National Diabetes Prevention Programme (NDPP)

"Healthier You" Diabetes Prevention Programme:

Guide for Practices

August 2019

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

Index

Background

In June 2016 the process for roll out of the Healthier You: NHS Diabetes Prevention Programme (NHS DPP) began with a first wave of 27 areas covering 26 million people, half of the population, and making up to 20,000 places available. In April 2017 the programme mobilised across a further 13 sustainability and transformation partnerships (STP), achieving 75% nationwide coverage.

By April 2017 over 48,000 people had been referred to the service with 18,000 people commencing on programmes to date. All remaining areas of England which are not currently included in the programme will commence during 2018.

The group sessions of 20 encourage peer support and build trust, therefore although some drop out is expected sessions will only start when there are enough motivated people to attend a group session. Please assist with the process by speaking to as many people as possible and referring those motivated to make change.

The service will be closely monitored by NHS England and on-going review will determine whether referral rates need to be amended via increased contact with those eligible or more staged referral. The provider will be as flexible as they can with starting new groups in areas of demand. A list of currently identified venues for both Initial Assessments & groups can be found at Appendix 1.

May 2019 data shows the Programme has received over 400,000 referrals and over 208,000 patients have now attended an initial assessment since the Programme commenced. Uptake from referral to initial assessment remains consistent at just under 53%.

Within the HCV programme the average weight change from Initial Assessment (IA) to 9 months review is currently 3.88Kg, with 82% of group participants showing a reduction on weight at their 9 month review.

Information GP Practices will need when setting up the National Diabetes Prevention Programme (NDPP)

Prior to commencing the NDPP the following information will be provided to you:

- Contact details for ICS healthcare and wellbeing are within this pack.
- Contact details for how to submit a referral (including a copy of the referral form) will be supplied to you. Where your practice uses SystmOne as its clinical system the referral template has already been installed for you. Emis practices will have to import the supplied EMIS Referral Template;
- A copy of the referral pathway can be found on page 5;
- Promotional materials from the NDPP provider will be sent directly to the Practice and electronic copies are included within this pack;
- A presentation about the programme for wider members of the practice is available, if required;
- A list of the Read code(s) to be used during the programme are within this pack;
- Standard scripts for letters/phone messages are available in this pack;

Additional information:

- The NDPP Provider will deal with patient queries about the programme;
- Once the patient is on the programme, the NDPP Provider handles the care pathway;
- You will need to identify your cohort of patients who are eligible for NDPP by using the criteria to run searches on your Practice system.
- Once identified, you will need to discuss the referral with your patient. Options might include: letter/ phone/ text message/ ask during routine appointments or clinics etc.
- The patient needs to have had a HbA1c between 42-47 mmol/mol (6.0%-6.4%) or Fasting Plasma Glucose between 5.5-6.9 mmols/l within the last 12 months
- The things that might put pressure on the practice are:
    - Patient searches (should be minimal impact);
    - Making a referral (should be minimal impact – referral forms are supplied);
- This is the link to the Healthier You NHS Diabetes Prevention Programme for current information about the programme nationally https://www.healthcheck.nhs.uk/commissioners_and_providers/delivery/healthier_you_nhs_diabetes_prevention_programme/

Items that will be sent to the Practice from the project group

Tick (when received)	Received
	Referral form and how to integrate into your clinical system (EMIS ONLY)
	Promotional materials
	Patient & referrer information sheets
	Read codes
	Standard scripts for letters/phone messages

Practice Mobilisation Actions Checklist

Tick (when completed)	**Actions**
	Practice visit by members of project group – to explain pathway etc. (if required)
	Baseline search completed by practice to identify patients
	Baseline figures sent to Scott Walker Project Officer (Diabetes), Humber, Coast & Vale Health & Care Partnership. (scott.walker15@nhs.net)
	Referral forms uploaded to the practice system
	Test referral from GP practice sent to ICS Healthcare and Wellbeing
	Promotional materials displayed in the practice
	Eligible patients contacted and offered the programme
	Referrals to NDPP provider started
	Read code added to patient record
	Signed up to national NDPP diabetes bulletin https://www.england.nhs.uk/email-bulletins/nhs-diabetes-programme-bulletin/

Provider reports on patients progress within the programme will be sent directly to practices every Quarter. An example report can be viewed below:

