Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Runciman (Chair), Craghill, Cuthbertson, Looker.

Dr Nigel Wells (Vice Chair) – Chair, NHS Vale of York Clinical Commissioning Group

Dr Emma Broughton – Chair of the York Health and Care Collaborative & a PCN Clinical Director

Sharon Sholtz – Director of Public Health, City of York Council

Amanda Hatton – Corporate Director of People, City of York Council

Lisa Winward – Chief Constable, North Yorkshire Police

Alison Semmence – Chief Executive, York CVS

Sian Balsom – Manager, Healthwatch York

Shaun Jones – Deputy Locality Director, NHS England and Improvement

Naomi Lonergan – Director of Operations, North Yorkshire & York – Tees, Esk & Wear Valleys NHS Foundation Trust

Simon Morritt – Chief Executive, York Teaching Hospitals NHS Foundation Trust

Stephanie Porter – Director for Primary Care, NHS Vale of York Clinical Commissioning Group

Mike Padgham – Chair, Independent Care Group

Date: Wednesday, 21 July 2021

Time: 4.30 pm

Venue: Remote Meeting

A G E N D A

1. Declarations of Interest

At this point in the meeting, Board Members are asked to declare:

- any personal interests not included on the Register of Interests
- any prejudicial interests or
- any disclosable pecuniary interests

which they may have in respect of business on this agenda.

2. Minutes (Pages 1 - 12)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on Wednesday 5 May 2021.

3. Public Participation

At this point in the meeting members of the public who have registered to speak can do so. Members of the public may speak on agenda items or on matters within the remit of the committee. Please note that our registration deadlines have changed to 2 working days before the meeting, in order to facilitate the management of public participation at remote meetings. The deadline for registering at this meeting is at **5.00pm on Monday 19 July 2021.**

To register to speak please visit http://www.york.gov.uk/AttendCouncilMeetings to fill out an online registration form. If you have any questions about the registration form or the meeting please contact the Democracy Officer for the meeting whose details can be found at the foot of the agenda.

Webcasting of Remote Public Meetings
Please note that, subject to available resources, this remote public meeting will be webcast including any registered public speakers who have given their permission.

The remote public meeting can be viewed live and on demand at www.york.gov.uk/webcasts. During coronavirus, we've made some changes to how we're running council meetings. See our coronavirus updates (www.york.gov.uk/COVIDDemocracy) for more information on meetings and decisions.

FOCUS ON HEALTH INEQUALITIES

4. Impact of Covid-19 on Health Inequalities (Pages 13 - 62)
The Health and Wellbeing Board will consider a report which provides a summary of the information it received at an April 2021 workshop on the impact of Covid-19 on health inequalities. The Board is asked to identify the actions and/or work streams that they would like to see taken forward.

OTHER BUSINESS

5. Update from the York Health and Care Alliance (Pages 63 - 80)
The Board will consider a report which will provide an update on the progress of the York Health and Care Alliance, including minutes of Alliance meetings for Board members to note.

6. Covid-19 Update
The Director of Public Health will give a presentation on the current situation in relation to Covid-19 including recovery plans. This item will be in presentation format to ensure that the most up to date information can be presented to the Health and Wellbeing Board.

7. Healthwatch York Annual Report (Pages 81 - 124)
The Board will consider a report which provides information and shares details about the activities of Healthwatch York in 2020/21 with the Health and Wellbeing Board, and gives details of plans for work throughout 2021/22.

8. Better Care Fund Update (Pages 125 - 190)

The Board will consider a report which will provide an update on:

- the national reporting process for the 2020-21 BCF Plan
- 2020-21 Performance report
- progress of the Better Care Fund Review
- recommendation on Intermediate Care
- the planning arrangements for 2021-22
- recommendation to review the BCF Performance and Delivery Group Terms of Reference

9. Report of the Chair of the York Health and Care Collaborative (Pages 191 - 200)

The Board will consider a report on the work of the York Health and Care Collaborative.

10. Urgent Business

Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Joseph Kennally
Telephone No – 01904 551573
Email – joseph.kennally@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting:

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports and
- For receiving reports in other formats

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja może być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almanız mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

☎ **(01904) 551550**

This page is intentionally left blank

Agenda Item 2

City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	5 May 2021
Present	Councillors Runciman (Chair), Craghill, Orrell and Perrett Dr Nigel Wells (Vice Chair), Chair NHS Vale of York Clinical Commissioning Group (CCG) Dr Emma Broughton, Chair of the York Health and Care Collaborative & a PCN Clinical Director, Amanda Hatton, Corporate Director of People, City of York Council, Shaun Jones, Deputy Locality Director, NHS England and Improvement, Naomi Lonergan, Director of Operations, North Yorkshire and York - Tees, Esk and Wear Valleys NHS Foundation Trust, Simon Morritt, Chief Executive, York Teaching Hospital NHS Foundation Trust, Stephanie Porter, Director of Primary Care, NHS Vale of York Clinical Commissioning Group, Lisa Winward, Chief Constable, North Yorkshire Police, David Harbourne, Chair of York CVS (Substitute for Alison Semmence), Janet Wright, Chair of Healthwatch York (Substitute for Sian Balsom), Beverley Proctor, Chief Executive, Independent Care Group (Substitute for Mike Padgham)

	Peter Roderick, Consultant in Public Health, City of York Council/NHS Vale of York Clinical Commissioning Group (Substitute for Sharon Sholtz)
Apologies	Alison Semmence, Chief Executive, York CVS Sian Balsom, Manager, Healthwatch York Mike Padgham, Chair, Independent Care Group Sharon Stoltz, Director of Public Health, City of York Council

36. Declarations of Interest

Board Members were invited to declare any personal, prejudicial or disclosable pecuniary interests, other than their standing interests, that they had in relation to the business on the agenda. None were declared.

37. Minutes

Resolved: That the minutes of the meeting held on Wednesday 10 March 2021 be approved as an accurate record and then signed by the Chair at a later date.

The Board received a clarification relating to the discussion of Covid-19 deaths in care homes under Minute 32. This was as follows:

- *'The reported figure for deaths in care homes in York via ONS is 128 to date (slightly higher than the reported figure by homes – there is always a slight discrepancy as ONS counts some non -care home settings), given we have 1524 registered care home beds in the City, this would equate to approx. 8% of total bed capacity so nowhere near the third that was quoted. Also – that is beds and more people would have been through the services than that number during the year so the actual figure of residents would be even lower.'*

Cllr Craghill requested an update regarding Dr Crane's public participation comments on Vocare and York's Emergency Department in the previous meeting detailed in Minute 31. It

was reported that the issue had been discussed at the meeting of the Health and Adult Social Care Policy and Scrutiny Committee on Tuesday 13 April 2021, and that the key points arising from that discussion were that there were no plans to alter the services provided by Vocare and that staff from the York Emergency Department would not become Vocare employees. The need to continue engagement between the primary care community (GPs) and the hospital as well as Vocare on ongoing issues such as making access to healthcare easier to understand for patients.

38. Public Participation

It was reported that there were no registrations to speak at the meeting under the Council's Public Participation Scheme.

39. York Mental Health Summit

The Board received a report which provided it with information about the recent York Mental Health Summit and how outputs from the summit were being progressed. The independent Chair of the Health and Wellbeing Board's Mental Health Partnership and the Accountable Officer at NHS Vale of York Clinical Commissioning Group were in attendance to present the report.

Key points raised in the presentation of the report included:

- That there was considerable demand for mental health services in York which, although not out of step with national trends, highlighted the urgent need for differing sectors to work together in creating a short, medium and long term plan on the issue of mental health.
- That the Board expressed their satisfaction with the response from key partners at the York Mental Health Summit, who made commitments to contribute to the aforementioned short medium and long term plan; the need to link together efforts in the public and private sector was also emphasised.
- The recognition of the pressures on mental health staff and the ongoing issues of recruitment of mental health professionals.

From the perspective of the primary care sector, it was noted that:

- Mental health had gone from being the fifth to the second most common issue that GPs dealt with.
- It was important to link mental health community assets in York such as walking groups and other initiatives to increase social interaction and combat loneliness.

In response to questions from Board members, it was noted that:

- The main mechanism by which progress on the listed actions will be given, was through the Community Mental Health Partnership, which may provide the Board with updates whenever necessary.
- The main pressure points in the 20% of the population who are facing increased need or previously unmet need were in primary care with issues such as eating disorders, but there was pressure across all areas and particular attention was being focused on improving care for those formerly at the 'threshold' of eligibility for mental health services.
- Partners in education were being worked with closely to provide new courses in nursing, social care and mental health and that efforts were being made to increase the capacity of mental health professionals to meet the increasing demand for the next three years, with a course in Nursing at York St John University beginning in September being highlighted.
- The community mental health programme was seeking to reduce gaps between primary and secondary care as well as linking with children's services to provide a more comprehensive service.

The Chair thanked members for the discussion of the report and emphasised the need for local provision for social interaction and combating loneliness as the country begins to leave lockdown.

Resolved:

(i) That the contents of the report be noted.

(ii) That members of the Board will ensure that adequate resources are made available within their individual organisations to progress the actions within the timescales identified in the action plan at Annex A to this report.

Reason: To allow the Board to receive the information about the recent York Mental Health Summit and to ensure that the action plan detailed at Annex A can be progressed.

40. Ageing Well Partnership: Progress Report

The Board received a report which presented it with an update on the work of the Ageing Well Partnership undertaken since last reporting to the Board in March 2020. The report was presented by one of the co-chairs of the partnership.

Key points raised in the presentation of the report included:

- That the regular meetings and work of the Ageing Well Partnership had been disrupted by the onset of the Covid-19 pandemic, but that this period had enabled the creation of a Co-Chairship which has allowed for closer collaboration with the NHS Vale of York Clinical Commissioning Group, the York Healthcare Collaborative and the City of York Council.
- That the membership of the Partnership had become broader, with more community/voluntary sector involvement, in line with the Terms of Reference's acknowledgment of the need for engagement.
- That there were currently three priority work streams of the Ageing Well Partnership: the Age Friendly York Project, developing a dementia strategy for York and a focus on deconditioning, particularly as the restrictions due to Covid-19 are lifted.

In response to questions from Board members, it was noted:

- That the Covid-19 pandemic had caused a large increase in operation waiting times, and that deconditioning would therefore be vital in optimising patients' health during that period.
- That the importance of ensuring that the perception and worth of older people as contributing members of society should not be forgotten, including that public health matters such as campaigns against smoking should not be aimed exclusively towards the young, especially in light of recent evidence linking tobacco smoking to dementia.
- That as part of work on the Partnership's priorities, a research of the Older People's Survey should be considered, and that in response to concerns around

some of the delivery timescales of the Age Friendly Community Project, the Partnership may assess whether they need altering in the future.

- That it was important for the Partnership to work collaboratively with other areas in relation to older people's issues, for example the work of the City of York Council's Older People's Programme in Housing Delivery, especially in areas of intergenerational policy.

The Chair thanked the report author and the Ageing Well Partnership for their work and the progress made since the last update, especially around the issue of dementia.

Resolved:

(i) That the refreshed Terms of Reference at Annex C be ratified.

(ii) That the Board indicates its ongoing support for the direction of travel for the Ageing Well Partnership, including the three identified priorities around progressing the Age Friendly York project; developing a dementia strategy and undertaking further work around deconditioning.

Reason: To give the Health and Wellbeing Board oversight of the work of the Ageing Well Partnership and assurance in relation to strategy delivery.

41. Covid-19 Update

The Board received an update on the latest data regarding Covid-19 in York.

The key points arising from the update included:

- That the most recent provisional data (26/04/21 to 02/05/21) showed a rate of 17 Covid-19 cases per 100,000 in York and the most recent validated data (23/04/21 to 29/04/21) showed a rate of 21.8 per 100,000.
- That York had one of the lowest rates of Covid-19 in the country, and the second lowest in the Yorkshire and Humberside Region.

- That there had been a slight increase in cases in recent weeks, but that such a change was to be expected with the easing of restrictions and that it was small enough that it could be a chance fluctuation. There had been a similar increase in NHS 111 enquiries, which was not cause for concern but was being monitored.
- That 1 in 100 PCR tests in York were positive, which was broadly similar to national and lower than regional trends; 0.1% of lateral flow test results were positive.
- That there had been 395 Covid-19 related deaths since the beginning of the pandemic in York, 168 more deaths than might have been expected otherwise.
- That there were currently no recorded Covid-19 infections in York care homes, and that an outbreak had not been reported since February.
- That the dramatic decrease in infections in the over 60s cohorts was an indication of the vaccine programme's success. 90% of over 70s had received both doses of the vaccine and the last month had seen efforts particularly focused on increasing administrations of second doses.
- That it had been observed in the past that Covid-19 cases were concentrated in deprived areas of York, but at present the cases were spread fairly evenly.

Comments from Board members and discussion of questions included:

- That 4 school-age children in separate schools had recently tested positive, but unlike in previous cases, there was not a need to isolate whole portions of the school population.
- That a vaccine tracing initiative had been set up, to directly contact those who had turned down the vaccine multiple times through multiple mediums in order to understand their reasons for refusing the vaccine and in the hopes of engaging them in a conversation about the vaccine's benefits.
- That the main reasons for those who have not been taking up vaccines were that many were not resident in the UK, that some were currently too ill, and some had chosen not to. Transport hardship funds for those who cannot make it to vaccine centres were being implemented, as well as options for taking the vaccine to the patient when required and possible.
- That demand for vaccines outstripped supply, and that the primary care sector was asking the public to be patient as

greater supply was expected in the future. There was also concern about the attendance of vulnerable groups such as those with learning difficulties and dementia. It was noted that Nimbus Care had put on specialised learning difficulty and autism vaccination sessions more accessible to those groups.

- That from the perspective of the care home and domiciliary care sector, it was important to cater to individualised need around vaccination, for example through an escalation system for individuals in need of the vaccine.
- That there was one Covid-19 positive patient in York hospitals, and that the hospitals thanked primary care for their role in preventing hospitalisation. It was also noted that demand levels for non-Covid work were increasing back to normal levels.

The Chair thanked the update's author and all of the members of the Board for their contributions, as well as expressing the gratitude of the Board to all vaccination volunteers who were making the vaccine rollout possible.

Resolved:

(i) That the contents of the update be noted.

(ii) That a recovery update will be presented a future Health and Wellbeing Board meeting.

Reason: To inform the Board of the current situation in York relating to the Covid-19 pandemic.

42. Better Care Fund Update

The Board received a report which provided an update on the national reporting process for the 2020-21 Better Care Fund Plan, the progress of the Better Care Fund Review, the national small grants scheme and the planning arrangements from 2021-22.

Key points arising from the update included:

- An explanation of the 4 key elements to the report: the national reporting process 2020-21, the work to review the

BCF, the successful national small grants scheme bid and planning arrangements for the current financial year.

- That the national small grants scheme bid was successful in acquiring £15,000 of funding for a pilot of an innovative model of care with Care Rooms Ltd which will give support to those leaving hospital. The collaborative network around the pilot was emphasised, which includes representatives of the Independent Care Group.
- That the BCF aims to create a person centred integrated care system where health, social care, housing and other services work together seamlessly to provide better services for York residents.
- That the total value of the BCF in 20/21 was £19.233 million, and that it was entering the second consecutive year of financial rollover due to a lack of national planning and policy requirements.
- That the BCF has completed the first three phases of the review, which has looked at all of its schemes not only to calculate value for money, but the social value and social return on investment, as well as individual outcomes, prevention and population health improvement, which the BCF sees as currencies in their own right.
- That longer term strategic recommendations will be presented to the Health and Wellbeing Board's meeting in July.
- That focus of the BCF was on clarifying business processes and improving communication between commissioners and scheme providers; the Fund seeks to join up arrangements between the City of York Council and the Vale of York Clinical Commissioning Group.
- A discussion of the work of the York Integrated Care Team, which is fully funded by the BCF and is involved in many areas of its competence.

In response to questions and comments from Board members, it was noted that:

- The primary care sector thanked the BCF and particularly the York Integrated Care Team's care plans, which have reduced visiting levels of GPs as well as hospital admissions significantly through its proactive reaching out to members of the community in need.
- The universal reach of the Integrated Care Team, which will provide aid to any member of the community without imposed boundaries was praised.

- Members thanked the BCF for their work in bringing different areas of health and social care and other sectors together, fostering collaboration and innovation while allowing funding to spread across institutions.

The Chair thanked the BCF and the York Integrated Care Team for their work and report, and Board members for their contribution to the discussion.

Resolved:

(i) That the York Better Care Fund update be received by the Board.

Reason: The HWBB is the accountable body for the Better Care Fund.

(ii) That authority is delegated to the Chair to sign off on the End of Year Expenditure template prior to submission.

Reason: The submission date of 24 May falls between meetings of the Board. This convention has been adopted routinely for previous submissions to NHSE.

(iii) That the progress of the review of the financial allocations for BCF 2021-22 to ensure maximum impact on outcomes for the system be noted.

Reason: It is important for the sustainability and stability of the whole system than the funding commitment is reviewed regularly to be assured of value for money and impact on outcomes. The Chair and Vice Chair have approved this approach, supported by CYC's Corporate Director of People and the CCG Accountable Officer.

(iv) That the Board will receive further reports on the progress and outcomes from the BCF review at future meetings.

Reason: The HWBB is the accountable body for the Better Care Fund.

Cllr. C. Runciman, Chair
[The meeting started at 4.30 pm and finished at 6.24 pm].

This page is intentionally left blank

Health and Wellbeing Board **21st July 2021**

Report of the Consultant in Public Health

The Impact of Covid-19 on Health Inequalities

Summary

1. In April 2021 the Health and Wellbeing Board (HWBB) held a workshop to help them better understand the impact of Covid-19 on health inequalities

2. This report summarises the information they received at the workshop and their ensuing discussions. It asks HWBB to identify the actions and/or work streams that they would like to see taken forward.

Background

3. Health inequalities are avoidable and systematic differences in health between different groups; e.g. income or ethnicity. York's Joint strategic Needs Assessment (JSNA) sets out the multiple dimensions of inequality in York.

4. HWBB received information at their workshop focused around inequality and this is summarised below:

   - **Life expectancy inequalities**: within York life expectancy varies by area across the city up to 6 years for males and 8 years for females and over the last decade we have only seen improvement in life expectancy for more affluent population groups, widening health inequalities

   - **Preventable deaths**: these are deaths which could have been avoided by public health intervention focusing on wider determinants, such as behaviour and lifestyle factors, socioeconomic status and environmental factors. In York there

are three times as many preventable deaths in our most deprived areas than in our least deprived areas

- **Multiple long term conditions**: people living in the more deprived areas of York are more likely to have multiple long term health conditions and are more likely to develop these conditions earlier in life and develop a larger number of conditions

- **Learning disability and health**: life expectancy is 62 years for people with a mild or moderate learning disability in the UK. 40% of premature deaths in this population nationally were avoidable through access to good quality health care

- **Healthy weight**: being overweight or obese shortens life expectancy and increases the risk of chronic ill health. Overall one in three Year 6 pupils in York is overweight. Ward data shows that this ranges from 8% in Copmanthorpe and Bishopthorpe to 20% in Westfield and Hull Road. Black and Asian children are also more likely to experience obesity

- **Smoking**: this is still the most significant factor in chronic ill health. The smoking rates in York are similar to the England average (in York 11.9% of the adult population is a smoker). However, York should not be complacent. Compared with similar cities, York is making slower progress on stop smoking in the priority groups of expectant mothers (10.8% smoke in early pregnancy and 10.4% by the time of delivery) and those in routine and manual jobs (26.9% of this priority group smoke)

- **Alcohol related harm**: York has higher rates of alcohol consumption and alcohol related hospital admissions than the England average and there are marked inequalities in alcohol related hospital admissions; these impact men more than women

- **Mental ill health and physical ill health in adults:** Conditions like anxiety and depression, and muscular skeletal conditions are relatively common, currently, each condition impacts about 1 in 7 York adults. Due to factors like social exclusion and relative deprivation, some groups are particularly likely to have both mental health and MSK conditions, this includes LGBT people, some ethnic minority groups, and people who are unemployed

- **Covid Vaccination:** reflecting national trends, there is variance in uptake of the COVID-19 vaccination, and those from less affluent groups and those from a BAME background showing lower levels of vaccination coverage. Work on vaccine inequalities led by Public Health and the CCG aims to bridge these gaps.

5. The board also read a number of testimonies that had been provided by local organisations. These testimonies detailed what health inequalities the people who accessed their services were experiencing and how Covid-19 had impacted these inequalities. These testimonies are at **Annex A** to this report.

Discussion

6. Following on from the information set out above the HWBB acknowledged that both inequality and deprivation were multi-faceted. Inequalities in the city were growing and the impact of Covid-19 on this was gradually becoming clearer.

7. To help focus their discussions at the workshop the board considered the information they had received in the context of three questions. These are set out below along with some of the board's initial thoughts:

i. What gap or challenge troubles you most?

- Alcohol support
- Mental Health (surge in demand for services; eating disorders in children; complex mental health cases; presentation in secondary care)
- Delayed diagnosis for cancer
- Access to dental care in children and appointment availability during lockdown
- Carer support throughout the pandemic
- Health of the traveller community
- LGBT health
- Ethnicity and health (the links have become clearer during the pandemic)

- Poverty/extreme poverty
- Fragile state of health services
- Smoking in pregnancy
- Life expectancy for those with a learning disability
- Increased speech and language problems in children and young people
- Insecurity in housing tenure

ii. <u>How do we use our assets better to reduce inequalities?</u>

- Increase capacity within the social prescribing service
- Make better use of group counselling
- Consider establishing a poverty truth commission
- Increase co-production going through one cohort at a time (e.g. diabetes)
- Target health checks, stop smoking services in the areas of the city/or at the groups of the population where they are most needed
- Increase understanding of what and where our assets are and what capacity they have

iii. <u>How do we protect the next generation from the impact of COVID and the effects of inequality?</u>

- Intelligent targeting and a 20 year vision to reduce health inequalities within the city
- Reducing/eradicating smoking in pregnancy
- Co-location of services
- Improved and increased support for parents
- Enable a healthy food environment
- Assertive outreach

- By further understanding the impact of Covid-19 on children, young people and families and by being able to provide them with appropriate support

Next steps

8. Health and Wellbeing Board members are asked to further consider the information and discussions from the workshop, with a particular focus on the testimonies they received from local organisations with a view to identifying 3 or 4 key actions and/or work streams that they would like to see progressed. They are asked to clearly identify what their expectations are in terms of outcomes and indicate timescales and lead officers/groups for progressing these.

9. For each action and/or work steam identified the board are asked to identify a HWBB member to sponsor this and be the accountable person for ensuring that this is progressed. The sponsor will work with the Health and Wellbeing Partnerships Coordinator and any other group identified to ensure that actions and/or work streams are progressed and progress updates are provided to the HWBB and/or the HWBB Chair.

10. In addition to the information received at the workshop it may be helpful for board members to revisit and/or familiarize themselves with the seven indices of deprivation **(Annex B refers)** to enable them to identify where action is most needed.

11. For York, this composite index of deprivation (IMD) including health, income, employment, crime, education, housing and environmental factors shows that we have one small geographical area (within Westfield ward) with a population of 1,647 that is in the 10% most deprived in England, and 6 areas with a combined population of 9,479 within the bottom 20% most deprived in England (IMD 2019), spread through the city in areas such as Clifton, Hull Road and Westfield wards.

Consultation

12. No formal consultation has taken place to prepare this report. However, at their April workshop, the board received a number of testimonies from local organisations that detailed what health inequalities the people who accessed their services were experiencing and how Covid-19 had impacted these inequalities. These testimonies are at **Annex A** to this report.

Options

13. There are no specific options for the Health and Wellbeing Board but they are asked to identify actions and/or work streams which they would like to see progressed.

Implications

14. Health inequalities are increasing within the city and some groups are more impacted than others. Leading partnership work to tackle health inequalities is one of the core functions of the Health and Wellbeing Board, and this involves deep work to understand where, why and how these differences exist and what mechanisms and opportunities exist to reduce them. The Health and Wellbeing workshop was a helpful moment in time to consider what the data and what York stakeholders are telling us on health inequalities, and this public meeting provides a further opportunity to identify actions and commitments partners can take.

Recommendations

15. The Health and Wellbeing Board are asked to

- Identify three or four actions and/or work streams that they would like to see progressed along with expected outcomes, timescales and lead officers/groups
- Identify a board sponsor for each of the above identified

Reason: To ensure that work happens to reduce health inequalities within the city

Contact Details

Author:	**Chief Officer Responsible for the report:**
Peter Roderick Consultant in Public Health	Sharon Stoltz Director of Public Health
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator	**Report Approved** ✓ **Date** 9th July 2021

Specialist Implications Officer(s)
None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
Annex A: Testimonies from local organisations
Annex B: The English Indices of Deprivation 2019

Glossary

BAME – Black, Asian and Minority Ethnic
CCG – Clinical Commissioning Group
HWBB – Health and Wellbeing Board
IMD – Index of Multiple Deprivation
JSNA – Joint Strategic Needs Assessment
LGBT – Lesbian, Gay, Bisexual and Trans
MSK – Musculoskeletal

This page is intentionally left blank

York Health and Wellbeing Board Workshop – 28th April 2021

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation: The Healthy Child Service

For the people and groups who access your services:

What 'health inequalities' do they experience compared to the rest of the population?

In the less advantaged areas in York, smoking during pregnancy is higher and breast feeding rates are lower compared with more advantaged areas. Low birth weight is also correlated with less advantaged wards in the city as is the number of babies born to teenage mothers. These factors that occur before the child is even born places them at greater risk of poorer outcomes and impact on the long term health and educational outcomes. Correlations also exist between higher numbers of overweight/ obese and severely obese children in less advantaged areas in the city. Being overweight/obese impacts on the emotional and mental health of children and young people as well as increasing risk for physical health conditions such as diabetes and heart disease.

How has COVID-19 impacted these inequalities?

- Community breast feeding support has not been as widely available during the pandemic, it is yet to be seen from the data if lack of support has impacted rates of initiation and duration of breast feeding.
- Increase in reported regression of preschool age children's emotional and social development, activities of daily living such as toileting skills.
- Increase in referrals to School Nurses for emotional health support for young people.
- Perinatal mental health issues can impact women from any group of characteristics however increased numbers of women with PNMH issues during the pandemic. Low mood and anxiety can impact on a parent's ability to be emotionally attuned and available to their infants which is fundamental to secure attachments and healthy brain development which lays foundations for adulthood.

York Health and Wellbeing Board Workshop – 28th April 2021 (updated for July HWBB meeting)

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation: York Carers Centre

For the people and groups who access your services:

What 'health inequalities' do they experience compared to the rest of the population?

- lack of identification of carers by GP's, health professionals etc carers do not receive referral/support
- respite and support services reduced or removed completely leaving carers abandoned and in fear of returning to 'normal'
- carers being unable to access tele support where their 'cared for' is in the same house
- elderly, frail carers providing care alone without support (often for 50hrs+ pr wk) eg for someone with dementia, with care through the night, coping with behavioural problems; no respite or support; impacting on their mental and physical health
- young and young adult carers unable to maintain education without IT equipment; who often consider school a break from their caring role; living in cramped housing with no space/time to themselves

York Health and Wellbeing Board Workshop – 28th April 2021 (updated for July HWBB meeting)

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation: York Carers Centre

For the people and groups who access your services:

How has COVID-19 impacted these inequalities?

- placed additional demand/pressure on carers
- increased isolation, caring longer hours, shielding with the vulnerable / extremely vulnerable “cared-for” during the pandemic
- fear of Covid, coping with coming out of restrictions
- impact on carers breaks/respite, tele contact is difficult where cared for is present, therefore unable to access tele support
- lack of consistent support for carer ID re priority access supermarkets, PPE, vaccination
- poor messaging for instance in visiting care homes; priority for vaccine
- bereavement support
- increase in carers mental health problems and suicidal thoughts
- young/young adult carers unable to maintain education through demanding inappropriate caring responsibilities

York Health and Wellbeing Board Workshop – 28th April 2021

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation: York Travellers Trust

For the people and groups who access your services:

What 'health inequalities' do they experience compared to the rest of the population?

Romany Gypsies, Scottish Gypsy Travellers and Travellers of Irish Heritage (along with the other non ethnic Travellers) are widely known has having much worse health issues even when compared with the worst comparable community.
The world of academia has shown that, the average life expectancy of Ethnic Gypsy and Traveller people living in the UK (housed, sited and roadside) was 50, that a Gypsy or Traveller mother is much more likely to experience the death of child under 5 and that the suicide rates are as high as 1in 4 in some Traveller communities.

How has COVID-19 impacted these inequalities?

Covid-19 has seen a large rise in hospitalisations due to (non covid) cardiovascular issues.
Most worryingly we saw a steep rise in the already high poor mental health of these communities. Within the space of a few months, in Yorkshire alone we saw 6 community members, including 2 teenage girls, die from suicide. we also had many attempted that we lost count of. A group of communities that already felt isolated and alone, feel more detached and ignored

ANNEX A

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation: York Mind

For the people and groups who access your services:

What 'health inequalities' do they experience compared to the rest of the population?

- Difficulty in finding and retaining jobs
- Stigma due to lack of understanding of mental ill-health
- Poverty
- Isolation and loneliness

How has COVID-19 impacted these inequalities?

- Those with existing serious mental ill-health found their symptoms worsened especially anxiety and depression.
- People are struggling with poverty and lack of access to digital. This includes insufficient monies to pay for broadband and smart phones and/or inability to use technology for communication

York Health and Wellbeing Board Workshop – 28th April 2021 (updated for July HWBB meeting)

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation: York Older People's Assembly

For the people and groups who access your services:

What 'health inequalities' do they experience compared to the rest of the population?

- Significant drop in income for some people affecting activities, social communication. mobility
- Older people's illnesses are often lower priority e.g. depression, falls, mobility, nutrition
- Loneliness and isolation particularly after the death of a partner
- Greater reliance on public transport
- Unable to work
- Likely to have more long term conditions
- Lack of on line access prevents information e.g. repeat prescriptions
- Care home access becomes an issue and lack of contact with friends reduces confidence

How has COVID-19 impacted these inequalities?

- Reduced face to face access with medical staff with reduced early identification of problems
- Health teams focus has moved from COVID but the backlog is such that the big issue now is how long a person has to wait to be seen for non urgent conditions.
- Fear of going out has increased loneliness and isolation
- Disconnection from routine e.g. going to shops. libraries that had "contact" associated with it.
- Feeling of loss of self worth and value especially after loss of life time partner
- Inability to earn from that "little job" that brought in that little bit of extra cash that made life meaningful
- Fear of driving again – loss of confidence

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation:

York Older People's Assembly

For the people and groups who access your services:

Additional Information Provided

In many ways, the bigger issue is what has changed as a result of the COVID constraints of the last 16 months. There are known health inequalities for older people but the dramatic change has been the lack of face to face contact for many people with the knock-on effects of:

- Limited social contact intensifying the feelings of isolation and loneliness
- Reduced direct access to medical staff on non covid issues leading to the massive backlog of outstanding operations etc - probably impacting more on older people than any other group
- The enormous impact on Care Homes in terms of the number of deaths to those communities, the restrictions on access by families and friends, the reduced occupancy and the financial impact long term on social care
- Mental Health challenges as a result of all of the above including in many cases, the lack of time and opportunity to grieve for families and especially for those who have lost a life long partner

York Health and Wellbeing Board Workshop – 28th April 2021

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation: Changing Lives (York Drug and Alcohol Service)

For the people and groups who access your services:

What 'health inequalities' do they experience compared to the rest of the population?

People who access the services in York (like many across the country) experience numerous health inequalities, these include access to mental and physical health support, access to work or educational means as well as social and cultural opportunities, some barriers to these can be physical, language used, the way information is given, stigma and accessibility to name a few. Many of those people who access drug and alcohol services have Multi Complex Needs (MCN)as well as some history of previous trauma and access to appropriate support is difficult.

How has COVID-19 impacted these inequalities?

With a move to more digital technology access to appropriate support/services has been made more difficult for some people. Those people with MCN, live in higher states of deprivation were (and are) exposing themselves to COVID-19 and with existing poor health puts them at increase risk. Access to testing was difficult for some due to the booking system and lack of knowledge on how to do this. Anecdotally there has been an increase in those people accessing the service stating mental health concerns.

ANNEX A

Tackling York's health inequalities in the aftermath of COVID-19

Name of organisation: Changing Lives

For the people and groups who access your services:

Additional Information Provided

As well as negative factors linked to Covid 19, we (as a service) have seen some positives, reduced drug use for some, greater ownership of treatment, increase in contact and engagement via phone calls to name a few, we are not seeing a big increase in alcohol referrals but I think that will come when we move back out of full lockdown.

This page is intentionally left blank

Ministry of Housing, Communities & Local Government

The English Indices of Deprivation 2019 (IoD2019)

Statistical Release

26 September 2019

About this release:

- This release updates the English Indices of Deprivation 2015
- The English Indices of Deprivation measure relative levels of deprivation in 32,844 small areas or neighbourhoods, called Lower-layer Super Output Areas, in England
- The data indicators used to construct the IoD2019 are based on the most up-to-date information available

Key findings:

- Overall, 88 per cent of neighbourhoods that are in the most deprived decile according to the Index of Multiple Deprivation 2019 (IMD2019) were also the most deprived according to the IMD2015
- Deprivation is dispersed across England. 61 per cent of local authority districts contain at least one of the most deprived neighbourhoods in England
- Middlesbrough, Liverpool, Knowsley, Kingston upon Hull and Manchester are the local authorities with the highest proportions of neighbourhoods among the most deprived in England. This is largely unchanged from the IMD2015
- Many London Boroughs have seen a reduction in the proportions of their neighbourhoods that are highly deprived from the IMD2015
- Seven of the 10 local authority districts with the highest levels of income deprivation among older people are in London – this is unchanged from the IMD2015
- Middlesbrough and Blackpool rank as the most deprived districts regarding income deprivation among children

Responsible Statistician:
Bowie Penney
Statistical enquiries:
office hours:
0303 444 0033
indices.deprivation@communities.gov.uk
Media Enquiries:
0303 444 1209
newsdesk@communities.gov.uk

ANNEX B

Introduction

Since the 1970s the Ministry of Housing, Communities and Local Government and its predecessors have calculated local measures of deprivation in England. This Statistical Release contains the latest iteration of these statistics, the English Indices of Deprivation 2019 (IoD2019). The IoD2019 is an update to the 2015 Indices and retains the same model of multiple deprivation, using the same approach and utilising data inputs from the most recent time points where possible.

This release provides an overview of the findings from the IoD2019 focussing on national and sub-national patterns of multiple deprivation, patterns of income and employment deprivation and some analysis of the supplementary Income Deprivation Affecting Children Index (IDACI) and Income Deprivation Affecting Older People Index (IDAOPI). A full **Research Report**, **Technical Report** and comprehensive **guidance documents** accompany this release, along with a series of supporting **data tables**, **interactive tools** and **Open Data facilities** to aid user's exploration of the data.

Things You Need to Know

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England and is part of a suite of outputs that form the Indices of Deprivation (IoD). It follows an established methodological framework in broadly defining deprivation to encompass a wide range of an individual's living conditions. People may be considered to be living in *poverty* if they lack the financial resources to meet their needs, whereas people can be regarded as *deprived* if they lack any kind of resources, not just income[1].

Key Info:
IoD2019 Domains

The IoD2019 is comprised of seven distinct domains of deprivation which, when combined and appropriately weighted, form the IMD2019. They are;

- **Income** (*22.5%)*
- **Employment** (*22.5%*)
- **Health Deprivation and Disability** (*13.5%*)
- **Education, Skills Training** (*13.5%*)
- **Crime** (*9.3%*)
- **Barriers to Housing and Services** (*9.3%*)
- **Living Environment** (*9.3%*)

The IoD2019 is based on 39 separate indicators, organised across seven distinct domains of deprivation which are combined and weighted to calculate the Index of Multiple Deprivation 2019 (IMD2019, see **Key Info** box). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower-layer Super Output Area (LSOA), or neighbourhood, in England. All neighbourhoods in England are then ranked according to their level of deprivation relative to that of other areas. High ranking LSOAs or neighbourhoods can be referred to as the 'most deprived' or as being 'highly deprived' to aid interpretation. However, there is no definitive threshold above which an area is described as 'deprived'. The Indices of Deprivation measure deprivation on a *relative* rather than an *absolute* scale, so a neighbourhood ranked 100th is more deprived then a neighbourhood ranked 200th, but this does not mean it is twice as deprived.

[1] See 2019 Technical Report, available online here – https://www.gov.uk/government/publications/english-indices-of-deprivation-2019-technical-report

Ministry of Housing, Communities & Local Government

The English Indices of Deprivation 2019 (IoD2019)

The Indices relatively rank each small area in England from most deprived to least deprived

1st most deprived area

There are 32,844 small areas (Lower-layer Super Output Areas) in England, with an average population of 1,500

32,844th least deprived area

There are 7 domains of deprivation, which combine to create the Index of Multiple Deprivation (IMD2019):

Income (22.5%)

Measures the proportion of the population experiencing deprivation relating to low income

Supplementary Indices

Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families

Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of those aged 60+ who experience income deprivation

Employment (22.5%)

Measures the proportion of the working age population in an area involuntarily excluded from the labour market

Education (13.5%)

Measures the lack of attainment and skills in the local population

Health (13.5%)

Measures the risk of premature death and the impairment of quality of life through poor physical or mental health

Crime (9.3%)

Measures the risk of personal and material victimisation at local level

Barriers to Housing & Services (9.3%)

Measures the physical and financial accessibility of housing and local services

Living Environment (9.3%)

Measures the quality of both the 'indoor' and 'outdoor' local environment

How can the IoD2019 be used?

