



**Notice of a public meeting of
Health and Wellbeing Board**

To: Councillors Runciman (Chair), Waller, Looker, Craghill

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

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

Lisa Winward – Chief Constable, North Yorkshire Police

Alison Semmence – Chief Executive, York CVS

Siân 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

Jamaila Hussain – Corporate Director of Adult Social Care and Integration

Date: Wednesday, 20 July 2022

Time: 4.30 pm

Venue: The Snow Room - Ground Floor, West Offices (G035)

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. 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 our meetings.** The deadline for registering at this meeting is **5:00pm on Monday 18 July 2022.**

To register to speak please visit www.york.gov.uk/AttendCouncilMeetings to fill in an online registration form. If you have any questions about the registration form or the meeting, please contact Democratic Services. Contact details can be found at the foot of this agenda.

Webcasting of Public Meetings

Please note that, subject to available resources, this meeting will be webcast including any registered public speakers who have given their permission. The 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.

- 3. Draft Joint Health and Wellbeing Strategy** (Pages 1 - 18)
This report presents a draft version for the Board's comments of the York Joint Health and Wellbeing Board Strategy 2022-32.
- 4. Better Care Fund Update** (Pages 19 - 42)
This report is to provide an update on:
 - Better Care Fund.
 - 2021/2022 year end sign off.
 - Progress on the reablement and intermediate care pathway redesign.
- 5. York Place Update** (Pages 43 - 52)
This report provides an update to the Health and Wellbeing Board (HWBB) in regards to the achievements of the Health and Care Alliance, the move to the York Place Health and Care Partnership Board, progress to date and next steps.

**6. Joint Report from Healthwatch North (Pages 53 - 98)
Yorkshire & Healthwatch York: Accessible
Information**

This report is for the attention and action of Board members, sharing a joint report from Healthwatch North Yorkshire and Healthwatch York providing feedback from people, especially those whose information needs are not currently being met.

7. Healthwatch York Annual Report (Pages 99 - 126)

This report is for information, sharing details about the activities of Healthwatch York in 2021/22 with the Health and Wellbeing Board.

8. Update on the Development of a Dementia Strategy (Pages 127 - 160)

This report aims to brief members on the work in progress towards the publication of a Dementia Strategy for York place this summer. Members are requested to consider the appended draft and approve the plan for its publication.

9. Progress Report: Citywide System Mental Health Transformation (Pages 161 - 166)

This report is to provide an update on the Connecting our City mental health transformation project, and in particular the design and prototyping of a mental health hub model for York. A presentation will be tabled at the meeting

10. Report of the Chair of the York Health and Care Collaborative (Pages 167 - 174)

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.

11. Presentation on the Day: Covid 19 Update: Recovery and Living with Covid

The Board to receive a presentation regarding Covid 19 Update: Recovery and Living with Covid.

12. Urgent Business

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

Democracy Officer:

Angela Bielby

Telephone No – 01904 552599

Email – a.bielby@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)

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 **(01904) 551550**

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

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Health and Wellbeing Board**20 July 2022**

Report of the Consultant in Public Health, City of York Council

Draft Joint Health and Wellbeing Strategy 2017-2022**Summary**

1. This report presents a draft version for the Board's comments of the York Joint Health and Wellbeing Board Strategy 2022-32.

Background

2. The current [Joint Health and Wellbeing Strategy 2017-2022](#) expires at the end of the year. It follows a life course approach and identifies four principal themes to be addressed namely starting and growing well; living and working well; ageing well and mental health and wellbeing. Within each of these themes there are a number of discrete priorities and delivery against these continues.
3. Progress has been reported back via Health and Wellbeing Board update reports, the most recent of these in [2018/19](#).
4. Additionally the Health and Wellbeing Board undertook a mid-term review of its strategy and in early 2020 approved a [supplementary document](#) identifying the focus for the remaining time of the strategy.

Renewing the Strategy

5. It was agreed at the Board's January meeting that the new strategy should have a lifespan of 10 years, with its high-level principle being to reduce gaps in life expectancy and healthy life expectancy in populations across the city.
6. Ambitions and Goals in the Strategy have been identified using the evidence in the JSNA, through workshops and through public engagement, a process which is explained directly in the Strategy itself ('How we made his Strategy').

7. The text of the Strategy is presented in the Annex, in full but at a draft stage. This allows for Board member's comment, and requests for amendments and additions to the text.
8. The Ambitions of the Strategy are currently being considered by a Joint Overview and Scrutiny Committee process, together with the other two major city strategies in development (Economic Strategy and Climate Change Strategy). This also includes a resident consultation ('Our Big Conversation: 10 Year Strategies Consultation') running across July and August this year.
9. The feedback from these various opportunities for involvement in the Strategy will be collated, with a final version of the strategy coming to the Health and Wellbeing Board for sign off in September.

Consultation and Engagement

10. As a high-level document setting out the strategic vision for health and wellbeing in the city, the new Health and Wellbeing Strategy capitalizes on existing consultation and engagement work being undertaken on deeper and more specific projects in the city. Engagement opportunities for partners and the public within the writing process for the new Health and Wellbeing Strategy, including formal consultation, are set out in the document itself, and described above.
11. Co-production is a principle that has been endorsed by the HWBB and will form a key part of the delivery, implementation and evaluation of the strategy

Implications

12. It is important that the priorities in relation to both the current and any new joint health and wellbeing strategy are delivered. Members need to be assured that appropriate mechanisms are in place for delivery. The Terms of Reference for the Health and Wellbeing Board and its governance arrangements will be reviewed together with its relationship to the new NHS partnership arrangements.

Recommendations

13. Health and Wellbeing Board are asked to discuss and comment on the York Joint Health and Wellbeing Strategy 2022-2032, and suggest required amendments or additions.

Reason: To ensure that the Health and Wellbeing Board fulfils its statutory duty to produce a Joint Health and Wellbeing Strategy

Contact Details

Author: Peter Roderick
Consultant in Public Health, City of York Council

Chief Officer Responsible for the report: Peter Roderick
Consultant in Public Health, City of York Council

**Report
Approved**



Date 11.07.2022

Specialist Implications Officer(s)

None

Wards Affected:

All

For further information please contact the author of the report

Glossary:

HWBB: Health and Wellbeing Board
JSNA: Joint Strategic Needs Assessment
NHS: National Health Service

Definitions:

Healthy Life Expectancy: the average number of years that an individual is expected to live in a state of self-assessed good or very good health, based on current mortality rates and prevalence of good or very good health

Life Expectancy: the average number of years that an individual is expected to live based on current mortality rates

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York Health and Wellbeing Strategy 2022-2032

Contents

Foreword and introduction from the York Health and Wellbeing Board	3
The context for our health and wellbeing strategy	4
Our challenges and strengths	5
How have we made this strategy?	6
The strategy at a glance	7
Four big communities	8
Six big ambitions	9
Ten big goals	10
Working as one city to deliver	13

Foreword and introduction from the York Health and Wellbeing Board

As a group of senior leaders in health and care – clinicians, voluntary sector leaders, local authority directors, healthcare managers, elected members, leaders in public engagement – we want to thank you for taking the time to read our Joint Health and Wellbeing Strategy for York 2022-32.

We have worked together to develop this strategy because we believe *health is precious*, and we want more of it for the 200,000 people who live within our wonderful city of York.

At first glance, walking round our beautiful city might give you the impression that the job is done; we've already achieved our goal; York is already a healthy place. And we certainly can celebrate many things about the place we live. We have a strong cultural heritage, beautiful buildings, green spaces, good community roots, a thriving voluntary and community sector, and higher rates of physical activity and other things which keep people healthy; York certainly is a city full of assets and strengths.

But we also have plenty of health needs still remaining, and while it may seem like York is a city in 'good health', in reality:

'good health' is not evenly distributed

We know that in York the 2010s were a 'lost decade', in which life expectancy improvement stalled, and in the more deprived areas of York declined for the first time in generations.

'good health' is not best health

We know that York's overall health outcomes, compared to our regional neighbours, look good, but compared nationally are often average: for example York ranks 89th out of 152 Local Authorities on female life expectancy at birth and 77th on mortality from preventable causes.

'good health' hides uneven health

We know that there are several areas of longstanding concern for the city's health, where we don't do as well as our affluence would indicate: for instance more people are admitted to hospital with alcohol-related conditions or after an episode of self-harm than we'd like; demand for our children's mental health services is growing dramatically.

This Strategy is all about how we bridge these gaps, and setting a framework to guide our partners over the next decade towards our vision, which is that

York will be a healthier and fairer city, with time to care.

We all know that strategies don't, on their own, achieve anything: it's the action that results from them which makes the difference. The purpose of a strategy is so that together, we pull on all the resources at our disposal in a coordinated direction, and we do it for the long haul. That's why we've set this strategy to run over 10 years. The things we want to influence are long-term, involving the complex web of factors in society which create health, such as education, jobs, community connection, the impact of the pandemic, economic changes, healthcare services, environmental sustainability. We won't change these things overnight.

It's also why we've kept this strategy high-level. There is simply no way we will be able to articulate all the thousands of actions that will be necessary to get to where we want to get in this strategy. Our real hope with this document is that it inspires, motivates and instigates action. That it gives organisations, partnerships, staff and ultimately the people of York a unified vision and set of goals for a healthy city, from which they can develop their own plans and priorities.

The Health and Wellbeing Board meet regularly, in public, to discuss the key issues in health and care and to collaborate on achieving our vision. We commit to you that through these meetings – and behind the scenes – we will work tirelessly to make the words you read in this strategy a reality.

The context for our health and wellbeing strategy

York's 10 year Plan

As a city, we are following a sustainable approach to developing our ambitions for the decade ahead. The goal of sustainability is to, “create and maintain conditions, under which humans and nature can exist in productive harmony, that permit fulfilling the social, economic, and other requirements of present and future generations.” or put simply - ‘Enough, for all, forever’.

This means that sustainable approaches consider the interdependencies between actions that might affect the environment, society, and the economy. To this end, three strategies have been developed to inform city-wide direction over the next decade. These strategies cover health and wellbeing, economic growth and climate change. They all work under 5 key principles:

1. increase collaboration and cooperation
2. adapt to change
3. build fair, healthy and sustainable communities
4. create new employment and investment opportunities
5. act under good governance and evidence based planning

Together, we now have the health, economic and environmental goals of the city aligned, and with them the building blocks for health.



COVID-19 recovery

At the time of writing this strategy, we are more than two years into a global pandemic which has had a deep impact on the health of our city. Together with the direct impact of the virus and the lives it has changed and claimed, the indirect impacts of the last two years on our physical and mental health are still emerging. It is clear that from the educational impacts of lockdown to the increased demand on mental health services and the pressures on physical health services, COVID-19 has taken a heavy toll.

This strategy is written in light of all this, and with recovery in mind. Among many things we have learnt from the pandemic, we have, positively, seen how well a city can pull together, bureaucracy be broken down, and swift action save lives. We have also seen, negatively, how underlying inequalities in society can amplify a global shock like a pandemic virus, and how, yet again, those with less in our city were more exposed and likely to suffer harm.

Our recovery efforts, and this strategy, seek to learn these lessons by emphasising collaboration, building on the assets already present in our city, and tackling the inequalities which we know also exist.

Reforms to the Health and Care System

There are currently national reforms to the health and care system, which involve the establishment of Integrated Care Systems (ICSs) to cover every area of the country. Locally, we are working with colleagues across Humber and North Yorkshire to bring care together, increase the quality and outcomes from our health and care services, and improve population health across our region.

Much of this work will be done locally, in our York ‘place’ area, but in the context of a wider regional structure for our NHS and care partners. One key purpose of the strategy is to articulate York’s health ambitions, our priorities, our needs and the things which matter to people living in our city. Part of the job of ICSs (in fact a statutory requirement) is to listen to local places through their Joint Health and Wellbeing Strategies and respond by working with them and giving them the appropriate resources to match their local goals.

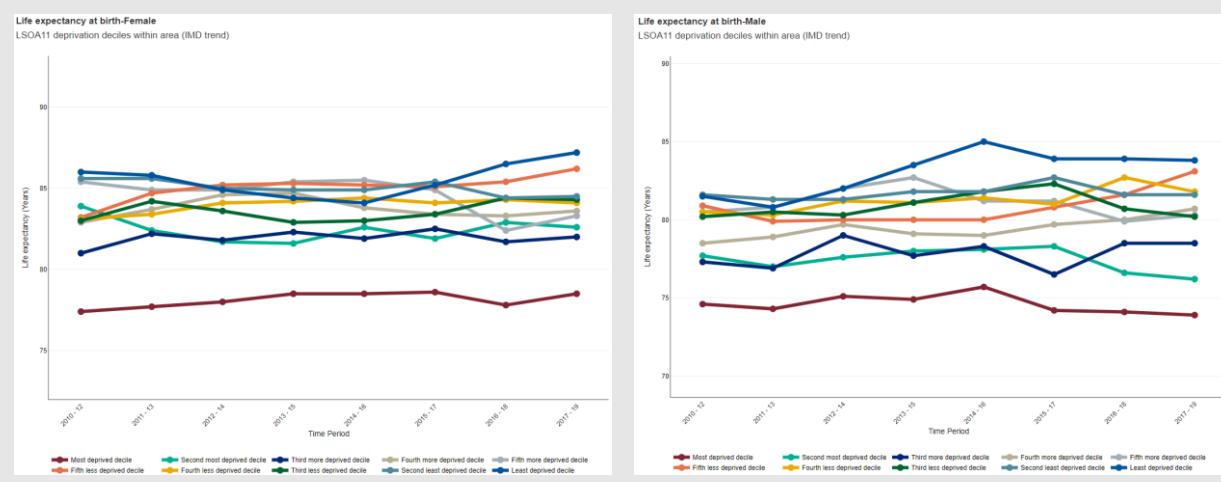
Our challenges and strengths

One of the Health and Wellbeing Board's key tasks is to assess and monitor the health needs of the city as a whole, and the communities within it. This means we are collecting, publishing and interpreting data on a wide range of things to do with health in the city, through the Joint Strategic Needs Assessment (JSNA), including overviews of each stage of life (Start Well, Live Well, Age Well, and Mental Health) and over twenty deeper pieces of work on specific communities. Doing this work enables us to step back and take a broad view on the headline health challenges in the city:

<p>Wider determinants of health High number of noise complaints 10% of children living in poverty Housing affordability</p>	<p>Widening inequality gaps Life Expectancy / Healthy Life Expectancy* Health of those with a learning disability School readiness</p>
<p>York's 'red flags' Alcohol consumption/admissions People living with multiple complex needs Drug related death</p>	<p>Examples of preventable ill-health 1 in 10 people smoke 2 in 3 adults overweight or obese 1 in 7 live with depression</p>
<p>Changing Demographics An ageing population, which will lead to a: 4% increase in hospital use (annually) 10% increase in social care use and 2.5% increase in GP use (over 5yrs)</p>	<p>Mental Health Under u18s admissions for mental illness High prevalence of common mental illness High suicide and self-harm rate Student mental health</p>

*Recent trends in health inequality in York

The charts below show three clear trends in life expectancy in York: firstly, over the last 10 years the increase in the number of years lived seen since the Second World War stalled; secondly, in the more deprived deciles of the population life expectancy declined for the first time in generations, further widening the inequalities gap; thirdly, there is a larger drop in life expectancy between the bottom 10% and 20% of the population than between any other sections of the population.



Whilst we need to understand our health challenges, in York our approach has also been to focus on what's strong, not what's wrong. We take a strengths-based approach which sees people as valuable, not vulnerable, and recognises that everyone has gifts, talents and skills, which empower people as active citizens and gives them hope, rather than simply being a passive recipient of services. Work which has been developed in the city over the last decade such as local area coordination or social prescribing changes the relationship between statutory services and citizens and communities, by enabling our staff and practitioners to build up a trusted relationship with a person to find out about their skills and gifts, and focus on people's goals and resources, rather than their problems.

This extends to seeing our city as full of assets to use for health. For instance, we could highlight our thriving voluntary and community sector with over 250 organisational members of our Centre for Voluntary Services (CVS); or we could highlight that the average distance to green space in York is around a third of a kilometre, versus a national average distance of a whole kilometre.

How have we made this strategy?

As part of developing this strategy we have tried to listen both to citizens of our city and to health and social care colleagues.

One way we did this was by facilitating local community groups to host conversations with people and ask them a very simple question:

What helps you to live a happy and healthy life?

We collected this information on what helps people to live a happy and healthy life; about health, care and support services; about local communities and our city; what is working well already and what needs to change. The feedback to this exercise has been integrated throughout this strategy and shapes it in its broadest sense.



Having digested this work, the Health and Wellbeing Board also held a workshop to look at our Joint Strategic Needs Assessment and what it was telling us about the health and care needs of the York population. They also looked at existing strategies, frameworks and partnerships in York, mindful of the fact that the Board itself will not be able to deliver our aspirations on its own, and we need the help of the rich tapestry of partnership groups and collaboratives in the city to pull with us towards the outcomes we want to achieve.

Consideration was also given to reports from Healthwatch York, whose job it is to represent the voice of the citizen on the Health and Wellbeing Board. These provided us with quality information on areas of health and social care residents have raised concerns about.

Once some draft principles for this strategy were established, we commenced a process of public consultation, including a number of public Overview and Scrutiny meetings, a public Health and Wellbeing Board, and 'Our Big Conversation: strategy consultation', together with the Economic and Climate Change Strategies.

What has emerged from this is a strategy which focuses on:

Our **four big communities**

These are the who; a description of four key groups in our population and how good health is built up over the life course

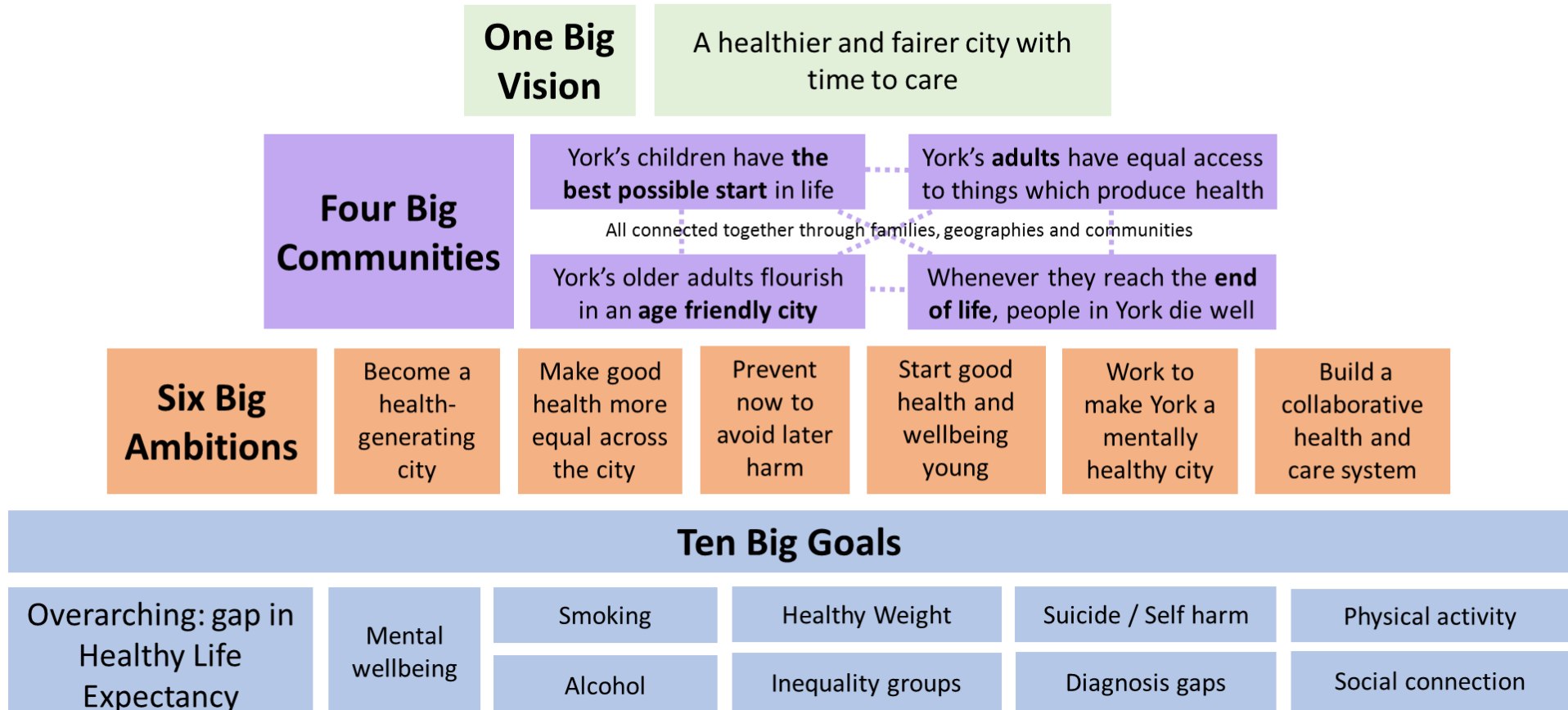
Our **six big ambitions**

This is the what: the dreams we have for the type of healthy city we want to be

Our **ten big goals**

This is the how: the measurable, tangible improvements in health outcomes we want to see for our population

YORK HEALTH AND WELLBEING STRATEGY AT A GLANCE

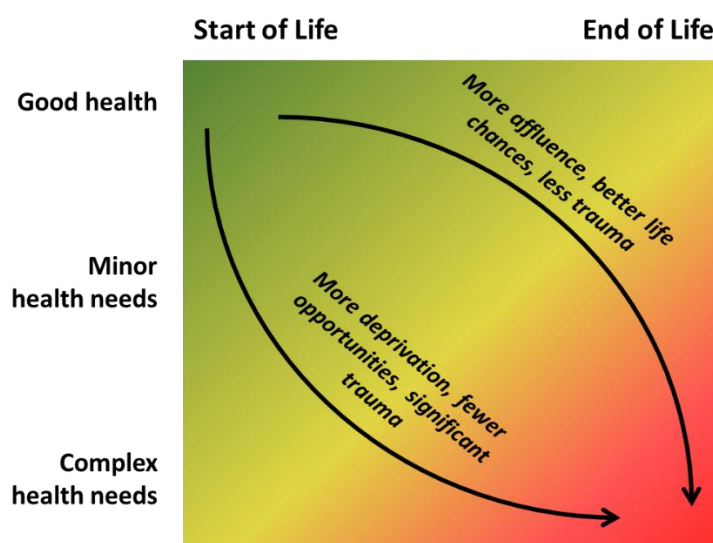


Four big communities

Through this strategy we want to improve health for all in York, as seen through the lens of the four big communities within York, our four stages of life.

Since the work of Michael Marmot in the first decade of the century, the concept of the 'life course' has become familiar. Central to it is the concept that disadvantage starts before birth and accumulates throughout life, with a person's health (or the health of a population group) being the sum of all the health advantages or disadvantages it's members have been exposed to. Rather than framing health as an individual's responsibility – a consequence of their 'choices' – it recognises that health is created by the conditions which surround us; the conditions we experienced even before birth, and during childhood especially, shape our abilities to live healthily as adults, to age healthily in our later years, and to die well.

The journey of life takes us from young to old, and inevitably it takes us from good health to complex health needs and eventually death. However as shown by this graphic, when looking at the population as a whole we are all on the same journey, but not all take the same route:



So in York, we want our citizens to experience the best health possible in all four stages of life:

York's children have the best possible start in life

York's adults have equal access to things which produce health

York's older adults flourish in an age friendly city

Whenever they reach the end of life, people in York die well

Crucially, whilst people are generally in just one of these stages at a time, they are all connected together through families, geographies and communities. The health of our mothers in York will affect the health of our babies; the health of our teachers will affect our pupils; the health of our volunteers will affect those receiving help; the health of older people on a street in Tang Hall will affect the health of younger people on the same street; the health of carers will affect the health of those who they care for; the health of communities and organisations will affect all who participate in them. It's all connected.

We will use this concept of the 'life course' to structure our meetings as a health and wellbeing board, for instances in the reports we commission and discuss. It will ensure we don't leave anyone out of the conversation.

Six big ambitions

This leads us on to the big ambitions of our strategy, which we hope will drive the work of the Health and Wellbeing Board and its partners. These phrases came out loud and clear in the engagement work we developed.

BECOME A HEALTH-GENERATING CITY, where our starting point is that strong and supportive communities are the best medicine, where we build on the strengths of our people, and give our citizens the best possible chance of staying healthy, especially through three key building blocks of health: good housing, jobs and education

MAKE GOOD HEALTH MORE EQUAL ACROSS THE CITY, recognising that people in the poorest areas of York die ten years earlier than those in the richest areas, and to address this we need to deliver our services scaled at a level proportionate to people's need, and thereby reduce health inequalities

PREVENT NOW TO AVOID LATER HARM, acknowledging that two thirds of the gap in healthy life expectancy in York comes from preventable diseases, and therefore ensuring that prevention is in the job description of all health and care staff in the city in order to bring healthy lifestyles within reach of all our residents

START GOOD HEALTH AND WELLBEING YOUNG, giving special emphasis to the key formative early years of life as the best place our investment can go, creating from maternal/preconception health and beyond the conditions for our families, communities and young people to live healthy and flourishing lives

WORK TO MAKE YORK A MENTALLY HEALTHY CITY, ensuring that mental health and wellbeing is given the same attention as physical health, investing in the things which keep people happy and connected, and working together to support people quickly when they need it

BUILD A COLLABORATIVE HEALTH AND CARE SYSTEM with fewer dividing lines between organisations, creating a local culture of integration built by engaged and valued staff who listen to (and involve) our citizens, so that our care can be accessed by all, and is compassionate, high quality, financially and environmentally sustainable

We hope that these ambitions, as aspirational as they are, will set the standard for all changes and developments in health services and beyond in the city over the next decade, giving us bold dreams to measure our plans against and holding us to account.

Ten big goals

Now we have described our communities and the ambitions we have for a healthy York, we want to set out some clear goals for this strategy – things we can measure, things which are ambitious, things which if we achieved them would mean our city truly has become healthier and fairer over the next ten years.

So we have chosen ten goals which draw upon the things which people have told us in our engagement work they want to see, and on the strengths and challenges we have identified through our JSNA process. They are not a comprehensive list of all that needs to change over the next decade, but they represent some of the most important areas that lead to early illness and death in the city, and therefore feel like the things we need to focus our minds on.

1 OVERARCHING GOAL: Reduce the gap in healthy life expectancy between the richest and poorest communities in York

Why? Public health experts the world over tell us that the best measure of the health and fairness of a local population is the gap between the number of years lived in good health for its richest and poorest communities. When that gap is narrower, communities enjoy greater trust and cohesion, better overall physical and mental health, and are more sustainable – i.e. everyone benefits. Currently in York, the life expectancy difference between wards is a stark 10 years for men and 6 years for women (2015-19 data). Older data suggesting *healthy* life expectancy differences are above a decade for both men and women.

This is the ultimate goal we are trying to reach for our population, but it will only be met if the other goals are too.

2 Support more people to live with good mental health, reducing anxiety scores and increasing happiness scores

Why? As well as ensuring the city has good mental health services to respond to illness, we want to raise the overall level of mental *health* in the city through community assets (e.g. green spaces, community connections), creating a happier population in 2032 than now. The Office for National Statistics measures four dimensions of wellbeing, and we have chosen two of them: one where we do worse than the national average (in 2020/21, 27.1% of York residents had a high anxiety score vs 24.2% nationally) and one where we do better (in the same year, 8.8% of York residents had a low happiness score vs 9.2% nationally).

3 Bring smoking rates down below 5% for all population groups

Why? Smoking is the leading preventable cause of death in York, and one in every two people who smoke will die because of tobacco-related causes such as heart disease, cancer, and respiratory illness. There are still more than 20,000 smokers in the city – more than 1 in 10 people – and whilst rates have fallen over the last decade, this has mainly been in our more affluent population, meaning smoking prevalence is higher in routine and manual occupations (1 in 6 people), as well as those with a mental health problem (1 in 3) and opiate users (1 in 2). So our local approach to tobacco control sets an ambition to halve the number of people who smoke by preventing and supporting smokers to quit, and crucially we want to see this across all groups in the city, closing the gap.

