**ANNEX A**

## Report of York Health and Care Collaborative; Update July 2021

### 1. Introduction

This report provides update on the work of the York Health and Care Collaborative (YHCC); briefly outlining the progress that has been made since the last report in July 2021.

### 2. Progress on Priorities

**Alcohol Pilot update:**

The primary care alcohol pilot is funded by CYC and delivered by Changing Lives, supporting those that are not dependent on alcohol but are consuming hazardous amount of alcohol which may become a bigger problem in the future. The pilot will comprise of two link worker posts, one post has been recruited to and the second is currently out to advert. The first post has had a staff member in place for 6 weeks, their initial focus has been completing their induction and understanding the local recovery focused system.

An 8 week programme has been developed based upon Acceptance Commitment Therapy (ACT), which will be the support delivered to residents who access the service. Promotional materials have been finalised and are ready to go to print, with the link worker beginning discussions with GP practices to promote the service. It was initially anticipated that the service would target delivery in one PCN area, however following discussions between CYC and Changing Lives, it has been agreed that all PCNs will be able to refer into the service. Changing Lives are working with GP practices to co-locate the link workers within practice sites, making the service as accessible as possible to residents.

The programme will work with those scoring close to and under 16 on the Alcohol Audit Score (detail in Table 1 below). YHCC attendees from Primary Care have been asked to monitor their lists for patients that may be eligible to be part of this pilot once it starts.

**Table 1**

| Risk Level | AUDIT-C Score | AUDIT Score | Action |
|---|---|---|---|
| Lower | 0-4 | 0-7 | Re-enforce positive behaviour<br>PHE How Are You? Quiz<br>Very Brief Advice (MECClink) |
| Increasing | 5-7 | 8-15 | Refer to CYC Health Trainers |
| Higher | 8-10 | 10-18 | Refer to GP alcohol worker (ACP)<br>(if at the lower end, use clinical judgement and patient preference to decide between CYC Health Trainers and ACP)<br>(WoNE, PMG, YMG and York City Centre PCNs only, referral link to follow) |
| Possible Dependence | 11-12 | 20-40 | Refer to YDAS |

**Community Mental Health Programme:**

First Contact Mental Health workers are now in post in primary care. Learning from these roles will be discussed at YHCC meetings so that planning for next year can start. There are discussions about PCNs working together to share roles and recruit a variety of professionals from different speciality areas.

There is progress in the 'Connecting our City' project with planning around the development of three mental health hubs. The outcomes of a workshop held in October will be shared with primary care at the November YHCC meeting so that patients can be informed of the services that are available. The location of the hubs has not been decided yet, but it has been agreed that people will self-navigate to the hubs which will work with mental health workers from primary and secondary care. Social prescribers will also be essential in this work.

There is a pathway to recovery for those discharged from Foss Park. A social worker and a peer support will work with people about to be discharged to make sure they have access to all the support that they will need. Social prescribers will work with the individual as soon as they are admitted, to identify who might need the most support at discharge. Evidence from the pilot showed that 85% of those discharged went home alone so this work is a priority. There will be an opportunity for primary care to work with these teams. Further discussions around possible support will be brought to YHCC in November.

**Learning Disabilities**

The main focus of the September meeting was Learning Difficulties (LD). The objectives of the meeting were:

- To improve data sharing to help identification of people with a learning disability and increase the number of people on the practice LD registers. This work will be supported by the population health hub.
- To explore how to improve people's health and wellbeing outcomes by improving onward referral for support
- To understand the training that the TEWV Community Learning Disability team can offer to primary care provider to support with identification and ongoing care for patients with an LD.

There was a push during the pandemic to increase the number and quality of health checks that were delivered for those on the LD register. As a result, all Vale of York practices delivered more health checks than in any of the years before the pandemic.

It was agreed that care providers need to flag up themes where access for people with LDs is not as good as it should be. Through identifying these gaps, processes can be put in place to improve health and social care outcomes.

The YHCC meetings will be used as a place for providers to share methods that have improved the identification of those that are eligible for health checks in addition to methods that have had little success in engaging those with an LD, such as sending letters.

York CVS records where there are gaps for those with an LD and works with providers to try and fill these gaps and meet needs. The intention is to build on the existing services with local providers to improve access, rather than introducing new services.

The LD team, the council and GP practices all hold different LD registers, but information governance rules prevents the information from being shared between providers. One of the

key priorities of the Population Health Management hub for LD is to look at how to combine these lists.

The meeting identified that there was a training gap around Learning Difficulties and an action was taken from the meeting to discuss the options available for training with representatives from TEWV.

**Carers in York**

Representatives from the York Carers Strategy Group attended the YHCC meeting in September. The session was designed to give a greater insight into the lives and needs of carers to the health and care providers and commissioners within YHCC. This was very warmly received by the group.

**End of Life Care**

St Leonard's delivered a workshop at the October YHCC meeting which gave providers and commissioners across the city an understanding of the current pressures faced by the hospice. The meeting was also attended by York Trust's Lead Nurse for End of Life Care.

The workshop looked at the service provision for palliative and end of life patients and what the current gaps were. The following feedback was provided by the group for consideration by the hospice:

- Feedback should be taken from service users in a structured way to include how people are and what they think could be done to improve, this information can then be considered in shaping the service in the future.
- When looking at coordination of services, having one single point of access through the nursing workforce is beneficial. This helps to remove duplication and minimise inefficiency, especially as we move into winter.
- There is a need to get carers group to have discussions earlier to try to educate and equip them to deal with situations that may take place outside of service hours.
- There are inefficiencies around medication and the amount of time to get pain relief to patients can be high.
- There may be a need for a small team in the community to be able to deliver intrathecal injections.

**Population Health Management (PHM)**

The York Population Health Hub has been set up with 3 main priorities:

- Supporting the York health and care system to use population health data and PHM as a tool
- Improving the JSNA to make it more useful. This will involve refreshing the JSNA core process and getting better date from seldom heard communities
- Leading tangible PHM projects which show the benefits of this approach. Projects include diabetes, LD/Autism and Complex Needs. Further information around the diabetes project is included below:

The diabetes project is being run in conjunction with York CVS. There is a cohort of around 400 patients enrolled. The project aims to help people live well with diabetes and to help prevent further long term conditions developing. Weight management, blood pressure management and social prescribing all form part of this work.

The main focus of the November YHCC meeting is going to be prevention.

## ANNEX A

### Update from the YHCC Frailty Steering Group

The frailty steering group have identified the following priorities:

- Common adoption of Rockwood[1] clinical frailty scoring
- The use of common templates across all health providers
- The use of common frailty coding across all health providers

The group have agreed that the Rockwood scoring methodology is the most appropriate to use across both primary and secondary care providers. The Ardens Frailty Template and the Enhanced Summary Care Record will be used for reporting and sharing frailty scoring between providers.

The group has recommended sending a survey to all Vale of York GP practices to find gaps and identify what support is needed in assessing and recording frailty scores. The aim is to be able to identify and code all frail patients in a way that recognises those that are the highest priority without overwhelming the system. Once the priorities of the group have been met, work will start to build separate pathways for people that have been assessed as having mild, moderate or severe frailty.

**Minutes of the YHCC meetings for September and October are embedded below, for further detail:**


2021 09 30 YHCC minutes.docx


2021 10 28 YHCC minutes.docx