Sample GP Report May 2018.xlsx

National Diabetes Prevention Programme Referral Pathway

Eligibility Criteria

- Over 18 years of age
- Registered with a GP Practice in one of the following areas:
  - NHS East Riding of Yorkshire CCG
  - NHS Hull CCG
  - NHS North East Lincolnshire CCG
  - NHS North Lincolnshire CCG
  - NHS Scarborough and Ryedale CCG
  - NHS Vale of York CCG
- HbA1c between 42-47 mmol/mol (6.0%-6.4%) or Fasting Plasma Glucose between 5.5-6.9 mmols/l within the last 12 months
- Not pregnant
- Able to take part in light to moderate physical activity

GP/nurse to discuss with patient

- Implications of developing type 2 diabetes
- Option to refer to prevention programme

Patient consents to referral

- Referral made via GP system to ICS Healthcare and Wellbeing (SystmOne/EMIS)

ICS healthcare and wellbeing programme

- Commitment to a 9 month programme

Referral Pathway Steps for Practices

Please refer to the pathway diagram

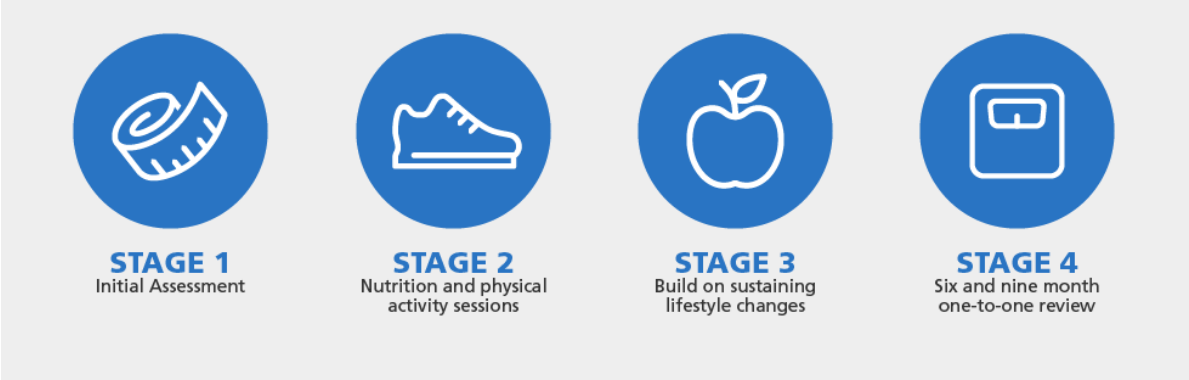
Ethnicity Check

As per the pathway diagram, patients within certain ethnic groups have a higher risk of diabetes before the age of 40. Diabetes UK has an excellent screening tool https://riskscore.diabetes.org.uk/start that can be done with the patient to determine whether they should be added to the High Risk Register and monitored annually.

High Risk of Diabetes Register

The register is a list of people who are at high risk of diabetes and require annual HbA1c testing. The only reason that a patient should come off the list is if they are diagnosed with diabetes.

Service Model



Stage 1: *Initial Assessment*

60 minute 1:1 appointment with trained Health Coach

- Anthropometric measurements
- Point of Care testing
- Smoking status
- Wellbeing measure
- Goal setting
- Signposting onto other services

Stage 2: Core: *Healthy Foundations*

7 x weekly group session (2 hours each)

- Week 1 - What is pre-diabetes & diabetes
- Week 2 - Physical Activity (chair based resistance exercises)
- Week 3 - Carbohydrate awareness
- Week 4 - Food labels
- Week 5 - Long-term health complications related to impaired glucose regulation
- Week 6 -- Energy balance and fat awareness
- Week 7 - Physical Activity session and progress review

Stage 3: ***Maintenance: Prevention Plus***

4 x monthly group sessions (2 hours each)

- Session 1-Barriers to change, health values, habits and goals
- Session 2- Stress, emotional eating and mindfulness
- Session 3- Habitual thoughts, triggers, inner critic and self-compassion
- Session 4- Gaining control of your health, willpower and review

Stage 4: ***6 & 9 Month Reviews***

- 1:1 reviews between the Healthcoach and patients are organised at 6 and 9 months during the programme