4 Reduce from 20% to 15% the proportion of York residents drinking to the Chief Medical Officer alcohol guidelines (under 14 units a week)

Why? Alcohol is widely available and consumed by the majority of adults in England; however its harms are often under-appreciated. It is estimated that nearly 600,000 people need speciality treatment for alcohol dependency every year, and alcohol consumption leads to nearly 25,000 deaths. Drinking at lower levels still causes harm, including liver disease, a number of types of cancer, and increased risk of cardiovascular conditions. Whilst there may be no safe level of drinking, the Chief Medical Officer advises adults drink no more than 14 units a week; however that is not the case for around 1 in 5 adults in York (21.7%), with over 1,000 residents admitted to hospital for alcohol-specific conditions in 2020/21. To decrease the population-level harm of alcohol by reducing the proportion drinking over 14 units to 15%, we need to work on the availability of alcohol, the social norms around its use, and support people to manage down drinking levels and choose alternatives.

5 Reverse the rise in the number of children and adults living with an unhealthy weight

Why? Every year, more people nationally are over a healthy weight, and York is no exception. Being overweight or obese has been shown to affect virtually all bodily systems, raising the risk of mental health problems, Type 2 diabetes, stroke, cardiac conditions, cancer, asthma amongst others. In York, over 1 in 5 reception-aged children, 1 in 3 year six children and nearly 2 in 3 adults are overweight. Obesity rates double in primary school, increase with deprivation, and have risen year on year over the last decade. These trends are driven by complex factors: for instance the commercial determinants of health (e.g. marketing), by our food systems, and by trends in the way we travel and move about in daily life. As an indicator which is worsening, our goal is to reverse this trend, and change the direction of travel on weight for both children and adults; this also includes supporting work to help people with an eating disorder achieve and maintain a healthy weight.

6 Reduce health inequalities in specific groups: people with a severe mental illness, a learning disability, those from an ethnic minority, or a marginalised group

Why? We know that certain groups experience radically worse health outcomes. Sixty-three percent of people with learning disabilities die before reaching the age of 65, compared to 15 percent in the general population, and in York you are four times more likely to die before the age of 75 if you have a severe mental illness. There are inequalities experienced in health and healthcare if you are from an ethnic minority in the city, and the health outcomes of people in marginalised groups within our community are worse too, for instance those from Gypsy, Roma or Traveller backgrounds, those who are new migrants, who are homeless or who use substances. We aspire to build proactive and inclusive services which will level off health inequalities for these groups.

7 Reduce both the suicide rate and the self-harm rate in the city

Why? Death by suicide is a tragedy which affects so many people. Between 2018 and 2020, 70 people died by suicide in York, continuing a trend seen for a number of years of higher rates locally than the regional average. Males are four times more likely to die than females, and whilst complex reasons lie behind every death, there is a clear correlation with deprivation. In 2020/21 there were over 400 hospital admissions for self-harm in the city, with half of them in people aged 10-24. A large amount of human distress lies behind this data, and we want to work together to create the kind of mentally healthy city in which these trends are reversed.

8 Improve diagnosis gaps in dementia, diabetes and high blood pressure, and increase the % of cancer detected at an early stage

Why? The early detection of long term conditions gets people treatment faster, avoids illness and saves lives. In York, we see some large delays in diagnosis: for dementia, only 53% of the population estimated to be living with the condition have a diagnosis; for diabetes it's 71%, and for high blood pressure across the Vale of York area it's 60%. All of these rates are worse than national and regional comparators. For cancer, over 400 people in the Vale of York area diagnosed with the disease presented with their first symptoms in A+E in 2020/21 – a sign that earlier detection was needed. Through things like blood pressure checks, screening, and NHS Healthchecks, we hope to close these diagnosis gaps.

9 Reduce sedentary behaviour and increase physical activity by 5% across the whole population

Why? York has consistently been one of the most active cities in the country. Nearly three quarters of adults are classed as 'active', which means meeting the Chief Medical Officer guidelines of 150 minutes physical activity per week. But there are still 25% of adults who are classed as inactive, and they are more likely to be inactive if they have a disability or long term health condition, are from an ethnically diverse community, or are female. Activity levels also decline with age, and have declined dramatically during the COVID-19 pandemic. The more we move the greater we benefit, and it is often said by medical practitioners, if physical activity were a pill it would be the most prescribed drug on the market. We think we can go further and get 4 in 5 adults in the city classed as physically active by 2032.

10 Increase the proportion of carers and care users who have their desired amount of social contact

Why? Loneliness has been described as 'the feeling we get when our need for rewarding social contact and relationships is not met'. It can happen at any stage in life, and we know that only 2 in 5 adult social care users in York had as much social contact as they would like. This number is similar for adult carers too, whether under or over 65, and all this data shows that York is similar to the national average. This is a problem which cannot be solved by medicine, and requires a community response, as the health effects of loneliness have been shown to significantly increase the risk of disease and premature death.

Creating the conditions to achieve these goals: the wider determinants of health

Wider determinants, also known as social determinants, are a diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances. The Marmot review, published in 2010, raised the profile of wider determinants of health by emphasising the strong and persistent link between social inequalities and disparities in health outcomes. Variation in the experience of wider determinants (i.e. social inequalities) is considered the fundamental cause (the 'causes of the causes') of health outcomes, and as such health inequalities are likely to persist through changes in disease patterns and behavioural risks so long as social inequalities persist. Addressing the wider determinants of health has a key role to play in reducing health inequalities.

Several studies have attempted to estimate the contribution of the wider determinants to population health, finding that wider determinants have a greater influence on health than health care, behaviours or genetics.

Working as one city to deliver

This strategy deliberately doesn't contain a detailed action plan. A lot will change over the next ten years, and our goals are very broad. We don't just rely on the Health and Wellbeing Board to achieve them, but must pull on all the strengths and people we have in our system.

It is useful, however, to set out how all the pieces of the puzzle fit together, and what the scope and remit of each part of our health and care system is in delivering this strategy:

York Health and Wellbeing Board

- Act as a public forum for decision making, and engagement with this strategy
- Provide leadership and direction to the system, influencing and advocating for these ambitions and goals to be embedded in operational plans
- Hold organisations, including Integrated Care Systems, to account on how they are delivering the priorities of the York Strategy

Health and Care Organisations

- Co-produce plans for service change with service users and people with lived experience,
- Provide and commission services which support the six 'Big Ambitions' of the York Health and Wellbeing Strategy
- In particular, lead on the sixth ambition to 'build a collaborative health and care system'

Other Partnership Groups

- Take ownership on aspects of detailed partnership work needed to deliver the York Health and Wellbeing Strategy, for instance around mental health
- Create plans and strategies which help achieve the ten 'Big Goals' York Health and Wellbeing Strategy
- Promote partnerships wherever possible, working as one organisation for York

Communities and People

- Participate in the public work of the Health and Wellbeing Board, and hold organisations to a high standard on quality and equality
- Take ownership and responsibility for promoting community health and wellbeing
- Support vulnerable members of the community to be healthy and have strong social connections
- Make best use of community assets and leadership to create local solutions

To illustrate how this might work, we asked each member of the Health and Wellbeing Board to

Give just one example of how you and your organisation will be supporting this strategy

This is what they said: [content to be added after board conversation 20/7/2022]

- City of York Council (Public Health)
- York and Scarborough Teaching Hospitals NHS Foundation Trust
- Humber and North Yorkshire Health and Care Partnership
- NHS England
- City of York Council (Children's Services)
- North Yorkshire Police
- City of York Council (Adults Services)
- York CVS
- Healthwatch York
- Tees Esk and Wear Valleys NHS Foundation Trust

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York Health and Wellbeing Board

Health and Wellbeing Board 20 July 2022

Report of the Corporate Director of Adult Services and Integration and Interim Director of Children Services.

Better Care Fund Update

Summary

1. This report is to provide an update on:
 - Better Care Fund.
 - 2021/2022 year end sign off.
 - Progress on the reablement and intermediate care pathway redesign.

Background

2. The Better Care Fund framework was published in September 2021. Through the Better care Fund delivery group partners completed a narrative plan that has previously been shared and signed off by the Health and Wellbeing board.
3. In addition to this the Better Care Fund delivery group agreed to commission Venn consulting to review our early intervention, reablement and crisis care pathway. This review has provided an opportunity for partners in particular health and social care to explore further alignment of assessment and delivery.
4. The Venn consulting review highlighted areas of opportunity and challenge as well as supporting a reduction in high cost crisis care.
5. The report in particular stated our early intervention approaches were good and supported people to remain at home with little or no

support from statutory services. However our reablement and intermediate care pathways through health and social care were disjointed with over five different referral pathways, complex handovers, and differing eligibility criteria, making access into services difficult for both staff and individuals to navigate.

6. The performance target for reablement supports this view as month on month the target has not been met. This is due to a combination of factors including the Venn's observations above, as well as wider external market care availability.

National reporting process for the 2021-22 BCF Plan -

7. The Better Care Team (NHSE&I) issued the BCF Planning template for 2021-22. A year end plan has been submitted, however requires formal sign off by the Health and Well Being Board.
8. Attached is the 2021-22 planning template for approval by the Health and Wellbeing Board.
9. A further plan will commence for 22/23 and will be shared with the Health and Wellbeing Board in October 2022.

Performance update-

10. There are four key performance indicators:
 - Avoidable admissions.
 - Length of stay.
 - People staying at home after discharge into reablement services.
 - Admissions of older people to residential/nursing care homes.
11. **Avoidable admissions:** The new target of avoidable admission came in September as part of the updated BCF planning guidance. Workforce challenges, covid and patients requiring additional acute care has meant that this target has not been met. We are as a system 3% over the target set for York. Further work is ongoing to ensure we work towards reducing avoidable hospital admissions through out of hospital support and a review of urgent care.

12. **Length of Stay:** This is a new target set within the Better Care Fund planning guidance in September 2021. It replaces the delayed discharges target. The system has not managed to reach this target and further work is required to ensure the target is met through 22/.23.
13. **People staying at home after discharge from hospital into reablement/rehabilitation services:** in 21/22, 87.9% of older people (aged 65 or over) that were discharged into reablement/rehabilitation services were found to be still living at home 91 days after leaving hospital. This target has improved from last year as well as being higher than the national average (79%) and higher than the Yorkshire and Humber regional average (76%). However there has been significant increases in care required to support people to remain at home and this has created overspends within Council budgets.
14. **Admissions of older people into residential/nursing care:** in 21/22, there were 192 admissions of older people (aged 65 or over) into residential/nursing care homes in York that were arranged by City of York Council, this is a rate of 525 per 100,000 population. This is a rise from 20/21 where we had 135 admissions in to residential or nursing care. This is due to a combination of the D2A programme as well as higher patient need.

Progress of the Better Care Fund Review

15. A review of schemes is underway to ensure all schemes listed in appendix 1 are the right schemes and supporting better outcomes. The Better Care Fund delivery group has been tasked to review and recommission/redesign schemes as required.

Consultation

16. The Better Care Fund Plan 2021-22 has been developed within a collaborative process with partners across health, social care and the community and voluntary sector, and is co-produced with the scheme providers, taking account of the learning from the previous year review process. The Better Care Fund Performance and Delivery Group discussed the draft financial plan at the May 22 meeting, and confirmed the end of year plan.

Options

17. n/a

Analysis

18. n/a

Strategic Direction /Operational Plans –

19. The Joint Health and Wellbeing Strategy is the overarching strategic vision for York; this plan supports the delivery of the desired outcomes, reducing inequalities, supporting better health outcomes. This strategy is currently being refreshed and is to be published later in the year.
20. This work is congruent with the Council Plan and the NHS Long Term Plan. The White paper on integration as well as the Health and Care act responsibilities.
21. **Financial** – The financial plan has been developed with the detailed support of the finance officers of the CCG and council and approved by the HWBB on 21st July 2021. No major variances are anticipated at this point. 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. The total BCF budget for 21/22 is £20,010,81
22. **Human Resources (HR)** – many of the schemes funded through Better Care Fund are supported by staff on fixed term contracts. The prevalence of short-term funding and fixed term employment contracts remain a significant risk to the stability and continuity of our system.
23. **Equalities** – none
24. **Legal** – none
25. **Crime and Disorder** - none

26. **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.
27. **Property** – none
28. **Other** – none.
29. **Risk Management.** A Memorandum of understanding for 21/22 and 22/23 has been agreed, however further clarity is required for subsequent years.
30. Governance processes are in place between the partners to manage the strategic risks of the Better Care Fund as part of our whole system working. Updates on this programme will also be provided to the York Health and Care Place Board.

Recommendations

31. The Health and Wellbeing Board are asked to:
 - Receive the York Better Care Fund update for information.
 - Agree the attached 21/22 year end return.
 - Agree delegated authority for future returns to be signed off by the Corporate Director of Adults and Integration, appropriate ICS lead in partnership with the HWBB chair Cllr Runciman.
 - The HWBB is the accountable body for the Better Care Fund.

Contact Details

Author:

*Jamaila Hussain
Corporate Director of Adult
services and Integration
and interim Director of
Children Services.*

HWWB Chair:

*Cllr Carol Runciman
HWBB Chair
City of York Council*

**Report
Approved**

Date *Insert Date*

**Report
Approved**

Date *Insert Date*

All

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:

Annexes – All –

Annex 1 – 2021 - 22 schemes
Appendix 2 Attached

BCF Schemes 2021-22

Scheme	Expenditure (all figures in £000)
--------	-----------------------------------

Urgent Care Practitioners	£509.78
Street Triage	£159.05
Disabled Facilities Grant and falls prevention	£1,468.00
Reablement contract	£1,130.62
Packages of Care – Care at Home	£4,411.11
Packages of Care - Placements	£731.96
Contribution to social work staff capacity – BAU and Statutory Duties	£867.00
Carers' Centre	£363.00
Carers' Support	£145.00
Carers' support workers posts	£168.67
Be Independent	£458.25
Out of Hospital Services	£6,270.77
Local Area Co-ordination	£293.62
Live Well York	£50.98
Health Champions	£35.00
Ways to Wellbeing	£160.68
Alcohol Prevention	£48.55
Small Tasks at Home	£30.60
Cultural Commissioning	£30.00
Community Response Team (CRT)	£128.55
Rapid Assessment and Therapy Service (RATS)	£214.82
Self-Support Champions	£102.00
Home From Hospital	£54.00
Hospice at Home (H@H)	£203.00
York Integrated Care Team (YICT) / Priory Outreach	£997.29
A Bed Ahead and Vaccinations outreach	£89.51
Fulford Nursing Home & other Step Up / Down beds	£520.90
Venn Capacity and Demand	£40.00
BCF Support Role	£20.00
IT support for single care record	£10.00
Move Mates	£40.00
Dementia Support	£31.70
NQ Project manager	£20.00
CCG VCS contracts	£174.00
Health Champion - additional hours	£8.00
Additional OT in step down beds (M1-6 only)	£23.70
Total Expenditure	£20,010.81

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 Area 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

Better Care Fund 2021-22 Year-end Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2021-22, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social

The key purposes of BCF reporting are:

- 1) To confirm the status of continued compliance against the requirements of the fund (BCF)
- 2) To confirm actual income and expenditure in BCF plans at the end of the financial year
- 3) To provide information from local areas on challenges, achievements and support needs in progressing the
- 4) To enable the use of this information for national partners to inform future direction and for local areas to inform

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service

BCF quarterly reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the BCF Team will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange

Note on entering information into this template

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

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It 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
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and
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.bettercaresupport@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

3. 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 2021-22 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

<https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/>

This sheet sets out the four conditions and requires the Health & Wellbeing Board 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 within the quarter 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.

In summary, the four national conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG Minimum

National condition 3: Agreement to invest in NHS commissioned out-of-hospital services

National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of hospital stays that are 14 days or over, Proportion of hospital stays that are 14 days or over, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for This section captures a confidence assessment on achieving the plans for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.

The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Long length of stay (14 and 21 days) and Discharge to usual place of residence at a local authority level to assist systems in understanding performance at

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:

- In making the confidence assessment on progress, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national

5. Income and Expenditure

The Better Care Fund 2021-22 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, and the minimum CCG contribution. A large proportion of areas also

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2021-22 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template.
- The template will automatically pre populate the planned expenditure in 2021-22 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed into the area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from
- Please provide any comments that may be useful for local context for the reported actual income in 2021-22.

Expenditure section:

- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2021-22 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2019/20.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2021-22 through a set of survey questions

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions. These are set out

Part 1 - 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 2021-22
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our

Part 2 - 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

Please highlight:

8. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2021-
9. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2021-

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.

[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-
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

7. ASC fee rates

This section collects data on average fees paid by the local authority for social care.

Specific guidance on individual questions can be found on the relevant tab.



Better Care Fund 2021-22 Year-end Template

2. Cover

Version 2.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will be 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.

Health and Wellbeing Board:	York	
Completed by:	Jamaila Hussain	
E-mail:	jamaila.hussain@york.gov.uk	
Contact number:	7718995696	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off	
If no, please indicate when the report is expected to be signed off:	Wed 20/07/2022	<< Please enter using the format, DD/MM/YYYY
Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):		
Job Title:	Corporate Director DASS	
Name:	Jamaila Hussain	

Checklist	
Complete:	
	Yes
	Yes
	Yes
	Yes
	Yes
	Yes
	Yes
	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. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes
7. ASC fee rates	Yes

[<< Link to the Guidance sheet](#)

Better Care Fund 2021-22 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 2021-22:
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? <small>(This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)</small>	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) Plan for improving outcomes for people being discharged from hospital	Yes	

Checklist

Complete:

Yes

Yes

Yes

Yes

Better Care Fund 2021-22 Year-end Template

4. Metrics

Selected Health and Wellbeing Board:

York

National data may like be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Support Needs

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,690.0				Not on track to meet target	As reported in the York Trust April 2022 board report, the workforce risk that the Trust highlighted as part of 2021-22 activity plan materialised to a greater extent than was anticipated. This affected not just the	Actual: 1778 (3% above target)
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	14 days or more (Q3)	14 days or more (Q4)	21 days or more (Q3)	21 days or more (Q4)	Not on track to meet target	The %age of patients remaining in hospital for 14 days or more, and 21 days or more increased steadily month-on-month during This does not appear to be related to increasing emergency admissions, but is	Actual: i) Q3: 10.9% Q4: 13.5% ii) Q3: 6.2% Q4: 8.4%
		9.9%	10.9%	5.3%	5.9%			
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.0%				On track to meet target	Although the performance target was met in Q1, it slightly dipped under 95% in Quarters 2-4 with the YTD actual at 94.8. Q4 performance was fractionally below the 95% target, at 94.9% There has been an increase	Actual: 94.9%
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)	312				On track to meet target	We set ourselves an ambitious (financially-based) target for 2021-22, and the (provisional) final outturn was that we had 192 admissions of those aged 65+ to res/nursing care, a rate of 525 per 100,000	We managed to reduce the rate of admissions in the second half of the year by diverting people to home care services. The rate is likely to be in line with the national average.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	87.9%				On track to meet target	Our (provisional) 2021-22 outturn was 88.2%, so on target. CYC always records a very low number of people for this indicator (because of those who are eligible).	Met target and improved on 2020-21 performance (84.8%).

* In the absense of 2021-22 population estimates (due to the devolution of North Northamptonshire and West Northamptonshire), the denominator for the Residential Admissions metric is based on 2020-21 estimates

Checklist Complete:
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2021-22 Year-end Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board:

Income

		2021-22	
Disabled Facilities Grant	£1,467,977		
Improved Better Care Fund	£5,210,953		
CCG Minimum Fund	£13,331,151		
Minimum Sub Total		£20,010,081	
	Planned		Actual
CCG Additional Funding	£0		
LA Additional Funding	£0		
Additional Sub Total		£0	£0
	Planned 21-22	Actual 21-22	
Total BCF Pooled Fund	£20,010,081	£20,010,081	

Actual	
Do you wish to change your additional actual CCG funding?	No
Do you wish to change your additional actual LA funding?	No

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22

Expenditure

	2021-22
Plan	£20,010,081

Do you wish to change your actual BCF expenditure?

Actual

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22

Checklist
Complete:

Yes

Yes

Yes

Yes

Yes

Better Care Fund 2021-22 Year-end Template

6. 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 2021-22. 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 to 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
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	We have built strong working relationships across York in particular through our BCF delivery group and various sub groups. The shared vision and plan has further helped with this.
2. Our BCF schemes were implemented as planned in 2021-22	Agree	Yes all plans in place
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Strongly Agree	Yes this has really helped with alignment and integration of resources

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 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes
Success 1	5. Integrated workforce: joint approach to training and upskilling of workforce	We have worked together with health colleagues to further develop intermediate care pathways, we commissioned VENN consulting to review our care and support offer. We have had a challenging year maintaining the workforce and work has commenced with our York acute trust to develop closer recruitment and retention policies and shared recruitment options.
Success 2	2. Strong, system-wide governance and systems leadership	We have in place a strong governance system working with providers and commissioners to agree future spend and delivery, as well as holding each other to account for service delivery. Regular updates are provided to the HWBB.

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges

Challenge 1	6. Good quality and sustainable provider market that can meet demand	We have had challenges with the market that has caused some flux in the system over 21/22 we have had some providers who have no longer been able to a service. We continue to ensure good quality safe care through our monitoring contract and quality assurance processes.
Challenge 2	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	Due to Covid we have not been able to have face to face conversations with our population, however we will continue to ensure people and service users are involved through patient groups, workshops going forward..

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 2021-22 Year-end Template

7. ASC fee rates

Selected Health and Wellbeing Board:

York

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to external care providers, which is a key part of social care reform.

Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we are exploring where best to collect this data in future, but have chosen to collect 2021-22 data through the iBCF for consistency with previous years.

These questions cover average fees paid by your local authority (gross of 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 (gross of client contributions/user charges), reflecting what your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market support such as the Infection Control Fund but otherwise, including additional funding to cover cost pressures related to management of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have been paid had the pandemic not occurred. This counterfactual calculation was intended to provide data on the long term costs of providing care to inform policymaking. In 2021-22, areas are only asked to provide the actual rate paid to providers (not the counterfactual), subject to than the exclusions set out below.

Specifically the averages SHOULD therefore:

- EXCLUDE/BE NET OF 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.
- EXCLUDE/BE NET OF 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.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund payments.
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE 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.
- EXCLUDE care packages which are part funded by Continuing Health Care 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 2020-21 fee as reported in 2020-21 end of year reporting *	Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates
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)	£21.45	£21.45	£25.22	17.6%
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)	Either the HWB name is not selected on the cover sheet, or a lookup error has occurred.	£850.00	£900.00	5.9%
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)	Either the HWB name is not selected on the cover sheet, or a lookup error has occurred.	£1,200.00	£1,300.00	8.3%
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. Please do not use more than 250 characters.		The D2A process we feel increased bed values causing the market to become in some part unaffordable. Prices are still high however are stabilising.		

Footnotes:

* "." in the column C lookup means that no 2020-21 fee was reported by your council in the 2020-21 EoY report

** 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.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last year figures as reported by the former Northamptonshire County Council.

Checklist

Complete:
Yes
Yes
Yes
Yes



York Health and Wellbeing Board

Health and Wellbeing Board 20th July 2022

Report of the Corporate Director of Adult Services and Integration, and Interim Director of Children Services. City of York Council.

1. Summary

- 1.1 This paper provides an update to the Health and Wellbeing Board (HWBB) in regards to the achievements of the Health and Care Alliance, the move to the York Place Health and Care Partnership Board, progress to date and next steps.

2. Introduction

Partners across York have worked closely together to commission and deliver services for our population. We have an agreed vision and aspire to raise our overall population health outcomes to **become the healthiest city in Northern England**. With a focus in our Health and Wellbeing Strategy being on population health, we are theming our work using a life course approach of **Starting Well, Living Well, Aging and Dying Well**. At present there is a consensus that we must focus on poverty, prevention and early intervention as well as building person-centred care as specific priorities. This is alongside a strong integrated workforce in order for our city to become health **generating** instead of illness-generating. As an alliance partnership we have already started to mobilise change and building on this momentum will ensure that key themes and success are not lost.

- 2.1 During 2021 York partners set up the Health and Care Alliance, this was chaired by Cllr Aspden and this has provided a solid platform to build on. The Health and Care Alliance agreed a set of values and core behaviors that underpin all the work we do. The Alliance set itself three key areas of delivery and transformation:

Learning Disabilities and/or Autism, Complex Care and Diabetes. This was the start of our vision to support York to be a healthy city.

2.2 Alongside the key priorities a population hub has also been developed. This has enabled the collection of a wealth of data, which has provided a clearer picture of the health of the population of York and also the inequalities people face across the borough. This clearly shows that there is still work to do if we are to achieve equality of health across the city.

2.3 Data collected through the population hub clearly shows that:

- **Good Health is not evenly distributed.** In York the 2010s were a 'lost decade' in which life expectancy improvement stalled, and in the more deprived deciles of the population life expectancy declined for the first time in generations.
- **Good Health is not best health.** York's overall health outcomes compared nationally are often average, for example York ranks 89th out of 150 Local Authority's (LA) on female life expectancy at birth and 77th on under 75s mortality from preventable causes.
- **Good Health hides uneven health.** There are several areas of longstanding concern for the city's health, where we don't do as well as our affluence would indicate:

<p>Preventable ill-health 1 in 10 smoke 2 in 3 adults overweight or obese 1 in 7 live with depression</p>	<p>Widening Gaps Healthy Life Expectancy Health of those with a learning disability School readiness</p>	<p>York's 'red flags' Alcohol consumption/admissions, multiple complex needs, drug related death, student health</p>
<p>Economic Factors Lower than average income 10% of children living in poverty Housing affordability gap</p>	<p>Changing Demographics Aging & growing population 4% ↑ hospital use (annual), 10% social care, 2.5% ↑ in GP (over 5yrs)</p>	<p>Mental Health u18s admissions for mental health need High prevalence of common MH illness Higher than average suicide and self-harm</p>

- 2.4 Therefore, as we move forward to place based delivery we can clearly identify the issues and have a clear baseline to start to improve the health and wellbeing of our population collectively as a partnership.
- 2.5 Through the Health and Care Alliance we have moved forward in key aspects of delivery of services in particular through primary care (Nimbus) joint working between primary care / PCNs, community health and the and Voluntary and Community Sector (facilitated by the CVS) as well as positive relationships and joint commissioning between acute trusts and the local authority. Recovery following COVID is ongoing with an emphasis on supporting care homes, achievement of elective targets, reducing the length of hospital admissions and supporting more people to stay in their own homes for as long as possible. The work of the alliance is ongoing and will continue to form part of place delivery as we move forward.

