NHS
North Yorkshire
Clinical Commissioning Group

# North Yorkshire CCG

## Scrutiny of Health Committee Update

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# Supporting Recovery – NHS 6 Planning Requirements

1. Supporting the health and wellbeing of staff and taking action on recruitment and retention
2. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
3. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
   - **Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service**
   - **Restore full operation of all cancer services**
   - **Expand and improve services for people with a learning disability and/or autism**
4. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
   - **Restoring and increasing access to primary care services**
   - **Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities**
5. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
   - **Transforming community services and improve discharge**
   - **Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments**
6. Working collaboratively across systems and sectors to deliver on these priorities

# North Yorkshire and York Vaccination Programme

**The NYY Covid-19 Vaccination programme continues to make excellent progress and as at 7 June 2021 the number of doses administered is:**

| Area | Vaccinations |
|---|---|
| **North Yorkshire CCG** | • 1st doses – 282,760<br>• 2nd doses – 220,312 |
| **Vale of York CCG** | • 1st doses – 221,810<br>• 2nd doses – 156,997 |
| **Total NY&Y** | • 1st doses – 504,570<br>• 2nd doses – 377,309 |

- Will complete **all 1st doses of cohorts 1-12** by **31 July 2021** as well as the majority of 2nd doses
- Over **94.5%** of those who received a first dose have come forward to received their second
- Targeted work is being done in areas of inequality e.g. Scarborough and **uptake is increasing**
- Currently preparing for a **Covid booster programme** to be carried out in the autumn
- Also preparing for the **winter 2021 Flu programme** which will, as last year, **include all over 50s**

# Elective Recovery Programme

- The number of patients waiting for an elective procedure has increased as the system returns to usual levels of referral and demand and in a context of organising services as the pandemic continues
- Waiting lists continue to be prioritised due to clinical need and include patients waiting for a diagnostic test
- Trusts are planning to deliver 85% of pre-covid activity levels by July by creation of additional capacity, both in house and by using the independent sector
- Recovery supported by the introduction of shared waiting lists facilitating mutual aid across providers
- Continuation of advice and guidance and expert input to ensure that referrals are optimised with virtual appointments available where appropriate
- Significant reduction in time waiting for Priority 2 patients (patients who require surgery within 1 month) – 90% will be seen in 28 days by Sept
- Waiting well programme being developed to support patients assessed with a low risk waiting for a surgical procedure