National Diabetes Prevention Programme provider contact details

ICS Health and Wellbeing		
Email completed referral forms to	scwcsu.hcv-ndpp@nhs.net	
Ryan Morrow	Ryan.Morrow@icshealth.co.uk	Regional Manager
Jan Gould Martin	Janet.GouldMartin@icshealth.co.uk	Operations Manager

NHS Diabetes Prevention Programme Referral

Patient must meet the essential criteria below
HbA1c results between 42–47mmol/mol (6.0– 6.4%) or Fasting plasma glucose result between 5.5-6.9 mmols/l Blood test results within the last 12 months
Does not have Type II Diabetes - if a reading is in the diabetic range (HBA1c >48 or FPG ≥7) the individual is not eligible
Registered with a GP Practice within Hull, Scarborough & Ryedale, East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire, Vale of York, is not pregnant and aged 18 years or over
There is no medical reason why this patient should not take part in a programme that includes light-moderate physical activity

Patient details			
Title:		Preferred contact number: Can we leave a voicemail?	☐ Yes ☐ No
First name:			
Surname:		Alternative contact number: Can we leave a voicemail?	☐ Yes ☐ No
Address:		What is the patient's first language?	First Language
		Does the patient speak English	☐ Yes ☐ No
		Is the patient on the Severe Mental Illness Register?	☐ Yes ☐ No
Postcode:		Is the patient on the Learning Disability Register?	☐ Yes ☐ No
Email address:		Does the patient have a learning disability?	☐ Yes ☐ No
NHS Number:		Does the patient have any mobility issues?	☐ Yes ☐ No
Date of birth:		Is the patient registered disabled? ☐ Yes ☐ No If yes, provide details please:	
Gender:	☐ Male ☐ Female		

Referral weight			
Referral weight measurement (kg)		Date of weight measurement	

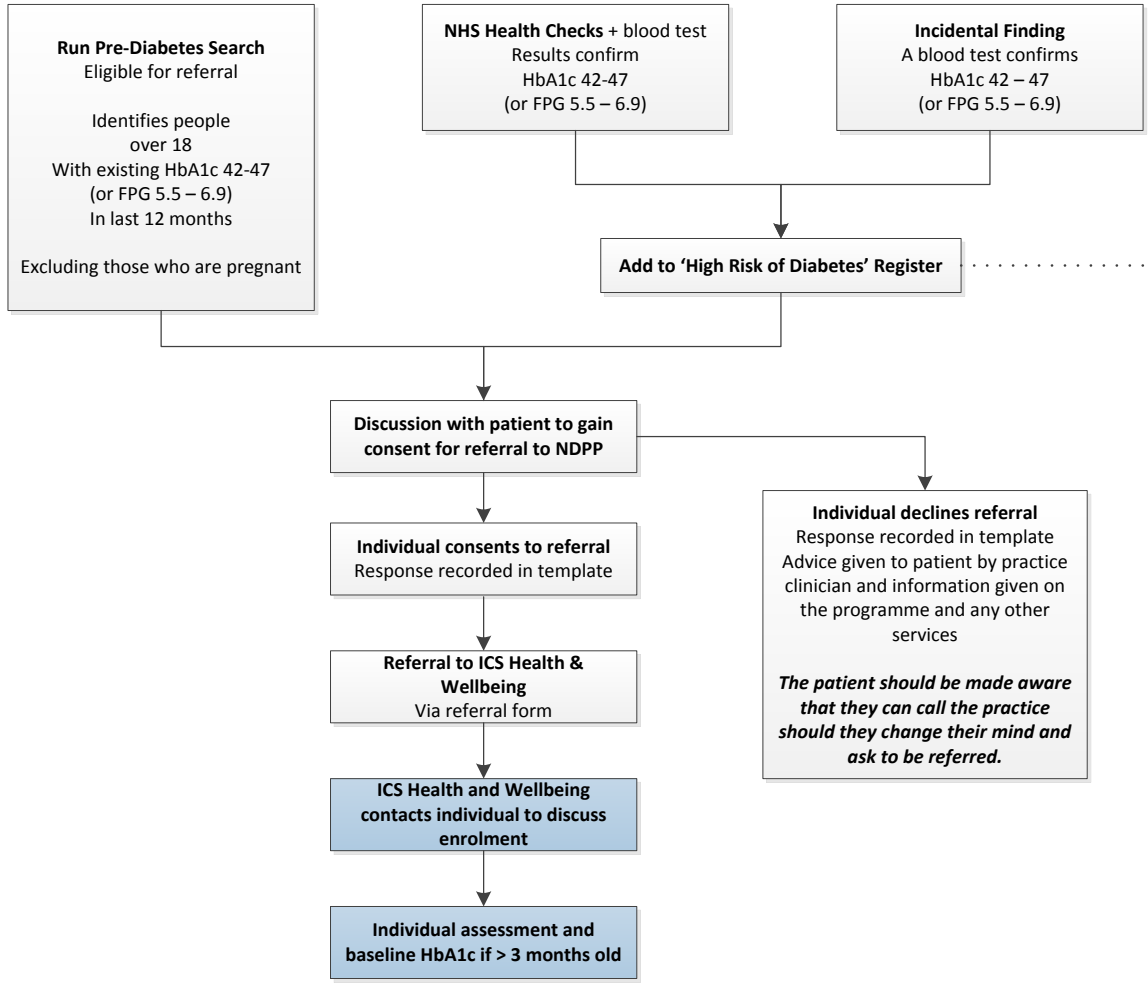
Blood test			
☐	HbA1c	Reading:	Date:
☐	Fasting Plasma Glucose	Reading:	Date:
Is there a clinical reason why HbA1c cannot be used to track glycaemic response to the intervention?			☐ Yes ☐ No