3. National and Local Context

- 3.1 The York system continues to make progress in what is a dynamic and challenging environment for all partners. On Friday 24th of December 2021, NHS England and NHS Improvement (NHSE/I) published the 2022/23 operational planning guidance, setting out ten priorities for the next financial year. These are:
1. Investing in the workforce and strengthening a compassionate and inclusive culture
 2. Delivering the NHS COVID-19 vaccination programme
 3. Tackling the elective backlog
 4. Improving the responsiveness of urgent and emergency care and community care
 5. Improving timely access to primary care
 6. Improving mental health services and services for people with a learning disability and/or autistic people
 7. Developing approach to population health management, prevent ill-health, and address health inequalities
 8. Exploiting the potential of digital technologies
 9. Moving back to and beyond pre-pandemic levels of productivity
 10. Establishing ICBs and enabling collaborative system working

- 3.2 Similarly, the White Paper on integration outlines clear expectations on reducing inequalities and placed based delivery, this includes the expectation that the NHS and Local Authorities work together to develop strategic plans and deliver services in an integrated way thereby reducing duplication of work and stabilising the workforce to achieve better outcomes for people.
- 3.3 The Health and Care Act (H&C) came into law during April 2022. This has enabled the dissolution of CCG's and the implementation of an Integrated Care Board (ICB). The executive team is in place including the Chief Executive, Chair and Chief Operating Officer. The Humber and Yorkshire ICB has been established alongside 6 place boards. The new H&C Act (2022) places a duty and responsibilities on the ICB to perform the following functions:
- Commissioning Hospital and other Health Services
 - Commissioning Primary Care Services
 - Transfer schemes in connection with the transfer of Primary Care Functions
 - Commissioning Arrangements
 - General Functions
 - Expansion of financial duties of integrated care boards and their partners.
- 3.4 Integrated Care Systems (ICS) as well as partners will be reviewed for effectiveness and delivery of safe effective services through the care quality commission. Additional inspections have also been announced for adult social care.
- 3.5 The new legislation clearly sets out a new pathway for the commissioning of health services, supporting further partnerships, pooling and/or integrating finances including the Better Care Fund (BCF) as a lever for the integration of health and care resources and delivery. The H&C Act (2022) focusses on statutory agencies working closely together supporting the commissioning and delivery of services across populations and place.
- 4. Update on the work of the Alliance and Current position.**

- 4.1 Following the establishment of the ICS partners across the system agreed that a strategic delivery direction was to ensure that each place had a Board that supported population health delivery. The Health and Care Alliance agreed to move towards a place base approach and the first York Place Health and Care Partnership Board meeting took place in May 2022. Ian Floyd, Chief Operating Officer (COO) of the City of York Council has been appointed as Chair.
- 4.2 A 10-year Health and Wellbeing Strategy for York is being developed alongside the Humber and North Yorkshire Integrated Care Partnership Strategy (by the end of 2022). These two documents will form the basis of improving the health and wellbeing of the citizens in York, reducing unnecessary hospital admissions for adults and children, improving access to primary care Primary Care, Mental Health and Social Care Services by moving to a more proactive and sustainable model with Enhanced Prevention and Early Intervention Approaches at its heart
- 4.3 The York Place Health and Care Partnership Board has a diverse membership covering an all age approach and a richness of discussions to ensure strategic decisions are collective and take in account inequalities citizens of York face both in terms of services as well as access.
- 4.4 Through the Health and Care Prospectus Process the York Health and Care Alliance Board engaged with stakeholders, academics and residents and have established the following key principles:
 - We growing our health and care assets
 - We act early and prevent further deterioration
 - We care as one York Team, aligning services and integrating services so citizens experience a seamless care journey
- 4.5 During Q1 of 2021 the Health and Care Alliance completed a functional design exercise to understand what could potentially be delivered at place, regional and at a system level. Key areas such as ones below could all be delivered at place with some integration within the wider system.
 - Quality and Safety

- Sustainable Integrated Workforce
- Performance Management
- Financial Allocation at Place
- Governance Framework
- Primary Care Network support
- Early Intervention and Prevention functions including Community services, child health, public health services,, integration with the Voluntary Sector (e.g. social prescribing)

5. Next Steps

- 5.1 The York partnership has shown that there is enormous potential within the system to find innovative ways of managing and improving care. Strong systems and strong relationships complement and support each other.
- 5.2 Financial frameworks have often been cited as a barrier to the development and delivery of integrated approaches. There is no one-size-fits-all approach, especially given how different local systems are in terms of the populations they serve.
- 5.3 However, York has navigated its way around this complexity and there are now mechanisms that we have used to pool budgets this is underpinned by legislation through section 256 and 75 agreements. The BCF has also been extended and York BCF plans have been praised for integrated approaches and close partnership working to deliver national targets. This has shown system maturity to commission and agree the delivery and redesign of services.
- 5.4 Moving forward the York Place Health and Care Partnership Board will be the key strategic board ensuring oversight of the delivery of the ICS expectations at a Place level as well as the delivery of the York HWBB strategy and NHS Operational Plan.
- 5.5 To do this, there is a need to work in coming months on establishing detailed arrangements for the functions listed at 4.5, including staffing support and assurance.

6. Membership

- 6.1 To ensure that the Board is able to meet the key obligations and responsibilities set by the ICS we may wish to explore the membership of the board. The current membership is diverse and includes key agencies such as Schools, Police, Patient Voice and the Community/voluntary Sector.
- 6.2 To deliver the extensive programme of place-based delivery the York Place Health and Care Partnership Board is considering the implementation of work streams. This may include integrating sub-groups that are already in place to reduce duplication and adding in additional groups to ensure a clear focus on commissioning, redesign and delivery.
- 6.3 A further update on the configuration of these will be presented at the September 2022 HWBB.

7. Implications

8.1 Legal Implications

The Health and Care Act (2022) is now in place, over the next 12 months the place board will further explore governance process as these will continually change as the ICB and place board develops.

8.2 Risks

- We need to ensure as partners we update our maturity framework in readiness for becoming a joint committee of the ICB and receive delegated powers over the next 6/12 months
- To continue to work with elected members, ensuring they play a key role in the development of place.
- Currently we are awaiting further information in respect to the appointment of an NHS Place Lead.

8. Conclusion

As a partnership we have a strong basis on taking the work forward and have key levers in place to fulfil our ambition of making York a healthy city not only supporting people to live longer but to live longer healthier and fulfilled lives.

9. Recommendations for The Board to Agree

The Health and Well Being Board is asked note:

- i) the content of the report and progress made,
- ii) the work of the previous York Alliance as we move forward with the York Place Health and Care Partnership Board,
- iii) that a further report will be presented to the HWBB highlighting specific work streams, as well as an updated prospectus in line with the HWBB strategy,

Contact Details

Author:

Jamaila Hussain Corporate Director of Adult Services and Integration. Interim Director of Children Services

HWWB Chair:

Cllr Carol Runciman HWBB Chair City of York Council

Report Approved

Date *Insert Date*

Report Approved

Date *Insert Date*

All

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

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Health and Wellbeing Board
Report of the Manager, Healthwatch York

20 July 2022

Joint Report from Healthwatch North Yorkshire and Healthwatch York: Accessible Information Report

Summary

1. This report is for the attention and action of Board members, sharing a joint report from Healthwatch North Yorkshire and Healthwatch York providing feedback from people, especially those whose information needs are not currently being met.

Background

2. As part of plans to better support engagement across the ICS, both at Humber and North Yorkshire level, and at North Yorkshire and York level, Healthwatch North Yorkshire and Healthwatch York are beginning to work more closely together. Our first joint report, led by Healthwatch North Yorkshire, looks more closely at some of the barriers people experience in accessing health and care service. It reflects on how well local providers are meeting the Accessible Information Standard, which came into effect in August 2016. It includes survey data alongside case studies from individuals to demonstrate the impact of failing to provide information in a format people can access.
3. We also reached out to partner organisations such as MySight York to encourage more people to share their experiences with us and hear the organisation's challenges in helping people access health and care information.

Main/Key Issues to be considered

4. Our report highlights nine principles for organisations, based on the feedback received. We strongly encourage all providers and commissioners to consider how they can embed these nine principles throughout local service delivery. We would welcome

opportunities to work with organisations to develop and deliver action plans based on these principles.

Consultation

5. In producing this report, we publicised a survey for members of the public, a survey for organisations, held focus groups and had some semi-structured interviews with people affected.

Options

- a. There are a number of recommendations within this report set out on page 16. These are:
 - Ask what helps and do something about it. Put the user first.
 - Make Accessible Information an organisational priority from the top down and make sure everyone knows why it is important. Have understanding, committed staff championing this at all levels.
 - Make sure that you ask people about their preferred format. Record this and use it to provide information in that format as standard.
 - Once identified, share people's information needs within organisations. Information about people's needs should only need to be recorded once for people across the organisation to get it right.
 - Involve people with lived experience to help find pragmatic answers.
 - Provide choice. Don't assume that everyone with a particular issue needs information in the same format or that everything is accessible. Digital is not the solution for everyone.
 - Each organisation should have one contact / team who work across that organisation to find solutions to accessible information needs quickly and effectively.
 - Seek and share good practice. Providing information in accessible formats isn't always easy but lots of organisations are trying. Share progress and challenges so that things are constantly improving.

- Review what you are doing to make sure it is working and learn from what is and isn't going well.

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

6. 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 equalities implications in this report, as it highlights particular challenges experienced in the main by disabled people.

- **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

7. There are no risks associated with this report.

Recommendations

- 8. The Health and Wellbeing Board are asked to:
 - i. Receive this joint report, Accessible Information
 - ii. Remind members of the Board to respond directly to Healthwatch York within 28 days regarding the recommendations made to their organisation.

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:

Report Approved

Date *Insert Date*

Wards Affected: All

All

For further information please contact the author of the report

Background Papers:

Annexes

**Annex A – [Accessible-Information-Report-June-2022.pdf](https://www.healthwatchyork.co.uk/accessible-information-report-june-2022.pdf)
([healthwatchyork.co.uk](https://www.healthwatchyork.co.uk))**



**Accessible
information report**

June 2022



“Ask me what helps me, and do something about it.”



Contents

Introduction	2
Principles	3
I want to be independent	4
Inaccessible information makes me feel: frustrated, sad and angry	7
Organisations need to listen and respond	8
It is not just about format, it is about the whole experience	11
Organisations should learn from good practice	13
Organisations need to get experts involved to find solutions	15
Recommendations and actions	16
Appendix one	18
Appendix two	19

Introduction

Everyone has the right to receive information in a format they can access and understand. To ensure this happens, from August 2016 all organisations that provide NHS care or publicly funded adult social care have been legally required to follow the Accessible Information Standard¹. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Many people have been fighting for accessible information for decades and although the Accessible Information Standard has been a legal requirement for six years, unfortunately, for many people things have not improved and they still do not receive information in a format that is accessible to them.

“Why is being disabled so difficult in the 21st century, 26 years after the introduction of the Disability Discrimination Act?”

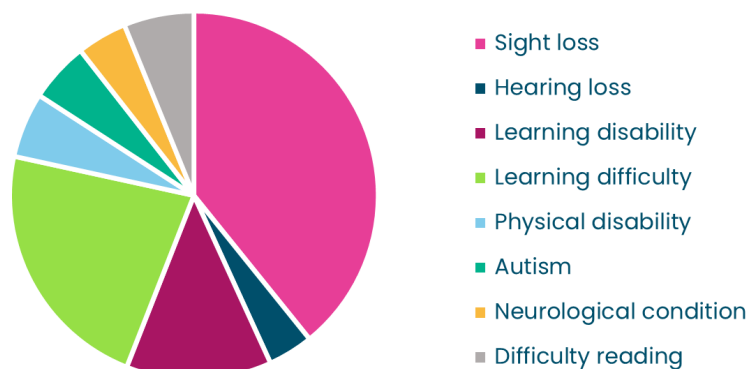
“Since I was diagnosed with a sight impairment I have had to fight for large print format, [it’s taken] three letters to CEOs over two years before I’ve largely succeeded, but [it] can still be hit and miss. I worked for 30 years as CEO of a charity for sight impaired people so I’m aware of [the] requirements. Although retired for 10 years I continue the fight not only for myself but for others and I will not give in, I will keep at them until I get it done”.



Through surveys, focus groups and conversations with 329 people and 10 organisations across North Yorkshire and York, we have gathered feedback about whether people get information in a format they can access and understand, and have developed a series of principles and actions based on this feedback (see appendix for demographic details of the sample and for the list of organisations). This was a partnership project between Healthwatch North Yorkshire and Healthwatch York. North Yorkshire County Council supported us in speaking to forums and groups with whom they engage, and is undertaking its own internal project to ensure good practice in accessible information is embedded within the organisation and it provides information in appropriate formats to local people.

We heard from people with a range of different information and communication support needs, as illustrated below.

Why respondents need information in a different format



*Note that some respondents have a mix of different needs.

Healthwatch England has also recently published a nationwide evidence review on this topic², which reinforces the issues raised in this report and further highlights the need for organisations to consistently produce information and communication in an accessible way. Alongside this evidence review, Healthwatch England has produced a set of recommendations to support the implementation of the Accessible Information Standard across the country³.

Principles

These nine principles are based on the feedback we received and provide a guide for what organisations can do to make sure in another six years' time, no one is still having to fight to get information in a format they can access and understand.

1. Ask what helps and do something about it. Put the user first.
2. Make Accessible Information an organisational priority from the top down and ensure everyone knows why it is important. Have understanding, committed staff championing this at all levels.
3. Ensure that you ask people about their preferred format. Record this and use that information to provide information in a person's preferred format. There is no point in having a flag on a record which is ignored.
4. Once identified, share people's information needs across organisations. Information about people's needs should only have to be recorded once for people to get the right format from all parts of that organisation.
5. Involve people with lived experience to help find pragmatic answers.
6. Provide choice. Don't assume that everyone with a particular issue needs information in the same format or that everything is accessible. Digital is not the solution for everyone.
7. Each organisation should have one contact or team who works across that organisation to find solutions to accessible information needs quickly and effectively.
8. Seek and share good practice. Providing information in accessible formats isn't always easy, but lots of organisations are trying. Share progress and challenges so that things are constantly improving.
9. Review what you're doing to make sure it is working and learn from what is and isn't going well.

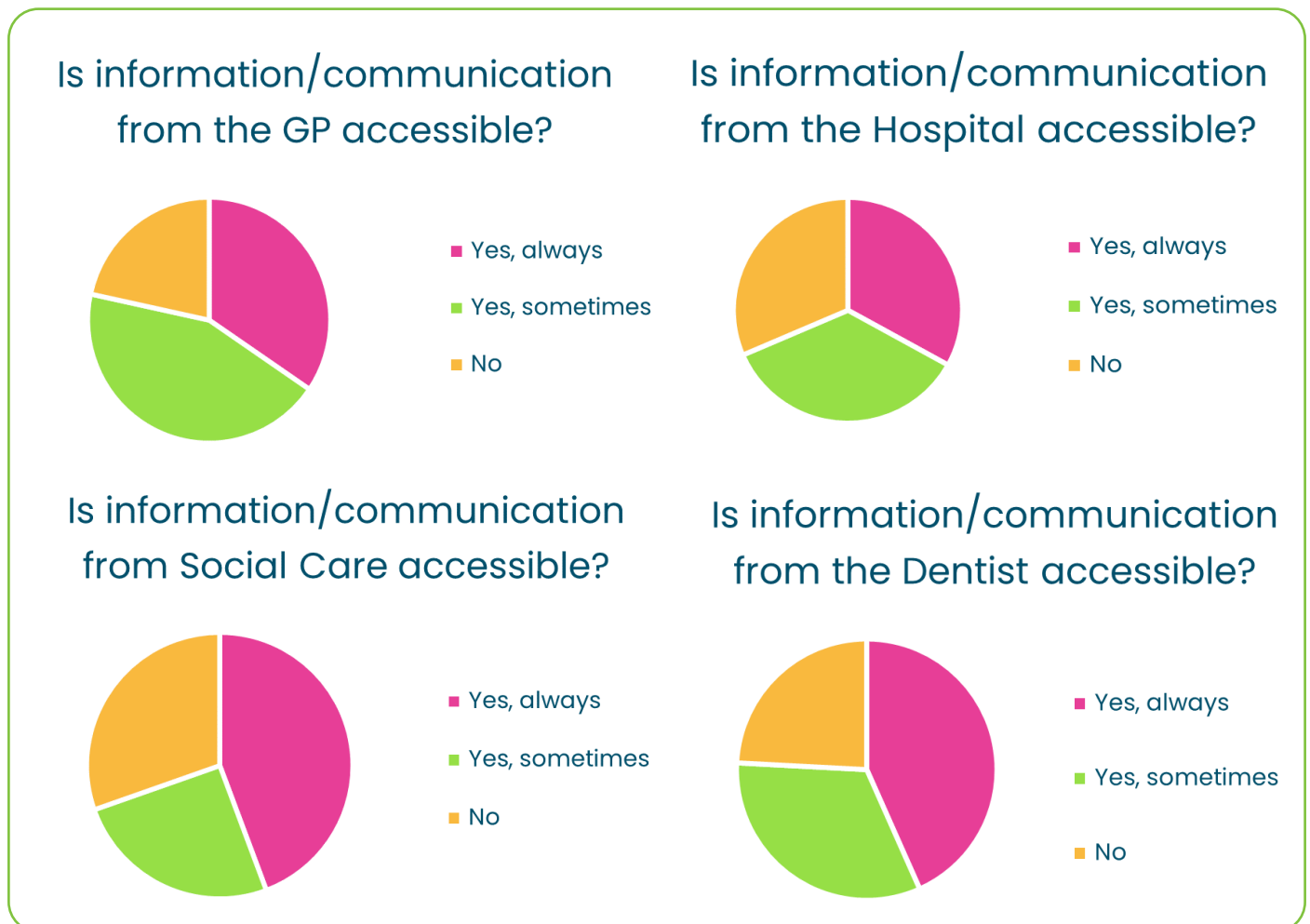
Healthwatch North Yorkshire and Healthwatch York would like to work with organisations to encourage the development and delivery of action plans based on these principles to ensure accessible information is produced as standard.

² [The Accessible Information Standard findings from our evidence review February 2022 \(healthwatch.co.uk\)](https://healthwatch.co.uk)

³ [Your Care, Your Way Campaign Full Recommendations \(healthwatch.co.uk\)](https://healthwatch.co.uk)

I want to be independent

A large majority of survey and focus group respondents said they want to be independent but feel deprived of their independence as a result of not getting health and care information in a way they can read themselves. As shown below, in this sample, people who need information in an accessible format do not get it regularly or consistently from health and care organisations, who are legally obliged to do so.

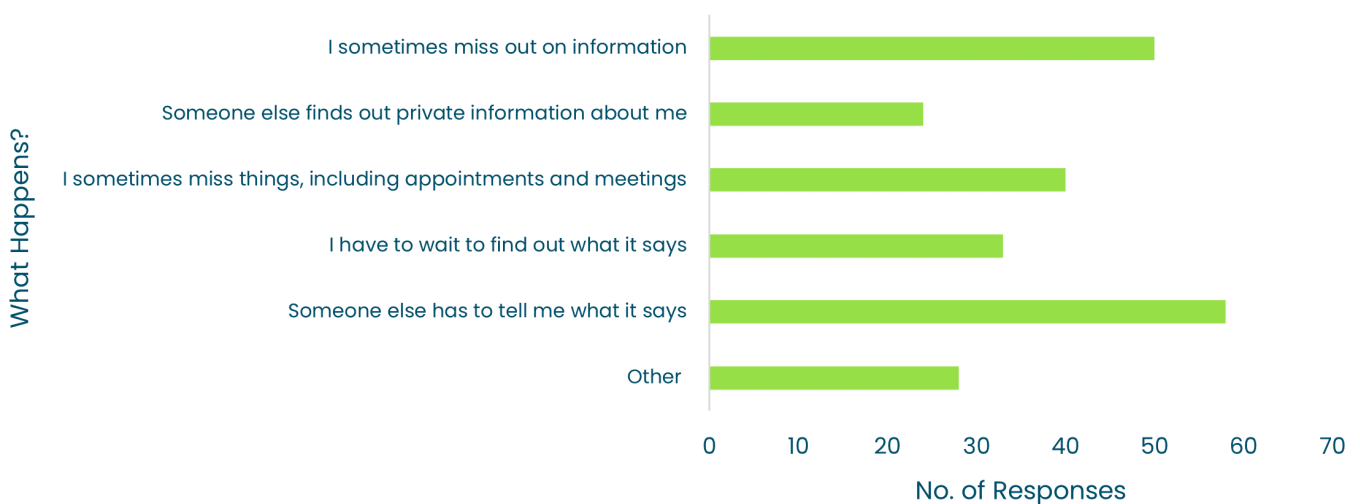


In our sample, 59% of respondents said if they do not get information or communication in their preferred format this means someone else has to tell them what it says and someone else may find out private information about them. Many organisations send information in a standard letter format and only offer a phone number for queries, to change appointments or to book follow up appointments.

However, some people with sight loss, learning difficulties or other conditions cannot access or understand a standard print letter and rely on others to read it out to them. Similarly, some people who are D/deaf, people who are neurodiverse, or have speech issues cannot always use the phone. With no other option to contact services, they have to rely on someone else to have conversations on their behalf.

Over half (65%) of respondents also said if they do not get information in the right format this can mean they miss out on information or appointments. This is not only stressful and disappointing for the person but also costs organisations time and money.

What happens if you do not get information/communication in your preferred format?



We all have rights in health and care. Most of us take for granted that we are the first people to know the news about personal health or care issues. This is not the case for many people who need information in a different format. Having to rely on somebody else means people are being deprived of their independence, privacy and control over their care. Respondents said this loss of independence makes them feel frustrated, invisible and like a second class citizen.

“It’s frustrating. My husband is quite capable of managing things for himself if it’s in the right format. It’s very annoying when it isn’t as I have to help which is time consuming for me and limits his independence”.

“[There are issues with] leaflets covering hospital procedures, or pre/post procedural measures to aid recovery. [It is] never even considered that the patient needs them in a format that is comfortable for them to understand, allowing them the independence they desire and crave, without having to go through unnecessary fretting, worrying, fussing from loved ones or friends. There are things a patient would like to keep private within their personal control”.

“I would like them to have Video Relay Service for British Sign Language (BSL) so I can ring them anytime I want to discuss things for myself by myself!”.

The case study below from Ian further reinforces the profound impact not getting information in an accessible format has on people's independence and privacy.

Ian, who lives in Whitby, has Motor Neurone Disease which has affected his speech so email is his preferred format. He can read letters sent to him, his issue is about how he can respond if needed as almost always the only option is a telephone number. Ian said: "Many people who do not use telephones are still able to manage their own administration. It may be a financial issue that the disabled person does not want to share with carers; it may be a personal health or personal care issue which again they don't want to share. Quite simply why should I ask, and pay, a carer to do anything for me that I can do myself?"

Ian feels all health organisations need to better understand the impact on disabled people having to fight the system to get accessible information and services. It is the emotional impact (frustration, anxiety) of going to an appointment not knowing if what you need will be provided. Will there be an interpreter if you need one, a quiet room if you need one, support etc. Too many people go to appointments not knowing if they will be able to express themselves or understand what they are being told or asked. It also costs money, as not sending information in an appropriate format means people will miss appointments (that they do not know they have) and that will financially impact the NHS.

Ian's GP surgery pre Covid gave a lot of excuses about not providing information in the right way for Ian. However, post Covid, Ian now has a GP's email address and the generic practice email he can use.

When organisations do not provide alternatives that enable Ian to communicate, Ian has challenged them. Some organisations are receptive including North Yorkshire County Council who are trying to find solutions. Ian's biggest frustration is with hospital trusts he is in touch with for appointments, where he has been told communication by email is impossible.

Ian added: "It is amazing in the 21st century that these issues are still there. The system doesn't anticipate that not everyone can use the phone. It is a legal requirement of the Equality Act that NHS Trusts make reasonable adjustments by providing alternatives to use of a telephone."



Organisations need to listen and respond

It is essential that organisations ask people what format they need and then act on this information. In the survey we sent to organisations, 82% of the organisations who responded (mostly GPs and hospital trusts) said they do ask people what format or communication method they would prefer and note their needs in some way. However, if this is happening it is not always consistent as 67% of the individuals who responded to our survey said they had not been asked by any organisation about which format they need information or communication in.

Unfortunately, on many occasions, the responsibility is still on the person to ask for information in their preferred format. However, even when it is raised many times, respondents said their needs are often still not taken into account. Some respondents said they know their medical notes include information about not phoning them up, but still the default is for them to get a phone call or to be told to phone up. Others said that they cannot read or access text messages, but appointment updates are still sent by text, meaning they can miss appointments or turn up to appointments that have been cancelled.

This highlights the need for organisations not only to ask people what format they require, but also to act on this from the outset. To ensure this happens, IT systems need to work effectively to flag the issue and staff also need to note and consistently act on the information stored on the system.

“For seven months I’ve been finding it very difficult to get a GP appointment. The receptionist always offered phone call appointments with a GP. This [is] a nuisance as I am profoundly deaf and it is not a good way to communicate. I’ve always found it challenging to get a face to face appointment. I chatted to the GP in March about this problem and they raised it with reception. Still no improvement. I come to get an appointment booked again as the same problem still around. Once again offered a phone appointment. Ridiculous. I eventually got [a] GP appointment but had to wait a week”.

“Hardest thing for me by far is being texted re important things –i.e. from doctors who I keep telling I cannot see texts”.

“My husband asked the doctors to phone on the landline as he can’t use a mobile. They did once and now they ring on the mobile again”.

“I would like them to ask me once, and then receive everything in large print thereafter”.



Some respondents expressed particular frustrations they have with receiving inaccessible information from eye clinics and hearing clinics. One respondent said they have been given important instructions about what to do after an eye operation in standard print which they could not read. Information should be accessible in any healthcare setting, but it should be the default for certain settings such as eye and hearing clinics.

“You would think all eye clinic patient letters would be defaulted to large print...[The] issue with [the] eye clinic is that at the end of an appointment, the professional provides a leaflet with printed information which can’t be read. When you ask for them to email a pdf/word version it is as if they have never heard of that as an option. Why can’t they have accessible versions available through the hospital or another website, so all they have to do is say, you can find a copy in x to download or print to the right size. Or they could take your details, pass them on to an admin person and ask them to email you an appropriate copy”.



“Getting a discharge letter after having a cataract operation, given instructions about what to do, in standard print. Need to think in advance and provide larger print and/or have the option to email it to the patient later”.

It is also important to note that the same format does not work for everyone. Respondents were clear that assumptions only lead to problems and not every person with a particular condition wants information in the same way; choice is key. Similarly, whilst some people are keen on using technology for information and communication, for others, digital is not the most appropriate or accessible option meaning it should not be the default.

“It should be a standard question asked at the start of any process: ‘What is your preferred means of communication.’ Please do not assume”.



“[Organisations] need to understand that not everyone has a smart phone or can use the internet well. There should always be an option - often this is not the case”.



This case study from Alex highlights the need for organisations to listen and crucially, to act on what people say is their preferred format of information or communication.

Alex, who lives in Craven, has autism which has had a negative impact on his senses as he has got older meaning he finds using the phone very difficult. He says it is like watching television with the volume at two, so you know people are speaking but have to concentrate extremely hard to work out what they are saying.

While no health organisation has asked Alex about his preferred format, he has continued to let his GP and hospital know not to use the phone for the past four years. With help from his social worker (who emails) 'no phone calls' is now on his notes, but often it is ignored.

He added: "Medication reviews are particularly difficult as the pharmacist telephones and only leaves a message on the third unanswered call to say that they have tried to call and as you did not respond you cannot order a repeat prescription. There is no non-phone option."

Airedale Hospital generally sends information by post, but a phone number is the only option for queries or to change appointments. Alex's hospital record also says not to phone, but when the GP referred Alex for an x-ray, the hospital phoned him to arrange a time. To do this, they would have had to go onto his record to get the phone number, which is next to a note saying 'don't phone'!

Alex has found some good practice. When he had Covid and had to rearrange a face to face appointment with the Memory Clinic, he was able to arrange an online appointment using Microsoft Teams (the admin person had to check whether Teams was available at the Outreach Clinic!). It wasn't easy to arrange, but worked for him and the consultant.

Leeds GIC care coordinator is good at using email but the video software used by the consultant 'Attend Anywhere', is a mystery to the consultant when it comes to enabling Alex's Support Worker to join the meeting which Alex has been told is doable, so Alex ends up having to attend the appointment on his own and struggles to remember what was said.

Leeds Sleep Clinic has updated the technology that monitors sleep apnoea so it can be read remotely. Reviews are offered by phone or by filling in a form which works brilliantly for Alex if there is nothing to discuss. However, if Alex needs to talk to someone, they do not offer a video option, so he has to go to the hospital (an 84 mile round trip) to see someone face to face.

Alex feels: "there is an assumption that everyone has someone who can help them if needed. By not listening or reading my notes, healthcare professionals are saying I do not matter and my needs are a nuisance."