- ✓ comparing small areas across England
- ✓ identifying the most deprived small areas
- ✓ exploring the domains (or types) of deprivation
- ✓ comparing larger administrative areas e.g. local authorities
- ✓ looking at changes in relative deprivation between iterations (i.e. changes in ranks)
- × quantifying how deprived a small area is
- × identifying deprived people
- × saying how affluent a place is
- × comparing with small areas in other UK countries
- × measuring absolute change in deprivation over time

The IoD2019 is based on the same methodology as the 2015 Indices, providing a consistent suite of outputs which are in line with previous iterations. Although it is not possible to use the Indices to measure changes in the *absolute* level of deprivation in places over time, it is possible to explore changes in *relative* deprivation, or changes in the pattern of deprivation, between the IoD2019 and previous iterations of the Indices. This will be explored further throughout this release.

At the neighbourhood-level, the IoD2019 provides a place-based insight into deprivation. However, this description does not apply to every person living in these areas. Many non-deprived people live in deprived areas, and many deprived people live in non-deprived areas. It is important to note that the IoD2019 is designed to identify and measure specific aspects of deprivation, rather than measures of affluence.

The IoD2019 methodology is designed to reliably distinguish between areas at the most deprived end of the distribution, but not at the least deprived end. This means that differences between the least deprived areas in the country are less well defined than differences between the more deprived areas.

Exploring Changes in Deprivation Over Time

The purpose of the Indices of Deprivation is to measure as accurately as possible the relative distribution of deprivation at a small area level, but this comes at the expense of 'backwards' comparability. Care should be taken when comparing iterations of the Indices over time (see **Key Info** box). However, the data can be used to provide the best measure of relative deprivation as a snapshot in time. When exploring changes in deprivation between the IoD2019 and previous releases, users should be aware that iterations of the Indices **cannot be used to identify real change over time**. The IoD2019 has been produced using the same approach, structure and methodology for the IoD2015 and previous releases. Keeping a consistent methodology in this way **does allow relative rankings between iterations to be compared over time**. For example, an area can be said to have become more deprived relative to other areas if it was within the most deprived 20 per cent of areas nationally according to the IMD2015 but within the most deprived 10 per cent according to the IMD2019. However, it would not necessarily be correct to state that the level of deprivation in the area has increased on some absolute scale, as it may be the case that all areas had improved, but that this area had improved more slowly than other areas and so been 'overtaken' by those areas.

Key Info:

Changes between Indices mean that care should be taken when comparing iterations over time.

Common changes include:

- changes to indicators used to measure deprivation
- changes in administrative or statistical geographies
- revisions to population estimates

More detail is included in section 3.4 of the Research Report

Small Area Deprivation

Across England, the patterns of deprivation are complex. The most and least deprived neighbourhoods are spread throughout the country. **Map 1** illustrates the geographical spread of deprivation based on ranking all 32,844 LSOAs, or neighbourhoods, nationally and dividing them in to 10 equal groups (or deciles) according to their deprivation rank. Areas shaded dark blue are in the most deprived 10 per cent (or decile) of neighbourhoods in England while areas shaded pale green are in the least deprived 10 per cent.

As was the case in previous versions of the Indices, the IoD2019 reveals concentrations of deprivation in large urban conurbations, areas that have historically had large heavy industry manufacturing and/or mining sectors (such as Birmingham, Nottingham, Hartlepool), coastal towns (such as Blackpool or Hastings), and parts of east London. There are also pockets of deprivation surrounded by less deprived places in every region of England.

The most deprived neighbourhood in England according to the IMD2019 is to the east of the Jaywick area of Clacton on Sea (Tendring 018a). This area was also ranked as the most deprived nationally according to the IMD2015 and IMD2010. Neighbourhoods in Blackpool then account for eight of the ten most deprived neighbourhoods nationally, with the Anfield area in the centre of Liverpool (Liverpool 019C) making up the ten most deprived areas in England (see **Key Info** box).

Key Info

LSOAs

Lower-Layer Super Output Areas (LSOAs) are small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 Lower-layer LSOAs in England. LSOAs are a standard statistical geography produced by the Office for National Statistics for the reporting of small area statistics. LSOAs are also referred to as neighbourhoods throughout this release.

Most deprived LSOAs based on IMD2019 Rank

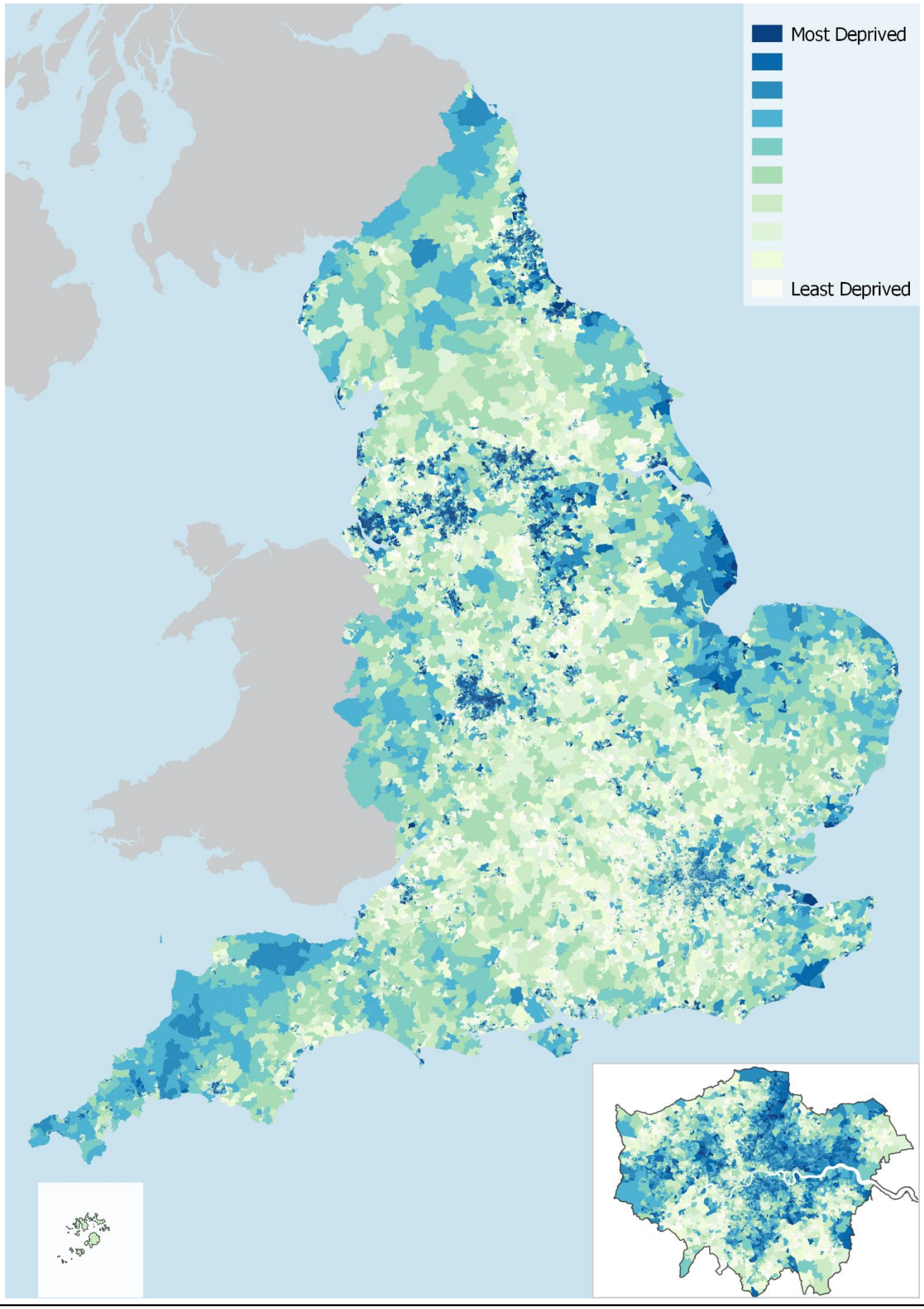
	LSOA name	Local Authority name
1.	Tendring 018A	Tendring
2.	Blackpool 010A	Blackpool
3.	Blackpool 006A	Blackpool
4.	Blackpool 013B	Blackpool
5.	Blackpool 013A	Blackpool
6.	Blackpool 013D	Blackpool
7.	Blackpool 010E	Blackpool
8.	Blackpool 011A	Blackpool
9.	Blackpool 008D	Blackpool
10.	Liverpool 019C	Liverpool

Deprivation in some areas has persisted across iterations of the Indices. There are five neighbourhoods which have been ranked among the most deprived 100 LSOAs on each Index of Multiple Deprivation update since 2004. Two of these are located in Liverpool (Liverpool 024A and Liverpool 024B) and one in Wirral (Wirral 011C), Rochdale (Rochdale 010C) and Middlesbrough (Middlesbrough 003F)[2]. See section 5.4 of the Research Report for further detail.

According to the IoD2019, many of the most deprived 10 per cent of neighbourhoods in England face multiple challenges across the domains comprising the IMD2019 (see **Table 1**). Almost all of these areas (98.7 per cent) are ranked as highly deprived (i.e. in the most deprived decile) on at least two of the seven domains of deprivation. Nearly two-thirds (65.5 per cent) are highly deprived on four or more domains, and just under a third (30.7 per cent) are highly deprived on five or six of the seven domains. No neighbourhoods fall into the most deprived decile across all seven domains.

[2] Analysis based on 31,672 Lower-layer Super Output Areas that have not changed boundaries between 2001 and 2011 updates.

Map 1: Distribution of the Index of Multiple Deprivation (IMD) 2019 by LSOA in England



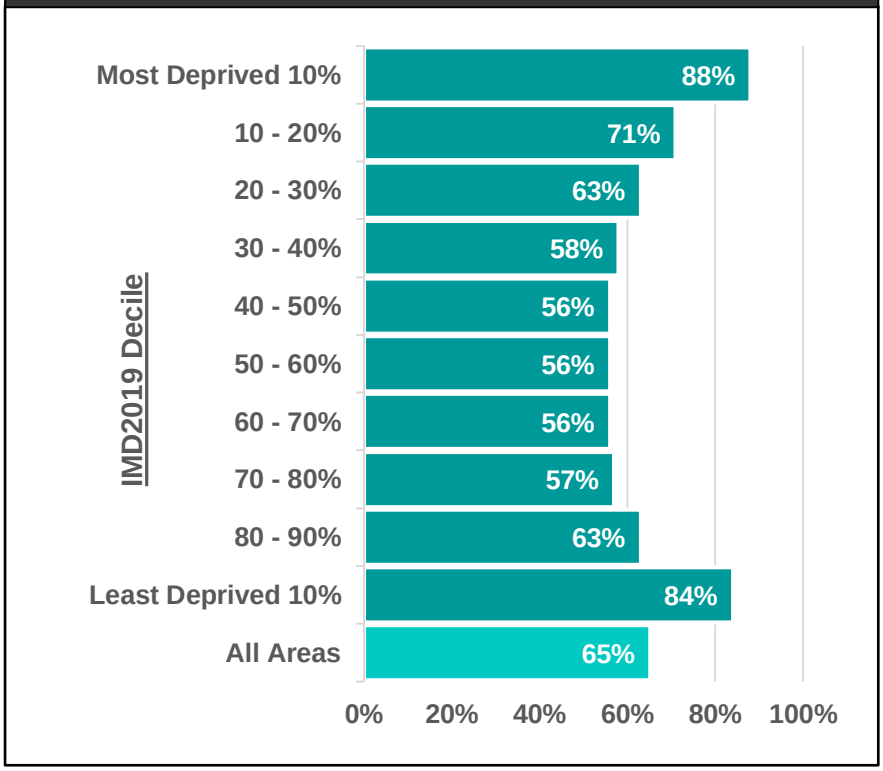
Of these most deprived 10 per cent of neighbourhoods in England (3,284), 137 rank as highly deprived on six of the seven domains. These neighbourhoods are not evenly distributed across England: 88, or 64 per cent of them, are located within just 8 local authority districts - Blackpool contains 15 such neighbourhoods; Liverpool, 14; Birmingham and Leeds, 13 each, and Bradford, 11. Blackpool and Burnley have proportionately more neighbourhoods ranked as highly deprived on six of the seven domains: 15 (or 16 per cent) of 94 neighbourhoods in Blackpool met this criterion, as did 7 (or 12 per cent) of 60 neighbourhoods in Burnley.

Table 1: The most deprived 10 per cent of neighbourhoods nationally based on the IMD2019, by the number of domains on which they are also in the most deprived decile

Number of Domains	Number of LSOAs	Percentage of most deprived LSOAs	Cumulative Percentage of most Deprive LSOAs
7	0	0.0%	0.0%
6	137	4.2%	4.2%
5	870	26.5%	30.7%
4	1,145	34.9%	65.5%
3	778	23.7%	89.2%
2	312	9.5%	98.7%
1	42	1.3%	100.0%
Total	**3,284**	**100%**	

Change since the Indices of Deprivation 2015 (IoD2015)

Chart 1: Proportion of neighbourhoods in each decile of the IMD2019 that were in the same decile of the IMD2015



The IoD2019 is broadly based on the same methodology as the 2015 Indices. Although it is not possible to use the Indices to measure absolute changes in deprivation over time, it is possible to explore changes in relative deprivation, or changes in the pattern of deprivation, between iterations – as if comparing two snapshots in time.

Chart 1 shows the proportion of neighbourhoods in each decile of the IMD2019 that were in the same decile according to the IMD2015. Overall, 65 per cent of neighbourhoods remained in the same decile of deprivation between iterations. There was relatively little movement of neighbourhoods between deciles at the extreme ends of the distribution. This indicates that, in relative terms at least, the most deprived areas and least deprived areas have tended to remain the same between updates.

The majority, 88 per cent, of neighbourhoods that are in the most deprived decile according to the IMD2019 were in the same decile based on the IMD2015, as were 84 per cent of the least deprived (see **Table 2**).

Table 2 presents a more detailed analysis of changes in the relative deprivation of neighbourhoods across deciles by illustrating the numbers of LSOAs in each decile of the IMD2015 and their corresponding deciles according to the IMD2019.

Table 2: Number of neighbourhoods in each decile of the IMD2019 and the IMD2015

Number of Lower-layer Super Output Areas		Index of Multiple Deprivation 2015										
		Most deprived 10%	10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%	80-90%	Least deprived 10%	*Total*
Index of Multiple Deprivation 2019	**Most deprived 10%**	**2883**	400	1	0	0	0	0	0	0	0	*3284*
	10-20%	395	**2316**	567	6	0	0	0	0	0	0	*3284*
	20-30%	6	545	**2073**	643	18	0	0	0	0	0	*3285*
	30-40%	0	22	612	**1892**	726	31	1	0	0	0	*3284*
	40-50%	0	1	32	663	**1834**	721	31	3	0	0	*3285*
	50-60%	0	0	0	76	652	**1838**	685	33	0	0	*3284*
	60-70%	0	0	0	3	49	641	**1833**	719	38	1	*3284*
	70-80%	0	0	0	0	6	51	682	**1862**	671	13	*3285*
	80-90%	0	0	0	1	0	2	51	650	**2076**	504	*3284*
	Least deprived 10%	0	0	0	0	0	0	1	18	499	**2767**	*3285*
	Total	*3284*	*3284*	*3285*	*3284*	*3285*	*3284*	*3284*	*3285*	*3284*	*3285*	***32844***

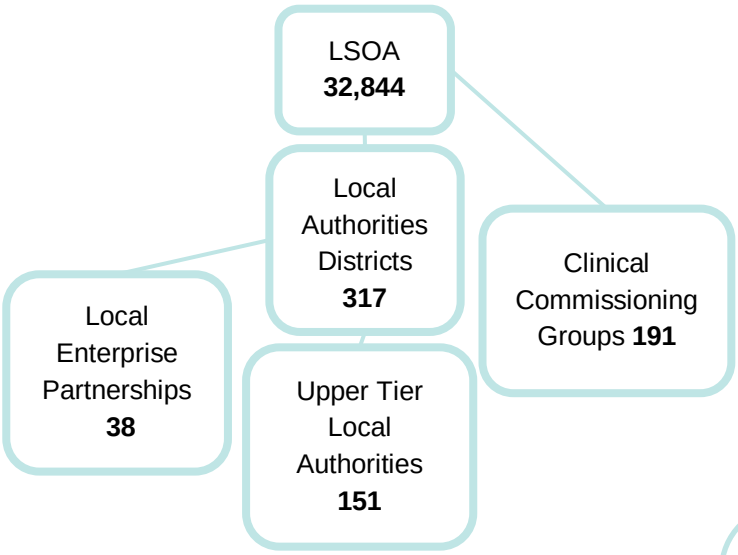
Comparing the distributions in this way shows the extent of changes in relative rankings, and how large the changes are for those areas that have moved. Although 2,883 neighbourhoods were in the most deprived decile according to both the IMD2015 and the IMD2019, 401 areas have moved out of the most deprived decile since the IMD2015; almost all of these (395) shifted to the next decile (10 – 20 per cent most deprived) and 6 moved further, to the third most deprived decile.

The table also illustrates that some LSOAs have experienced a considerable change in their relative level of deprivation since the IMD2015, with a small number of areas moving by up to three deciles, and one area (Westminster 016C) moving five deciles from the forth to the ninth decile of the IMD2019. In total, 19 neighbourhoods have seen changes in relative deprivation of more than plus or minus two deciles between the IMD2015 and IMD2019. Its important to note here that the Indices of Deprivation methodology is designed to reliably distinguish between areas at the most deprived end of the distribution, but not at the least deprived end.

Area Summaries – Local Authority

Although the Indices is designed primarily to be a small-area or neighbourhood measure of relative deprivation, LSOA level outputs are often aggregated and used to describe relative deprivation for higher-level administrative geographies, such as local authority districts. To facilitate this, a range of summary measures are produced for larger areas. These have been carefully designed to help users understand deprivation patterns in higher-level areas. The measures focus on different aspects of deprivation such as identifying the overall intensity of deprivation, how deprivation is distributed across large areas, and the overall volume, or 'scale', of deprivation. These measures are described in section 3.8 of the Technical Report and advice on their interpretation is provided throughout section 3 of the Research Report.

Figure 1: LSOAs to higher level administrative geographies for the IoD2019



The sub-national analysis presented in this Statistical Release focuses mainly on the 10 per cent of neighbourhoods that are most deprived nationally according to the IMD2019 summary measure, although other summaries are explained throughout and key differences between them described to aid interpretation. Summary measures from the IMD2015 and some key domains have been reaggregated to 2019 local authority boundaries to aid the interpretation and comparison of relative changes (this data is available online as **File 14**).

LSOA's form the building blocks of all higher-level geography summaries of the Indices (see **Figure 1**). However, both statistical and administrative geographies have changed over time (see **Key Info** box). Specifically, the number of LSOAs and local authorities in England has changed between iterations of the Indices.

Key Info:

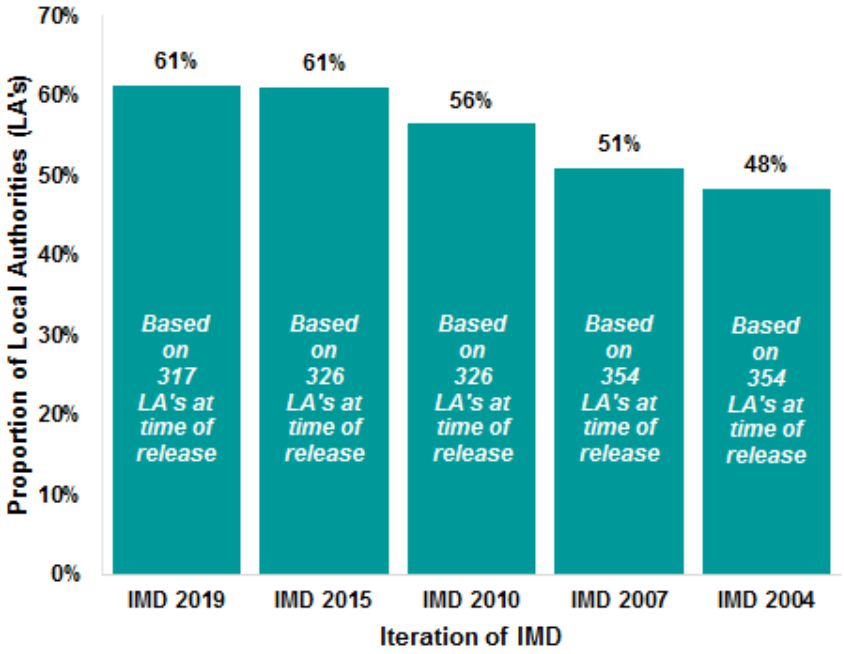
The number of local authority districts in England have changed between iterations of the Indices:

- IoD2019 – 317 local authorities – 32,844 LSOAs
- IoD2015 – 326 local authorities – 32,844 LSOAs
- IoD2010 – 326 local authorities – 32,482 LSOAs
- IoD2007 – 354 local authorities – 32,482 LSOAs
- IoD2004 – 354 local authorities – 32,482 LSOAs

Since the IoD2004, deprived neighbourhoods have become more dispersed across local authority areas. The proportion of local authorities containing at least one neighbourhood in the most deprived decile has increased with successive updates of the Indices, based on the number of local authorities and LSOAs at the time of each release (see **Chart 2**). Just under half (48 per cent) of local authorities contained at least one highly deprived neighbourhood according to the IMD2004 compared to 61 per cent in the IMD2015 and IMD2019, based on the statistical and administrative geographies at the time of each release. These changes may have had had an impact on the pattern of deprivation observed in some places.

When considering more extreme neighbourhood deprivation, local authorities containing at least one neighbourhood in the *one per cent* most deprived nationally for example, deprivation is more concentrated according to the IMD2019. Overall, 71 local authorities, about one in five or 22 per cent, contain at least one such area. This is similar to the IMD2015.

Chart 2: Proportion of local authorities with at least one neighbourhood in the most deprived decile nationally



Note: this analysis uses local authority district and LSOA boundary configurations as at the time of each release.

Because patterns of deprivation across larger areas can be complex, there is no single summary measure that is the 'best' measure to use in measuring deprivation. Rather, each of the summary measures that are published highlight different aspects of deprivation, and each lead to a different ranking of areas. Comparison of the different measures is needed to give a fuller description of deprivation for larger areas. It is important to remember that the higher-area measures are summaries and that each is measuring a different aspect of deprivation; the LSOA level data provides more detail than is available through the summaries (see **File 1**).

Summary measures help describe relative deprivation at a higher geographical scale. Local authority level summaries are used here to help illustrate three of the most widely used summary measures, their differences and outcomes. Further breakdowns and rankings by the full range of summary measures can be found in the accompanying online tables and technical documentation. Table 3.2 of the Technical Report provides a more detailed summary of each.

(Rank of) Average Rank – this measure summarises the average level of deprivation across an area, based on the population weighted ranks of all the neighbourhoods within it. For example, all LSOAs in a local authority, whether highly deprived or not so deprived, contribute to this summary measure. Overall, highly deprived areas and less-deprived areas will tend to average out in the overall rank, so an area that is more uniformly deprived will tend to rank higher on this measure compared to other summary measures.

(Rank of) Average Score - this measure summarises the average level of deprivation across an area, based on the scores of all the neighbourhoods contained within. Scores are calculated by taking the population weighted average of the combined scores for the neighbourhoods in a larger area. This measure also covers the whole area including both deprived and less-deprived neighbourhoods. The main difference from the average rank measure is that more deprived neighbourhoods tend to have more 'extreme' scores than ranks, so highly deprived areas will not tend to average out in the same way as when using ranks. With scores, highly polarised authorities will tend to score higher on the average score measure than on the average rank.

Proportion of LSOAs in most deprived 10 per cent nationally – this measure summarises the proportion of neighbourhoods in a larger area that are in the most deprived 10 per cent of neighbourhoods in the country. As such, this measure is only focused on illustrating the number of neighbourhoods within a larger area which are the most deprived in England. However, neighbourhoods just outside the 10 per cent most deprived are not included as part of this measure, so large areas, such as local authorities or local enterprise partnerships, may not appear to be so deprived relative to others if they contain zero or few of the most deprived neighbourhoods in the country.

Most deprived local authorities based on Rank

1. Blackpool
2. Manchester
3. Knowsley
4. Liverpool
5. Barking and Dagenham
6. Birmingham
7. Hackney
8. Sandwell
9. Kingston upon Hull
10. Nottingham

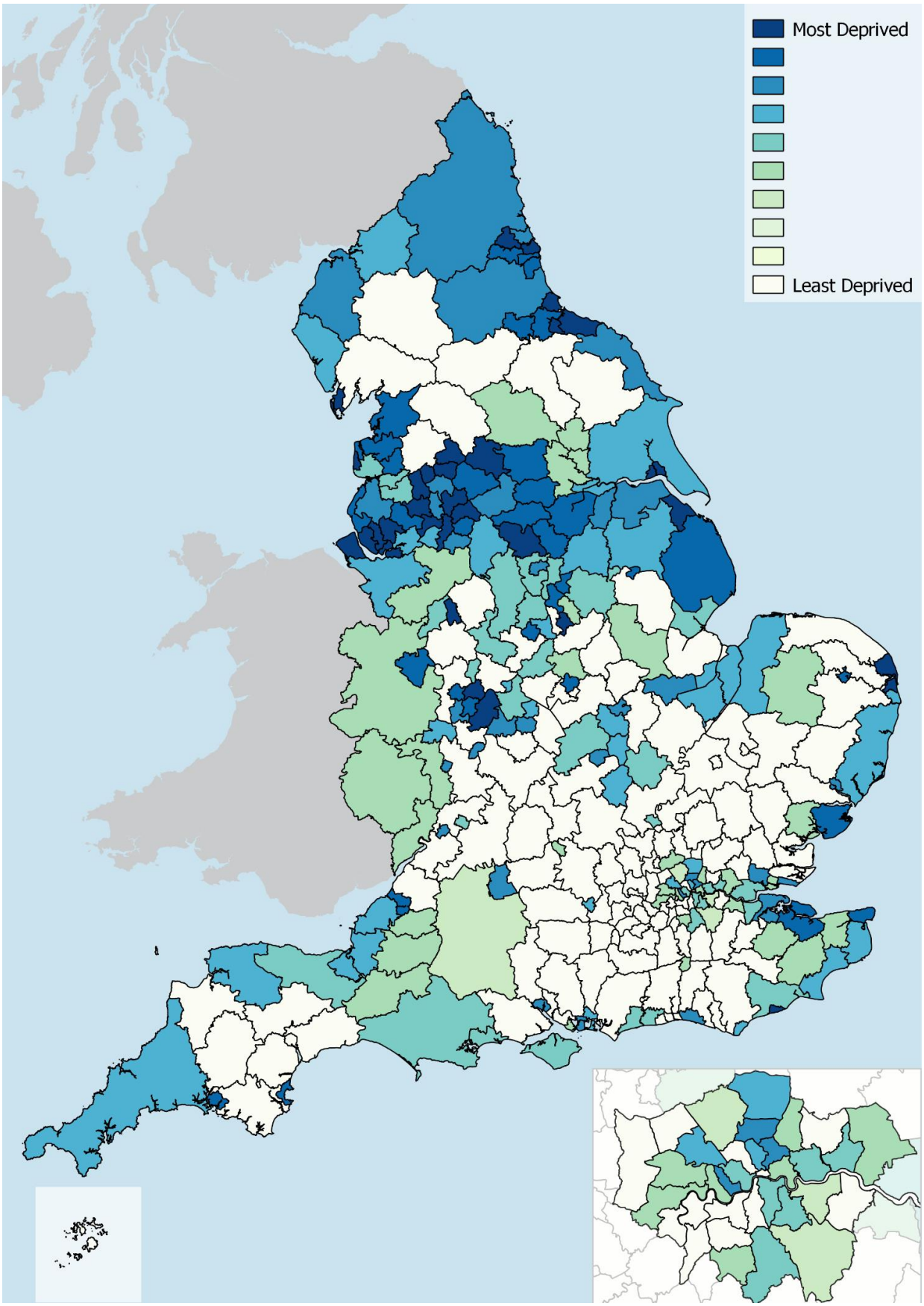
Most deprived local authorities based on Score

1. Blackpool
2. Knowsley
3. Liverpool
4. Kingston upon Hull
5. Middlesbrough
6. Manchester
7. Birmingham
8. Burnley
9. Blackburn with Darwen
10. Hartlepool

Most deprived local authorities based on the Proportion of LSOAs in the most deprived 10% nationally

1. Middlesbrough
2. Liverpool
3. Knowsley
4. Kingston upon Hull
5. Manchester
6. Blackpool
7. Birmingham
8. Burnley
9. Blackburn with Darwen
10. Hartlepool

Map 2: Distribution of the Index of Multiple Deprivation (IMD) 2019 by local authority based on the proportion of their neighbourhoods in the most deprived decile nationally



Note: there are 123 Districts with no Lower-layer Super Output Areas in the most deprived 10 per cent of areas. These areas score zero on this summary measure and are shown in the least deprived decile.

Map 2 illustrates the geographical spread of deprivation for local authority districts across England according to the proportion of neighbourhoods in the most deprived decile nationally. This higher-level geography masks some pockets of deprivation that are visible in **Map 1**. Areas shaded dark blue are the 10 per cent of local authority districts in England that contain the largest proportion of highly deprived neighbourhoods. Areas shaded pale green contain proportionately few highly deprived neighbourhoods and are relatively less deprived. In total, 123 of the 317 districts (39 per cent) do not contain any highly deprived neighbourhoods and are therefore equally ranked on this measure. These 123 districts are banded together and shown in pale green, corresponding to the least deprived decile.

Change at Local Authority Level since the Indices of Deprivation 2015 (IoD2015)

This section focuses on changes in relative deprivation at a local authority district level from the IoD2015 to the IoD2019. Care should be taken in interpreting change between updates of the Indices. The changes being described are relative, in terms of changes in the degree to which the neighbourhoods in a local authority district are among the most deprived nationally, as determined by each version of the Indices. If an area experienced some absolute decrease (i.e. improvement) in deprivation levels but less so than other areas, the Index would still show an increase in relative deprivation. Summary measures from the IMD2015 and some key domains have been reaggregated to 2019 local authority boundaries to aid the interpretation of relative changes (this data is available online as **File 14**).

It should be noted that geographically large local authorities shown on the **Map 2** may have relatively small populations, while geographically small authorities may contain larger populations. However, neighbourhood level LSOAs have a broadly consistent total population (see **Key Info** box on pg.5). Middlesbrough, Liverpool, Knowsley, Kingston upon Hull and Manchester are the five local authority districts with the largest proportions of highly deprived neighbourhoods in England, ranging from 49 per cent in Middlesbrough to 43 per cent in Manchester (see **Table 3**). By definition, each district would contain just 10 per cent of such highly deprived neighbourhoods if deprivation was evenly distributed across all local authorities in England.

The same five local authority districts have the greatest proportions of highly deprived neighbourhoods according to both the IMD2015 and the IMD2019 (**Table 3**). Middlesbrough was ranked most deprived according to the IMD2015 with just under half (49 per cent) of all neighbourhoods in the authority ranked as in the most deprived decile nationally. This has remained the same according to the IMD2019. The other areas have shifted in the rankings but remain in the top five for this summary measure.

Of the very most deprived neighbourhoods, the most deprived 1 per cent or 328 from 32,844 LSOAs in England, Liverpool is the local authority with the largest number of the most deprived areas (31 out of its 298 neighbourhoods, or 10 per cent are in this group). But Blackpool has the highest proportion of its neighbourhoods in the most deprived one per cent nationally (22 out of 94, or 23 per cent). See Table 4.4 of the Research Report for further analysis.

Table 3: The 20 local authority districts with the highest proportion of neighbourhoods in the most deprived 10 per cent of neighbourhoods nationally on the IMD 2019, and change since the IMD2015

	Local Authority	IMD2019		IMD2015		Percentage point change from 2015
		Count of LSOAs in 1st Decile	% of LSOAs in 10% most deprived nationally	Count of LSOAs in 1st Decile	% of LSOAs in 10% most deprived nationally	
1.	Middlesbrough	42	48.8%	42	48.8%	0.0
2.	Liverpool	145	48.7%	134	45.0%	3.7
3.	Knowsley	46	46.9%	45	45.9%	1.0
4.	Kingston upon Hull	75	45.2%	75	45.2%	0.0
5.	Manchester	122	43.3%	115	40.8%	2.5
6.	Blackpool	39	41.5%	36	38.3%	3.2
7.	Birmingham	264	41.3%	253	39.6%	1.7
8.	Burnley	23	38.3%	20	33.3%	5.0
9.	Blackburn with Darwen	33	36.3%	28	30.8%	5.5
10.	Hartlepool	21	36.2%	19	32.8%	3.4
11.	Bradford	104	33.5%	101	32.6%	1.0
12.	Stoke-on-Trent	51	32.1%	48	30.2%	1.9
13.	Halton	25	31.6%	21	26.6%	5.1
14.	Pendle	18	31.6%	16	28.1%	3.5
15.	Nottingham	56	30.8%	61	33.5%	-2.7
16.	Oldham	43	30.5%	32	22.7%	7.8
17.	North East Lincolnshire	32	30.2%	31	29.2%	0.9
- .	Hastings	16	30.2%	16	30.2%	0.0
19.	Salford	45	30.0%	43	28.7%	1.3
20.	Rochdale	40	29.9%	38	28.4%	1.5

Note: table based on 2019 local authority configurations. For 2019, Halton and Pendle rank 13th and 14th respectively and are presented here with the same percentage of LSOAs in the 10% most deprived nationally according to the IMD2019 due to rounding. North East Lincolnshire and Hastings (17th) are equally ranked according to the IMD2019.

Changes have also occurred between iterations in other areas. **Chart 3** shows the ten local authority districts that experienced the largest percentage point decreases on this summary measure and the ten which experienced the largest percentage point increases. A number of London Boroughs have seen large decreases in the proportion of their neighbourhoods that are highly deprived. In Tower Hamlets and Westminster in particular, there were reductions of 22 percentage points and 12 percentage points respectively. This is based on the percentage point change between the proportion of LSOA's present in a local authority area which are ranked in the most deprived 10 per cent nationally from the IMD2015 to the IMD2019. Oldham and Rossendale have seen an increase in the proportion of their neighbourhoods being ranked amongst the most deprived nationally. Oldham has seen an 8 percentage point increase in the proportion of its neighbourhoods ranked in the most deprived 10 per cent nationally. Rossendale has seen an increase of 7 percentage points.

Five of the ten local authority districts with the largest percentage point increases on this summary measure (Oldham, Walsall, Blackburn with Darwen, Halton and Burnley) were also among the most deprived districts nationally according to this summary measure. This is illustrated in **Chart 4** which depicts the 32 most deprived local authority districts according to this measure on the IMD2019 and how they have fared relative to other areas on the IMD2015.

Chart 3: Change in the proportion of neighbourhoods in the most deprived decile according to the IMD2019 and the IMD2015 by local authority district: the ten authorities with the largest percentage point decreases and increases respectively

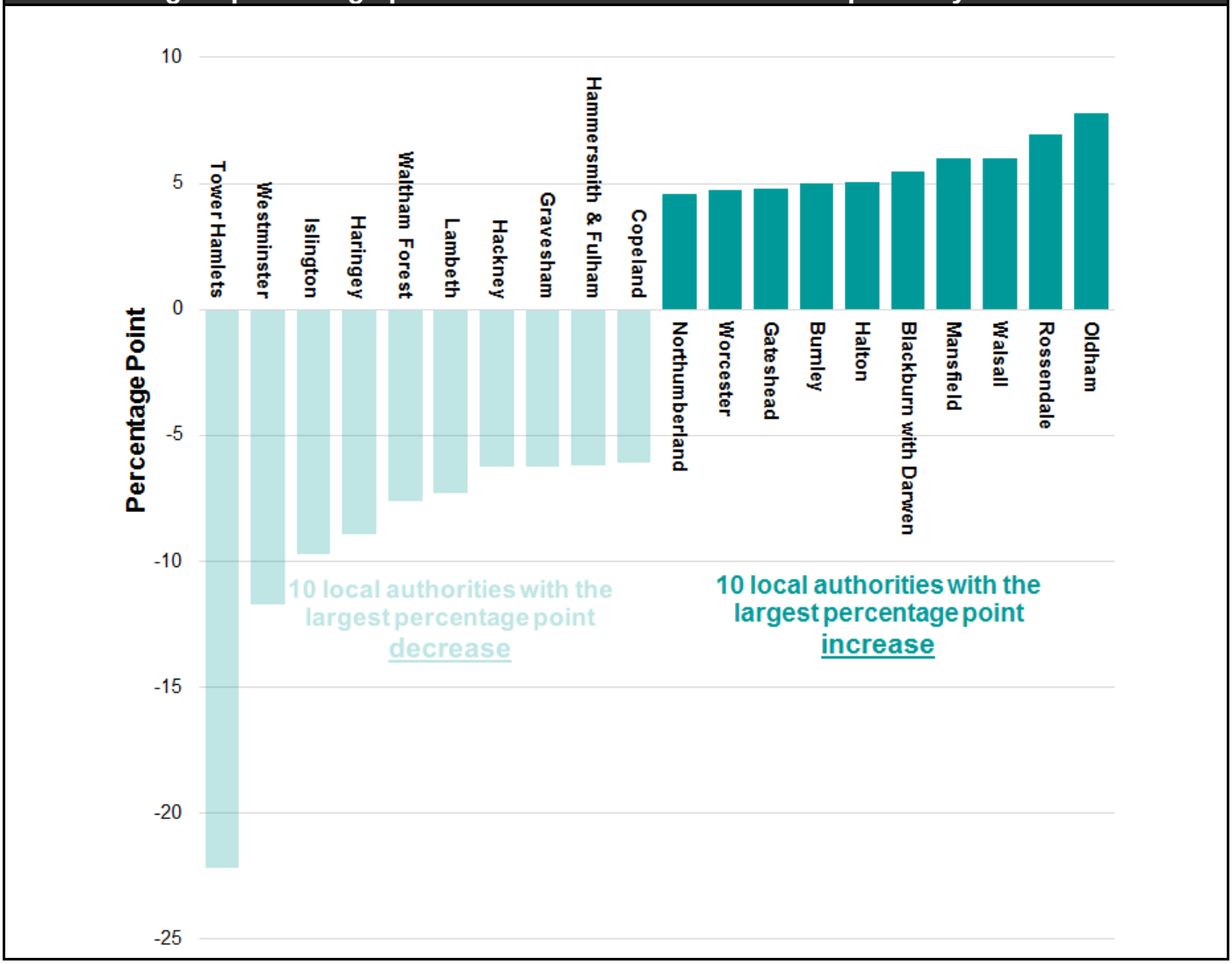


Chart 4 ranks local authority districts according to the proportion of their neighbourhoods that were in the most deprived decile of the Index at the time. The slope of the lines indicates change in rank position, that is whether the local authority district has become relatively more or less deprived. It is possible that a district may have become less deprived in real terms since the previous Index but more deprived relative to all other districts (or vice versa). However, any change in rank – even of several places – may not represent a large increase or decrease in absolute levels of deprivation.