GP details			
Patient's GP surgery name:			
Surgery address:			
Surgery tel. number:		Practice code:	
Was the patient referred following a NHS Health Check?			☐ Yes ☐ No

Referrer details	
Referrer's name and organisation:	
Date of referral:	

Email completed forms to scwcsu.hcv-ndpp@nhs.net

National Diabetes Prevention Pathway – Referral Pathway Diagram



'High Risk of Diabetes' Register
Patients who require annual HbA1c testing.

1. Patients with the following diagnosis are to be added:

- Severe Mental Health Disorders
- Learning Difficulties
- Chronic Pancreatitis
- History of Gestational Diabetes
- PCOS (Polycystic Ovarian Syndrome)

2. Patients who have had the following results at any time are to be added:

- HbA1c 42 – 47 mmol/mml
- FPG 5.5 – 6.9 mmol/mml

3. Patients who have this diagnosis time should be added at clinical discretion

- IGT
- IFG

Ethnicity Screening
Patients who are of the following ethnicity have a heightened risk of developing diabetes before the age of 40

South Asian
Chinese
African-Caribbean
Black African

The patients should be assessed via the diabetes.uk risk assessment tool and a decision made as to whether they should be added to the register

https://riskscore.diabetes.org.uk/start

NHS Diabetes Prevention Programme Read Codes

Status	Description	Notes	National	V2	V3	SNOMED CT	EMIS	System 1
Current	Patient has had a risk score completed.	Leicester Diabetes Risk Score		38VZ	XaeDt	1025571000000101 Leicester Diabetes Risk Score (assessment scale)		
Current	Patient has been categorised as being at risk of developing Type 2 diabetes: *****Important - When choosing an 'at risk of developing Type 2 diabetes' code - practices must pick only one of the three codes above and use this consistently throughout all practice sites. Please make sure this code is communicated to all practice staff. We recommend amending the above table to your choice of code before circulating to all practice staff to ensure consistency*****	Non-diabetic hyperglycaemia **(NHSE preferred code)** **OR** Pre-diabetes **OR** Impaired glucose tolerance Non-diabetic hyperglycaemia.		C317 **OR** C11y5 **OR** C11y2	XaaeP **OR** XaZq8 **OR** X40Jh			
New	NHS DPP invitation	Patient sent invitation letter to join NHS DPP (Referral not complete). Patient has been invited to the NHS DPP – either to consent to referral by making contact with an NHS DPP provider, or following a meeting with a health professional.			Xaglb	1090701000000104 National Health Service Diabetes Prevention Programme invitation (procedure)	EMISNQNH18	

Current	Referral to NHS DPP	Patient has consented to direct referral to an NHS DPP provider.	679m4	679m4	XaeDH	1025321000000109 Referred to National Health Service Diabetes Prevention Programme (procedure)	EMISNQRE91	XaeDH