It is not just about format, it is about the whole experience

A number of respondents in the survey and particularly in the focus groups highlighted that it is not just the format of the information or communication that needs to be accessible, the content also needs to be easy to understand and the experience at the appointment itself must take people's needs into account.

Unfortunately, services do not always provide information in a way people can easily understand; wording can be complex and is not always in Plain English. Respondents also said Easy Read is not always formatted correctly, sometimes Easy Read information is just pictures added to existing text, with wording that is full of jargon.

Any information sent electronically by health and care organisations should also be able to be accessed by the technology someone uses. Some respondents with sight loss said the screen readers they use cannot always read a pdf so Word documents should be used, with any images having a written explanation.

“Letters should be formatted in an easier way to understand, not just bigger print. A letter with an appointment has most of the important information – time, place etc. – in just one sentence. It would be better if it could be in bullet points”.



Services also need to ensure people's needs are met when they attend an appointment. For example, someone with sight loss should not be asked to respond to visual information. One respondent said doctors often call out the name of a blind or visually impaired person and then walk away, expecting them to follow without any problems. Similarly, someone who is D/deaf cannot be expected to hear when their name is called out in a waiting room. Accessible information extends to providing BSL interpreters when people need them. Plus, having the skills to talk to all people and make sure they understand what is being said in any health or care environment.

“Doctors call you in the waiting room and then you don't know where they have gone”.

“In waiting rooms, not everyone can see a screen or hear a name being called. People need to read the notes and provide additional support if needed. If you're not sure, ask”.



This case study from Marnie further reinforces the importance of both the format and content of information being accessible.

Marnie is a student at Henshaws College in Harrogate and is blind. Her preferred format is Braille, but she is able to access email and some documents thanks to her Brailliant, a Braille keyboard which can translate text into Braille and vice versa. Marnie is really clear about how people should send information: "I need information in the body of the email or in a Word document. I cannot access pdfs. If pictures are included, they need a caption or description to explain what the photo is showing. Wording should also be in Plain English."

"I want information in my preferred format so I can understand what it says and no-one has to explain it to me, I won't miss any appointments and no-one else will see private information about me."

Unfortunately, Marnie's GP, social worker and dentist all send printed letters.

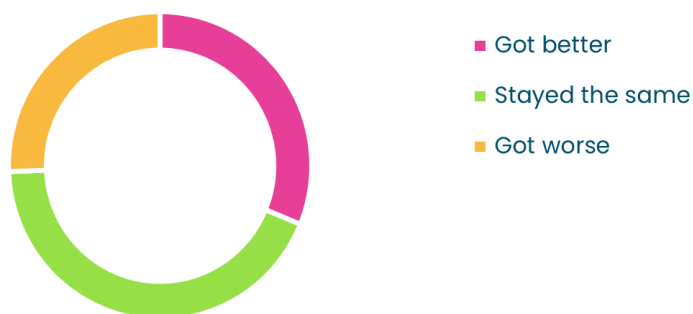
If Marnie were speaking to the Prime Minister, she said: "I would explain why information should be in accessible formats. I would tell him that excuses about cost are not good enough and that if it is difficult, it does not matter. People need information in the right format for them."



Organisations should learn from good practice

When asked whether getting information in their preferred format has improved over the past five years, a quarter of respondents said it has got better which shows some progress has been made and highlights that there are some examples of good practice within the health and care sector.

Has getting information/communication in your preferred format improved over the past 5 years?



It is important that organisations work together and work across departments to share good practice, learn from each other and best support their service users. It is likely that each organisation will face similar challenges, so it is logical for organisations to share ideas and possible solutions.

In the survey we sent to organisations, all but one organisation said they had an Accessible Information policy and most said they are asking and recording what format people need information and communication in and are providing some formats on request. However, available formats varied among organisations, with some only providing large print, and others providing a full range of formats. Only two organisations said they provide BSL, audio and Braille and only three said they provide Easy Read, which suggests even though some efforts are being made to support people with communication needs, many organisations still have work to do.

The case study below provides an example of good practice, where the respondent's GP always sends information in an accessible format. The respondent also suggests a way NHS services could work better together to ensure accessible information is available across all services.

One respondent from York is blind. Her preferred format is email as she can use screen reader technology to read the information sent.

She has asked her GP practice to send information by email and they do this and it generally works really well so she can access the information herself and does not have to ask her neighbours or home visitors for help.

She does have an app (Seeing AI) on her phone which can scan and read letters, but has difficulty in pointing the camera in the right direction to get the information she wants. Usually she can use it to understand if the letter is important and then ask for help.

While her GP has addressed her information and communication needs Covid tests and screenings are difficult. She hasn't been anywhere she needed to show a negative Covid test as she cannot do them without help. She feels that if they sent the test instructions by email, she could do most of the test herself, but would still need help to see the result. She also tried to do her bowel cancer screening herself, but did not know if she got the sample in the right place.

She thinks the NHS should work better together about accessible information: "It would be better if the health service joined up its information. Why can't your accessible information need be linked to your NHS number, so every part of the NHS has the information and can act on it. That would be so much easier."

While there are examples of good practice, as illustrated, this is not happening consistently across organisations or across all departments within organisations.

An example of inconsistent provision was given by one respondent who said when clients ask for information or communication in a different format such as BSL interpreting or translation into BSL video clip the responses have been "hit and miss". They said they could have BSL interpreters at one meeting but no interpreter booked for the next one. It is also concerning that, within our sample, only one organisation said it had audited its accessible information provision and developed an action plan as a result. This suggests organisations need to do more, by providing training opportunities for staff and regularly auditing their provision to ensure consistent good practice.

"I would like organisations to have training on how to make things Easy Read and accessible for disabled people".

"Many organisations do not realise how easy it is to produce email and large print".

"[Social] care plans are in written English but they book a BSL interpreter to go discuss it with me. I don't get a BSL video to explain the plan - I ask for this and they won't provide it".



Organisations need to get experts involved to find solutions

People with lived experience and organisations who support these people can help find simple and practical solutions to ensure information or communication is accessible to all. More than 300 people shared their experiences with us, many of whom would be willing to be part of the solution and help if organisations are struggling to provide information in a particular format. It is important that every organisation listens to and involves people with lived experience in developing and delivering action plans that lead to improvements.

“Services need to engage directly with their users who have lived experience of needing accessible communication”.

[Organisations need to] communicate better internally and externally, be patient focused/patient-led to be more efficient and effective for good outcomes. Improve feedback systems to improve outcomes”.



It is also important to recognise that there are challenges for organisations when it comes to accessible information, for example due to inflexible computer systems and technical difficulties. However, no matter what the challenges are, organisations should always try to find a way to ensure everyone’s needs are met.

There are many organisations across North Yorkshire and York that support people with a range of different needs. They are working to find ways to communicate effectively with their service users and members. Such voluntary organisations and charities could share their learning and provide support to help health and care organisations overcome the challenges they are facing to provide information in a range of accessible formats.

“There are technical difficulties where systems don’t talk to each other and different departments in a council or hospital use different databases and save someone’s information in a different way. But in the 21st century there should be ways to address this”.

“Have a designated representative assigned to these questions and queries who care, show willingness to help, and feedback with positive response i.e. your letters, pdfs, leaflets will now be sent by email – if you do not receive something in this way, please email or contact me. Thus enabling further dialogue, and not prematurely closing the door on people without a satisfactory conclusion”.



Recommendations

The feedback we received has highlighted a number of clear principles. Alongside these we have recommended a number of actions to follow in order to achieve these principles. If these are followed, we are confident that if we ask people in another six years, they will be getting information in the right format and will feel positive, independent and empowered as a result.

Healthwatch North Yorkshire and Healthwatch York are committed to supporting these changes and would welcome an opportunity to work in partnership with organisations to help make this happen.

Principle	Action
<p>Ask what helps and do something about it. Put the user first.</p>	<p>Organisation: ensure there is a policy of asking every person if they have a communication need as part of a wider accessible information policy or strategy and action plan. Staff and volunteers: ask if your organisation has an accessible information policy/action plan. If not, ask why not and urge it to do so.</p>
<p>Make Accessible Information an organisational priority from the top down and ensure everyone knows why it is important. Have understanding, committed staff championing this at all levels.</p>	<p>Organisation: promote the accessible information policy and ensure that it has champions at every level and a regular agenda item for appropriate meetings. Staff and volunteers: Read and follow the policy and challenge any behaviour which is not delivering the policy's principles.</p>
<p>Ensure that you ask people about their preferred format. Record this and use that information to provide information in a person's preferred format. There is no point in having a flag on a record which is ignored.</p>	<p>Organisation: ensure a person's information needs are clearly recorded on a person's record and that all staff are aware of this and know where to find the information. Staff and volunteers: check if a person's record highlights any information or communication need and act on it.</p>
<p>Once identified, share people's information needs within organisations. Information about people's needs should only need to be recorded once for people to get the right format from all parts of that organisation.</p>	<p>Organisation: ensure information is shared across the organisation, either through a central IT system or another means so that a person only needs to tell you their information needs once. Staff and volunteers: ensure someone's information need is on their record and that the information is shared with or highlighted to others you are working with.</p>

<p>Involve people with lived experience to help find pragmatic answers.</p>	<p>Organisation: ensure your accessible information policy and action plan includes ways to find solutions if these do not already exist. Ensure the organisation will not condone an answer of 'that is not possible' without exploring a range of alternatives.</p> <p>Staff and volunteers: be clear who in your organisation can help you to find a solution if someone needs something and you do not know how to provide it. Also work with the person to identify alternatives as appropriate.</p>
<p>Provide choice. Don't assume that everyone with a particular issue needs information in the same format or that everything is accessible. Digital is not the solution for everyone.</p>	<p>Organisation: make sure you offer and can deliver a range of alternatives and this is clear to service users and staff and staff know how to access the formats.</p> <p>Staff and volunteers: make sure you know what your organisation is offering and how to provide that.</p>
<p>Each organisation should have one contact/team who works across that organisation to find solutions to accessible information needs quickly and effectively.</p>	<p>Organisation: identify someone to take the role of central contact for accessible information and ensure they have all the support, training and information they need to deliver this. Ensure the rest of the organisation knows about the role and works with them.</p>
<p>Seek and share good practice. Providing information in accessible formats isn't always easy, but lots of organisations are trying. Share progress and challenges so that things are constantly improving.</p>	<p>Organisation: identify and learn from good practice and what is not working. Share information across organisations and between organisations.</p> <p>Staff and volunteers: share good practice with colleagues, managers and others. Also let people know when things are not working so they can be improved.</p>
<p>Review what you're doing to make sure it is working and learn from what is and isn't going well.</p>	<p>Organisation: regularly review your policy and action plan to ensure things are improving. Update your policy and action plan to reflect changes and improvements.</p>

Thank you to everyone who worked with us on this project, responded to our survey or attended one of our focus groups and contributed feedback.

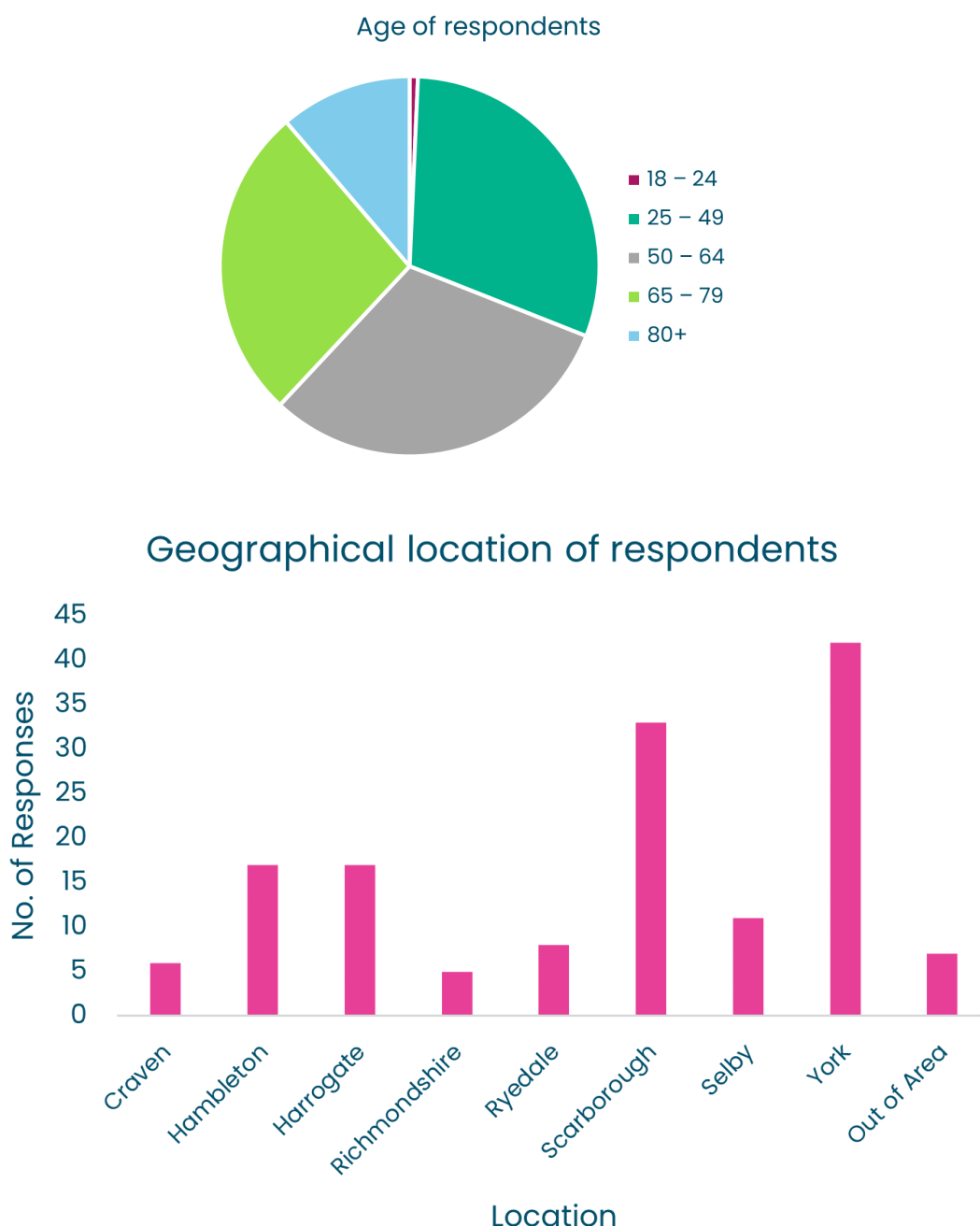
A particular thank you to the people who provided case studies and to North Yorkshire County Council, Key Ring, Leeds Society for Deaf and Blind People, MySight York, Sight Support Ryedale, The Wilf Ward Family Trust and its Jigsaw group, Vision Support Harrogate District and Yorkshire Coast Sight Support.

Your voices help inform and shape health and social care services in North Yorkshire and York. The more feedback we receive the greater chance we have in influencing change – so thank you for sharing your experiences with us.

Appendix one

Demographics

Our survey sample included, 66% female and 30% male (4% preferred to use their own term or would rather not say). The majority of respondents were aged between 25–79, and a large proportion (93%) were White British (3% were Asian, Black or from mixed multiple ethnic groups and 4% said they were from other ethnic groups/ would prefer not to say). The geographical location of the survey respondents is illustrated below.



Within the focus groups there were a mix of ages, but generally those with sight loss were over 60. There was also a mix of male and female participants from a range of different geographical locations.

Appendix two

Organisations

Our survey was shared with all health related Trusts and Clinical Commissioning Groups (CCGs) across North Yorkshire and York. Through the CCGs we aimed to circulate the survey to all Primary Care Networks and GP practices. The organisations who responded to our survey are listed below.

- NHS Vale of York CCG
- Communities and Prevention Team - City of York Council
- Humber Teaching NHS Foundation Trust
- Stillington Surgery (Hambleton district)
- Ampleforth and Hovingham Surgeries (Ryedale district)
- Pickering Medical Practice (Ryedale district)
- Dyneley House Surgery (Craven district)
- York and Scarborough Teaching Hospitals NHS Foundation Trust
- Leeds Road Practice (Harrogate district)
- Danby Surgery (Scarborough district)

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North Yorkshire



Thank you to everyone who gave their feedback - we will continue to call for improvements on health and social care across North Yorkshire, and the more feedback we receive the greater chance we have in doing so - so thank you for continuing to share your experiences with us.



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Accessible Information report: “Ask me what helps me and do something about it”

June 2022

Contents

Introduction	2
Principles.....	3
I want to be independent.....	5
Inaccessible information makes me feel: frustrated, sad and angry	8
Organisations need to listen and respond	9
It is not just about format, it is about the whole experience	12
Organisations should learn from good practice	14
Organisations need to get experts involved to find solutions.....	16
Recommendations	17
Appendix one	19
Appendix two.....	20

Introduction

Everyone has the right to receive information in a format they can access and understand. To ensure this happens, from August 2016 all organisations that provide NHS care or publicly funded adult social care have been legally required to follow the Accessible Information Standard¹. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Many people have been fighting for accessible information for decades and although the Accessible Information Standard has been a legal requirement for six years, unfortunately, for many people things have not improved and they still do not receive information in a format that is accessible to them.

- **“Why is being disabled so difficult in the 21st century, 26 years after the introduction of the Disability Discrimination Act?”**
- **“Since I was diagnosed with a sight impairment I have had to fight for large print format, [it’s taken] three letters to CEOs over two years before I’ve largely succeeded, but [it] can still be hit and miss. I worked for 30 years as CEO of a charity for sight impaired people so I’m aware of [the] requirements. Although retired for 10 years I continue the fight not only for myself but for others and I will not give in, I will keep at them until I get it done”.**

Through surveys, focus groups and conversations with 329 people and 10 organisations across North Yorkshire and York, we have gathered feedback about whether people get information in a format they can access and understand and have developed a series of principles and actions based on this feedback (see appendix for demographic details of the sample and for the list of organisations). This was a partnership project between Healthwatch North Yorkshire and Healthwatch York. North Yorkshire County Council supported us in speaking to forums and groups with whom they engage and is undertaking its own internal project to ensure good practice in accessible information is embedded within the organisation and it provides information in appropriate formats to local people.

We heard from people with a range of different information and communication support needs, as indicated below.

Why respondents need information in a different format?

Sight loss – 89 responses
Hearing loss – 9 responses
Learning disability – 29 responses
Learning difficulty – 51 responses
Physical disability – 13 responses
Autism – 12 responses
Neurological condition – 10 responses
Difficulty reading – 14 responses

¹ [NHS England » Accessible Information Standard](#)

Healthwatch England has also recently published a nationwide evidence review on this topic², which reinforces the issues raised in this report and further highlights the need for organisations to consistently produce information and communication in an accessible way. Alongside this evidence review, Healthwatch England has produced a set of recommendations to support the implementation of the Accessible Information Standard across the country³.

Principles

These nine principles are based on the feedback we received and provide a guide for what organisations can do to make sure in another six years' time, no one is still having to fight to get information in a format they can access and understand.

1. Ask what helps and do something about it. Put the user first.
2. Make Accessible Information an organisational priority from the top down and ensure everyone knows why it is important. Have understanding, committed staff championing this at all levels.
3. Ensure that you ask people about their preferred format. Record this and use that information to provide information in a person's preferred format. There is no point in having a flag on a record which is ignored.
4. Once identified, share people's information needs across organisations. Information about people's needs should only have to be recorded once for people to get the right format from all parts of that organisation.
5. Involve people with lived experience to help find pragmatic answers.
6. Provide choice. Don't assume that everyone with a particular issue needs information in the same format or that everything is accessible. Digital is not the solution for everyone.
7. Each organisation should have one contact/team who works across that organisation to find solutions to accessible information needs quickly and effectively.
8. Seek and share good practice. Providing information in accessible formats isn't always easy, but lots of organisations are trying. Share progress and challenges so that things are constantly improving.
9. Review what you're doing to make sure it is working and learn from what is and isn't going well.

Healthwatch North Yorkshire and Healthwatch York are keen to work with organisations to encourage the development and delivery of action plans based on these principles to ensure accessible information is produced as standard.

² [Briefing \(healthwatch.co.uk\)](https://www.healthwatch.co.uk/briefing)

³ [Your Care, Your Way Campaign Full Recommendations \(healthwatch.co.uk\)](https://www.healthwatch.co.uk/your-care-your-way-campaign-full-recommendations)

I want to be independent

A large majority of survey and focus group respondents said they want to be independent but feel deprived of their independence as a result of not getting health and care information in a way they can read themselves. As shown below, in this sample, people who need information in an accessible format do not get it regularly or consistently from health and care organisations, who are legally obliged to do so.

Is information/communication from the GP accessible?

Yes, always - 48

Yes, sometimes - 61

No - 30

Is information/communication from the hospital accessible?

Yes, always - 42

Yes, sometimes - 45

No - 40

Is information/communication from social care accessible?

Yes, always - 35

Yes, sometimes - 20

No - 24

Is information/communication from the dentist accessible?

Yes, always - 52

Yes, sometimes - 39

No - 29

In our sample, 59% of respondents said if they do not get information/communication in their preferred format this means someone else has to tell them what it says and/or someone else finds out private information about them. Many organisations send information in a standard letter format and only offer a phone number for queries, to change appointments or to book follow up appointments.

However, some people with sight loss, learning difficulties or other conditions cannot access or understand a standard print letter and rely on others to read it out to them. Similarly, some people who are D/deaf, people who are neurodiverse, or have speech issues cannot always use the phone. With no other option to contact services, they have to rely on someone else to have conversations on their behalf.

Over half (65%) of respondents also said if they do not get information in the right format this can mean they miss out on information and/or appointments and meetings. This is not only stressful and disappointing for the person but also costs organisations time and money.

What happens if you do not get information/communication in your preferred format?

I sometimes miss out on information – 50 responses

Someone else finds out private information about me – 24 responses

I sometimes miss things, including appointments and meetings – 40 responses

I have to wait to find out what it says – 33 responses

Someone else has to tell me what it says – 58 responses

Other – 28 responses

We all have rights in health and care. Most of us take for granted that we are the first people to know the news about personal health or care issues. This is not the case for many people who need information in a different format. Having to rely on somebody else means people are being deprived of their independence, privacy and control over their care. Respondents said this loss of independence makes them feel frustrated, invisible and like a second class citizen.

- **“It's frustrating. My husband is quite capable of managing things for himself if it's in the right format. It's very annoying when it isn't as I have to help which is time consuming for me and limits his independence”.**
- **“[There are issues with] leaflets covering hospital procedures, or pre/post procedural measures to aid recovery. [It is] never even considered that the patient NEEDS them in a format that is comfortable for them to understand, allowing them the independence they desire and crave, without having to go through unnecessary fretting, worrying, fussing from loved ones or friends. There are things a patient would like to keep private within their personal control”.**
- **“I would like them to have Video Relay Service for British Sign Language (BSL) so I can ring them anytime I want to discuss things for myself by myself!”.**

The case study below from Ian further reinforces the profound impact not getting information in an accessible format has on people's independence and privacy.

Ian, who lives in Whitby, has Motor Neurone Disease which has affected his speech so email is his preferred format. He can read letters sent to him, his issue is about how he can respond if needed as almost always the only option is a telephone number.

Ian said: "Many people who do not use telephones are still able to manage their own administration. It may be a financial issue that the disabled person does not want to share with carers; it may be a personal health or personal care issue which again they don't want to share. Quite simply why should I ask, and pay, a carer to do anything for me that I can do myself?"

Ian feels all health organisations need to better understand the impact on disabled people of having to fight the system to get accessible information and services. It is the emotional impact (frustration, anxiety) of going to an appointment not knowing if what you need will be provided. Will there be an interpreter if you need one, a quiet room if you need one, support etc., Too many people go to appointments not knowing if they will be able to express themselves or understand what they are being told/asked. It also costs money, as not sending information in an appropriate format means people will miss appointments (that they do not know they have) and that will cost the NHS.

Ian's GP surgery pre Covid gave a lot of excuses about not providing information in the right way for Ian. However, post Covid, Ian now has a GP's email address and the generic practice email he can use.

When organisations do not provide alternatives that enable Ian to communicate, Ian has challenged them. Some organisations are receptive including North Yorkshire County Council who are trying to find solutions. Ian's biggest frustration is with hospital trusts he is in touch with for appointments, where he has been told communication by email is impossible.

Ian added: "It is amazing in the 21st century that these issues are still there. The system doesn't anticipate that not everyone can use the phone. It is a legal requirement of the Equality Act that NHS Trusts make reasonable adjustments by providing alternatives to use of a telephone."

Inaccessible information makes me feel frustrated, sad and angry

The words below represent the words people used to say how getting information in a format they cannot access makes them feel.

- Frustrated
- Angry
- Sad
- Annoyed
- Ignored
- Upset
- Excluded
- Hassle
- Anxious
- Unhappy
- Irritated
- Resigned
- Indifferent
- Grumpy
- Discounted
- Confused
- Overlooked
- Uncomfortable
- Demotivated
- Isolated
- Numb
- Withdrawn
- Cross
- Belittled

The overwhelming response was to say frustrated, followed by sad, angry and annoyed. Some people said they felt ignored, belittled and discounted and a few people were resigned to the fact of never getting information in the way they want it.

Organisations need to listen and respond

It is essential that organisations ask people what format they need and then act on this information. In the survey we sent to organisations, 82% of the organisations who responded (mostly GPs and hospital trusts) said they do ask people what format or communication method they would prefer and note their needs in some way. However, if this is happening it is not always consistent as 67% of the individuals who responded to our survey said they had not been asked by any organisation about which format they need information/communication in.

Unfortunately, on many occasions, the responsibility is still on the person to ask for information in their preferred format. However, even when it is raised many times, respondents said their needs are often still not taken into account. Some respondents said they know their medical notes include information about not phoning them up, but still the default is for them to get a phone call or to be told to phone up. Others said that they cannot read or access text messages, but appointment updates are still sent by text, meaning they can miss appointments or turn up to appointments that have been cancelled.

This highlights the need for organisations not only to ask people what format they require, but also to act on this from the outset. To ensure this happens, IT systems need to work effectively to flag the issue and staff also need to note and consistently act on the information stored on the system.

- **“For seven months I've been finding it very difficult to get a GP appointment. The receptionist always offered phone call appointments with a GP. This [is] a nuisance as I am profoundly deaf, and it is not a good way to communicate. I've always found it challenging to get a face-to-face appointment. I chatted to the GP in March about this problem, and they raised it with reception. Still no improvement. I come to get an appointment booked again as the same problem still around. Once again offered a phone appointment. Ridiculous. I eventually got [a] GP appointment but had to wait a week”.**
- **“Hardest thing for me by far is being texted re important things -i.e., from doctors who I keep telling I cannot see texts”.**
- **“My husband asked the doctors to phone on the landline as he can't use a mobile. They did once and now they ring on the mobile again”.**
- **“I would like them to ask me once, and then receive everything in large print thereafter”.**

Some respondents expressed particular frustrations they have with receiving inaccessible information from eye clinics and hearing clinics. One respondent said they have been given important instructions about what to do after an eye operation in standard print which they could not read. Information should be accessible in any healthcare setting, but it should be the default for certain settings such as eye and hearing clinics.

- **“You would think all eye clinic patient letters would be defaulted to large print...[The] issue with [the] eye clinic is that at the end of an appointment, the professional provides a leaflet with printed information which can't be read. When you ask for them to email a pdf/word version it is as if they have never heard of that as an option. Why can't they have accessible versions available through the hospital or another website, so all they have to do is say, you can find a copy in x to download or print to the right size. Or they could take your**

details, pass them on to an admin person and ask them to email you an appropriate copy”.

- **“Getting a discharge letter after having a cataract operation, given instructions about what to do, in standard print. Need to think in advance and provide larger print and/or have the option to email it to the patient later”.**

It is also important to note that the same format does not work for everyone. Respondents were clear that assumptions only lead to problems and not every person with a particular condition wants information in the same way; choice is key. Similarly, whilst some people are keen on using technology for information and communication, for others, digital is not the most appropriate or accessible option meaning it should not be the default.