The absence of any notable changes in rank among the five most deprived local authority districts is of interest as this indicates areas that have been persistently most deprived across historic iterations of the Indices. As well as being the five most deprived local authorities according to the IMD2019 and IMD2015, Middlesbrough, Liverpool, Knowsley, Kingston upon Hull, and Manchester have comprised the most deprived five local authorities since the IMD2010. These five areas were also among the ten most deprived local authorities according to the 2007 and 2004 updates (see Chart 5.4 of the Research Report).

There have been more visible changes further down the ranking. For example, areas such as Walsall, Wirral, South Tyneside and Redcar and Cleveland have become relatively more deprived compared to the IMD2015. Areas such as Wolverhampton, Leicester, Tower Hamlets and Sandwell have become relatively less deprived, given their presence in the most deprived 32 local authority districts according to the IMD2015 but their absence from the list according to the IMD2019.

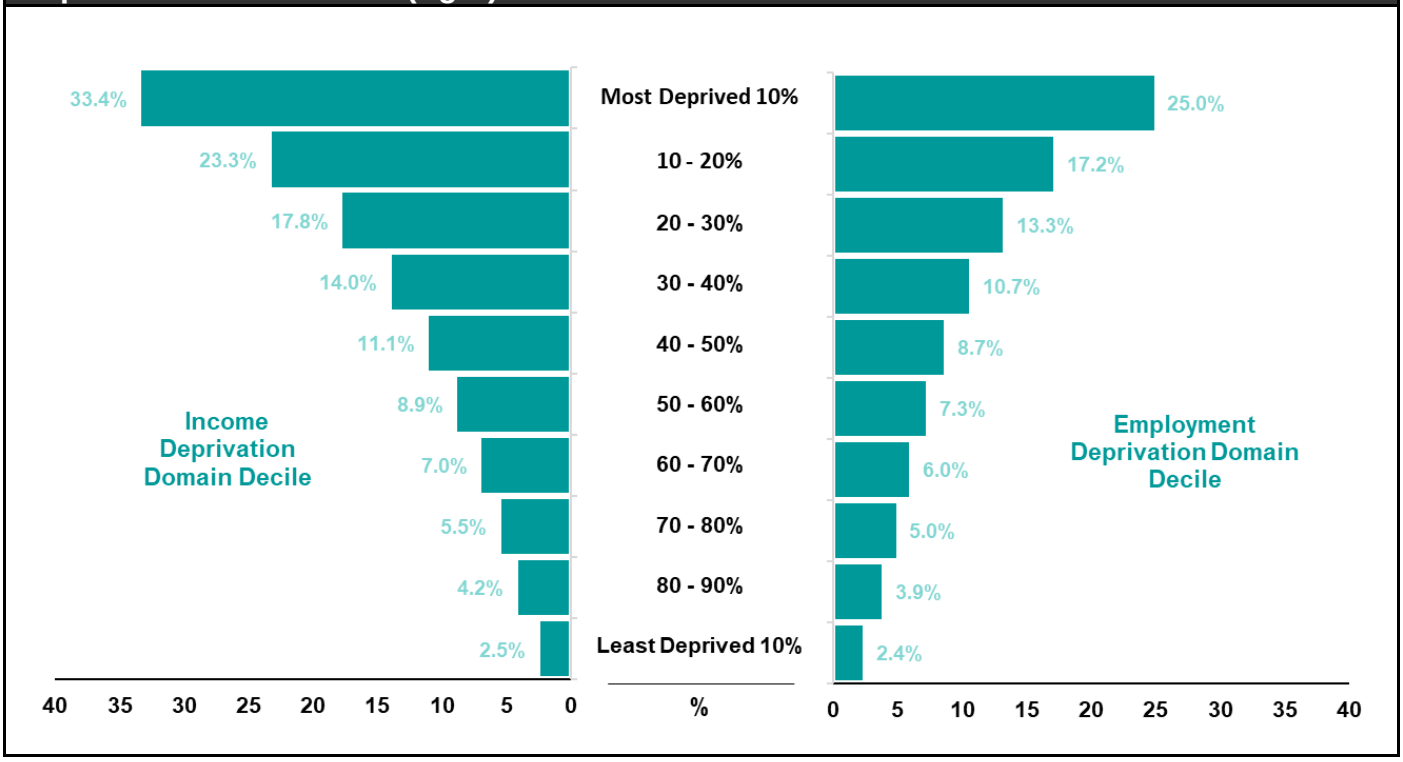
Chart 4: The most deprived local authority districts according to the IMD2015 and the IMD2019 - local authorities are ranked on the proportion of neighbourhoods in the most deprived 10 per cent nationally

Note: table based on 2019 local authority configurations. For the IMD2015, which has recast 2015 data to 2019 local authority boundaries, Stoke-on-Trent and Hastings are equally ranked (13th). For IMD2019, North East Lincolnshire and Hastings (17th) are equally ranked.

Income Deprivation and Employment Deprivation

The analysis so far has focused on the Index of Multiple Deprivation (IMD). This section focuses on the two domains of deprivation which contribute the most weight to the overall Index: the Income Deprivation Domain and Employment Deprivation Domain. In addition, this section explores the supplementary indices of income deprivation among children (IDACI) and older people (IDAOPI). These indices describe deprivation in terms of proportions of deprived people so allow for direct comparison of deprivation between areas.

Chart 5: Proportion of the population living in income deprived households, for all LSOAs grouped into deciles by Income Deprivation Domain rank (left) and proportion of working-age adults in employment deprivation, for all LSOAs grouped into deciles by Employment Deprivation Domain rank (right)



Levels of income deprivation and employment deprivation vary widely between neighbourhoods. In the most deprived decile of neighbourhoods on the Income Deprivation Domain, on average, 33 per cent of the population are income deprived. But in the least deprived decile of this deprivation domain, only 3 per cent of people are income deprived (**Chart 5**, left side). A similar pattern is observed for employment deprivation among the working-age population. In the most deprived decile of neighbourhoods on the Employment Deprivation Domain, on average, 25 per cent of the working-age adults are employment deprived, compared with 2 per cent of those in the least deprived decile of this domain (**Chart 5**, right side).

Because people experiencing employment deprivation are very likely to also experience income deprivation, the local authority districts that are ranked as most deprived on the Income Deprivation Domain are also ranked as most deprived on the Employment Deprivation Domain (see **Table 4**). Levels of income deprivation and employment deprivation are both highest in Knowsley, Middlesbrough, Blackpool, Liverpool and Hartlepool.

Table 4: The 20 local authority districts with the highest proportions of income deprivation and employment deprivation, respectively

Rank	Income Deprivation Domain		Employment Deprivation Domain	
	Local Authority District	Score - Proportion of population living in income deprived households	Local Authority District	Score - Proportion of working age adults in employment deprivation
1.	Middlesbrough	25.1%	Blackpool	20.9%
2.	Knowsley	25.1%	Knowsley	20.2%
3.	Blackpool	24.7%	Middlesbrough	19.1%
4.	Liverpool	23.5%	Hartlepool	18.5%
5.	Hartlepool	22.8%	Liverpool	17.6%
6.	Kingston upon Hull	22.7%	South Tyneside	17.2%
7.	Birmingham	22.2%	Kingston upon Hull	16.6%
8.	Manchester	21.9%	Redcar and Cleveland	16.5%
9.	Sandwell	21.5%	St. Helens	16.5%
10.	Blackburn with Darwen	21.2%	Burnley	16.3%
11.	Wolverhampton	21.1%	Blackburn with Darwen	16.2%
12.	South Tyneside	20.6%	Great Yarmouth	16.2%
13.	Burnley	20.3%	Sunderland	16.1%
14.	Hastings	20.2%	Hastings	16.0%
15.	Rochdale	20.1%	Halton	15.8%
16.	Walsall	20.0%	Rochdale	15.8%
17.	Nottingham	19.9%	Wirral	15.7%
18.	Leicester	19.6%	Thanet	15.5%
19.	Hackney	19.6%	Wolverhampton	15.4%
20.	Barking and Dagenham	19.4%	Birmingham	15.3%

Note: proportions derived from the published 'average score' statistics for the Income Deprivation Domain and the Employment Deprivation Domain.

The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. This is one of two supplementary indices and is a sub-set of the Income Deprivation Domain. The most deprived local authorities on this measure are typically found in the Midlands or the north of England. Around 30 per cent of children in Liverpool, Kingston upon Hull, Nottingham and Manchester are living in income-deprived families according to this measure. In Middlesbrough, Blackpool and Knowsley, over 30 per cent of children are living in income-deprived families (see **Table 5**).

The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. This is a second supplementary indices which is a sub-set of the Income Deprivation Domain. According to the IDAOPI, more than two in five older people are income deprived in Tower Hamlets and Hackney. Seven of the most deprived ten districts based on the IDAOPI are London boroughs.

Nine local authorities appear in the most deprived 20 nationally across both supplementary indices – Knowsley, Liverpool, Kingston upon Hull, Nottingham, Manchester, Birmingham, Islington, Tower Hamlets and Sandwell.

Table 5: The 20 local authority districts with the highest proportions of children and older people in income deprivation, respectively

Rank	Income Deprivation Affecting Children Index (IDACI)		Income Deprivation Affecting Older People Index (IDAOPI)	
	Local Authority District	Score - Proportion of children living in income deprived households	Local Authority District	Score - Proportion of older people living in income deprived households
1.	Middlesbrough	32.7%	Tower Hamlets	43.9%
2.	Blackpool	30.7%	Hackney	40.7%
3.	Knowsley	30.3%	Newham	37.3%
4.	Liverpool	29.9%	Manchester	33.6%
5.	Kingston upon Hull	29.8%	Islington	33.6%
6.	Nottingham	29.8%	Southwark	31.2%
7.	Manchester	29.7%	Lambeth	30.2%
8.	Hartlepool	28.3%	Liverpool	30.0%
9.	Birmingham	27.6%	Haringey	29.9%
10.	Islington	27.5%	Leicester	29.8%
11.	North East Lincolnshire	27.4%	Knowsley	29.4%
12.	Wolverhampton	27.1%	Barking and Dagenham	26.1%
13.	South Tyneside	26.7%	Sandwell	26.0%
14.	Tower Hamlets	26.6%	Birmingham	25.8%
15.	Hastings	26.5%	Brent	25.8%
16.	Sandwell	26.3%	Kingston upon Hull	25.7%
17.	Walsall	26.1%	Hammersmith and Fulham	25.6%
18.	Stoke-on-Trent	25.7%	Lewisham	24.0%
19.	Redcar and Cleveland	25.6%	Blackburn with Darwen	23.8%
20.	Burnley	25.5%	Nottingham	23.8%

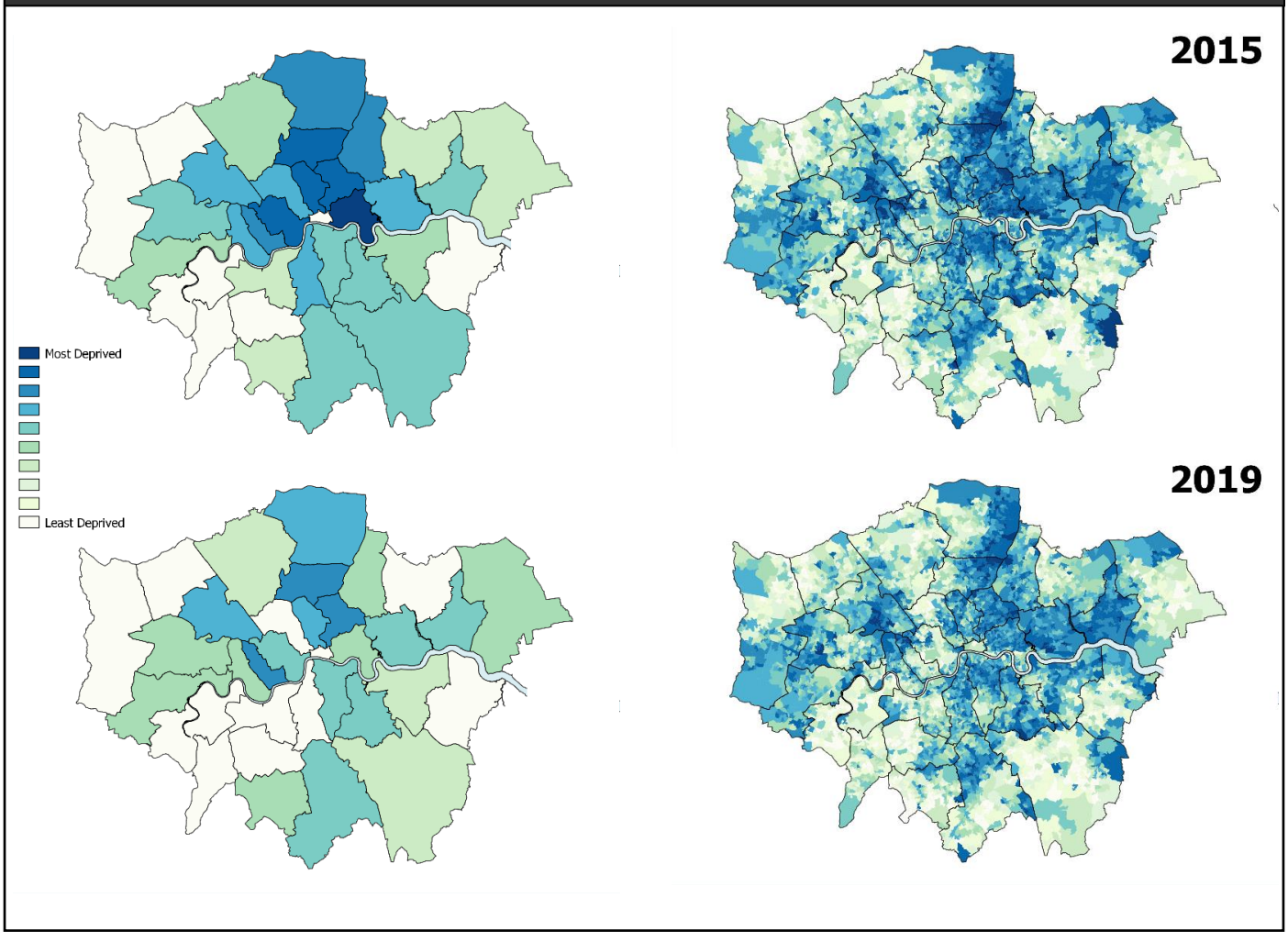
Note: proportions derived from the published 'average score' statistics for the supplementary indices of the Income Deprivation Domain, IDACI and IDAOPI.

Area Summary Case Study – London

Some areas have become less deprived between the IoD2015 and IoD2019. As a case study, local authority districts in London have seen a relative decrease in their levels of deprivation between the IMD2015 and the IMD2019. This overall pattern is shown in **Map 3**. According to the IMD2015, eight London Boroughs were ranked in the most deprived 30 per cent of local authorities when looking at the proportion of their neighbourhoods which were the most deprived nationally - Tower Hamlets, Haringey, Hackney, Islington, Westminster, Enfield, Kensington and Chelsea and Waltham Forest (see **Map 3**, left side). According to the IMD2019, only three London Boroughs are ranked in the most deprived three deciles (Hackney, Haringey Kensington and Chelsea). Tower Hamlets has become considerably less deprived on this measure, ranking 24 in the IMD2015 and 175 in the IMD2019 indicating that the neighbourhoods within the authority have become less deprived relative to other neighbourhoods in England.

This change can also be seen at LSOA level. According to the IMD2015, 274 LSOAs, or neighbourhoods, in London were in the most deprived decile. For the IMD2019, this has reduced to 107. This change is illustrated in **Map 3** (right side).

Map 3: Distribution of the IMD2015 and IMD2019 in London by local authority (left, based on the proportion of their neighbourhoods in the most deprived decile nationally) and LSOA (right, by IMD decile)



ANNEX B

Accompanying Tables, Reports and Resources

Accompanying tables are available to download alongside this release.

Neighbourhood (Lower-layer Super Output Area) level data

File 1	Index of Multiple Deprivation - the full Index of Multiple Deprivation (IMD2019) ranks and deciles at LSOA level across England
File 2	Domains of deprivation
File 3	Supplementary Indices - Income Deprivation Affecting Children Index (IDACI) and Income Deprivation Affecting Older People Index (IDAOPI)
File 4	Sub-domains of deprivation
File 5	Scores for the Indices of Deprivation (IoD2019)
File 6	Population denominators
File 7	All ranks, deciles and scores for the Indices of Deprivation, and population denominators (CSV file)
File 8	Underlying indicators
File 9	Transformed domain scores

Summary data for higher-level geographies

File 10	Local Authority District Summaries
File 11	Upper-tier Local Authority Summaries
File 12	Local Enterprise Partnership Summaries
File 13	Clinical Commissioning Group Summaries
File 14	Local Authority District Summaries from the IoD2015 reaggregated to 2019 Local Authority District boundaries

The following supporting reports and guidance documents have been published:

- An **Infographic** which illustrates how the Index of Multiple Deprivation is comprised and provides guidance concerning the use of Indices data.
- A **Frequently Asked Questions (FAQs)** document, providing a range of user guidance to aid interpretation of the data, caveats and answers to many of the most commonly asked questions.
- A **Research Report** provides guidance on how to use and interpret the datasets and presents further results from the IoD2019. It includes a full account of the set of summary statistics available for higher-level geographies such as local authority districts, with an example of their use, and advice on interpreting change over time.
- A **Technical Report** presenting the conceptual framework of the IoD2019; the methodology for creating the domains and the overall IMD2019; the quality assurance carried out to ensure reliability of the data outputs; and the component indicators and domains.

All of the data files and supporting documents are available from:
www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Previous versions of the Indices of Deprivation are available from:
www.gov.uk/government/collections/english-indices-of-deprivation

Open Data

These statistics are available in fully open and linkable data formats via the departments **Open Data Communities** platform:

- https://opendatacommunities.org/def/concept/folders/themes/societal-wellbeing
- Neighbourhood-level or Postcode level data - http://imd-by-postcode.opendatacommunities.org/imd/2019
- Local authority district level data: http://imd-bygeo.opendatacommunities.org/imd/2019/area

The **IoD2019 explorer** helps to illustrate the relative deprivation of neighbourhoods for selected areas according to the IoD2019 and IoD2015 and allows users to search by a place name or postcode. The explorer includes a dashboard which provides a brief summary of how relatively deprived the area selected is in each iteration. Data can be downloaded directly using this tool - http://dclgapps.communities.gov.uk/imd/iod_index.html#

Mapping Resources

The **IoD2019 Local Authority dashboard** allows users to explore the range of summary measures across the IoD2019 at local authority level and the LSOAs within each district. The maps displayed illustrate the location of the local authority within England, the LSOAs within the selected local authority and which decile each LSOA is in for the IMD2019 – https://www.gov.uk/guidance/english-indices-of-deprivation-2019-mapping-resources

A Geopackage, shapefiles, mapping templates and further **mapping resources** are available online here - https://www.gov.uk/guidance/english-indices-of-deprivation-2019-mapping-resources

MHCLG in collaboration with the University of Sheffield have created a suite of **Local Authority maps** covering all 317 districts in England. These are available online here - https://imd2019.group.shef.ac.uk/#. Each map uses the IMD2019 to illustrate deprivation at LSOA level within each area. Each map also displays the number of LSOAs each area has in each decile of deprivation.

Definitions

Indices of Deprivation (IoD2019)

The Indices of Deprivation 2019 provide a set of relative measures of deprivation for small areas (Lower-layer Super Output Areas) across England, based on seven different domains of deprivation: Income Deprivation, Employment Deprivation, Education, Skills and Training Deprivation, Health

Deprivation and Disability, Crime, Barriers to Housing and Services and Living Environment Deprivation. Two supplementary indices are also available; the Income Deprivation Affecting Children Index (IDACI) and the Income Deprivation Affecting Older People Index (IDAOPI).

The Index of Multiple Deprivation 2019 (IMD2019), domain indices and the supplementary indices, together with the higher area summaries, are collectively referred to as the IoD2019.

Index of Multiple Deprivation (IMD2019)

The Index of Multiple Deprivation 2019 combines information from the seven domains to produce an overall relative measure of deprivation. The domains are combined using the following weights: Income Deprivation (22.5%), Employment Deprivation (22.5%), Education, Skills and Training Deprivation (13.5%), Health Deprivation and Disability (13.5%), Crime (9.3%), Barriers to Housing and Services (9.3%), Living Environment Deprivation (9.3%). The weights have been derived from consideration of the academic literature on poverty and deprivation, as well as consideration of the levels of robustness of the indicators. A fuller account is given in section 3.7 and Appendix G of the Technical Report.

Income Deprivation Domain

The Income Deprivation Domain measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).

Employment Deprivation Domain

The Employment Deprivation Domain measures the proportion of the working age population in an area involuntarily excluded from the labour market. This includes people who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities.

Education, Skills and Training Deprivation Domain

The Education, Skills and Training Deprivation Domain measures the lack of attainment and skills in the local population. The indicators fall into two sub-domains: one relating to children and young people and one relating to adult skills.

Health Deprivation and Disability Domain

The Health Deprivation and Disability Domain measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation.

Crime Domain

The Crime Domain measures the risk of personal and material victimisation at local level.

Barriers to Housing and Services Domain

The Barriers to Housing and Services Domain measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: 'geographical barriers', which relate to the physical proximity of local services, and 'wider barriers' which includes issues relating to access to housing such as affordability and homelessness.

Living Environment Deprivation Domain

The Living Environment Deprivation Domain measures the quality of the local environment. The indicators fall into two sub-domains. The 'indoors' living environment measures the quality of housing; while the 'outdoors' living environment contains measures of air quality and road traffic accidents.

Income Deprivation Affecting Children Index

The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. Family is used here to indicate a 'benefit unit', that is the claimant, any partner and any dependent children for whom Child Benefit is received. This is one of two supplementary indices and is a sub-set of the Income Deprivation Domain.

Income Deprivation Affecting Older People Index

The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. This is one of two supplementary indices and is a sub-set of the Income Deprivation Domain.

Lower-Layer Super Output Areas (LSOAs)

LSOAs are small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 LSOAs in England. They are a standard statistical geography and were produced by the Office for National Statistics for the reporting of small area statistics. LSOAs are referred to as 'neighbourhoods' throughout this release.

Decile

Deciles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into 10 equal groups (i.e. each containing 3,284 or 3,285 neighbourhoods). These deciles range from the most deprived 10 per cent of neighbourhoods nationally to the least deprived 10 per cent of neighbourhoods nationally

ANNEX B

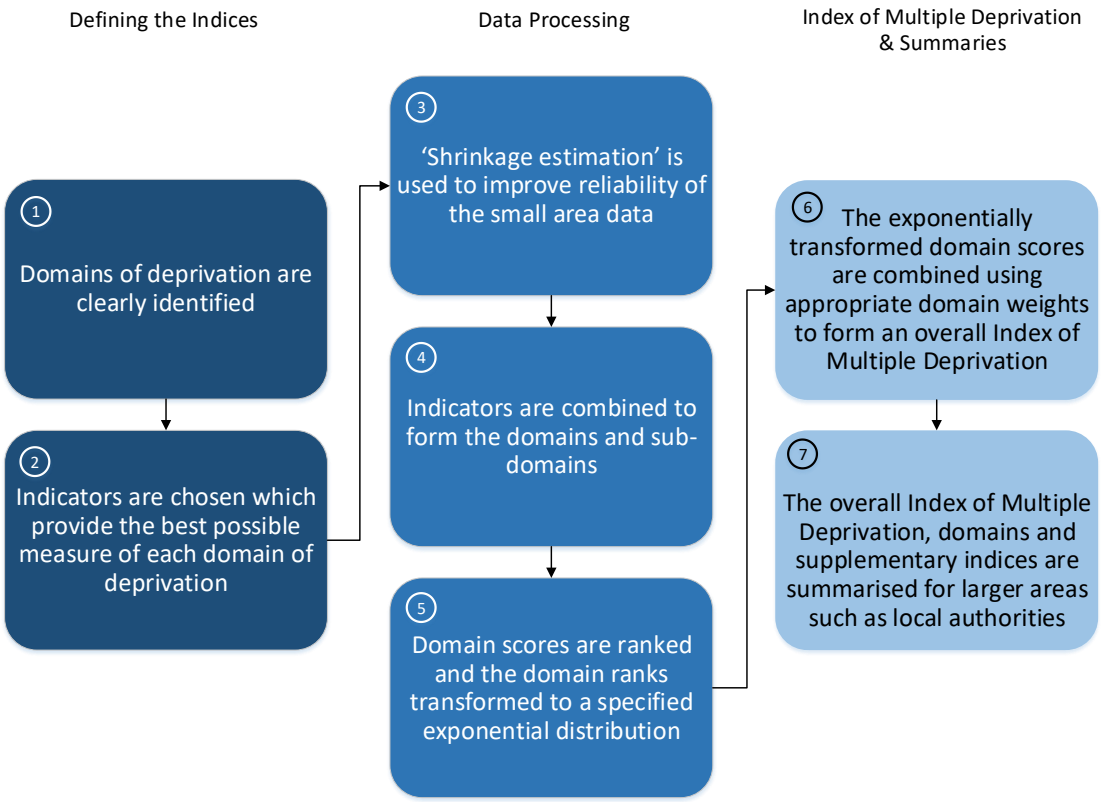
Technical Notes

Methodology and Data Sources

The Indices of Deprivation 2019 have been constructed for the Ministry of Housing, Communities and Local Government (MHCLG) by Oxford Consultants for Social Inclusion (OCSI) and Deprivation.org.

The construction of the Indices of Deprivation 2019 broadly consists of the following seven stages. These stages fulfil the purposes of defining the Indices, data processing, and producing the Index of Multiple Deprivation and summary measures. These stages are outlined in **Figure 2** below, which can also be found in the Research Report. Chapter 3 of the Technical Report describes these steps in more detail.

Figure 2: Overview of the methodology used to construct the Indices of Deprivation 2019

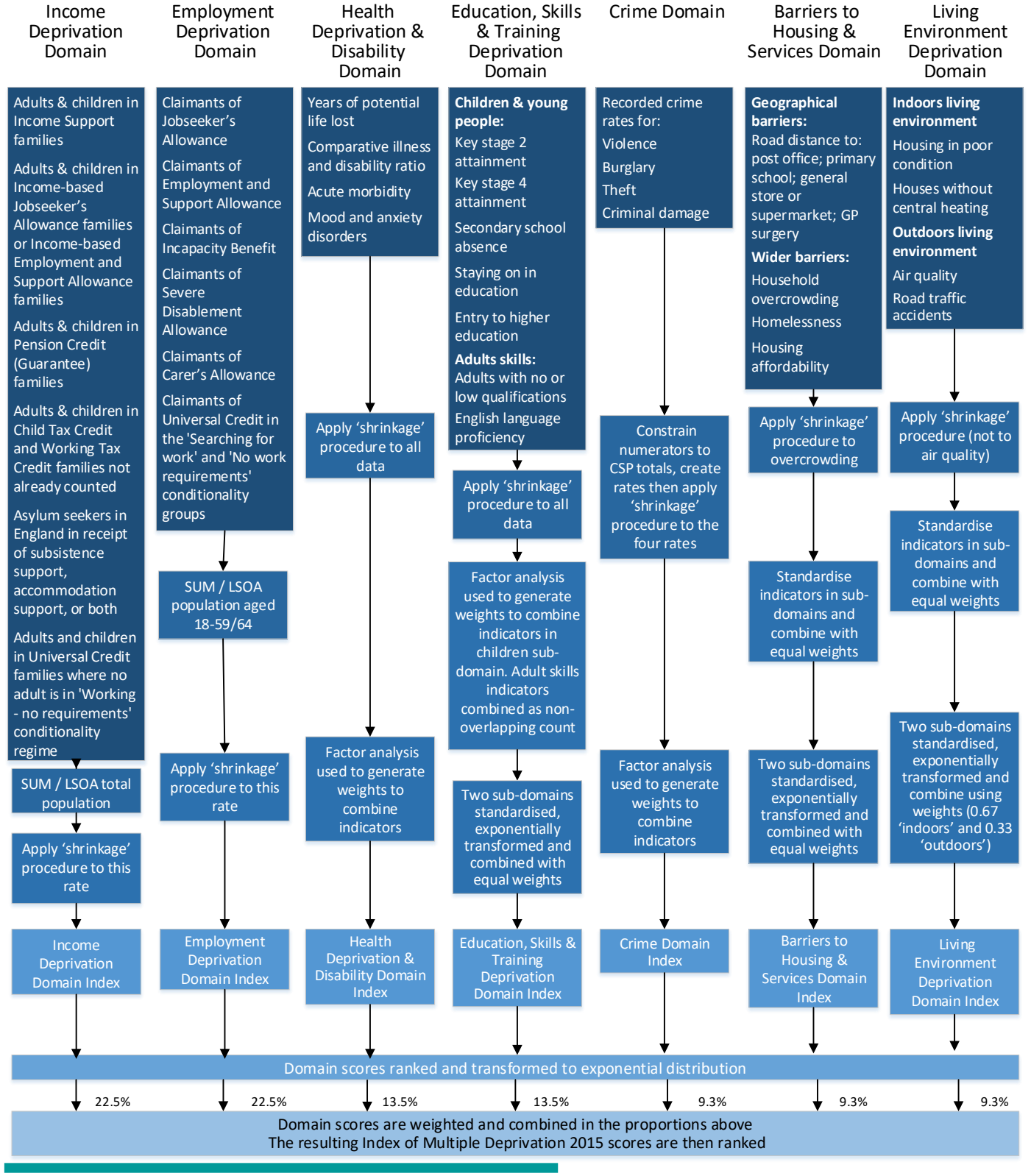


The majority of the data used for the indicators is sourced from administrative data such as benefit records from the Department for Work and Pensions. Census data is used for a minority of indicators where alternative data from administrative sources is not available. **Figure 3** below provides a summary of the domains, indicators and statistical methods used to create the IoD2019. This can also be found in the Research Report.

As far as is possible, the data sources used in each indicator were based on data from the most recent time point available. Using the latest available data in this way means that there is not a single consistent time point for all indicators. For the highest weighted domains, indicators in the Indices of Deprivation 2019 relate to a 2015/16 time point. As a result of the time points for which

data is available, the indicators do not take into account changes to policy since the time point of the data used. For example, the 2015/16 benefits data used do not include the impact of the wider rollout Universal Credit, which only began to replace certain income and health related benefits from April 2016. Chapter 4 and Appendix A of the Technical Report describe the 39 component indicators in the Indices of Deprivation 2019, including the data sources and time points used.

Figure 3: Summary of the domains, indicators and data used to create the Indices of Deprivation 2019



ANNEX B

Data Quality

The Indices of Deprivation 2019 follow on from the previous iterations of the release and have been carefully designed to ensure the robustness and reliability of the output datasets and reports. The design is based on a set of principles and practices that help to ensure data quality. These are described in Chapter 5 of the Technical Report. For example, the domains and Index of Multiple Deprivation bring together 39 indicators of deprivation, from a wide range of data sources (see **Figure 3** above). This sheer diversity of inputs leads to more reliable overall data outputs; to be highly deprived on the Index of Multiple Deprivation, an area is likely to be highly deprived on a number of the domains. Due to the variety of data inputs, there is little chance that an area is identified as highly deprived due to a bias in one of the component indicators; the use of multiple independent indicators increases robustness of the final outputs. The construction of the Indices involves a number of different processes. The quality assurance procedures for the methods, input data sources, data processing steps and outputs build on the experience held by members of the department's contractors (OCSI and Deprivation.org) in developing the Indices of Deprivation since 2000. These are described in Chapter 5 of the Technical Report (with further details in Appendices J, K and L) and include, but are not limited to:

- Use of appropriate and robust indicators, based on well understood data sources. The preference was to use, wherever possible, existing high-quality published data sources that have themselves been validated as National Statistics (or variations thereof). In the absence of these, the second preference was to derive indicators from established and well-understood administrative data sources. In a small number of cases, specially-modelled indicators were used. In determining whether the data source was suitable for the purpose of measuring deprivation the quality of each input data source used was assessed and documented, and there was close communication with data suppliers to ensure the strengths and weaknesses of the underlying data were well understood.
- Minimising the impact of potential bias and error in the input data sources through the design principles outlined above.
- Using audited, replicable and validated processing steps to construct the Indices.
- Real world validation of the data inputs and outputs.

The quality assurance process also drew on the quality assurance and audit arrangements practice models developed by the UK Statistics Authority to ensure that the assessment of data sources and methodology carried out is proportionate to both the level of public interest in the Indices, and the scale of risk over the quality of the data.

Revisions policy

This policy has been developed in accordance with the UK Statistics Authority Code of Practice for Official statistics and the Ministry of Housing, Communities and Local Government Revisions Policy (found at https://www.gov.uk/government/publications/statistical-notice-dclg-revisions-policy). There are two types of revisions that the policy covers:

Non-Scheduled Revisions

The Indices of Deprivation draw upon the best available data at the time of their production and, as outlined above, undergo a substantial range of quality assurance checks. However, should an error be identified, the department will consider its impact and review whether an unscheduled revision is required.

Scheduled Revisions

There are no scheduled revisions to the Indices of Deprivation 2019.

Uses of the Data

Since their original publication in 2000 the Indices of Deprivation have been used very widely for a range of purposes, including:

- By national and local organisations to identify places for prioritising resources and more effective targeting of funding;
- To help inform eligibility for Government policies and indicatives;
- Developing the evidence base for a range of national and local policies and strategies;
- Frequent use in funding bids, including bids made by councillors for their neighbourhoods, and from voluntary and community sector groups.

The Indices of Deprivation are appropriate for such uses where deprivation is concentrated at a neighbourhood level. Examples of uses of the Indices are also available in section 1.3 of the Research Report.

User Engagement

As part of the IoD2015, extensive user engagement exercises were carried out to help inform the release and improve the Indices as a resource to help better suit the broader needs of all groups. These recommendations have been carried over to help inform the construction of the IoD2019 with a specific focus on consistency of method and the timely release of an updated dataset. Alongside, key user groups have been consulted to help develop a more complete and comprehensive suite of outputs and resources. The department is grateful to users of the Indices who contributed their thoughts on the development of this update and on how the outputs could be improved.

Users are encouraged to provide feedback on how these statistics are used and how well they meet user needs. Comments on any issues relating to this statistical release are welcomed and encouraged. Responses should be addressed to the "Public enquiries" contact given in the "Enquiries" section below.

The department will also seek opportunities to disseminate the Indices and meet with users through seminars, conferences and bespoke events.

The departments engagement strategy to meet the needs of statistics users is published here: https://www.gov.uk/government/publications/engagement-strategy-to-meet-the-needs-of-statistics-users

The views expressed on the Indices during the course of this update and following this publication, such as on outputs and changes to indicators, will be revisited when the department embarks on the next update. Information on how users will be kept informed of future updates and how they can contribute their views is given below under 'Date of the next publication'.

Devolved Administration Statistics

Indices of Deprivation data is published for each of the countries in the United Kingdom. These datasets are based on the same concept and general methodology, however there are differences in the domains and indicators, the geographies for which the indices are developed and the time points on which they are based. These differences mean that the English Indices of Deprivation published here should not be directly compared with those from the Indices produced in Wales, Scotland and Northern Ireland.