Status	Description	Notes	National	V2	V3	SNOMED CT	EMIS	System 1
Current	NHS DPP patients who have declined / opted out	Patient has declined referral to an NHS DPP provider and / or declined to take up the referral	679m3	679m3	XaeDG	1025301000000100 Referral to National Health Service Diabetes Prevention Programme declined (situation)		XaeDG
Current	NHS DPP Started	Patient has attended Initial Assessment of NHS DPP.	679m2	679m2	XaeD0	1025271000000103 National Health Service Diabetes Prevention Programme started (situation)		XaeD0
Current	NHS DPP Not Completed	Patient has been discharged by the provider and attended fewer than 60% of the NHS DPP sessions	679m0	679m0	XaeCw	1025211000000108 National Health Service Diabetes Prevention Programme not completed (situation)	EMISNQDI236	XaeCw
Current	NHS DPP Completed	Patient has attended more than 60% of the NHS DPP sessions	679m1	679m1	XaeCz	1025251000000107 National Health Service Diabetes Prevention Programme completed (situation)		XaeCz
Current	High risk of diabetes mellitus annual review	The annual review for people with Non-diabetic hyperglycaemia to check for progression to Type 2 diabetes and offer appropriate intervention		66Az	XaZhv	850581000000106 | High risk of diabetes mellitus annual review (regime/therapy)		

Telephone Scripts

DRAFT

Good morning/afternoon, is it possible to speak with Mr/Mrs X please?

My name is x and I am HealthCare Assistant/practice nurse at X Practice.

Before I go any further I need verify whom I am talking to, can I please ask your DOB? .. xx/yy/zz

That's great

Your GP has asked me to contact you regarding your Hba1c (blood sugar) result. You may recall you have a reading in the range 42 to 47? This means you are at increased risk of developing Type 2 diabetes.

I'm calling today to let you know that we can offer you a place on the new National Diabetes Prevention Programme called 'Healthier You'.

The programme includes

- *An initial assessment here at the surgery*
- *(And) 11 further group sessions on understanding pre-diabetes, discussing how to live a healthier lifestyle and supporting you to meet your personal goals. The programme also includes a 6 month and 9 month progress review*

The programme is already successfully improving peoples health and reducing their risk of developing Type 2 diabetes in other areas across England.

If you're interested, we can refer you to get started soon, and the cost of the programme is covered by the NHS.

That's great our provider ICS Healthcare will contact you to arrange an initial 1:1 appointment with a trained health coach here at the surgery.

Thank you, bye.

Humber, Coast and Vale

Organisation Full Address (stacked)

Tel: Organisation Telephone Number

Title Calling Name Surname
Home Full Address (stacked)

Short date letter merged

Dear Title Surname

National Diabetes Prevention Programme

We have recently performed an audit at the surgery and note that you had a screening test for diabetes during the past 12 months. The result shows that you **DO NOT** have diabetes but are at increased risk of developing Type 2 diabetes in the future compared with the general population.

You may have discussed these results with your health professional already, but we are now in a position to offer you a place on the **NEW** NHS Diabetes Prevention Programme.

This is a **FREE** personalised healthy lifestyle programme which will help you to reduce your future risk of developing Type 2 diabetes. We are looking for a number of courses to start in your area.

If you would like to register your place or find out more about the programme please visit the NHS Diabetes Prevention Programme website by inputting this link into your web browser: https://preventing-diabetes.co.uk/self-referral/

If you experience any problems registering please call the contact centre on **0333 577 3010** where the booking team are available from 8am-5pm Monday – Friday

Please do not phone the surgery to register your place.

Please note that you will be asked to confirm your NHS number, your blood result and the date of when your blood test was taken when you register your place, so please have the information in this letter to hand when you call or visit the website.

Your NHS number: NHS Number
Your blood result: Single Code Entry: Haemoglobin A1c level - IFCC standardised...
Date of your blood result: <Merge Field Required>

We hope you will feel able to take this opportunity to work with the programme to reduce your future risk of Type 2 diabetes.