- **“It should be a standard question asked at the start of any process: ‘What is your preferred means of communication.’ Please do not assume”.**
- **“[Organisations] need to understand that not everyone has a smart phone or can use the internet well. There should always be an option - often this is not the case”.**

This case study from Alex highlights the need for organisations to listen and crucially, to act on what people say is their preferred format of information/communication.

Alex, who lives in Craven, has autism which has had a negative impact on his senses as he has got older meaning he finds using the phone very difficult. He says it is like watching television with the volume at two, so you know people are speaking but have to concentrate extremely hard to work out what they are saying.

While no health organisation has asked Alex about his preferred format, he has continued to let his GP and the hospital know not to use the phone for the past four years. With help from his social worker (who emails) ‘no phone calls’ is now on his notes, but often it is ignored.

He added: “Medication reviews are particularly difficult as the pharmacist telephones and only leaves a message on the third unanswered call to say that they have tried to call and as you did not respond you cannot order a repeat prescription. There is no non-phone option.”

Airedale Hospital generally sends information by post, but a phone number is the only option for queries or to change appointments. Alex’s hospital record also says not to phone, but when the GP referred Alex for an x-ray, the hospital phoned him to arrange a time. To do this, they would have had to go onto his record to get the phone number, which is next to a note saying ‘don’t phone’!

Alex has found some good practice. When he had Covid and had to rearrange a face to face appointment with the Memory Clinic, he was able to arrange an online appointment using Microsoft Teams (the admin person had to check whether Teams was available at the Outreach Clinic!). It wasn’t easy to arrange, but worked for him and the consultant.

Leeds GIC care coordinator is good at using email but the video software used by the consultant ‘Attend Anywhere’, is a mystery to the Consultant when it comes to enabling Alex’s Support Worker to join the meeting which Alex has been told is doable, so Alex ends up having to attend the appointment on his own and struggles to remember what was said.

Leeds sleep clinic has updated the technology that monitors sleep apnoea so it can be read remotely. Reviews are offered by phone or by filling in a form which works brilliantly for Alex if there is nothing to discuss. However, if Alex needs to talk to someone, they do not offer a video option, so he has to go to the hospital (an 84 mile round trip) to see someone face to face.

Alex feels: “there is an assumption that everyone has someone who can help them if needed. By not listening or reading my notes, healthcare professionals are saying I do not matter and my needs are a nuisance.”

It is not just about the format, it is about the whole experience

A number of respondents in the survey and particularly in the focus groups highlighted that it is not just the format of the information/communication that needs to be accessible, the content also needs to be easy to understand and the experience at the appointment itself must take people's needs into account.

Unfortunately, services do not always provide information in a way people can easily understand; wording can be complex and is not always in Plain English. Respondents also said Easy Read is not always formatted correctly, sometimes Easy Read information is just pictures added to existing text, with wording that is full of jargon.

Any information sent electronically by health and care organisations should also be able to be accessed by the technology someone uses. Some respondents with sight loss said the screen readers they use cannot always read a pdf so Word documents should be used, with any images having a written explanation.

- **“Letters should be formatted in an easier way to understand, not just bigger print. A letter with an appointment has most of the important information - time, place etc. - in just one sentence. It would be better if it could be in bullet points”.**

Services also need to ensure people's needs are met when they attend an appointment. For example, someone with sight loss should not be asked to respond to visual information. One respondent said doctors often call out the name of a blind or visually impaired person and then walk away, expecting them to follow without any problems. Similarly, someone who is D/deaf cannot be expected to hear when their name is called out in a waiting room. Accessible information extends to providing BSL interpreters when people need them and having the skills to talk to all people and make sure they understand what is being said in any health or care environment.

- **“Doctors call you in the waiting room and then you don't know where they have gone”.**
- **“In waiting rooms, not everyone can see a screen or hear a name being called. People need to read the notes and provide additional support if needed. If you're not sure, ask”.**

This case study from Marnie further reinforces the importance of both the format and content of information being accessible.

Marnie is a student at Henshaws College in Harrogate and is blind. Her preferred format is Braille, but she is able to access email and some documents thanks to her Brailliant, a Braille keyboard which can translate text into Braille and vice versa.

Marnie is really clear about how people should send information: “I need information in the body of the email or in a Word document. I cannot access pdfs. If pictures are included, they need a caption/description to explain what the photo is showing. Wording should also be in Plain English.

“I want information in my preferred format so I can understand what it says and no-one has to explain it to me, I won’t miss any appointments and no-one else will see private information about me.”

Unfortunately, Marnie’s GP, social worker and dentist all send printed letters.

If Marnie were speaking to the Prime Minister, she said: “I would explain why information should be in accessible formats. I would tell him that excuses about cost are not good enough and that if it is difficult, it does not matter. People need information in the right format for them.”

Organisations should learn from good practice

When asked whether getting information in their preferred format has improved over the past five years, a quarter of respondents said it has got better which shows some progress has been made and highlights that there are some examples of good practice within the health and care sector. The information below indicates how people responded to whether getting information has changed over the past five years.

Has getting information/communication in your preferred format improved over the past 5 years?

Got better – 39 responses

Stayed the same – 54 responses

Got worse – 32 responses

It is important that organisations work together and work across departments to share good practice, learn from each other and best support their service users. It is likely that each organisation will face similar challenges, so it is logical for organisations to share ideas and possible solutions.

In the survey we sent to organisations, all but one organisation said they had an Accessible Information policy and most said they are asking and recording what format people need information/communication in and are providing some formats on request. However, available formats varied among organisations, with some only providing large print, and others providing a full range of formats. Only two organisations said they provide BSL, audio and Braille and only three said they provide Easy Read, which suggests even though some efforts are being made to support people with communication needs, many organisations still have work to do.

The case study below provides an example of good practice, where the respondent's GP always sends information/communication in an accessible format. The respondent also suggests a way NHS services could work better together to ensure accessible information is available across all services.

One respondent from York is blind. Her preferred format is email as she can use screen reader technology to read the information sent.

She has asked her GP practice to send information by email and they do this and it generally works really well so she can access the information herself and does not have to ask her neighbours or home visitors for help.

She does have an app (Seeing AI) on her phone which can scan and read letters, but has difficulty in pointing the camera in the right direction to get the information she wants. Usually she can use it to understand if the letter is important and then ask for help.

While her GP has addressed her information/communication needs Covid tests and screenings are difficult. She hasn't been anywhere she needed to show a negative Covid test as she cannot do them without help. She feels that if they sent the test instructions by email, she could do most of the test herself, but would still need help to see the result. She also tried to do her bowel cancer screening herself, but did not know if she got the sample in the right place.

She thinks the NHS should work better together about accessible information: “It would be better if the health service joined up its information. Why can’t your accessible information need be linked to your NHS number, so every part of the NHS has the information and can act on it. That would be so much easier.”

While there are examples of good practice, as illustrated, this is not happening consistently across organisations or across all departments within organisations. An example of inconsistent provision was given by one respondent who said when clients ask for information/communication in a different format such as BSL interpreting and/or translation into BSL video clip the responses have been "hit and miss". They said they could have BSL interpreters at one meeting but no interpreter booked for the next one. It is also concerning that, within our sample, only one organisation said it had audited its accessible information provision and developed an action plan as a result. This suggests organisations need to do more, by providing training opportunities for staff and regularly auditing their provision to ensure consistent good practice.

- **“I would like organisations to have training on how to make things Easy Read and accessible for disabled people”.**
- **“Many organisations do not realise how easy it is to produce email and large print”.**
- **“[Social] care plans are in written English but they book a BSL interpreter to go discuss it with me. I don't get a BSL video to explain the plan - I ask for this and they won't provide it”.**

Organisations need to get experts involved to find solutions

People with lived experience and organisations who support these people can help find simple and practical solutions to ensure information/communication is accessible to all. More than 300 people shared their experiences with us, many of whom would be willing to be part of the solution and help if organisations are struggling to provide information in a particular format. It is important that every organisation listens to and involves people with lived experience in developing and delivering action plans that lead to improvements.

- **“Services need to engage directly with their users who have lived experience of needing accessible communication”.**
- **[Organisations need to] communicate better internally and externally, be patient focused/patient-led to be more efficient and effective for good outcomes. Improve feedback systems to improve outcomes”.**

It is also important to recognise that there are challenges for organisations when it comes to accessible information, for example due to inflexible computer systems and technical difficulties. However, no matter what the challenges are, organisations should always try to find a way to ensure everyone’s needs are met.

There are many organisations across North Yorkshire and York that support people with a range of different needs. They are working to find ways to communicate effectively with their service users and members. Such voluntary organisations and charities could share their learning and provide support to help health and care organisations overcome the challenges they are facing to provide information in a range of accessible formats.

- **“There are technical difficulties where systems don’t talk to each other and different departments in a Council or hospital use different databases and save someone’s information in a different way. But in the 21st century there should be ways to address this”.**
- **“Have a designated representative assigned to these questions and queries who care, show willingness to help, and feedback with positive response i.e. your letters, pdfs, leaflets will now be sent by email – if you do not receive something in this way, please email or contact me. Thus enabling further dialogue, and not prematurely closing the door on people without a satisfactory conclusion”.**

Recommendations

The feedback we received has highlighted a number of clear principles. Alongside these we have recommended a number of actions to follow in order to achieve these principles. If these are followed, we are confident that if we ask people in another six years, they will be getting information in the right format and will feel positive, independent and empowered as a result.

Healthwatch North Yorkshire and Healthwatch York are committed to supporting these changes and would welcome an opportunity to work in partnership with organisations to help make this happen.

Principle	Action
Ask what helps and do something about it. Put the user first.	<p>Organisation: ensure there is a policy of asking every person if they have a communication need as part of a wider accessible information policy or strategy and action plan.</p> <p>Staff and volunteers: ask if your organisation has an accessible information policy/action plan. If not, ask why not and urge it to do so.</p>
Make Accessible Information an organisational priority from the top down and ensure everyone knows why it is important. Have understanding, committed staff championing this at all levels.	<p>Organisation: promote the accessible information policy and ensure that it has champions at every level and a regular agenda item for appropriate meetings.</p> <p>Staff and volunteers: Read and follow the policy and challenge any behaviour which is not delivering the policy's principles.</p>
Ensure that you ask people about their preferred format. Record this and use that information to provide information in a person's preferred format. There is no point in having a flag on a record which is ignored.	<p>Organisation: ensure a person's information needs are clearly recorded on a person's record and that all staff are aware of this and know and where to find the information.</p> <p>Staff and volunteers: check if a person's record highlights any information or communication need and act on it.</p>
Once identified, share people's information needs within organisations. Information about people's needs should only need to be recorded once for people to get the right format from all parts of that organisation.	<p>Organisation: ensure information is shared across the organisation, either through a central IT system or another means so that a person only needs to tell you their information needs once.</p> <p>Staff and volunteers: ensure someone's information needs is on their record and that the information is shared with or highlighted to others you are working with.</p>
Involve people with lived experience to help find pragmatic answers.	<p>Organisation: ensure your accessible information policy and action plan includes ways to find solutions if these do not already exist. Ensure the organisation will not condone an answer of 'that is not possible' without exploring a range of alternatives.</p> <p>Staff and volunteers: be clear who in your organisation can help you to find a solution if someone need something and you do not know how to provide it. Also work with the person to identify alternatives as appropriate.</p>
Provide choice. Don't assume that everyone with a particular issue needs information in the same format or that	<p>Organisation: make sure you offer and can deliver a range of alternatives and this is clear to service users and staff and staff know how to access the formats.</p>

everything is accessible. Digital is not the solution for everyone.	Staff and volunteers: make sure you know what your organisation is offering and how to provide that.
Each organisation should have one contact/team who works across that organisation to find solutions to accessible information needs quickly and effectively.	Organisation: identify someone to take the role of central contact for accessible information and ensure they have all the support, training and information they need to deliver this. Ensure the rest of the organisation knows about the role and works with them.
Seek and share good practice. Providing information in accessible formats isn't always easy, but lots of organisations are trying. Share progress and challenges so that things are constantly improving.	Organisation: identify and learn from good practice and what is not working. Share information across organisations and between organisations. Staff and volunteers: share good practice with colleagues, managers and others. Also let people know when things are not working so they can be improved.
Review what you're doing to make sure it is working and learn from what is and isn't going well.	Organisation: regularly review your policy and action plan to ensure things are improving. Update your policy and action plan to reflect changes and improvements.

Thank you to everyone who worked with us on this project, responded to our survey or attended one of our focus groups and contributed feedback.

A particular thank you to the people who provided case studies and to North Yorkshire County Council, Key Ring, Leeds Society for Deaf and Blind People, MySight York, Sight Support Ryedale, The Wilf Ward Family Trust and its Jigsaw group, Vision Support Harrogate District and Yorkshire Coast Sight Support.

Your voices help inform and shape health and social care services in North Yorkshire and York. The more feedback we receive the greater chance we have in influencing change – so thank you for sharing your experiences with us.

Appendix one

Demographics:

Our survey sample included, 66% female and 30% male (4% preferred to use their own term or would rather not say). The majority of respondents were aged between 25-79, and a large proportion (93%) were White British (3% were Asian, Black or from mixed multiple ethnic groups and 4% said they were from other ethnic groups/ would prefer not to say). The geographical location of the survey respondents is illustrated below.

Age of respondents

18-24 – 1 respondent

25-49 – 43 respondents

50-64 – 44 respondents

65-79 – 38 respondents

80+ - 16 respondents

Geographical location of respondents

Craven – 6 respondents

Hambleton – 17 respondents

Harrogate – 17 respondents

Richmondshire – 5 respondents

Ryedale – 8 respondents

Scarborough – 33 respondents

Selby – 11 respondents

York – 42 respondents

Out of Area – 7 respondents

Within the focus groups there were a mix of ages, but generally those with sight loss were over 60. There was also a mix of male and female participants from a range of different geographical locations.

Appendix two

Organisations:

Our survey was shared with all health related Trusts and Clinical Commissioning Groups (CCGs) across North Yorkshire and York. Through the CCGs we aimed to circulate the survey to all Primary Care Networks and GP practices. The organisations who responded to our survey are listed below.

- NHS Vale of York CCG
- Communities and Prevention Team - City of York Council
- Humber Teaching NHS Foundation Trust
- Stillington Surgery (Hambleton district)
- Ampleforth and Hovingham Surgeries (Ryedale district)
- Pickering Medical Practice (Ryedale district)
- Dyneley House Surgery (Craven district)
- York and Scarborough Teaching Hospitals NHS Foundation Trust
- Leeds Road Practice (Harrogate district)
- Danby Surgery (Scarborough district)



Health and Wellbeing Board
Report of the Manager, Healthwatch York

20 July 2022

Healthwatch York Annual Report

Summary

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

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 stakeholdersⁱ. The report, Annex A, contains information about how Healthwatch York have fulfilled their statutory function over the past year. Also attached at Annex B is our Annual Independent Stakeholder Evaluation of our work. This is a contractual requirement.

Main/Key Issues to be considered

3. 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

4. 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

5. Health and Wellbeing Board are asked to note Healthwatch York's Annual Report 2021/22.

Strategic/Operational Plans

6. Areas of work discussed within the report have helped contribute to a number of different strategic and operational plans.

Implications

7. 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

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

Recommendations

9. The Health and Wellbeing Board are asked to:

- i. Receive Healthwatch York's Annual Report

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

Contact Details

Author:

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Healthwatch York
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Wards Affected: All

All

For further information please contact the author of the report

Background Papers:

Healthwatch York Evaluation 2021/22

Annexes

Annex A - Healthwatch York Annual Report 2021/22

https://www.healthwatchyork.co.uk/wp-content/uploads/2022/07/HWY_AR_Com_02_pp.pdf

Annex B – Independent Stakeholder Evaluation of Healthwatch York

[HWY-Evaluation-2022-final.pdf \(healthwatchyork.co.uk\)](https://www.healthwatchyork.co.uk/HWY-Evaluation-2022-final.pdf)

i

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

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Annual Report

Influence and impact
2021-2022



Contents

Message from our Chair	3	Working together as a Network	14
Your health and social care champion	4	With other local Healthwatch and Healthwatch England.	
We believe the best people to help shape our health and care system are those who use it.		Financial summary	15
Impact summary	5	Strategy	16
What matters to you	7	The way we work, and our future priorities.	
GP snapshot report: We listened to people's experiences of accessing GP services.		Our volunteers	18
Peer Research Cafe	10	How our 23 outstanding volunteers help us to spread our reach across York.	
A case study: We trained a small group of researchers in participatory research methods.		Information & signposting	20
What matters to you	11	A case study: An example of how this service supports local residents.	
Dentistry: Gaps in Provision: In 2021 we launched an online survey about people's experiences of dentistry in York.		Healthwatch York Representation	22
		Sharing your experiences with service providers.	
		Contact us	24

“ We have been [doing] what we enjoy most; getting out and speaking with York residents, whose voices we are here to represent. ”



Message from our Chair

Welcome to Healthwatch York's 2021/2022 Annual Report.



It's been another challenging twelve months

which began when we were still working under government Covid-19 restrictions but, as we go out to publication, ends in a

period when we have been able to do what we enjoy most; getting out and speaking with York residents, whose voices we are here to represent.

As a team we have said goodbye to valued colleagues and welcomed new ones. The world of health and social care is ever changing, and we have developed roles to enable us to adapt to these changes. We now have a dedicated information officer as well as a volunteers and engagement officer. These posts, alongside our

information guides, will support people to navigate their way through the health and care services in York.

We are proud of our partnership working and our connections across the statutory, voluntary, and private sector and our York community. Between us the team are members of over 40 different meetings and networks. We are using those partnerships to develop a voice network, York volCeS. The network will bring together professionals and the public to share their experiences, and to hear about what is happening locally – particularly important as we move into the new Integrated Care Systems across England from July 2022.

This year we undertook an extensive piece of research into NHS dentistry provision within York. Our reports received media coverage and were referred to by our MP in the House of Commons. Highlighting these local issues has fed into the national debate regarding the need to change how dental services are commissioned.

In response to local issues raised with us, we have begun producing snapshot reports which highlight concerns around a particular topic. Most recently we have circulated a report on access to GP surgeries. Whilst representing individuals' issues, the report opened meaningful conversations with GP practices, enabling

“ Between us the team are members of over 40 different meetings and networks. ”

us to fully understand the challenges they're facing and to discuss practical and achievable solutions to the issues raised.

I hope you will enjoy this Annual Report in which you will read about the team and the work that has been undertaken. I am proud to be the Chair of Healthwatch York and proud of the work undertaken by the team through such an everchanging environment. As we move into what will be another challenging year for many, we will continue to represent your issues and concerns and push for improvements within your local health and care services.

Janet Wright

Your health and social care champion

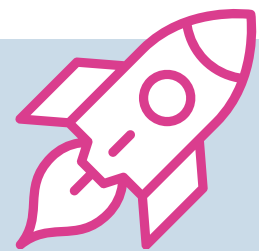
Healthwatch York at York CVS is based on a very simple idea – that the best people to help shape our health and care system are those who use health and care services.

We believe that by making sure people’s experiences are right at the heart of decision making around health and care, we can make York work better for everyone. We can help you to find reliable and trustworthy information and advice.

We will:

- Be responsive
- Understand what’s really happening in relation to health and social care and speak up about it
- Use your words and stories to show the impact of services – good and bad
- Involve you in the work we do
- Champion your involvement in your health and care
- Work with existing partners
- Reach new people and partners

Our Mission



“ 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. ”

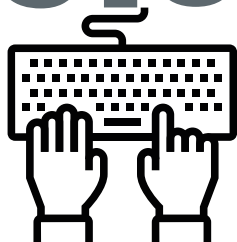


Our Values

empowering
 participative
 informative
 responsive
 inclusive flexible
 diversity
 choice
 accountable

Impact summary

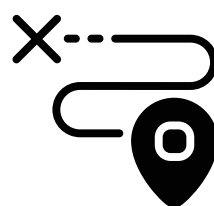
310



experiences of health and social care services shared with us and logged...

...experiences that we then carried forward in our reporting and engagement work.

164



informative responses provided via our information and signposting service

237



networks, events, workshops & action groups

attended by the team to advocate for changes in health and care, and capture user experience

28



bulletins and four magazines

circulated to local residents and professionals to inform the public of local services and system changes

8



published reports

sparking evidence based conversations with service providers and used to generate and inform wider discussions.

9

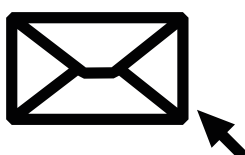


surveys published & nine promoted

inviting the community to contribute to improvements in local health and care services.

823

people



received up to date and trusted information

on local health and care issues by post or email **(308 posted, 515 via email)**

2

Publications

Our Mental health and dementia guides have been updated.

And a Christmas service list was published – helping professionals and the public to navigate local health and care systems.

Impact summary (continued)

And the team that makes it happen...

.....
six

staff members:

(From left): **Emily, Roger, Siân, Olivia, Rachael, and Helen.**



Feedback received on our Mental Health Guide:

“ An employee was struggling with knowing how to best support a family member / child and was desperate for help. Your guide provided answers when others couldn't, and helplines and contacts which could help, and in this instance, was life saving! ”



What matters to you

GP snapshot report

Every month Healthwatch York reviews what people tell us about their experiences. This information is gathered via our signposting, information and advice work and our online feedback centre.

We also work in partnership with other organisations to hear what all communities across York are saying.



Worryingly, but perhaps unsurprisingly, we can see from our data that York residents' experiences of accessing GP services matches the trends found by Healthwatch England, The British Medical Association and NHS England.

View the report:
www.hwy.link/GPsnapshot

GP snapshot report

What we did

In November 2021, we published a report highlighting your experiences of accessing GP services during the pandemic.

These experiences had been shared with us throughout 2021. The report captures real experiences from York residents. We also worked in partnership with York Carers Centre, York Mind and Community Voices York to capture further detailed experiences.

Findings:

- The use of telephone and online consultations has increased the number of appointments available.
- However, demand continues to outstrip supply.
- Although digital triage solutions are working well for some, they have increased the risk of deepening existing health inequalities.
- There is a need to publicise and encourage take up of evening and weekend appointments to improve access to health care for workers.
- There is a need for clear 2-way communication between GP surgeries and patients, allowing for expectations and understanding to be set.
- There is a need for carefully considered access for parents supporting children.
- There is still a need for face-to-face appointments, particularly for disabled people and those with complex health issues.
- Simple changes can be made to address health inequalities locally, which will lead to a healthier and happier community.

Lorna is deaf and has trouble booking a GP appointment:

“ I haven’t been able to contact my GP as they don’t allow emails or text messages, I cannot go into reception, and they don’t have an online facility to contact them. ”

York Carers summarises the experiences carers face. With support, carers are eventually able to access the care they need.

“ Generally there is a feeling of being overwhelmed at the thought of getting an appointment.

This is mainly around constant changes to systems causing confusion. Carers are being told to ring on the day; are not able to book ahead; no [consideration is made toward] work / caring roles; there’s a lack of available appointments.

Trying to obtain an appointment becomes such a task and can go on for days. ”

York Carers Centre



As a result

We've worked with Nimbus care to gain a better understanding of constraints within primary care and the issues GP surgeries are having to overcome, including issues with recruitment and burn out.

This has led to further work within our information and signposting service, around patient/practice relationships and expectation. Through understanding the systems at play, we're able to provide sensible and actionable recommendations that partners are happy to work with us on.

We've raised awareness around the practice/patient relationship and the need for improved communication. For example, following concerns around the closure of a local surgery, we contacted the surgery to gain an understanding of what was going on. The surgery was able to inform us that due to reception recruitment issues, the reception has been closed in the afternoons – but the surgery is still making phone and urgent face to face appointments. We were able to inform the community of this, and allay fears that the GP was reducing its services and reassure people that the surgery was offering services as usual.

We opened conversations with groups such as Age UK York who wanted to discuss their specific issues. Other networks have also reached out to us wanting to know how they can amend their systems to better meet the needs of those they serve.

The information has fed into further work around Accessible information conducted in partnership with Healthwatch North Yorkshire.

Listening to your experiences

Services can't make improvements without hearing your views. That's why over the last year we have made listening to feedback from all areas of the community a priority. This allows us to understand the full picture, and feed back to services to help them improve.

From these findings we recommended

- **Make patients more aware of options for call backs during evening and weekend and promote the Top Tips on how to get the most out of digital appointments.**
- **Provide clearer information regarding the provision of interpreter services.**
- **Review provision of interpreter services through contract monitoring.**
- **Develop better information for patients about options in accessing healthcare, including details of AHP roles in Primary Care and the benefits of accessing these.**
- **Urgently review access to online services for parents.**
- **Work together with those facing greatest difficulty in getting GP appointments to understand what could work better for them.**

Peer Research Cafe

A case study

In the Summer of 2021 we trained a small group of researchers in participatory action research methods. All the participants had lived experience of homelessness/addiction or mental health issues.

The researchers were all part of the York Multiple Complex Needs Network and Good Organisation.

The group organised a 'pop-up cafe' based at Carecent (a breakfast centre for all homeless, unemployed or otherwise socially excluded members of our community) and worked alongside attendees of the cafe to discuss issues in an informal but purposeful and safe way.

The research involved mapping, timelines of a day in the life, deeper analysis of homelessness, physical and mental health and access to services. The data from the research was analysed and themed through the autumn and used to present at key strategic meetings.

Astrid Hanlon at Good Organisation said:

“...watching Roger facilitate and as a result, learning some of the participatory research skills was invaluable. In the process a trusted space evolved, relationships were built and some interesting, valuable and unexpected data was generated. It was also fun, fun to do and fun to get to know people.”

“Creating a trusted space that we could do that in was a critical part of the process and we will continue to use the space to gather more data with the hope to feed into potential change; we are using the research data as a platform to discuss ways to develop strategies with high level decision makers.”

Miles Goring (Research Volunteer) said:

“A humbling yet inspiring piece of work which truly allowed the individual to emerge. We were not interested in the people as statistics, we got to know them as human beings.

“I felt no better, no worse but privileged that they gave their time to engage with us. Really enjoyed having fun with people. Trust and a feeling of ease to share some deeper experiences in a place that participants may not have previously felt safe to do so.”

The cafe is still meeting and gathering more data to help inform the York Poverty Truth Commission and feed into strategic thinking in a number of health and social care related networks across the city.

“A humbling yet inspiring piece of work which truly allowed the individual to emerge.”

What matters to you

Dentistry: Gaps in provision

Since Healthwatch York started in 2013, you have been raising your concerns about dentistry with us.

In 2018 we published 'Filled to Capacity: NHS Dentistry in York – a Report Based on Local People's Experience', our first dentistry report that found it was difficult to access NHS dental care in the city.

At that time 46% of people that responded to our survey reported that they couldn't find an NHS dentist that was taking patients and 45% of people who had been looking for an NHS dentist said they had been trying for over two years.

This appeared to be an issue across all demographics, regardless of age, ethnicity and gender.

Gaps in Provision, January 2022:
www.hwy.link/Dentistry



Dentistry: Gaps in provision

In July 2021 we published ‘NHS Dentistry – A Service in Decay?’ which exposed a continuing decline in access to NHS dentistry in the city.

Volunteers and staff at Healthwatch York contacted all 39 practices in the city. At the time of the research in May and June 2021 we found that no practice in York was currently accepting new NHS adult patients. We called for urgent and rapid reform of NHS dentistry.

What we did

In the Autumn of 2021 we launched an online survey for people in York about their experiences of accessing NHS dentistry in the city and complemented this with outreach sessions at a variety of locations including Carecent and Red Tower. We undertook focused conversations about dentistry from September to November 2021.

Some of what we found

- ➔ In our 2018 survey we asked, ‘do you have a dentist?’ 84% of those who answered this question said they had a dentist. This represents a decline over 3 years of 30%.
- ➔ Those respondents who did not have an NHS dentist were asked why this was so. In 2018 46% of people replied that they ‘couldn’t find a dentist taking on NHS patients’. In 2021 this had risen to 71%, an increase of 54%.

