobacco Control Alliance continues to oversee this work and will identify specific joint initiatives/actions.

b) **Substance misuse**; drugs and alcohol; in December YHCC considered the population health intelligence on alcohol misuse, where overall York performs poorly on most indicators. It was agreed that the Alcohol Clinical Leads Group membership would be reviewed to ensure that all stakeholders were represented, and to work more closely with primary care. This group has now been reinstated and is focussing on a pilot of a small Primary Care Alcohol intervention service in the city with two members of staff delivering interventions for the 'middle tier' of residents whose drinking is harmful and

cannot be managed in primary care, but who do not meet the threshold for alcohol dependency treatment.

c) **Weight management, obesity and diabetes**; this will be a priority for work in 2020/21, linked to the work on multi-morbidity. The Healthy Weight Steering Group continues to meet and deliver work on the wider determinants of healthy weight (through the Healthy Weight Declaration) and weight management pathways, the city's physical activity strategy, and work to tackle excess weight in childhood.

2.2 Ageing Well, Frailty and Multimorbidity

a) Ageing Well and Frailty

A multi-agency, multi-professional group has been established to take this work forward and has met twice. Informed by the initial base-line assessment the following priorities have been identified;

- Improving the use of eFrailty (a population risk stratification tool which identifies groups of people who are likely to be living with varying degrees of frailty) in general practice to improve the identification of patients with frailty.
- Establish a consistent way of assessing frailty by recommending the use of the Clinical Frailty Index (Rockwood) Score[1] and promoting its widespread use.
- Developing a stratification tool that can be used consistently across health and care settings, so that people with frailty and health and care staff are clear about what support and intervention is needed and how this is provided.
- Working with the York Ageing Well Partnership to promote healthy ageing, with an emphasis on addressing and preventing deconditioning (given the impact of the Covid-19 restrictions on this).

Work has started to develop a stratification tool and work is underway with the Ageing Well Partnership to develop a joint approach about what people can do in their home and community to prevent deconditioning, starting with a joint communication initiative.

b) Multi-Morbidity

Work started in December 2020 to develop a population health management approach to addressing the needs of people with multi-morbidity; diabetes has been identified as the priority for this approach in 2021/2022, as it has been shown to be the most common 'first' condition that people in York develop who go on to live with more than one long term condition. The Population Health Management approach is being supported by NHS England/Optum and currently clinical and professionals are in the middle of this 20-week learning programme.

[1] https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf

2.3 Mental Health

The responsibility for leading mental health transformation is with the Mental Health Partnership. YHCC supports two main aspects of this work; the aim to achieve better integration of mental health into the broader provision of community and primary care services, where joint work has recently started and good progress is being made, and in addressing the need to improve the physical health of people with severe mental health illness (SMI), in particular by addressing the need for good uptake of Health Checks for people with SMI. This continues to present challenges, as often patients don't attend for their check. Work on this will therefore continue, aiming to identify new ways of supporting patients e.g. by working more closely with the Voluntary Sector.

2.4 Covid-19 Preparedness and Resilience

The York Covid Resilience and Response Group is a multi-agency group that has been in operation since March 2020, to lead and coordinate the Covid-19 response between community services (both physical and mental health) primary care services and local authority services. The aims of the group are;

a) to ensure that all sectors are briefed on up to date epidemiology so that they are able to plan their response
b) to provide a forum to share information, problem solve and provide mutual support
c) to identify people/patient groups where a coordinated response is needed to provide more effective services, particularly for people/patient groups who are more vulnerable or at greater risk.

Covid Support Hub – SPA (single point of access); The group identified that unless identified as very unwell and referred on, patients with Covid-19 are advised to self-isolate and contact 111 or their GP if they later feel unwell. Concerned that patients may not always recognise how ill they are, especially around day 7 where there is significant risk of rapid decline in health, a pro-active approach to identifying and supporting Covid-19 patients was put in place in wave 1. The service, which is operated by volunteers has now supported over 3,300 people. Patients really appreciate the calls and feel reassured that they are being contacted. A number of patients have then been referred to their GP practice for further support. Some patients have been identified as needing more help with food and medication supplies, most of these patients are then onward referred to routine welfare calls.

The service has further developed since it was established to include; provision of active links to contact tracing, links to the Health Trainer Service (so that people's health is optimised) and more recently supporting people to use pulse oximeters to monitor their condition at home (as part of the national roll out of the national pulse oximetry@home programme). As a result of the implementation of the pulse oximetry@home service a number of patients have been seen by their GP or admitted to hospital for care as their deteriorating clinical condition was identified early.

3. Future work and further development of York Health and Care Collaborative in 2021/2022

3.1 Priority Setting

One of the prime objectives of YHCC is to *"understand the health and care needs of the population and address health and care inequalities"* informed by the Joint Strategic Needs Assessment. In 2021/2022 work will continue in each of our priority areas, as reflecting the JSNA priorities of Ageing Well, Living and Working Well and Mental Health. In addition, we will consider the needs of children and young people and how YHCC contributes to "Starting and Growing Well" for inclusion in our work programme for 2021/2022.

YHCCs priorities will also be considered alongside the requirements of the relevant NHS England transformation programme (the Mental Health Transformation Programme, the Community Services and Ageing Well Transformation Programme and the Children and Young People Transformation Programme) as well as the need to consider the ongoing response to Covid-19.

3.2 National and Local Context; YCHH Role in Place based integration

The NHS White paper (published on 11th February) emphasises the case for improved collaboration within the NHS and between the NHS, local government and other partners, with a renewed emphasis on the importance of the local government footprint and the emphasis on "Place" as the focus for meaningful local integration; YHCC will be well placed to make a significant contribution to this as this is wholly consistent with the way that YHCC has worked to date.