Usual GP Full Name
On behalf of Organisation Name

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

List of available promotional materials

Patient information in the following languages:

- Arabic
- Bengali
- Hindi
- Indic Urdu
- Pakistani Urdu
- Polish
- Punjabi Shahmuhki
- Somali
- Turkish

Information governance

A data sharing agreement needs to be considered by the practice depending on how you plan to refer patients into the programme. The referral route requires the patient to consent to being referred onto the programme and therefore in most cases a data sharing agreement between the practice and provider is not required.
More guidance on information governance from NHS England can be viewed below:


IG Guidance for NDPP (2).docx

FREQUENTLY ASKED QUESTIONS

What does the programme deliver?
The overall "Healthier You" programme is a 9 month intervention which is split into 4 stages with ongoing 1:1 support. The programme is focussed around an evidence based curriculum ('X-pert' health curriculum, written by Dr Trudi Deakin, published 2003). It is referred to as 'Discovery Learning' which gives the patients an informed choice and empowers them to make decisions about their own health and wellbeing.

Stage 1: Initial Assessment
60 minute 1:1 appointment with trained Health Coach
Anthropometric measurements
Point of Care testing
Smoking status
Wellbeing measure
Goal setting
Signposting onto other services

Stage 2: Core: Healthy Foundations
7 x weekly group session (2 hours each)
Week 1 - What is pre-diabetes & diabetes
Week 2 - Physical Activity (chair based resistance exercises)
Week 3 - Carbohydrate awareness
Week 4 - Food labels
Week 5 - Long-term health complications related to impaired glucose regulation
Week 6 -- Energy balance and fat awareness
Week 7 - Physical Activity session and progress review

Stage 3: Maintenance: Prevention Plus
4 x monthly group sessions (2 hours each)
Session 1-Barriers to change, health values, habits and goals
Session 2- Stress, emotional eating and mindfulness
Session 3- Habitual thoughts, triggers, inner critic and self-compassion
Session 4- Gaining control of your health, willpower and review

Stage 4: 6 & 9 Month Reviews
1:1 reviews between the Health coach and patients are organised at 6 and 9 months during the programme

Signposting onto other local services

Can patients with a diabetes Type 2 diagnosis be referred?
No, only patients meeting the following eligibility criteria can be referred to the NDPP service:-

- 18 years old and over
- Registered with your GP Practice
- HbA1c between 42-47 mmol/mol (6.0%-6.4%) or Fasting Plasma Glucose between 5.5-6.9 mmols/l
- Not pregnant
- Able to take part in light to moderate physical activity

Do all referrals need to be sent from a specific practice email address?
No, it does not matter which email address the referral is made from only that it is a secure "@nhs.net" address. We would however recommend that a generic practice email address that is monitored regularly is used in case ICS need to clarify anything on the referral and the referrer is on annual leave or away from the practice for any reason.

Will I receive confirmation that a referral has been received?
Yes, confirmation of receipt of referral will be emailed to the email address the referral was sent from.

Can a patient with previous gestational diabetes be referred to the service?
Patients with gestational diabetes usually return to normal glycaemia post-partum and are therefore not currently eligible (as they would not have a blood reading indicating non-diabetic hyperglycaemia (NDH)). NHS England are aware that these patients remain at a high risk of developing the condition and are currently piloting the suitability of the NHS DPP for these individuals in Newham (London). Once this study is completed they will consider if and how to widen access to this cohort of patients and what, if any, tailoring or separate support is required for these individuals.

Is there provision for housebound or people in residential/ nursing homes to take part either through pick up and drop off or 1 to 1 sessions.
As the programme is delivered in group sessions it would not be suitable for housebound patients. We ensure venues used for delivery have disabled facilities and access.

Am I able to refer non English speaking patients?
Yes, if the demand is there we will run a language specific programme. Otherwise they will be asked if they can bring a friend/family member that can speak English.

Is there a limit on the number of times a patient can be referred/number of courses attended?
Currently no, however this scenario is being monitored and may be reviewed at a later date.

How long will a patient have to wait from referral to commencing a course?
Demand led, the higher the number of quality referrals from practices received by the provider enables them to progress the patients to the next steps of initial assessment then behavioural intervention course. Generally 80 referrals are required within a local area to achieve 1 behavioural course. If sufficient quality referrals are received courses could be operational within 6-8 weeks.