.....

“ I’ve tried 20 dentists, but got nowhere. Over the last 12 years my teeth have been falling out and it’s now difficult to eat properly. ”

“ I was in a lot of pain and couldn’t get to see a dentist last year, I tried and tried, but got nowhere, so I thought *## it!* I’ll pull it out”. I used salt water and it healed up eventually. ”**



When did you last see a dentist? (156 respondents)

There was a large increase in the percentage of respondents who had not seen their dentist for:

	2018	2021	% increase
Within the last 2 wks	13%	7%	
3 weeks to 1 month	14%	11%	
2 to 3 months	23%	10%	
4 to 6 months	25%	9%	
7 to 12 months	10%	10%	
1 to 2 years	5%	15%	200%
2 to 3 years	3%	22%	633%
Only in emergencies	3%	9%	200%
I don't	3%	6%	100%

From these findings we recommended:

- Rapid and radical reform of the way dentistry is commissioned and provided
- Reform commissioning to tackle the twin crises of access and affordability
- Improve the clarity of the information about NHS dentistry
- Use dental practices to support people's general health

As a result

We've shared your views and our findings with local decision makers; continuously raising this as a significant local issue.

This includes conversations with our local MP who brought our research to Parliament's Question Time.

We've developed a clear pathway for people to access the NHS dental treatment that is available; that includes identifying those who are accepting patients on waiting lists, helping people to understand when they should use 111 for emergency care, directing people towards the community dentistry who may be eligible.

Through our Information and Signposting service we've been able to help direct those in need of NHS dental care. This has resulted in children and adults understanding their eligibility for use of the community dentist which means they've been better able to manage their own oral health around other conditions.

We've also been able to give a picture of the long term impact to health and wellbeing when individuals are unable to access affordable care, making the issue much more personal. This has resulted in conversations with our local MP who is currently exploring initiatives to addressing the issue. We will continue to push for rapid and urgent reform within dentistry.

A Service in Decay, July 2021:
www.hwy.link/Decay

Working together as a Network

Healthwatch York is part of the Healthwatch Network. Healthwatch England looks at all Network data to highlight shared concerns. Here's what the wider network achieved through April 2021 to March 2022.

- With online appointments becoming the norm, our top tips helped professionals and patients get the most out of digital appointments.
- When people struggled to see their GP face-to-face, we asked the NHS to confirm this right for all patients, resulting in updated guidance to practices.
- We supported the **#BecauseWeAllCare** campaign which saw 54,000 people come forward to tell Healthwatch about issues they faced with services.
- To support the COVID-19 vaccination programme we talked to different communities to understand their hesitancy towards the vaccine and published guidance to improve trust.
- Healthwatch urged the Government to act after reporting a 452% increase in people struggling to see an NHS dentist.
- From running advice lines to delivering medication, Healthwatch volunteers helped combat COVID-19.
- Healthwatch quickly alerted regulators about care homes using 'Do not attempt to resuscitate' forms without consent.
- Teaming up with the British Red Cross, Healthwatch called for improvements to make leaving hospital safer during the pandemic.



Financial summary

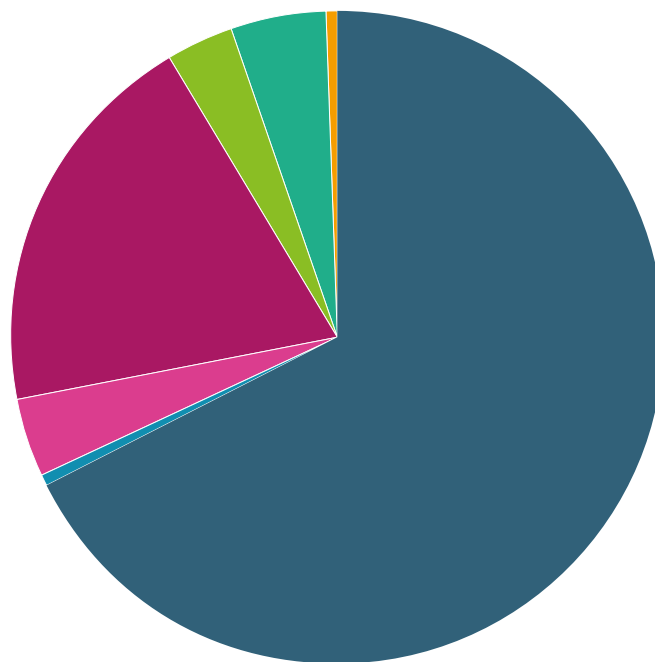
1st April 2021 to 31st March 2022

Income

City of York Council	£122,898
Other grants & contracts ①	£20,680
Total	£143,578

Expenditure

Staff salaries and expenses ②	£92,783
Meetings and events ③	£770
Marketing, printing, reports ④	£5,577
York CVS management fee ⑤	£26,611
Legal and professional fees ⑥	£4,310
Office running costs ⑦	£6,551
Unrecoverable VAT on Purchases	£671
Total expenditure	£137,273
Underspend for the year 2021/22	£6,305



Notes:

- Other Grants & Contracts made up of:-**
£10K NHS App income of which £9.3k is to be spent in 22/23; **£2k CYC Income for Mental Health Guide Publication**; **£1.2k Income for CQC Recruitment Board** which is ongoing; **£3.8k earned income from hosting the Census Support**; and **£3.7k from Lankelly Chase for CareCent**.
- Staff salaries and payroll support, expenses and training
- Costs of venue hire and associated costs for meetings and events
- Costs of producing publications, and promoting Healthwatch York
- Payment to York CVS covering accommodation costs, financial, IT, telephones and administration
- Cost of legal and professional fees, including Project Evaluation and HR, where needed to support Healthwatch York
- Computers, Website and online feedback centre, including accessibility software, office costs including freepost, equipment and stationery

There was no reimbursement of expenses incurred by volunteers during the year – no face to face volunteer activity undertaken during the pandemic.

Strategy

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Future priorities

Top priorities for 2022–23

1. **Improved access to mental health care, with a focus on crisis care**
2. **Improved access to primary care, with a focus on accessible information**
3. **Maintain pressure for rapid and urgent reform within dentistry**
4. **Patient voices are deeply embedded in local decision making**

Next steps

The pandemic has shone a stark light on the impact of existing inequalities when using health and care services, highlighting the importance of championing the voices of those who all too often go unheard.

Over the coming years, our goal is to help reduce these inequalities by making sure your voice is heard, and decision makers reduce the barriers you face, regardless of whether that's because of where you live, income or race.

The way we work

How we involve people, including volunteers, in our work.

Our Healthwatch board consists of voluntary and health care representatives. Their role is to provide direction, oversight, and scrutiny to our activities. Our Steering Group ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community.

Through 2020/21 the Steering Group met and made decisions on matters such as risk assessment and management, key partners we should be involving across our work, and volunteer recruitment. Each member has an area of expertise, offering an informed view.

Your feedback is vital to help shape our priorities every year.

1. **We draw information from the issues we log, our feedback centre, information from the networks and forums we attend, and our event and engagement work.**

We're also aware of local and national initiatives including Healthwatch England, City of York Council, and CCG/ICS interests. We come together as a team to discuss these. Trends/topics are noted and discussed in team meetings each month.

2. **We also keep note of, and regularly discuss, the local and national environment, agendas, initiatives, changes and priorities.**
3. **From this information we list all of the key topics.**

4. We then plot priorities by mapping the key topics against expectations from others and whether the topic had appeared on an agenda or was an opportunity to create a new one.
5. Considerations are made around organisational capacity, ensuring any new projects sit alongside and/or feed into existing activities.
6. We then score the top priorities against things such as: does it fit with our aim, do we have the skills to make an impact, do we have the resources, can we describe the long term/short term outcome.
7. With the information gathered, we explore what the wider issue is under the priority and, with consideration to organisational skills and capacity (as identified in step 6), identify an area of focus.
8. Set intended outcomes and, through theory of change, establish the activities necessary to achieve outcomes.
9. The priorities are publicised across our communication and engagement channels offering opportunity for comment.
10. Comments are discussed as a team and amendments made.
11. Activities and strategy are discussed with the steering group (Our board comprised of local VCSE representatives).

During 2020/21 we have been available by phone, by email, provided a webform on our

“ The pandemic shone a stark light on the impact of existing inequalities when using health and care services. ”

.....

website, provided a feedback centre/rate and review system, attended virtual meetings of community groups and forums, provided our own virtual activities and engaged with the public through social media.

We've also amended our approach to inviting a 'call to action' – you can see this in our approach to social media and bulletins.

We are committed to taking additional steps to ensure we obtain the views of people from diverse backgrounds who are often not heard by health and care decision makers. This year we have done this by, for example, assessing our demographic reach in our engagement and research. We're also in the consultation phase of our new EDI strategy. As a result of this, we've begun to hold hybrid meetings which has already received positive feedback with people appreciating that this can be easier for those in rural localtion and with unpredictable health conditions.

We've also developed a new website with accessibility features such as text size and colour and readability features. We will be asking representatives of different community groups to comment on the accessibility.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We publish it on our website, making use of the accessibility features. We also post this out to people and can have it printed in different formats.

Recommendations and requests

This year, due to the COVID-19 pandemic, we did not make use of our Enter and View powers. Consequently, no recommendations or other actions resulted from this area of activity.

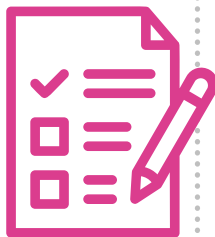
There were no issues or recommendations escalated by our Healthwatch to Healthwatch England Committee and so no resulting special reviews or investigations.

Our volunteers

We're lucky to have 23 outstanding volunteers, who dedicate their free time to improving local health and care services. Thanks to their knowledge and skills, we're able to spread our reach across York and improve the way we do things as a team.

Helped people have their say from home

carrying out surveys over the telephone and online.



Contributed to change to our internal systems and supported with administration

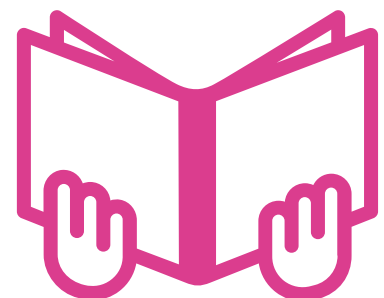
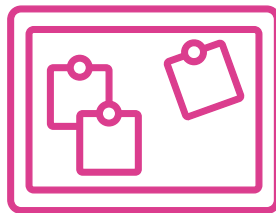


Created digital content on our website and social media.



We hold annual volunteer meetings and regular tea and chats with our volunteers

Monthly information bulletins for volunteers share what's happening in health and care locally and nationally.



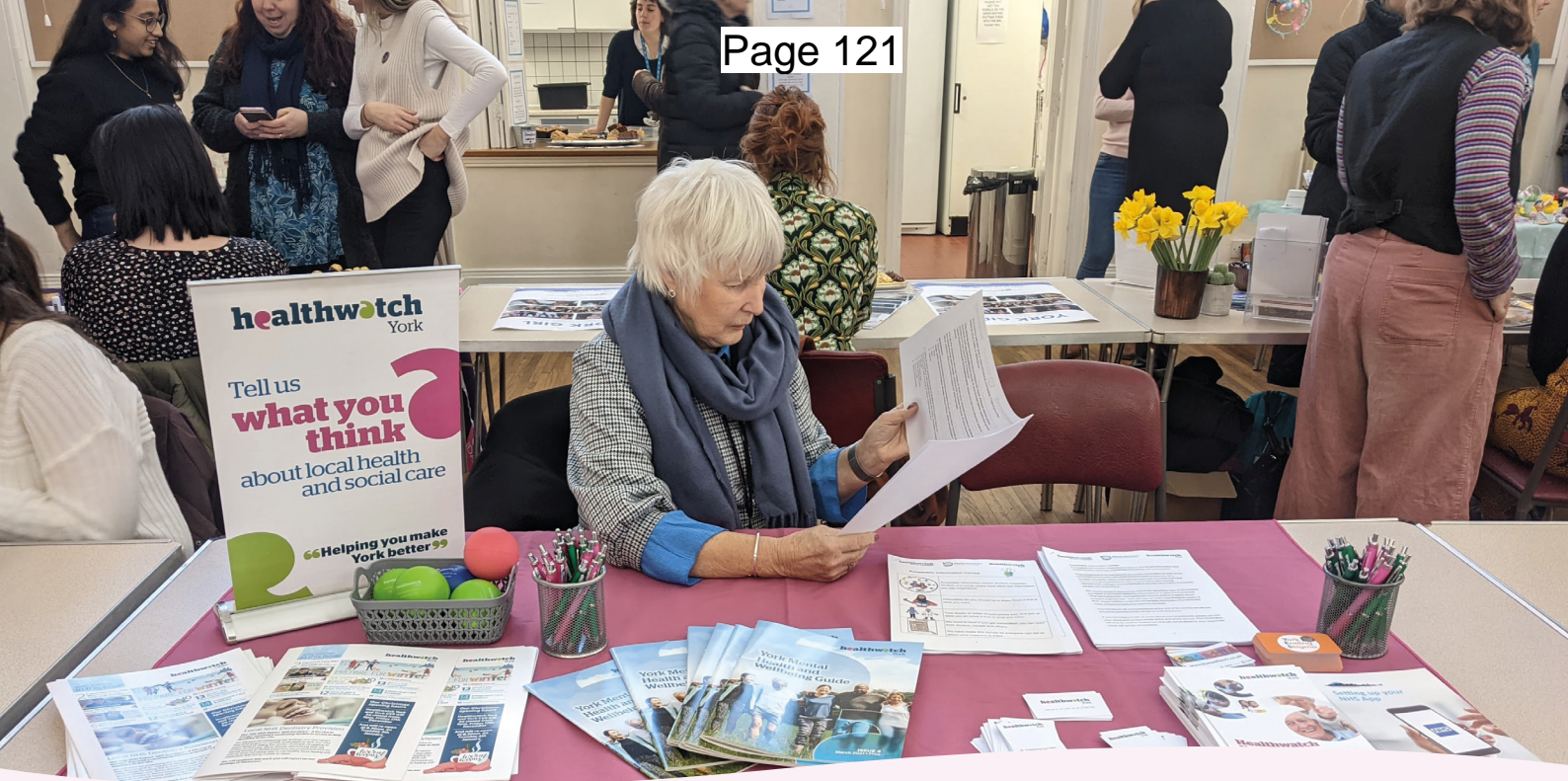
Assisted as part of 'Readers Panels'

Checking local services' publications to make them more people focused and easier to read. Provided a Readability Panel who review publications from services including York Hospital and City of York Council to help improve their accessibility.

Carried out website and telephone reviews for local services on the information they provide and assessing their accessibility.



Continue with the local volunteering efforts **supporting those who were self-isolating.**



“ Chatting with members of the public and giving them the opportunity to voice their experiences in using health & social care services and seeing changes made.

Lesley, Engagement Volunteer

“ I telephoned all York dental practices to enquire if there were slots for NHS patients.

I must say, I was disappointed to receive negative answers from all practices, including those that had NHS contracts when I worked as a dentist (some years ago now!).

I had no idea of the struggle to find an NHS dentist in York and felt sure there would be a couple of practices, at least, who would have been able to hold an NHS contract! ”

Research volunteer

Do you feel inspired?

We are always on the lookout for new volunteers, so please get in touch today.

01904 621133

healthwatch@yorkcvs.org.uk

www.healthwatchyork.co.uk



Information & signposting

A case study

We received a call from the sister of a mum of 3 children, one of whom had autism.

Her 6-year-old had a broken arm that wasn't healing well. They needed IV antibiotics three times a day for several weeks.

They were given two options; stay in hospital or come in twice a day for appointments at 6am and 11am with a district nurse visit in the afternoon for the third dose.

Mum did not have a car, does not live close to the hospital, and was concerned about how she could manage all the appointments and her other children. Her only childcare was her mother who was already doing as much as she could to support her daughter. She was also worried about how much sleep any of them would get with this arrangement.

Our team provided information from other hospitals about their IV antibiotics at home programs, including a training information pack from a Yorkshire and Humber children's hospital, and encouraged her to discuss whether this was an option with PALS (Patient Advice and Liaison Service).

We discussed the potential barriers to doing this, including how hard some parents find it to be injecting their child. She felt confident having read all the information that this was something she could do, and contacted the hospital.

They agreed, she received training, successfully began administering the drugs at home, and the family were able to spend Christmas together at home.

.....
“ We discussed the potential barriers to doing this, including how hard some parents find it to inject their child. ”
.....



Advice and information

We can provide confidential support and free information to help you understand your options and get the help you need.

Whether it's finding an NHS dentist, how to make a complaint or choosing a good care home for a loved one. We are committed to providing the information you need in whatever format you need.

.....
“ Talking to Healthwatch York was very helpful. It was a joy to realise I am not alone. ”
.....

Feedback received on our information and signposting service:

“ Thank you for your very honest and detailed reply - I really appreciate it and the realism of the response.

I have tried most of the dentists you mention, but will try the other two and maybe at least find out which has the shortest waiting list. If no luck there, I will make a complaint to NHS England.

Thank you and the rest of Healthwatch for also pushing politically to try and get this difficult situation sorted out. ”



Healthwatch York Representation

We use many methods to encourage people to share their views on health and care

This year the focus has been on dentistry, dementia, GP access, and care home staffing. Our work on these issues has led to wider media attention. It's not unusual for local TV, Radio, and Press to be calling us for comments and interviews. This helps more people hear about our work, encourages them to share their experiences. This further strengthens our push for change.

“Healthwatch York are a well-informed presence at system level; they are connected across the city and we value being able to connect with them.”

- Miles Goring and Astrid Hanlon, LIFE

2021–2022 Outcomes

As a team, we are active participants in over 45 Networks and forums. Here are some examples of how we use your voice to help shape health and care decision making.

Health and wellbeing board

“They bring to the table their expertise in asking the right questions in an intelligible way. Healthwatch York has a skill of asking deep questions and extracting the information needed from service users for strategy development.”

- Cllr Runciman, Chair of York Health and Wellbeing Board

York Safeguarding Adults board

Here we contribute to local Safeguarding decision making and strategy. We're keeping the local health and care services informed of service experience and sharing best practice to ensure safeguarding is personal to you.

**Your voice,
your words.**

Work with the CCG

“ When the CCG procured the adult autism and ADHD service, we relied heavily on Healthwatch York to reach people and to be a critical friend; for example, to ensure that we are accessible.

As a commissioner, I am reassured that there are opportunities for the voices of people who use services to be heard.

Ensuring that the Dementia Collaborative was able to continue was a real example of Healthwatch York’s influence, particularly their ability to facilitate contributions to the Dementia Strategy. ”

- Sheila Fletcher, CCG

Work with CYC

“ We are able to let people know that if they want to have input into the way services are developed, we can signpost them to Healthwatch.

As health services begin another large re-organisation, Healthwatch has an important role to play in helping to keep people like me in the loop, so I can understand the new structures and help people in the community to understand them too. ”

- Wendy Kent, York Explore

Our work with other Healthwatch

“ It has been an enjoyable and constructive experience building a positive working relationship with Healthwatch York. We are starting to see the impact of our collaboration, for example through our joint working on dentistry and accessible information. ”

- Ashley Green, Chief Executive, Healthwatch North Yorkshire

Listening to carers of people with dementia

In February 2022 we published ‘Dementia Support – Listening to carers of people living with dementia in York’.

Key issues in the report included; diagnosis, access to services/support after diagnosis, longer term support, how services work together, planning for the future, activities and socialising and being listened to. The full report will be available this summer.

The report has helped inform and shape the draft dementia strategy and action plan for York. The initiative is being led by the City of York Council and NHS Vale of York CCG.

The findings of the report were presented to York Health and Wellbeing Board on the 16th March:

www.hwy.link/YHWB_dementia

and shared with the multi agency dementia strategy working group to help inform their work. The council has confirmed they will hold responsibility of overseeing the dementia strategy and action plan going forward. In the absence of further funding and with the work of York Dementia Collaborative, we’ve been able to keep the conversations about the involvement of people with dementia alive in the city.

The publication of a second report focusing on the experiences of people living with dementia is planned for the summer of 2022.

How to get in touch

Pop in and see us at:

Healthwatch York
15 Priory Street
YO1 6ET

Send us a letter:

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

Visit our new more accessible website

which includes an E-reader and can translate information into different languages:
www.healthwatchyork.co.uk

Give us a call

01904 621133

Or **WhatsApp** us a voice note on:
07512342379

You can also email us:

healthwatch@yorkcvs.org.uk

Twitter: @healthwatchyork

Facebook: @healthwatch.york

Instagram: hw_york

Linkedin: Healthwatch York

If you need information provided in a different format – let us know, we're happy to help.

healthwatch
York



Health and Wellbeing Board

20th July 2022

Report of the Corporate Director of Adult Social Care, Jamaila Hussain
(Portfolio of the Executive Member, Councillor Carol Runciman)

Developing a 5yr Dementia Strategy for York

Summary

1. This paper aims to brief members on the work in progress towards the publication of a Dementia Strategy for York place this summer. Members are requested to consider the appended draft and approve the plan for its publication.

Recommendations

2. *The Health and Wellbeing Board are asked to consider:*

Approval of the draft Strategy

Reason: Having a York Dementia Strategy will clearly establish the common goals for health, social care, and community organisations in the City to deliver quality support to people with dementia and their carers. Once we have an agreed Strategy, we can progress with a delivery plan to achieve the goals outlined, and improve the experience for the thousands of people living with dementia in our City.

Background

1. The Health and Wellbeing Strategy 2017-2022 and the All Age Mental Health Strategy 2018-2023 both confirm our commitment to being a Dementia Friendly City, with the latter specifically stipulating the need to develop *a joint strategy for improving dementia diagnosis and support services*. This is aligned to the Council Plan's key priority of providing *good health and wellbeing* for our citizens. Ageing well and caring for people with dementia are both key priorities in The NHS Long Term Plan.

2. Work has been underway to develop a Dementia Strategy for the City of York and there has been significant engagement with people with lived experience, carers and families of people with dementia to understand the current environment and the ambition for Dementia support in the future.
3. Engagement exercises have identified areas of practice in which more immediate solutions have been warranted, and thus over this period significant work has been, and continues to be undertaken. A significant recent example is the development of a Dementia Hub as a collaboration between City of York Council, primary health (Nimbuscare), and Dementia Forward.
4. A draft York Dementia Strategy 2022-2027 is available at Annex A for consideration by the Board.
5. The Strategy follows the National Dementia Well pathway and focusses our local ambitions for dementia support over the next 5 years. Within each stage, the Strategy highlights the current challenges and opportunities, as well as an agreement between stakeholders of what we believe good to look like for dementia support in the City.
6. The proposed delivery timeline is as follows:



Consultation

1. Healthwatch York, with funding from the Joseph Rowntree Foundation, have worked alongside people with dementia, carers and organisations across York who support people living with dementia to plan, develop and deliver an engagement project between 2017-2021.
2. This project has hosted a series of engagement events and surveys to ascertain views about current services and people's experiences of living with dementia in the City.
3. Concurrently, a Dementia Strategy working group was initiated, with membership from City of York Council, primary and secondary care, the Clinical Commissioning Group, Healthwatch and VCSE organisations.

4. A strategy has been drafted by this group and updates have been received in recent months by the Health and Wellbeing Board (18 May 2022), the Ageing Well (26 April 2022) and Mental Health Partnerships (14 June 2022), The City of York Council's corporate management team and council members (through portfolio holder CMT and a special commissioned HASC policy and scrutiny committee, 5 July 2022).
5. A consultation event is planned for 11 July 2022 with people living with Dementia to hear their feedback on the current draft.

Implications

- **Financial:** The Strategy does not specify investment in Dementia Support but it is recognised that some ambitions will only be achievable through ongoing consideration of how each system partner can best contribute resources in this area.
- **Human Resources (HR):** As above, the strategy does not specify impact upon Human Resources but it is recognised that some ambitions may require stakeholders to think about how they best use their human resource to achieve the collective goal. Advice is being sought from CYC workforce development advisers due to the training implications.
- **Equalities:** An equalities impact assessment is being undertaken to ensure that the Strategy complies with the law, by taking account of equality, human rights and socioeconomic disadvantage implications in the decisions made.
- **Legal:** legal oversight of the final draft is being sought
- **Crime and Disorder:** There are no crime and disorder implications
- **Information Technology (IT):** The Dementia Strategy will need to be accessible and easy read. City of York Council communications team are engaged to support with this.
- **Property:** there are no property implications

Risk Management

7. There is potential reputational risk to delays in the publication of a Dementia Strategy, as there has been significant public commitment to this for a significant length of time.

Council Plan

8. The York Dementia Strategy is aligned to the Council Plan's key priority of providing *good health and wellbeing* for our citizens. It should also dovetail with the Dementia Strategy being developed by the Integrated Care Board. The intention is for the HNY Strategy to consider quality issues and associated costs across the wider footprint, but to also use the stages of the Dementia Well Pathway, to bring a commitment to consistency of support services.

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York Dementia Strategy

2022-2027



Foreword

York has been awaiting a Dementia Strategy for some time. This document fills a vital space, setting our aspirations as a city to be Dementia Friendly, with a clear focus on tackling inequality and making sure no-one is left behind following the disproportionate impact the Covid-19 pandemic has had on people with dementia and their carers (identified in the Alzheimer's Society [report](#), September 2020).

The newly formed York Health and Care Alliance recognises a need to improve outcomes in the city in the broad areas of prevention, mental ill-health, and frailty. They aspire to see York as *'the best city in which to grow old...where adults have the best chance to stay healthy, and older citizens can live independently'*.

In this strategy, we are pleased to introduce our vision for Dementia support in York, which seeks to improve outcomes for people with dementia and their families and carers. We know that people living with dementia face a variety of challenges and have a range of needs, everyone's journey is different. To achieve our vision, it is essential that organisations work together to transform the approach to dementia in York. The strategy provides the chance to reaffirm our joint commitment to do this, so that people can enjoy good health and wellbeing by achieving what matters to them.

The most important part of developing this strategy has been talking to people living with dementia. Our priorities have been shaped by the York Minds and Voices strategy, the former Dementia Action Alliance (now the York Dementia Collaborative), and through engagement research funded by the Joseph Rowntree Foundation. This research, led by Healthwatch York, has involved significant contribution from the following local organisations:

- Age UK
- the Alzheimer's Society
- Dementia Forward
- New Earswick Folk Hall
- Support groups for people with dementia and their carers, including Beetle Bank Farm, Clements' Hall, Deans Garden Centre Carers Group, and York Minds and Voices.
- Ways to Wellbeing Service (Social prescribers)
- York Teaching Hospital

We extend our thanks to all, and further gratitude to the Alzheimer's Society for their 2021 Local Dementia Profile report which has provided us with critical information about people living with dementia in the city; and much of their research is referenced throughout this Strategy.

Pivotal to making this Strategy work will be the delivery of its Action Plan. It is our aspiration that, on reading the action plan, those people who offered us vital feedback about our current services will hear their voice and will see our ambition to respond.



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Vale of York CCG

DRAFT

Contents

About the strategy

Our Vision

National Context

Local context

Demographics

Age Friendly, Dementia Friendly City

The Dementia Pathway in York

Preventing Well: The risk of dementia is minimised

Living Well: I can live normally in a safe and accepting community, with post diagnostic support available when I need it

Diagnosing Well: timely, accurate diagnosis, care plan and review within the first year

Supporting Well: Safe high-quality health & social care for people with dementia and carers

Dying Well: To die with dignity in the place of your choosing

About the Strategy

This is a Dementia Strategy for the City of York, and a priority of the [York Health and Wellbeing Board](#). Its intended audience is the citizens of York, people leading local health and social care organisations and the health and care workforce, and community, voluntary and social enterprise organisations – in short, everyone involved in the experience of both drawing on and offering support for people with dementia.