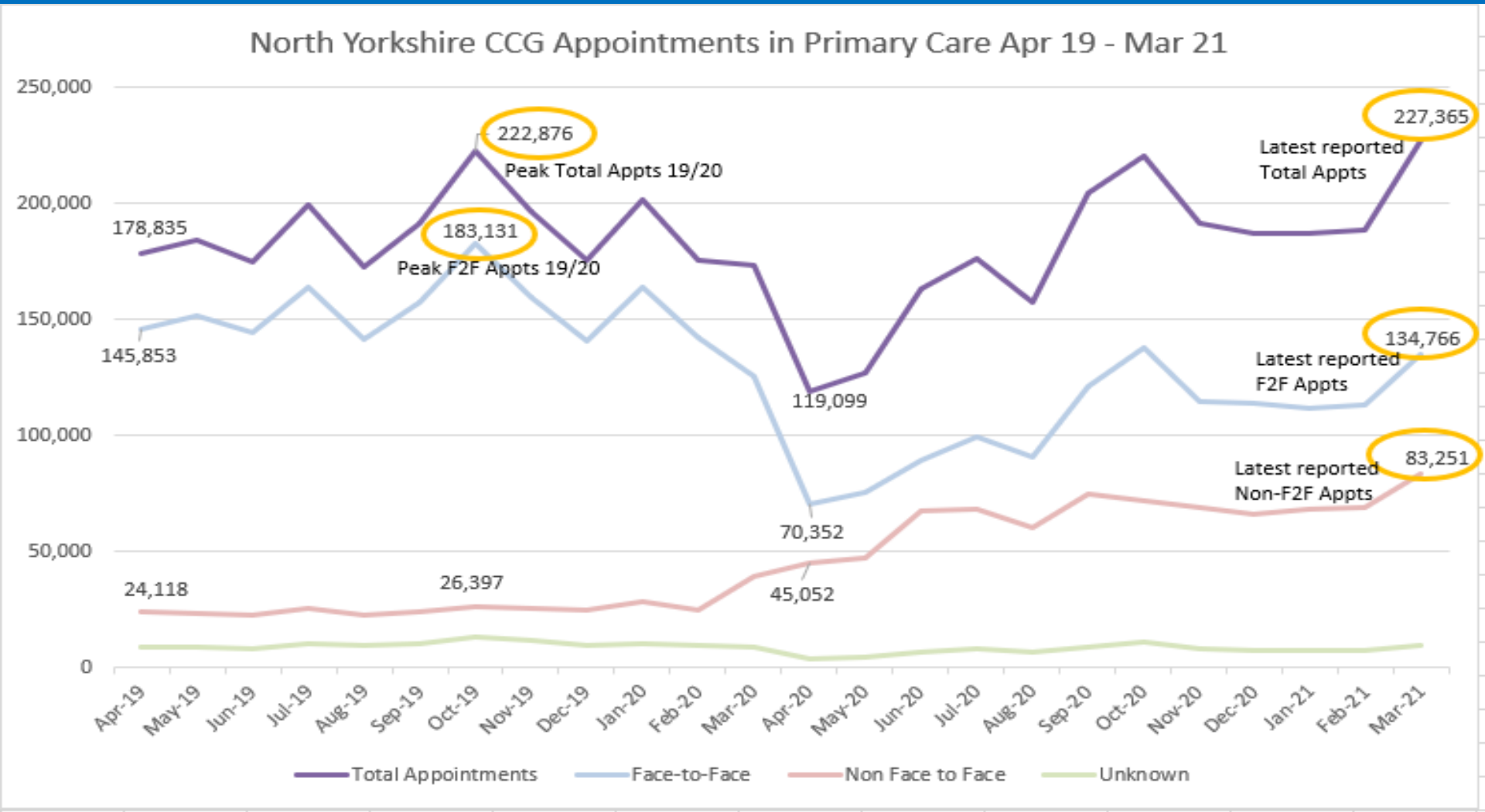
# Cancer programme priorities

- **Restoration of all cancer services**
- Aim to reduce the number of patients **waiting over 62 days** for treatment to pre-pandemic levels and improve waiting times across **cancer pathways**
- Meet the increased levels of referrals and treatments required to address the **shortfalls seen during the pandemic**, **reducing inequalities and variation**
- **Clinically led** programmes of work to support recovery;
  - **Awareness and Early Diagnosis** – Raising awareness and signs of cancer through education in the community; Increasing the uptake of screening programmes in Primary Care
  - **Diagnostics** - Implementing increased community diagnostic capacity
  - **Treatment and Pathways** - Implementing timed (RAPID) pathways for Lower/Upper GI, Lung and Prostate cancers; Embedded multi disciplinary approach to ensure all cancer staging data is made available
  - **Living with and Beyond Cancer** - Ensuring all patients have access to personalised care and support including at least one holistic needs assessment and care plan
- Implementation of **clinical innovations** and use of **digital** technology to support recovery

# A focus on Primary Care

- Face to face appointments and digital interactions (on line consultations, video consultations) have all **increased steadily** since the first lockdown in March 2020 and are now **back to almost pre-covid levels**
- **Demand for primary care** has been rising significantly since April of this year while practices continue to work with **higher levels of restriction** due to infection prevention and control measures
- **Focus on reducing any backlog** around routine reviews for chronic conditions and screening work, and supporting patients waiting for hospital procedures and appointments
- Continuing to lead on delivery of the national **Covid-19 vaccination programme**
- **Supporting PCN organisational development** and strengthening partnership working through provider collaboratives
- **Promoting use of the NHS APP** to help patients and clinicians manage their time and care more effectively
- Developing a targeted programme of work to **use digital/technology to improve access** to care for our population

# GP Access - Face to Face and Digital Appointments




Face to face appointments are almost at pre covid levels and total appointments have exceeded pre covid levels by circa 50,000 from April 2019 to those seen in March 2021

# Transforming Community Services

- **Admission Avoidance**
  - 2 hour crisis response implementation
  - Joint health & social care team integrated approach across NYY
  - Building a 'Home First' to support people better in their own home
- **Discharge to Assess**
  - Single approach across North Yorkshire with specified beds in place to discharge people safely
- **Frailty & Ageing Well**
  - Proactive identification , management and support for a frail person
  - 7 day frailty turn-around at hospital front door to avoid admission if not appropriate
  - Frailty competency development across local partners – raising awareness and recognition
  - Engaging with communities to recognise and support frailty
- **Long Covid & Pulmonary Rehabilitation**
  - Providers to further develop & extend Long Covid assessment clinics
  - Long Covid capacity and capability to be reviewed ahead of winter
  - Oximetry@Home available across primary care and care homes

# Population Health Management (PHM) – understanding health inequalities

## Achieved So Far…

**Rapid Public Health Driven Needs Assessment** on the impact of the four phases of covid

Strong engagement in the **PHM Development Programme in 3 Primary Care Networks**

- Whitby Coast and Moors PCN -focus on **patients aged 50-74 years with depression, and diabetes** with aim to deliver community-based, personalised support to improve their health and well-being using social prescribing link workers
- Selby Town PCN focus on **patients 50-64 years old with hypertension and frailty**
- York Place focus on **patients with Diabetes aged 50-64 with risk factors for progression to multi-morbidity**

**Health Navigator pilot** in Scarborough and Harrogate helping to reduce hospital admissions

**North Yorkshire and York business intelligence** and **working groups established**

## Next Phase of Work…

Agree a **partnership plan** based on a collective and shared understanding of our communities

**Grow capability** across our **BI and PH intelligence communities** with access to place and PCN level data

Make progress with full implementation of a shared care record to provide patients and clinicians with timely information about their care needs