What do I do if I have a query around a specific referral?
If you have a query around a specific referral please email the contacts below rather than the general admin hub as they have local knowledge of the HCV area;

Ryan Morrow	07979 193229	Ryan.Morrow@icshealth.co.uk
Janet Gould Martin	07425 622108	Janet.GouldMartin@icshealth.co.uk

What is the venue for the course?
Venues are not booked until sufficient numbers of patient referrals have been achieved, however the provider is working to pair postcodes with appropriate, local venues so that practices can advise their patients of the likelihood of a course being run in a particular venue (depending upon demand)

What days/times will the courses be available?
Demand led, courses can be made available Monday-Saturday, daytime or evening but will be determined by what the majority of patients require.

Can a patient attend with a friend/relative/carer to support them?
ICS will accommodate requests wherever possible; however this is not guaranteed or advertised as is dependent on the capacity of the venue chosen. Support requirements to be identified/discussed at the patient's initial assessment clinic.

Can a patient join a course part-way?
No, the courses operate on a 'closed' group basis

Do patients have to attend all of the sessions to remain on the course?
Patients do have to be committed to attend all of the sessions of the course which includes an initial assessment, 7 weekly 2 hour education sessions, 4 monthly maintenance sessions, 6 month review, and then a final 9 month review, however in exceptional circumstances, the patient can discuss any attendance issues with the health and wellbeing advisors and a decision can be made as to the most appropriate action to be taken.

If a patient leaves a course can they re-join it at a later date?
If a patient leaves a course part-way it is unlikely that they would be able to re-join the same course, however this is dependent on how many sessions have been missed and the circumstances for non-attendance. However a patient who does leave a course part-way can be re-referred back to the service provider to attend a new course at a later date.

How much do ICS (NDPP service provider) pay for room hire?
ICS would wish to conduct the initial assessment in a practice if possible and some practices choose to provide this room free of charge. ICS have a budget of £10 per hour for a clinical / consultation room to carry out one-to-one initial assessments and £15 per hour for a group delivery room such as a class room or meeting room, which needs to accommodate 15-20 people.

What are the qualifications/training of the Health & Wellbeing Coaches delivering the programme?

- Undergraduate degree e.g. Sport and exercise science, nutrition, public health
- Additional training e.g. CBT, coaching, multiple health behaviour change topics
- REPS 2/3 (if delivering physical activity lessons)

Initial training is a 13 day face-to face and online programme with assessment which covers the following competencies:

- Information Governance
- Incidents and Complaints
- Health and Safety
- Equality and Diversity
- Type 2 Diabetes Management: risk factors and prevention
- Health Behaviour Change
- Smoking Cessation
- Motivational Interviewing
- Goal Setting
- Blood Tests
- Communicating Results
- Delivering Healthy Foundations (X-PERT Health)
- Delivering Prevention PLUS
- Physical Activity & Promotion

Service quality is continually monitored thereafter.

What are the messages being provided in relation to diet?
The dietary messages are focussed on providing the patients with an awareness of different dietary approaches and allows the patient to create their own dietary strategy. They are offered information on a variety of diets such as low fat, Mediterranean, intermittent fasting, low carb diet and the essentials for any dietary approach. The aim is to enable the patient to make an informed decision on a diet that best suits their lifestyle, budget, preference etc.

How will the HbA1c be monitored within the programme?
As part of ongoing changes to the NHS Diabetes Prevention Programme, providers will no longer be required to perform point-of-care HbA1c testing to establish baseline measurements or evaluate response to the intervention. Cessation of point-of-care HbA1c testing occurred from 31st May 2019.

We are also working to promote best practice, in line with NICE Guidance, for people with non-diabetic hyperglycaemia, specifically regarding annual reviews in primary care to monitor for progression to type 2 diabetes. We are aware that there is currently variation in whether such reviews are offered by practices and the form that reviews take. **NICE Guidance PH38** states:

- Offer a blood test at least once a year (preferably using the same type of test). Also offer to assess their weight or BMI;
- At least once a year, review the lifestyle changes people at high risk have made. Use the review to help reinforce their dietary and physical activity goals, as well as checking their risk factors. The review could also provide an opportunity to help people 'restart', if lifestyle changes have not been maintained.