The Office for National Statistics previously published information explaining in more detail the similarities and differences between the four Indices: https://webarchive.nationalarchives.gov.uk/20141119170512/http://neighbourhood.statistics.gov.uk/dissemination/Info.do?page=analysisandguidance/analysisarticles/indices-of-deprivation.htm

The most recent Indices of Deprivation data for the Devolved Administrations are available via the links below:

- Welsh Index of Multiple Deprivation (WIMD) - https://gweddill.gov.wales/statistics-and-research/welsh-index-multiple-deprivation/?lang=en
- Scottish Index of Multiple Deprivation (SIMD) - https://www2.gov.scot/Topics/Statistics/SIMD
- Northern Ireland Multiple Deprivation Measure - https://www.nisra.gov.uk/statistics/deprivation

The department continues to work with the devolved administrations to explore future opportunities for UK wide alignment.

Enquiries

Media enquiries:

Office hours: 0303 444 1209
Email: newsdesk@communities.gov.uk

Public enquiries:

Office hours: 0303 444 0033
Email: indices.deprivation@communities.gov.uk

Queries submitted to the address above will receive an automatic acknowledgement stating that the query has been received. We will endeavour to respond to queries within 20 working days, and more quickly when possible. Complex queries may take longer to resolve. Where the answer to a query is contained within the auto response message, users may not receive a direct reply. Users are encouraged to review the guidance documents prior to emailing the department. The Indices of Deprivation draws upon the best available data at the time of its production and, as outlined above, they undergo a substantial range of quality assurance checks. Where queries relate to the perceived accuracy of the data that feeds into the Indices, it may not be possible to explore all concerns raised but the department will consider referring issues with specific data sources to the suppliers.

Information on Official Statistics is available via the UK Statistics Authority website:
https://www.gov.uk/government/statistics/announcements

Information on other MHCLG statistics is available online here:
www.gov.uk/government/organisations/department-for-communities-and-local-government/about/statistics

Date of the Next Publication

The Indices of Deprivation are typically updated every 3 to 4 years, but the dates of publication for future Indices have not yet been scheduled. Users can be kept informed of future updates, developments and how they can contribute their views by registering for e-mails alerts about the Indices. To register, please e-mail indices.deprivation@communities.gov.uk with ‘subscribe’ in the subject heading.

This document/publication is also available on our website at www.gov.uk/MHCLG
If you have any enquiries regarding this document/publication, email contactus@communities.gov.uk or write to us at:

Ministry of Housing, Communities and Local Government
Fry Building
2 Marsham Street
London
SW1P 4DF
Telephone: 030 3444 0000

September 2019

For all our latest news and updates follow us on Twitter: https://twitter.com/mhclg

This page is intentionally left blank

Health and Wellbeing Board July 21st 2021

Report of the Joint Consultant in Public Health, Vale of York CCG / City of York Council

York Health and Care Alliance Update

Summary

1. This report is to provide an update on the progress of the York Health and Care Alliance, including minutes of Alliance meetings for Board members to note.

Background

2. The York Health and Care Alliance was established in April 2021 as our city's response to the changes and reorganisation of the NHS proposed in the government's white paper 'Integration and Innovation'.

3. The Alliance Board was established as a sub-group of the Health and Wellbeing Board through consultation with the Health and Wellbeing Board and through Full Council in April 2021. Papers relating to the establishment the Alliance board, including a description of its purpose and its terms of reference, can be found in Council Executive papers from their meeting on 18th March 2021.

4. As part of this arrangement, an update on the Alliance Board and minutes of meetings held since April are presented to the Health and Wellbeing Board in this paper.

Main/Key Issues to be Considered

Update on NHS reforms

5. Two key documents have been recently published which set out some more information on the government's plans for health and social care after April 2022.

6. The first is the Health and Social Care Bill, published on the 6th July. This lays out the legislative framework for the changes which were first proposed in the 'Integration and Innovation' White paper. The key reforms include:

- The statutory establishment of Integrated Care Systems (locally, Humber Coast and Vale ICS)
- The constitution of an ICS consisting of two statutory bodies:
    - the ICS Partnership (including local authority membership) to support integration, promote partnerships and develop a plan to address systems' health, public health and social care needs
    - the ICS NHS Body which will run the NHS day-to-day in local systems
- The abolition of Clinical Commissioning Groups and merger of staff, functions, assets and liabilities into their local ICS
- Specific changes to the procurement and provider selection regime in the NHS, removing many of the elements of competitive tendering and aiming to foster more collaborative approaches to give greater flexibility to how services are delivered
- Giving the Secretary of State interventional powers, including power to intervene in local service reconfiguration and power to transfer functions between Arm's Length Bodies
- Specific provisions around social care (e.g. on data sharing), public health (e.g. measures on advertising of products high in fat, salt and sugar) and safety (e.g. establishment of a Health Services Safety Investigations Body)

7. The second is the ICS Design Framework, which sets out guidance on how ICSs should arrange themselves locally. This includes:

- Constitution and membership of the two statutory ICS groups

- arrangements for place-based partnerships, along with five options for governance arrangements at place level
- arrangements for provider collaboratives around specific health and care sectors, for instance acute care and primary care

8. There is currently a great deal of work happening within the regional (Humber Coast and Vale), sub-regional (North Yorkshire and York) and local (York) geographies to agree how arrangements for decision making and commissioning health care services will be made after the abolition of CCGs in April 2022. This involves determining the future of a large range of statutory and non-statutory functions, significant contracts and budgets, and a large number of staff. It is a complex piece of work with some significant uncertainties still remaining. However over the last few months partners in York have developed close collaboration to tackle these challenges, and together have outlined a strong ambition to create future structures and future relationships which will serve to improve population health and deliver integrated, high quality services.

9. Links to both the Health and Social Care Bill and the ICS Design Framework are given below.

Alliance Board meetings

10. The York Health and Social Care Alliance has met monthly since April 2021, with the membership, aims and purpose and terms of reference presented to the council Executive in March.

11. Topics discussed so far as part of the board's work include:

- The ICS ambitions for place-based partnerships
- Alliance 'areas of first focus':
  - Diabetes and Healthy Weight
  - Learning disabilities and autism
  - Mental Health
  - Complex care
- The development of the Population Health Hub in York

- Section 75 arrangements / joint commissioning models between health and care
- Quality and service improvement
- Developing an Alliance engagement and coproduction approach
- Elective recovery

Consultation

12. The work of the Alliance involves key partners from each health and care provider organisation in the city and all of them have been heavily involved in its work. A number of engagement events have been held to share the plans and details on NHS reforms with partners in the city, and more will be possible when the detailed structures have been agreed.

Options

13. The HWBB will receive further reports on the progress of the NHS reforms and the York Health and Care Alliance.

Strategic/Operational Plans

14. The Joint Health and Wellbeing Strategy is the overarching strategic vision for York, and the work of the York Health and Care Alliance supports the delivery of the desired outcomes.

Implications

- **Financial** – There are no financial implications as yet from this report. Any future decisions about finances take by the Alliance will be made through the governance of each partner organisation at this stage, while the Alliance is a partnership rather than a formally constituted body.

- **Human Resources (HR)** – There are no human resources implications as a result of this paper, but significant HR implications of the NHS reforms in general should be noted.

- **Equalities** – the Alliance aligns with the Health and Wellbeing Strategy in aiming to tackle and improve health inequalities

- **Legal** - There are no legal resources implications as a result of this paper, but significant legal and contractual implications of the NHS reforms in general as noted above
- **Crime and Disorder** - none
- **Information Technology (IT) –**none
- **Property** - none
- **Other** – none.

Risk Management

15. Governance processes are in place between the partners to manage the strategic risks of these reforms

Recommendations

16. The Health and Wellbeing Board are asked to:

- Note the update on the NHS reforms and work of the York Health and Care Alliance
- Note and receive the minutes of the York Health and Care Alliance

Contact Details

Author:

Peter Roderick
Joint Consultant in Public Health, Vale of York CCG and City of York Council
Peter.roderick@york.gov.uk

Chief Officer Responsible for the report:

Sharon Stoltz
Director of Public Health
City of York Council

Report Approved *x* **Date** *12/07/2021*

Report Approved *x* **Date** *12/07/2021*

All *x*

Wards Affected: *List wards affected or tick box to indicate all [most reports presented to the Health and Wellbeing Board will affect all wards in the city – however there may be times that only a specific area is affected and this should be made clear]*

For further information please contact the author of the report

Background Papers:

Health and Social Care Bill – available here

ICS design framework – available here

Annexes

Annex 1 – York Health and Care Alliance Minutes (April and May 2021)

Annex 1

York Health and Care Alliance Board

Minutes of the meeting of the York Health and Care Alliance Board in shadow form on 26 April 2021 conducted via Microsoft Teams

Present

Cllr Keith Aspden (Chair)	Leader City of York Council
Gail Brown	Chair, York School and Academies Board
Dr Rebecca Field	Joint Chair of York Health and Care Collaborative
Amanda Hatton	Corporate Director People, City of Yok Council
Professor Mike Holmes	Chair, Nimbuscare York
Emma Johnson	Chief Executive, St Leonards Hospice
Brent Kilmurray	Chief Executive, Tees, Esk and Wear Valleys Foundation Trust
Phil Mettam	Accountable Officer, Vale of York CCG
Simon Morritt	Chief Executive, York and Scarborough Hospital NHS Foundation Trust
Alison Semmence	Chief Executive, York CVS
Sharon Stoltz	Director of Public Health, City of York Council

In Attendance

David Hambleton	DH Leadership Alliance, NECS Associate
Denise Nightingale	Executive Director of Transformation, Complex Care and Mental Health, Vale of York CCG
Tim Madgwick	Independent Chair of the York Health and Wellbeing Board's Mental Health Partnership
Rob McGough	Partner, Hill Dickinson LLP
Peter Roderick	Consultant in Public Health, City of York Council/VOY CCG
Eleanor Tunnicliffe	Legal Director, Hill Dickinson LLP
Jo Baxter	Executive Assistant, Vale of York CCG

AGENDA

The agenda was discussed in the following order.

1. Welcome and update on action points from the last meeting

The chair welcomed everyone to the meeting and noted there were no apologies.

In reviewing the actions from the previous meeting, Phil referred to the response from the Integrated Care System (ICS) circulated earlier in the day. He highlighted that the letter was a positive endorsement of the work of the Alliance so far with encouragement to continue. The ICS would join a future meeting as local and national guidance emerged.

Board members were reminded to provide details of the Concord ratification within their organisations to complete the central record and feedback on the Shared Learning from Covid-19 paper.

Integration with the York Health and Care Collaborative (YHCC)

In response to a query at the last meeting, a discussion had taken place outside of the meeting to explore the role of the existing YHCC within the overall Alliance. Rebecca reported back on the meeting and provided a presentation on the YHCC; this encompassed the current structure and function of YHCC, the role and membership of the group and outlined the progress made so far.

She highlighted the overlap in terms of YHCC work and identified programmes of the Alliance Board and the opportunities this could bring to align priorities by working together within the Alliance. Proposed next steps from YHCC included a reform of its membership and purpose to provide an executive function and feedback was sought from Board members in this respect.

Phil referred back to a discussion at the last meeting where support had been received to explore a proposed Alliance Leadership Team to take forward and enact the agreed priorities and help develop the behaviours of people in the system. It was proposed that David, with nominated representatives from the Board would also consider how this could be taken forward with the proposal from YHCC**.**

The Board:

- Noted the proposal from YHCC
- Were supportive of further exploration regarding the development of an Alliance Leadership Team and whether this could be based on the YHCC ahead of the next meeting in May.

2. Consideration of programmes for the areas of first focus, including programme leads

Denise and Tim joined the meeting for this item

The Chair welcomed Denise and Tim to the meeting who would present around the agreed areas of first focus for the Alliance.

Complex Case Management

Denise referred to the paper which outlined the first phase of integrating elements of Vale of York CCG's complex care services with the City of York Council's (CYC) adult social care services. This was in line with the health and social care White Paper.

The areas in scope for the first phase had been considered where there were currently joint responsibilities for funding and case management and moving to a fully integrated approach would offer services and user groups maximum benefits to patients and the system at place; these were proposed as:

- Health and social care joint funded package of care
- Discharge to assess funding (pre-covid-19 pandemic)
- Section 117 Aftercare

Commencing the programmes of work as outlined in the paper would allow statutory organisations to gain confidence and assurance with new and joint ways of working ahead

of Section 75 agreement in 2022 when new governance arrangements would be set up.

Approval was therefore being sought to develop the first phase of the plan set out in the paper to align care services and budgets across health and social care in advance of formal Section 75 agreement being developed for April 2022.

Amanda welcomed the paper and commented that a review of where the work was being undertaken would be sensible to avoid any duplication. In addition, Amanda would share lessons learned from a recent positive exercise on reviews undertaken by CYC. Brent also welcomed the paper which he felt could bring positive changes for practitioners; he requested that consideration be given to engagement with users and carers (s117) around any new approaches.

The Board:

- Approved the first phase of Health and Social Care Integration for Complex Care

York Mental Health Summit

Tim joined the meeting to provide an update from the recent York Mental Health Summit; this had been arranged as a call to action to address the predicted surge in mental health need and the increased pressure on services across the city. The Summit had been well attended by two York MPs and senior representatives from key organisations.

Tim summarised the key actions identified from the Summit and sought commitment from Board members to help progress the actions. The report was also being presented to the York Health and Wellbeing Board with regular meetings in place to move the agenda forward.

The Board:

- Noted the report and committed to progressing the action plan within their organisations.

Learning Disabilities and Autism

Denise advised that further thought was required in this area in respect of the Alliance alongside the work of an existing Transforming Care Partnership and a paper would be presented back to the Board in the coming months.

Amanda added that the paper should also consider the work of the current SEND Improvement Board in place.

The Board:

- Noted that the item would be discussed at a future meeting

3. Approach to NHS elective recovery in York

Peter presented on the work taking place to understand how patients could be supported

as they waited for care; this was being established as the "Waiting Well Programme". The improvement work would be critical to the collective recovery across the ICS, keeping patients safe and avoiding more pressure on waiting lists and workforces.

The HCV Partnership (ICS) Clinical and Professional Leaders Group had recognised the scale of the number of patients on waiting lists across the ICS, and the risk of potential deterioration along with poor patient and clinical experience and had asked a task and finish group to look in detail at how patients on surgical waiting lists could be supported during their time whilst waiting for an operative intervention.

A Waiting Well approach was therefore being developed centred around need, risk and wrap around support available. The Clinical and Professional Group had proposed a methodology using predictive modelling for the risk stratification, which had transformational funding approved from the ICS and would shortly start working with acute providers to roll out.

The Board:

- Noted the work underway and welcomed future updates

4. Agreeing a Partnership Development Plan including establishing an Alliance Leadership Team

David, Rob and Eleanor left the meeting for this item and re-joined after the break

The external support provided to develop the York place-based model so far had now come to an end. Phil recapped on the discussion at the previous meeting where the Board had agreed that further developmental input would be essential to maintain momentum and expertise over the coming year.

Hill Dickinson and NECS had now prepared their proposal which would see a continuation of the support including facilitated conversations, organisational development and legal support building on the previous work to develop the model and work towards the implementation and development of the City of York Place with the intention of preparing this for operation, as a place-based partnership operating under the new legal framework from April 2022.

The Chair welcomed comments from Board members who confirmed their support to the proposal. Phil would therefore take this forward with the ICS regarding financial support alongside the continued ambition to be an exemplar in the ICS and wider.

In respect of the valued external support, a suggestion to consider bespoke input to different partners via additional and dedicated sessions with focus groups was agreed as helpful and Phil would follow this up with Hill Dickinson and NECS.

The Board:

- Were supportive of the proposal for continued external support
- Welcomed consideration of external bespoke input via focus groups

5 MINUTE BREAK

5. Doing engagement differently

Alison presented a paper on the proposed approach to engagement for the Alliance which had been written collaboratively by engagement leads at York CVS, Vale of York CCG and City of York Council to begin the conversation about engagement and citizen voice in the work of the Alliance.

The paper highlighted the desire for a co-production approach to service design and outlined the practical implications for the work of the Alliance with recommendations on how to proceed.

The Chair welcomed comments on the paper and the challenges of co-production were acknowledged by Board members with examples provided where this had been unsuccessful. It would be important to learn from these approaches as the Alliance continued to aspire to co-production and synergy across existing meetings, such as the Health and Wellbeing Board would also need to be considered.

Board members thanked Alison for the paper and were supportive of the approach and further intelligence being gathered to support the proposed direction.

The Board:

- Supported the Proposed Approach to Engagement paper.
- Requested that an update on progress be presented at the June meeting.

6. Establishing a Population Health Hub in York

Peter presented his paper on the proposed Population Health Hub which had stemmed from discussions at previous workshops in setting up the Alliance. It was proposed that the Hub would focus on issues of population health, health inequalities, and the health and care services which impacted both those things and then build and shape systems, organisations and staff accordingly. The paper detailed the anticipated new way of working through the Alliance with a suggested operating model and areas of first focus.

Board members were being asked to approve the formation of the Hub with comments requested on the suggested functions for the Hub and the resources needed.

In response to a query, Peter clarified that the funding had been identified for the initial Core Hub team from a mix of current roles within the CCG and CYC public health. Funding from current vacancies within CYC and the CCG had been identified for the intelligence analyst posts awaiting final sign off. The benefits of securing CCG staff to support the work now in the CCG transition period was noted

The Board:

- Approved the formation of the Population Health Hub

7. Developing Opportunities for Integration CCG / CYC

Sharon gave a presentation to update Board members on discussions to date between the CCG and CYC around integration opportunities. The presentation set out the potential areas for integration with proposed priorities for the next 4-6 months, focussed on those with achievable outcomes within the timescales.

Phil advised that the priorities would help with the understanding of where CCG work could sit in the new system from April 2022; an update on the work happening across the ICS was also suggested by Simon to compliment this.

Amanda requested that consideration be given, at a future meeting, to a discussion and sense check around children's services in the emerging health arrangements and structures.

The Board:

- Noted the work in progress
- Requested an update on work across the ICS and a discussion on children's services at a future meeting

8. Any Other Business

Prior to opening for any other business, the Chair welcomed Gail Brown, Chair of York School and Academies Board who had joined part way through the meeting. The inclusion of York School and Academies Board was now reflected in the Alliance Concord and Gail would become their representative.

Urgent Care Review

Mike referred to the Urgent Care review taking place as current contracts came to an end. He advised that managed conversations were happening, and an Urgent Care Alliance had been put in place to ensure the right decisions were being made for the population of York. The CCG was also involved in the discussions. Mike described the situation as a good learning opportunity for commissioning in the new world and suggested regular updates were brought back to the Alliance.

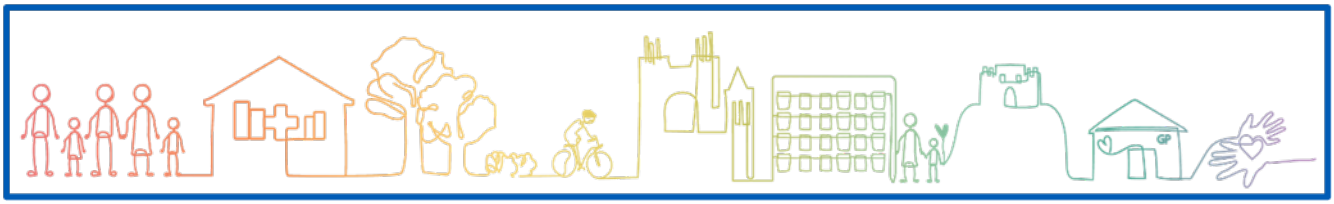
In addition, Amanda suggested a discussion outside of the meeting in relation to the Social Care Out of Hours currently under review from North Yorkshire County Council.

The Board:

- Noted the update and welcomed the proposed regular updates

9. Confirmation of next steps and summing up

The Chair closed the meeting and noted the next meeting date was Monday 24 May.



York Health and Care Alliance Board

Minutes of the meeting of the York Health & Care Alliance Board on 24 May 2021 conducted via Microsoft Teams

Present

Cllr Keith Aspden (Chair)	Leader, City of York Council
Gail Brown	Chair, York School and Academies Board
Dr Rebecca Field	Joint Chair of York Health and Care Collaborative
Professor Mike Holmes	Chair, Nimbuscare York
Emma Johnson	Chief Executive, St Leonards Hospice
Brent Kilmurray	Chief Executive, Tees, Esk and Wear Valleys Foundation Trust
Phil Mettam	Accountable Officer, Vale of York CCG
Simon Morritt	Chief Executive, York and Scarborough Hospital NHS Foundation Trust
Alison Semmence	Chief Executive, York CVS
Sharon Stoltz	Director of Public Health, City of York Council

In attendance

Michelle Carrington	Executive Director for Quality & Nursing at VOY CCG; Director of Nursing and Quality Lead for Humber Coast and Vale ICS
Rob McGough	Partner, Hill Dickinson LLP
Peter Roderick	Consultant in Public Health, City of York Council/ VOY CCG
Eleanor Tunnicliffe	Legal Director, Hill Dickinson LLP

AGENDA

The agenda was discussed in the following order.

1. Welcome and apologies for absence

The chair welcomed everyone to the meeting and noted the apologies received from Amanda Hatton. No deputy was attending as Sharon Stoltz was in attendance.

Simon Morritt apologised that he was not able to attend for the entirety of the meeting. Therefore, agenda item 6, *Possible ICS approach to Place*, was moved up the agenda to item 3.

The minutes of the meeting of 26 April 2021 were approved by the meeting.

As part of matters arising from the minutes the chair invited Phil to provide an update on the financial support from the ICS for the development of City of York Place. Phil reported the conversation that he had had with Stephen Eames, who had explained the ICS's expectation that the local partners in York would cover the costs of further development work. Phil explained that he was awaiting a costed support proposal from external partners and that this would be brought to the next Board meeting

The chair noted that the Concord that underpinned the York Health & Care Alliance Board had now been signed by all parties.

2. Declarations of interest and agreement of Managing of Conflicts of Interest Policy

Rob provided a verbal update on the conflicts of interest policy that was being developed for the Alliance. A draft had been produced and this was now being considered by governance leads at City of York Council (CYC) and Vale of York CCG. This work was being led by Abigail Combes at the CCG. The policy was light touch and would supplement rather than replace the organisation-specific conflicts of interest policies adopted by Alliance members.

The Board:

- Noted that the conflict of interest policy would be finalised and considered at a future meeting.

3. Possible ICS approach to Place

Simon explained that York was one of six Places in Humber Coast and Vale ICS (**"the ICS"**) and that each Place had its own journey to maturity. This was consistent with approach being taken at national level – there was no "national blueprint" for Place. The approach of each Place would depend on its own circumstances. Some Places had a mixture of unitary and two tier local authorities, where the local authorities were not coterminous with Place e.g. in North Yorkshire. In other Places the boundaries of the CCG are coterminous with those of upper tier councils, meaning that Place arrangements can build on pre-existing arrangements as in Rotherham and Doncaster.

Within the ICS, there are two "Strategic Partnerships". One covers the Humber (four Places) and the other North Yorkshire & York (two Places). North Yorkshire has a big footprint and is developing a way of working that reflects its communities. This has led to the establishment of four Local Care Partnerships: Harrogate; Hambleton & Richmondshire; East Coast (from Whitby to Scarborough); Vale and Selby. Each of these is supported by GP Federations and PCNs. Together, the four Local Care Partnerships will be considered as one Place by the ICS.

Under the new legislation it will be the ICS that will have statutory responsibility for the delivery of NHS services. Some of those responsibilities will be taken on by the Strategic Partnerships, who can in turn devolve responsibility down to Place. We are still waiting for guidance on how the principles of subsidiarity/ primacy of Place will work in practice. Rob explained that the ICS had developed a maturity matrix. The expectation was that each Place would carry out a self-assessment against the maturity matrix and this would inform the level of responsibility that could be devolved down to Place.

Simon added that it was unlikely that there would be a wholesale devolution of capitated budgets to Places at first. Instead, the responsibilities allocated to Place would be "agenda led". The ICS would want to see a plan for City of York Place that helped to meet the aims of the ICS before it devolved resources and decision-making responsibility for particular pathways or areas to Place level. Rob noted that national guidance on financial governance had been expected in July but had been delayed.

Simon concluded by noting the opportunities for City of York Place. Organisations in York had come together early and created a space in which partners could start to work together differently. The Alliance was therefore in a strong position to capitalise on the opportunities for Place.

The Board discussed the opportunities for Place. The ambition of the Board was that York would be an exemplar and to do this momentum needed to be sustained. To do this Alliance members would need to continue to invest their time and also make good use of CCG staff.

The Board

- Thanked Simon for the update and asked to continue to be updated on developments at ICS level.

4. Establishing future scope

Diabetes

Peter provided an update on the diabetes population health management work and set out some of the wider context around diabetes and how it was dealt with by the current healthcare system.

Peter highlighted the estimate that in York there were approximately 3,000 residents with undiagnosed diabetes and 20,000 residents with pre-diabetes. There were comparatively low referrals into the NHS Diabetes Prevention Programme. Diabetes was often the first condition that lead to others and residents experiencing multiple long-term conditions. Costs associated with treating diabetes are projected to rise from £6.1m to £7.2m.

Peter outlined the work carried out by Optum, who had looked at three years of linked data from primary care, secondary care, community and mental health to identify appropriate interventions. There were lots of diabetes programmes in York and some transformational funding. However, the delivery of these different programmes was complex.

The key question for the Board was how do we build a joined up accountable care model for the residents most at risk of developing diabetes and the 20,000 imminently at risk from disease progression? In particular, how do we achieve a shift of funding into prevention and how do we support people to live well with diabetes in its early stages? Any new model would require cultural change as well as changes to care/ prevention pathways.

The Board discussed Peter's presentation. The disinvestment in public health was noted: CYC had lost £2million over 5 years. This meant that the funding for CYC public health services such as social prescribing and health trainers were fragile. Gail noted the impact of lockdown on school children who have put on weight and exhausted their resilience. There was a need to tackle childhood obesity and also to consider pre-natal interventions. Mike noted that there was an interesting model in Bradford, where treatment for diabetes was community based. There was an appetite across Board members to take a transformational approach to how the system tackles diabetes.

The Board

- Asked Peter to develop an outline of an accountable care model for the prevention and treatment of diabetes in York

Quality

Michelle Carrington joined the meeting to present this item and the following discussions

Michelle began by asking what the Board understood by "quality" of services. She suggested that the Board adopt the National Quality Board (NQB) definition and make it come alive for local residents.

Michelle highlighted the opportunities for driving up the quality of services at Place level and also the risk that structural change/ reorganisation can put quality at risk. Michelle went on to outline what the ICS was looking for from Places in terms of quality:

- a "seat at the table" at City of York Place
- agreement across the Alliance partners about what "good" looks like
- an ask from City of York Place for what it needs to support quality work
- some independent assurance of quality
- City of York Place able to speak with one voice about quality.

Michelle expected that the ICS approach to quality would be light-touch and leaner than current arrangements, with an emphasis on mutual aid between Places and enabling Places to harness the specialist quality and nursing workforce. Existing quality groups would be replaced by a more stream-lined structure. There would need to be a culture of "unlearning" old habits and doing things differently.

Ideally there would be one way to investigate quality across Place, rather than different organisations taking different approaches. Quality of services would be considered in the context of the whole care pathway rather than within organisational silos. Michelle could help with developing a model.

The Board discussed the issues raised by Michelle's presentation. Board members were keen to develop a local solution. Brent explained that some progress on this had been made in Tees Valley ICP, where there was a shift to a more mature and collaborative approach to quality.

The Board

- Was supportive of adopting the NQB definition but members wanted some time out of the meeting to consider it in detail and how it would work for York, including for CVS services
- Thanked Michelle for her offer of support and asked if she could prepare a proposal for discussion at the July Board meeting

5. Urgent Care Alliance update

Mike explained that the current arrangements for urgent care come to an end in 2022. Weekly meetings were taking place between the partners responsible for delivering urgent care in York (York & Scarborough Teaching Hospitals, Vocare and Nimbus) regarding the shape of future services. Conversations were also taking place with Emergency Department consultants at York Hospital.

Phil emphasised that the CCG wanted all sectors to engage with the development of the new model – this was not an "NHS only" project. The redesign needed to be concluded by September 2021 to give time update contracts and mobilise.

The Board

- Asked to be updated of further developments

6. Alliance Leadership Team proposal

As David Hambleton was not able to attend the meeting, Phil presented the proposal.

David had carried out interviews with various people and there was support to establish an Alliance Leadership Team. This would have two roles: 1) designing, mobilising and delivering against the Alliance's priorities and 2) organisational development – resetting cultural norms for York. If the Board supports the proposal David will present a more detailed proposal to the June Board meeting, with the aim of the ALT having its first meeting in July.

The Board agreed the proposal. The Board noted the need for there to be sufficient resource to support the ALT and that this could feed in to the ask to the ICS for CCG staff to be deployed into Place.

The Board

- Agreed the direction of travel set out in the proposal
- Noted the need for resource to support the ALT

7. AOB

Phil informed the Board that the University of York Vice Chancellor, Prof Charlie Jeffery, had asked if the University could join the Alliance and if he could join the Board.

The Board

- Agreed that the University of York should join the Alliance and that Prof Jeffery could attend the Board as its representative
- University of York to be sent a copy of the Concord for signature

8. Confirmation of next steps and summing up

The Chair closed the meeting and noted the next meeting date was the 28 June 2021. The Chair would not be able to attend, so Simon would be chairing.

This page is intentionally left blank

Health and Wellbeing Board 21 July 2021
Report of the Manager, Healthwatch York

Healthwatch York Annual Report and 2021/2022 Workplan

Summary

1. This report is for information, sharing details about the activities of Healthwatch York in 2020/21 with the Health and Wellbeing Board, and giving details of plans for work throughout 2021/22.

Background

2. Healthwatch York has a legal duty to produce an Annual Report by 30 June each year, and to share it with local and national stakeholders[i]. The report, Annex A, contains information about how Healthwatch York have fulfilled their statutory function over the past year.

3. Healthwatch York also provides an update to the Health and Wellbeing Board each year about their planned and emerging activities for the year 2020/21. This report is included as Annex B.

Main/Key Issues to be considered

4. The ongoing involvement and engagement of Healthwatch York with the work around Integrated Care Systems has been identified by a number of stakeholders as key. Healthwatch York are keen to work with all partners to make sure we collectively develop a wide range of ways for people to be at the heart of this transformation.

Consultation

5. As part of the Annual Report writing process, Healthwatch York commissions an evaluation of their work, engaging local stakeholders in this. A link to this is provided in the background papers section of this report.

Options

6. Health and Wellbeing Board are asked to note Healthwatch York's Annual Report 2020/21 and their summary work plan for 2021/22.

Strategic/Operational Plans

7. The workplan for 2021/22 has been developed to support Healthwatch York continue to explore issues affecting people when accessing or trying to access health and care services in York, and to connect to key initiatives driving change forward. All partners have identified the need to understand the barriers to accessing care and removing them as essential to the transformation of local health and care through the work of the ICS at place.

Implications

8. There are no specialist implications from this report.

- **Financial**

There are no financial implications in this report.

- **Human Resources (HR)**

There are no HR implications in this report.

- **Equalities**

There are no equalities implications in this report.

- **Legal**

There are no legal implications in this report.

- **Crime and Disorder**

There are no crime and disorder implications in this report.

- **Information Technology (IT)**

There are no IT implications in this report.

- **Property**

There are no property implications in this report.

- **Other**

There are no other implications in this report.

Risk Management

9. There are no risks associated with the Annual Report.

10. The only risk associated with the workplan is that local priorities can change, and new themes can emerge suddenly. This impacts on the capacity to deliver existing work plans. However, this can be managed internally within the Healthwatch York team by pausing areas of work for a short time.

Recommendations

11. The Health and Wellbeing Board are asked to:

i. Receive Healthwatch York's Annual Report and workplan

Reason: To keep up to date with the work of Healthwatch York

Contact Details

Author:

Siân Balsom
Manager
Healthwatch York
01904 621133

Chief Officer Responsible for the report:
Sian Balsom
Manager, Healthwatch York

Report Approved ✓ **Date** 7th July 2021

Wards Affected: All **All** ✓

For further information please contact the author of the report

Background Papers:
Healthwatch York Evaluation 2020/21
https://www.healthwatchyork.co.uk/wp-content/uploads/2021/07/HWY-Evaluation-2021-Final.pdf

Annexes

Annex A - Healthwatch York Annual Report 2020/21
https://www.healthwatchyork.co.uk/wp-content/uploads/2021/06/HWYAR2021.pdf

Annex B – Summary work plan for 2021/22

---

[i] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262761/local_healthwatch_annual_reports_directions_2013.pdf

ANNEX A

healthwatch York

Annual Report 2020/21

Welcome!

ANNEX A

healthwatch York

ANNEX A

Message from our Chair

WELL, WHAT A 12 MONTHS IT'S BEEN! Having recently retired from 40 years working in various roles in Health and Social Care I wanted to use my skills and experience in a voluntary capacity. On March 12th 2020 I attended my induction to join Healthwatch York. On March 23rd the Prime Minister announced that we were all to stay at home! Like many other brilliant volunteers I helped out by making welfare calls to people who were shielding or who could benefit from regular check-ins. I talked with people in really difficult situations. Hopefully I was able to offer calm reassurance and connect them to help where needed; in turn I was supported by staff at Healthwatch York and York CVS, with information, advice and that same listening ear. Personally, I found I got as much from these calls as the people I was calling. The effects of loneliness and social isolation cannot be underestimated and I hope that one outcome from the impact of Covid is that communities continue to pull together to support each other.

When the role of Healthwatch Chair was advertised I applied and was delighted to be offered the position. I took over the Chair role in December 2020. I have since attended various meetings and forums and met lots of new people, sadly mainly by Zoom. I'd much rather be getting to know people face to face, but at least I have this other option. But it does feel like our whole world moved online almost overnight. Our role is to find out what matters to people living in York who use Health and Social Care services and make sure their voices are heard. As we continue to learn to live with Covid-19, digital literacy and access to the internet, or the lack of it, is something which we all need to be mindful of. Not just when thinking about what people need right now, but also when thinking about how Health and Social Care is planned and delivered in the future if we are to be increasing equality of access. Choice is vital in making sure everyone has the same chance to be heard and seen.

The independence of Healthwatch is key to its role but so too is its ability to support effective partnership working, both York's people and the local Health, Social Care and Voluntary organisations. This Annual report is our chance to highlight some of the ways we've tried to do this over the last 12 months. I hope you enjoy hearing more about what we've been doing.

> ***Throughout the year the Be Kind movement has been a reminder to us all to treat each other with respect.***

In my six months as Chair I have heard people's stories where they felt that the Health and Social Care system fell short in its duties and responsibilities. I have also heard stories where those same organisations and professionals have gone beyond what any of us could expect. Throughout the year the Be Kind movement has been a reminder to us all to treat each other with respect. Whether we are a person using services, a carer of a loved one, or a professional working in Health and Social Care we all have our own story. As part of the Healthwatch York team, we look forward to hearing those stories and to speaking up on your behalf.

Janet Wright
Chair

ANNEX A

Thank you!

To **our colleagues at York CVS** for the usual stuff like keeping our office clean, making sure we get paid and we pay our bills. And for the less usual stuff – working with us to make sure people in York got the help they needed when things got really tough.

To **City of York Council** – for our contract, and also not worrying too much about what it said when there were clearly better things for us all to be doing. We've appreciated you letting us do the right things, whatever we're usually meant to be up to.

To **NHS Vale of York CCG** for including us in their Urgent Care Work and valuing what we can bring to it.

To **Lankelly Chase** – for continuing to believe in and invest in opportunities through the MCN network for all of us in York to rethink how we make sure everyone can have good health and care.

To **our volunteers** – some of you have continued with the work we do together, some have taken on new challenges, and some of you have patiently waited for when we can start doing the things you used to love doing for us again.

We can't do what we do without you, and we're looking forward to tackling what we can all do together again over the coming months.

To **John Clark,** our former Chair, for all his help and support for our first 8 years together!

Neil Bond, our brilliant designer, for being there with us and making our publications sing.

And last, but not least: To everyone who's been doing extraordinary things over this past year, whatever that has meant for you.

Whether you've returned to the medical profession from retirement, added "part-time teacher" to your parenting CV, taken on a new volunteering role, waved at small children excited by the vehicle you are driving, or been kind to people you meet when out and about – you're all amazing, even when it really doesn't feel like it.

ANNEX A

Our people – staff update

Healthwatch York is run by a staff team of five people. We're a small team, all part-time, so about the same as just over 3 people working full time. We work hard to get a lot done and are proud of our ability to punch above our weight.

This year, we know things have been very different for everyone. They've been very different for us too. All face-to-face activities were stopped in March 2020. We're looking forward to coming out to see you all again very soon.

Like lots of other small groups, we've had to make decisions about how we use our time, energy and people to help support those struggling most during the pandemic. We at Healthwatch York realised very quickly that we could help most by working closely with our colleagues in York CVS. There's much more information about our work during the pandemic later in this report.

Alongside these extraordinary activities, we continue the day-to-day business of:

- **Taking phone calls and responding to emails**
- **Conducting research and writing reports**
- **Sharing information about what's going on in health and care in York**
- **Working with partners including City of York Council, NHS Vale of York Clinical Commissioning Group, as well as lots of local charities and community groups**

Despite the challenges of this year, we continue to gather people's stories and experiences, and use them to make change happen in York. We listen. We represent. We influence. Whatever is happening locally, we want to make sure you remain at the heart of it.