We recognise that the participation and contribution from people with dementia and their families and carers is vital in designing and improving dementia care and support. The York Dementia Collaborative has had a key role in ensuring that voices are heard and, through their knowledge and experience, they will continue to actively influence service development and provision, particularly highlighting gaps in services which lead to poor outcomes for people.

There are different levels of accountability for the Strategy's delivery, but it provides the framework within which local services can deliver improvements to dementia services, address health inequalities, and deliver a shared vision for what dementia support should look like.

The strategy has been developed through collaboration between City of York Council, the Dementia Collaborative, Healthwatch York, local community and voluntary providers, our local NHS Mental Health service provider (Tees Esk and Wear Valleys Trust), the Vale of York Clinical Commissioning Group, and York Teaching Hospital. Through face-to-face conversations, online surveys and focus groups with people who have experience of living with dementia in York, and with those staff and organisations who have learned experience of the opportunities and challenges this creates, we have been able to better understand how York can become a better place to live, with better quality services for people with dementia and their carers.

This strategy is a living document, which we hope will make a real and positive impact for people in the city. It is complemented by a detailed Delivery Plan, which considers the tasks required to reach our ambitions. As the Delivery Plan is a working document, it is available for anyone to see on request.

Our Vision

Our vision is to make sure that people with dementia, their families and carers, are supported to live life to their full potential. We want the people of York to be able to say:

- I can live a life of my own
- I live in a dementia friendly community
- I know who/where to turn to for information, advice and support
- I know I have access to a timely and accurate diagnosis, delivered in an appropriate way

- I have access to the right support that enables me to live well at home for as long as possible
- My voice is heard and makes a difference
- I know that when the time comes, I can die with dignity, in the place of my choice

National Context

An estimated 675,000 people in England have dementia, the majority of whom are over 65 and [have underlying health conditions](#). They are supported by a similar number of carers, many of whom are older people themselves. It is estimated that a quarter of people in acute hospitals and three quarters of the residents of care homes have dementia, yet 200,000 people with moderate and severe dementia do not get any kind of funded or professional support (Health and Social Care Committee's 7th report 2021-22). The number of people living with dementia in the UK is set to rise to [1.6 million by 2040](#).

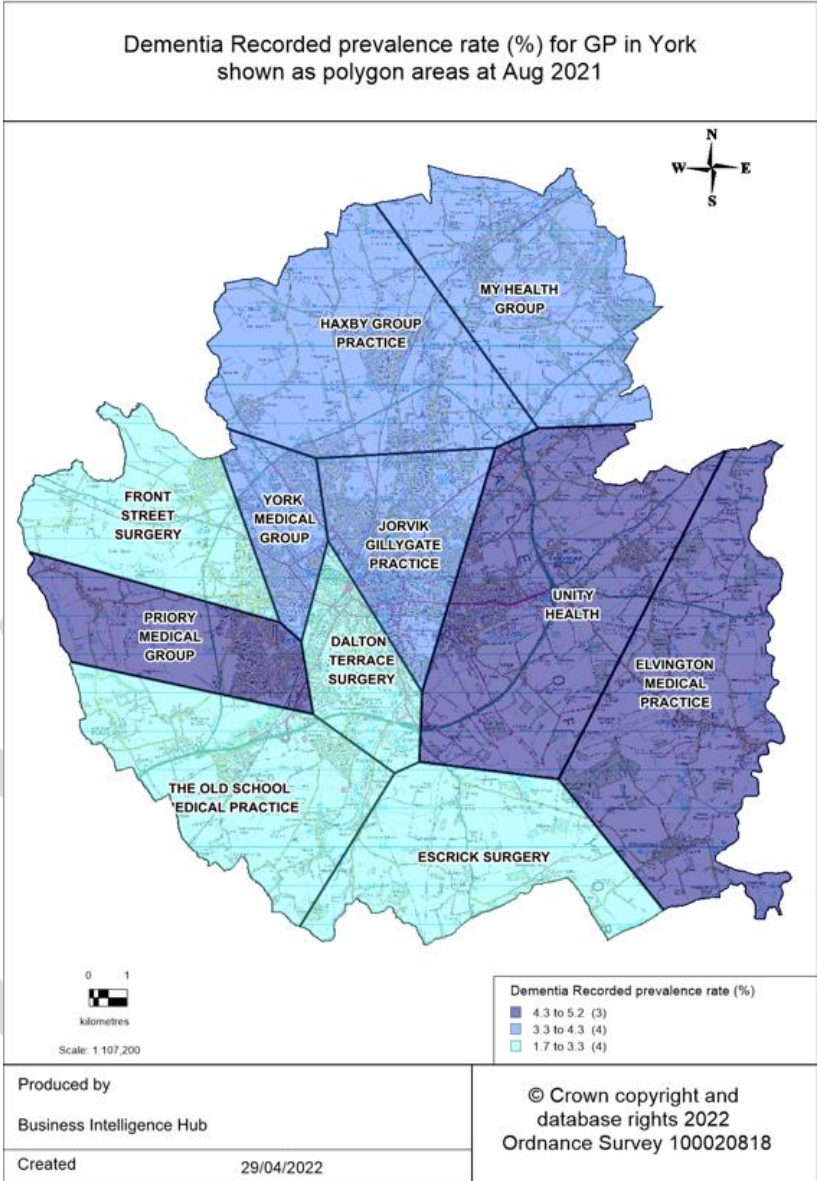
Dementia is not a natural part of growing old and, although dementia is more common in people over the age of 65, the condition can also be found in younger people. When a person develops dementia before the age of 65, this is known as 'young-onset dementia.'

As the number of people living with dementia, and the complexity of their situations steadily increase, the government and NHS England have pledged to make improvements to dementia care a key priority. The scale and the need to prevent, diagnose, support, live and die well with dementia will only become greater (Alzheimer's Society, 2021).

[The NHS Five Year Forward View](#) and the [Prime Minister's challenge on Dementia](#) 2020 set out a clear rationale for providing a consistent standard of support for people with dementia and their family and carers. The [Well Pathway for Dementia](#) has five elements based on the themes outlined in the Prime Minister's Challenge, which reflect the breadth of the experience of people with dementia, their families, and carers, from prevention to end-of-life care.

Ageing well and caring for people with dementia are both key priorities in [The NHS Long Term Plan](#). The Plan focuses on the need for people to be helped to stay well and to have control over their support, using tools such as personal health budgets and assistive technology. It also calls for a transformed workforce with a more varied and richer skill mix, integration between health and social care, and the expansion of service models such as Anticipatory Care (advanced care planning), Enhanced Health in Care Homes, and Urgent Community Response Teams. The aim of these initiatives is to ensure that everyone receives the right care, in the right place, at the right time.

Local Context





There are an estimated **2,812 people over 65 living with dementia** in York²

1 in 20 people over 60, & 1 in 5 people over 80 has a form of Dementia



Of those 2,812, only **1,554 people have received a diagnosis**
The dementia **diagnosis rate for York is 54.4%** - the average for England is 61.7%¹



It is estimated that **2/3 of people with dementia in York are living in the community**, whilst **1/3 are living in care** ²



Currently there are **15,006 people under the age of 65 living with dementia** in England⁷



The value of dementia support provided by **unpaid carers in York is £71.3m**³



3,860 people will be living with dementia in York by 2030³



By 2030, it is estimated that there will be **2,483 of people living with severe dementia** in York⁴



In York, **56.7% of carers** spend 100 hours or more per week providing care¹⁶



It is predicted that the cost of dementia care in York by 2030 **will be £171m**⁶



Currently, the annual cost of dementia care in York is **£108m**⁵



In York, **60% of carers reported feeling stress or anxiety**²¹



34.5% of all carers reported caring for someone living with dementia in York¹⁷

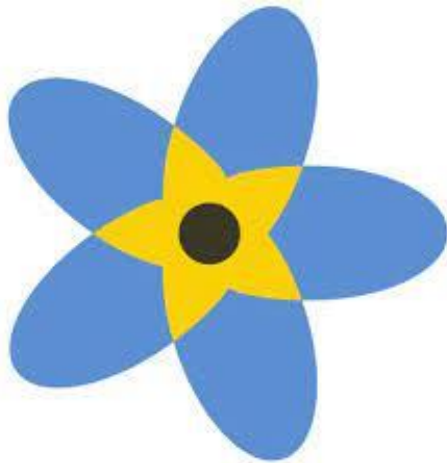
¹ NHS Digital Nov 2021

² NHS Digital November 2021

³ Alzheimer's Society York Profile 2021 (NB 'severe dementia' refers to the later stages where there is a growing impact on movement and physical capabilities)

Age Friendly, Dementia Friendly City

We recognise that it is important to support people living with dementia to live the life they choose and to feel included in the community. Through the dementia-friendly communities programme, organisations in York have agreed to try to make the city 'dementia friendly', making it a good place to live for people with dementia and their carers. York's Dementia Friendly Communities programme is working to improve four key areas in the City:



- **Improving our place:** Making York as easy as possible to move around and enjoy, with uncluttered and clear signage, and making public transport and facilities comfortable, easy to use and accessible. York already has many assets in terms of leisure, cultural and spiritual resources, which we can enable and encourage people with dementia to enjoy.
- **Improving our people:** With training for staff who provide key services in the wider community, such as in banks, libraries and shops, we can improve customer service and 'understanding of needs', and remove stigma.
- **Improving resources:** Using the 'dementia friendly' forget-me-not symbol to denote dementia-friendly services and venues (theatres, cinemas, cafes) we can support businesses to become dementia-friendly and recognise such credentials. We can consider the needs of people with dementia when developing all services, not just health and care services.
- **Improving networks:** By encouraging people with dementia and carers to network and share experience, and by creating a York Dementia Action Alliance, partners can commit to action within their own organisations and support this movement, building a sense of corporate responsibility across all sectors.

The Dementia Pathway in York

A dementia pathway will begin at the point that someone becomes aware of changes to their memory, or other symptoms associated with dementia, and will progress through diagnosis, post-diagnosis support, living well with dementia, and eventually end-of-life care (Alzheimer's Society, 2021). The national Dementia Pathway describes how support should 'wrap around' a person when they need it and is dependent upon how much they need at each point in time, sometimes close and intense, and sometimes more distant, but there if and when required.

In York, we recognise that we have work to do in each section of the pathway, and we have used the 5 recognised stages to illustrate our strategy to provide better support for those living with Dementia in the City.



Preventing Well

“The risk of people developing dementia is minimised”

Current Challenges & Opportunities

- York has a larger than national average gap between the expected prevalence of dementia within our population, and the actual number of people diagnosed. Primary care has a challenge to proactively seek and assess people who may be at risk, and identify the condition as early as possible to ensure the right people get the right support at the right time.
- Much of York’s health and social care support starts with a person’s strengths, and the city has a long history of building resilient communities, where it is understood that local people are best placed to understand and find solutions to their needs. This offers the opportunity to develop community networks to prevent, reduce and delay the need for formal support for people with Dementia.
- Recent survey results demonstrate that many older people in York experience loneliness, a distressing emotion which [research](#) links with dementia. Similarly, there is growing awareness that untreated depression can be a risk factor for dementia, and that treatment of depression in older adults is lower than treatment for those of working age.
- Works by the Alzheimer’s Society tells us that language barriers, cultural perceptions of dementia and a lack of culturally appropriate diagnosis and support services can all affect how people interact with and receive services.
- People with a [learning disability](#) are at greater risk of developing dementia as they age, with higher numbers developing young-onset dementia.

What ‘Good’ Would Look Like

- People live, work, and socialise in communities that promote health and wellbeing, and reduce social isolation.
- Campaigns, such as ‘What’s good for your heart is good for your head’, and campaigns targeted on the basis of local public health data, are visible in the city to reduce the risk factors which can contribute to a third of dementia cases.
- Information and advice are available through GP practices and tools such as the Healthwatch Guide and Live Well York, to enable people to make informed choices which could potentially prevent, delay, or reduce the impact of dementia on their lives. People are aware that dementia can present differently when there is a learning disability.
- Over 75% of the over 65 population (including those with a learning disability) have an NHS health check where dementia is discussed. The uptake is monitored quarterly, and the percentage of those where dementia is discussed reported to the Integrated Care Partnership.
- Community connectors, such as Social Prescribers, Local Area Coordinators and Adult Social Care Talking Points, plus third sector organisations, ensure sufficient reach across the City (including reaching into Dementia Hubs) to get the right information to the right people in a timely manner.
- Primary Care services identify symptoms of conditions (such as depression and frailty), which may contribute to dementia in older adults and treat them appropriately.
- We proactively address issues such as language barriers and cultural perceptions on dementia to positively impact how people interact with and receive services.

Key Actions & Priorities

- Develop the work of the Ageing Well partnership around York being a Dementia Friendly City.
- Ensure Public Health services have a forward plan for preventative campaigns which include regular reference to reducing the modifiable risk factors linked to dementia, including making tangible progress towards York being a carbon net zero city.
- Develop a dedicated space for information and advice about Dementia on Live Well York (an information and advice community website for all adults in the city).
- Work with Public Health services and our local GP's to develop what is included in, and how performance is measured on, the NHS health checks in the city.
- Ensure in-reach from community connectors to Dementia Hubs to promote the support that people can access within their own communities, and according to their unique experiences.
- Develop assurance around diagnosis and treatment of depression in older adults in the city



Diagnosing Well

Timely accurate diagnosis, support plan and review within the first year

Current Challenges & Opportunities

- Our diagnosis rate (54.4%) is below the national average (61.7%) and the national target (66%). This means that there are significant numbers of people living in York with undiagnosed dementia.
- The fear of stigma can prevent a person from accessing a diagnosis, and we need to provide good information about dementia and the benefits of diagnosis
- We have a challenge to ensure we are taking all opportunities to diagnose young-onset (under the age of 65) dementia. People often face different challenges (e.g., continuing to work, having a young family), and there is often a long

What 'Good' Would Look Like

- Organisations involved generally in care and support, are skilled in identifying the symptoms of dementia, and know what steps to take to support people to receive a diagnosis. Likewise, they are aware of the impact of common physical health problems on cognition.
- The dementia work stream of the Humber and North Yorkshire Integrated Care System, will support and monitor targeted work in primary care where diagnosis rates remain low, with a target for diagnosis rates to be above 67% by the end of this Strategy's lifecycle.
- People working within dementia care promote inclusive practice at all times, and consider how they provide accessible information in appropriate formats.
- There are embedded processes for monitoring and reporting the average length of time people are awaiting diagnosis. The benchmark will initially be against pre-pandemic timescales, and the target will be a maximum of 6 weeks. This includes people under the age of 65, people with learning disabilities, people from BAME and minority groups, and people with alcohol-related dementia.
- People know what to expect of the diagnostic process, and diagnoses are delivered in a compassionate way, using positive hopeful language (which signals the beginning and not the end of a process). Diagnosis

wait for diagnosis as other conditions are explored. Follow-up is critical and the support designed for older people is often not suitable, meaning people with young-onset dementia can find themselves isolated within their community.

- People face unique challenges in seeking a dementia diagnosis (perhaps due to issues such as age, gender, race, culture and religion, sexual identity, caring roles and socioeconomic status), which need to be understood.
- We need to ensure that the diagnosis pathway is seamless and that we minimise bottlenecks to access the Memory Service and neurology.
- We have an opportunity to continue work already started to reduce delays in referral from GP's to the memory clinic, by making the process easier for GP's without compromising the quality of referrals.
- We must develop a post-diagnostic pathway of support, as consultation with citizens has told us that many people have felt unsupported after diagnosis, and feedback would suggest that there is inconsistency across the city.

is also timely, affording people the best opportunity to ensure their wishes are considered in the development of their support plan and more chance to take part in research if they wish to do so.

- We build upon the current diagnosis pilot with people 90+ and people considered vulnerable, and extend this to consider diagnosis for 'harder to reach' communities, such as those who can't leave their homes, those with other ill health complications, and those with delirium. We offer support to people discharged from hospital with delirium, to monitor their cognition and prevent deterioration.
- We have adapted referrals pathways between hospitals and importantly the A&E department, to make it easier to refer directly from these settings into Memory Assessment Services.
- There is integrated working between neurology, neuroradiology and psychiatry in assessment of young-onset dementia and Parkinson's disease Dementia (as per the NICE guidance). We are exploring the use of a Picture Archiving and Communication System within the Memory Assessment Service.
- People diagnosed with dementia and their family or friend carers have easy access to information on planning and making choices about their care at the end-of-life. Information and advice are easily accessible throughout the person's journey and as their needs change. This includes access to support and advice around medications routinely used following a new diagnosis of dementia, including written information to allow people to make informed decisions about treatment options.
- With support from the ICS, we explore and implement technological solutions to ensure that people with dementia have a single digital health and care record that is accessible to them and to all health and care professionals involved in their care. This includes access to advance care plans.
- Referrals made to the Memory Service are streamlined and efficient, with all involved understanding what is required to reduce the delay from referral to assessment as much as possible.
- Our Memory Service:
 - Accepts referrals from sources other than primary care, especially in urgent or crisis situations.
 - Builds on existing work to explore alternative diagnostic pathways, for example, using other professionals and tools such as DiADeM (Diagnosing Advanced Dementia Mandate), and proactive in-reach to care homes
 - Has clear pathways to enable effective and consistent access to psychiatrists, psychologists, occupational therapists, social workers and dementia advisers, as well as linguists and interpreters, during the diagnostic process.
 - Provides a choice of appointments such as telephone, video conference or face-to-face appointments where appropriate
 - Has a diagnostic pathway for young-onset dementia and GP's are responsive to symptoms
 - Has a post-diagnostic dementia adviser service, with automatic referral to the service unless people opt out.
 - When people have been prescribed medications, they have access to a named memory nurse within the service for advice, support and changes to their dose.

- People with dementia and their carers are able to influence the design of pre and post-diagnostic support through their involvement in the implementation of this strategy.

Key Actions & Priorities

- Deliver training to the health and social care workforce to ensure skills in identifying the symptoms of dementia, knowledge of the impact of common physical health problems on acute cognition, and knowledge of the steps required to take to assist someone to receive a diagnosis.
- Develop a programme of targeted support for GP practices to increase the rate of diagnosis, supported by Dementia Coordinators.
- Develop monitoring and reporting processes to track the time people have to wait between referral and diagnosis
- Set clear expectations around how and when diagnoses are delivered and what people can expect in terms of support and advanced care planning at this stage
- Raise awareness and increase the use of the DiADeM tool (the Diagnosis of Advanced Dementia) to support GP's in diagnosing advanced dementia.
- Work with the ICS to develop and implement technological solutions for shared care records
- Improve the integration of dementia advice and community support within GP practices.



Supporting Well

"Access to safe high-quality health and social care for people with dementia and carers"

Current Challenges & Opportunities

- People need comprehensive support that encompasses medical, emotional and social wellbeing. Yet [nationally](#) these needs are not being met in a consistent and timely way.
- When support needs go unmet, crises – such as hospitalisation, carer breakdown and health deterioration – become more common.
- Apart from annual dementia reviews, there are no other performance metrics in England that look at the effectiveness of the care and support offered after diagnosis

What 'Good' Would Look Like

- People of York are able to make informed choices about the support they need, using readily available information, advice, and guidance, which is accessible in different formats and covers issues such as financial support, carers' rights, and local support options. Community connectors such as the Council's Talking Points, Local Area Coordinators, Social Prescribing and third sector organisations, are available to offer this in person.
- People with dementia are involved in planning their support, and different approaches are used to ensure their maximum contribution.
- Dementia support workers are available in each primary care network, as part of an overall, integrated 'stepped' model of care where people can easily access more specialist intervention within the community as their needs become more complex

- Diagnosis without sufficient post-diagnostic support leaves people living with a complex and potentially devastating condition with limited understanding, capability or tools to cope with or manage its symptoms
- The complexity of dementia requires a multidisciplinary approach to support, including both health and care providers, which is frequently lacking in primary care.
- People with dementia experience worse outcomes when admitted to hospital than those without the condition.
- Three in five (59.5%) of people affected by dementia in Yorkshire and Humber did not feel they had received enough support in the last 12 months³.
- 35.6% of people affected by dementia in Yorkshire and Humber did not feel confident managing their or their loved one's condition
- One in five (20.5%) were unsure when they last had an annual review of their dementia care³. Over half (52%) of those who did have an annual review said it did not help them manage their condition
- Engagement research in York found many stories of services working well together, but some reported not receiving any support at all, and others gave examples of inflexible and impersonalised support.
- York's care and support market is facing unprecedented workforce challenges, both in terms of recruiting and retaining staff. This impacts both upon the available skills to deliver good quality dementia care and upon the number of spaces within care homes registered to support people with dementia.
- High land value in the city presents a further challenge which prohibits investment from larger specialist dementia services.
- There are challenges in discharging people with dementia safely from hospital because of issues such as finding the right level of support for people with complex needs, or

- Support stopped due to coronavirus precautions has been safely reinstated without the need for unnecessary further assessment, and the support required to aid recovery from the adverse effects of Covid-19 is considered. Annual reviews return to pre-pandemic levels of 75%.
- Annual reviews conducted in primary care take account of the NHSE Good Care Planning resource and are holistic, taking into account other health conditions, and involving other professionals where appropriate to consider needs beyond medical care.
- Work is underway towards a single digital health and care record, to help reduce the need for people to tell their story multiple times, and to increase their control over their situation. This work includes efforts to mediate the risks of digital exclusion. Health and social care records ensure that a system is in place to identify those with dementia who are most vulnerable and at risk of crisis, who can then be offered more frequent care plan reviews if needed.
- Everyone who has received a dementia diagnosis, and their informal carers where present, have immediate short-term support to help come to terms with their diagnosis and plan for the future.
- We have a dementia support worker for every primary care network.
- People with dementia who live alone are supported where needed and receive appropriate information and support to ensure they can maintain social networks, activities and live safely in their own home. Assistive technology is proactively considered.
- People are automatically referred to a dementia adviser in either the Memory Service or primary care (with the ability to opt out); and everyone with a dementia diagnosis has a named health or social care professional within one of these services, to support them to coordinate their care from the point of diagnosis to the end-of-life.
- Evidence-based, post-diagnostic support interventions are provided for people with dementia and carers/family members where present, including support to maintain inclusion, occupation and identity, and social relationships; and tools such as personal health budgets and assistive technology to increase choice and control. Where anti-psychotic medication is appropriate, its use is closely monitored to ensure safe and high quality practice.
- Support is provided in a strength based way to the person and not their 'dementia', and is delivered in a way which is considerate of their individuality. Decisions made about diagnosis, care or treatment are made collaboratively with the person and where there is a carer/family member, they will be included.
- Where a person with dementia has a carer, there is appropriate support available to enable that carer to have breaks from this role if needed, both on an emergency and planned basis

knowing whether their support is primarily to be provided by health or social care.

- There are gaps in provision for people with young-onset dementia. Carers of people with young-onset dementia report a lack of age-appropriate activities and support, and the need for support to be flexible to accommodate employment.
- There are gaps in provision for people with alcohol-related dementia.
- York's rate of emergency hospital admissions for people with dementia is lower than the national average (3375 per 100,000), but people with dementia are staying in hospital twice as long as other older people.
- There is a challenge in finding crisis support around the clock.
- There is a challenge to ensure that all health and social care staff who may support someone with dementia, have the appropriate level of training,

- The risk of a crisis is prevented wherever possible and where a crisis occurs there is a comprehensive joined-up offer of support. This means that where admission to hospital, inpatient facilities or residential care cannot be avoided by a community response, the person receives compassionate and skilled support in dementia and carer friendly environments, and is discharged without unnecessary delay (utilising the Mental Health Liaison team and specialist nurses in primary and secondary care).
- Opportunities have been taken from the creation of the Integrated Care Board to simplify the funding arrangements for support for people with severe dementia.
- People who live in care homes receive appropriate assessment, diagnosis, and subsequent care planning, as clinical leads are able to identify the needs of their population and the right pathways for support. The Care Homes and Dementia Team are able to provide clinical input and quick access to advice and support for care home staff, which will enhance health, enabling residents to thrive and to avoid unnecessary hospital admissions.
- We have a diverse workforce (including peer supporters and newer roles to the dementia field), with a broad skill set. Every health and social care professional directly supporting people with dementia should be trained to at least Tier 2 of the NHS-backed Dementia Training Standards Framework, and we learn from people with dementia themselves, actively drawing on their expertise to improve the training offered. We utilise our community assets for their support.
- The Council has a Market Position Statement which promotes collaborative approaches to delivery of services, and all commissioned support is required to use a dementia-specific approach to care delivery, that promotes equal rights and access.
- We have the appropriate system-wide data to inform planning and commissioning of high-quality dementia support services, including regular engagement and ongoing conversation with people with dementia. We promote active engagement in research by people with both lived and learned experience of dementia to build an evidence base for practice (e.g. Dementia Enquirers).

Key Actions & Priorities

- Ensure that information, advice and guidance is readily available, accessible and provided in different formats, including in person. Explore the idea of Dementia Hubs, which provide a physical space for people with dementia and their carers to visit to access information, advice and support.
- Audit health and care records to establish where support may have been suspended due to the coronavirus and seek assurance that work is underway to remedy this.
- Monitor and contribute to work underway to develop a local shared care record.
- Work to develop a clear pathway of support following diagnosis, both in the short term and throughout the person's lifespan

- Work to develop evidence-based, person-centred interventions and support for people with dementia and their carers
- Implement an automatic referral to Dementia Support workers, at the point of diagnosis (with the option to decline)
- Work to improve the way systems supports people through crises, to ensure choice and control and minimise the negative consequence of intervention.
- Develop the work of the Care Homes and Dementia Team and the skills of clinical leads within care homes to ensure appropriate diagnosis, assessment, support planning and review for care home residents.
- Work to embed the Dementia Standards Training Framework across dementia support providers in the city, and ensure that there are contractual obligations to deliver a dementia-specific approach
- Work to develop a minimum data set which allows us to monitor progress in how we support people with dementia and their carers, and to consider gaps in knowledge or provision which warrant research.
- Learn from good local hospital discharge practice, to increase the number of people who have a safe discharge from hospital at the right time, to the right place, with the right level of support.



Living Well

“People with dementia can live normally in safe and accepting communities”

Current Challenges & Opportunities

- The Alzheimer’s Society’s 2021 survey found that 13.9% of carers in York reported feeling socially isolated. Loneliness associated with social isolation can increase the risk of dementia.
- York citizens have reported a need for improved way-finding and signage in some public buildings

What ‘Good’ Would Look Like

- People are enabled to live at home through dementia friendly communities and tailored home support. Dementia awareness is improved through dementia friends training, media communications and social networking. Assistive technology is used wherever helpful.
 - We identify people living with dementia from marginalised groups and ensure they have equal opportunity to inform best practice dementia care in the city.
- Community spaces and building-based support is accessible and dementia-friendly, and local universal services (e.g. opticians, hGP/airdressers) have the opportunity to build their skills to be dementia friendly.
- People affected by dementia and their carers (where present) feel accepted, supported and understood in their communities. They can maintain and develop their relationships and are able to contribute to their community.

- There is a challenge to address the stigma associated with dementia and reduce the fear of diagnosis and social exclusion
- People living with dementia from marginalised groups can be further oppressed without clear understanding of their unique experience and challenges.
- There can be a challenge to support people at home with dementia as their condition progresses, but equally, a challenge for a person to leave their home and their familiar environment. Both can impact upon familial relations.