Who can I contact if I need more information?
If you require any further information please contact:

Scott Walker **Project Officer (Diabetes)**
Humber Coast & Vale Health and Care Partnership

Mob No: 07860 501217
Email: scott.walker15@nhs.net

Appendix 1

Initial Assessments & Group Locations

CCG Name	Postcode areas	IA venues	Group venues
ER CCG	DN14	The Marshes, Goole.	Airmyn Village Hall
ER CCG	HU10	Albion Mills; Alexandra Health Centre; Calvert Health Centre	Cottingham Road Baptism Church
ER CCG	HU12	The Alexandra Hall	Preston Community Hall; The Alexandra Hall; Scawby Village Hall
ER CCG	HU13	Alexandra Health Centre, Calvert Health Centre	Cottingham Road Baptism Church
ER CCG	HU14; HU15	Brough Community Centre	Brough Community Centre
ER CCG	HU16	Cottingham Civic Hall	Cottingham Road Baptism Church; Cottingham Civic Hall
ER CCG	HU17	St. Nicholas Community Church Hall	St. Nicholas Community Church Hall
ER CCG	HU18	Hornsea Cottage Hospital (tbc)	Hornsea Cottage Hospital (tbc)
ER CCG	HU19	The Meridian Centre (tbc)	The Meridian Centre (tbc)
ER CCG	YO15; YO16	Field House Surgery The Old Parcels Office	Field House Surgery The Old Parcels Office
ER CCG	YO25	Driffield Community Centre	Driffield Community Centre
ER CCG	YO43	Market Weighton Surgery	Market Weighton Community Centre
Hull CCG	HU1; HU4; HU5	Alexandra Health Centre; Calvert Health Centre	Cottingham Road Baptism Church
Hull CCG	HU11	Bilton Community Centre (tbc)	Bilton Community Centre (tbc)
Hull CCG	HU3	Wilberforce Health Centre	Cottingham Road Baptism Church
Hull CCG	HU6; HU7	Orchard Park Health Centre; Bransholme Health Centre; Kingswood Health Centre	Bransholme Health Centre
Hull CCG	HU8	Longhill Health Centre.	Longhill Health Centre.
Hull CCG	HU9	Marfleet Group Practice	Marfleet Group Practice
N Lincs CCG	DN15; DN16; DN17	Grange Farm Hobbies Centre; Ancora Medical Practice	Grange Farm Hobbies Centre
N Lincs CCG	DN18	Barton Community Hub	Barton Community Hub
N Lincs CCG	DN20	Riverside Surgery	St John the Evangelist Church Hall; Scawby Village Hall
N Lincs CCG	DN21	Gainsborough health centre	Gainsborough health centre
N Lincs CCG	DN38; DN40; DN41	The Roxton Practice	The Roxton Practice
N Lincs CCG	DN9	Epworth Community Hub	Epworth Community Hub
NE Lincs CCG	DN31; DN32; DN32; DN34	Scartho Medical Practice Centre 4, 17a Wootton Rd	Scartho Medical Practice Centre4, 17a Wootton Rd

CCG Name	Postcode areas	IA venues	Group venues
NE Lincs CCG	DN35; DN36	Scartho Medical Practice Beacon Health Centre	St Peters Church Scartho Medical practice
S&R CCG	YO11; YO12; YO13; YO14	Eastfield Medical Centre	The Street, 12 Lower Clark St
S&R CCG	YO17	Sherburn Practice	
S&R CCG	YO62	Kirbymoorside Surgery	Kirbymoorside Library
VoY CCG	LS24; LS25	Tadcaster Health Centre	Selby Town Hall, Airmyn Village Hall
VoY CCG	YO1	St Clements Hall	St Clements Hall
VoY CCG	YO10	Regen Centre, Riccall	Regen Centre, Riccall
VoY CCG	YO18	Pickering Medical Practice	The Parish Hall
VoY CCG	YO19; YO23	Fulford Social Hall	Fulford Social Hall
VoY CCG	YO24	Foxwood Community Centre	Foxwood Community Centre
VoY CCG	YO26	The Old Forge Surgery	All Saints Hall
VoY CCG	YO31; YO32; YO61	Haxby & Wigginton Health Centre; Huntington Surgery; New Easrwick Surgery	St. Aelred's Community Centre; Oaken Grove Community Centre
VoY CCG	YO41; YO42	Elvington Medical Practice	Wilberfoss Community Centre
VoY CCG	YO60	Sherburn Practice; Terrington Surgery (tbc)	Milton Tearooms.
VoY CCG	YO8	Scott Road Medical Centre	Brayton Community Centre