Goodbye Abbie

In January this year, our brilliant Engagement Officer, Abbie Myers, successfully applied to become an NHS Link Worker.

We're thrilled for her, and know she will be as much of a superstar for them as she has been for us. Having originally joined us as an Apprentice, we're so proud of everything she's achieved and to have been a small part in her journey.

Our people – volunteers

Welfare Call volunteers

In the early days of the pandemic, we wanted to play a role in making sure people who might be isolated stayed connected.

We worked with local GPs to identify people who could benefit from a welfare call – basically a check-in where we just made sure everything was ok. We started receiving referrals from GPs and making welfare calls to isolated people on 4th April 2020 during the 'first wave' of the pandemic. The service grew from one volunteer and one referral to 223 people to ring every week and a team of 7 volunteers. We also received help from York Cares who responded very quickly to our call for extra help. We referred any requests to the York CVS Ways to Wellbeing project including help with food and prescriptions, ongoing medical conditions, and urgent healthcare needs and even sorted out library books!

We asked some of the recipients for feedback:

"I knew that if I had a problem they would be able to help."

"It was a bad time of the pandemic, it was very good to chat."

We also asked the welfare volunteers:

"We were both delighted to have something to do that was helpful and gave us a purpose during lockdown."

"Really positive response if we raised concerns or issues. Fantastic and very quick reaction to get things sorted out for the people who needed more help."

The volunteers really demonstrated their deep care and commitment to helping vulnerable people across the city and made a real difference.

One of the GPs that referred their patients to us said:

"It is difficult to overstate how transformative it has already been to thread the voluntary sector into the fabric of NHS primary care in York. In many ways patients, GPs, GP practices and Voluntary organisations have in the past felt like islands surrounded by choppy waters...now we finally see and embrace the voluntary sector and feel like we are in one continent focused on patients."

Dr Daniel Kimberling, GP Partner, Haxby Group Practice Clinical Director

ANNEX A

Our people – volunteers

Roger Newton, Healthwatch York Research Officer:

“In the nine weeks between 6th April and 8th June we went from 0 to 7 volunteers and 0 to 223 welfare call recipients. We made 876 calls!

A quick look through my ‘urgent’ folder tells us some more of the story. Working together with the ‘Ways to Wellbeing’ Superheroes we got urgent medical care to people, called in paramedics, got food to people, sorted out stockings, hearing aid batteries, inhalers, and ‘whodunnit’ books.

We helped people in poverty, contacted seemingly uncontactable people, and deciphered impenetrable medical language. We arranged transport, supported carers, gave advice and support on shielding, and calmed the nerves of over 200 people including our own.

Most of all we proved that someone, somewhere actually does care. So to our amazing welfare call volunteers all I can say is “Thank you so much for your time and skill, and for sticking with it when times were tough. I take my hat off to you all.”

Lisa Egginton, Operations Manager at York CVS:

“The welfare calls were a vital part of our response to Covid-19 and lockdown. This would not have been possible without the help of our dedicated volunteers. We cannot thank them enough for their time and commitment.”

Readability volunteers

Readability Group

The work of the readability volunteers continued throughout the pandemic. This work is part of our commitment to providing accessible information about health and social care. Volunteers read leaflets and documents and comment on language, layout and whether the document is easy to understand. In the last year the team commented on 8 documents from York Teaching Hospital and City of York Council.

We have received very positive feedback about the value of this work.

“This is fantastic, please pass on my grateful thanks to all the volunteers who took the time to go through this and offer such helpful feedback.”

Steve Reed
York & Scarborough Teaching Hospital NHS Foundation Trust

Many thanks to our readability volunteers.

ANNEX A

Healthwatch York by numbers

In the first lockdown from March to June, alongside York CVS colleagues we:

Were part of the team supporting 1759 people

Supported 7 volunteers

Made 876 welfare calls to 223 people

Feedback via website	**112**
Twitter impressions	**65,700**
Twitter followers	**2,592**
Instagram posts	**53**
Instagram followers	**348**

443

People and organisations on our mailing list, by email and by post

Surveys launched 9

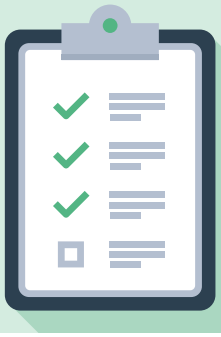
Survey responses 296

People who shared their views (issues, survey responses):

Issues: 496

Survey responses: 296

Total: 792

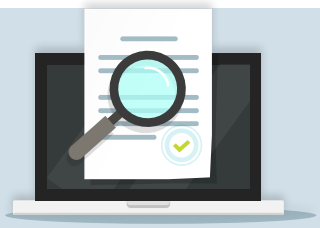


40

amazing volunteers

96 people signposted to help / support

(logged from Sep to Mar)



Number of reports HWY published 6

Documents reviewed by readability 9

ANNEX A

How we've made a difference – highlights of our year

- Published our report about the experiences of people from ethnic minority backgrounds in accessing health and social care.
- Published our report on the work of York CVS during the first lockdown, highlighting the different challenges people were experiencing.
- Worked alongside Tim Madgwick, Independent Chair of the Mental Health Partnership in York, carer Ros Savege, and colleagues at City of York Council including Kate Helme, Chris Weeks and Tracy Wallis, to start up an emerging co-production network to support the transformation of our city's approach to mental health.
- Encouraged local York residents to share their Covid-19 experiences via an item in a City of York Council (CYC) leaflet that went to every household.
- Undertook an "Urgent Care Rapid Appraisal" for NHS Vale of York Clinical Commissioning Group, to make sure what they heard included the experiences of seldom-heard groups.
- Highlighted the problems some vulnerable people experienced from their employers during the early days of the pandemic.
  ↳ www.hwy.link/YorkPressArticle (quick link)
- Provided information for students needing support to self-isolate on return to campus.
- Launched our 4th edition of the guide to mental health and wellbeing.
  ↳ www.hwy.link/MHguide (quick link)
- Provided opportunities for people to share their views on how peer support and peer carer support should be developed to support people being discharged from Foss Park Hospital.
- Worked with colleagues at Explore York to provide opportunities for local people to get support with completing their Census Forms and raise awareness of this across York.
- Helped to #LightUpLockdown with colleagues from York CVS
- Published our Annual Report 2019/20.
- Recruited a new Chair of our Steering Group, Janet Wright, as well as 3 new Steering Group members, Richard Frith, Fiona Hicks and Jenny McNeill.
- Worked with the Making Every Adult Matter team at Changing Lives to hear the views of people supported by their service.
- Supported a team of Welfare Call Volunteers to keep in contact with people who were feeling isolated during the pandemic
- Shared a free / low cost food map for people in York struggling to feed themselves or their families during the pandemic.

ANNEX A

Health and care that works for you – *Putting people at the heart of our health and care system*

"If we want the system to work for people, we need to hear and understand the experiences of those who get put through the system." Siân

We believe the only way to make sure our services work for those who use them is if these same people help design and shape them. That's why we champion co-production as the best way of doing this.

What is co-production?

Co-production means that everyone, from people who use services, their family members and carers, frontline staff, managers and those who buy services for York, come together as equals to look at what works, what doesn't, and explore how we can make things better for everyone.

Developing a Mental Health Co-production Network for York

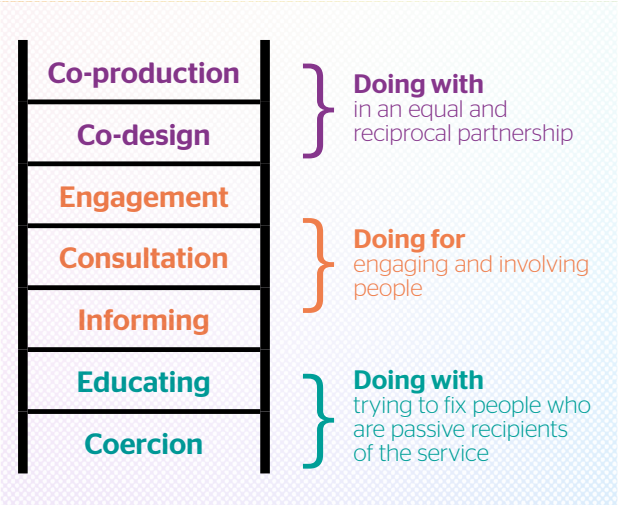
York's Health and Wellbeing Board have highlighted improving mental health as their greatest priority. York's Mental Health Partnership (MHP) is a subgroup of the Health and Wellbeing Board, tasked with overseeing the delivery of our mental health priorities. The MHP has identified that ***"in order to make our vision for the city a reality, we need to make co-production a reality."*** The network will help us fundamentally transform how we see the relationship between commissioners, providers (both statutory and voluntary), people who use services, carers and the wider community.

Tim Madgwick, Independent Chair of York's MHP:

"Healthwatch York were part of that prompting, saying: we don't need a pandemic to start thinking about how to work differently."

To function properly, this network needs representation from across all these groups. It is vital that engagement becomes an ongoing relationship so people feel valued, listened to, and that their input and involvement has had a positive impact.

Healthwatch York was involved in early plans for the network, helping develop a list of key contacts who were invited to join. We co-Chair the network meetings alongside Ros Savege, a carer for her daughter who has experience of mental ill-health.



Tim Madgwick:

"Healthwatch York are always key because they are genuinely in touch with the community and various groups for people who access services."

The network is still in its early days. We have developed our mission, values and ways of working, we've started to develop plans around training to help us create a shared platform to work together. We've also identified areas of work we can, and want to, get involved in.

You can read more about the vision, mission and purpose of the network here:

www.hwy.link/MHCN (quick link)

We want the network to grow. Anyone with experience of mental ill health is welcome to join us.

healthwatch@yorkcvs.org.uk to find out more.

Our role as part of York Multiple Complex Needs (MCN) Network

We have been an active member of the York Multiple Complex Needs (MCN) Network since it began. We have supported a number of initiatives this year, including:

Understanding experiences and barriers

We worked with staff at Changing Lives who support people using the Making Every Adult Matter (MEAM) approach. Alongside people with lived experience, we developed a survey to gain a better understanding of the experiences and barriers facing people with multiple complex needs. We published a report based on this feedback. This has been used by local commissioners, to shape their plans. You can read about our plans for further work with MCN on **page 19.**

www.hwy.link/MEAM (quick link)

Kelly Cunningham, Enabling Team at York MCN:

"The pandemic has shone a light on the health inequalities within the city and Healthwatch York has been really present within those conversations."

Shared office space pilot

We hosted a survey for frontline workers across different organisations to explore the option of sharing an office space to improve partnership working. This has led to a pilot with representatives from North Yorkshire Police, City of York Council, Changing Lives, and Social Prescribers among those coming together to share an office space at York CVS.

Creative Action Working Group

We co-Chair the Creative Action Working Group which is busy developing projects such as an Arts Bank, similar to a food bank, to ensure everyone has the means to join in with our creative activities.

What is York MCN?

York MCN involves lots of projects, organisations and people working together to create change and improve the lives of those experiencing severe and multiple disadvantage in and around the city.

People facing disadvantage in this way have been pushed to the margins of society. They may come up against several complex and interlinked problems at the same time, such as mental ill health, homelessness, drug and alcohol misuse and offending.

The York Multiple Complex Needs (York MCN) Network brings people with lived experience, frontline workers and strategic leads together. It provides a space to share experiences, forge stronger links and build trusting relationships that lead to more collaborative actions.

ANNEX A

How we've made a difference – Our Covid-19 Response

In October 2020 we published a report, looking at the work of York CVS during the first lockdown, from March to June.

It is important to state that we, the Healthwatch York team, were just a small part of the team doing work together to support people in the pandemic. However, we believe working together in this way made the most of everyone's skills, knowledge and experience to provide the best support we could to our local community.

Alison Semmence Chief Executive, York CVS:

"The speed at which lockdown happened meant we had to respond extremely quickly to ensure people who needed support were not let down. Faced with a whole range of challenges the team were not phased – they went the extra mile to ensure people got what they needed. It hasn't been easy but they have done a fantastic job!"

Local GP practices added an option to their phone menus, for people in need of nonmedical support. On selecting this phone option, callers were put through to York CVS staff (mainly the Social Prescribing team but Healthwatch York staff also supported this) to answer calls. We could then provide social, emotional and wellbeing support, and organise practical help.

In addition, GP practices provided us with lists of vulnerable people of potential concern, for us to ring and offer support including a weekly welfare call. These lists included people with dementia (or who were in the process of receiving a dementia diagnosis) and they were supported by the York Dementia Action Alliance (YDAA).

Staff and volunteers made weekly welfare calls to vulnerable people, to make sure they had food, medicines and any other essential help. There's more about these on **page 6.**

Our report aimed to bring some of this work to life – to highlight some of the issues people experienced, and show how these had been addressed.

We also wanted to celebrate the roles of other organisations in helping resolve people's problems. All names were changed, to protect people's privacy.

1,759
people were supported through the GP Hot Line

Out of the people supported:

92% needed social support

8% needed a GP/Nurse appointment

1,005
people were referred for social support

393 people continue to receive support from the Link worker team or welfare calls

876 needed a GP/Nurse appointment

ANNEX A

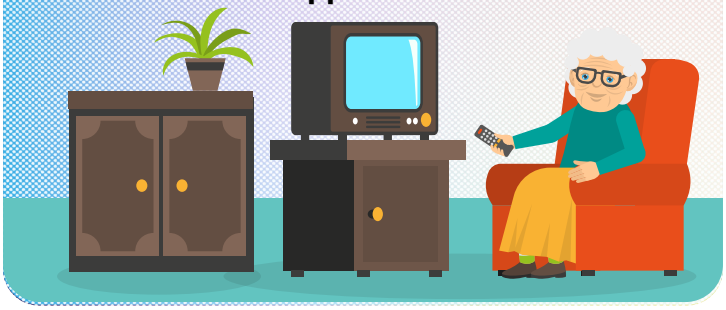
How we've made a difference – Covid stories

Margaret is an older woman living alone. She registered with the Government scheme for food parcels and was hoping to get a priority slot for their online shop, but heard nothing back. She was already tearful and feeling anxious about Covid-19.

We provided the number for Morrison's doorstep delivery in the interim while sorting them a food parcel. We then called back the following week for a chat and to make sure Margaret was doing ok.

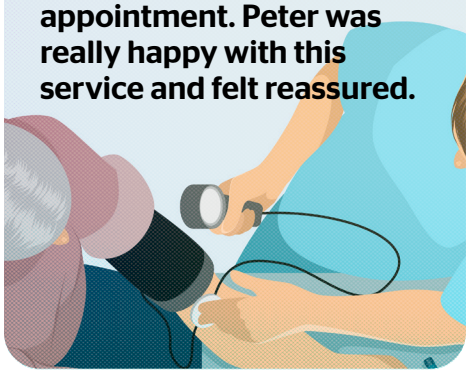
Betty phoned us seeking financial help. She explained that she was retired and on a half pension, and had no food. Betty depended on her local weekly PAYF café and was struggling without it.

We helped Betty speak to Citizens Advice York, who secured her more financial support. We signed Betty up for regular food parcels, and gave her information about Morison's Doorstop Delivery service, who could help her with any other necessities. We rang Betty weekly and she was very thankful for this support.



Peter had learning difficulties, was confused by the lockdown and needed transport for an urgent GP appointment.

We worked with the surgery to change the time of the appointment so that Dial-a-Ride could do the pick-up and safely get Peter to and from his appointment. Peter was really happy with this service and felt reassured.



Jacob's prescription was ready to be collected from his nominated pharmacy, but he was shielding.

Jacob rang us as he was worried about how he would be able to collect it. We sent a referral to Move the Masses (MTM) and arranged for a volunteer to deliver the medication. Jacob was really happy with the help from both York CVS and the volunteers from MTM.

ANNEX A

Reaching Out – information and advice

We believe that good information empowers people. It helps people find the right help and support.

In our work, we frequently come across situations where the lack of good information has meant small problems become much bigger. So we try to make sure we provide useful, factual and readable information at all times.

Tim Madgwick:

"That's probably one of the really strong arms of HY is that it is trusted information. It's not opinionated, it's factual."

During the pandemic, Abbie, our Engagement Officer, identified that local students were struggling to find help when returning to York and needing to self-isolate. We also heard from staff members at the University who didn't know where to signpost them to. She quickly put together an A4 document to give them this vital information.

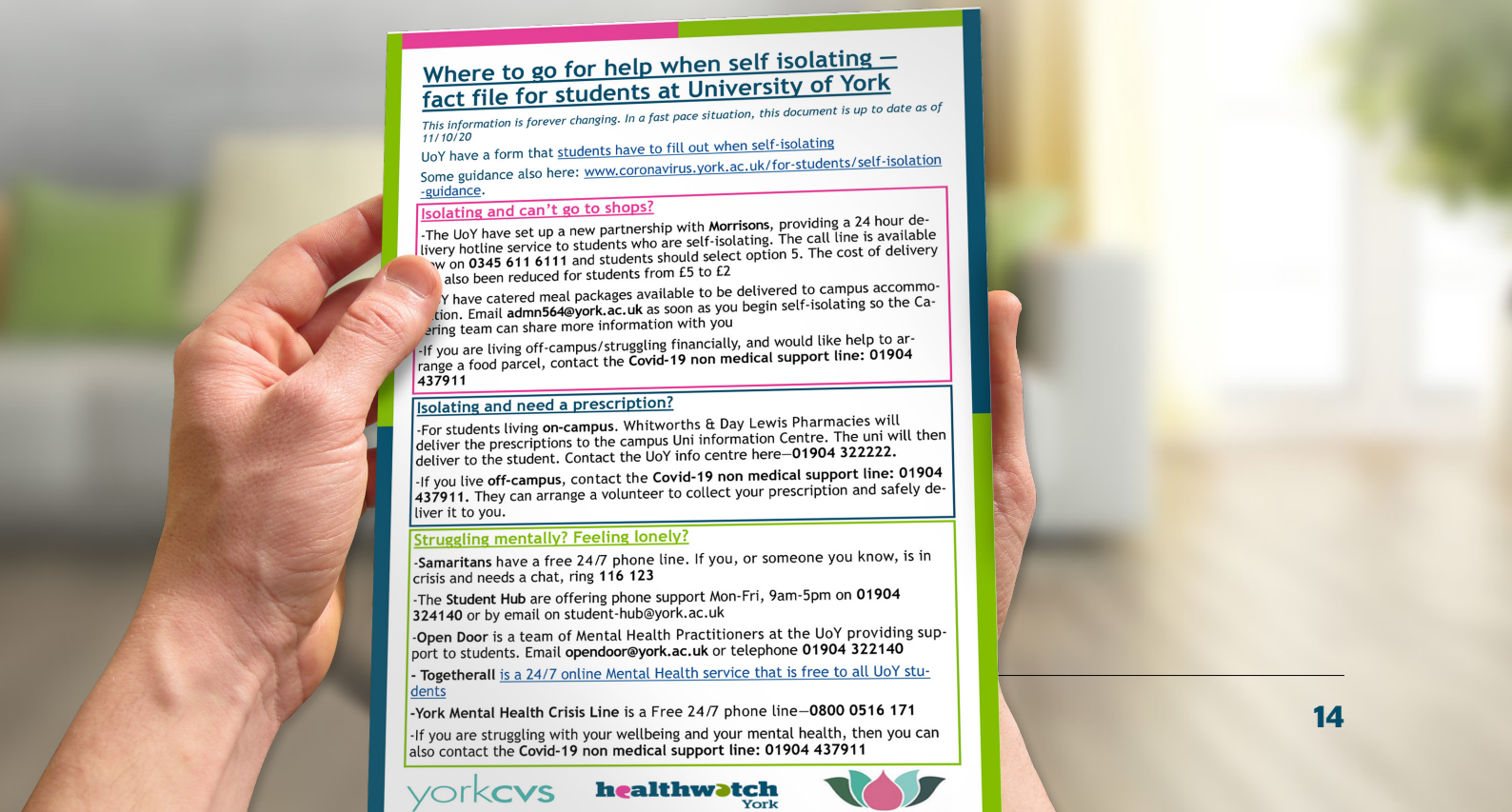
We also shared it with City of York Council, to share with their teams, local councillors and other partners in the city. They let us know straight away how useful it was

"Many thanks for this, super helpful. We will circulate it with our next partner update." — Claire Foale, City of York Council

As we began to expect a further lockdown was coming, she created another information document covering places offering food support in November 2020. This was also widely shared.

Feedback from a Local Area Coordinator at City of York Council:

"This is so helpful Abbie!! I have literally just forwarded it to a resident that contacted me regarding food provision this morning. Thank you so much."



ANNEX A

York Mental Health and Wellbeing Guide - Issue 4

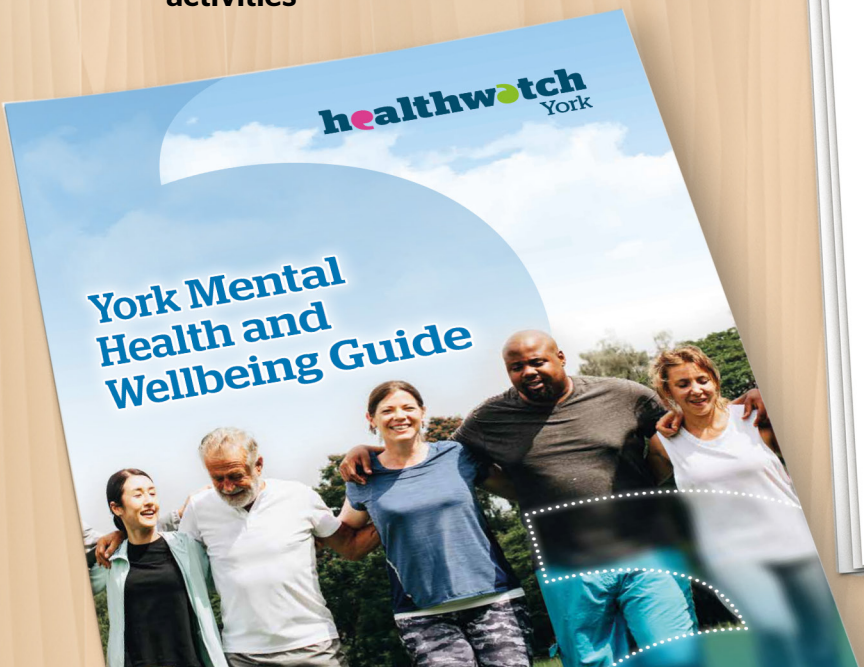
Healthwatch York has published the 4th edition of the guide to mental health and wellbeing in York.

The free guide is available to anyone in York who wants to know more about the help available for people experiencing mental ill health. It is available online via their website. Printed copies have also been made available, due to the backing of the three statutory partners of the York Safeguarding Adults Board, City of York Council, NHS Vale of York Clinical Commissioning Group and North Yorkshire Police. The guide will also be shared with all organisations working in York supporting people experiencing mental ill health.

The guide, which was first published in 2015, has received local and national praise from people living with mental health issues and organisations providing mental health support.

The guide provides information and advice to help people:

- **Know what to do if they, or someone they care about, experiences a mental health crisis**
- **Look after their mental wellbeing**
- **Find organisations that can provide advice, help, support and social activities**

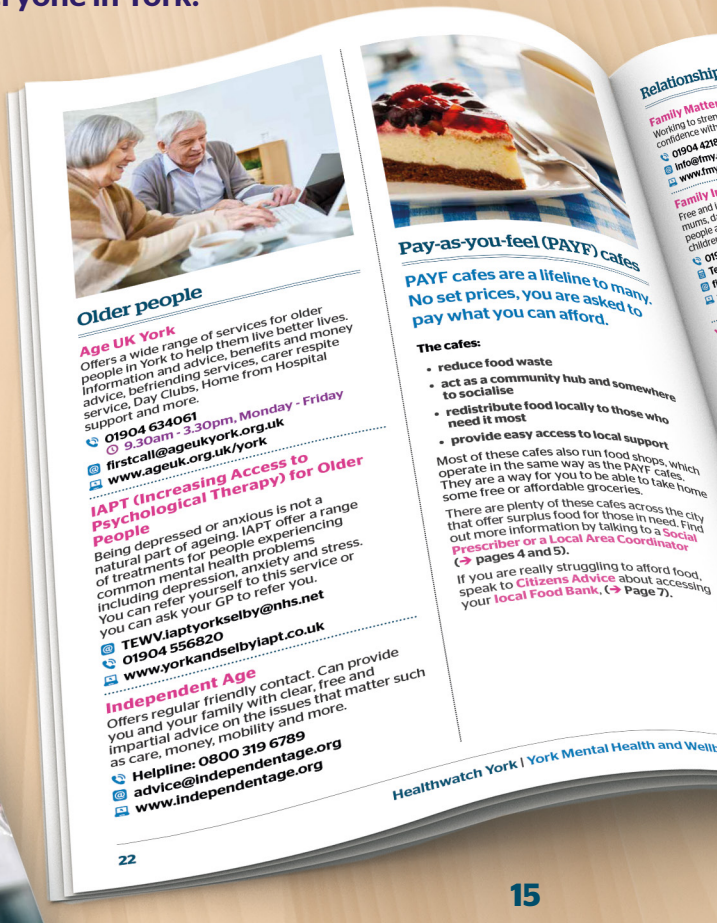


Abbie officially left our team in January when she secured a well-deserved promotion to an NHS Link Worker role. But she stayed with us, working extra hours throughout January, February and March to make sure we were able to publish a 4th edition of our guide to Mental Health and Wellbeing in the city.

We are delighted that it continues to be warmly appreciated by local people looking for help, and by people working in local organisations to help them connect people they work with to the support they need.

Abbie:

"I'm really excited to have taken up my new role as an NHS Link Worker. That's all about building connections, making sure people can do the things that matter to them. But I was determined to get this done before I move on. I'm passionate about people finding out the right information first time - good information gives people the power to change their lives for the better. I'm so pleased this is now available to everyone in York."



ANNEX A

Reaching out – starting our work around health, care, race and ethnicity

Reaching out – listening to people from ethnic minorities about their experiences of health and care

Even before the pandemic hit, we were aware there was a lack of information about the experiences of people from ethnic minorities accessing health and care services in York, and that they had poorer health outcomes than others in the city.

Alongside others in the city, including City of York Council and Vale of York CCG we were concerned about this gap in our local knowledge. During the pandemic, with the news of the disproportionate impact Covid-19 was having on Black and Asian people and communities these concerns increased further.

We had already begun to work with local organisations representing and working with people from ethnic communities. Although the pandemic made this work more challenging, we decided it was too important to let this stop us.

"It has long been acknowledged within our health and care system that the voices of people from ethnic minorities haven't been heard. We knew it would be really challenging to reach people during the Covid-19 pandemic – so many of our usual engagement routes simply weren't an option. But we wanted to start this conversation, build better working relationships with key partners, and make sure everyone in York knows we're here to represent them in shaping the future of health and care in our city. This is just the first step for us." — Abbie

Over the summer, we launched a survey to understand more about people from Black Asian and Minority Ethnic communities' experiences when using health and care services in the city. We published a report of our findings in November 2020.

www.healthwatchyork.co.uk/wp-content/uploads/2020/11/Listening-to-BAME-people-about-Health-and-Social-care-services-in-York-Final-report.pdf

↳ **www.hwy.link/BAMEreport** (quick link)

On 6 January 2021 this report went to York's Health and Wellbeing Board.

When asked about their experiences, the responses indicated an even split between positive and negative, with GP services receiving the most feedback, both good and bad. Maternity services and midwives were also singled out for praise.

In line with concerns previously raised by Healthwatch York, problems accessing dental services were also flagged up, with respondents acknowledging this is a problem affecting our whole population.

The majority of respondents did not feel their ethnicity or skin colour had affected how they were treated when accessing health and care services. However, nearly a quarter felt they were treated differently because of their ethnic background.

There was also feedback about a lack of awareness regarding cultural differences on when to access healthcare services, and concern that some local health professionals may not be aware how certain conditions would present on non-White skin.

We know this is just a first step – making sure everyone knows we are here, and want to be able to reflect our whole communities' experience in accessing health and care. We plan to continue the conversation in 2021/22.

"The reality for us is that every voice counts. By sharing these results, we hope to encourage more people to share their experiences and join the conversation too." — Emily

We have also taken part in a number of awareness raising sessions and training events, including Gypsy and Traveller awareness, Anti-Racist training, and Unconscious Bias training.

SPEAK UP DIVERSITY

help us do something real about racial inequality and injustice

"This was a very important and inclusive step. It was designed to lift up the voices of people from Black, Asian and other Ethnic Minority groups who have and continue to be disproportionately affected in the accessibility and treatment of healthcare services. The transparency of the survey results is an opportunity for decision-makers to recognise the inequities and disparities and therefore use this as the driving force to work with BAME-led organisations in identifying appropriate measures in place to benefit everyone regardless of their creed, race, ethnicity or background."

— Haddy at Speak Up Diversity

Siân Balsom, Healthwatch York Manager:

"This is about us too, acknowledging in the wake of Black Lives Matter that we want to be part of the solution not just waiting for change to happen. We're on a learning journey with the support of wonderful partners like York Racial Equality Network, York Travellers Trust, Speak Up Diversity and MYnority York. We may make mistakes along the way. But we'd rather try, even if it means we get it wrong. Because Racism isn't a political issue, it's a human rights problem, and it's time we all come together to address that."

ANNEX A

Our finances

1st April 2020 to 31st March 2021

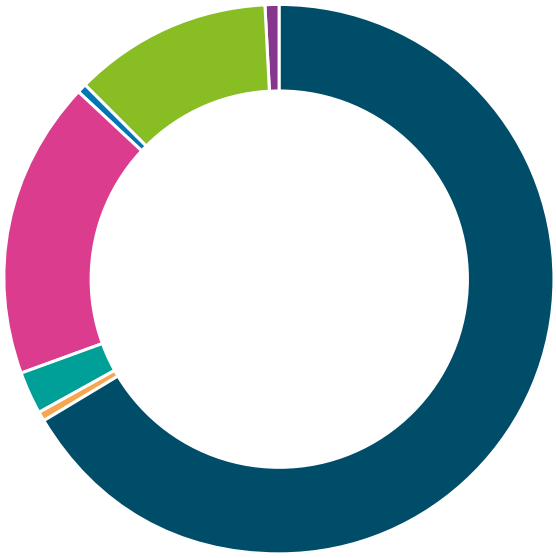
Income

City of York Council	£122,898
Donations	£280
Other grants & contracts	£12,475
Total	**£136,145**

Expenditure

Staff salaries and expenses	£88,271
Volunteers expenses and training	£0
Meetings and events	£257
Marketing, printing, reports	£3,701
York CVS management fee	£23,096
Legal and professional fees	£672
Office costs, equipment, computers, website	£15,125
VAT	£1,067
Total expenditure	**£132,190**
Underspend for the year 2020/21	**£3,956**

Summary of Expenditure



1. Staff salaries and expenses
2. Volunteers expenses and training
3. Meetings and events
4. Marketing, printing, reports
5. York CVS management fee
6. Legal and professional fees
7. Office costs, equipment, computers, website
8. VAT
9. Underspend

Notes explaining expenditure during the year

1. Staff salaries, expenses and training
2. Re-imbursement of expenses incurred by volunteers, plus training costs - no face to face volunteer activity undertaken during the pandemic
3. Costs of venue hire and associated costs for meetings and events
4. Costs of producing publications, and promoting Healthwatch York
5. Payment to York CVS covering accommodation costs, financial, HR and payroll support, IT, telephones and administration
6. Cost of legal and professional fees where needed to support Healthwatch York
7. New computers. Website and online feedback centre, including accessibility software, office costs including freepost and stationery
8. VAT on all purchases
9. Underspend includes cost of Census Support salaries paid out during April and May

Our plans for next year

In 2021-2022 we have already started to look at dentistry in the city. This is the challenge we get most enquiries about – where in York can I find an NHS dentist?

So we have worked with our research volunteers to design a survey to find out what services are currently being offered by dental practices in York. We are also reviewing our survey from 2018 which asked about the experiences of people trying to access dentistry in York, to look at running this again.

We often hear from people with dementia and their care partners about difficulties finding or getting the right support when dementia needs become more complex. We are also interested in finding out about and highlighting support focussed on the individual person and how this is working, or is not, across local services. We're encouraging people with dementia, their family members and carers, to share their experiences of dementia support in the city.

We're collecting these stories and experiences for a report, which will share everything we've learnt with City of York Council and NHS Vale of York Clinical Commissioning Group as they develop a dementia strategy for the city. As mentioned above by 'report' we mean something that is rich in people's voice.

We want to make sure this has a real impact for people living with dementia in York.

Other plans for the year

- **Developing a project in partnership with a local school to get young people involved in researching health issues that matter to them**
- **Working with people with lived experience of homelessness, mental ill-health, drug and alcohol issues and offending to develop a peer-research project linked with the Multiple Complex Needs network**
- **Updating our guide to dementia support in the city**
- **Helping local partners survey people with severe mental illness about their experiences of physical health checks and how to improve take-up of these**
- **Publishing the results of surveys we've worked on in partnership with others, such as a groups and activities survey with Live Well York, Age UK York and Age Friendly York, and in partnership with the Northern Quarter about peer support and peer carer support linked to people leaving Foss Park hospital**
- **Continuing our work on the Safeguarding Stories project for the City of York Council Safeguarding Adults Board (long-form interviews with people who have experienced the safeguarding process, to identify shared themes)**

Contact us

Freepost RTEG-BLES-RRYJ
Healthwatch York
15 Priory Street
York YO1 6ET

01904 621133
healthwatch@yorkcvs.org.uk
Twitter: @healthwatchyork
Like us on Facebook
www.healthwatchyork.co.uk

York CVS

Healthwatch York is a project at York CVS. York CVS works with voluntary, community and social enterprise organisations in York.

York CVS aims to help these groups do their best for their communities, and people who take part in their activities or use their services.

This Annual Report is available to download from the Healthwatch York website: www.healthwatchyork.co.uk

Paper copies are available from the Healthwatch York office and local libraries.

If you would like this Annual Report in any other format, please contact the Healthwatch York Office

We use the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

This annual report is published on our website and has been circulated to Healthwatch England, CQC, NHS England, NHS Vale of York Clinical Commissioning Group, Health, Housing and Adult Social Care Policy and Scrutiny Committee and City of York Council

healthwatch York

proud to be part of yorkcvs

ANNEX B

Summary workplan for 2021/2022

healthwatch York

Priority Area	Description and activity
Exploring people's access to care	Dementia surveys and request for stories. Part of the Multi-Agency dementia strategy group, linking in with key partners to try and reach as many people as possible living with dementia and their carers. Supporting the York Dementia Collaborative.
Exploring people's access to care	Dentistry work – report looking at availability of NHS dentistry in York, and what people have told us. Will lead to repeat of 2017 survey asking people to share their experiences locally.
General engagement activity	Healthwatch York Awareness Survey 2021 Links with contract requirement to demonstrate that local people feel we accurately represent their views. To be developed through the summer for launch early Autumn.
Connecting with key initiatives	Taking part in CMHT work. Helping to develop a Mental Health Coproduction Network to underpin this.
Connecting with key initiatives	Active member of the Multiple Complex Needs network.
Emerging issue	Access to GP services – digital exclusion, barriers for people with other communication needs, travel.
Explaining the system	Feature about ICS in Spring Mag. Continuing to share information about York Health and Care Alliance and wider work across Humber, Coast and Vale.
Ongoing work	Readability work – continuing to encourage local providers and commissioners to 'sense check' their information work through our panel of volunteers.
Work to review and re-establish as restrictions lift	Care Home Assessor programme – in partnership with CYC. PLACE programme – Patient Led Assessment of the Care Environment – good links with YSTH for when this work restarts. Face to face engagement work – including Market Stall initiative and other information stands. Safeguarding Stories work – initial plans and process drawn up 2018. No referrals through the pandemic. Work with York Safeguarding Adults Board and other partners to consider next steps.
Additional areas to consider	Supporting engagement around ICS. Developing ongoing engagement with organisations working around equalities and diversity.
Following up – Reaching new people	Potential plans to work with young people to explore their experiences of health and care – previously paused due to pandemic, dependent on partner organisation status.

This page is intentionally left blank

An independent evaluation of the service provided by Healthwatch York during the pandemic March 2020 to June 2021 from the Stakeholders' Perspective

June 2021

Conducted by:

Michelle Smith
michelle@quietleaders.org
www.quietleaders.org

Angela Portz
angela@aeportz.com
www.aeportz.com

Contents.

1. Executive Summary

There is clear evidence, from the stakeholders who were interviewed, to demonstrate that Healthwatch York (HWY) rapidly adapted to a new way of working at the start of the pandemic. Whilst working hard to meet its existing outcomes, new approaches emerged that will be valuable for the future.

Stakeholders expressed their gratitude to HWY for their wide-ranging contributions across the city whilst resources were stretched and during this particularly challenging time. This included the provision of information, guidance and signposting; research and reporting; activities with young people; welfare calls and using its network to support partners' capacity.

Regular and consistent attendance at the city's boards and forums ensured that the voices of York's residents were represented and that this contributed to action planning and recovery planning. Throughout the pandemic, the team focused on reaching groups of residents in the city whose voices are seldom heard and stakeholders have expressed a desire to continue this work in a collaborative style under a model of co-production.