- There are mechanisms for an open and ongoing conversation between people with dementia and service providers so we are constantly striving for better conditions in which people with dementia can live a good life.
- York's employers support and value people living with dementia and their carers, and people are able to make meaningful contribution.
- York has an Inclusive Transport Strategy, which recognises that not all disabilities (including dementia), are visible.
- The Disabled Facilities Grant (DFG) is used to support those who are eligible, to adapt their homes to make them safe and suitable for their individual needs. There are suitable housing options for people who need to move to somewhere with support but who do not necessarily require a 'care home'.
- We positively influence how people perceive living with dementia through active campaigns and intergenerational projects. Discrimination and disabling language, attitudes and environments are challenged.
- We support established peer support groups and similar initiatives to help build resilience, ensure the availability of support which accounts for people's individuality (e.g., Nursing with Pride, Free to Be Me in Care), protects human rights, and develop social action solutions.
- There are ongoing opportunities for people with dementia and carers to access support interventions, information and education following diagnosis, to help them to live for longer in the way that is important to them. This includes age-appropriate activities &/or support to access mainstream activities for people with young-onset dementia.
- Our Carers' Strategy includes a specific focus on carers of people with dementia (including those with young-onset), detailing the support available to them, including access to evidence based interventions, psychological support, practical training, bereavement support and vital breaks where needed.
- Unpaid carers are routinely offered a flexible assessment of their own needs (virtual or face-to-face) and are treated as partners in the care of the person living with dementia.

Key Actions & Priorities

- Contribute to the work of the Ageing Well Partnership, meeting an objective of the City of York Council's Plan to promote dementia friendly services and buildings.
- Improve the use of equality data to ensure targeted work is undertaken where required, to reduce health and social care inequalities for people living with dementia and their families.
- Contribute to York's Inclusive Transport Strategy to ensure that the issue of non-visible disabilities is acknowledged and addressed.
- Information, guidance and advice are developed to address the different stages of the Dementia Well Pathway.
- Consideration is given to the spaces, places and people who can encourage open and ongoing conversations about creating the sort of city in which people with dementia and their carers can live good lives.
- Contribute to campaigns and intergenerational projects being developed through the Ageing Well Partnership.

- Ensure symbiosis between the Dementia Strategy Delivery Plan and the Carers' Strategy Delivery Plan to ensure that the right opportunities and support are available for carers of people with dementia.



Dying Well

"People with dementia die with dignity in the place of their choosing"

Current Challenges & Opportunities

- We need more understanding of the barriers to people receiving appropriate end-of-life care that considers them as the individual beyond their diagnosis, and to planning care and support in advance. This is a global need, but we need to ensure that we consider adults who live alone, and the needs of people who are caring for a friend or family member with dementia, but who also have dementia themselves.
- A lack of common discussion of matters around death and dying among the public means that the wishes of people with dementia, even on basic matters, are often unknown as they reach the end of their life. People with dementia in York have told us that they want to know where to go to for support when dementia progresses and they would like more time with involved professionals to plan for the end of their lives.
- There can be a challenge for clinicians to support people with dementia who are in pain or discomfort at the end of their life, due to the difficulties with communication. There can also be challenges in supporting those with other health conditions, and to make decisions about when to withhold or withdraw treatment.
- It is recognised nationally that there can be difficulties identifying that a person with dementia is approaching the end of their life. This can be because symptoms are complicated by other health conditions, and/or changes to how a person communicates. It's important to educate all involved in supporting the person at the end of their life, to avoid missing important moments in the last days.

What 'Good' Would Look Like

- We work in partnership with people with lived and learned experience to break down barriers to good quality health and social care at the end-of-life.
- Everyone has the chance to have the right support and setting at the end-of-life, and to be as comfortable as possible. There is support for people to die with dignity in a place of their choice, and all efforts are made to avoid unnecessary obstructions to this.
- People with dementia have choice and control, and are included in decisions relating to their end-of-life care. Where the person themselves lacks the mental capacity to make decisions, family and carers will be provided with the relevant information and tools to support best interests decisions.
- All people living with dementia and their carers have the opportunity to discuss advance care plans at each stage of their pathway.
- We have appropriate information, advice and guidance to enable people to make early and informed decisions around planning for the future and end-of-life care. We also have information which supports families, friends and carers to identify signs of a changing condition, where to go and what to do.
- Advance care planning training is offered to any professional working within the field of dementia care and we have effective tools, including improved nonverbal communication strategies and use of people's life stories, to ensure person-centred support.
- All directly delivered or commissioned services meet agreed and recognised standards for end-of-life care. Work has been done to assess the use of the Gold Standards Framework, One Chance to Get It Right, and Priorities of Care

- We know that in the advanced stages of dementia there is often a hidden cost to those who provide support, as their caring role can increase, they can feel more isolated, and they can feel extra pressure if involved in making significant decisions on a person's behalf. We want carers to feel valued and supported, and able to get support when needed.
- Nationally there is some research to suggest concern about the number of professionals who visit a person when dying at home.
- It is recognised that dementia is a terminal condition (in 2020, it was the leading cause of death in England and Wales after COVID-19) but work needs to be done to better understand the standardised rate of mortality for people living with dementia in York. It is currently lower than the national average (794.2 as opposed to 849.3) for people over 65.

for the Dying Person as national frameworks which could ensure best practice locally.

- We have an agreed best practice protocol for assessing pain, which can be utilised widely to assess the impact of pain and discomfort in people who have difficulty vocalising their needs.
- Families and carers are provided with timely coordinated support before death, at the time of death, and during bereavement.
- There are opportunities for people with dementia, their families, and staff from key stakeholders, to share knowledge and experience to inform best practice, and consider research opportunities to improve this.
- We have ongoing audit and monitoring of services to identify gaps in service delivery in order to ensure that capacity of specialist palliative care provision meets demand in all settings.

Key Actions & Priorities

- Alongside people with lived experience of dementia, undertake research to identify the barriers to people receiving appropriate end-of-life care and support, and work to address these
- Develop information and guidance to support people with dementia and their carers to make decisions about the support they want at the end of their life
- Alongside people with lived experience, identify and deliver appropriate workforce development around advanced care planning and end-of-life care
- Ensure we have the appropriate support in place for families and carers when their loved one is diagnosed as being at the end-of-life.
- Audit and monitor the availability of palliative care in community, health and care home settings, and set out a framework of monitoring and review to ensure sufficiency.

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York Dementia Strategy Delivery Plan

2022-2027



Our Vision

Our vision is to make sure that people with dementia, their families and carers, are supported to live life say:

- I live in a dementia friendly community
- I know who/where to turn to for information, advice and support
- I can live a life of my own
- I have access to the right support that enables me to live well at home for as long as possible
- My voice is heard and makes a difference
- I know that when the time comes, I can die with dignity, in the place of my choice



to their full potential. We want the people of York to be able to

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
Campaigns	Ensure Public Health have a forward plan for sensitive campaigns which include regular reference to reducing the modifiable risk factors linked to dementia and address issues such as gender representation and comorbid issues such as frailty, depression and loneliness. Also to making tangible progress towards York being a carbon net zero city.		
	Ensure reach into existing campaigns (such as the changing habits programme at York Drug and Alcohol service) to connect to cognitive decline		
	Contribute to the work of the Ageing Well partnership around York being a Dementia Friendly City.		
	Consider visibility of campaigns in post-pandemic environment (e.g., when physical GP attendance is a lot lower). Consider the		
	Increase engagement with people from ethnic minorities who may be experiencing cognitive decline		
Info and Advice	Develop a dedicated space for information and advice about Dementia on Live Well York (an information and advice community website for all adults in the City).		
	Ensure we have the right advice for each stage of the Dementia Pathway, in accessible formats		
	Promote the Healthwatch directory so its more readily available		
Primary Care interventions	Work with public health and our local GPs (e.g., through Nimbus Care) to develop what is included in, and how performance is measured on the NHS health checks in the City. Work with GPs to ensure that health checks for people with LD are on track to		
	Review the number of face to face appointments being offered where there is cognitive decline and how successful virtual appointments are		
	Develop assurance around diagnosis and treatment of associated conditions such as depression and frailty in older adults in the City		
	Make every contact count- capture the voices of those seldom heard, and ensure that holistic needs are considered within appointments		
Hubs	Ensure in-reach from community connectors to Dementia Hubs, to promote the support that people can access within their own communities either instead of or in addition to formal 'care'.		
	Ensure the availability of social befriending and/or social activities that address loneliness across the different communities in the city		



Measure Impact	Monitor the impact of prevention activity in the City, as it specifically relates to people with Dementia (e.g., can we monitor the impact of focussed interventions to tackle loneliness on a person's cognitive decline? Do health champions/move mates etc., manage to reduce risks associated with dementia?)		
	Increase our awareness around the needs of local people from marginalised groups		

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
Workforce development	Deliver universal training to the health and social care workforce to ensure skills in identifying the symptoms of dementia, knowledge of the impact of common physical health problems on acute		
Primary Care Interventions	Develop a programme of targeted support for GP practices to increase the rate of diagnosis, supported by Dementia Coordinators.		
	Improve the integration of dementia advice and community support within GP practices		
Measuring Impact	Develop monitoring and reporting processes to track the time people are having to wait between referral and diagnosis		
Improving the Diagnosis Pathway	Set clear expectations around how and when diagnoses are delivered and what people can expect in terms of support and advanced care planning at this stage		
	Raise awareness and increase the use of the DiADeM tool (the Diagnosis of Advanced Dementia) to support GPs in diagnosing dementia for people living with advanced dementia.		
	Work with the ICS to develop and implement technological solutions for shared care records to support an easier diagnosis pathway		
	Consider our local approach to diagnosis where there are complications around delirium		
	Improve the memory service referral pathway to: * address current bottlenecks resulting in long wait; * include direct referrals from acute services and minimise unnecessary waits between stages; * Explore alternative pathways to diagnosis from community and specialist settings * Improve communication for patients and their families while waiting for assessment to provide a better experience both practically and emotionally of the diagnosis process. * Explore the reasons for high DNA rates and options for supporting people while on waiting lists to minimise this.		



Diagnosing Well

Timely accurate diagnosis, care plan and review within first year

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
Information and Advice	Ensure that information, advice and guidance is readily available, accessible and provided in different formats, including in person. Explore the idea of Dementia Hubs, which provide a physical space for people with dementia and their carers to visit to access information, advice and support.		
	Educational videos, needs to be developed to support people who struggle with English language literacy		
Improving the Pathway	Monitor and contribute to work underway to develop a local shared care record.		
	Work to develop a clear pathway of support following diagnosis, both in the short term and throughout the person's lifespan		
	Work to ensure meaningful annual reviews which consider the holistic support needs of the person and, where applicable, their carer		
	work to address inequities in follow up support for people with non-Alzheimer's disease dementia types		
	Work to embed annual reviews which are meaningful, and pilot a person-centred approach to this (? At Acomb Garth)		
Evidence based support interventions	Work to develop evidence based, person centred interventions and support (particularly daytime activities and company) for people with dementia and their carers		
	Work alongside people with dementia to look at best practice examples from across the country (e.g., the Bristol Dementia Wellbeing Service, the Islington Memory Navigation Service, the Debenham project, the TRIO befriending project) and think about how we can mirror such developments here.		
	Work to ensure appropriate and regular medication reviews for people with dementia and continuity of GP access where possible (known benefits of safer prescribing, reduced risk of delirium and incontinence, fewer hospitalisations and lower mortality) or of dementia support workers		
	Explore the need for local pharmacological research with the ICS		
	Work to develop how the system supports people through crises, to ensure choice and control and minimise the negative consequence of intervention		
	Develop the work of the Care Homes and Dementia team and the skills of clinical leads within Care Homes to ensure appropriate diagnosis, assessment, care planning and review for people with Dementia.		
	Learn from good practice locally around hospital discharge, to increase the number of people who have a safe discharge from hospital at the right time, to the right place, with the right level of support.		
	Explore good practice around carer support particularly access to psychological support and counselling		
	Contribute to local research and testing of assistive technology to ensure that the needs of people with dementia are represented		
	Offer equitable access to non-pharmacological interventions as per national guidance, such as cognitive stimulation therapy (CST), and ensure all memory services have access to CST by April 2024.		



	Explore the current offer in the city for non-pharmacological/psychosocial interventions such as reminiscence therapy and cognitive rehabilitation; cognitive stimulation therapy and evidence based interventions such as coaching, or occupational therapy training for carers. Consider what our 'interventions of choice' are and how we ensure easy access to these		
	Engage in the DReAMs project to understand how sleep interventions can impact upon people with dementia and their carers		
	The York IAPT service isn't able to work with people presenting with severe difficulties and cognitive functioning or impairment which would require intervention from a specialist service, but is open to people with mild to moderate impairment. The service is currently looking at guidance (alongside the MH Services for Older People Team) for clinicians for determining if IAPT is the most appropriate intervention. This is currently in draft and its impact will require monitoring		
	Work with the continence service to understand our current offer of continence aids in the city, and whether these promote dignity for people with dementia		
Workforce development	Complete exercise to understand best training standards framework for the City, and embed training within this, ensuring that there are contractual obligations to deliver a dementia specific approach		
	Work to develop training/in-reach for staff on general wards within hospital and healthcare settings		
	Monitor and review impact of new training offers/approaches		
	Ensure occupational therapists, psychologists and other allied health professionals have protected time to carry out post-diagnostic support at memory service level alongside their diagnostic responsibilities, including home visits if appropriate, in line with patient need and symptom deterioration		
	Explore whether occupational therapists in the city are trained to deliver cognitive rehabilitation and if indeed they do this.		
Measuring Impact	Work to develop a minimum data set which allows us to monitor progress in how we support people with dementia and their carers; and to consider gaps in knowledge or provision which warrant research.		
	Explore ability to extract data around the number of people with dementia who have multiple professionals involved (do people need to tell their stories multiple times? Could those professionals work better together?). International research has shown a shared care approach between different professionals within primary care improves care and outcomes.		
	Improve recording of statistics for people living with dementia (typically from primary care) according to race, religion, sexuality and gender re-assignment so we can establish the diverse needs of people with dementia in the city.		
	Improve recording (and most likely diagnostic rates) for people living in the city with a learning disability and dementia (numbers currently suggest we have 22 – 11 male/11 female)		

<p><i>Look at local data around hospital admissions for people with dementia and target community support accordingly. Evidence suggests that hospital admission of people with dementia is strongly associated with multimorbidity (having two or more health conditions), polypharmacy (being on multiple medications), lower functional ability, unintentional weight loss and falls. Urinary tract infections, pneumonia/chest infections and delirium as well as falls – common reasons for admission – are potentially preventable admissions.</i></p>		
<p>Explore data around the use of Social Prescribing by people with dementia in York. The Alzheimer's Society suggest that nationally the numbers of people with dementia who are referred to social prescribing are low.</p>		
<p>Audit health and care records to establish where support may have been suspended due to the coronavirus and seek assurance that work is underway to remedy this.</p>		
<p>Consider research into predictors of people needing care home support, to see if we can prevent, reduce or delay this. The Alzheimer's society state that the median time to someone with a dementia needing to be admitted to a care home or similar is 47 months after diagnosis. Predictors of people needing care home support more rapidly include severity of dementia, greater functional impairment, greater unmet needs in activities of daily living, severity of behavioural and psychological symptoms, fewer caregiving hours and higher caregiver stress.</p>		

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
Campaigns	Contribute to the work of the Ageing Well Partnership to promote dementia friendly services and buildings		
	Improve way finding and signage in public buildings, consider dementia friendly shopping hours, access to toilets etc.		
	Contribute to campaigns and intergenerational projects being developed through the Ageing Well Partnership		
	Ensure symbiosis between the dementia strategy delivery plan and the carers strategy delivery plan to ensure the right opportunities and support are available for carers of people living with dementia.		
	Contribute to York's inclusive transport strategy to ensure that the issue of non-visible disabilities is acknowledged and addressed		
	Consider work with licensing, around encouraging people such as taxi drivers and publicans to develop their awareness of dementia		
Info and Advice	Information, guidance and advice developed to address the different stages of the Dementia Well Pathway includes reference (e.g., to things like the Disabled Facilities Grant).		
	Consider the development of dementia champions in places like York Racial Equality Network and York LGBT forum to ensure that people with protected characteristics who access these services, have the best support to live well with dementia		
Coproduction	Consideration given to the spaces, places and people who can encourage open and ongoing conversations about creating the right City in which people with dementia and their carers can live good lives.		
Evidence based support interventions	Expolre opportunities to simplify the process for booking short-term 'as needed' respite support for carers of people living with dementia.		
	Explore the local implementation of discretion in the award of blue badges for people with dementia. Promote ease of access wherever possible to enhance quality of life ahead of loss of mobility.		

THEME	KEY ACTION	LEAD PERSON	DATE TO BE ACHIEVED BY
Workforce development	Identify and deliver appropriate workforce development around advanced care planning and end of life care, ensuring that directly delivered or commissioned services meet the National Gold Standards Framework		
Evidence based interventions	Ensure we have the appropriate support in place for families and carers for when their loved one is diagnosed as end of life		
	Consider holistic interventions for pain management in end of life care, for example https://www.alzheimers.org.uk/Care-and-cure-magazine/spring-19/namaste-care-research-update		
	Consider how we embed advanced support planning into practice with health and social care professionals (scope who we expect to do this and where advanced care plans may be stored)		
	Consider the local options around place of death and how hospice support can be utilised		
	Consider whether we have consistency of approaches to assessment and intervention in end of life care and how we may achieve this to ensure best practice across the system (e.g., Research appropriate use of tools to base clinical judgement within end-of-life care, so advance care plans can be honoured)		
Info and Advice	Alongside people with dementia, consider the information important to people at the end of life (for example setting up authorities for decision making, meeting emotional, sensory and spiritual needs, and stating preferences for last places of care) and how best to ensure people have the right information at the right time to make the right choice for them.		
Market sufficiency	Conduct a review of the capacity and access to palliative care in care home settings, and at home, and set out a framework of monitoring and review to ensure sufficiency.		





Health and Wellbeing Board

20th July 2022

Report of Tim Madgwick, Independent Chair of the York Mental Health Partnership

Citywide system mental health transformation

Summary

1. This report is to provide an update on the Connecting our City mental health transformation project, and in particular the design and prototyping of a mental health hub model for York. A presentation will be tabled at the meeting.
2. The Health and Wellbeing Board are asked to:
 - Note the content of the report
 - Support the request for staff to be released to participate within the hub prototyping process
 - Ensure appropriate representation within the hub planning and leadership groups to ensure operationalisation of the hub design
 - Notify us of any key meetings/forums where an update on this project would be helpful

Background

3. The Connecting Our City Project represents a partnership approach to achieving citywide mental health transformation. The Mental Health Partnership has led the development of the strategy and vision for this project. National mental health transformation funding has provided the opportunity for us to progress our ambitions at pace. One of the key priorities for the partnership has been the development of a community mental health hub model for York, inspired by Trieste.

4. We are delighted that additional GP access funding was identified to support the involvement of the Innovation Unit to support the design and prototyping of a hub model for York and share learning across North Yorkshire. This work is now well underway, and partners are asked to consider their individual roles in supporting this major transformation process over the coming months.

Main/Key Issues to be Considered

5. Please refer to the presentation tabled at the meeting.

Strategic/Operational Plans

6. The joint health and wellbeing strategy for 2017-22 identifies four principal themes to be addressed. One of these themes is mental health and wellbeing with the key priority for that theme being 'to get better at spotting the early signs of mental ill health and intervening early'.
7. Other aims in the joint health and wellbeing strategy in relation to mental health are:
 - Focus on recovery and rehabilitation
 - Improve services for young mothers, children and young people
 - Ensure that York becomes a Suicide Safer city
 - Ensure that York is both a mental health and dementia-friendly environment
 - Improve the services for those with learning disabilities (to be addressed in its own strategy)
8. These are expanded and explored in more detail in the Health and Wellbeing Board's all age mental health strategy 2018-2023.
9. Additionally in 2019 the Health and Wellbeing Board undertook a mid-way review of the joint health and wellbeing strategy and identified that the following priority should be their focus for mental health for the rest of the strategy's lifetime:

The board will promote awareness and understanding of the protective factors that support good mental wellbeing and ensure that compassionate, strength-based approaches in communities are developed.

Consultation

10. The vision and priorities for the connecting our city project were coproduced as part of a series of events and workshops.
11. A monthly coproduction network has been meeting for the last 18 months and continues to inform the project.
12. All workstreams include people with lived experience and carers.
13. The hub codesign team involved a significant number of people with lived experience and carers. The team have clearly outlined the need to continue this involvement as part of the ongoing governance structure of the hub.

Implications

- **Financial** There are no current financial implications. The prototyping will involve informal arrangements to 'loan' staff to the process. Additional voluntary sector provision has been funded through the community mental health transformation funding.
- **Human Resources (HR)** The prototyping will involve informal arrangements to 'loan' staff to the process. These staff will remain employed by their existing organisations. Therefore, this report does not specify impact upon Human Resources, but it is recognised that the wider ambitions of mental health transformation may require stakeholders to think about how they best use their human resource to achieve the collective goal.
- **Equalities** Inequality of access to mental health services is a priority focus of the transformation funding and we are utilising the funding to ensure appropriate focus and investment within this area.
- **Legal** There are no legal implications.
- **Crime and Disorder** There are no crime and disorder implications.

- **Information Technology (IT)** The prototyping process is likely to explore the challenges around interoperability of different systems and how we can best support interagency working.
- **Property** It is intended that the prototype hub will be based at Clarence Street. This is a council building which is already host to daytime recovery services and the Haven.

Risk Management

14. Demand for mental health services has increased dramatically. In order to be able to meet these needs and provide the right support to people at the right time, we need to transform the way that services work across the system.

Recommendations

15. Members of the Health and Wellbeing Board are asked to:
 - Note the content of this report and its ongoing support of the Mental Health Partnership
 - Support the request for staff to be released to participate within the hub prototyping process as relevant
 - Ensure appropriate representation within the hub planning and leadership groups to ensure operationalisation of the hub design
 - Notify us of any key meetings/forums where an update on this project would be helpful

Contact Details

Author:

Tim Madgwick
Independent Chair of the
Mental Health Partnership

Specialist Implications Officer(s)

Wards Affected:

All

For further information please contact the author of the report

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Health and Wellbeing Board20th July 2022**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.

Consultation

4. York Health and Care Collaborative includes representation from the Voluntary Sector, who have been engaged right from the start and throughout.

Options

5. There are no specific options for the Health and Wellbeing Board to consider.

Strategic/Operational Plans

6. 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

7. York Health and Care Collaborative priorities for 2022/2023 cover, prevention, ageing well/frailty, mental health and children and young people, all of which align with the Joint Health and Wellbeing Strategy.

Implications

8. 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

9. 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 Collaborative agreed to provide regular updates on its work and progress.

Contact Details

Author:

Dr Emma Broughton
Dr Rebecca Field

Chief Officer Responsible for the report:

Dr Emma Broughton
Chair of York Health and Care Collaborative

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 2022

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Report of York Health and Care Collaborative; Update July 2022

1. Introduction

This report provides update on the work of the York Health and Care Collaborative (YHCC); briefly outlining the scope of each priority workstream.

2. Progress on Priorities;

2.1 Prevention

The responsibility for leading health promotion and prevention activities across the city is with City of York. YHCC provides a forum to share population health intelligence across a wide ranging provider and commissioning partners including York CVS, and identify where a collaborative approach can increase the impact and effectiveness of interventions.

- a) **Smoking**; prevalence in York is below the regional and national average. However, smoking rates in those with an SMI have increased by 1% in the last year. Through speaking to people with lived experience it is clear that it is difficult to access smoking cessation as there is a perception that people are not trained to manage SMI. CYC are looking to find a provider to educate health trainers in managing SMI.

Prory Medical Group started a pilot working with a Health Trainer in primary care to offer follow up interventions after LD and SMI health checks. The success of this was discussed in YHCC and as a result, all of the Primary Care Networks across York have agreed to fund CYC health trainers in primary care.

- b) **Substance misuse**; drugs and alcohol; an update was provided to YHCC on alcohol misuse, an area where overall York performs poorly on most indicators. The community alcohol liaison officers have been running the Changing Habits programme since November 2021 and a number of people have been referred into the service.

York has commissioned a service through York Mind to work with individuals that have a dual diagnosis, one of the most vulnerable cohorts of patients, and TEWV are looking at recruiting multiple Emotional and Complex Needs Specialists to work with people that have chaotic lives and complex health needs. YHCC will discuss where it would be best for these roles to be based to have the greatest impact.

YHCC are also looking to run a future session about the impacts of drugs and alcohol on children and young people.

- c) **Weight management, obesity and diabetes;** The Healthy Weight Steering Group continues to meet and deliver work on the wider determinants of healthy weight and weight management pathways. An update from the group was provided to YHCC in June 2022. Work is underway to bring partners together to look at treatment pathways for adults and children in Tier 2. Slimming World, GLL and HENRY will continue to be commissioned to deliver services in York.

At the June meeting, it was highlighted by a representative from Primary Care that the data for Tier 3 services in York needs to be updated, this will be actioned as a result of the meeting.

2.2 Ageing Well, Frailty and Multimorbidity

a) Ageing Well and Frailty

The YHCC Frailty Steering Group continues to meet regularly, the aim of the group is to understand how to code frailty and ensure that the coding is readily accessible to all health care professionals supporting frail people. The group has achieved the following:

- Secured funding for all General Practice staff to complete training on Rockwood Frailty Scoring. All practices received a letter in May detailing how the funding can be claimed and some options for delivering the training.
- Increasing the number of people consented to the Enhanced Summary Care Record (ESCR) so that Rockwood scores can be seen by all health providers. The group are looking to trigger a letter to a patient as soon as they are assigned a Rockwood score to ask them to consent to ESCR.
- Three workshops are being scheduled to run from September to look at the services that are available for mild, moderate, and severe frailty. Partners from across York's health, care and voluntary services will be invited to attend the workshops.
- Secured funding for Ardens for this financial year to ensure a consistent approach to identifying, coding, and reporting frailty in General Practice.

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 and addressing the need to improve the physical health of people with severe mental health illness (SMI).

An update was provided by TEWV to YHCC in April 2022. TEWV are working with the Innovation Unit to look at the implementation of hub sites across the City of York. The purpose of the programme is to establish a whole community approach to delivering mental health services where people can receive support wherever they present in the system.

The ICS Digital Lead will be looking at how to introduce a single system that will allow information recorded by the hubs to be accessible in primary care.

Deprivation Workshop – In May, YHCC ran a workshop that looked at the impact of deprivation on access to services. Attendees were asked to consider 'How do people from a deprived background access a particular service, or receive care in a way that is different from the wider population?'

Minutes of the workshop:



2022 05 26 YHCC
Minutes.docx

As a result of the workshop, YHCC would like to understand from the Health and Wellbeing Board, where it thinks the gaps are in supporting deprived communities in York, to aid the group in future discussions about how YHCC can assist closing these gaps by working together.

Covid Recovery Hub – In the June meeting, the group agreed that the Covid Recovery Hub would become a steering group that reports into YHCC. The Covid hub continues to offer welfare calls to those who are at the most risk when they test positive for Covid-19, helps patients in the Long Covid Pathway, and supports the Waiting Well programme by contacting individuals on P4 (long) hospital waiting lists to offer interventions to ensure that they are ready for surgery when they are called. Patients are risk stratified based on a combination of health and social factors to make sure those that the most vulnerable are contacted first. Contacts are then made through care coordinators, social prescribers and health trainers to deliver a range of support.

Since the beginning of the pandemic, the Covid Recovery hub has been a multi-agency collaboration between Primary Care Networks, Nimbuscare, York CVS, CYC and VoY CCG. The collaboration between organisations has ensured a rapid response to the emerging needs of the population of York arising from the pandemic. As the relationships continue to thrive,

new opportunities for working together will emerge and align with the priorities of YHCC.

3. Future work and further development of York Health and Care Collaborative in 2022/2023

3.1 Diabetes Design Group

A design group of GPs with an interest in Diabetes, a specialist diabetic nurse, public health, and NHS commissioners is being established in York to clinically review diabetes services commissioned in primary care, with a view to a future service delivering improved outcomes for York residents diagnosed with diabetes. Like Frailty, the group will report as a steering group to YHCC to ensure opportunities for multi-agency collaboration and an integrated approach are maximised.

3.2 Priority Setting

Priorities for the group set in 2021/22 will continue into 2022/2023. The group awaits confirmation of any new priorities identified by the ICB and Health and Wellbeing Board from 1st July 2022.