2. Context

Healthwatch York (HWY) provides the means for local people to influence health and social care services – hospitals, care homes, GP surgeries, home care services and many others. Healthwatch York helps people to become involved in shaping these services. It provides information about local services, improving and increasing access; signposts to independent complaints advocacy; listens to views about local services and makes sure these are considered when services are planned and delivered.

HWY has been in place since 2013. It is a project that sits within the independent charity that is York CVS, with a 'Steering Group' that acts as an advisory board. Ultimate accountability sits with the Trustees of York CVS.

HWY operates under a contract from City of York Council, with the equivalent of 3.3 full time equivalent paid staff and approximately 40 volunteers, who carry out roles as Engagement Volunteers, Care Home Assessors, Research Volunteers, Readability Volunteers, Representatives, Enter and View Volunteers, Communications Volunteers, and members of the Steering Group.

During the past year, the activities of many of these volunteer roles have been stopped. In line with Covid-19 guidance all face to face engagement was suspended with immediate effect in March 2020. This directly affected the activities of HWY Engagement Volunteers, Care Home Assessors, and Enter and View Volunteers. It also indirectly impacted Research Volunteers as staff capacity was redirected to volunteer management linked to welfare calls. There was also an indirectly impact on the Representative role as many of the meetings went online, which some volunteers were unable or unwilling to engage with.

Recent topics of focus for its work have included reaching out to people from ethnic minorities in York to explore their experiences of health and care, supporting work to start up a Mental Health Co-production Network in the city, and exploring the challenges people faced during the first Covid-19 lockdown.

3. Healthwatch York's Mission and Aims

Healthwatch York's Mission Statement is:

> "Healthwatch York puts people at the heart of health and social care services, enabling you to be heard. We believe that together we can help make York better for everyone".

The aims are;

- Healthwatch York is responsive to the needs of York residents.
- Healthwatch York understands what is happening in relation to health and social services in York.
- Healthwatch York speaks up about the provision of health and social care services in York.

- Healthwatch York uses the reviews, words, and stories of service users to show the impact of health and social care services in York.
- Healthwatch York involves the public in the work they do.
- Healthwatch York advocates for people's active involvement in their health and social care.
- Healthwatch York provides an effective service for the people of York using health and social care services.
- Healthwatch York reaches new people and partners.

4. Purpose and method of the evaluation

The aims of the evaluation are, in the context of the pandemic, to explore:

- what has been different about Healthwatch York;
- the value that stakeholders have placed on Healthwatch York's contribution;
- how Healthwatch York has been able to meet some of its outcomes in principle and in spirit if not in detail;

For the purposes of this evaluation, the Healthwatch York team provided a list of key stakeholders with whom they have worked throughout the pandemic. The sample came from the statutory and voluntary community sector organisations within health and social care. Interviewees are listed at Appendix A.

5. Findings

5.1 What has been different about Healthwatch York during the pandemic?

Stakeholders offered a range of specific examples to demonstrate how Healthwatch York (HWY) had rapidly diverted resources from the start of the pandemic and how this continued throughout the year. It was clear from the interviewees that HWY adapted the way in which they operated very quickly. Some examples are listed below:

- Following their involvement in the initial multi-agency meeting at the start of the pandemic, York CVS took on responsibility for carrying out welfare calls, with HWY providing support to volunteers making these calls. Between March and June volunteers made 876 welfare calls to 223 vulnerable and isolated people in the city. HWY staff also joined the Link Worker team to arrange support for people in need during the first lockdown. Many needed support with basics like accessing food and medicines. All these calls supported primary care and social care which, in turn, released valuable resources from partner agencies.

This enabled other services to function without having to do this work (welfare calls). GPs thanked the volunteers for their work (JW)

- The re-publication of the mental health guide[i], with hard copies funded by the York Safeguarding Adults Board, helped those without access to the internet to have access to all services. This guide was welcomed and shared widely by a range of professionals whose work touched on mental health and digital exclusion.

For some people that is almost their telephone directory of up-to-date services (TM)

- In the early days of the pandemic stakeholders looked to York CVS and their teams, including HWY, and its established networks, to support connection and engagement with voluntary and community groups to meet community need. Initially, concerns around isolation, access to services and digitalisation were highlighted. HWY worked with key local partners to engage with black and minority ethnic communities. They also worked with the Multiple Complex Needs network in order to provide more inclusive information from those who are adversely affected by change or protected characteristics. By taking part in street interviews and working in partnership with key agencies, they were able to contact people affected by mental ill health, drugs, alcohol and homelessness and capture their experiences.

It is a good network, and a valuable aspect of their work is their willingness to be involved (VB)

- Throughout the pandemic, HWY supported health and social care agencies by regularly attending forums, carrying out research, and providing feedback and reports from more adversely affected groups such as carers and people with disabilities. This provided information towards a local rapid Joint Strategic Needs Assessment (JSNA)[ii] that helped to inform the city's approach to recovery.

Healthwatch York (HWY) could not have done more than was asked of them. HWY was very much at the table. Everyone was pleased with HWY's attendance at forums during the pandemic- people acknowledged the importance of them being there. They retained their presence and maintained visibility throughout the pandemic (JW)

- HWY was involved in the production of a range of reports. These included:

    - 'Listening to BAME people about Health and Social care services in York!'[iii]
    - 'Listening to Young People about Health and Social Care in York!'[iv] – this report was used to inform the Clinical Commissioning Group's Transformation Report.[v]
    - 'Survey about the impact of coronavirus (covid-19) on the Vale of York residents'[vi]
    - 'What we did during the Covid-19 lockdown: March-June 2020'[vii]
    - 'Urgent Care Rapid Appraisal' [viii]
    - Making Every Adult Matter (MEAM) report[ix]

Their reports are really useful, and they help to get the breadth of voice (VB)

- Stakeholders reported that everyone was in search of reliable information throughout the pandemic. HWY was a source of that

information, guidance and signposting. Social media remained positive throughout.

Probably one of the really strong arms of HWY is that it is trusted information. It's not opinionated, it's factual (TM)

- In their ambitions to reach a wider range of local communities, HWY partnered with the Youth Justice Team and Changing Lives to develop a project linking a local business with young people from the youth justice system. This resulted in a local business donating wood so that the young people could build bird boxes. These were in turn donated to the local community.

I just think they are a fantastic organisation that is out there with a lot of resources, information for people (KB)

- In order to support volunteers to develop their own understanding of the needs of the community, HWY arranged for them to have the opportunity to attend awareness raising training such as sessions from the York Travellers Trust.
- At the beginning of the pandemic, HWY compiled a food map to enable residents to access food and essentials safely. This included contact details for food banks, food deliveries and prescriptions.

5.2 The value that stakeholders have placed on Healthwatch York's contribution during the pandemic.

Stakeholders provided good evidence of how much they have valued HWY's support throughout the pandemic. Services were focused on responding collectively and collaboratively, and HWY were very much at the centre of the work, encouraging others to think about how to involve people in co- production in order to achieve improved outcomes. The aim was to better meet their needs and to promptly develop a way of working that helped people to use services in a time of crisis.

HWY were part of that prompting, saying: 'we don't need a pandemic to start thinking about how to work differently' (TM)

Really reliable and trusted in terms of... if you contact them, you know that they will want to help out and do their best to help out (VB)

At the beginning of lockdown, stakeholders reported that, in some areas, there appeared to be a disconnect between services and those trying to use them. Professionals found themselves involved in regular meetings whilst trying to navigate the new ways of working and this deterred people from asking for support, particularly from a mental health perspective. Stakeholders reported feeling adrift from people trying to gain access to services. HWY spoke out on behalf of people affected by the pandemic, who were struggling with remote working and their inability to find appropriate support.

During the pandemic they (HWY) took the challenge head on and looked to work collaboratively within the city and within the networks that they have already got, because, as an organisation, HWY is firmly rooted within partnership working within the city (VB)

Whilst carrying out the welfare calls, as part of the York CVS team supporting the primary care helpline, HWY helped people to get the support they needed at the appropriate place, for example, by not always requiring a GP appointment. This helped primary care health partners with capacity issues.

They are always key because they are genuinely in touch with the community and various groups for people who access services. (TM)

Stakeholders reported that HWY provided an active and positive social media presence throughout the pandemic. This offered helpful information and guidance whilst still highlighting the challenges that people were facing. HWY focused on using social media to share public health messages to those who needed them. They also issued press releases providing guidance on the rights and responsibilities of people in employment who had been advised to shield.

Interviewees voiced how much they valued HWY's ability to continue contributing throughout the pandemic, particularly in terms of listening to those who find it difficult to have their voices heard. The Multiple Complex Needs network worked with HWY to produce a 'Making Every Adult Matter' (MEAM) [x]report to influence future commissioning. They continued to do that work through the pandemic. Working with HWY is seen as essential as it is independent and neutral: not a provider and a well-respected organisation. This means that data sourced by HWY can be useful when seeking to influence decision makers to improve existing methods of service delivery.

The pandemic has shone a light on the health inequalities within the city and HWY has been really present within those conversations (KC)

Whilst not a provider of health and social care, HWY has been described as "the bridge between the providers where people are struggling to know where to access support". Stakeholders felt that the pandemic had helped to break down barriers and has helped partners to introduce different ways of working very quickly.

HWY has remained a constant throughout the pandemic, and have obviously had to change how they work…like everyone else…but they have remained central to providing that information resource (KC)

5.3 How Healthwatch York has been able to meet some of its outcomes in principle and in spirit if not in detail throughout the pandemic.

- **Healthwatch York is responsive to the needs of York residents** *by continuing its provision of information, guidance and signposting along with additional provision such as the welfare calls and work with young people.*

They continued to make contributions right through the pandemic, not just at the start (TM)

- **Healthwatch York understands what is happening in relation to health and social services in York** *by consistent attendance at boards and forums throughout the period.*

HWY is firmly rooted in partnership working within the city (VB)

- **Healthwatch York speaks up about the provision of health and social care services in York** *by working hard with its wider networks to access the seldom heard voices and to represent those groups.*

They did street interviews…they pulled together a report that was really helpful in thinking about the voice of those who are more adversely impacted by change…which helped feed into our urgent care report…and they still made time to do that even though they were busy (VB)

- **Healthwatch York uses the reviews, words, and stories of service users to show the impact of health and social care services in York** *by maintaining an active social media presence and by being present in groups across the city.*

HWY created pressure… in the sense that they put upbeat communications out but reminded people that this wasn't representative of the whole community (TM)

- **Healthwatch York involves the public in the work they do** *by working with volunteers across a range of projects throughout the period and by recognising their value.*

HWY team members communicated very well with volunteers during the pandemic. They demonstrated real appreciation by leaving small gifts on their doorsteps (JW)

- **HWY advocates for people's active involvement in their health and social care** *by creating an open and non -judgmental*

environment for residents to feel comfortable in becoming involved. Throughout the pandemic, HWY has continued to sit on existing boards and groups- this includes the Wheelchair Forum that meets 3 times a year.

HWY is there to offer feedback and know what is happening if wheelchair users contact them. Attendees feel valued and listened to (VB)

- **Healthwatch York provides an effective service for the people of York using health and social care services** *by being present in conversations and representing people at the highest level.*

Thank you to HWY, they have done a great job during the pandemic. They are a trusted and valued resource and also partner in everything that we do. I always think about involving HWY and they have made themselves that way. (VB)

- **Healthwatch York reaches new people and partners** *by using its wide-ranging networks effectively.*

The report was really good, and it helped us to meet our legal duty to ensure we are thinking about those other vulnerable groups…it's the reach that HWY have to those groups and the connections that they have… They have built that trust, so it seems less tokenistic. (VB)

6. Recommendations

Stakeholders were all mindful of the resource limitations placed on HWY, particularly during the pandemic. All interviewees demonstrated a real desire to work collaboratively with HWY by learning what has worked well and using this learning to continue to develop partnerships, thereby improving services for the city and all its residents. Below we make some recommendations for HWY to consider in relation to their internal workings and in their work with partners.

6.1 Internal recommendations

Communication

Recommendation: ***HWY to review its communications strategy to make sure that the organisation is using all opportunities to make people aware of who it is, what it does and how to engage with it.***

There was a general feeling that improved marketing and communication across local services will allow HWY to have a bigger presence and share its good work. Some stakeholders highlighted that they had not been aware of HWY before the pandemic. Once involved, they became aware of the great benefits of working together. They are keen to continue to develop partnership working in the future.

An important issue to highlight is that for some people involved in a number of services, HWY is "yet another" service or professional. It is crucial for HWY to promote itself as an independent service and to clarify and communicate the purpose of its role.

> ***I just think they are a fantastic organisation that is out there with a lot of resources, information for people so they are just fab really, I wouldn't say anything else. Keep doing what they are doing but let's maybe do it on a bigger scale and reach those hard-to-reach groups (KB)***

Equality, diversity, and inclusion (internal)

Recommendation: ***HWY to review the way in which its staff and volunteers are reflective of the wider community.***

Whilst HWY represents the community in its work, stakeholders highlighted that its own staff and volunteers are not fully representative of York's diverse communities. Interviewees felt that HWY could consider how they can attract staff and volunteers from across the wider community when recruiting.

> ***They need to feel safe when talking to someone or trying to access services- that the person who is dealing with them really understands them from a cultural perspective and from a heritage perspective (HN)***

Volunteers

Recommendation: ***HWY to re-engage with its volunteers and maintain connections, highlight ongoing opportunities post-pandemic and link volunteers with a wide range of training opportunities.***

A large contingent of people offered their services as volunteers through the pandemic. Whilst everyone celebrated the fact that so many people had offered to help during this time of crisis, there were not always systems in place to understand the skills and experience being offered, nor the opportunity to take part in training to support people to take up a new volunteering role. As a result a very significant proportion of potential volunteers were not called upon. Many were upset or frustrated by the failure to use them. It was challenging to explain all these reasons publicly.

HWY played its part by asking volunteers to carry out welfare calls to some of the city's older population, and those with identified health issues. As we emerge from the pandemic, the desire to be involved in community action remains high. HWY can use this sense of community to re-engage and maintain connections with existing and new volunteers.

6.2 Partnership wide recommendations

New structures for ICS

Recommendation: ***HWY continues and grows its involvement in the new ICS.***

Stakeholders stressed the importance of HWY's involvement in the new Integrated Care System (ICS) structures that will replace the Clinical Commissioning Group (CCG) in order to ensure independence and that partners in the new framework are listening to the right voices. HWY staff have attended the initial meetings. Their perspective is essential when considering how to build consistent engagement across the whole area and in order to deliver the top priorities. Suggestions for HWY's involvement in future work include:

- Working towards more integrated, holistic commissioning rather than health, housing etc being commissioned separately.
- Supporting those who are dependent on services and cannot wait for appointments.

HWY is encouraged to continue with its collaborative approach and to develop relationships with partners at a more senior level.

Mental health

Recommendation: ***HWY works closely with partners on the mental health partnership board to make sure that mental health services are accessible for all those who need support, including those in most urgent need who may not be known to services.***

Stakeholders raised the question of HWY's role in relation to access to mental health provision. Two key areas were highlighted:
a) HWY reacted immediately to support people with mental ill-health where there was an established element of need before the pandemic. It was more difficult to support those where the acuity element was high, including those who needed to access the most secure services. The challenge for HWY remains in how to raise awareness of support for those who develop mental health needs very quickly and who were not known to services pre-pandemic.
b) York has a population of around 25,000 students from around the world. Whilst the university has its own structures, students are transient members of the city's community. There is a risk that they will become a very vulnerable group in the coming years, and this will be a challenge for the city with HWY being part of that challenge. As this group may need to access local, acute services, there will be a need to engage with this group. HWY, as part of the Mental Health Partnership Board has an opportunity to offer some innovative ideas and flexible responses in relation to what the community may need.

Co- production

Recommendation: ***HWY to work with partners to increase the involvement of the wider community in co-production of services and to make sure that communications are clear and accessible for all, thus helping to reduce barriers to engagement.***

All stakeholders focused on the importance of co- production and HWY is recognised as having the ability to gather people together in a way that other organisations are not able to. HWY's involvement is fundamental to shaping the culture and values of co- production work and is seen as central to a co-production "pillar of change" by being involved with development work from the outset. HWY is encouraged to continue to model and raise awareness of good practice in co-production whilst recognising the constraints within the wider system.

Equality, diversity and inclusion (external)

Recommendation: HWY to work with agencies, services, and funders to continue its work in reaching, listening to, and acting on behalf of the most seldom heard voices across the whole of the city.

HWY to make sure that they consider people of colour and not just wait until a report needs to be done…and they are trying to have access to them (HN)

Stakeholders recognise that HWY has made some progress in this area. It has good levels of engagement and methods of listening to communities by going to directly to them. The pandemic has highlighted the importance of ensuring that boards and forums across the city are more representative and inclusive of the wider communities they serve. It is felt that HWY, with its wide and expanding network, can play a pivotal role in tackling this issue by encouraging and supporting those who are keen to have their voices heard but who lack confidence in coming forward.

HWY is well placed to support boards and forums in creating more informal, accessible board structures that allow people to feel that they can contribute.

There was a reminder from one interviewee that not all residents want to participate in engagement activities. They choose to self-segregate for their own reasons and this choice should be respected.

Safeguarding and risk

Recommendation: ***HWY to work with partners to consider how the pandemic has changed people's approaches to accessing healthcare and making choices about their own healthcare.***

Stakeholders raised concerns about the huge backlog of people with multiple health needs and/or urgent issues and the potential impact this will have on future health services, waiting times and on mental health from a psychological point of view.

By using public health communications, HWY is in a position to take a role in considering and articulating the high-risk factors that might influence people's healthcare choices. This will support York's residents to make informed choices.

Influencing and challenging.

Recommendation: ***HWY to explore the use of participatory research and how those principles can be used to better achieve its aims.***

> ***For some of our clients, those who are marginalised with complex needs, the pandemic hasn't influenced them. They are still homeless. They haven't been able to watch Netflix and have their shopping delivered so it has been interesting to get some of that feedback. That information isn't going to go to HWY, they will have to go and seek that information if they want to hear it and then use some of that information to challenge or influence. (KC)***

HWY has been commissioned by the Multiple Complex Needs (MCN) network for York to investigate participatory research. This will focus on how to improve methods of engagement and finding a way of listening better. It is hoped that the research will open some new possibilities and put HWY in a position to ensure that the most marginalised residents are able to add their voice. One example is the support for street sex workers, including access to contraception and sexual health clinics.

> ***The partnership would be poorer without HWY, a lot poorer. It is absolutely key. York needs more challenge generally and HWY are one of those that do provide challenge but sometimes they need***

others to come on board with them and challenge more collectively. (TM)

Appendix A

List of stakeholders who took part in the evaluation.

Victoria Binks	Vale of York Clinical Commissioning Group	Head of engagement
Kate Bryan	Changing Lives and Youth Offending Team	Victim Liaison Officer
Kelly Cunningham	Multiple Complex Needs Network	
Tim Madgwick	Safeguarding Adults Board and Mental Health Partnership Board	Chair
Haddy Njie	Speak Up Diversity	Founder
Janet Wright	Healthwatch York	Chair

[i] https://www.healthwatchyork.co.uk/wp-content/uploads/2021/03/MGWB-guide-web-version-final.pdf
[ii] https://www.healthyork.org/media/68577/rapid-review-voluntary-sector-impact-of-covid-19-august-2020.pdf
[iii] https://www.healthwatchyork.co.uk/wp-content/uploads/2020/11/Listening-to-BAME-people-about-Health-and-Social-care-services-in-York-Final-report.pdf
[iv] https://www.healthwatchyork.co.uk/wp-content/uploads/2020/03/Healthwatch-York-CAYP-report-A4-Final-Version33101.pdf
[v] https://www.valeofyorkccg.nhs.uk/seecmsfile/?id=4920
[vi] https://www.valeofyorkccg.nhs.uk/seecmsfile/?id=4154
[vii] https://www.healthwatchyork.co.uk/wp-content/uploads/2020/10/York_CVS_COVID-19_What_we_did_09.2020_FINAL.pdf
[viii] https://www.healthwatchyork.co.uk/wp-content/uploads/2020/09/Healthwatch-York-Urgent-Care-Rapid-Appraisal-Report-June-2020.pdf
[ix] https://www.healthwatchyork.co.uk/wp-content/uploads/2020/09/MEAM-report.pdf
[x] https://www.healthwatchyork.co.uk/wp-content/uploads/2020/09/MEAM-report.pdf

Health and Wellbeing Board 21st July 2021

Final Report of the Assistant Director – Joint Commissioning,
City of York Council and Vale of York Clinical Commissioning Group

Better Care Fund Update

Summary

1. This report is to provide an update on:

- the national reporting process for the 2020-21 BCF Plan
- 2020-21 Performance report
- progress of the Better Care Fund Review
- recommendation on Intermediate Care
- the planning arrangements for 2021-22
- recommendation to review the BCF Performance and Delivery Group Terms of Reference

Background

2. The background information on the BCF has been previously reported to the Health and Wellbeing Board (HWBB), with quarterly updates now the normal routine, most recently in May 2021.

3. The government did not publish a Policy Framework and Planning Requirements for 2020-21, and HWBBs were not required to submit a plan for the year. The traditional processes have been interrupted by the pandemic. The York plan has largely followed the pattern of previous years, and we have referred to it as a 'roll forward' of the schemes from 2019-20.

Main/Key Issues to be considered

National reporting process for the 2020-21 BCF Plan

4. The Better Care Team (NHSE&I) issued an End of Year template to report on the BCF expenditure in 2020-21. The template was submitted ahead of the 24th May 2021 deadline, as agreed at the HWBB meeting earlier that month. The submission was signed off by the chair of HWBB. The full excel template is attached at **Annex 1**, and the strategic narrative has been provided as a word document excerpt at **Annex 2** for readers' convenience.

Performance update

5. There are four key performance indicators which have been associated with the BCF since its inception, and which have been reported to the HWBB in previous years. During the pandemic the reporting requirements changed, for example there is now no submission on Delayed Transfers of Care, and the non-elective admissions to hospital cannot be compared to earlier years due to the drastic change in circumstances across the health and care system.

6. The BCF key performance indicator dashboard confirming the outturn for 2020-21 is attached at **Annex 3**.

Progress of the Better Care Fund Review

7. As 2021-22 is the third, successive, single year plan, the council and CCG agreed to review the York BCF to ensure we are achieving the right outcomes and the best value from the pooled investment. The HWBB supported the establishment of a small review team and the proposed approach to ensuring that the BCF is delivering the greatest impact possible.

8. Schemes in York were given an interim commitment of continuation until at least 30th June 2021. The review has been completed in line with the timetable previously reported to the HWBB. The annual evaluation sessions with schemes have also been held in May, bringing together a rich picture of the outcomes achieved for local people, under the 'BCF umbrella'. Schemes were asked to present their information under headings which will support the preparation of the annual report to HWBB in the autumn of 2021, and also to respond to the key lines of enquiry linked to BCF in the NHSEI returns.

9. The previous reports on the BCF review included an overview of the findings to date. The overarching messages which are applicable to the whole programme are set out below:

a. Make improvements to the business processes and contractual arrangements between commissioners and scheme providers to simplify bureaucracy, reduce duplication, increase clarity and timeliness. Treat schemes proportionately in relation to reporting requirements. Where possible place schemes on a sustainable, secure footing for the longer term.

b. Use the positive review findings in 2020-21 as the baseline for future plans and consider all opportunities to add value and further improve outcomes in future. Develop our thinking around the range of currencies we apply to gauge the value of schemes.

c. Develop an Intermediate Care Strategy for York, alongside undertaking an End to End, whole system redesign of Intermediate Care, based on an evidence based assessment of the level of true demand and the capacity requirement for the range of relevant services.

d. Schedule an End to End review of Equipment and Assistive Technology and related services as a further area for whole system planning and improvement.

e. Provide a clear narrative on the history and heritage of the York BCF Plan – differentiate between the schemes where BCF provides 100% of the budget and those where BCF makes a contribution to a larger budget.
    - 100% BCF: Review Group and Partners can instigate or direct review / redesign / service improvement
    - BCF contribution: BCF partners are stakeholders who support wider system experts to review / redesign / improve services. BCF can influence and shape direction of travel towards integration, prevention, collaboration.
    - Group schemes according to high level themes within the financial plan to highlight interdependencies and opportunities for further collaboration.

10. The detailed findings will inform the agenda of the Better Care Fund Performance and Delivery Group as we begin to plan for longer term investments from 2022 onwards.

11. It remains our expectation that the government will establish a standalone BCF, and enable multi-year agreements to be reached. This will have positive advantages in York, in particular to reduce our reliance on fixed term contracts and enable expansion of core preventative services, such as the long-standing commitment to extend Local Area Co-ordination to more areas of the city.

Intermediate Care

12. Among the review recommendations, the most significant area of work to be taken forward is related to the development of an Intermediate Care Strategy for York, taking account of best practice guidance and a refreshed assessment of our true demand and service capacity.

13. The BCF Performance and Delivery Group agreed the need for this work to be carried out, and supported the establishment of a small group to take this forward. The refresh of the Venn Demand and Capacity model provides a starting point for this work, and further proposals will be drawn up about the resourcing and practical implementation of this across the partnership. HWBB sponsorship for the development of an Intermediate Care Strategy is requested, in the context of the overarching Joint Health and Wellbeing Strategy.

The National Small Grants Scheme 2020-21

14. York was successful in its bid for an award from the National Small Grants Scheme in March 2020, securing the maximum allocation of £15,000 to pilot an innovative model of short term care in partnership with North Yorkshire BCF and Care Rooms Ltd. The pilot is for six months initially. The pilot is in progress, with a reference group having been established as a support network for the provider of the pilot. We will report on our learning to the HWBB later in the year or early in 2022.

The Planning Arrangements for 2021-22

15. The detailed planning guidance has not been published at the time or writing, therefore the HWBB will be notified of any changes through a future report. Areas have been advised to plan for its continuation through existing funding streams, with allocations and grant determinations already in place, for example iBCF and Disabled Facilities Grant.

16. The financial plan for 2021 – 22 was developed and supported by the Performance and Delivery Group in June 2021. It is therefore recommended for formal approval by the HWBB. It is attached at **Annex 4.**

17. As we prepare for the planning process for future years it is a suitable time to review the Terms of Reference for the BCF Performance and Delivery Group, last updated in January 2018. These are attached at **Annex 5**. Since that time there have been changes in local organisational structures and representation, and we anticipate further changes to the legislative framework, in line with the NHS White Paper.

Consultation

18. The BCF Plan 2021-22 has been developed in a collaborative process with partners, and is co-produced with the scheme providers, taking account of the learning from the review process. The BCF Performance and Delivery Group discussed the draft financial plan at the June meeting, and confirmed the investment intentions.

Options

19. *n/a*

Analysis

20. *n/a*

Strategic/Operational Plans

21. The Joint Health and Wellbeing Strategy is the overarching strategic vision for York; this plan supports the delivery of the desired outcomes.

22. The York BCF Plan 2017-19 provided the foundation for the BCF Plan 2019-20 and 2020-21. It has evolved each year in line with refreshed intelligence and national directives.

23. This work is congruent with the Council Plan and the NHS Long Term Plan. The NHS White Paper further promotes the policy objectives of BCF.

24. BCF schemes have been central to the COVID-19 pandemic response, including the implementation of the Hospital Discharge Policy.

Implications

- **Financial** – The financial plan has been developed with the detailed support of the finance officers of the CCG and council. It is compliant with regulations, and will be monitored quarterly through the BCF Performance and Delivery Group. Any future decisions about investment or disinvestment would be consulted upon with partners and would have legal governance and assurance through the section 75 agreement used to establish the BCF pooled budget.

- **Human Resources (HR)** – many of the schemes funded through BCF are supported by staff on fixed term contracts. The prevalence of short-term funding and fixed term employment contracts are a significant risk to the stability and continuity of our system. The review has prioritised the schemes which are most affected. CYC staff contracts have now been extended where required.

- **Equalities** - none

- **Legal** - none

- **Crime and Disorder** - none

- **Information Technology (IT) –** information technology and digital integration forms part of the system wide improvement plan, relevant representatives from statutory agencies attend the project board, and there are plans to engage non-statutory services and the patients, customers and families in our developments. The national and regional work on this agenda guides our local work.

- **Property** - none
- **Other** – none.

Risk Management

25. Governance processes are in place between the partners to manage the strategic risks of the BCF as part of our whole system working.

Recommendations

26. The Health and Wellbeing Board are asked to:

i. Receive the York Better Care Fund update for information, including the formal submission of the 2020-21 End of Year report to NHSEI.

Reason:

The HWBB is the accountable body for the Better Care Fund.

ii. Approve the financial plan for 2021-22.

Reason:

The HWBB is the accountable body for the Better Care Fund.

iii. Support the development of a new, multi-agency Intermediate Care Strategy for York.

Reason:

York does not currently have a strategy in place to cover the range of services described as Intermediate Care.

iv. Receive further reports on the progress and outcomes from the Care Rooms pilot project.

Reason:

The HWBB is the accountable body for the Better Care Fund.

v. Instigate a review of the terms of Reference for the Performance and Delivery Group to reflect changes in the local and national arrangements and to prepare for future requirements.

Reason:

The Terms of Reference have not been updated since 2018.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Pippa Corner *Assistant Director – Joint Commissioning* *People Directorate* *City of York Council & NHS Vale of York CCG* *07500973261*	*Amanda Hatton* *Corporate Director - People* *City of York Council*
Report Approved ✓	**Date** 06.07.2021

Wards Affected: **All** *x*

For further information please contact the author of the report

Background Papers:

Annexes

Annex 1 – NHSEI End of Year Template 2020-2021

Annex 2 – excerpt from the end of year template – strategic narrative

Annex 3 – BCF KPI Performance Dashboard 2020 -21

Annex 4 – 2021 - 22 Financial Plan

Annex 5 – BCF Performance and Delivery Group terms of reference

Glossary

A&E – Accident and Emergency
BCF – Better Care Fund
BI – Be Independent
CCG – Clinical Commissioning Group
CYC – City of York Council
DHSC - Department of Health and Social Care
DToC – Delayed Transfers of Care
ED - Emergency Department
GP – General Practitioner
HR – Human Resources
HSG – Human Support Group
HWBB – Health and Wellbeing Board
IT – Information Technology
KPI – Key Performance Indicator
LAC – Local Area Co-ordinator / Local Are Co-ordination
MDT – Multi-Disciplinary Team
NHS - National Health Service
NHSE&I - NHS England & Improvement
RATS - Rapid Assessment and Therapy Service
SDEC - Same Day Emergency Care
VOYCCG – Vale of York Clinical Commissioning Group
YTH – York Teaching Hospital

This page is intentionally left blank

ANNEX 1

Better Care Fund 2020-21 Year-end Template

1. Guidance

Overview

This template is for Health and Wellbeing Boards (HWBs) to provide end of year reporting on their Better Care Fund (BCF) plans. The template should be submitted to the BCF team by 24 May 2021. Since BCF plans were not collected in 2020-21, the end of year reporting will collect information and data on scheme level expenditure that would normally be collected during planning. This is to provide effective accountability for the funding, information and input for national partners and into national datasets.

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For an optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (all sheets)

1. On each sheet, there is a section that helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are 'Green' containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete'.
5. Please ensure that all boxes on the checklist tab are green before submission.

Cover

1. The cover sheet provides essential information on: the area for which the template is being completed; contacts; and sign off.
2. 'Question completion' tracks the number of questions that have been completed. When all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to **england.bettercarefundteam@nhs.net**
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2020-21 (link below) continue to be met through the year, at the time of the template's sign off.

https://www.gov.uk/government/publications/better-care-fund-policy-statement-2020-to-2021/better-care-fund-policy-statement-2020-to-2021

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met during the year and how this is being addressed. Please note that where a national condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

The four national conditions are as below:

- National condition 1: Plans covering all mandatory funding contributions have been agreed by HWB areas and minimum contributions are pooled in a section 75 agreement (an agreement made under section 75 of the NHS Act 2006).
- National condition 2: The contribution to social care from the CCG via the BCF is agreed and meets or exceeds the minimum expectation.
- National condition 3: Spend on CCG commissioned out of hospital services meets or exceeds the minimum ringfence.
- National condition 4: The CCG and LA have confirmed compliance with these conditions to the HWB.

Income and Expenditure Actuals

The Better Care Fund 2020-21 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) grant, and the minimum CCG contribution.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2020-21. Please include income from additional CCG and LA contributions in 2020-21 in the yellow boxes provided.
- Please provide any comments that may be useful for local context for the reported actual income in 2020-21.

Expenditure section:

- Please enter the total HWB level actual BCF expenditure for 2020-21 in the yellow box provided.
- Please share any comments that may provide a useful local context to the reported actual expenditure in 2020-21.

Year End Feedback

This section provide an opportunity to feedback on delivering the BCF in 2020-21 through a set of survey questions which are, overall, consistent with those from previous years.

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2020-21.
There is a total of 5 questions. These are set out below.

Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2020-21
3. The delivery of our BCF plan in 2020-21 had a positive impact on the integration of health and social care in our locality

Part - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institute for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2020-21.
5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2020-21?

As noted above, these are free text responses to be assigned to one of the following categories from the SCIE Integration Logic Model - Enablers summarised below. Please see link below for fuller details:
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Social care fees

This section collects data on average fees paid by the local authority for social care. This is similar to data collected in Q2 reporting in previous years.

The questions have been updated for 2020-21 to distinguish long term fee rates from temporary uplifts related to the additional costs and pressures on care providers resulting from the COVID-19 pandemic
Specific guidance on individual questions can be found on the relevant tab.

CCG-HWB Mapping

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level.

Better Care Fund 2020-21 Year-end Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information, including that provided on local authority fee rates, will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist: Complete:
Health and Wellbeing Board:	York	Yes
Completed by:	Pippa Corner / Michael Ash-McMahon	Yes
E-mail:	pippa.corner@york.gov.uk / m.ash-mcmahon@nhs.net	Yes
Contact number:	07500 973261 / 07814 961726	Yes
Is the template being submitted subject to HWB / delegated sign-off?	No, sign-off has been received	Yes

Where a sign-off has been received, please indicate who signed off the report on behalf of the HWB?

Job Title:	Chair of H&WB	Yes
Name:	Councillor Carol Runciman	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Income	Yes
5. Expenditure	Yes
6. Income and Expenditure actual	Yes
7. Year-End Feedback	Yes
8. iBCF	Yes

<< Link to the Guidance sheet

Better Care Fund 2020-21 Year-end Template

3. National Conditions

Selected Health and Wellbeing Board: York

Confirmation of Nation Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2020-21:**
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) The CCG and LA have confirmed compliance with these conditions to the HWB?	Yes	

Checklist

Complete:

Yes

Yes

Yes

Yes

ANNEX 1

Better Care Fund 2020-21 Year-end Template

4. Income

Selected Health and Wellbeing Board: York

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
York	£1,467,977
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,467,977**

iBCF Contribution	Contribution
York	£5,210,953
Total iBCF Contribution	**£5,210,953**

Are any additional LA Contributions being made in 2020-21? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Vale of York CCG	£12,727,980
Total Minimum CCG Contribution	**£12,727,980**

Are any additional CCG Contributions being made in 2020-21? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding. If you are including funding made available to support the Hospital Discharge Service Policy in 2020-21, you should record this here
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£12,727,980**	

	2020-21
Total BCF Pooled Budget	**£19,406,910**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

Better Care Fund 2020-21 Year-end Template

5. Expenditure

Selected Health and Wellbeing Board: York

Running Balances	Income	Expenditure	Balance
DFG	£1,467,977	£1,467,977	£0
Minimum CCG Contribution	£12,727,980	£12,727,980	£0
iBCF	£5,210,953	£5,210,953	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£19,406,910	£19,406,910	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£3,682,541	£6,049,174	£0
Adult Social Care services spend from the minimum CCG allocations	£6,030,145	£6,151,806	£0

Checklist

Complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Link to Scheme Type description

					Expenditure								
Scheme ID	Scheme Name	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£1,467,977	Existing
2	Care package pressures due to demographic	Home Care or Domiciliary Care			Social Care		LA			Private Sector	Minimum CCG Contribution	£2,502,545	Existing
3	Care package pressures due to demographic	Home Care or Domiciliary Care			Social Care		LA			Private Sector	iBCF	£1,045,000	Existing
4	Contribution to Social Work post	Care Act Implementation Related Duties	Other	Early intervention and prevention	Social Care		LA			Local Authority	Minimum CCG Contribution	£145,011	Existing
5	Carers Support	Carers Services	Carer Advice and Support		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£674,650	Existing
6	Implementation of Care Act	Care Act Implementation Related Duties	Other	Advocacy, population wellbeing, carers	Social Care		LA			Local Authority	Minimum CCG Contribution	£463,080	Existing

7	Community Facilitator	Prevention / Early Intervention	Other	Information advice and guidance for self-	Social Care		LA			Local Authority	Minimum CCG Contribution	£31,620	Existing
8	Reablement (Human Support Group)	Intermediate Care Services	Reablement/Rehabilitation Services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£1,165,960	Existing
9	Step-up/Step-down beds	Intermediate Care Services	Bed Based - Step Up/Down		Social Care		LA			Local Authority	Minimum CCG Contribution	£321,000	Existing
10	Telecare and Falls	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£195,840	Existing
11	Communtiy Equipment	Other		Equipment for daily living	Social Care		LA			Local Authority	Minimum CCG Contribution	£185,400	Existing
12	Home adaptations	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£77,250	Existing
13	Increased reablement capacity	Intermediate Care Services	Reablement/Rehabilitation Services		Social Care		LA			Charity / Voluntary Sector	iBCF	£173,000	Existing
14	Self-support champions	Prevention / Early Intervention	Other	Information advice and guidance for self-	Social Care		LA			Local Authority	iBCF	£102,000	Existing
15	Social Prescribing - Ways to Wellbeing	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	iBCF	£161,000	Existing
16	Expanded Handyperson Service	Prevention / Early Intervention	Other	Small tasks at home	Social Care		LA			Charity / Voluntary Sector	iBCF	£31,000	Existing
17	Improved curation of Information and advice	Prevention / Early Intervention	Other	Web based information advice and	Social Care		LA			Local Authority	iBCF	£51,000	Existing
18	Alcohol advice	Prevention / Early Intervention	Other	Training for Primary Care staff	Social Care		LA			Local Authority	iBCF	£49,000	Existing
19	7 day working	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services		Social Care		LA			Local Authority	iBCF	£300,000	Existing
20	Local Area Coordination	Prevention / Early Intervention	Other	Information advice and guidance for self-	Social Care		LA			Local Authority	iBCF	£175,000	Existing
21	Performance Support role	Other		Performance management	Other	Management	LA			Local Authority	iBCF	£30,000	Existing
22	Capacity and demand exercise	Other		Planning and future forcasting	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£10,000	Existing
23	Physiotherapy in step-down beds	Intermediate Care Services	Reablement/Rehabilitation Services		Social Care		LA			NHS Community Provider	iBCF	£36,000	Existing

24	IT support for single care record	Enablers for Integration	Shared records and Interoperability		Other	Management	LA			Local Authority	iBCF	£45,000	New
25	Community Response Team (Expanding care at	Community Based Schemes			Community Health		CCG			NHS Community Provider	iBCF	£110,000	Existing
26	Increased access to Primary Care	Prevention / Early Intervention	Other	Implementation of OPEL system to maintain	Primary Care		CCG			NHS Community Provider	iBCF	£22,000	New
27	START - dementia carers support	Prevention / Early Intervention	Other	Carers support	Other	Voluntary Sector	LA			NHS Mental Health Provider	iBCF	£35,000	New
28	Home from Hospital	Home Care or Domiciliary Care			Social Care		LA			Charity / Voluntary Sector	iBCF	£27,000	Existing
29	5 Additional Short term Stepdown/up beds.	Intermediate Care Services	Bed Based - Step Up/Down		Social Care		LA			Local Authority	iBCF	£39,000	Existing
30	12 Additional Care Beds at the Chocolate Works.	Residential Placements	Nursing Home		Social Care		LA			Private Sector	iBCF	£224,000	Existing
31	Secure capacity to enable placements to be made to	Residential Placements	Care Home		Social Care		LA			Private Sector	iBCF	£351,000	Existing
32	Retaining Home Care Packages "open" for 4	HICM for Managing Transfer of Care	Chg 7. Focus on Choice		Social Care		LA			Private Sector	iBCF	£14,000	Existing
33	Live in Care	Personalised Care at Home			Social Care		LA			Private Sector	iBCF	£84,000	Existing
34	Be Independent falls Support	Community Based Schemes			Social Care		LA			Local Authority	iBCF	£20,000	Existing
35	York Integrated Care Team	Integrated Care Planning and Navigation	Care Coordination		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£750,000	Existing
36	Urgent Care Practitioners	Intermediate Care Services	Rapid / Crisis Response		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£500,000	Existing
37	Hospice at Home (extended hours)	Home Care or Domiciliary Care			Community Health		CCG			Local Authority	Minimum CCG Contribution	£170,000	Existing
38	Street Triage (part fund with NYCC)	Intermediate Care Services	Rapid / Crisis Response		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£156,000	Existing
39	CCG Out of Hospital commission	Community Based Schemes			Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£4,462,000	Existing
40	CCG Out of Hospital commission	Community Based Schemes			Community Health		CCG			NHS Community Provider	iBCF	£1,588,953	Existing

41	Changing Lives - A Bed Ahead	Housing Related Schemes			Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£81,000	Existing
42	Fulford Nursing Home	Intermediate Care Services	Bed Based - Step Up/Down		Community Health		CCG			Private Sector	iBCF	£195,000	Existing
43	Fulford Nursing Home - Occupational	Other		Support to Fulford Nursing Home	Community Health		CCG			Local Authority	iBCF	£59,000	Existing
44	RATS Extended Hours	Intermediate Care Services	Rapid / Crisis Response		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£164,000	Existing
45	RATS Extended Hours - Social Worker	Intermediate Care Services	Rapid / Crisis Response		Social Care		CCG			Local Authority	Minimum CCG Contribution	£50,000	Existing
46	Priory Outreach	Intermediate Care Services	Rapid / Crisis Response		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£180,000	Existing
47	Vaccinations Outreach	Prevention / Early Intervention	Other	Flu vaccinations for homeless	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£4,000	Existing
48	LAC expansion x 3	Enablers for Integration	Integrated commissioning models		Social Care		LA			Local Authority	iBCF	£25,000	New
49	Additional Physio and Occ. therapy input to	Community Based Schemes			Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£17,600	New
50	Dementia - support to individuals and	Community Based Schemes			Mental Health		LA			Charity / Voluntary Sector	iBCF	£16,000	New
51	Northern quarter project manager (grade 9)	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	Minimum CCG Contribution	£13,000	New
52	Increased support at home (Post 6 weeks)	Home Care or Domiciliary Care			Social Care		LA			Local Authority	Minimum CCG Contribution	£206,950	New
53	Step up / down beds (winter months spot	Intermediate Care Services	Bed Based - Step Up/Down		Social Care		LA			Private Sector	iBCF	£203,000	New
54	Cultural commissioning	Other		Restoration of previous theme to tackle isolation	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£12,500	New
55	Mass flu vaccinations (IT and staff	Prevention / Early Intervention	Other	Additional support to flu vaccination	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£35,000	New
56	CCG VCS contracts	Carers Services	Carer Advice and Support		Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£97,000	New
57	Mass Flu vaccination site - HCA for MFV	Prevention / Early Intervention	Other	Additional support to flu vaccination	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£10,631	New

58	Supporting COVID-19 recovery YICT	Integrated Care Planning and Navigation	Other	Additional support to mass vaccination	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£21,263	New
59	Nimbus SPA covid	Integrated Care Planning and Navigation	Single Point of Access		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£14,680	New
60	Move the Masses	Prevention / Early Intervention	Other	Voluntary sector support	Other	Voluntary Sector	LA			Charity / Voluntary Sector	Minimum CCG Contribution	£10,000	New

This page is intentionally left blank

^^ Link back up

Scheme Type	Description	
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	

Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	

Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	

Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

^^ Link back up

Better Care Fund 2020-21 Year-end Template

6. Income and Expenditure actual

Selected Health and Wellbeing Board: York

Income

	2020-21
Disabled Facilities Grant	£1,467,977
Improved Better Care Fund	£5,210,953
CCG Minimum Fund	£12,727,980
Minimum Sub Total	£19,406,910

	Planned	Actual
CCG Additional Funding	£0	
LA Additional Funding	£0	
Additional Sub Total	£0	£0

	Actual	
Do you wish to change your additional actual CCG funding?	No	
Do you wish to change your additional actual LA funding?	No	

	Planned 20-21	Actual 20-21
Total BCF Pooled Fund	£19,406,910	£19,406,910

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2020-21	

Expenditure

	2020-21
Plan	£19,406,910

Do you wish to change your actual BCF expenditure?	No
Actual	
Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2020-21	

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes
- Yes

Better Care Fund 2020-21 Year-end Template

7. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2020-21
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: York

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	The positive working relationships which have developed over recent years in the BCF were critical to the co-ordinated and collaborative response to the pandemic. Our previous investment in asset based community development, such as LAC, social prescribing and cultural commissioning, provided the foundations for our community hubs across the city	Yes
2. Our BCF schemes were implemented as planned in 2020-21	Agree	Services responded to the pandemic rapidly putting in place IPC and social distancing measures, meaning that some schemes such as Local Area Co-ordination balanced remote work and face-to-face in a COVID-19 compliant way. Ways to Wellbeing Social Prescribing re-focused their approach to deliver welfare calls by telephone, and supported the	Yes
3. The delivery of our BCF plan in 2020-21 had a positive impact on the integration of health and social care in our locality	Strongly Agree	Our BCF schemes have developed to become interdependent and highly collaborative, with many teams working across organisational boundaries to deliver better outcomes for individuals. We have delivered integration by pooling resources, (without focusing on structural change and reconfiguration), working together and co-ordinating shared	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2020-21	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	Our asset based community development over recent years placed us in a powerful position at the start of the pandemic. Over the difficult months of 2020 the schemes continued to work with local people to find innovative ways of maintaining social connections and responding to the mental and emotional impacts of the pandemic, including the isolation of lockdowns. People found meaning and value in offering to volunteer, while others helped re-shape social action through mutual aid groups. In the autumn our BCF group co-produced a winter resource plan, using a portion of the BCF to enable	Yes
Success 2	8. Pooled or aligned resources	During 2020-21 our BCF schemes have worked closely and collaboratively to respond to the changing circumstance of the pandemic at each stage. We have a rich pattern of schemes across statutory, community and voluntary sectors, which form our asset based community capacity. These schemes have pivoted their approaches to ensure that the most isolated and most at risk from COVID-19 were supported to remain connected and engaged with their communities and natural networks. They were at the heart of our urgent response to the first lockdown, and resulted in new relationships and new	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2020-21	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	3. Integrated electronic records and sharing across the system with service users	Although there has been some progress, for example in relation to shared records in palliative / end of life care pathways using Black Pear, and GPs have been 'on-boarded', the Yorkshire and Humber Care Record has not been implemented across the system as rapidly as we had hoped. We have funded a project management post through BCF to support the development of shared care records, and this enabled better communication and prepared the foundations for local authority engagement in YHCR, but CYC is part of the 3rd wave, and has not yet been prioritised for 'on-boarding'. Our	Yes
Challenge 2	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	The long term financial challenges in York across the health system, and increasingly the local authority, have meant that our focus on system transformation has required savings and efficiencies while attempting to improve outcomes. The single-year funding agreements in BCF has detrimentally impacted on our ability to plan for the long term and we lose good staff who require greater job security and can gain better remuneration in other geographical areas or sectors. The anticipated move by government to multi-year agreements for BCF will make a considerable improvement to our ability to attract and retain	Yes

Footnotes:
Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2020-21 Year-end Template

8. improved Better Care Fund

Selected Health and Wellbeing Board: York

These questions cover average fees paid by your local authority (including client contributions/user charges) to external care providers for your local authority's eligible clients.
The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

We are interested ONLY in the average fees actually received by external care providers for your local authority's eligible supported clients (including client contributions/user charges). Specifically the averages SHOULD EXCLUDE:
- Any amounts that you usually include in reported fee rates but are not paid to care providers e.g. your local authority's own staff costs in managing the commissioning of places.
- Any amounts that are paid from sources other than eligible local authority funding and client contributions/user charges, i.e. you should EXCLUDE third party top-ups, NHS Funded Nursing Care and full cost paying clients.

Respecting these exclusions, the average fees SHOULD INCLUDE:
- Client contributions /user charges.
- Fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.
- Fees that did not change as a result of the additional IBCF allocation, as well as those that did. We are interested in the whole picture, not just fees that were specifically increased using additional iBCF funding.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing requested below (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) **please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:**
1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	For information - your 2019-20 fee as reported in Q2 2019 20*	Average 2019-20 fee. If you have newer/better data than at Q2 2019-20, enter it below and explain why it differs in the comments. Otherwise enter the Q2 2019-20 value from the previous column	What was your anticipated average fee rate for 2020-21, if COVID-19 had not occurred?	What was your actual average fee rate per actual user for 2020-21?**	Implied uplift: anticipated 2020-21 rates compared to 2019-20 rates.	Implied uplift: actual 2020-21 rates compared to 2019-20 rates.	Checklist Complete:
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£19.48	£19.48	£20.06	£21.45	3.0%	10.1%	Yes
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£707.00	£707.00	£728.21	£720.47	3.0%	1.9%	Yes
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£744.00	£744.00	£766.32	£762.92	3.0%	2.5%	Yes
4. Please provide additional commentary if your 2019-20 fee is different from that reported at Q2 2019-20. Please do not use more than 250 characters.							Yes
5. Please briefly list the covid-19 support measures that have most increased your average fees for 2020-21. Please do not use more than 250 characters.		Increased placement cost by 2% above infl for April to Jun Use of more expensive home care providers not on our framework to address demand					Yes

111 characters remaining

Footnotes:

* ".." in the column C lookup means that no 2019-20 fee was reported by your council in Q2 2019-20

** For column F, please calculate your fee rate as the expenditure during the year divided by the number of actual client weeks during the year. This will pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

This page is intentionally left blank

CCG to Health and Well-Being Board Mapping for 2020-21

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.4%	87.2%
E09000002	Barking and Dagenham	08C	NHS Hammersmith and Fulham CCG	0.1%	0.2%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.0%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.7%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.7%	3.7%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.2%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	07P	NHS Brent CCG	2.1%	2.0%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000003	Barnet	08E	NHS Harrow CCG	1.3%	0.8%
E09000003	Barnet	08Y	NHS West London CCG	0.2%	0.1%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.3%	0.2%
E09000003	Barnet	93C	NHS North Central London CCG	25.0%	96.3%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.5%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	1.1%
E06000022	Bath and North East Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	21.0%	98.4%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	78H	NHS Northamptonshire CCG	0.2%	0.6%
E09000004	Bexley	08C	NHS Hammersmith and Fulham CCG	0.0%	0.1%
E09000004	Bexley	72Q	NHS South East London CCG	12.5%	98.4%
E09000004	Bexley	91Q	NHS Kent and Medway CCG	0.2%	1.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	38.7%	17.5%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E08000025	Birmingham	08C	NHS Hammersmith and Fulham CCG	0.6%	0.2%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.5%	81.8%
E08000025	Birmingham	18C	NHS Herefordshire and Worcestershire CCG	0.7%	0.4%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.7%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.8%	1.8%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.0%	97.7%
E06000009	Blackpool	02M	NHS Fylde and Wyre CCG	2.0%	2.3%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%

E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Poole	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000058	Bournemouth, Christchurch and Poole	11J	NHS Dorset CCG	52.7%	99.7%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.1%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.0%	96.7%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E08000032	Bradford	02T	NHS Calderdale CCG	0.3%	0.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	36J	NHS Bradford District and Craven CCG	90.5%	98.5%
E09000005	Brent	07P	NHS Brent CCG	89.1%	85.8%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	1.0%	0.7%
E09000005	Brent	08E	NHS Harrow CCG	6.0%	4.0%
E09000005	Brent	08Y	NHS West London CCG	4.1%	2.5%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.4%	0.8%
E09000005	Brent	93C	NHS North Central London CCG	1.4%	5.6%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	70F	NHS West Sussex CCG	0.0%	0.2%
E06000043	Brighton and Hove	97R	NHS East Sussex CCG	0.0%	0.1%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.6%	100.0%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000006	Bromley	36L	NHS South West London CCG	0.3%	1.5%
E09000006	Bromley	72Q	NHS South East London CCG	17.2%	98.1%
E09000006	Bromley	91Q	NHS Kent and Medway CCG	0.0%	0.2%
E06000060	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E06000060	Buckinghamshire	06F	NHS Bedfordshire CCG	0.5%	0.4%
E06000060	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E06000060	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E06000060	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.5%	0.7%
E06000060	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.5%	94.9%
E06000060	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%
E06000060	Buckinghamshire	78H	NHS Northamptonshire CCG	0.1%	0.2%
E08000002	Bury	00T	NHS Bolton CCG	0.7%	1.1%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.4%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.1%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	1.9%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	36J	NHS Bradford District and Craven CCG	0.2%	0.7%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.7%	96.8%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	3.9%	1.4%
E10000003	Cambridgeshire	26A	NHS Norfolk and Waveney CCG	0.3%	0.4%

E09000007	Camden	07P	NHS Brent CCG	1.2%	1.7%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	1.1%	1.2%
E09000007	Camden	08Y	NHS West London CCG	0.3%	0.3%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.4%	4.7%
E09000007	Camden	93C	NHS North Central London CCG	15.4%	92.1%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.7%	94.9%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.7%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.1%	1.7%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.6%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.2%	0.6%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.2%
E06000049	Cheshire East	27D	NHS Cheshire CCG	51.6%	97.4%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E06000050	Cheshire West and Chester	27D	NHS Cheshire CCG	47.3%	99.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	66.3%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.1%	4.3%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.3%	12.8%
E09000001	City of London	08Y	NHS West London CCG	0.0%	0.2%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	3.4%
E09000001	City of London	72Q	NHS South East London CCG	0.0%	0.3%
E09000001	City of London	93C	NHS North Central London CCG	0.0%	12.7%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000047	County Durham	00P	NHS Sunderland CCG	1.1%	0.6%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	16C	NHS Tees Valley CCG	0.1%	0.1%
E06000047	County Durham	84H	NHS County Durham CCG	96.8%	98.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.6%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E08000026	Coventry	05R	NHS South Warwickshire CCG	0.1%	0.0%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000008	Croydon	36L	NHS South West London CCG	23.9%	93.7%
E09000008	Croydon	72Q	NHS South East London CCG	1.0%	4.7%
E09000008	Croydon	92A	NHS Surrey Heartlands CCG	0.6%	1.4%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.5%
E10000006	Cumbria	01K	NHS Morecambe Bay CCG	53.2%	36.5%
E06000005	Darlington	16C	NHS Tees Valley CCG	15.2%	96.6%
E06000005	Darlington	42D	NHS North Yorkshire CCG	0.0%	0.1%
E06000005	Darlington	84H	NHS County Durham CCG	0.7%	3.3%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.6%	100.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%

E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.6%	0.3%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.5%
E10000007	Derbyshire	52R	NHS Nottingham and Nottinghamshire CCG	0.9%	1.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	15N	NHS Devon CCG	66.0%	99.2%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.7%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	97.0%	97.7%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	11J	NHS Dorset CCG	45.9%	95.7%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.4%	0.9%
E08000027	Dudley	05C	NHS Dudley CCG	91.9%	90.6%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	7.0%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.7%	1.5%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	18C	NHS Herefordshire and Worcestershire CCG	0.1%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	2.1%	1.9%
E09000009	Ealing	07W	NHS Ealing CCG	87.0%	89.7%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.4%	3.3%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.1%	3.5%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	08Y	NHS West London CCG	0.8%	0.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.4%	0.2%
E09000009	Ealing	93C	NHS North Central London CCG	0.0%	0.1%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.2%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	8.7%	7.5%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.8%	7.1%
E06000011	East Riding of Yorkshire	42D	NHS North Yorkshire CCG	0.2%	0.2%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.6%
E10000011	East Sussex	70F	NHS West Sussex CCG	0.7%	1.2%
E10000011	East Sussex	91Q	NHS Kent and Medway CCG	0.2%	0.7%
E10000011	East Sussex	97R	NHS East Sussex CCG	99.4%	97.5%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000010	Enfield	93C	NHS North Central London CCG	21.6%	98.9%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.5%	0.6%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%

E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	07H	NHS West Essex CCG	97.2%	19.9%
E10000012	Essex	07K	NHS West Suffolk CCG	3.0%	0.5%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.2%	0.0%
E10000012	Essex	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E10000012	Essex	08F	NHS Havering CCG	0.4%	0.0%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.1%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.3%	11.4%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.1%	97.7%
E08000037	Gateshead	84H	NHS County Durham CCG	0.5%	1.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.3%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.5%	98.6%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	18C	NHS Herefordshire and Worcestershire CCG	0.5%	0.6%
E10000013	Gloucestershire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.1%	0.2%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.8%	0.8%
E09000011	Greenwich	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000011	Greenwich	72Q	NHS South East London CCG	15.2%	99.2%
E09000011	Greenwich	93C	NHS North Central London CCG	0.0%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.1%	92.2%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	1.4%	1.3%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.7%	0.7%
E09000012	Hackney	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.3%	0.2%
E09000012	Hackney	93C	NHS North Central London CCG	1.0%	5.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.2%
E06000006	Halton	27D	NHS Cheshire CCG	0.2%	1.0%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.5%	1.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.6%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	67.9%	87.0%
E09000013	Hammersmith and Fulham	08Y	NHS West London CCG	7.0%	7.6%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.6%
E09000013	Hammersmith and Fulham	36L	NHS South West London CCG	0.0%	0.4%
E09000013	Hammersmith and Fulham	72Q	NHS South East London CCG	0.0%	0.1%
E09000013	Hammersmith and Fulham	93C	NHS North Central London CCG	0.0%	0.2%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.9%	0.0%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.3%	16.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.4%	14.1%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%

E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.7%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	4.9%	1.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.2%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.6%	0.6%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	70F	NHS West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	92A	NHS Surrey Heartlands CCG	0.6%	0.5%
E10000014	Hampshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.6%	0.4%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.6%	12.4%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.9%	0.9%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000014	Haringey	93C	NHS North Central London CCG	18.3%	95.9%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	07P	NHS Brent CCG	3.8%	5.1%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.0%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000015	Harrow	08E	NHS Harrow CCG	89.6%	83.9%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	1.9%
E09000015	Harrow	08Y	NHS West London CCG	0.1%	0.1%
E09000015	Harrow	93C	NHS North Central London CCG	1.1%	6.2%
E06000001	Hartlepool	16C	NHS Tees Valley CCG	13.6%	99.2%
E06000001	Hartlepool	84H	NHS County Durham CCG	0.1%	0.8%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.7%	3.1%
E09000016	Havering	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000016	Havering	08F	NHS Havering CCG	91.6%	95.6%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.7%	0.8%
E09000016	Havering	08W	NHS Waltham Forest CCG	0.1%	0.1%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	1.0%
E06000019	Herefordshire, County of	18C	NHS Herefordshire and Worcestershire CCG	23.2%	98.6%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.8%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.9%	0.2%
E10000015	Hertfordshire	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.0%
E10000015	Hertfordshire	93C	NHS North Central London CCG	0.2%	0.2%
E09000017	Hillingdon	07P	NHS Brent CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.3%	7.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.2%	1.2%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.1%	1.7%

E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.4%	89.5%
E09000017	Hillingdon	08Y	NHS West London CCG	0.1%	0.0%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%
E09000018	Hounslow	07W	NHS Ealing CCG	5.3%	7.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.5%	87.1%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	1.1%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	08Y	NHS West London CCG	0.2%	0.2%
E09000018	Hounslow	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000018	Hounslow	36L	NHS South West London CCG	0.7%	3.8%
E09000018	Hounslow	92A	NHS Surrey Heartlands CCG	0.1%	0.4%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07T	NHS City and Hackney CCG	3.3%	4.0%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	1.5%	1.8%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.6%	0.6%
E09000019	Islington	93C	NHS North Central London CCG	15.0%	93.7%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.2%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.4%	2.3%
E09000020	Kensington and Chelsea	08Y	NHS West London CCG	63.8%	91.6%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	36L	NHS South West London CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	93C	NHS North Central London CCG	0.0%	0.4%
E10000016	Kent	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E10000016	Kent	72Q	NHS South East London CCG	0.4%	0.5%
E10000016	Kent	91Q	NHS Kent and Medway CCG	84.6%	99.4%
E10000016	Kent	97R	NHS East Sussex CCG	0.3%	0.1%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	91.3%	98.6%
E09000021	Kingston upon Thames	08C	NHS Hammersmith and Fulham CCG	0.1%	0.2%
E09000021	Kingston upon Thames	36L	NHS South West London CCG	11.3%	98.8%
E09000021	Kingston upon Thames	92A	NHS Surrey Heartlands CCG	0.2%	1.1%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.6%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.3%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.6%	1.4%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	36J	NHS Bradford District and Craven CCG	0.5%	0.7%
E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	87.0%	88.1%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.2%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.7%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.1%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	1.6%	1.3%
E09000022	Lambeth	08Y	NHS West London CCG	0.1%	0.0%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	1.5%	0.9%
E09000022	Lambeth	36L	NHS South West London CCG	1.2%	4.9%
E09000022	Lambeth	72Q	NHS South East London CCG	18.3%	92.6%
E09000022	Lambeth	93C	NHS North Central London CCG	0.0%	0.3%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%

E10000017	Lancashire	00R	NHS Blackpool CCG	14.0%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	29.9%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.8%	0.2%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.7%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	45.0%	12.3%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.3%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.4%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.0%	8.6%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E10000017	Lancashire	02M	NHS Fylde and Wyre CCG	98.0%	13.7%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.5%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E08000035	Leeds	15F	NHS Leeds CCG	97.6%	98.7%
E08000035	Leeds	36J	NHS Bradford District and Craven CCG	0.6%	0.5%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	1.6%	1.3%
E06000016	Leicester	04C	NHS Leicester City CCG	93.0%	96.0%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.9%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.0%	4.1%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	52R	NHS Nottingham and Nottinghamshire CCG	0.6%	1.0%
E10000018	Leicestershire	71E	NHS Lincolnshire CCG	0.9%	1.0%
E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.9%	0.8%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	36L	NHS South West London CCG	0.0%	0.2%
E09000023	Lewisham	72Q	NHS South East London CCG	16.6%	98.7%
E09000023	Lewisham	93C	NHS North Central London CCG	0.0%	0.1%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	5.0%	1.1%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	52R	NHS Nottingham and Nottinghamshire CCG	0.3%	0.4%
E10000019	Lincolnshire	71E	NHS Lincolnshire CCG	96.4%	97.5%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.3%	2.6%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.5%	1.0%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.4%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.7%
E06000032	Luton	06P	NHS Luton CCG	97.5%	95.3%
E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	00Y	NHS Oldham CCG	0.8%	0.3%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%

E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.9%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	3.8%	1.4%
E08000003	Manchester	14L	NHS Manchester CCG	91.1%	95.8%
E06000035	Medway	91Q	NHS Kent and Medway CCG	15.0%	100.0%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.4%	0.5%
E09000024	Merton	36L	NHS South West London CCG	14.5%	97.5%
E09000024	Merton	72Q	NHS South East London CCG	0.3%	2.0%
E06000002	Middlesbrough	16C	NHS Tees Valley CCG	22.4%	99.8%
E06000002	Middlesbrough	42D	NHS North Yorkshire CCG	0.0%	0.2%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	78H	NHS Northamptonshire CCG	0.5%	1.3%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.9%	0.8%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	59.5%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	3.9%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.6%	0.3%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	1.3%	0.9%
E09000025	Newham	08M	NHS Newham CCG	96.6%	96.1%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.3%	0.3%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	72Q	NHS South East London CCG	0.0%	0.1%
E09000025	Newham	93C	NHS North Central London CCG	0.0%	0.2%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.6%	0.7%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.1%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.5%	0.7%
E10000020	Norfolk	26A	NHS Norfolk and Waveney CCG	87.7%	98.6%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.5%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000012	North East Lincolnshire	71E	NHS Lincolnshire CCG	0.3%	1.3%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.2%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.2%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.8%	96.8%
E06000013	North Lincolnshire	71E	NHS Lincolnshire CCG	0.3%	1.4%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.5%	98.3%
E06000024	North Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.4%	1.5%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.3%	96.5%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.8%	1.0%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.5%	0.7%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.8%	19.0%

E10000023	North Yorkshire	03R	NHS Wakefield CCG	1.9%	1.2%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	16C	NHS Tees Valley CCG	0.3%	0.4%
E10000023	North Yorkshire	36J	NHS Bradford District and Craven CCG	8.1%	8.3%
E10000023	North Yorkshire	42D	NHS North Yorkshire CCG	99.4%	67.9%
E10000023	North Yorkshire	84H	NHS County Durham CCG	0.1%	0.1%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.1%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.5%	1.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.0%	1.0%
E10000021	Northamptonshire	71E	NHS Lincolnshire CCG	0.2%	0.2%
E10000021	Northamptonshire	78H	NHS Northamptonshire CCG	99.0%	94.8%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	84H	NHS County Durham CCG	0.0%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.8%	0.6%
E06000018	Nottingham	52R	NHS Nottingham and Nottinghamshire CCG	33.5%	100.0%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	96.9%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.4%	1.7%
E10000024	Nottinghamshire	52R	NHS Nottingham and Nottinghamshire CCG	64.7%	83.8%
E10000024	Nottinghamshire	71E	NHS Lincolnshire CCG	0.2%	0.2%
E08000004	Oldham	00Y	NHS Oldham CCG	94.6%	96.3%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.7%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.6%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.5%	1.8%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.4%	0.3%
E10000025	Oxfordshire	78H	NHS Northamptonshire CCG	0.1%	0.1%
E10000025	Oxfordshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.7%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.2%	96.4%
E06000031	Peterborough	71E	NHS Lincolnshire CCG	1.1%	3.6%
E06000026	Plymouth	15N	NHS Devon CCG	21.9%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.6%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.3%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.3%	1.0%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.0%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.8%	3.2%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.3%	0.3%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.3%	1.6%

E09000026	Redbridge	08N	NHS Redbridge CCG	92.2%	89.5%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.2%	3.0%
E09000026	Redbridge	93C	NHS North Central London CCG	0.0%	0.1%
E06000003	Redcar and Cleveland	16C	NHS Tees Valley CCG	19.9%	98.8%
E06000003	Redcar and Cleveland	42D	NHS North Yorkshire CCG	0.4%	1.2%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.7%	6.8%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.6%	0.7%
E09000027	Richmond upon Thames	08Y	NHS West London CCG	0.0%	0.1%
E09000027	Richmond upon Thames	36L	NHS South West London CCG	12.3%	92.2%
E09000027	Richmond upon Thames	92A	NHS Surrey Heartlands CCG	0.0%	0.1%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.5%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.2%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.0%	1.1%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.9%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	10.0%	86.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.4%
E06000017	Rutland	71E	NHS Lincolnshire CCG	0.6%	12.5%
E06000017	Rutland	78H	NHS Northamptonshire CCG	0.0%	0.5%
E08000006	Salford	00T	NHS Bolton CCG	0.3%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.3%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.5%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.6%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.5%	88.5%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.4%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.2%
E08000014	Sefton	01J	NHS Knowsley CCG	1.9%	1.1%
E08000014	Sefton	01T	NHS South Sefton CCG	95.9%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.7%	41.8%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.2%	0.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.4%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.9%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.4%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.3%
E06000051	Shropshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	1.3%	0.9%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.4%	1.5%
E06000051	Shropshire	18C	NHS Herefordshire and Worcestershire CCG	0.6%	1.6%
E06000051	Shropshire	27D	NHS Cheshire CCG	0.2%	0.4%

E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.2%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.2%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.7%	5.7%
E06000039	Slough	15D	NHS East Berkshire CCG	34.3%	93.7%
E06000039	Slough	92A	NHS Surrey Heartlands CCG	0.0%	0.1%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.3%	0.4%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	16.9%	99.0%
E08000029	Solihull	18C	NHS Herefordshire and Worcestershire CCG	0.0%	0.3%
E10000027	Somerset	11J	NHS Dorset CCG	0.4%	0.6%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.4%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.8%	1.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.9%	1.9%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.6%
E06000025	South Gloucestershire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.2%	0.6%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E06000045	Southampton	10X	NHS Southampton CCG	95.1%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.7%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	1.9%	1.5%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.6%	1.7%
E09000028	Southwark	36L	NHS South West London CCG	0.0%	0.2%
E09000028	Southwark	72Q	NHS South East London CCG	17.7%	95.9%
E09000028	Southwark	93C	NHS North Central London CCG	0.1%	0.6%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.2%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.4%	2.2%
E08000013	St. Helens	01X	NHS St Helens CCG	91.6%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.4%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	2.9%	1.1%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.9%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	94.9%	23.1%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.3%
E10000028	Staffordshire	05N	NHS Shropshire CCG	0.9%	0.3%
E10000028	Staffordshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	96.1%	23.0%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.7%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	9.2%	3.0%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.7%	0.6%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.5%	0.8%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.6%

E10000028	Staffordshire	27D	NHS Cheshire CCG	0.3%	0.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.7%	96.7%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E08000007	Stockport	14L	NHS Manchester CCG	1.0%	2.1%
E08000007	Stockport	27D	NHS Cheshire CCG	0.4%	1.0%
E06000004	Stockton-on-Tees	16C	NHS Tees Valley CCG	28.5%	99.3%
E06000004	Stockton-on-Tees	42D	NHS North Yorkshire CCG	0.0%	0.1%
E06000004	Stockton-on-Tees	84H	NHS County Durham CCG	0.2%	0.6%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.3%	0.1%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	90.8%	97.2%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.7%
E10000029	Suffolk	07K	NHS West Suffolk CCG	90.5%	29.8%
E10000029	Suffolk	26A	NHS Norfolk and Waveney CCG	12.0%	16.4%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	95.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	84H	NHS County Durham CCG	1.6%	3.0%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.8%	0.2%
E10000030	Surrey	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.7%	7.6%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.3%
E10000030	Surrey	36L	NHS South West London CCG	1.2%	1.6%
E10000030	Surrey	70F	NHS West Sussex CCG	1.4%	1.0%
E10000030	Surrey	72Q	NHS South East London CCG	0.0%	0.1%
E10000030	Surrey	92A	NHS Surrey Heartlands CCG	97.3%	84.1%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	22.8%	4.1%
E09000029	Sutton	08C	NHS Hammersmith and Fulham CCG	0.0%	0.1%
E09000029	Sutton	36L	NHS South West London CCG	12.7%	97.8%
E09000029	Sutton	72Q	NHS South East London CCG	0.0%	0.3%
E09000029	Sutton	92A	NHS Surrey Heartlands CCG	0.4%	1.8%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.1%	0.2%
E06000030	Swindon	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	24.9%	99.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.4%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	87.9%
E08000008	Tameside	14L	NHS Manchester CCG	2.1%	5.8%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.6%	97.1%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	98.7%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.4%	0.4%
E06000034	Thurrock	08F	NHS Havering CCG	0.3%	0.4%
E06000034	Thurrock	08M	NHS Newham CCG	0.0%	0.1%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000027	Torbay	15N	NHS Devon CCG	11.6%	100.0%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	1.2%	1.1%

E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	2.6%	2.2%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.6%	94.5%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.7%	0.5%
E09000030	Tower Hamlets	72Q	NHS South East London CCG	0.0%	0.2%
E09000030	Tower Hamlets	93C	NHS North Central London CCG	0.3%	1.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.9%	92.3%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000009	Trafford	14L	NHS Manchester CCG	2.8%	7.4%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	0.6%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.1%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.6%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.7%	3.3%
E08000030	Walsall	05Y	NHS Walsall CCG	92.7%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.5%	1.4%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.0%	4.7%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.8%	0.8%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.3%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.2%	95.3%
E09000031	Waltham Forest	93C	NHS North Central London CCG	0.0%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.9%	1.4%
E09000032	Wandsworth	08Y	NHS West London CCG	0.9%	0.6%
E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	1.3%	0.8%
E09000032	Wandsworth	36L	NHS South West London CCG	22.0%	93.3%
E09000032	Wandsworth	72Q	NHS South East London CCG	0.8%	3.8%
E09000032	Wandsworth	93C	NHS North Central London CCG	0.0%	0.1%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	1.9%
E06000007	Warrington	02E	NHS Warrington CCG	97.5%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.1%	21.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.6%	30.4%
E10000031	Warwickshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.0%	46.0%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	18C	NHS Herefordshire and Worcestershire CCG	0.2%	0.2%
E10000031	Warwickshire	78H	NHS Northamptonshire CCG	0.2%	0.2%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.6%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	29.7%	97.7%
E06000037	West Berkshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.0%	0.4%

E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.0%	1.0%
E10000032	West Sussex	70F	NHS West Sussex CCG	97.7%	97.4%
E10000032	West Sussex	92A	NHS Surrey Heartlands CCG	0.8%	1.0%
E10000032	West Sussex	97R	NHS East Sussex CCG	0.3%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	1.5%	1.7%
E09000033	Westminster	08Y	NHS West London CCG	22.4%	21.6%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	77.6%	70.8%
E09000033	Westminster	72Q	NHS South East London CCG	0.0%	0.2%
E09000033	Westminster	93C	NHS North Central London CCG	0.6%	3.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.2%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.7%
E08000010	Wigan	01X	NHS St Helens CCG	3.5%	2.1%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.3%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.9%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.9%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.2%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.4%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	51.0%	97.8%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.2%	0.1%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.0%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	33.7%	96.9%
E06000040	Windsor and Maidenhead	92A	NHS Surrey Heartlands CCG	0.0%	0.5%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.6%
E08000015	Wirral	27D	NHS Cheshire CCG	0.2%	0.4%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E06000041	Wokingham	15A	NHS Berkshire West CCG	32.1%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.5%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.4%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.2%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	1.9%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.4%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	94.0%	93.4%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.4%	1.1%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	18C	NHS Herefordshire and Worcestershire CCG	74.6%	95.8%
E06000014	York	03Q	NHS Vale of York CCG	59.8%	99.9%
E06000014	York	42D	NHS North Yorkshire CCG	0.0%	0.1%

Produced by NHS England & Improvement using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by NHS Digital.

This page is intentionally left blank

ANNEX 2

Annex 2 BCF End of Year Template - Narrative submission by York HWBB (word version)

May 2021

1. The overall delivery of the BCF has improved joint working between health and social care in our locality

Strongly Agree

The positive working relationships which have developed over recent years in the BCF were critical to the co-ordinated and collaborative response to the pandemic. Our previous investment in asset based community development, such as Local Area Co-ordination, social prescribing and cultural commissioning, provided the foundations for our community hubs across the city and joined forces with primary care to develop the COVID-19 (single point of access) SPA Hub, providing non-clinical support for people recovering from the virus. Our powerful volunteering and mutual aid groups responded immediately to the first lockdown, to support Clinically Extremely Vulnerable / shielding and isolated people in hyper local neighbourhood networks. Our BCF schemes were instrumental in responding to the Hospital Discharge Policy requirements, and maximised the opportunity for Home First to be achieved.

2. Our BCF schemes were implemented as planned in 2020-21

Agree

Services responded to the pandemic rapidly putting in place Infection Prevention and Control and social distancing measures, meaning that some schemes such as Local Area Co-ordination balanced remote work and face-to-face in a COVID-19 compliant way. Ways to Wellbeing Social Prescribing re-focused their approach to deliver welfare calls by telephone, and supported the development of the Single Point of Access COVID-19 Hub with primary care.

3. The delivery of our BCF plan in 2020-21 had a positive impact on the integration of health and social care in our locality

Strongly Agree

Our BCF schemes have developed to become interdependent and highly collaborative, with many teams working across organisational boundaries to deliver better outcomes for individuals. We have delivered integration by pooling resources, (without focusing on structural change and reconfiguration), working together and co-ordinating shared objectives. The key has been relationship building and communication.

Part - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institute for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2020-21.

4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production

Our asset based community development over recent years placed us in a powerful position at the start of the pandemic. Over the difficult months of 2020 the schemes continued to work with local people to find innovative ways of maintaining social connections and responding to the mental and emotional impacts of the pandemic, including the isolation of lockdowns. People found meaning and value in offering to volunteer, while others helped re-shape social action through mutual aid groups. In the autumn our BCF group co-produced a winter resource plan, using a portion of the BCF to enable increased access to therapies for the increasing complexity of care needs, to support as many people as possible to retain or regain their independence; we invested in more support for carers of people with dementia to

combat their isolation, and access to exercise for people needing support to get outside when most services were closed; we contributed to the development of the mass vaccination site booking system, and expanded the York Integrated Care Team to increase health care assistants' presence at the site to enable check-ups for people unable to come to surgeries. The mass vaccination site was also supported by COVID-19 volunteers working with Ways to Wellbeing, to maximise the benefit to population health. Our partners have published a range of impact reports on their work in 2020, showing how local people have been engaged in the city wide response to the crisis, and how this has shaped the way communities will recover.

8. Pooled or aligned resources

During 2020-21 our BCF schemes have worked closely and collaboratively to respond to the changing circumstance of the pandemic at each stage. We have a rich pattern of schemes across statutory, community and voluntary sectors, which form our asset based community capacity. These schemes have pivoted their approaches to ensure that the most isolated and most at risk from COVID-19 were supported to remain connected and engaged with their communities and natural networks. They were at the heart of our urgent response to the first lockdown, and resulted in new relationships and new ways of working to benefit the community, rapidly evolving to meet need as it emerged, rather than waiting to be directed or commissioned to deliver traditional services designed for old-world problems. For example, our COVID-19 SPA Hub was initiated through a multi-agency collaboration between primary care GPs, mental health services, social prescribing, local area co-ordination, community health services and the voluntary sector (among others). Similarly, our network of commissioned health and social care services in the intermediate tier quickly worked together to ensure as many people as possible were supported in their own homes, including at the end of life. Joint packages were put in place where no one service could meet the need, the discharge hub command centre was established quickly based on existing positive multi-agency relationships, and a designated COVID positive care home

(Peppermill Court) was established in April 2020, under the council's CQC registration. It opened in the first week of May, in a building vacated by Tees, Esk and Wear Valleys Mental Health Foundation Trust, on loan from York St John university, supported by NHS Property Services, and upgraded by the local authority. With primary care support from a GP, CCG commissioning and Infection Prevention and Control team input, public health and community health in reach, local authority care staff and management, the project was led and co-ordinated by the council commissioning team. The endeavour protected our independent care sector by ensuring people could recover safely out of hospital while still in their 14 day isolation period. It provided vital care for 88 residents of York, North Yorkshire and East Riding during the three waves of infection in 2020-21.

Outline two key challenges observed toward driving the enablers for integration (expressed in CIE's logic model) in 2020-21?

3. Integrated electronic records and sharing across the system with service users

Although there has been some progress, for example in relation to shared records in palliative / end of life care pathways using Black Pear software, and GPs have been 'on-boarded', the Yorkshire and Humber Care Record (YHCR) has not been implemented across the system as rapidly as we had hoped. We have funded a project management post through BCF to support the development of shared care records, and this enabled better communication and prepared the foundations for local authority engagement in YHCR, but City of York Council is part of the 3rd wave, and has not yet been prioritised for 'on-boarding'. Our services still rely on a variety of IT systems which do not yet communicate with each other, and staff continue to manage this challenge through work-arounds.

ANNEX 2

1. *Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)*

The long term financial challenges in York across the health system, and increasingly the local authority, have meant that our focus on system transformation has required savings and efficiencies while attempting to improve outcomes. The single-year funding agreements in BCF has detrimentally impacted on our ability to plan for the long term and we lose good staff who require greater job security and can gain better remuneration in other geographical areas or sectors. The anticipated move by government to multi-year agreements for BCF will make a considerable improvement to our ability to attract and retain vital workforce (by offering permanent contracts), as well as to our ability to plan and implement system transformation and integration.

This page is intentionally left blank

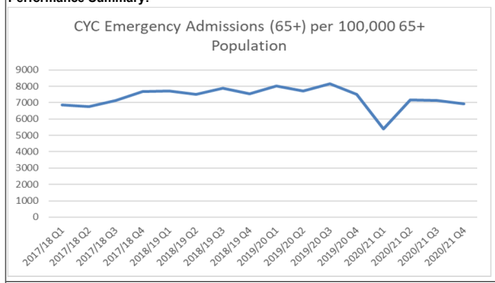
BCF National Metrics - Quarterly Performance to end of Q4 2019/20

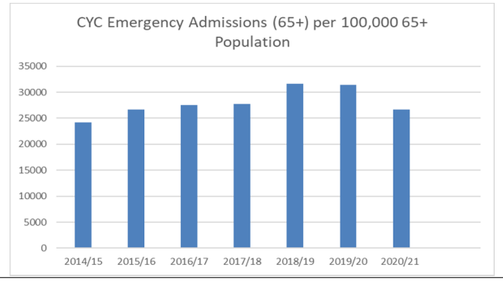
		Previous Years outturn				2019/20						2020/21							
						Actuals				Total Plan	Outturn	Total plan	Actuals				Q4 YTD Actual	Q4 YTD plan	Polarity
Indicator	Description	2015/16	2016/17	2017/18	2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4				Quarter 1	Quarter 2	Quarter 3	Quarter 4			
CCG_NEL	Reduction in non-elective admissions (General & Acute)	20,819	22,639	23,135	24,628	6,105	6,048	6,683	6,419	25,035	25,254	N/A	4,347	5,313	5,382	5,084	20,126	n/a	**Stable**
Performance Summary: From YTHFT December 2020 Board Report - 79.3% of ED patients were admitted, transferred or discharged within four hours during February 2021. This compares with 81.7% in February 2020. Root cause analysis of Emergency Care Standard (ECS) breaches continues at both sites, themes include delays in ED assessment and admission. During February both York and Scarborough sites have had front line staff absences due to COVID-19 Track and Trace and self-isolation requirements. York Hospital Locality ECS Performance was 82.2%. The estate has been reconfigured throughout the third wave to support the COVID-19 Surge Plan, with two COVID-19 positive wards plus one admitting ward in operation as at the 10th of March. Non-Elective admissions have been affected by the third national lockdown; down 32% in February 2021 on the same period last year (-1,623 admissions). York Hospital saw a reduction of 902 admissions (-28%) with Scarborough seeing a reduction of 721 (-41%) compared to February 2020.																		
BCF1	Delayed Transfers of Care: Raw number of bed days	8,463	10535 (115/152)	8494 (108/152)	10,969 (143/151)	3,164	2,258	1,943	1,590 (to end of Feb)	7,559		N/A	No data	No data	No data	No data	No data	No data	**N/A**
Performance Summary - NHS England have not required organisations involved in the counting of Delayed Transfers of Care to submit data during the Covid-19 pandemic period, and has done so since March 2020. It is unlikely that DToC counting in its previous form will resume.																			
ASCOF2B(1)	Percentage of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	76%	79% (111/152)	93%(15/152)	83% (86/152)	No data	No data	No data	81%	84%	**81%**	84%	No data	No data	No data	85%	85% (provisional)	**84% (provisional)**	**Increasing**
Performance Summary - the SALT return for 2020-21 showed that 28 of the 33 people who were eligible to be recorded as having reablement/rehabilitation were at home 91 days after they left hospital. It is higher than the percentage for 2019-20.																			
ASCOF2A(2) & BCF2	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (older people) (YTD Cumulative) (New definition for 2015/16)	683	648 (87/152)	656 (100/152)	672 (107/152)	181	165	107	83	605	**536**	136	72	120	141	125	459	**136**	**Decreasing**
BCF2	Number of permanent admissions to residential & nursing care homes for older people (65+)	260	248 (87/152)	246 (100/152)	252 (107/152)	68	62	40	31	227	**201**	51	27	45	53	47	172	**51**	**Decreasing**
Performance Summary - the decrease in admissions during 2020-21 is a reflection of CYC's "Home First" policy, where the needs of those that are discharged from hospital are assessed and, where appropriate, giving packages of care that are aimed to increase independence by placing them at home. Although the numbers exceed the planned numbers, the plan was for financial balance to be achieved during 2020-21, which was accepted as an incredibly difficult target.																			

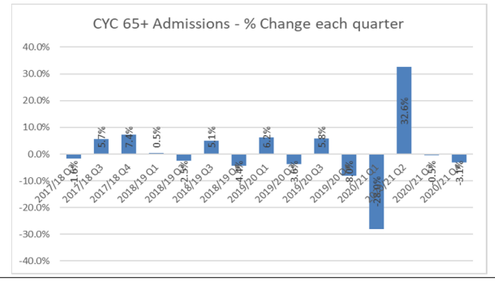
BCF National Metrics - Quarterly Performance to end of Q4 2020/21

		Previous Years outturn				2019/20						2020/21							Polarity
						Actuals				Total Plan	Outturn	Total plan	Actuals				Q4 YTD Actual	Q4 YTD plan	
Indicator	Description	2015/16	2016/17	2017/18	2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4				Quarter 1	Quarter 2	Quarter 3	Quarter 4			
CCG_NEL	Reduction in non-elective admissions (General & Acute)	20,819	22,639	23,135	24,628	6,105	6,048	6,683	6,419	25,035	25,254	N/A	4,347	5,313	5,382	5,084	20,126	n/a	Stable
CQC Interface	Emergency Admissions (65+) per 100,000 65+ population	25,413	26,712 (89/152)	27,512	27,765	8,043	7,802	8,257	7,572	31,674	N/A	N/A	5,412	7,174	7,137	6,917	26,639	0	Stable

Performance Summary:







Impact of BCF Schemes

York Integrated Care Team- YICT have continued to work towards integration of the place-based resource for the City of York area – so continuing to do good things with more people.
During this time we have continued to work closely with other partner schemes linking together by supporting RATS to avoid hospital admissions daily. During Covid we have worked alongside hospice at home, Community Nursing and CRT to ensure provision of care in the community during a difficult period.

Specialist Community Nursing -

Urgent Care Practitioners - see PDF's in Eval Pack.

RATS - Extended Hours - Percentage of patients discharged home or to rehab/respite bed vs admission remains constant and similar to last year despite the Covid challenges.

75% all patients assessed by RATs service are not admitted – supported to return home/placed in IPU/bed based facility outside of acute hospital setting.

In summary this quarter has been challenging and the RATS team have worked hard to provide a consistent service that supports the staff in the ED and the many complex service uses who require their help. The 'Home First' and 'what matters most' philosophies remain strong within the team and they have shown great ingenuity and resilience during this difficult time. They have worked hard to understand and utilise new care/referral pathways, communicating with a wide variety of community services and liaising with many voluntary and statutory services in order to achieve the best outcomes for each individual service user.

Street Triage -

Hospice at Home - Responding to pandemic pressures and increase in caseload demand - Noted 30% increase in service activity levels on previous year
Geography – 30% increase in activity levels noted in North Ryedale on previous year.
Increasing demand via SPOC and contingency planning

Handyperson Service -

Blueberry Academy
• 20 households supported
• Average of 1 visit per household
• 1 on the waiting list

Community Bees
• 28 residents supported
• 6 residents happy to pay for service afterwards
• 15 volunteers
• Total number supporting this project - 14

Alcohol Prevention - No activity has been undertaken, due to the COVID19 outbreak. Public Health staff and focus has been moved away from business as usual work and focussed on the outbreak response. Planned courses have had to be cancelled due the inability to deliver face to face training and healthcare staff being unavailable to attend training sessions.

YMG - Vaccination Outreach -

BCF National Metrics - Quarterly Performance to end of Q4 2020/21

		Previous Years outturn				2019/20						2020/21						
						Actuals				Total Plan	Outturn	Total plan	Actuals				Q4 YTD Actual	
Indicator	Description	2015/16	2016/17	2017/18	2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4				Quarter 1	Quarter 2	Quarter 3	Quarter 4		Polarity
BCF1	Delayed Transfers of Care: Raw number of bed days	8,463	10535 (115/152)	8443 (108/152)	10969 (143/151)	3,164	2,258	1,954	1,590 (to end of Feb)	**7,559**	8,966 (to end of Feb)	**7,559**	Not Collected	Not Collected	Not Collected	Not Collected	N/A	N/A
CQC Interface	Percentage of discharges (following emergency admissions) which occur at the weekend	17.4%	17.6%	17.8%	19.0%	18.3%	18.1%	18.5%	18.8%	**N/A**	**N/A**	**N/A**	21.5%	19.6%	24.1%	**19.5%**	**20.9%**	**Improving**
CQC Interface	90th percentile of length of stay for emergency admissions (65+)	22 days	21 days (75/152)	21 days	16 Days	14 Days	13 Days	12 Days	14 Days	**N/A**	**N/A**	**N/A**	13 Days	11 Days	13 Days	13 Days	13 Days	**Improving**

Performance Summary - NHS England have not required organisations involved in the counting of Delayed Transfers of Care to submit data during the Covid-19 pandemic period, and has done so since March 2020. It is highly unlikely that DToC counting in its previous form will ever resume. The percentage of discharges at the weekend was higher in each 2020-21 quarter than in the corresponding quarter of 2019-20. With the exception of Q3, the 90th-percentile length of stay for emergency admissions of older people was shorter in each 2020-21 quarter than in 2019-20, continuing the downward trend of recent years.

Impact of BCF Schemes

Seven Day Working -

Step Down/up Beds -

Fulford Nursing Home Beds - This quarter saw admissions return with success. The home and the crt team have managed to find a way to complete covid safe rehab by using testing, isolation and working in rooms. 63% of patients returned home. An average stay of 19 days due to one larger stay of 39 days.
37% returned to hospital with other significant medical need that was not picked up on the original assessment but was managed well.

Changing Lives - A Bed Ahead - Referral numbers for accommodation on discharge from hospital increased significantly in Q4, returning to virtually pre-pandemic levels. Average length of stay on a discharge bed was however reduced due to improvements in inter-agency working, with all but one individual (who abandoned the provision) who was accommodated moved on successfully to an appropriate longer-term accommodation option within target timescale.

Age UK Home from Hospital -
We've continued to provide support to older people on discharge, including transport and ongoing support. The pandemic has required great flexibility and seen increased anxiety among the older people we work with about seeking timely medical support. We've noticed a significant drop in patients discharged from A+E (probably reflecting lower numbers of patients in (A+E) but plenty from the rest of hospital. Most patients discharged and home within 2 hours. We are now planning resourcing for increases in patients as regular care returns to normal through the summer months.

This page is intentionally left blank

BCF National Metrics - Quarterly Performance to end of Q4 2020/21

		Previous Years outturn				2019/20						2020/21						
						Actuals				Total Plan	Outturn	Total plan	Actuals				Q4 YTD Actual	
Indicator	Description	2015/16	2016/17	2017/18	2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4				Quarter 1	Quarter 2	Quarter 3	Quarter 4		Polarity
ASCOF2B(1)	Percentage of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	76%	79% (111/152)	**93% (15/152)**	**83%**	No Data	No Data	No Data	**81%**	**84%**	**81%**	**84%**	No Data	No Data	No Data	85% (provisional)	**85% (provisional)**	**Increasing**
CQC Interface	Percentage of older people (65 and over) who are discharged from hospital who recieve reablement/rehabilitation services		0.8% (149/152)	**0.8% (148/152)**	**0.7% (150/152)**	No Data	No Data	No Data	**0.5%**				No Data	No Data	No Data			**Increasing**

Performance Summary - the SALT return for 2020-21 showed that 28 of the 33 people who were eligible to be recorded as having reablement/rehabilitation were at home 91 days after they left hospital. It is higher than the percentage for 2019-20. Although the number of older people discharged from hospital that received reablement/rehabilitation services (33) in 2020-21 Q3 is known, the number of OP that were discharged from hospital in this period is not yet available, so the percentage for 2020-21 cannot yet be calculated. However, when known, It is likely to be less than 1%.

Impact of BCF Schemes

Reablement (HSG) – 17.2% of service users discharged require no care or a reduced level of support; 42.7% require same or increased level of care; 6.6% go into hospital (new or re-admissions); 1.8% go into a care home and 1.4% have died.

Priory Outreach - continued to work with other services and the integration of “One Team” in York, to provide support for a very busy caseload with more complex patient needs and requirements. We have also continued to work closely with other partners CRT, RATS, Social services and HSG to avoid hospital admissions/facilitate discharges. Due to additional funding, we were able to recruit and provide additional health care support in this quarter to a highly vulnerable cohort at home, supporting the above re admission prevention and to facilitate discharge from YH and actively support YICT caseload along with nurse intervention as required.
During this period Priory Outreach have increased their caseload due to the increased demand in the community not only due to the normal winter pressure but also the effects of shielding from Covid and the effects of long Covid and Covid affected families and carers.

This page is intentionally left blank

BCF National Metrics - Quarterly Performance to end of Q4 2020/21

		Previous Years outturn				2019/20						2020/21						
						Actuals				Total Plan	Outturn	Total plan	Actuals				Q4 YTD Actual	
Indicator	Description	2015/16	2016/17	2017/18	2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4				Quarter 1	Quarter 2	Quarter 3	Quarter 4		Polarity
ASCOF2A(2) & BCF2	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (older people) (YTD Cumulative) (New definition for 2015/16)	683	648 (87/152)	656 (100/152)	672 (107/152)	181	165	107	83	605	**536**	136	72	120	141	125	**459**	Decreasing
BCF2	Number of permanent admissions to residential & nursing care homes for older people (65+)	260	248 (87/152)	246 (100/152)	252 (107/152)	68	62	40	31	227	**201**	51	27	45	53	47	**172**	Decreasing

Performance Summary - the decrease in admissions during 2020-21 is a reflection of CYC's "Home First" policy, where the needs of those that are discharged from hospital are assessed and, where appropriate, giving packages of care that are aimed to increase independence by placing them at home. Although the numbers exceed the planned numbers, the plan was for financial balance to be achieved during 2020-21, which was accepted as an incredibly difficult target.

Impact of BCF Schemes

Community Support Packages –

Home Adaptations –

Telecare and Community Equipment -

Carers Support - New carer registrations in Q4 were 321 against a quarterly target of 97 (230% increase). This brings annual total to 714 against a target of 386 (84% increase).

Carer referrals into the Carers Support Service in Q4 was 426 against the quarterly target of 273. The number of referrals for Carers Needs Assessments in Q4 were 25, against a quarterly target of 29.5.

235 1:1 advice sessions were completed in Q4 against a quarterly target of 105. The annual total was 1032 against a target of 410 (overachievement of 151%).

Number of carer referrals into FSS in Q4 was 54.

There were 156 general advice sessions delivered through telephone appointments and the Wednesday Evening Advice Line (against a quarterly target of 100). Annual total is 742 against a target of 400 (overachievement of 85%). Home, and Centre appointments are still on hold presently due to Covid.

All school drop in sessions and school assembly carer awareness sessions were still on hold as a result of Covid-19. Hubs and pop up hubs remain suspended.

Local Area Coordinators/Community Facilitator - The total number of people the team has worked with to date is 3096 and currently 721 are active (including reactivated cases). Most referrals have come from self-referrals (16%), Adult Social Care (12%) and CMHT or CAMHS (9%). 48% of cases are unemployed and 22% are retired. The main reasons for making contact across all cases are currently Mental Health (16%), Isolation (14%), and Housing Issues (10%) – these account for over a third of concerns.

Self Support Champions (increased capacity in CAAT and ISS) -

Social Prescribing (W2W) - Ways to Wellbeing, alongside partners at York CVS, lead on a programme of weekly welfare calls to help reduce the feelings of loneliness and isolation experienced by some individuals during this challenging time. With the continued impact of Covid-19 and a number of services remaining closed or operating in a different capacity we are continuing to deliver welfare calls to those who need the regular telephone contact which has been supported both by York CVS staff and a number of volunteers. We will continue to deliver these calls while there continues to be demand.

During Q4 Ways to Wellbeing has increased focus on the three new areas of development improving access to Social Prescribing across mental health, community safety and hospital discharge.

Live Well York -

This page is intentionally left blank

ANNEX 4

City of York Council and Vale of York Clinical Commissioning Group Better Care Fund :
Outturn 2020/21 and Budgeted plan 2021/22

Outturn 2020/21		Funding available	Plan 2021/22
12,728		VOY CCG BCF for use in conjunction with CYC	13,403
1,468		City of York Council - Disabled Facilities Grant	1,468
5,211		City of York Council - Improved Better Care Fund	5,211
19,407			**20,082**
		Schemes arranged by theme	
		Base Budget/Historic	
500	B1	Urgent Care Practitioners	503
156	B2	Street Triage	157
1,468	B3	Disabled Facilities Grant and falls prevention	1,468
1,166	B4	Reablement contract	1,131
4,026	B5	Packages of Care – Care at Home	4,463
1,087	B6	Packages of Care - Placements	732
908	B7	Contribution to social work staff capacity – BAU and Statutory Duties	875
369	B8	Carers' Centre	369
139	B9	Carers' Support	139
167	B10	Carers' support workers posts	169
458	B11	Be Independent	458
6,101	B12	Out of Hospital Services	6,312
16,545		**total**	**16,775**
		Prevention	
232	P1	Local Area Co-ordination	300
51	P2	Live Well York	51
-	P3	Health Champions	21
161	P4	Ways to Wellbeing	161
-	P5	Alcohol Prevention	49
31	P6	Small Tasks at Home	31
13	P7	Cultural Commissioning	30
488		**total**	**641**
		Home First	
110	HF1	Community Response Team (CRT)	129
214	HF2	Rapid Assessment and Therapy Service (RATS)	215
102	HF3	Self-Support Champions	102
27	HF4	Home From Hospital	54
170	HF5	Hospice at Home (H@H)	203
930	HF6	York Integrated Care Team (YICT) / Priory Outreach	997
1,553		**total**	**1,700**
		Care Settings	
85	CS1	A Bed Ahead and Vaccinations outreach	90
493	CS2	Fulford Nursing Home & other Step Up / Down beds	521
578		**total**	**611**
		Infrastructure	
10	I1	Venn Capacity and Demand	10
30	I2	BCF Support Role	20
45	I3	IT support for single care record	10
22	I4	Increased access to Primary Care	-
107		**total**	**40**
		New schemes	
10	N1	Move Mates	40
16	N2	Dementia Support	32
13	N3	NQ Project manager	20
97	N4	CCG VCS contracts	174
-	N6	Health Champion - additional hours	8
	N8	Additional OT in step down beds (M1-6 only)	25
136		**total**	**299**
19,407		**Scheme total**	**20,066**
-		**Contingency**	**16**
		Proposals for use of contingency	
-	N5	Community Transport	35
	N7	Intermediate care review - project management and consultancy	35
			70
		Contingency after proposals	**- 54**

This page is intentionally left blank

BETTER CARE FUND PERFORMANCE AND DELIVERY GROUP

TERMS OF REFERENCE

BETTER CARE FUND (BCF)

The Department of Health published the current BCF Policy Framework in March 2017. It sets out the national approach to local integration of health and social care, summarised thus:

People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.

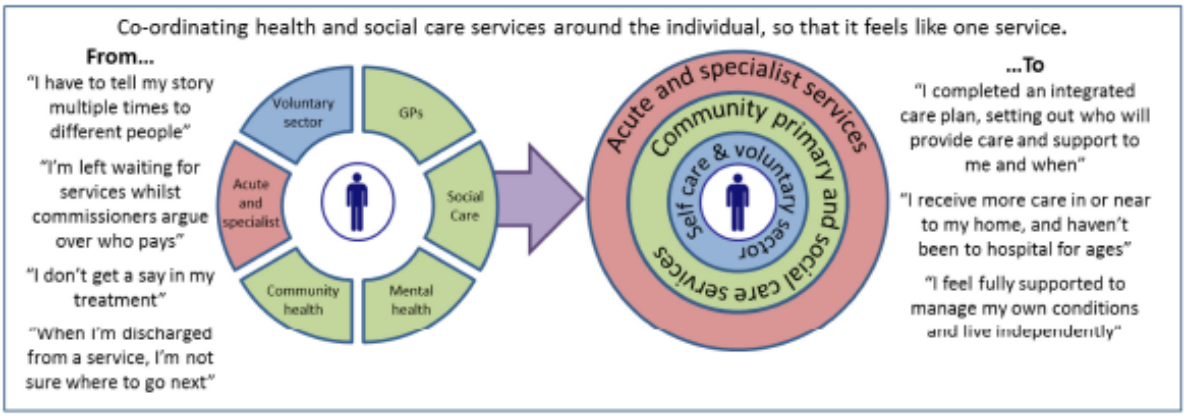


Figure 1: Co-ordinating health and care services around the individual

There is no single way to integrate health and care.

The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding.

For 2017-19, there are four national conditions, rather than the previous eight:

1. Plans to be jointly agreed

2. NHS contribution to adult social care is maintained in line with inflation

3. Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care

4. Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: **Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

As part of Better Care Fund planning, we are asking areas to set out how they are going to achieve further integration by 2020. We would encourage areas to align their approach to health and care integration with Sustainability and Transformation Plan geographies, where appropriate.

What matters is that there is locally agreed clarity on the approach and the geographical footprint which will be the focus for integration.

The framework includes the following examples of integration already in operation around the country:

	Joint commissioning	Lead commissioning	Accountable Care Organisation (ACO)[17]
Characteristics	Some or all CCG/LA commissioning decisions made jointly. Budgets (and other resources) pooled or aligned in line with extent of joint commissioning.	One body exercises some or all functions of both the CCG and the LA, with the relevant resources delegated accordingly.	CCG and LA pay a set figure (possibly determined by capitation) to an Accountable Care Organisation to deliver an agreed set of outcomes for all health and care activity for the whole population, using a multi-year contract. The ACO decides what services to purchase to deliver those outcomes. MCPs and PACs are types of ACOs.

There was a further update to the Planning Framework in July 2018. It sets out:

- accountability structures and funding flows for 2017-19 plans
- refreshed metric plans for 2018-19
- guidance on amending BCF plans
- guidance on reporting on and continued compliance with BCF 2017-19 conditions
- the support, intervention and escalation process
- the legislation that underpins the BCF

In response to this the York BCF S75 Agreement will be updated to reflect new spending commitments which remain within the original financial envelope, and do not require the submission of a revised planning template.

BETTER CARE FUND PERFORMANCE AND DELIVERY GROUP (BCF P&DG)

PURPOSE OF THE GROUP

On behalf of NHS Vale of York CCG, City of York Council and York Health and Wellbeing Board:

- To fulfil the requirements of the BCF Policy Framework
- To comply with the BCF planning requirements
- To provide assurance on the BCF to the Health and Wellbeing Board, reporting through the newly forming One York (Improvement Board)
- To develop and promote opportunities for integration

RESPONSIBILITIES

On behalf of NHS Vale of York CCG, City of York Council and York Health and Wellbeing Board (HWBB) to lead and manage all aspects of the BCF:

- Develop the Integration and BCF narrative plan in accordance with planning requirements – for approval by HWBB
- Respond to changes in guidance
- Complete the necessary returns to government as required
- Report to the York Improvement Board (once established) and the HWBB
- Guide the management of the pooled fund
- Manage the strategic risks associated with BCF
- Provide strategic direction to schemes funded through BCF or iBCF
- Provide local leadership on the operation of schemes in the context of improving integration
- Receive financial and performance information and use this intelligence to develop the BCF and improve outcomes

ACTIVITIES

- Monthly meetings and action between meetings
- Preparation and discussion of relevant reports including development of integration vision and strategy for York
- Monitor and manage the financial position of York BCF
- Monitor and manage the performance of the BCF overall and of individual schemes
- Annual evaluation of schemes
- Annual review of BCF P&DG Terms of Reference and agreements
- Information sharing
- Maintain communication with NHSE BCF manager

FORWARD PLAN

January – March: Q3 returns (19-1-18), develop performance framework

April – June: Q4 returns (24-4-18), re-launch BCF, evaluate schemes, develop draft integration strategy

July – September: Q1 returns, initiate planning for 2019 - 2020

MEMBERSHIP

- NHS Vale of York CCG;
- City of York Council;
- Tees, Esk & Wear Valley NHS Foundation Trust;
- York NHS Foundation Trust;
- Vale of York Clinical Network;
- York Council for Voluntary Service.

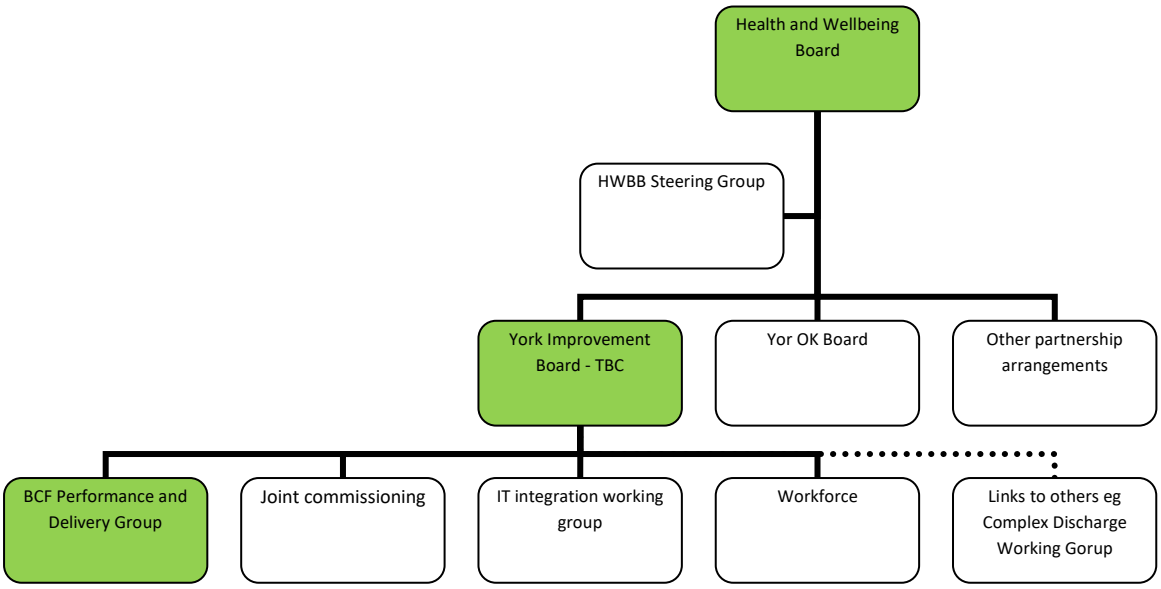
MEETINGS

- Monthly, CYC and VOYCCG sharing administration support
- Quorum requires VOYCCG and CYC attendance

REVIEW

The terms of reference will be reviewed annually at the time of the Section 75 renewal.

Draft illustration



This page is intentionally left blank

Health and Wellbeing Board 21st July 2021

Report of the Chair of The York Health and Care Collaborative.

Summary

1. The Health and Wellbeing Board is asked to consider a report on the work of the York Health and Care Collaborative which is attached at Annex A.

2. The Collaborative is chaired jointly by Dr Emma Broughton and Dr Rebecca Field, who will present the report at the meeting.

Background

3. The York Health and Care Collaborative is a multi-agency group that brings together a range of organisations involved in health and care in the city. As such it contributes to the delivery of the Joint Health and Wellbeing Strategy and is instrumental in the implementation of the NHS Long Term Plan in York.

4. At its meeting in October 2020, the Health and Wellbeing Board agreed that the York Health and Care Collaberative provide regular reports on its activities; this is the second report.

Consultation

5. York Health and Care Collaberative includes representation from the Voluntary Sector, who have been engaged right from the start and throughout. As a relatively new organisation, we have not held any formal public consultation to date.

Options

6. There are no specific options for the Health and Wellbeing Board to consider.

Strategic/Operational Plans

7. The work of the York Health and Care Collaborative contributes to the implementation of the NHS Long Term Plan (2019) which is a strategic objective for all NHS Organisations

8. York Health and Care Collaborative priorities for 2021/2022 cover, prevention, ageing well/frailty, mental health and children and young people, all of which align with the Joint Health and Wellbeing Strategy.

Implications

9. It is important that the priorities of the Joint Health and Wellbeing Strategy and the objectives of the Long-Term Plan in relation to integration are delivered.

Recommendations

10. The Health and Wellbeing Board are asked to;

    a. note the report of the Chair of the York Health and Care Collaborative

Reason; there is a shared objective of improving the health and wellbeing of the population. The York Health and Care Collaborative is unique in bringing together; providers and commissioners of health and social care services (from the NHS and City of York Council), colleagues from City of York Public Health together with the voluntary sector as a means of working on joint priorities to achieve this objective. The York Health and Care Collaberative agreed to provide regular updates on its work and progress.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Dr Emma Broughton Dr Rebecca Field	Dr Emma Broughton Chair of York Health and Care Collaberative

Report Approved ✓ **Date** 8th July 2021

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes

All annexes to the report must be listed here.
Annex A – Report of the Chair of the York Health and Care Collaborative July 2021

This page is intentionally left blank

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 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

The Covid-19 pandemic has continued to have an impact on the ability to make progress on new workstreams. The system is experiencing a greater demand than that experienced pre-pandemic and all organisations and professionals continue to deliver additional workload as well as running a successful vaccination programme. The progress made in each of the following workstreams will be highlighted within this report:

- 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.

   The Tobacco Alliance group is now actively participating in work with HCV. By 2024 every inpatient, outpatient and maternity setting will have tobacco treatment available. There is also a big piece of work around illicit tobacco being undertaken, with NEMS is putting together a survey in relation to York's illicit and contraband tobacco market.

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.

The Community Alcohol Pilot, funded by CYC, has advertised roles to recruit link workers to support those that are not dependent on alcohol but are consuming hazardous amount of alcohol which may become a bigger problem in the future. The job adverts for the link workers are live and all services are ready to start as soon as the posts are filled. Work is being completed by the Central PCNs to identify a 'waiting list' of people with alcohol related problems, who would benefit from the support of the link workers. Services are due to be fully implemented by October 2021.

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.

CYC are using funding to increase capacity for GLL, who offer provision for those in Tier 2. GLL have just relocated to a number of additional sites and will be able to offer further weight management courses and programmes. The Healthy Weight Steering Group are also looking at spending half of the money available to fund participation in weight management programmes but this is dependent on an upcoming procurement process.

The Healthy Weight Steering Group have identified a gap in York for weight services for young children. Additional funding will be used to create a service for pre-school and reception aged children with a focus on health, exercise, and nutrition in the really young (HENRY approach).

Representatives from the National Weight Management Programme, National Diabetes Prevention Programme and Low-Calorie Diet Programme have all attended YHCC to explore how these services can be rolled out across York to benefit individuals and how any health inequalities can be addressed.

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, this group meets monthly. Informed by the initial base-line assessment the priorities of this group are;

- 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.

The PHM Diabetes Pilot was due for discussion at the June meeting but not discussed so will roll over the next meeting

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,

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

aiming to identify new ways of supporting patients e.g. by working more closely with the Voluntary Sector.

Through YHCC a co-production meeting has been set up between Primary Care, TEWV and a representative from a Carers Group to identify what the main barriers are for people with SMI in attending general practice for health checks and routine appointments. The aim is to reduce the barriers and increase the attendance rates.

2.4 Covid-19 Preparedness and Resilience

The York Covid Resilience and Response Group is a multi-agency group that was set up in 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.

The Covid Resilience and Response Group was stood down in May 2021 due to the vastly decreased number of positive cases being reported in York. It was agreed that the group was beneficial and would be restarted if the number of Covid cases in the area necessitated. Current Covid rates are being monitored closely and being reported daily by VOYCCG for the seven communities of care across VOYCCG.

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 4,200 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.

Funding for the service formally expired on 31st March 2021; April to June 2021 was funded by NimbusCare and funding for July to September 2021 has been agreed with VOYCCG. The team are currently discussing the role of the service in an emerging post-Covid environment to continue support to Covid and Long Covid patients and reviewing alternative funding to support the service from October 2021.

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.

This page is intentionally left blank